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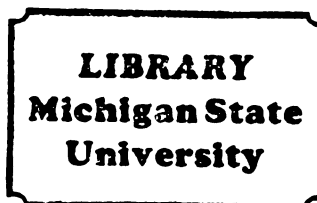
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Ph.D. degree in Anthropology

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MEDICAL COST CONTAINMENT:
THE POLICY AND PRACTICE OF DIAGNOSIS RELATED GROUPS (DRGs)

Volume I

By

Mark Edward Notman

A DISSERTATION

Submitted to
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ABSTRACT

MEDICAL COST-CONTAINMENT: THE POLICY AND PRACTICE OF DIAGNOSIS RELATED GROUPS (DRGS)

By

Mark Edward Notman

Diagnosis Related Groups (DRGs) began in 1983 as a means of reducing the federal government's costs for hospitalized Medicare patients. They set in motion a series of changes in the U.S.'s medical system which continue today. This dissertation describes their impact in a Michigan community via observations of physicians at work in three hospital settings and of patients receiving care. Governmental officials involved with medical policy, hospital administrators, physicians, and patients were also interviewed about their experiences and understandings of cost-containment.

DRGs have changed medical care in this country. There are fewer hospitals and less hospitalized care; more patients are cared for by some sort of "managed" system; and increased need for ambulatory and home care places larger burdens on informal familial networks to deliver services. Hospitals have become "smart businesses," watching their bottom line and attempting to maximize their efficiency and profits via mergers and joint operating

agreements with other institutions, computerization and standardization, managerial and department reorganizations, and increased physician monitoring. Physicians feel threatened by DRGs. They fear loss of autonomy for their profession and believe hospitals and the patients they treat are being affected negatively. Patients experiencing cost-containment point out the social and economic costs they incur related to the new system and the added burden placed on them and their social networks.

DRGs increase the rationalization and commodification of medical services. They thus highlight a number of cultural contradictions centered around independence and dependency and governmental and familial responsibility for providing services. Contradictions are also raised regarding the effects of DRGs on medicine's ineffectiveness in dealing with the existential and symbolic experiences involved in sickness and healing.

DRGs are part of larger social processes associated with dominant structures linked to capitalism, the welfare state, bureaucratization, and corporatization. As power and control are centralized in economic structures dominated by the state and the corporate class, medicine has become organized increasingly around the principles of corporate America. This limits the ability of cost-containment to alter the system radically since the groups

ving for control of medical power share the same
interests.

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This work is dedicated to my parents,
Lorraine and Edward,
my partner-in-life, Fidelia,
and our children,
Ross Taylor Herman and Vanessa Lenae.

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CHAPTER ONE

INTRODUCTION

The delivery of medical services in the United States has undergone a dramatic change during the 1980s. In an attempt to contain costs, insurers in public and private domains have altered the way they reimburse medical services. The federal government, for example, began the Diagnosis Related Group (DRG) program for all hospitalized Medicare patients in 1983. This program assigns each hospitalized Medicare patient, primarily according to his or her diagnosis, to a category (a DRG) associated with a relatively fixed level of reimbursement and an estimated average length of stay. According to the Health Care Financing Administration (HCFA), "the DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital." They "provided the first operational means of defining and measuring a hospital's case mix complexity" (Averill 1985:1).

"Case mix," as used by clinicians, describes the severity of patients' medical problems and the difficulty in treating them, their prognoses, and relative need for

intervention. Administrators (including hospital and federal officials), on the other hand, use the concept to refer to the costs incurred for treating certain types of diseases (Averill 1985:2). DRGs are a way of prospectively quantifying those expenditures and reimbursing hospitals on the basis of an average cost associated with treating patients with particular diseases. The previous system of reimbursement paid hospitals their average costs for treating patients with particular diseases plus a defined profit (the "cost-plus" method of reimbursement). DRGs were instituted to help contain rapidly escalating medical costs for Medicare patients. Soon after they began on the federal level, DRG-like reimbursement schemes spread to a number of state Medicaid programs and private insurers.

DRGs have changed (and are still changing) the milieu of medical care delivery. This dissertation examines the nature of this change and its impact on hospitals, physicians, and on elderly patients in a local community. Using an approach combining a political economy perspective with one focusing on agency or practice, it examines the implementation of cost-containment policies historically and from the multiple perspectives of those formulating and those affected by such policies. DRGs are viewed as representative (and part) of larger, more general historical shifts occurring in U.S. society including the growth and spread of the welfare state, corporatization,

bureaucratization, and increased rationalization. DRGs represent these trends in the delivery of and reimbursement for diagnostic and treatment protocols.

This dissertation's theoretical orientation and the methods used in data collection and analyses are discussed in Chapters Two and Three. Chapter Four describes and discusses DRGs as one component of a broad historical array of cost-containment measures, situating them in the context of the U.S. medical system and its expanding governmental influence. Succeeding chapters illustrate how hospitals, physicians, and elderly patients are responding to changes related to cost-containment. The final chapter provides a summary of the research findings and a discussion about the likelihood of cost-containment's success.

Throughout this dissertation, the data are organized around various themes which illuminate the goals of cost-containment (DRGs in particular) and its effects (structural, social, and normative) on the social actors involved with it. These themes highlight the ways policy makers, providers, and patients perceive and respond to cost-containment. They also highlight the contradictions that cost-containment engenders given cultural values centered around the right of access to care, independence, and familial responsibility.

This dissertation grew out of my involvement with a number of research projects examining the delivery of

medical services, especially long-term care to the elderly. In the early 1980s, there was increasing discussion among nursing home administrators, physicians, and others in the medical community of the soon to be implemented DRGs and the negative impacts they would have on medical care in general and, especially, on that delivered to the elderly. The research upon which this dissertation is based sought to uncover what these negative effects were. Findings of the study, however, paint a complex picture of the changing medical care arena in the United States during the 1980s. On the one hand, DRGs have resulted in fewer medical services being delivered in acute care settings. Whether or not this has saved money as was originally intended is arguable, but the change is positive in that it represents a shift in emphasis in our medical delivery system perhaps toward a more comprehensive, realistic system focused on the non-acute chronic care needs of our growing elderly population. DRGs may represent, as argued by Brody and Magel (1984), the start of a comprehensive system of "short term long-term care," centered around the home and family and organized in conjunction with regionally coordinated health delivery systems providing full-spectrum social and medical services emphasizing quality of life (and, by extension, humane, non-technicized death whenever possible). On the other hand, DRGs continue the rationalization of medical care, resulting in increased

bureaucratization and corporatization among the deliverers of medical services. Furthermore, they help support and perpetuate the commodification or reification of medicine as a social enterprise. By reducing individual patients and their illness experiences to discrete categories, DRGs reinforce the "thingification" of sickness experience, further rationalizing the commodity production of medical care (Taussig 1980).

Hospitals have had to respond vigorously to the new medical care environment or face going out of business. They have consolidated their operations and cut out waste. They now monitor costs and the services, physicians, and staff who contribute to them. They also market their services and cooperate with other health care deliverers to maximize profitability. These cost-saving measures have been taken while attempting not to sacrifice the quality of care delivered.

Physicians are scrutinized like never before. Their decisions on how, when, and where to treat patients are increasingly influenced by non-medical criteria linked to financial and regulatory imperatives. Physicians display accommodation to DRGs in a way which minimizes the weakening of their professional status in the face of increasing governmental influence and compartmentalization of medical decision making. Though physicians have been affected to a lesser degree than hospitals, changes

underway and discussed in this dissertation portend a future of increasing governmental influences on medical practice at the most basic level--that of the doctor-patient relationship.

Patients are affected by cost-containment as recipients of medical care. Where they receive treatment and what types of treatment they get are increasingly determined by factors outside the realm of the "traditional" medical environment. These changes are affecting the delivery of care to elderly patients and, increasingly, patients of all ages placing new burdens on informal social networks to provide care. They thus help undermine basic values and norms associated with the delivery of medical care in this country. It is argued that DRGs, as they commodify and reduce sickness to a discrete diagnostic category, bring to the fore the contradiction inherent in biomedicine's inability to deal with the social, symbolic, and existential aspects of illness.

In my view, the bureaucratic trend studied here reflects cultural assumptions that everything, including medical care, can be made better if it is more uniform, more centralized, more predictable, and more "scientific." This perspective does not, however, necessarily adequately address the social reality of illness, health-seeking behavior, and healing or curative services. Though DRGs

and the trends to which they are linked set in motion a series of processes and structural changes that may, indeed, benefit the ill (e.g., by restricting access to hospitals unless absolutely necessary [Cf. Illich 1976]), the motives behind them are primarily economic in nature. They have little to do with providing alternatives to the institutions and services they obliterate or change. They also have relatively little to do with the day-to-day suffering of a chronically ill elderly patient with no relatives, little money, and a serious need for medical and social services. The support required represents what many believe is their due as a citizen of this country. Though the belief in "progress" underlies DRGs, its notions of increased efficiency and quality of care lag behind the realities facing sick patients. Each brings to the hospital setting a unique set of individual and social circumstances related to their illness which are complicated, confusing, painful, expensive, and of uncertain outcome.

DRGs are viewed as part of larger, more general historical trends, including the growth and spread of industrial capitalism and the welfare state. These trends have resulted in increased corporatization, bureaucratization, and rationalization of many spheres of modern life, including the delivery of medical services and, as epitomized by DRGs, in the reimbursement of

diagnostic and treatment protocols. These changes, with their concomitant systemic and social perturbations, represent an ideal focus for social inquiry. They allow an examination of the linkages between individual behaviors and structural changes, with each shaping and determining the other.

DRGs represent the realities inherent in a capitalist industrial society espousing equality and equitability while being governed by the contrary values of the dominant capitalist class. Social policy, including planning centered around the delivery of medical services, has generally consisted of a variety of piecemeal approaches, like DRGs, which symbolically address symptoms but not the disease. These approaches help support a medical and social system capable of delivering adequate (if not equitable) care for many diseases but does relatively little for *illnesses* as experienced by individuals, their close family, and friends. Though helping to reorganize medical care, DRGs are incapable of adequately addressing the systemic restructuring that would be necessary to achieve the espoused goals of equitable and quality medical care for all Americans.

CHAPTER 2

THEORETICAL ORIENTATION

The goal of this study is to document the effects of DRGs and other cost-containment strategies on the medical care system and those involved in it, including elderly patients, providers, and policy personnel. Combining a political economy orientation with one focusing on agency (Ortner 1984:141-160), the medical care system, as any social system, can be viewed as a structure linking macro-(structural or systemic) and micro-level (social) processes (DeWalt and Pelto 1985; Doyal and Pennell 1981; Habermas 1987). Groups associated with state and corporate interests are influential in creating and issuing policy goals and directives associated with the financing and delivery of medical services. These initiatives affect the various providers who carry out policy directives and deliver health care (e.g., physicians, nurses, hospitals, clinics), in turn affecting the recipients of care. Legislation and various regulatory statutes create a structure--a set of generative rules and resources (Habermas 1987)--which impinge on those providing and receiving medical services.

Yet policy gets reproduced as practice and as a strategy cutting across all medical services only when groups of actors, situated in the social structure and interacting with one another via purposeful communication entailing systems of meaning, norms, and power, deliver and receive medical services. These categories of people consist of social agents who, in their day-to-day lives involving (micro) interactions with others, create and recreate the social structure (system) in which their actions occur (Giddens 1976; Habermas 1981, 1987). Giddens (1979:53-85) refers to this as "structuration" and argues that it is made possible by the "duality of structure." He writes: "social structures are both constituted by human agency, and yet at the same time are the very *medium* of this constitution" (Giddens 1976:121, emphasis in original).

This dissertation examines the structures of medical cost-containment and the ways they affect social actors delivering and receiving medical services. It also describes how social actors give life to these structures, make them real, and, in essence, define what cost-containment is by delivering and receiving medical services in an era of cost constraints. In examining the structural components of cost-containment, this dissertation focuses on the stated and unstated goals of cost-containment

efforts and describes how each group is situated in the system and involved with cost-containment.

Cost-containment achieves different meanings among different social groups. The social actors creating, implementing, and receiving medical policy perceive and are affected differently by these directives based on their relative structural positions, associated asymmetries of power, and divergent and conflicting values, interpretations, and interests (Giddens 1976:21). Each group has its own unique conflicts, goals, and constraints which are constantly being shaped through ongoing intra- and inter-level interactions. Nonetheless, the state is very influential in defining the parameters within which social interaction occurs, and its goals and objectives impinge on the everyday activities of its citizens--including the delivery of medical care.

At the social (micro) level of analysis the goal is to come to an understanding about "the natural facts of life" of cost-containment for providers, policy makers, and elderly patients. This entails examining the "mutual knowledge" or "common assumptions" each group has related to cost-containment within the lifeworld (Garfinkel 1967; Habermas 1981, 1987; Schutz 1967, 1982). To determine the meanings and effects cost-containment has among these groups, attention is given to the discussion of medical care in the "voice of the lifeworld" (patients), the "voice

of medicine" (physicians) (Mishler 1984) and the "voices" of administrators and policy personnel.

Discussing the concept of "voices," Mishler (1984) points out the importance the study of discourse has in coming to an understanding regarding "lifeworld," as well as reactions to "the facts, norms or experiences" associated with everyday life. Mishler defines the voice of the lifeworld as "the natural attitude of everyday life." The voice of medicine, on the other hand, represents "the technical scientific assumptions of medicine" (Mishler 1984:14).

The concept of "lifeworld" has a long history within the social sciences. In general it refers to the set of common, unquestioned, unarticulated assumptions concerning the reality of human existence. The lifeworld is necessary for humans, as social beings, to go about the business of daily life as members of society and a culture. Habermas (1987:119) defines lifeworld "as the horizon within which communicative actions are 'always already' moving." Similarly, Schutz writes about "life forms" ("a stance toward the world which I-consciousness assumes") (1982:52-53), "the taken-for-granted," and the "stock of knowledge at hand."

The taken-for-granted . . . is always that particular level of experience which presents itself as not in need of further analysis. (Schutz 1967:74)

The "stock of knowledge at hand" refers to

the store of already constituted objectives of experience in the actual Here and Now, in other words, to the passive "possession" of experiences, to the exclusion of their reconstitution. (Schutz 1967:78)

This dissertation demonstrates that "the stock of knowledge at hand," "the taken-for-granted", the "voices" and "attitudes" of the social beings involved with the delivery of medical services are being affected by cost-containment measures. The taken-for-granted nature of delivering and receiving medical care is being altered by attempts to cut costs. These alterations change the "common assumptions" and "mutual knowledge" held by providers and patients regarding how, when, and where medical care is delivered. They do relatively nothing, however, to alter the privileged structural position of those controlling medical services or the vulnerability and existential crises faced by sick individuals.

DRGs are related to larger systemic movements associated with the general spread of "modernization" and the capitalist welfare state. Habermas (1987:332-373) discusses this movement at length by examining the ways in which the state "colonizes" the lifeworld of its citizens:

the subsystem of the economy and state become more and more complex as a consequence of capitalist growth, and penetrate ever deeper into the symbolic reproduction of the lifeworld. (Habermas 1987:367)

Cost-containment represents one of the ways in which the state is successfully penetrating the everyday worlds of patients and providers. It does this by altering the assumptions of what "good" medical care is and how this care is delivered, thus subverting and undercutting long held assumptions about the delivery of medical services in this country. Habermas argues that, through colonization of the lifeworld,

areas of life that are functionally dependent on social integration through values, norms, and consensus formation . . . [fall] prey to the systemic imperatives of economic and administrative subsystems growing with dynamics of their own, and [are] converted over, through the steering medium of law, to a principle of sociation that is, for them, dysfunctional. (Habermas 1987:372-373)

In the case of medical practice and cost-containment, this process occurs via an ever increasing role by the state and its capitalist institutions in shaping the delivery of medical services. Long held values and norms, in part shaped by this increasing state-level influence, are being subverted and altered as new principles enter the medical decision making process. This affects both practitioners and patients. Whether this process will ultimately prove to be dysfunctional, as Habermas asserts, or if the goals of cost-containment can be met are open questions.

It is possible that the effects of DRGs on medical practice may have no long lasting negative outcomes--for

example, increased pathology or morbidity related to the new organization of the medical system. It is clear, however, that increased state influence is having profound affects on the delivery and receipt of medical services. These changes are noticeable to the participants, and this dissertation attempts to delineate their concerns and responses to these changes. In so doing, an analysis is achieved which sheds light on the social production and reproduction of cost-containment as a social phenomenon.

CHAPTER 3

METHODS

This study draws upon over seven years of ethnographic fieldwork in the U.S. medical system. For the groups under study--policy makers, hospital administrators, physicians, and elderly patients--data collection and analysis focused on members' involvement with, perceptions of, and responses to cost-containment. One goal was to supply a "thick description" (Geertz 1973) of the "social life" of cost-containment as experienced by those involved with it, a contextualized ethnography of behaviors and attitudes associated with cost-containment (Marcus and Fischer 1986).

The "social life" of cost-containment is seen as "a set of *reproduced practices*" and studied (1) as a series of *acts*, "brought off" by various social actors; (2) as forms of *interaction*, involving the communication of meaning and power; and (3) as *structures* comprised of "collectivities" or "social communities" (i.e., policy makers, providers, and patients) (Giddens 1976:104; emphasis in original). Cost-containment as "reproduced practices" and "interactions" relates to the everyday existence of social

actors. It, like all social practices, is based, according to Habermas (1987:117), on "the integration of an action system . . . established by a normatively secured or communicatively achieved consensus" and representing social integration. Observations and interviews were used at the micro-level to explicate the social integration of cost-containment, the meanings it obtains and its effects on behavior.

At the structural level, cost-containment pertains to system integration, that is, "the systemic interconnection of functionally specified domains of action" (Habermas 1987:115). Domains of action (i.e., structures) related to cost-containment alter the reproduced practices and interactions of hospitals, physicians, and patients via a restructuring of the social environment involved with the delivery and receipt of medical care. Analyses of policy directives and hospital responses to cost-containment uncover the ways in which cost-containment structures reach "through and beyond [the] action orientations" (Habermas 1987:115) of providers and patients, imposing their own agenda upon the behaviors of physicians and patients.

Physicians and patients, however, are not merely passive recipients of these changes in medical policy. As discussed above, the symbolic constructs and behaviors of social actors related to cost-containment feed into the structures themselves, supporting and justifying (i.e.,

legitimizing) them and, in fact, producing or creating them. Thus, social inquiry must focus on both levels. As McCarthy (Habermas 1981:xxvi) points out:

The theory of society requires a combination of the two--of the internalist perspective of the participant with the externalist perspective of the observer, of hermeneutic and structuralist analysis with system-theoretic and functionalist analysis, of the study of social integration with the study of system integration.

This conceptualization is similar to Geertz's hermeneutic circle method:

Hopping back and forth between the whole conceived through the parts which actualize it and the parts conceived through the whole which motivates them, we seek to turn them, by a sort of intellectual perpetual motion, into explications of one another. (Geertz 1977:491)

This approach, argue Marcus and Fischer (1986), offers the advantage of supplying richly detailed ethnographic pictures of various social worlds, via "a jeweler's-eye view of the world," and analysis of the larger historical and structural contexts which help shape these microcosms of social action. Giddens (1977:166) points out:

Lay beliefs are not merely *descriptive* of the social world, but are the very basis of the *constitution* of that world, as the organized product of human acts. . . . The social world . . . is constituted and reproduced through and in human action; the concepts of "common sense," and the everyday language in which they are expressed are drawn upon by lay actors to "make social life happen." (Emphasis in original)

To achieve this meshing of approaches or perspectives, a number of methods were used in this study.

- Structured, open-ended interviews with policy makers, hospital administrators, physicians, and elderly patients (see Appendix A).
- Focused observations of physicians providing hospitalized care.
- Focused observations at policy hearings, professional conferences and symposia related to the public debate on cost-containment.
- Content analyses of documentary material.
- Participant observation of a physician residency program.
- Quantitative analyses of patient discharge data.
- Data obtained from a study of proxy medical decision making.

The goal was to uncover the groups' "practical consciousness" (i.e., "tacit stocks of knowledge which actors draw upon in the constitution of social activity") and "discursive consciousness" (i.e., "knowledge which actors are able to express on the level of discourse") pertaining to cost-containment (Giddens 1979:5). I now describe the nature of each research focus used in this study.

Cost-Containment Policy and Policy Makers

Analysis of DRG and other cost-containment legislation gleaned from legislative reports, various documents,

popular and professional media, and interviews with key policy personnel provide a picture of the structural environment shaping the delivery of medical services. Content analyses (Namenwirth and Weber 1987; Stone et al. 1966) of written documents (DRG-related legislation, editorials and articles in professional journals and lay publications, hospital by-laws, policy statements, and advertising and marketing efforts) uncover the legal realities of DRGs, various groups' public orientations to cost containment, and the many sources of information on cost-containment issues that the research subjects come in contact with.

These various documents ("outputs of collective processes") provide a portrait of the "deep structure" of cost-containment (Namenwirth and Weber 1987:12,16) and a picture of the shared "mutual knowledge" (Garfinkel 1967) of the various groups. They provide a general, though abstract, picture of the structural environment (system) of cost-containment and a context for observed behaviors and interview responses. As such, they serve as a background for comparisons with the observational data of physicians at work and interviews with policy makers, providers, and patients.

Structured interviews with key policy personnel--state-level representatives of the Health Care Financing Administration (HCFA), legislators and their aides, seniors

advocates, and Medicaid personnel--supplied information on cost-containment efforts as well as group perceptions of its effects on providers and patients. Individuals interviewed were chosen based on data gathered during the first three years of research. They represent those actively, aggressively, and intimately involved with the creation, implementation, or monitoring of various cost-containment strategies (see Table 1 and Appendix A).

Interviews lasted, on average, an hour and a half, and were conducted as "interactional events" rather than merely question and answer exercises (Jordan and Suchman 1987; Mishler 1986). The object was to let the subjects define, to a large extent, their meaningful categories relative to cost-containment and to discuss them as they saw fit. Most of the subjects interviewed found it easy to talk at great length about DRGs. Many began talking immediately after hearing the topic of the study, describing their experiences with DRGs and what they saw as their most important implications. I asked clarifying questions and served as a guide, when needed, helping to keep the discussion centered on cost-containment. All interviews were audiorecorded, transcribed verbatim, and entered into a computer database.

Table 1: Policy Interviews by Date

Date	Title
9/26/86	Committee Member, Health Care Cost Containment Study, League of Women Voters
10/29/86	Consultant, U.S. Senate committees dealing with health care cost-containment
10/30/87	Director, Area Agency on Aging
10/30/87	Seniors Advocate and Chair, Legislative Committee (state-level gerontological society)
11/20/87	Program Director, Offices of Services for the Aging
6/2/88	Regional Manager, state-level Peer Review Organization
6/2/88	Chief Operating Officer, state-level Peer Review Organization
6/2/88	Assistant Director of Review, state-level Peer Review Organization
7/20/88	Legislative Aide to State Representative
8/10/88	Health Policy Specialist to State Senator
8/19/88	Director of Health Services Review, Medicaid
8/19/88	Director of Program Policy, Medicaid
9/27/88	State Senator

Another source of data regarding policy is participant observation over the past seven years in the medical community. During this time I have worked in a number of research and administrative capacities in six university departments involved with medical care. These experiences provided the opportunity to attend and participate in many professional fora related to medical issues, including cost-containment. They also supply a broad view of the tenor of informal discourse and action surrounding cost-containment efforts via exposure to a myriad of unsolicited comments and actions occurring "naturally" (i.e., unprovoked by the researcher) in time and space. As such, they play an important role in helping situate the formal discourse obtained during interviews and observations. They provide a context for understanding cost-containment as a mundane event in the procession of events naturally occurring in a day rather than something "focused-on" by a researcher eager to know "all about it."

Hospitals

Twenty-five structured, open-ended ethnographic interviews were carried out with eighteen hospital administrators to determine the approaches to cost-containment taken by hospitals and the individuals' involvement with these policies. These interviews also served to determine administrators' perceptions of the

effects of cost-containment on the delivery of medical care, especially for physicians and elderly patients. Those interviewed were identified while carrying out observations of physicians at work as key players in the implementation and monitoring of cost-containment efforts in each of the hospitals. Interviews were carried out with vice presidents, directors of medical records, a chief of staff, department chairpersons, directors of utilization review, controllers, DRG coordinators, social workers, discharge planners, and directors of finance and medical education of three hospitals located in a mid-western community of about 500,000 people (Table 2). Data were also gathered more informally from the chair of the general practice department and a past chief-of-staff of a fourth hospital in the study community.

The four hospitals in the study community are affiliated with a nearby university's medical school and involved with teaching medical students and residents in a variety of settings. They are a subset of seven hospitals existing within a 50-mile radius. Three of the four local hospitals were chosen for in-depth study because of their willingness to participate in the study and my familiarity with them from previous research endeavors.

Table 2: Hospital Administrators Interviewed by Site and Date

Position	Hospital A	Hospital B	Hospital C
Director, Utilization Review	8/28/84 9/9/84 1/18/85	1/12/88	1/15/88
Utilization Review Staff	1/18/85	--	--
Controller/ DRG Coordinator	--	--	6/13/88
VP, of Finance	12/19/85 6/6/88	--	--
VP, Operations	--	--	4/19/88
Director, Medical Ed.	12/12/84 4/21/87	--	7/7/87
Director, Medical Records	5/13/85 ¹	--	6/18/87 5/24/88
Director, Ambulatory Services	--	2/6/87 3/3/87	--
Dir., Budget, Audits & Cost- Accounting	--	5/20/88	--
Director, Information Systems	--	--	7/6/88
Clinical Nurse Specialist	12/13/84 ²	2/5/87 ³	--
Discharge Planner	²	2/5/87 ³ 1/14/88 ⁵	11/10/87 ⁴
Chief of Staff	--	--	⁶

1. Interviewed by member of pilot study group.
2. Department of Pediatrics; plus numerous informal interviews while conducting observations, Sept. 1984-Jan. 1985.
3. Geriatric Assessment Unit.
4. Department of Nephrology.
5. Department of Medicine.
6. This physician was interviewed six times during the months of July and November 1987 during periods of observation while he was attending physician on a medicine service and once at a meeting outside the hospital.

Hospital A is a 250-bed county hospital serving as a regional referral center for two types of specialized surgery and a training site for over ten categories of allied health personnel. It specializes in the treatment of lung disorders, cardiology, orthopedics, and the treatment of various cancers. Hospital B is a 200-bed primary care hospital run by a religious organization and specializing in geriatric care and cancer and substance abuse treatment. Hospital C is a 502-bed private tertiary hospital. It serves as the regional referral center for burn patients, pediatric intensive care, and kidney dialysis.

A fourth hospital in the study area supplied data relative to cost-containment via its links to a family medicine residency program in which I have worked since mid-1985. Most of the clinical faculty involved with the residency and all the residents work at this fourth hospital (and others in the area). Participant observation carried out while working as the residency program's coordinator/evaluator allowed for a number of informal interviews with physicians (including the past chief-of-staff and two department chairpersons), as well as access to memoranda concerning the area hospitals' approaches to cost-containment and their correspondence with a number of provider groups.

Physicians

Fifty-nine visits were made to the three primary study hospitals between July 1984 and November 1987 to observe the delivery of care. These observations allowed study of the same physicians in multiple settings over time as well as exposure to new providers and types of patients. Table 3 outlines the services visited and the periods spent at each site making structured observations.

Research in Hospital A focused on the teaching services in the internal medicine and pediatrics programs. The first period of research, carried out during the last half of 1984 and early 1985, was part of a multidisciplinary pilot project aimed at examining the effects Medicare and Medicaid DRGs were having on physicians and residency training (Notman et al. 1987). This study period occurred six months after Medicare DRGs began and while Medicaid DRGs went into effect. Three internal medicine services were observed: two general internal medicine services--one run by physicians in private practice and the other by university-based physicians--and a pulmonary service staffed by private and university-based physicians. These services frequently had other personnel such as doctors of pharmacy, social workers, psychiatric residents, medical students, and, occasionally, physician assistants who attended rounds and interacted on a daily basis with the physician providers. From February 1987 through May

1987, another six visits were made to the university-based medicine service.

Table 3: Number of Hospital Research Site Observations by Site and Date

Hospital	Service	No. of Visits	Dates
A	Medicine Teaching Services	11	7/18/84-9/30/84
		6	2/18/87-5/28/87
	Pediatrics	15	9/27/84-1/22/85
B	Medicine Teaching Service	15	3/16/87-4/29/87
	Geriatric Assessment Center	7	2/5/87-3/12/87
C	Medicine and Nephrology Services	5	7/14/87-11/12/87

Research began on Hospital A's pediatrics ward in October 1984, when prospective payment for Medicaid cases began, and lasted through mid-January 1985. The personnel on these services included a supervising attending physician, one to three residents, medical students, and ancillary staff such as pharmacists, social workers, and nurse clinicians.

Internal medicine teaching services were observed in both Hospital B and Hospital C during 1987. One is a general medicine service and one combines treatment of general internal medicine patients with those needing

specialized care in nephrology. On each service an attending physician supervises one or more residents. Private physicians staff one service. The other is staffed by university-based physicians.

Observations of case conferences, psychiatric evaluations, social work consults, and family conferences were made in Hospital B's Geriatric Assessment Center (GAC) over five weeks. The GAC is an outpatient department administered jointly by the local university and the hospital. The staff consists of geriatricians, a geriatric psychiatrist, clinical nurse specialists, and social workers. Geriatric Fellows, residents, and medical students are also present. Other specialists (e.g., occupational therapists and dieticians) are used as needed. The GAC's goals are to promote maximum functioning and independence for patients and prevent inappropriate nursing home placement. About three patients a week are seen and provided a comprehensive, multi-disciplinary evaluations of their needs. Services include a home visit made by a social worker and a gerontological nurse specialist, a comprehensive medical and (if needed) psychiatric exam, a social work consultation, and a family conference with recommendations and plans for follow-up.

The GAC represents the state of the art in the assessment of elderly patient's medical care needs and in attempts to muster both medical and social resources to

keep patients functioning as long as possible outside of institutional settings. It is, therefore, not extremely cost-efficient (at least in the short term and as viewed by hospital administrators). Because of this, it serves as a good basis of comparison with acute geriatric hospital care where many efforts are employed to curtail costs.

Focused observations (Spradley 1980:100-11) and intensive study (Colson 1979 [1954]) of physicians providing care were undertaken with the goal of sampling the social reality (Hunt 1985:98-154) of DRGs and cost-containment. The extended-case method and situational analysis (Van Velsen 1979 [1967]) were used in observing physicians during the everyday delivery of care to document changes in "clinical reality" (Kleinman 1980) and medical practice occurring as a result of cost-containment. I was interested in how cost-containment affects what is considered clinically relevant evidence and the organization and interpretation of this evidence to rationalize, justify, and deliver specific treatment approaches (Kleinman 1980:110).

In the hospitals, observations focused on morning report, physician work rounds, and teaching rounds. At morning report physicians review the condition and care of the service's patients (including any admissions from the previous 24 hours). During work rounds they examine patients at bedside and write progress notes and orders.

At teaching rounds an attending physician or senior resident discusses issues centering around patient care with junior residents and medical students. Noon conferences, primary care meetings, grand rounds, subspecialty rounds, pediatric psychosocial rounds, and various other didactic events were also observed. Observations centered on documenting physicians' discussions of costs, cost-containment measures, and decisions regarding the admission, discharge, and treatment of patients. All statements and conjectures about cost-containment were noted in field notes. Over 200 case discussions were documented.

These observations were useful in examining the effects of cost-containment on Kleinman's "core clinical functions." These functions include (1) the general criteria which guide the health care seeking process and the existing treatment approaches; (2) the management of illness episodes; (3) healing activities (e.g., use of drugs, surgery, home care); and (4) the management of therapeutic outcomes such as cures, treatment failures, and recurrence (Kleinman 1980:71-72). One hypothesis was that cost-containment increases system rigidity and inflexibility by making professional medical practice increasingly standardized and rational (Mechanic 1968a:170).

Both formal (structured, open-ended) and informal ("on the spot") interactional ethnographic interviews were carried out with physicians to gain an understanding of their behaviors and perceptions relative to cost-containment. Formal interviews grew out of and fed upon the observations made of physicians at work. In all, 71 physicians were observed practicing medicine during the course of the study, 47 of them intensively (i.e., for more than five hours). Focused interviews concerning DRGs were conducted with 57 of the physicians who were observed at work (see Appendix A).

Data relative to physicians were also gleaned from articles dealing with cost-containment in leading professional journals and the popular media. These data illustrate cost-containment discussions on a public, formal level. They are especially useful in helping delineate formal statements made by professional provider groups regarding perspectives on cost-containment. Additional data were collected from the files of one hospital's medicine department chairman, another's chief-of-staff, and a senior resident made copies of all cost-containment literature received in the mail during her month on service in 1984.

Patients and Their Family Caregivers

Observations were made of over 200 patients receiving care. In-depth interviews were carried out with five elderly patients and four family caregivers to examine their perceptions of the care they received and how they saw it being affected by cost-containment. These interviews were conducted with patients recruited from all three hospitals between August and December 1987. A larger number of interviews were originally planned but a minority of the patients observed in the hospital were over 65 and many were too sick to participate. Many were also hospitalized for relatively long periods of time. Though these conditions decreased the available pool of potential participants, they allowed for multiple observations over time on most of the patients observed receiving care. Moreover, many patients were evidently not affected by cost-containment measures as judged by their satisfaction with the care received and their statements denying any knowledge of or experience with cost-containment. Because of these restrictions in access to patients who had anything to say regarding cost-containment, it was decided early in the study to focus on patients and their caregivers experiencing difficulty in receiving care and, especially, those familiar with cost-containment from first-hand experience.

Focused interviews were conducted with all identified elderly patients receiving care and experiencing difficulties because of cost-containment. Interviews were also conducted with two family caregivers (of two separate patients) who have extensive experience with the medical care system and cost-containment. One went to the highest level possible in fighting a Medicare denial of payment and has testified at local and national legislative hearings on cost-containment. The other has cared for his chronically ill wife at home for a number of years. He is active in lobbying his congressmen regarding increasing medical benefits and financial support for patients and those providing home-based care. Both have also been patients at one time or another and bring their own experiences in receiving care to bear on their complaints regarding cost-containment's negative effects on them as caregivers of others.

Interactive interviews with patients and their family caregivers, led by the use of an open-ended interview guide (Appendix A), focused on experiences in the medical system and perceptions regarding cost-containment. All interviews were tape recorded and the tapes transcribed verbatim for analysis. Interviews lasted, on average, one and a half hours.

To complement observational and interview data and to assess the impact of DRGs on Medicare patients, statistical

data were gathered in 1984 by two members of the pilot study team to trace changes in patients' bills and lengths of stay associated with the implementation of prospective reimbursement. These quantitative data served as an external check on the accuracy of claims by physicians and residents about the effects of DRG reimbursement on medical practice.

Abstracts of discharge records were collected from one study hospital for patients of the internal medicine teaching service during February, March, and April 1983 and for the same three months in 1984 to compare lengths of stay and charges for Medicare and non-Medicare patients before and after DRGs. Each discharge abstract listed length of stay, charges, DRG classification, and source of payment. Analysis of variance assessed the effects of year of discharge (1983, 1984) and source of payment (Medicare, non-Medicare) on patients' lengths of stay and hospital bills. The analyses were repeated after the outcome variables were normalized by dividing, as appropriate, by the mean length of stay or the cost index assigned by the Health Care Financing Administration (HCFA) to each patient's DRG (see Notman et al. 1987). In general, these findings indicate that Medicare patients had significantly shorter lengths of stays than non-Medicare patients less than one year after DRGs began.

Another source of data relevant to cost-containment's affects on patients and their family caregivers is the author's involvement, over a five year period, with a number of research projects studying various aspects of the medical system and issues related to the elderly. Notably, a study examining proxy medical decision making for the incompetent elderly provides data dealing with the perceptions of the elderly, their families and friends, and physician providers regarding the role of costs in a hypothetical medical situation.

Interviews conducted for the Proxy Decision Making Study (Tomlinson et al. 1990) were carried out between January 1986 and March 1987. They were part of a study aimed at understanding how well potential proxies (including family, friends, and physicians) could make medical treatment decisions for incompetent elderly persons. Elderly people in the community, in seniors housing, and in nursing homes were presented with three medical scenarios, each depicting a stark treatment choice--basically life or death. Respondents were then asked to imagine themselves in such situations, and to state whether they would or would not choose treatment. Their main reason for their treatment choice was elicited with an open-ended question. Elderly subjects also rated and ranked seven "Reason Statements" (supplied by the researcher) relative to their importance in guiding their

treatment choice. One of the scenarios explicitly asked respondents to consider cost considerations in their decision (see Appendix B, Scenario 3).

"Related Subjects"--potential proxy decision makers for the elderly--were also interviewed. These included family members, friends, and physician caregivers named by the primary elderly subjects. "Related Subjects" were presented with the same three scenarios presented earlier to the Elderly Subjects and asked to imagine their family member, friend, or patient in the same sets of circumstances and to decide whether or not treatment should be given. Their primary reasons for their treatment decisions were elicited and they also rated and ranked the supplied "Reason Statements."

These interviews supplied two data sets used in this dissertation. One set includes the open-ended primary reason responses (for or against treatment) obtained from all the people originally interviewed for the study. These include 486 responses from 45 elderly subjects, 61 family members, 29 friends, and 27 physicians and other caregivers for all three scenarios.

The second data set comprises treatment decisions, primary reasons for treatment decisions, and the ratings and rankings of supplied "Reason Statements" for the scenario forcing subjects to explicitly consider treatment costs (Appendix B, Scenario 3). Data were obtained from 43

elderly subjects, 95 "Related Subjects" (family members, friends, and "others"), and 20 physicians. Almost half of the elderly interviews were done by myself, as were half of the physician interviews, a third of the family interviews, and a third of those with friends (Table 4). All interviews were audiorecorded, transcribed, and entered into a computer database.

Table 4: Subjects Interviewed and Taped by Notman, Proxy Decision Making Study, June 1986-January 1987

<u>Category</u>	<u>No. Interviewed</u>	<u>Percent of Total Subjects (Total No.)</u>
Elderly	20	.47 (43)
-Nursing Home	(7)	
-Supervised Seniors Housing	(9)	
-Independent	(4)	
Family	17 ¹	.35 (49)
Friends	10 ²	.34 (29)
Physicians	10 ³	.50 (20)
(TOTAL = 57)		

-
1. Includes spouses, siblings, and children of 11 primary elderly subjects.
 2. Includes friends of 6 primary elderly subjects.
 3. Includes physicians of 9 primary elderly subjects.

These data shed light on the perceptions elderly persons, their physicians, and potential proxy decision makers have regarding the costs of medical care and how

cost considerations may enter into their medical decision making. They supply part of the context of cost-containment, representing how people experience and perceive cost-containment measures. They also shed light on the existential condition of the subjects relative to the role costs play--or should play--in determining the delivery and receipt of medical services.

CHAPTER 4

SITUATING DRGs IN THE CONTEXT OF COST-CONTAINMENT AND THE DELIVERY OF MEDICAL SERVICES TO THE ELDERLY

The attack on medical costs today occurs on many fronts and in many guises. DRGs are merely one form of cost-containment, part of a series of fundamental changes in the Social Security Act enacted by the federal government in the 1980s. To situate DRGs into their larger historical context, a brief history of U.S. governmental involvement in medical care for the elderly is presented below.

Though the federal and state governments have been involved in medical policy since the earliest colonial days (Quadagno 1986), over time this role has changed dramatically, both quantitatively and qualitatively. The state's involvement in the delivery of medical services--especially financially--has increased greatly. Correspondingly, there has been an increase in access to medical care (especially for the elderly and poor) as well as a steady expansion of services over time. The government has also, however, continuously worked to minimize its role by fostering, as much as possible, the

financing of medical care by the "private sector" (i.e., business and individuals) and state governments. Along with these efforts, there have been continued--and now escalating--efforts at containing costs and limiting services. DRGs represent a major effort to control medical costs via the commodification and rationalization of medical care. They help increase the standardization, bureaucratization, and corporatization of the medical care system and bring to the fore a major contradiction regarding medical services in the U.S.: the attempt to balance deep-seated cultural values and norms associated with universal access to good medical care and the economic reality of our capitalist system which must attempt to save money by limiting services without appearing to sacrifice quality.

History of Health Plans and Medical Care for the Elderly

Support for medical care and other services for the aged and needy has a long history in the United States, buttressed by Elizabethan values of providing for those in need (Quadagno 1986). As early as 1647 colonial legislatures were announcing poor laws stressing public responsibility for the needs of the elderly. These laws did not address medical services but were supported by others requiring recipients to be residents of the

community and mandating local and familial responsibility.

As Quadagno (1986:131) points out:

In these early years in the colonial period, administrators of relief to the needy were neighbors in small communities, and the concept of family governance reigned, as seen by the frequency with which boarding was used as a means for relieving the aged.

The federal government voiced support for the needy but had little actual responsibility in terms of delivering services.

Regulations minimizing state involvement operated until the late 1700s when colonial wars and the spread of capitalism created growing numbers of displaced people. Increased geographical mobility, concomitant familial dispersal, and a general increase in the number of individuals without families in any community (i.e., strangers) forced the state to increase its role in caring for the needy. No longer could the family or local community be expected to provide needed care (Quadagno 1986:132-33).

With this relative breakdown in community and influx of a variety of needy people into urban areas the elderly became merely one group among many vying for the generosity of various independent charitable organizations and state institutions (Quadagno 1986:136-7). In response, the state fostered the establishment of voluntary organizations and almshouses to supply necessary custodial care and other

services for the needy. In 1798 the federal government, recognizing the need for state-sponsored medical care and foreshadowing what would blossom in the Twentieth Century, entered the medical insurance business with the establishment of a governmental medical-insurance program for the merchant marines (Congressional Quarterly 1983:79).

During the 1800s, the state's role in social welfare continued to increase so that, by 1893, 41 percent of the federal budget went for the Civil War pension system, set up in 1862. This system represented the government's attempt to provide for the needs of the "respectable aged." Those deemed "unrespectable" were supported by a parallel, publicly funded program providing a "relief system of meager benefits and almshouses" (Quadagno 1986:138). Thus, by 1900 a two-tiered program was established and fostered, separating society into two groups with different social and medical resources.

During the first 30 years of the Twentieth Century, the federal government instituted a number of measures aimed at forcing states and private business to shoulder more of the welfare burden. Counties were pushed to provide foster care for the needy and pension laws became mandatory (even though compliance was tough to ensure and spotty at best). Despite these measures, it soon became apparent that more needed to be done. Large segments of the population needed support and it became obvious

established programs were not meeting the demand for services. The elderly, specifically, came to be seen as a group with special problems too often neglected by public and private welfare institutions (Quadagno 1986:150). Thus, the Social Security Act of 1935 was enacted, representing the culmination of a number of historical cultural realities and mirroring deep-seated values. The Act and its various amendments since 1939 are based partly on principles of insurance and partly on traditions of social welfare (Congressional Quarterly 1983:11). Over the years, it has effectively expanded coverage in a number of areas through new services and the inclusion of additional categories of people. Achenbaum (1986) contends that this period of growth has resulted in a welfare system of a certain configuration as well as a constituency whose "needs" are shaped by the system itself. He writes:

. . . during the "takeoff" period of the social security program, its central bureaucracy took actions that set into motion a dynamic relationship between entitlements and expectations. Not only were entitlements expanded, but so was the basis for expecting future entitlements. Social Security was not simply an insurance program; nor was it basically a welfare package. It was intended to be both simultaneously. And therein lay both the basis for the system's subsequent evolution and, at the same time, the source of widespread misunderstanding of the program's objectives and accomplishments. (Achenbaum 1986:167)

Perhaps more than anything else, this describes the general paradox created by social security in the U.S. It

also describes the foundation for the conflicts engendered by DRGs. Quadagno (1986:129) notes:

. . . some of the same conflicts over eligibility for aid that threatened the sense of community in the colonial era are still present in contemporary programs for the aged.

The Act did not, for example, contain any provisions for medical insurance despite long-standing public support for such coverage. The seed was planted, however; Social Security made it the government's mandate to care for its elderly citizens and this care would soon expand to encompass medical services.

Though not included in the original Social Security legislation, the idea of medical insurance remained current, with compulsory medical-insurance bills introduced regularly in Congress (but not passed) from 1935. Though labor groups supported the plans, there was stiff opposition from the American Medical Association (AMA), the private medical-insurance industry, and business groups (Congressional Quarterly 1983:79-80; Starr 1982).

In 1950 Congress acted to help states provide medical assistance for the elderly and poor by a series of amendments to the Social Security laws. These amendments helped subsidize states' costs of vendor payments (direct reimbursement to hospitals and clinics) for medical care of people eligible for various Social Security programs.

In 1952, congressional backers proposed paying for the hospitalization costs of retired persons with Old Age and Survivors Insurance benefits. This plan was to aid persons with high medical costs and low incomes who could not afford the high premiums of commercial medical insurance. There was no action taken on this plan during Truman's administration, however, and Eisenhower entered office in 1953 opposing compulsory medical insurance. Eisenhower introduced a plan to help the needy aged meet the costs of catastrophic illness (without compulsory national medical insurance) and insurance plans were again introduced in Congress in 1957, but there was little support (other than with the public) and no action was taken until the next decade (Congressional Quarterly 1983:80-82).

State involvement in medical insurance surged in the 1960s with a number of amendments to the Social Security Act. These effectively expanded a number of services to a variety of groups, and included the establishment of the Medicare and Medicaid programs, designed to cover part of the medical costs for the elderly and poor. These changes further expanded the bureaucratization and standardization of medical services, ultimately resulting in DRGs.

Medicare and Medicaid: The State's Promise to Provide
Medical Care for the Aged and Poor

Spread of the Programs

Medicare and Medicaid represent the culmination of many efforts to pass some type of compulsory medical insurance. In 1960, the Forand Bill called for compulsory medical insurance. Supported by organized labor, Democrats, and liberal groups, it was opposed by Republicans (including President Eisenhower), the American Medical Association (AMA), business groups, and the insurance industry (Congressional Quarterly 1983:82). President Johnson's first legislative message to the 89th Congress dealt with medical legislation, and in 1965 he introduced a bill which would have mandated partial coverage for hospital care, nursing home care, home-health visits, and outpatient hospital diagnostic services for all persons aged 65 and over (excluding government workers and some aliens). The AMA fought this bill on the grounds that it was not extensive enough, supporting for the first time, a form of medical insurance. Arguing the elderly needed more than just hospital benefits, they introduced "Eldercare," which covered doctor's bills and called for "a voluntary comprehensive medical insurance program that would be available to persons 65 and over if their state government signed up for the program" (Congressional Quarterly 1983:83-84).

These three bills contributed to the Medicare and Medicaid legislation enacted in 1965 as part of President Johnson's Great Society program (Congressional Quarterly 1983:85). The Health Insurance for the Aged Act was passed in July 1965, adding two new titles (XVIII and XIX) to the Social Security Act. Part A of Title XVIII was basically Kennedy's King-Anderson bill, providing coverage of hospital and related care costs. It took effect in 1966 and covered up to 90 days of inpatient hospital services (excluding those of radiologists, anesthesiologists, pathologists, and psychiatrists), 100 days of post-hospital care, outpatient diagnostic services, and up to 100 home visits by a nurse or physician assistant after a three day hospital stay for those 65 years and older. Recipients were to pay deductibles for most of these services and were to help finance the plan via payroll taxes. Employers and the self-employed were also taxed to support the plan, with funds kept in the newly created Social Security Trust Fund, which was to remain separate from other Social Security trust funds (Congressional Quarterly 1983:86-89; also see Haber and Cohen 1960 and Commerce Clearing House 1968).

Part B of Title XVIII drew heavily from the House's bill and called for a voluntary system of supplemental medical insurance covering doctor's fees and certain other medical services. The plan paid 80% of a patient's costs (after an annual \$50 deductible payment) for services of

physicians, surgeons, radiologists, anesthesiologists, pathologists, physiatrists and dental surgeons; up to 100 home health-care visits per calendar year; X-rays, various lab tests, and medical equipment like prostheses; and outpatient mental health services (limited each calendar year to \$250 or 50% of costs, whichever was smaller) (Congressional Quarterly 1983:87-88). Payment for routine exams, dental care, eyeglasses, or hearing aids was not included.

Title XIX of the act, Medicaid, provided federal matching grants to states choosing to make medical services available to welfare recipients and the medically indigent. Participating states are required to provide coverage for hospital, laboratory and x-ray charges, and skilled nursing home and physician services. States can provide additional services if they wish (Congressional Quarterly 1983:88-89).

The establishment of Medicare and Medicaid ushered in the current era of enhanced and increased governmental influence in the delivery of medical services. Though providers welcomed the legislation as a means of receiving payment for many previously uncompensated patients, they were also leery of what this increased governmental presence would bring. Expanding programs and coverage increased the costs of medical services and brought with them numerous cost-containment measures aimed at keeping the new programs solvent. As Kimberly and Zajac (1985:282-

283) point out, from the perspective of providers, Medicare caused an environmental shift

characterized as movement from a relatively munificent, placid, and benign environment to one which might, by contrast, be described as resource constrained, turbulent, and questioning.

Thus, in the midst of expanding services there arose a financial crisis centered around paying for medical care, leading ultimately to the creation of DRGs in 1983.

Increasing Costs, The Creation of a Crisis, and Cost-Containment

During the latter part of the 1960s and through the 1970s the costs of Medicare and Medicaid increased with the programs' implementation and subsequent expansions. In 1972, the Social Security Act was revised and "major alterations in both Medicare and Medicaid were enacted" (Congressional Quarterly 1983:90). The 1972 amendments, according to Achenbaum (1986:175), included a "20% across-the-board increase in social security benefits." They included extending Medicare coverage to an additional 1.7 million disabled Social Security beneficiaries, patients of chiropractors, and patients with chronic kidney disease and funding to support the enrollment of Medicare beneficiaries in HMOs (Congressional Quarterly 1983:90). Costs also rose due to federal support for the development of rural medical centers, the reimbursement of services provided by nurse

practitioners and physician assistants in rural clinics, and the ability of physicians' groups to stop Medicare from lowering their prevailing charges. Though bringing with them additional costs, these amendments were justified as increasing the quality of care provided (e.g., expansion into rural settings and to new categories of patients) as well as helping promote cheaper, more cost-effective types of care (HMOs and home health care).

These efforts, highlighting the expansion of the system, were paralleled by ways in which the federal government attempted to reign in costs. These measures include the establishment, and subsequent strengthening, of the oversight responsibilities of the Peer Standards Review Organization (PSRO) system. Created by the 1972 amendments, these organizations were made up of local groups of practicing physicians overseeing Medicare and Medicaid services. Though physicians were successful in delaying the establishment of PSROs and weakening their enforcement capabilities, they set the stage for the Peer Review Organizations (PROs) and the stronger sanctioning powers that were to follow (see below).

Other measures aimed at cutting costs included attempts to control providers' ownership of medical technology and services, the establishment of the Health Care Financing Administration (HCFA) as a part of the department of Health, Education and Welfare (HEW) to

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maintain and monitor medical programs more efficiently, and the creation of the Office of the Inspector General in HEW to deal with illegalities more effectively (Congressional Quarterly 1983:90-91).

Despite these measures to help contain the costs of the expanded Medicare system, by 1977 it was apparent benefit costs were growing much faster than the program's trust fund. A national crisis was born.

The events of the 1975-1985 decade . . . eroded the balance in the relationship between rising entitlements and changing expectation. In retrospect, four factors--the deleterious effects on short-term and long-range social security financing caused by operationalizing the 1972 amendments amid international stagflation; the sharp decline in public confidence in the future health of Social Security; the failure of "experts" to reach a consensus concerning either the proper role or the actual impact of the program on the political economy; and the inability of the federal government to regain control over the rate at which benefit levels increased--precipitated a new crisis mentality about the nation's largest and most important domestic program. (Achenbaum 1986:177)

In lieu of this crisis and to forestall the collapse of the Social Security system, by the end of his term President Carter had overseen the largest peacetime tax increase ever, had to renege on his campaign pledge of comprehensive medical insurance, and urged Congress to eliminate a number of "unnecessary" Social Security benefits (Congressional Quarterly 1983:23-4).

The 1980s witnessed a continued crisis mentality and expanded efforts at controlling the rising costs of Social

Security and, more specifically, Medicare and Medicaid. Increased benefits, especially medical costs were viewed as the main cause of the crisis. According to HCFA, the Consumer Price Index (CPI) rose 134% between 1970 and 1981 while medical costs rose 284 percent. Federal spending on medical services rose 374% during the same time period. In 1981, the national rate of spending for medical services increased 12.5% compared with a national inflation rate of 8.9% (the highest since 1935 when records were first kept). Between 1973 and 1981, Medicare and Medicaid costs grew each year by 19% while other entitlements grew at an annual rate of 14 percent. If unchanged, costs were expected to double between 1981 and 1986 and every six years thereafter until 2000, according to the Congressional Budget Office. HCFA estimated a 340% increase in hospital care costs between 1978 and 1990. Per capita federal health expenditures, almost \$359 in 1981, were projected to be over \$900 by 1990 (Congressional Quarterly 1983:96-98; Morreim 1985). In 1982, the system was paying out \$17,000 more a minute than it was bringing in (Congressional Quarterly 1983:24-30; also see Achenbaum 1986:182-183). States' Medicaid payments grew by 22% between 1981 and 1983, nearly twice as fast as tax revenues (Morreim 1985:30). In Michigan medicaid payments were 41.6% of the 1984-1985 Department of Social Services budget (Michigan Department of Social Services 1985:1).

Faced with these realities and a vision about the way America ought to be, the Reagan administration proposed a number of measures in the 1980s to forestall the crisis facing Social Security. In large part, the response was one of budgetary readjustments and cutbacks in benefits across the full spectrum of programs supplied by Social Security. Though the proposals faced instant opposition from a number of sources and had to be softened by the administration, they foretold the Reagan administration's response to budgetary crisis as well as increasing medical costs.

The ultimate goal of Reagan's changes was to reduce the role of the federal government in the lives of Americans. His approach to budgetary policy was centered on fostering freedom from governmental regulation and couched in classical economic terms. In the medical arena, the idea was to have individuals spend their own money for medical care, the assumption being they would demand better and cheaper services and, thus, cost and quality would be controlled by market forces, not government regulators (Congressional Quarterly 1983:92).

Reagan's early proposals laid out several ways in which Social Security cuts could be made: eliminating minimum benefit programs, raising the mandatory retirement age, cutting the benefits of early retirees, delaying cost-of-living allowances, establishing tougher eligibility

requirements for disability payments, and reducing benefits paid to workers on disability and initial benefits for future retirees. Reagan also instituted a series of budgetary changes to make the solvency of the system appear more secure. For example, monies were reallocated among trust funds to assure immediate solvency--despite legislation mandating the funds remain separate.

Reagan's earliest "free-market" or "competition-based" attempts at altering the medical arena included proposals which replaced Medicare with a "voucher system," allowing enrollees to purchase their own medical care; reimbursing hospitals according to preset limits; and taxing insurance premiums paid by companies for their employees. He was interested in laying the groundwork for "a future overhaul of health-care financing in the United States" (Congressional Quarterly 1983:92). The Economic Recovery Tax Act of 1981 increased deductible payments made by Medicare beneficiaries for Parts A & B and placed limits on reimbursements. It also required reductions in Medicaid spending of 3% in Fiscal Year (FY) 1982, 4% in FY 1983, and 4.5% in FY 1984. These cuts were expected to reduce federal spending for the programs by \$5.8 billion. This act also broadened the independent authority of states under Medicaid, giving them the option of restricting access to care in certain cases (Congressional Quarterly 1983:92-93). The 1981 Budget Reconciliation Bill expanded

coverage of home health services and for minor surgery or tests done outside hospitals in an attempt to contain hospital costs for both Medicare and Medicaid (Congressional Quarterly 1983:91-93).

In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) aimed at cutting Medicare and Medicaid spending by an estimated \$14.4 billion over three years (two and a half times the amount cut in 1981) (Congressional Quarterly 1983:93). Medicare was hit the hardest with \$13.3 billion in budget cuts. Reductions were to be achieved by a variety of measures including limiting payments to hospitals and physicians (and calling for the development of a prospective payment system--DRGs--for reimbursement of hospital costs), requiring employers to offer Medicare-eligible workers comparable medical insurance coverage, increasing Part B expenses for beneficiaries, and replacing the PSRO program with PROs under contract with the Department of Health and Human Services through HCFA (Congressional Quarterly 1983:93-94; also see Hogness 1982). Cuts in Medicaid, totaling \$1.14 billion, were to be achieved by various administrative cost-saving measures and by allowing states to charge nominal fees for medical services and place liens on the property of institutionalized beneficiaries to facilitate recovery of Medicaid costs after death (Congressional Quarterly 1983:94).

Despite the changes made and proposed in the early 1980s, the government still projected budget deficits in upcoming years. A crisis was perceived as being right around the corner and cost-containment became a concept with which most everyone involved in medical care became familiar.

Inflationary medical costs are not a unidimensional problem with only one cause simply remedied, however, making it difficult to confront with a simple, consolidated plan. The proliferation of government-sponsored and private medical insurances, for example, has spawned large administrative structures, fueling increased costs and overall consumption of medical services. The disjointed, uncoordinated nature of the medical care system also increases costs as does the type of care insurers are willing to cover. Focusing care delivery in centralized, hospitalized settings--with their reliance on highly paid, specialized personnel and expensive equipment and procedures for diagnosis and treatment--has made it certain costs would rise. Fee-for-service reimbursement based on "reasonable costs" has also added to increased costs, as does the nation's demographic profile. The elderly (especially those over 75) make up the fastest growing segment of the population. As a group, they have higher admission rates and utilize more resources than average when hospitalized. Per capita hospital expenditures for

those 65 and older are roughly three and a half times what they are for people under 65. Since over 95% of all Americans 65 and older are enrolled in Medicare and the largest portion of the nation's health dollar goes to hospitals (see Table 5), it was only a matter of time before the federal government would focus its cost-containment efforts on limiting Medicare payments to hospitals (Congressional Quarterly 1983:98-101).

Table 5: Recipients and Sources of the Nation's Health Care Dollar, By Percentage

Recipients		Sources	
Hospital Care	.41	Federal Government	.29
Other Personal		Direct Patient Payment	.29
Health Care	.21	Private Health Insurance	
Physician Services	.19	and Other Private	
Other Health		Third Parties	.29
Spending	.11	State and Local	
Nursing Home Care	.08	Governments	.13

Source: Congressional Quarterly 1983, p. 100.

Below, current cost-containment efforts are summarized, followed by a description of DRGs and the study state's PRO charged with monitoring their use and effectiveness. This will set the stage for descriptions, in following chapters, of the impact these changes' are having on providers and patients in the study community.

Summary of Current Cost-Containment Schemes

Though, as outlined above, there have been many attempts to control costs, most have proved unsuccessful (Ginzberg 1986; Schwartz 1981, 1987; Starr 1982). Costs have continued to rise despite repeated efforts along a number of fronts to contain them, and, since 1983, cost-containment has entered the everyday life of those involved in medical policy and the delivery of medical services. The primary means used to control medical costs generally involves some sort of *cost sharing* or *budget limits*. Cost sharing makes individuals responsible for all or part of the costs of received medical services via deductibles and co-payments. Budget limits specify the amount paid for a package of medical services (Congressional Quarterly 1983:102-103). As outlined above, the federal government has used both approaches in a variety of ways to help limit its financial involvement in paying for medical care.

Many cost-containment schemes are based on some kind of prospective payment system, with hospitals and other providers paid pre-arranged prices for the patients they treat. Some pay by the case, as in Medicare's and the study state's Medicaid DRG systems. Others pay by the day (such as California's MediCal program), by negotiated discount of physician fees and hospital costs (as in Preferred Provider Organizations--PPOs), or by capitated payments to providers for delivering defined services to a

population of enrollees (as in Health Maintenance Organizations) (Fifer 1984). They all have in common an approach geared toward the standardization, corporatization, and bureaucratization of the delivery of medical services.

The most explicit and prevalent form of cost-containment based on prospective payment (prior to DRGs) is the Health Maintenance Organization (HMO). Since they were first supported by the federal government in the early 1970s, their growth has been substantial even though their profitability and effectiveness in delivering quality care are still debatable (Manning et al. 1984; Moskal 1987; Nycz et al. 1987; Sleeth 1988). Two-thirds of the HMOs in the study state lost money in 1987 (Personal communication, state Medicaid official, 8/19/88).

Joining an HMO first became an option for Medicare and Medicaid recipients in 1972 with amendments to the Social Security Act. The HMO Act followed in 1973, offering federal assistance for establishing non-profit and profit-making HMOs. It also required businesses with over 25 employees to offer the option of membership in qualified HMOs. The number of HMOs in the United States increased from 30 in 1971 to 268 by mid-1982. In March 1981, approximately two percent of Medicare beneficiaries were enrolled in HMOs, according to HCFA. Five percent of the general population were enrolled in 1983 (Congressional

Quarterly 1983:103). In the research community an HMO expanded from one to four complexes in different parts of the city during the study period. Also, a local PPO--with reimbursement mechanisms similar to those of HMOs--was one of the fastest growing local businesses every year since its inception, despite purported continual financial difficulties.

Similar efforts at managed care have also spread to private insurers and state governments (Gerber 1986; Korcok 1984; Krieger 1986; Montgomery 1984). Interviews with people involved in medical policy at the state level (Table 1) revealed the study state's cost-containment efforts, including various types of pre-paid and managed medical insurance plans, Certificate of Need programs, new methods of financing (such as DRGs), privatization of medical services, preauthorization for hospital admissions, and increased utilization management. In mid-1988, the study state was piloting a number of managed care projects throughout the state in an attempt to reign in costs. Over 50% of the population in one of the state's most populated counties were enrolled in one such project (Personal communication, state Medicaid official, 8/19/88) and there are plans to try it in other high-Medicaid areas of the state.

Despite the fact that a number of cost-containment efforts are underway at both the federal and state levels,

there is minimal coordination of such efforts. Apparent from my interviews with state medical policy planners, cost-containment consists of a myriad of programs, regulations, and approaches aimed at cutting costs wherever possible. Each policy person interviewed discussed the problem from a different angle, signifying the multiple approaches and general lack of organization of such efforts. In part, this is due to our nation's lack of a coordinated system to deliver medical services. As one legislative specialist told me,

In fact, you know, my thinking is we don't have a system. This is part of the problem: We simply do not have a system of health care anymore. We have patches of health care, but it's not a system. . . . That's the challenge of the future: To deal with a complicated system of health in a rational manner.

Though the lack of a coordinated medical delivery system has resulted in a lack of coordination in fighting medical costs, most efforts attempt, in general, to maximize the utilization of resources and define what is and what is not "quality care." They attempt this by conceiving of medical care as a commodity, as something quantifiable and exchangeable. As such, it is just one commodity among many based on basic capitalist assumptions helping support the U.S. class system and the capitalist class' interests, i.e., making a profit (Navarro 1975 and 1984). HMOs (and DRGs) assume patients need fewer medical services and that these services are over-priced. In

response, they set limits on reimbursement and give physicians incentives to restrict the amount of care they deliver, setting in motion a series of responses involving the standardization of care which affects the way hospitals do business, physicians and other providers dispense care, and how patients receive care.

The remainder of the dissertation deals primarily with DRGs because they epitomize governmental efforts towards the increased commoditization and standardization of medical services. HMOs and other cost-containment measures are discussed merely to point out the context within which DRGs arose. In many ways DRGs are not unique; they were preceded by decades of proposals and historical trends which have made them possible. They are unique, however, in their unsurpassed ability to reshape the delivery of medical services in a way different from the "traditional" past. They set in motion and reinforced a series of changes having a profound affect on providers and patients. These effects and their responses are discussed below, following a brief description of what DRGs are and how they operate.

Diagnosis Related Groups (DRGs)

DRGs began on a national level in 1983, as a very visible and scrutinized program aimed at containing costs for hospitalized Medicare patients (Iglehart 1983; May and Wasserman 1984). With DRGs, care no longer was reimbursed

on a cost-plus basis (i.e., the hospital's costs in treating a case plus a percentage for profit). Reimbursement became *prospective*, based on defined categories of illnesses with each bringing a stipulated payment. It became the hospitals' burden to make a profit with the new system. Due to their intrusiveness relative to other means of medical cost-containment, and because they have received the most public and professional debate, DRGs have come to generally epitomize cost-containment efforts (Notman *et al.* 1987).

Commentators from many medically-related disciplines (Association of American Medical Colleges 1984; Siegler 1984; Thurow 1984) quickly pointed out that prospective reimbursement posed fundamental challenges for the medical care system. Though oftentimes coming to opposite conclusions, they outlined their perceptions of the hypothesized effects of DRGs on medical care (Berman 1984; Butler, P.W. *et al.* 1985; Carter 1984; Curtin 1983; Enright 1983; Grimaldi 1982; Lang 1984; Omenn and Conrad 1984; Schwartz 1981; Vladeck 1984; Weinberger *et al.* 1985; Young and Saltman 1983). Numerous editorials and articles (and even entire issues) in such journals as *Hospitals*, *Medical World News*, *American Medical News*, *Private Practice*, and *Modern Health Care* voiced concern about DRGs and highlighted perceptions regarding their effects.

It was suggested, for example, that DRGs would result in multiple and marginal patient admissions leading to restrictions in access, a slowdown in the development of new technologies, and the early discharge of patients using more than average resources--especially the elderly and poor (Dolenc and Dougherty 1985:19; Morreim 1985:32). Others argued that DRGs would increase the numbers of procedures and ancillary services, thus increasing costs (Berman 1984; Wirtschafter 1984:92). Some said they would increase hospital profits (Feder *et al.* 1987; Omenn and Conrad 1984:1315; Pauly 1986; Simborg 1981) while others stated that profits were jeopardized because of DRGs' underemphasis of the variation in severity of illness and consistent underpayment to hospitals for treating "underweighted" DRGs (Butler, P.W. *et al.* 1985; Dolenc and Dougherty 1985:29; Horn *et al.* 1985a; Weinberger *et al.* 1985; Wirtschafter 1984:89).

Proponents of DRGs, including the hospital industry (Korcok 1984:915), said they would pave the way for "a radical restructuring of Medicare" (Congressional Quarterly 1983:105). Brody and Magel (1984) argue they represent the government's attempt to create a much needed viable system of "hospital-based short term long-term care." Opponents, including the American Association of Retired Persons (AARP) and the Health Insurance Association of America, said they would not be effective unless also

applied to Medicaid and private medical-insurance plans; if only applicable to Medicare patients, they feared, costs would be shifted to other programs (Congressional Quarterly 1983:106).

Though it was debatable whether or not DRGs would help cut costs, most agreed they represented a system primarily aimed at cutting costs and not one necessarily geared toward providing the best medical care (even though it is touted as both by its proponents) (Fetter 1984:353). The details focused on and envisioned results varied by author but the consensus was that DRGs represented a major extension of government influence over medical care, including explicit financial incentives to reduce hospital services. Some suggested that the effort to control costs would further exacerbate an already unacceptable maldistribution of medical services (President's Commission 1983). Most agreed DRGs represented a challenge to the medical profession to find a way of accommodating the legitimate demand for cost-containment without sacrificing the interests of vulnerable patients.

DRGs officially began as an amendment to Social Security legislation passed in 1983. They are based on twenty years of experience with various hospital cost-containment programs (Bentley and Butler 1980; Finley 1983; Iglehart 1982a, 1982b; Sloan 1983) and comprise a system for classifying hospitalized Medicare patients based on

principle diagnosis and associated comorbidities, age, the need for surgery, and discharge status (Ernst and Whinney 1980; Grimaldi and Micheletti 1983). In essence, they cluster diagnoses by resource use (Wirtschafter 1984), creating 467 distinct groups within 23 major diagnostic categories (MDCs) based on body system (see Table 6). Each DRG category is prospectively assigned a relatively fixed reimbursement rate and each is associated with a mean hospital length of stay.

Here begins the classification of patients into a standardized treatment slot (Health Systems International 1985:7). Most MDCs have medical and surgical subgroups, helping to further define the clinical specialty involved. Medical patients are assigned to a category based on their principal diagnosis at the time of admission. Surgical patients are assigned according to the surgery received. Patients with multiple procedures are assigned to the surgical class highest in the hierarchy (e.g., a hysterectomy rates higher than a toenail removal) (see Appendix C) (Health Systems International 1985:9).

After assignment to a medical or surgical class, DRGs further classify patients according to their age, complications, and comorbidities--factors which, on average, consistently increase consumption of resources. "Complications" and "comorbidities" are defined as conditions that "would cause an increase in length of stay by at least one day in at least 75 percent of the patients" when associated with a specific principal diagnosis (Health Systems International 1985:12). Another variable considered is the patient's discharge status, denoting the amount of care needed after leaving the hospital, and how and where such care will be delivered. After taking all these factors into account, patients are assigned to one of 475 DRGs.

Each DRG payment to the hospital is based on the mean of the average national costs of treating patients with a particular illness. This base payment is adjusted for, among other things, variations in complexity of case mix, the hospital's education expenses, and for the number of "outliers" treated. These are patients using relatively more hospital days or generating relatively higher costs than the national mean (American Medical Association 1983). If a hospital's care for a Medicare patient costs less than the fixed rate, the hospital keeps the difference as profit. If care costs more than the fixed rate the hospital must absorb the extra charges.

Table 6: Major Diagnostic Categories (MDCs) of Medicare DRGs

-
1. Diseases and Disorders of the Nervous System
 2. Diseases and Disorders of the Eye
 3. Diseases and Disorders of the Ear, Nose and Throat
 4. Diseases and Disorders of the Respiratory System
 5. Diseases and Disorders of the Circulatory System
 6. Diseases and Disorders of the Digestive System
 7. Diseases and Disorders of the Hepatobiliary System and Pancreas
 8. Diseases and Disorders of the Musculoskeletal System and Connective Tissue
 9. Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast
 10. Endocrine, Nutritional and Metabolic Diseases and Disorders
 11. Diseases and Disorders of the Kidney and Urinary Tract
 12. Diseases and Disorders of the Male Reproductive System
 13. Diseases and Disorders of the The Female Reproductive System
 14. Pregnancy, Childbirth and the Puerperium
 15. Newborns and Other Neonates with Conditions Originating in the Perinatal Period
 16. Diseases and Disorders of Blood and Blood Forming Organs and Immunological Disorders
 17. Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms
 18. Infectious and Parasitic Diseases (Systemic or Unspecified Sites)
 19. Mental Diseases and Disorders
 20. Substance Use and Substance Induced Organic Mental Disorders
 21. Injuries, Poisonings and Toxic Effects of Drugs
 22. Burns
 23. Factors Influencing Health Status and Other Contacts with Health Services
-

Source: Health Systems International 1985, p. 8.

The implementation of Medicare DRGs was graduated. During the first year of implementation, 25% of Medicare funding was prospective, with 75% based on the hospital's past reimbursement level. The prospective portion of the payment increased by 25% each subsequent year so that, four years after implementation, reimbursement was 100% prospective. The first revisions in the system occurred in 1985 based on two years of experience and suggestions for change supplied to the HCFA from the medical industry (Health Systems International 1985). During the course of this study DRGs began for all Medicare and state Medicaid patients and similar systems also spread to other third-party payers and new categories of providers. It is now beginning to dominate the financing of medical services.

As Fetter (1984) points out, DRGs represent a multivariable system for classifying hospital discharges into patient groups with similar expected patterns of resource use. They measure hospital "products," that is, patients representing "outputs from a productive system" (Chase and Aquilano 1977, cited in Fetter 1984:336). As stated by their developers:

The DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. . . . The initial motivation for developing the DRGs was to create an effective framework for monitoring the quality of care and the utilization of services in a hospital setting. . . . The development of the DRGs provided the first

operational means of defining and measuring a hospital's case mix complexity. (Health Systems International 1985:1)

Case mix refers to a set of interrelated but distinct patient attributes: Severity of Illness, Prognosis, Treatment Difficulty, Need for Intervention, and Resource Intensity (Health Systems International 1985:1-2; also see Doremus and Michenzi 1983; Fetter *et al.* 1980; Jencks and Dobson 1987; Tatchell 1983; Wood *et al.* 1981; Young and Saltman 1982). Measure these attributes say the proponents of DRGs, and one can describe the types of patients treated. The problem, however, is that even their creators claim "case mix" has different meanings for clinicians and administrators/regulators:

From a clinical perspective case mix complexity refers to the condition of the patients treated and the treatment difficulty associated with providing care. On the other hand, administrators and regulators usually use the concept of case mix complexity to indicate that the patients treated require more resources which results in a higher cost of providing care. (Health Systems International 1985:2)

The purpose of the DRGs is to relate a hospital's case mix to the resource demands and associated costs experienced by the hospital. Therefore, a hospital having a more complex case mix from a DRG perspective *means that the hospital treats patients who require more hospital resources but not necessarily that the hospital treats patients having a greater severity of illness, a greater treatment difficulty, poorer prognosis or a greater need for intervention.* (Health Systems International 1985:3; Emphasis added.)

(One might ask, as an aside, If a patient does require "more hospital resources" [i.e., it is representative of increased case mix complexity from the administrator/regulator perspective], how can he or she not have "a greater severity of illness, a greater treatment difficulty, poorer prognosis, or a greater need for intervention"? If one of these does not pertain, what, then, is the cause of the patient's increased need for medical services?)

DRGs, in official parlance, are simply "a patient classification scheme consisting of classes of patients who were similar clinically and in terms of their consumption of hospital resources" (Health Systems International 1985:3). As such, they tend to minimize the uniqueness of each patient and have consequences for the care delivered to and received by patients, especially the elderly. Some patients will always need more care than others, even with the "same" disease. Also, increased age generally results in increased medical costs. Their developers state: "The presence of a complication or comorbidity and age 70 or over were found to be highly interrelated" (Health Systems International 1985:12).

By tending to ignore variation in patients' severity of illness, DRGs are inherently geared toward underpaying some patients' hospital bills in an attempt to restructure the delivery of medical services and contain government

expenses in the medical arena. Though the government stresses the system's ability to monitor and increase "quality of care"--making sure patients receive the "appropriate care" in the "proper" setting for their medical diagnosis--the general understanding was (and is) that DRGs were meant to decrease admissions and lengths of stay for hospitalized Medicare patients and close hospitals. They have achieved these goals by furthering the commoditization of illness and the means by which it is treated.

At the heart of this cost-cutting revolution is the assumption that health care is a commodity like any other, and therefore when regulatory adjustments force efficiencies, the unproductive elements in the economy will "shake-out" and the result will be cheaper, high quality care for all. (Dolenc and Dougherty 1985:27)

Thurow guesses this means patients will be "dumped" (that is, discharged early or not even admitted), inefficient hospitals will be shut down, and unprofitable services dropped. He argues:

To deny that this will happen is to deny that markets are efficient. Markets are designed to encourage firms to segment, "cream" and "dump," to find the most profitable niches while ignoring areas of low profitability. (Thurow 1984:1571)

In a market oriented environment fostered by DRGs and other cost-containment schemes (and, one might add, regardless of whether markets are ultimately judged efficient), both physicians and the hospital become

maximizers and patients customers. It is still an open question whether DRGs and cost-containment can both improve efficiency and still provide excellent medical care. There is no sign, however, of DRGs going away. As mentioned above, the plan has been adopted by many state governments and private insurers. Physicians' DRGs are imminent (see *Journal of the American Medical Association* 206(16), 1988 for a number of articles and Hsiao et al. 1988) and similar plans are under consideration for long-term nursing home care (Fries and Cooney 1985).

DRGs represent a major and a potentially permanent fixture on the medical scene. Because they are such a blatant and pervasive attempt to standardize and bureaucratize care, their effects have been pervasive and there is no indication they will subside soon. The creators of DRGs made it explicit when they were first introduced that the system was to be a dynamic process, changing over time.

The DRGs, as they are now defined, form a manageable, clinically coherent set of patient classes that relate a hospital's case mix to the resource demands and associated costs experienced by the hospital. . . . Through DRGs, hospitals can gain an understanding of the patients being treated, the costs incurred and, within reasonable limits, the services expected to be required. The classification of patients into DRGs is a constantly evolving process. As coding schemes change, as more comprehensive data is collected or as medical technology or practice changes, the DRG definitions will need to be reviewed and revised. (Health Systems International 1985:16)

In charge of reviewing and revising DRGs at the most basic level are the PROs briefly discussed above. Established in 1984 to monitor hospital use and quality of care for Medicare patients, they track the use of DRGs in practice and compile data used by HCFA to maintain (and change) the system. This chapter ends with a brief discussion of the study state's PRO's history, its review of Medicare and Medicaid cases, and the problems encountered in carrying out their activities. Following chapters detail how providers and patients are impacted by and perceive DRGs.

The Peer Review Organization (PRO)

History

The Peer Review Improvement Act of 1982 mandated that PROs be established in each state with "clear authority to sanction medically unnecessary, inappropriate or poor quality of medical care" (Horvat 1988:1). They were begun in 1984 as part of the TEFRA legislation, formally replacing the PSROs in place since 1972 (Dans et al. 1985; Gosfield 1984; Iglehart 1987). In part, the switch to PROs resulted from the failure of PSROs to effect changes in physician and medical practice and, hence, lower costs.

According to the study state's PRO Chief Executive Officer, "his" PRO is founded on the principles of

providing each physician in the state . . . a vehicle to participate in peer review; and improving, through the art and practice of peer review, the quality of health care provided to Medicare, Medicaid and other beneficiaries. (Horvat 1988:1)

An educational brochure states they represent "a bridge between those who purchase health care and those who provide it."

A major goal of the PROs is to save the federal government money. As stated by the organization's president in 1985, the

program is designed to utilize physician expertise to control the cost of federally-financed medical care while assuring quality care. (Burney 1985:2)

The Chief Operating Officer of the study state's PRO told me,

[Our] essential mission is to protect the Medicare Trust Program by being under contract with the federal government. And, you know, if you develop upon that mission statement, uh, primarily what we see ourselves doing is being able to protect the Medicare (and, now most recently, the Medicaid) beneficiary to make sure they're receiving appropriate, quality care within the health care community. . . . Um, as far as, and that's more or less our own established mission and philosophy.

Two PRO employees told me the official government figures are that PROs save two dollars for every one spent. Earlier estimates were as high as five dollars saved per one dollar spent (Wallace 1983).

Structure

The PRO in the study state is overseen by a Board of Directors comprised of 14 physicians from a variety of specialties and geographic regions of the state (elected by the 2,400 physician members of the PRO), a hospital administrator, and two consumer representatives. The consumer representatives were added in 1988 due to updated federal contractual requirements. One of them works for the Association of American Retired Persons (AARP) and the other is involved with the UAW and seniors' advocacy groups at the state level.

Under the Board of Directors, six regional peer review committees, each composed of six board certified physicians, assess cases that may constitute poor quality of care. These cases come to them after being reviewed by a nurse reviewer and one or more PRO-employed physician reviewers. Nurses employed by the PRO do all initial review. If cases are not approved by them, physicians and committees of physicians enter the review process. A Corporate Peer Review Committee and the Board of Directors reviews the findings of the six regional committees, resulting in at least 14 physicians reviewing cases displaying potential "patterns of poor performance or individual gross and flagrant" medical malpractice (Horvat 1988:2).

In mid-1988, the study state's PRO had 120 employees and over 200 physicians conducting peer review, with an annual budget of over \$6 million of combined federal and state allocations for the review of Medicare and Medicaid patients. The PRO receives its largest support from HCFA (over \$11 million in 1988 for a two-year contract) to review approximately 25% of all Medicare discharges (about 400,000 per year). They began reviewing Medicaid discharges for the state in 1988 (with a \$3.3 million two-year contract) and also make themselves available to corporations, HMOs, and other public and private organizations for various review functions. Among the services they market are preadmission, concurrent, and retrospective review, second surgical opinions, quality assurance studies, DRG validation, and management information services.

Medicare and Medicaid Review

WHAT IS REVIEWED

Approximately 85% of the PRO's activity centers around reviewing the care delivered to Medicare patients. The remainder of their time is spent on Medicaid patients (about 160,000 discharges a year). The federal and state contracts are essentially similar, mandating review of inpatient acute care, HMOs, and preauthorization for

elective admissions. In addition, the state requires second surgical opinions for Medicaid admissions.

In 1988 the PRO reviewed a 3% random sample of the state's Medicare discharges in addition to a large percentage of patients transferred to other institutions, readmissions, and DRG outliers. This amounted to 25 to 30% of all Medicare admissions. They also do extensive review of practitioners identified as having questionable admitting practices.

Reviewing cases involves assessing patients' need for admission, the appropriateness of discharge, the quality of care provided, and the accuracy of billing information. According to a PRO information sheet I obtained, two-thirds of all cases reviewed are approved by nurse reviewers. This first level of review screens patient charts to check lab values, pre- and post-admission data on patients' conditions, appropriateness of DRG assignment, referral status, and whether or not proper forms are filled out, including the "attestation statement" signifying the physician's agreement with the rank ordering of the diagnoses. The majority of the remaining cases are approved by a PRO-employed physician reviewer after additional information is received from the attending physician. I was told approximately 5% of all the reviewed cases in the study state are denied after being reviewed by a second PRO physician. This contrasts with a study done

of PRO denials in Connecticut, which found that only .37% of Medicare admissions were denied reimbursement (with 48% of these ultimately overturned) (Imperiale *et al.* 1988).

An analysis done by the PRO of their Medicare denials from October 1984 through September 1985 revealed that ten diagnoses accounted for over 40% of the denied admissions. (See Table 7). All but one of them are medical diagnoses and most represent chronic diseases. During the year covered by their study, the PRO reviewed 13,695 cases with these diagnoses, of which 1,236 (9%) were denied. Denial rates for the first five diagnoses listed in Table 7 have begun to decline, representing a change in physician practice patterns as a result of PRO review activities (Michigan Peer Review Organization 1985:4).

Since February 1, 1988 the PRO conducts two types of review for the state's Medicaid program. Prior Authorization Case Evaluation and Review (PACER) looks at all elective admissions, readmissions within 15 days, all transfers, and a 10% retrospective sample of all cases. The second type of review examines a 20% retrospective sample of all urgent and emergency admissions (Personal communication, state Medicaid official, 8/19/88).

Table 7: Top Ten Peer Review Organization Denials By
Diagnosis

Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders, Over Age 69 (DRG 182)
Heart Failure and Shock (DRG 127)
Diabetes, Over Age 35 (DRG 294)
Medical Back Problems (DRG 243)
Unrelated Operating Room Procedure (DRG 468)
Chronic Obstructive Pulmonary Disease (DRG 88)
Nutritional and Miscellaneous Metabolic Disorders, Over Age 69 (DRG 296)
Transient Ischemic Attacks (DRG 15)
Hypertension (DRG 134)
Bronchitis and Asthma, Over Age 69 (DRG 96)

Source: Michigan Peer Review Organization 1985:4.

Everybody interviewed at the PRO argued that the focus of review had shifted from utilization to quality, from saving money to making sure patients received "appropriate" quality care. The PRO's Chief Operating Officer told me that when the PRO was first established,

Utilization was the issue, if you want to look at it that way. Utilization--length of stay--not that we were trimming days off of length of stay because that wasn't really the issue, but denial of hospitalizations. And, of course, it's not that any of the denials were necessarily inappropriate. There were a heck of a lot of patients--I know that because I worked in the hospital--that were there that really didn't need to be in an acute care setting. But they were there because that's kinda like it had always been.

So those things changed. But now, of course, what's happening, rather than there being almost the panic that hit the industry back in late '83 and into '84 and '85, the panic was that, Oh my gosh, you know, here we are with, um, this situation where, you know, we gotta, we gotta, take action. So, number one,

obviously, lengths of stays were quickly--you know that if you look at [a] graph, you know--lengths of stays went down.

When this was accomplished, the PRO could focus its efforts more on "quality." Though I was told quality was always espoused as a valued outcome of their actions, early success in decreasing lengths of stay gave the PRO freedom to reallocate resources to this end.

A Medicaid official who worked with the PRO in establishing their contract to review state Medicaid cases had a somewhat different perspective on the PRO's espoused focus on quality.

If you base your assumption on the fact that they are essentially a physician organization--notwithstanding their support from the feds--then, sure, I think that as a physician organization their focus, whether it's a federal priority or not, tends to be substantially on quality of care. I don't think they'd be able to sell their participation and viability as an organization to the physician and professional community unless that was a major aspect of their operation.

He went on to add, however, that he doubted that quality took precedence over cost-containment:

On the fed side the feds have made it clear, after their foray into the PSRO area, that cost savings is at least as important as quality of care. When they went into PSROs, the interpretation was originally that quality of care was the important thing and cost savings was an ancillary aspect that simply came along with any quality care review. They've been very careful to articulate cost-savings as a major, if not the major, priority of [the PRO], with quality of care either being as important or occupying somewhat less of a seat.

So it's hard to say. Certainly [the PRO] knows what their charge and responsibilities are, and I think in a practical sense they have no choice but to consider cost-containment as a major, if not the major, objective. I think they're going along on that focus, and we've not seen--in the time that we've worked with them--any serious orientation problems to cost-containment. We have seen a reluctance--and I think it's probably a natural reluctance--to emphasize cost-containment over quality of care. If you're involved in the treatment of patients or the review of cases you'd like to--and to a large extent should--put quality of care first. So I think there's probably a natural reluctance on [the PRO's] part to give cost-containment a clear priority. I'm not sure that's an inappropriate reluctance, but they do follow up on cost-containment. And they have for us.

He admitted that, when drawing up the state's PRO contract, separate reviews and initiatives for quality had to be left out because of the state's unwillingness to pay an extra \$5 million.

COMMUNICATING WITH PROVIDERS

Communication between the PRO and hospitals and physicians is written and oral. Written communications from the PRO include letters informing providers that a case has been denied for problems involving either utilization or quality issues. Cases denied because of utilization issues entail a letter sent to the hospital only. Quality denials result in letters going to both the attending physician and the hospital. Physicians and hospitals respond to these notices by sending the PRO additional documentation and, oftentimes, by phone

conversations between the attending physician and a PRO physician reviewer.

The PRO's Chief Operating Officer argued the process aims at reaching some sort of medical consensus. To achieve this, cases are reviewed by physicians from the same specialty before they are denied. Consensus is oftentimes difficult to achieve, and the PRO is faced with justifying their decisions and attempting to coerce physicians (with the threat of sanctions, discussed below) into practicing medicine within federal guidelines. The dialogue occurring among PRO-employed physicians and those out in the community when decisions are made regarding whether or not to deny reimbursement shapes the practice of medicine as physicians are instructed to provide services that are reimbursable under the new system.

SANCTIONS

The primary sanction employed by the PRO is the denial of payment to hospitals for improper utilization of services. Physician payment is not affected with this kind of denial, though going through the process entails time spent on phone conversations and written correspondence aimed at clarifying the treatment process to justify reimbursement.

Though it is rare, physicians and hospitals also face quality denials when their care is deemed inappropriate.

Physicians facing quality denials are ranked according to the perceived threat of the care to the patient. Rank 1 refers primarily to documentation problems which are considered minor and relatively commonplace. Rank 2 violations, dealing with cases in which the delivered care was determined to have had minor detrimental effects on the patient, are the most common. Examples of this lack of quality include premature discharge and not following up on laboratory findings. Ranks 3 and 4 refer to cases where increased harm came to or could have come to the patient. Rank 4 violations are considered "gross and flagrant."

Once a physician receives a ranking of 2 or higher, they (or hospitals, if they are the recipient of a quality denial) must respond in a specified number of days to the PRO. If they fail to respond or respond ineffectively, the case is referred to committee and reviewed by additional PRO physicians. Physicians with repeated quality violations ultimately face a hearing before the Inspector General and, possibly, fines (usually the cost of the case) or exclusion from Medicare (or Medicaid). Physicians are more likely to face exclusionary sanctions while hospitals are usually fined.

Most quality cases result in providers being asked to submit a corrective action plan to the PRO. Physicians facing quality denials also face intensified review of all their Medicare (or Medicaid) patients. They may or may not

be informed of this intensified review. The PRO's Assistant Director of Review Operations told me they basically tell providers what to put into the corrective action plans. Their main goal is education, she said, not punishment.

We say to them, "Here." We practically write it for them, basically, but we, I write the letter, you know, I authored this letter that says, um, "Dear Doctor: We recently discussed X case. And here are our concerns: one, two, three, four, this is what we found was shaky about your care in this case. We would like you to address to us a corrective action plan addressing our concerns, and to include the following actions, you know, like in the future I'll seek specialty consultation." So we tell them basically what we want to be in the plan. Ask them to have it 20 days signed by committee chairman.

The administrators I talked with repeatedly stressed that true quality issues, involving major malpractice, are rare.

The PRO assistant director believed going after the physicians was the best option because it puts the blame on those responsible for ordering and supervising medical care and removing the onus from the hospital and the PRO (i.e., the federal government). She said the threat of sanction takes away

that one level of blame, you know, where they used to say the government's making us do it. And, you know, our position has always been, you, doctor, are the one who makes the decision when your patient needs to be admitted to the hospital or when he's ready to go home. We may make the decision whether or not it's appropriate to pay for it . . . but you're the one that makes those decisions still. Nothing has changed in that aspect. But if you feel that your patient is,

needs to be admitted for whatever reason, then it's still your position to admit the patient.

And I think that's the message that a lot of hospitals and physicians have failed to get. That the, you know, we haven't come into the patient-care triangle and stood between any of these three people. What we've done is say, you know, we still will reserve the right to pass judgment whether or not we can pay for it. And the one thing that I frequently have said to physicians on the phone that seems to ring a bell with them when they keep saying, you know, "Who are you and what right do you have?"--you get a lot of calls like that of course. And, you say, "You know doctor, I realize you're a self-employed business man and, you know, maybe you've never been in this situation, but, you know, every job I've ever had, the person that's paying my salary has the right to evaluate what I do for a living, you know?" And this is just the bottom line here, you know? The Golden Age of medicine's over, and this is the new health care. And that is, you know, we'll pay, and we'll pay you and we'll pay the hospitals, but we'll pay based on "appropriate." And, so, you know, now doctors have entered the real world.

Sanctions involving fines and programmatic exclusion are carried out by the Office of the Inspector General, separating the federal government, to a degree, from the burden of defending such actions. The PRO also reports all sanctioning activity to the state licensing board in an attempt to make them share some of the responsibility. I was told that, to date, no actions have been taken by these boards to reprimand physicians who have faced charges of low quality care.

During the PRO's first three years, hospitals were notified about physicians who had quality denials that were upheld after all appeals had failed. This practice was overturned in early 1988 when a federal judge decided this

broached physician confidentiality. The PRO administrators I interviewed found this frustrating because they felt hospitals should be informed of physicians practicing inferior medicine under their auspices. PRO officials told me hospitals, if informed, can better monitor physicians. Also a more recent federal decision makes it legal to inform hospitals of sanction decisions made by individual reviewers but not those made at the peer review committee level. This confusion and changing set of stipulations signifies the tug of war existing among the affected parties (i.e., the federal and state governments, hospitals and physicians) as they vie for influence and attempt to achieve their ends.

The PRO's stance, first and foremost, is that they should not be held accountable; officials argued they are merely making sure that medical care delivered in the state meets certain standards of quality. Their job is to educate physicians and hospitals how to work with the new system to minimize their headaches and to insure the maximization of quality. PROs existed, they argued, to help the system operate effectively and efficiently. The Assistant Director of Review Operations stated:

The one thing that I say most often to most physicians on the phone is that most of the quality problems that we see are not quality of care problems. They're quality of documentation problems. And the physician needs to document--which I feel they're doing more because of medical-legal reasons more than us [the PRO]--but I think they're doing a better job

of documenting what they're suspecting in this patient, what their plan is, what their alternatives are, and then some past history with this patient. You know, if this is somebody that they have seen every day in the office for a month, and they know some things about that, are making some assumptions or things about the patient that we can't tell by just looking at the one record. That needs to be included. And I think they, that's been a long time for them to realize those kinds of things that they need to--we need to see their thoughts on paper. Because it's really difficult sometimes for us to tell why they chose not to respond to this wildly elevated some kind of level in this patient, when they might know that that's how the patient gets along. If you get it down to normal, the patient doesn't do well, you know? And there are individual differences that we can't see. We always get accused of, oh, we're taking care of lab results and they're taking care of patients. Well, all we can see is the lab results. We can't see the patient unless he's well described to us by the physician.

COMMUNICATING WITH PATIENTS

In carrying out their mandate, the PRO has the responsibility of informing patients that their hospitalization will not be covered by Medicare. These "notices" must be initiated by the hospital and can be issued only when the hospital has the agreement of the attending physician or the PRO. There are three types of notices, each informing the patient that they will be liable for the costs of their hospitalization after receipt of the notice. Preadmission Non-Coverage notices are sent to patients prior to hospital admission if their care needs are not considered acute. Patients are liable for all the

Costs associated with the admission should they choose to go into the hospital and their condition remains non-acute.

Admission Non-Coverage notices are sent to patients already admitted to a hospital when it has been determined their care needs were never at an acute level. Beneficiaries become liable for costs on the day after receiving this notice if they remain in the hospital and their condition remains "non-acute."

Continued Stay Non-Coverage notices are also issued after hospitalization has already taken place. They signify that the hospital or the PRO has determined a patient's needs can now be met at a basic level of care and are no longer acute. Patients become liable for costs the day after receipt of the notice if they choose to remain in the hospital.

PRO notices to patients serve to restrict (and deny) admissions, limit hospital lengths of stay and unnecessary surgeries, penalize for the duplication of services, and foster quality care and sound discharge planning, according to the PRO. They also increase outpatient procedures and the need for home-based services.

In all cases, patients have the right to appeal notices of non-coverage. If successful in their appeal, costs will be covered by Medicare. Patients can appeal cases to the Office of the Inspector General. Most cases going before the judge are overturned, signifying that

payment should have been made. There are, however, no regulations stating how this payment is to be made. A Regional Manager for the PRO argued it was understandable that the judge would side with patients, but that the reasoning was difficult to understand since similar cases will be denied by the PRO in the future. The PRO is not required to go to these hearings and, if present, can not bring attorneys to argue their cause. The hearings appear to function primarily as a mechanism of patient appeasement. They do nothing to insure reimbursement of services or address the actual care needs of the affected elderly patients.

In early 1987 HCFA proposed a policy which would have made it mandatory for the PRO to notify Medicare beneficiaries when they received "substandard" hospital care. The policy also allowed for the denial of payment for services determined to be below professionally recognized standards of care and which negatively affected the patient. The state's PRO voiced strong opposition to this proposal via letters to the HCFA from the Board of Directors. Help also came from the American Hospital Association and the American Medical Association. They argued that such a notice would intensify the malpractice crisis already existing in the state, undermine physician-patient relationships, and weaken the medical care system. To date, these proposals have not been enacted and though

hospitals and physicians receive notices of substandard care (depending on who is responsible), patients are not notified. Quality issues are not brought to the attention of patients primarily because of the fear of breaching physician confidentiality.

EXPANSION OF THE SYSTEM

Since its inception, the PRO has expanded its purview to state Medicaid programs and strengthened its monitoring capabilities. In 1985, PROs were given the authority to review the quality of care received by Medicare beneficiaries enrolled in HMOs and Competitive Medical Plans (CMPs). In 1987, skilled nursing facilities and home health agencies were brought under their purview. In early 1988, the study state's PRO began reviewing Medicaid patients.

In mid-1988, the PRO's Chief Operating Officer discussed their revised scope of work for the upcoming budget period. Originally, all Medicare readmissions within seven days of discharge were reviewed. This was soon changed so that the limit was 15 days. The new proposed guidelines lengthened the limit to 31 days (with a sample of readmitted patients reviewed). Patients on ventilators, with extensive burns, or tracheostomies were to come under 100% review. A percentage of patients receiving ambulatory surgery and "intervening care" were to

be reviewed. None of these patients were focused on in the previous budget period. Contrarily, intensive review of COPD (Chronic Obstructive Pulmonary Disease) patients, those hospitalized for rehabilitation, and those receiving surgical procedures unrelated to their primary diagnosis have either been eliminated or stepped down as the PRO has successfully lowered lengths of stay and reduced admissions for those patient categories.

This process of expansion and adjustment mirrors the general expansion of governmental influence into the delivery of medical services. Since cost-containment efforts based on DRG-like systems first appeared, there has been a constant push to expand the system and make it work more efficiently while saving the government as much money as possible. Changes within the PRO are symptomatic of those occurring on a larger scale, centering around the increasing commodification of medical services. Significantly, they represent one of those areas of change potentially most likely to affect a transformation in the way medical services are delivered. They translate policy into practice by their monitoring of hospital and physician behavior and their ability to withhold payment if things are not done properly.

CHAPTER 5

HOSPITALS AND COST-CONTAINMENT

Hospitals as Target

Hospitals, representing the largest medically-related budget line-item of the federal and state governments and third-party payers, have been an obvious and understandable primary target of cost-containment measures.

They're bigger institutions. You know, it's easier to hit them. . . . It's like hitting GM for antitrust. Would you go after an AMC [i.e., patients or physicians]? No. You go after GM. You make your bang there and then get the rest of it. (Hospital Controller)

The focus on hospital care within our medical system follows from a reductionistic concept of disease and illness, a reliance upon high-technology and sophisticated procedures for diagnosis and treatment, and increased specialization within medicine. These trends have accelerated greatly over the past century, resulting in greater centralization and standardization of care (Starr 1982:145-179; Rosen 1963) and increased costs. As discussed in the previous chapter, cost increases have been

accompanied by continual, and recently escalating, cost-containment efforts aimed at hospitals.

The establishment of DRGs was one of nine provisions of the Tax Equity and Fiscal Responsibility Act of 1982 aimed at reducing the costs of hospitalized care for the elderly. These reductions were to be achieved through caps on payment and payment increases, reductions and eliminations in some spending categories, and standardization of rates (Hogness 1982). This chapter details how the study hospitals are responding to DRGs and other cost-containment measures.

The hospitals studied for this dissertation saw themselves as the target of governmental and other third-party payer cut-backs. One administrator told me DRGs are simply "a fee screen" aimed at cutting back on hospital reimbursement.

It's a fee screen, period, is what a DRG is. It's a fancy name for a fee screen. You have this patient in, who cares what it costs? This is what we're going to pay you.

A vice president told me he felt the main goal of DRGs was to squeeze hospitals:

Yes, they're killing us. Their object, in my own opinion, is that they want to close hospitals down. They want the weaker hospitals to get out of the scene. They don't want a free market right now. They want to control the market . . . and they feel that, really, the cost savings they're getting now are

minimal compared to what it would be if they could get rid of a whole bunch of hospitals and eliminate empty beds. . . .

Another administrator agreed:

Well, this is a shakedown period for hospitals and we knew that it was coming as soon as they talked about a prospective payment system. And it's happening. The 300 hospitals here [nationally] going out of business is a good indication of that. The question is who's gonna survive. And what they'll look like when they get done surviving.

In Michigan, 20 community hospitals closed between 1980 and 1988, representing about one-tenth of the total and one-twelfth of the beds. Eighteen of these closed after DRGs were instituted in 1983. In 1987, there were 196 hospitals in Michigan and it was fourth, nationwide, in number of closures (Hamilton 1989; Michigan Hospital Association n.d.). Nationally, hospital closures increased about 200% in the first five years of DRGs (McCarthy 1988:1684) and, by 1986, 60,000 hospital employees had lost their jobs (Himmelstein and Woolhandler 1986:444).

Though feeling threatened and voicing concern about DRGs and other forms of cost-containment, many administrators also stated the changes had their positive side. The budget director at one hospital, though believing hospitals are inordinately affected, stated he was pleased with the changes, referring to them as "good" and "smart." A director of ambulatory services stated:

There has to be a system of some sort. We've created a monster. Everyone's needs are now covered. Health care is more accessible than it ever was in the past. But what do we do with it? So there has to be some sort of cost-containment or system like DRGs. There's just too much excess capacity in the system the way it is now. So they're trying to put the inefficient hospitals out of business. That's the way it should be; if you can't run efficiently then you don't have any business operating.

Despite this general sentiment, administrators were quick to point out their hospitals are community institutions whose mission is to provide the highest quality care to their patients, and they lamented that they now had to run their institutions as businesses (see Ginzberg 1984). A budget director told me the bottom line is really patient care, "but then what you have to do is also keep fiscally solvent and you have to be able to cover your expenses obviously to reimbursement, otherwise you won't stay in business very long." He told me he did not think cutbacks had hurt patients yet, but "it's a real tug-of-war." Quality care still exists, he argued, and hospitals have to make sure it does not suffer.

The Spread of DRGs

Over the course of this study, DRG-like reimbursement and associated monitoring systems, once operating for Medicare, spread to many other programs. As discussed previously, Medicaid began DRG reimbursement in Michigan--the third state to institute such changes--soon after

Medicare began in 1983. In 1988, all outpatient surgeries and diagnostic and therapeutic radiological services switched from a cost-plus payment scheme to one based on fee-for-service. Plans to begin prospective payment for other groups of physicians and physician fees for ambulatory care are underway (*Lansing State Journal* 1991b).

Most third-party payers have adopted stricter rules for getting into the hospital and attempted to cut lengths of stay whenever possible. Hospitals in Detroit deal with over 100 preauthorization programs. The hospitals studied have dealt with around 50 unique plans since 1984. The state's largest third-party payer has ten different plans. A utilization review supervisor told me this number is increasing all the time.

Though most third-party payers still pay on a cost-plus basis, increased monitoring has cut into hospitals' profits. The state's largest insurance company pays 2% to 3% over costs--"not a heck of a lot," according to one controller. She complained that this insurer places caps on the amount paid over cost and bases their payments to hospitals on costs incurred in the previous year. Thus, if a hospital's costs increase, the "plus" portion of their payment may not be enough to realize a profit or even meet the added expenses the hospital incurs as part of its business operations.

This spread of DRG-like prospective payment systems aimed at cutting costs has had a major impact on the daily business of hospitals. They threaten their survival by removing revenue which was previously taken for granted. The biggest worry of the hospital administrators I talked with was the decreased income they all were receiving. This worry led all of them to increase their surveillance of costs and alter their mix of services to maximize profit. They expressed increased tensions between hospitals and physicians and a growing belief among patients that hospitals were unable to provide needed care. Each of these areas of concern on the part of hospital administrators is discussed below to outline the effects DRGs and other cost-containment measures have had on hospitals.

The Effects of DRGs on Hospitals

DECREASED INCOME AND INCREASED COSTS

Among the administrators I interviewed, the fear of decreased income due to cost-containment was widespread. The fear was multidimensional, but the general consensus was that there is a great deal of regional disparity in payments for patients suffering from the same diseases. They all felt that this problem had increased steadily

since DRGs began, with new and tighter restrictions continuously being implemented.

Though DRGs take into account an area's past labor and wage histories, most administrators still felt payments were disproportional and did not adequately reflect regional or state-wide variations. Additionally, they argued, payments did not adequately take into account the different types of patients different hospitals cared for. One controller reported that one of the area's other hospitals "got DRG reimbursement up the wazoo" because they do a lot of cardiac cases which have high DRG weights. She said a hospital in another town was "fat happy" when Medicaid went DRG because their costs had been so high in the past. She reported that her hospital's profits were 1.7% in 1986, .9% in 1987, and they were "hoping for .5%" in 1988. "Yeah on a \$167 million [revenue] we're not even going to make a million. . . . Give me a break! Something's got to be wrong."

This problem of regional payment disparity is compounded because many patients with diseases which bring high reimbursement are not admitted to the hospital as frequently as in the past. Thus, hospitalized patients are generally sicker and less profitable. A vice president of operations at one study site complained that hospitals are losing the "cream of the crop," the short-stay, money-making patients. These patients are now, as a rule,

treated as outpatients. Though the hospital can and does bill for the procedures it performs, it cannot be reimbursed for the room and board on those patients as in pre-DRG days.

Additionally, administrators argued DRGs do not take into consideration the variable amount of services and resources needed by patients with particular DRGs. A vice president told me that new computer programs prove this.

An MI [myocardial infarction, i.e., heart attack] is not an MI is not an MI. But their system, you know, they lived or died and that's about the only difference in an MI in their DRG system. The patient lived or the patient died. That's not true. You spend a whole lot more work on certain MIs than on others.

Most of the administrators I interviewed would agree with McCarthy, who argues that the Medicare payment system is "a sham."

First, the prospective payment system should be made both prospective and predictable. Today, payment predictability is a sham. The government continually changes the rules under which payments are made, while setting the rates of payment later and later in the fiscal year. Between October 1, 1987, and November 21, 1987, for example, the previous year's Medicare rates were in effect; from November 21, 1987, to April 1, 1988, those rates were increased by 0.4 percent, or 2.7 percent, minus a 2.3 percent reduction mandated by the Gramm-Rudman Act; for the final six months of the fiscal year, one of four different updates apply, depending on a hospital's location. Moreover, all this vital information remained conjecture until the President signed the fiscal-year 1988 budget-reconciliation legislation on December 22, 1987--almost three months into the year governed by the bill's provisions. . . . In sum, five

years into the DRG prospective payment system, reform is essential. Concept must merge with reality.
(McCarthy 1988:1685-1686)

Michigan Hospital Association statistics point out that in 1987 40% of the state's hospitals with 400 or more beds lost money on Medicare patients, compared with 90% of hospitals with 50 or fewer beds. Eighty-six percent of rural hospitals lost money compared with 64% of urban hospitals and 38% of teaching hospitals had negative reimbursement compared with 81% of non-teaching hospitals. Thirty-three percent (64) of Michigan's hospitals were losing money across the board, 43% (85) had negative operating margins, and 65% (128) had negative patient margins (Hamilton 1989).

Concerning the trend toward increasing restrictions, one budget director stated the dilemma as such:

So what we're finding is every year when your budget rolls around, for the same volume of patient-days or procedures you're doing, you get reimbursed less and less every year. Especially for the mid-west hospitals because we've got historically higher wage rates than, say, the southeast. . . . So it's difficult because everything keeps, gets ratcheting down, further and further. And so we've gotta come up with new ideas to draw business into the hospital to increase our volumes and market share.

These comments are supported by data on cuts in federal Medicare spending since DRGs began. In January 1984, two and a half months after DRGs were instituted, allocations for outlier patients were reduced 75% (Kampmann

1985). Day (1985a) reports 1984 hospital costs increased at the lowest rate since 1963 (4.5% compared with 10.2% in 1983). The federal government's proposed 1986 budget, predicted reductions of \$19 billion in Medicare and \$7 billion in Medicaid over the next three years. These cuts were to be achieved by keeping Medicare payment increases 2% below the increase in the hospital market-basket for goods and services, and by reducing payments for hospital capital expenses and graduate medical education (Wallace 1985).

[T]he program of health care for the elderly, which accounts for 9 percent of federal outlays, sustained 36 percent of the outlay cuts made to meet goals for reducing the federal deficit for fiscal 1988. The DRG system itself did not occasion these "savings" in Medicare outlays. Simple price fixing did, and any fee schedule within government control would have been equally effective. . . . Any buyer who can set the price saves substantially, whether payment is in beads or booty or DRGs. (McCarthy 1988:1683-1684)

In addition to decreased payments from the federal and state governments, hospitals have experienced increased costs associated with running and monitoring the new reimbursement systems. A vice president of operations argued that administrative costs always come with new programs: nurses to review patients, personnel to code all inpatient and outpatient admissions, added paperwork, retrieving and making copies of records all increase costs. New computers and software had to be purchased (Freidman and Martin 1987). New categories of employees had to be

created and additional employees hired. Quality assurance managers were hired or named at the hospitals to track practice and physician utilization. Utilization review staffs were also beefed up to deal with the coding and monitoring responsibilities associated with the new cost-containment regulations. One of the hospitals named their controller the "DRG Coordinator," and put her in charge of the various issues associated with DRGs. In New Jersey, it is estimated that \$7.23 was added to each patient's bill to recoup expenses associated with running the DRG program (May and Wasserman 1984:555).

Added expenses and increased workload, in conjunction with cutbacks in payments, have left hospitals facing a major crisis, according to those I interviewed and professional and lay publications. In general, they support Horn et al.'s assertion (1985b:1165) that the "use of the current DRG system for equitable prospective hospital reimbursement remains unsupported by any published study." A vice president of the state hospital association stated,

we're in deep woods. We're on a teeter-totter.
Hospitals are in deep trouble with big financial
problems.

Yet, despite this generalized lament, other evidence suggests that cost-containment has not had that deleterious an effect on hospitals' ability to make money. Schramm and

Gabel (1988:1681) report that hospital profits doubled in the first year of prospective payment, representing 6.2% of total revenues (three times higher than ten years before). Eighty percent of the hospitals in Michigan made more money in 1985 under DRGs than they would have under the old system of reimbursement (West Michigan Health Systems Agency Update 1986a). In 1986, HCFA reported that Medicare costs were \$41 million more under DRGs than they would be without prospective payment (Medical World News 1987). In New Jersey, where DRGs were first attempted, each hospital received an average of \$2.3 million more than they otherwise would have (May and Wasserman 1984:555).

It was not possible to explore in this dissertation the extent to which hospital profits have been negatively impacted by cost-containment. What is important to note, however, is the widespread *belief* that DRGs and other forms of cost-containment directly threaten hospital survival. It is this belief which has shaped the hospital responses to cost-containment described below.

TENSIONS WITH PHYSICIANS AND PATIENTS

It is inevitable that physicians should be affected by changes wrought by cost-containment. Determining which services patients receive, physicians play a large role in the costs hospital incur. As hospitals have faced decreased income and increased scrutiny of their costs,

they have understandably looked toward the physician as an institutional component which, if more efficiently controlled, could help in the quest for increased savings. Hospitals, mirroring federal and state systems, have adopted a number of strategies for monitoring and controlling physician behavior in order to control costs. All the administrators I interviewed thought time would only bring increased control and, along with it, increased tensions between physicians and hospitals.

I was told the system itself creates hospital-physician tension. Physicians get paid by Medicare for every Medicare patient they treat. The hospital's payment, on the other hand, is denied if the admission is determined unnecessary or the care provided is deemed to lack quality. The system supports physician abuses which are now seen as hazardous to hospital profits. A utilization review supervisor told me one of the study hospitals has a system with an

attending physician referring to consulting physician who refers to an admitting physician who refers to this physician who refers to that physician, that ends up in such an overuse. I mean everyone gets a fee and they don't need to.

There's a lot of abuses. There's a lot of things that with Medicare-Medicaid patients that are being paid for that shouldn't be paid for, that should not occur. And I don't know who's to fault there. I don't know, I mean hospitals kind of put up with anything doctors want. Ah, doctors want their paychecks big. Um, doctors on the other hand, hospitals tell them they need to fill their beds. You know, "keep our beds full. You can't bring me any

patients, why should you be on our staff?" . . . I know in the olden days it used to be, well, "How many beds do you think you can fill?"

This statement alludes to the changes that have occurred in hospital-physician relationships since DRGs began. Besides involving increased monitoring and control on the part of the hospital, both hospitals and physicians are faced with increasing numbers of ever-changing guidelines and restrictions on how they must conduct their business if profits are to be realized. This increases the tension between physicians and hospitals as it brings into question, and under hospital surveillance, physician behaviors that previously went unchecked. There is no efficient and effective way to communicate the many new regulations to hospitals or physicians. There is no one source of all the rules. They are also constantly being interpreted and reinterpreted ("reclarified") by their creators, with the hospitals responsible for keeping up with the changes and maintaining a sense of what is going on. One utilization review supervisor stated this is just the way it is and one has to live with it, but that it is always difficult to really feel as if one knows for certain what is expected of the hospital and physicians. This has consequences for the hospital-physician relationship as well as the care doctors deliver to patients.

Administrators stated that focusing cost-containment efforts on the hospital has led to a certain degree of

mistrust on the part of patients towards the medical system, especially hospitals. One controller told me:

It's difficult because we end up being the bad guy. We're the guy that tells the doc to kick them out. We're the guy that tells the patient to get out of here. We're the guy that tells the 65 year old lady who has a broken hip and no family, "Get the hell out of here, go take care of yourself. I don't care how you do it."

Cost-containment has set in motion a series of processes and changes in the delivery of medical services which are altering long-standing relationships among physicians, their patients, and hospitals. Each is having to adapt to the new medical care environment. In the next section, the ways in which hospitals are adapting is discussed. Though frustrating, the changes are perceived as inevitable and, for the administrators I interviewed, a source of forced innovation which is both threatening and exciting in its potential.

Hospital Responses

DRGs helped institute a series of changes in hospital business behavior aimed at protecting income. These include the withdrawal of non-profitable services; limiting treatment options (i.e., using a "hold back" rather than an "order freely" approach); restricting diagnostic testing; and shifting to various outpatient departments, ambulatory surgery centers, and emergency

satellite clinics (all of which still received payment on a cost-plus basis after DRGs began) (Katz 1983:108). They are monitoring their costs from trash can liners and laundry services to such high-tech procedures as open-heart surgery. They are limiting who they let into the hospital to receive care and they are monitoring and attempting to control the behavior of physicians like they have never done before. Hospitals are being forced to operate with less revenue, and, thus, are changing the nature of their business.

Despite these potentially threatening changes, national hospital organizations voiced early support for DRG legislation (Korcok 1984). Though it was debated whether or not costs could be curbed with DRGs and related cost-containment efforts, no one doubted that they were linked to many changes in the medical delivery system. The hospital administrators I talked to viewed DRGs as potentially having positive effects but felt their implementation was problematic and questionable as the best means to control inflationary health care costs (Ernst and Whinney 1980) and provide the highest quality care. Continuous articles in a wide variety of medically-related journals updated administrators and providers of new legislation and regulations, provider lobbying efforts, and the negative outcomes anticipated. DRGs were portrayed as instrumental in changing the medical delivery system--even

beyond cost-containment and economic spheres of action--that threatened traditional hospital operations and patient care. They were viewed as only one component, a symbolic representation, of what is wrong with the entire system as it is shaped by cost-containment and other general trends in the United States' medical care system.

Below, the hospitals' primary approaches to DRGs and other cost-containment measures are discussed, focusing on a series of general measures taken by the study hospitals to contain costs and maximize profits. Three midwestern hospitals of one community were studied between 1984 and 1987. These hospitals were, like hospitals throughout the country, facing the prospect of having to provide the same amount of services (if not more) for less money. All have responded in similar ways. The discussion is organized into sections dealing with Controlling Costs, Tracking DRGs and Physician Behavior, and Utilization Review and the Peer Review Organization. The chapter closes with a discussion of how hospital administrators believe cost-containment is affecting the care delivered to the elderly and other patients.

Controlling Costs

WATCHING HOSPITAL COSTS AND MAXIMIZING PROFIT

Since DRGs began in 1983, the study hospitals have made increasingly systematic efforts to obtain data on costs and establish methods to control them. Their attempts include comprehensive cost studies aimed at standardizing the purchasing of supplies and services and controlling the costs associated with medical procedures performed on budget-critical services (Applegate *et al.* 1983; Drucker *et al.* 1983; Egdahl 1983; Fisher and Plotnick 1984; Rooke and Osmundson 1986; Strauss *et al.* 1986; Winkelman and Hill 1984). Discussions with medical staff have led to cost-saving changes in routines associated with these services. Coordinating the purchasing of equipment and supplies among hospital departments has also resulted in "economy-of-scale" savings. In the first year of DRGs, hospitals reduced the rate of growth of expenses associated with supplies and services by about one-half (Schramm and Gabel 1988:1681).

The director of ambulatory services at one hospital site told me the first things affected by cost-containment were in areas not involved with patient care. Hospital administrators asked themselves: "What are essential services and how can we perform them more cost effectively?" His hospital bought video cameras and

monitors in order to reduce the number of security guards in the hospital. In purchasing, he reported an increase in group contracts, with supplies like bread and milk being bought from as few vendors as possible. It is "economy of scale," he said; they increase their purchases with particular vendors and it lowers their costs.

An administrator at another hospital told me about "adjusted-time inventory" or "Just-In-Time Deliveries." This purchasing technique allows hospitals to get supplies when they are needed rather than having to store them, thus reducing storage and inventory costs. They are also doing more bulk buying (for example, buying IV tubing by the train car load) to get a better price. One study hospital has been part of a national purchasing group of 16 hospitals since 1987, organized to get reduced rates on supplies. Also, as has been the trend throughout corporate America, the study hospitals have increased their relative number of part-time employees, reduced employee benefits, and fostered the use of managed group health plans such as HMOs and PPOs.

One administrator outlined some of the more mundane things done and being considered at her hospital to cut costs. For example, meat portions served to employees and visitors in the cafeteria were reduced from four to three and a half ounces.

[U]sing sterile vs. non-sterile gloves: You're talking 75 cents a pair versus ten cents. And think of how many gloves we go through in this institution, and how much money we could save if we only used sterile gloves where we had to use sterile gloves.

She was also attempting to change the number of temperature checks on non-risk obstetrical patients from every three to every four hours. She admitted it was hard to put the savings generated by such a change into dollars and cents, but

if they can get their charting done, and if they can deal with one less administrative supervisor because the RNs would be there and they could be doing double duty, we would be saving money.

These efforts would not necessarily result in huge savings, but would nonetheless save quite a bit of money over time.

In addition to the types of cost-cutting measures mentioned above, hospitals have been forced to examine ways to increase the cost-effectiveness of their delivery of medical services. As a result, figuring out and tracking patient-related hospital costs have been preoccupations since DRGs first appeared. The administrators I talked to denied cutting services, saying they emphasized doing things more efficiently, but all admitted they were studying the profitability of various services and devising plans to do away with unprofitable endeavors.

This has not been an easy task given 1) the long-standing policy of taking adequate reimbursement for

granted, 2) the difficulty in quantifying costs, and 3) because of the many components comprising costs which are not controllable by hospitals (Young and Saltman 1982). Additionally, hospitals have found it hard to convince their employees and physicians that cost-containment was necessary. One hospital's controller reported that 1985 was the most profitable year her hospital ever had:

So the more money made, the more you spend. 1986 and 1987 people began being more aware. Now they're starting to believe it's everybody's problem. We had a hard time convincing people that we needed to make money. They thought as a non-profit institution we didn't need to make money.

One of the measures taken by the study hospitals to control the costs associated with running their institutions is "zero-based budgeting." With this approach, department budgets are fixed, with each knowing how many hours they can utilize. Budgets are constantly being analyzed and each position must be justified on a regular basis. When employees leave, their positions must be rejustified to hospital administrators before the position is filled. The director of information systems at one research site reported the approach has been very effective so far.

We get X amount of hours to work and that's it. And we're very careful, more careful than I've ever seen the hospital before about the budgeting process, both capital expenses and the expense budget.

The vice president of operations at another hospital discussed his hospital's attempts to get full-time employees (FTEs) down from 4.7 or 4.8 in mid-1988 to about four per "adjusted patient day" (which includes outpatients). His hospital is attempting to establish a fluctuating work force with per deim-based payment and part-time employees. He said they need a full-time base with a fluctuating work force they can call in when needed since their business is characterized by "peaks and valleys." They have set up bonus programs to attract part-timers. Many hospitals have nursing pools to deal with variations in volume.

Monitoring and attempting to control the costs associated with treating patients has also occurred via standardization, a direct result of governmental and third-party attempts to cut costs via DRGs and similar cost-containment efforts. The administrators I interviewed expressed ambivalence about these changes. On one hand, these efforts create a good deal of expense and increased work for hospitals. On the other hand, hospital administrators viewed the changes as beneficial in that they help them understand their costs and expenditures and, hence, maximize profits. They also, however, complained to me about the difficulty in creating standardized procedures to please everyone and the resulting confusion these attempts engendered.

An illustrative example of forced standardization is the "UB-82 Claim Forms," created as a means of minimizing paperwork. An administrator in charge of one hospital's computers and keeping track of the hospital's costs and revenue told me the forms were first discussed in 1982 when:

The different agencies got together and said, "Wouldn't it be more appropriate if instead of having a separate claim form for Medicare, a separate for Medicaid, a separate for [third party-payers], a separate for this insurance company and that one, that they come up with a uniform bill? And so they did.

The "UB Committee" was made up of representatives from Medicare, Medicaid, other insurers, and hospitals. They developed a "billing format" consisting of "hard copy" (i.e., a billing form) and a computerized record of bills. The form was being adopted by a local physician-sponsored insurance plan in mid-1988 and there were plans for other commercial insurers to use it. When asked if he thought the forms were good, he replied that the concept sounds good on the surface

except when you get right down to the real nitty-gritty. Even though it's a uniform bill, each carrier will say, "I want the data organized this way on it, I want it organized somewhat differently, and I want it all together differently."

Attempts at standardization within hospitals center around the utilization of some sort of "case-mix management system" used to assign DRGs to inpatients. The goal of

these computerized systems is to reduce the costs associated with treating patients wherever possible. This monitoring ability allows for the production of many different types of computer reports, including those examining the utilization of services by physician for different categories of patients. A controller at one study hospital explained how this new monitoring capability has shaped her hospital's response to cost-containment.

Right now, we'll be working on--another new project we have is to take our top ten DRGs at the hospital, find out what kinds of procedures are used, and then see if we can target one or two of those procedures to take the cost down 50 cents or a dollar. You know, if we could achieve that on one procedure that we might have 4,000 occurrences of, that's \$4,000. . . . That's my new approach. Hospitals have approached cost reductions in a lot of different ways. And we've tried--and we made--we had a reduction in force a year ago and it wasn't real successful because we hadn't planned and/or couldn't have anticipated some of the problems that would happen with a low staff. And, so now, people are trying to do different things. Many people are trying to just look at the cost and challenge: How are we doing things? Can we do it different? Quicker? Better? Cheaper?

My approach is that with the top ten DRGs, although many--and you're talking involvement of physicians, your talking involvement of patients, everything; you've got so many variables there--that if we could cut the costs on one-item use on every one of them, it would be to our benefit. And nobody would be hurt. So that's my new approach to what cost-containment is.

She also told me her office reports monthly to the hospital's departments on "their budgeted and actual costs per procedure" as part of a "multiple reporting package."

Another way hospitals have cut their costs is by increasing the efficiency of patient billings. Not only has this resulted in receiving their money more quickly from payers, it has decreased the hospital's workload in a number of different areas.

For instance, where, getting our patients' payments posted may not have been a real priority in the past. They're five, ten dollar checks. They're a pain in the neck. What difference does it make? So they sit for a couple weeks. What difference? Well, if our statement cycle is every two weeks and we let the check sit for three, then we're sending out another mailer, increasing the postage, then the phone calls coming in from these people saying, "I sent you my check three weeks ago." So that's a cost--and that was reality, you know, when I took over. And now we may be two days late--behind--in posting cash.

They have less mailers going out and less postage, they are not paying for a computer operator or for someone to sort letters in the mail room, and they are not tying up the phone lines. She said you cannot measure this in dollars and cents, but you know that it is saving money.

INCREASED PRODUCTIVITY

A key theme in all the hospitals' responses to cost-containment, and linked to the efforts described above, has been what they call "increasing productivity." This has been necessitated by their need to cut costs and maximize profits and is associated with our society's attempt to reduce all activity to some kind of economic measure of

"output." A long history of this exists in hospitals (Tatchell 1983). DRGs illustrate this trend extremely well, as previously noted, and encourage (if not force) hospitals to adopt the stance of a business providing services reduced to products (Fetter et al. 1985; Kimberly 1982). As Young and Saltman (1982:802) note, DRGs have the

potential to assume many of the characteristics of management control systems found in many manufacturing organizations.

A utilization review administrator reported in 1988 a new hospital-wide employee evaluation process instituted to insure that "if people were not doing their job or producing as they should be it was dealt with accordingly." In a department such as medical records this is easy to do because everything the employees do can be measured ("you just count 'em"). Thus, in that department, the number of charts employees code in an hour is monitored. Typists' productivity is measured by how many minutes they work, using a computer and bar-coded microcassettes. They are paid an hourly rate plus 13 cents for every minute they type. She reports this incentive has worked well for the nine to ten years it has been in effect. Similar incentives were being instituted in all the hospital's departments where possible.

Even administrators at her hospital are not immune to having their behavior monitored and their professional

productivity assessed. Although harder to do with administrative positions because "it is more subjective and PR-related," this administrator reported numerous restructurings within her hospital's administration in an attempt to standardize and rationalize things as never before. (This is not the case at all three hospital study sites. At least one of them determined its administration was streamlined and efficient enough so as not to necessitate these types of changes.)

One administrator saved money in his department by determining which of the reports generated by his office dealing with departmental costs were actually utilized by departments and administrators in the hospital. He asked department heads to identify the reports they could live without. He claimed this simple survey resulted in an "incredible" reduction in the number of reports and in lowering the hospital's supplies expenses. It also increased productivity on the part of his department's employees.

The budget director at one hospital told me about the "productivity studies" his hospital began running in late 1987. Base-line figures were derived by determining the labor and supplies used for each of the procedures performed in the hospital. Time studies were then conducted which "costed-out the relative expense or utilization of each of the procedures in the hospital."

These standards formed the basis of their productivity study. Their goal, he stated, was to get the hospital's departments to work more efficiently:

So if you look at x-ray, for example, for one month, and you found out they did, let's say, 30 chest x-rays. Well, 30 chest x-rays should take X number of tech-time and X number of clerk-time, and X number of transport time. And so it gives us an idea of how much time we should have used versus how much time we actually did use. And so that gives us a feel for how efficient we're doing it in comparison to our standard. So that the standards developed with that cost-accounting are the same ones we use for productivity to keep it consistent.

Showing me a productivity report for the emergency department, the budget director said it was a "summation" sent monthly to the department head and the directors of nursing and the emergency room. It showed "Units of Service," a "combination of all the acuity levels or services they do for the month." He explained each of these units, multiplied by a standard in their computer system, gives "Variable Hours," representing the number of hours which should have been worked for that amount of "incremental units of service." A constant factor is then added in (for such things as educational expenses and the cost of the administrative director whose time is fixed) and this results in the variable "Earned Hours," or the number of hours that should have been worked for X number of procedures. This is compared with the number of productive hours actually worked, exclusive of sick and

vacation time, supplying a "Percentage of Efficiency." This particular report showed that the emergency department was running at 90% efficiency. The department head gets the report and works alone with the budget director to improve efficiency. It is up to the department head to write up, with one of the vice presidents, a plan and timetable to increase efficiency.

Once his hospital developed the capability to operationalize and measure efficiency, they did an "80-20 study": a close look at the 20% of procedures that result in 80% of the hospital's utilization or revenue. This amounted to "hundreds of procedures." Though results of these studies are interesting, their main impact will occur in the future, he stated. They aim to help fine-tune department standards over time. He claims these studies have increased productivity:

Yeah, it really has, because a lot of the emphasis has been on "work smarter" and to try to evaluate each department and what really needs to be done, you know, for quality care and things that maybe don't need to be done or are being done not as efficiently as possible. These usually try to be squeezed or phased out during the budget process.

Nationally, hospitals have also responded to cost-containment by removing employees and beds in an attempt to increase productivity. Schramm and Gabel (1988:1681) report a 2.3% reduction in workforce during the first year of prospective payment. McCarthy (1988:1684) notes that,

from 1983 through 1987 hospitals reduced their number of full-time employees by 114,000 and removed 45,000 beds from service.

Another strategy employed by hospitals to combat escalating costs and increase productivity involves the reorganization and consolidation of hospital departments. One hospital consolidated the medical records and admitting departments in March 1988 to reduce administrative costs and consolidate control over patient diagnosis and procedure coding. This consolidation also entailed a shift in how medical records was viewed, according to its director. She complained that for twenty-five years her department had been burdened by ever-increasing amounts of patient-related paperwork without much expansion in their ability to deal with it efficiently. Now the importance of the medical record department as the hub determining reimbursement for patient care is realized:

This department was seen as a place where you dump paper, to this is where revenue is generated, . . . this is where the billing process starts. And we better pay attention to what these people are doing to our database.

When she arrived in June 1986 as the head of medical records, the department had not processed any paperwork associated with outpatient surgeries for the past two years. In late 1985 there were "millions and millions and millions of dollars worth of cases that hadn't been billed

because we hadn't done what we had to do to them." Now she claims her hospital has a two week turn around time in billing.

The creation of the controller position at a different study hospital also represented a consolidation effort which helped contain costs:

what the job of controller really did was to get-- where we used to have somebody, an individual, over the accounting department, an individual over the reimbursement department, an individual over payroll and timekeeping, we now have all those departments reporting to me as a department manager controller-type.

She justified the consolidation as a way for the hospital to better monitor and control their costs:

Number one, there's things that happen on the reimbursement side that accounting needs to know and there's things that happen on the accounting side that reimbursement need to know. With having one department manager versus three, it just helps your information flow. There's still some problems with information flow, but it's a lot less than what it used to be. So, really, the move to make me controller was to strengthen our financial staff versus in response to cost-containment. Really to improve communication.

INCREASED AUTOMATION AND THE USE OF COMPUTERS

Increasing automation is another step taken by the study hospitals to increase productivity and lower costs. The case-management system briefly described above is just one attempt at automation aimed at keeping better track of

patients and services provided. The study hospitals are increasingly relying on computerized networks of micro and mainframe computers to register, admit, transfer, and discharge patients. These networks are also increasingly used to "order-entry" patient services such as lab work, x-rays, and medications to facilitate billing.

One study hospital's laboratory, radiology department, and pharmacy have been automated since 1982 with a direct computer-to-computer interface between lab and radiology. Orders placed on the nursing unit for lab work are automatically entered into the lab's computer system. Once a test is done (with results reported on a computer hooked up to 10 or 11 of their diagnostic machines), any nursing unit can inquire about lab results on their patients: "Very, very state of the art," according to one hospital's controller. She also told me about a new spreadsheet software recently purchased that will save 10 to 20 hours per week of clerical staff time. It also allows the manager time to do more management-related work. The budget director at a different hospital reported his hospital had purchased a computer program to do the hospital's cost-accounting which would pay for itself in two years.

All the study hospitals had undertaken similar steps to increase their control of information related to their non-medical staff's productivity and the costs incurred in

running their businesses. These steps were taken relatively recently and can be directly attributed to increased cost-containment efforts by third-party payers. The controller I interviewed voiced a reality similar to hospitals nationwide:

We didn't do it nearly to the level that we are now [mid-1988]. We had, in my opinion, we had some real severe, we were, in my opinion--this is my opinion--we were a well-run hospital. We were not a well run business. That statement can be said for any hospital and any bank. They're well run institutions, but they weren't well-run businesses. And we lacked automation, severely. When I started three and a half years ago there was one PC. And now we have eight.

Increased computerization, with its associated standardization, was viewed by those in charge of controlling and using the generated information as a very significant step in the process of helping the hospital contain costs by helping, first, to quantify them and, second, by aiding in the streamlining of departments. As the vice president of finance I interviewed put it:

What the DRGs did for us was make available information we never had before on computers. . . . I think it would have happened eventually anyway because the trend was really there. But DRGs gave us a nice handle and forced computerization of some things which has made it a whole lot easier for us to look at those issues that we wanted to look at before and couldn't because it was not possible.

DRGs definitely speeded up the trend toward monitoring, he believes.

It suddenly made available in a convenient way lots of patient information that could be tied to accounting information. Forced that, but at the same time made it available to those of us who like to look at and analyze that kind of information. Couldn't do it before because to do a little study by hand--and I've done, did a few of them through manual medical records systems--took months.

Studies that used to take "almost a week" can now be done in five minutes.

COOPERATIVE VENTURES BY HOSPITALS

Throughout this study, there was continual talk among hospital personnel and legislators regarding closing one of the area hospitals. Frequent stories in the local and national press and video media aired the plight of hospitals both locally and throughout the country. It was felt there were just too many beds given the reduction in inpatient censuses that hospitals were experiencing. In response, the study hospitals set about establishing a variety of linkages with one another, with physicians, and with local medical schools that occur to this day. These include various joint agreements, ventures, and shared services. By March 1989, two-thirds of the study state's 196 hospitals had merged or were negotiating such agreements (*Lansing State Journal*, March 6, 1989, p. 3B).

This trend mirrors national trends which have been in existence for some time. For instance, in 1983, the percentage of hospitals belonging to chains was 33%

(Business Week 1983:30-31). Arthur Andersen & Co. (1984:30-31), a national consulting firm, predicts that by 1995 40% of nongovernmental hospitals will be owned, leased, or controlled by multihospital systems (an increase of one-third over 1982 projections), the number managed by multihospital systems will grow to 13% (from a 1982 level of 6%), and investor-owned hospitals will increase sixty percent. These trends tend to blur the distinction between for-profit and not-for-profit institutions as cost-containment efforts increasingly affect hospitals in general (Culliton 1986a). Kimberly and Zajac (1985:286) refer to this trend as "strategic adaptation," and point to the proliferation of multiunit systems, changes in the locus of decision making, and changes in the design, control, and organization of work as common responses health care organizations must adopt if they are to survive.

Local cooperative ventures include area hospitals buying supplies together in bulk to reduce costs and the operation of a laundry cooperative. Linkages with the local university and area residency programs are continuously being made to bolster hospitals' teaching statuses, access to residents, and increase reimbursement (since Medicare pays additional monies for costs associated with the training of physicians).

Joint ventures undertaken between hospitals and physicians include agreements to purchase large pieces of expensive equipment and hospital underwriting of clinical expenses. Hospitals are buying outpatient clinics and staffing them with salaried physicians. This helps ensure patients for the hospital and increases the hospital's income from outpatient services--relatively unaffected by DRGs until recently and an important source of revenue. In late 1989, two of the study hospitals publicly announced their agreement to talk about working together along a variety of fronts in order to strengthen their survivability. In 1991, their talks continue and the other two hospitals in the area are beginning discussions along the same lines.

INCREASED DIVERSIFICATION AND MARKETING OF SERVICES

Diversification on the part of hospitals takes many forms and is aimed at expanding into profitable markets outside the scope of current cost-containment measures. One hospital in an outlying region opened a commercial laundry to bring in revenue. Most have entered the home care business and many now sell the equipment and supplies needed for such care. Others are purchasing physician's practices to ensure a pool of patients that will be treated at their hospital when care is needed and to ensure

business for their laboratory, radiology, and pathology departments.

Marketing their services has been done strenuously by all the hospitals I studied, as is the case nation-wide. Full page ads in the local newspaper and national magazines such as *Newsweek*, billboards, and advertisements on local radio and television are all utilized. Marketing strategies emphasize services for potential patients and are also aimed at recruiting physicians. "The pie is shrinking and what we're trying to do is keep our wedge of the pie at least the same," one administrator told me. A budget director reported his hospital had an increase of a couple percentage points in market share from 1986 to 1988 due to their advertising efforts--quite good for the health care industry, he said. The irony of having to spend large amounts of money to recruit patients in the new, fiscally-constrained environment seems to be lost on the administrators I interviewed.

SHIFT TO OUTPATIENT SERVICES

The diversification discussed above involves a large increase in outpatient services. The director of ambulatory services at one hospital reported a 22% increase in outpatient visits over budget projections in the second half of 1986. He said they had to look at ways to increase their outpatient services and revenue to offset losses

associated with inpatients. The controller at a different hospital reported her hospital's outpatient revenue had been increasing steadily since DRGs were first implemented: from 19% of total revenue in 1984, to 20% in 1985, 23% in 1986, and 26% in 1987. She said the percentage would be even higher in 1988. The number of outpatient surgeries at her hospital increased from around 40% to 45% of all surgeries in 1984 to 60% in mid-1988. At another study hospital the finance director told me their outpatient services grew from 40% of their business to 60% in 1985. In 1988 he reported a 70/30 ratio of outpatient to inpatient services.

These trends are similar to the national experience, where, in 1986, there was a 40% increase in ambulatory surgeries (up from 16% in 1980) (Schramm and Gabel 1988:1682). In a 1985 national survey of 27% (1,800 total) of all hospitals in the U.S., it was found that three-quarters expected to add or expand home care services, 74% outpatient surgeries, and 55% outpatient diagnostic capabilities. Sizeable numbers also planned on increased involvement with PPOs and HMOs, wellness and health promotion activities, cardiac rehabilitation, and oncology, rehabilitation, and substance abuse services, all done in outpatient settings (Moore 1985:74). With outpatient costs still reimbursed on a cost-plus basis, they generally

become lucrative ventures. As a Medicaid officer told me, this makes sense from the hospital's perspective:

I mean, just look at the Medicare for a second. Medicare switched to a price system for inpatient care, but they kept their costs system for outpatient. So they've got a fixed price, a fixed payment for any inpatient care, based on a DRG, but on the outpatient side it's still cost--full cost. Well, what's the incentive there? If I'm the CFO [Chief Financial Officer], I say, "Ah hah. I think I know how to maximize money here, or maximize reimbursement. The way I do it is, since my reimbursement is fixed on the inpatient side, whatever costs are incurred by the hospital, let's make sure they're counted as outpatient costs. And we're gonna minimize the amount of costs that are counted as inpatient costs because a cost that's counted on the inpatient side doesn't generate me any revenue. But a cost that's counted on the outpatient side does.

So, systematically, you get cost-allocation plans within hospitals being restructured to maximize the floor space--the whatever is the basis on which they allocate costs. They're maximizing their revenue by shifting things to the outpatient side. So it's only natural that you're gonna get hospitals saying: "Let's really balloon our outpatient business and we'll keep doing what we're doing on the inpatient side as much as we can, but we're gonna minimize the costs that are designated there." That's the way to do it.

The director of ambulatory services I interviewed mentioned many of the different kinds of organizations emphasizing outpatient services cropping up in response to the changing medical care environment. These include the media-named "alphabet soup" components: HMOs, IPAs (Independent Practice Associations), CPGs (Community Physician's Groups), and CPEs (Common Provider Entities). He discussed his hospital's involvement, in late 1984, with

a CPE ("a sort of HMO"), saying it represented a form of "Alternative Financing." In late 1987 his hospital opened their own HMO, in the research city as well as two others in the state. They are trying to increase the market share of this managed care plan by getting large employers to sponsor it. The UAW and GM offered this plan to their members and employees in another city in mid-1988 and attempts to get them to offer it in the research city were underway during the time of the interview.

Hospitals included in this study have also branched out into new services such as geriatric assessment, psychological testing, and addictions treatment delivered to paying customers in non-acute, outpatient settings. One of the study hospitals built a sports medicine and outpatient medical complex with close ties to a university in 1990, and they are exploring the possibility of constructing a facility aimed at providing long-term primary care to an elderly clientele. Others are subsidizing physicians' practices, as already mentioned.

Factors forcing hospitals to expand outpatient services can be illustrated by looking at patients needing laminectomies, a surgical procedure aimed at alleviating back pain. Most of these patients require a myelogram to specify the points of pathology on which the surgeon needs to focus. DRG regulations do not specify myelograms as outpatient procedures for Medicare patients, but if the

procedure is done in the hospital, with the patient discharged and then readmitted in the customary seven to ten days for the laminectomy, the hospital can get cited for either "fragmented care" or an "inappropriate admission" and penalized by the PRO. This effectively mandates myelograms be done on an outpatient basis.

When DRGs began, hospitals were paid for the myelogram and the laminectomy under two separate DRGs. In mid-1988, hospitals were notified by the federal government that they would not be penalized if patients were admitted for a myelogram, discharged after the procedure was performed, and then "readmitted" for the laminectomy. They were given approval to count the days between the discharge and admission as a "leave of absence." Hospitals now bill for one admission and get paid one DRG for both procedures. A vice president said this payment is less than the original payment. His hospital does myelograms as outpatient procedures so they get to bill the procedure at cost, but they still lose money, he said, because patients have to be kept overnight. He argued this is better than losing more money by admitting these patients to the hospital, but it highlights the dilemma hospitals face because of DRGs.

Another example of federal regulations forcing hospitals to increase outpatient services concerns Medicare reimbursement for kidney dialysis patients. All patients needing dialysis are potentially covered by Medicare,

regardless of age. Patients receiving peritoneal dialysis qualify for reimbursement on the date they become a peritoneal patient "because they're in self-training to do it at home," according to a nephrology social worker I interviewed. Hemodialysis patients, on the other hand, are not qualified for reimbursement until the end of the third month of treatment. The social worker told me she could not explain why the first three months are not covered. This policy, in effect, pushes hospitals and physicians to support peritoneal dialysis programs which stress home care.

These dilemmas involve making new decisions centered around whether or not to admit patients to the hospital and whether to categorize certain procedures as inpatient or outpatient for billing purposes. In part, the latter is a semantic distinction, but both directly affect a hospital's ability to make a profit or be adequately reimbursed for its services. The dilemma is highlighted due to ever-changing government regulations and "reclarifications" of medical policy.

The increase of outpatient services has had a definite impact on the hospital and patients. For one thing, the hospital's census is lower than it used to be. A UR manager told me she remembered when the hospital was about 75% to 80% full in 1984 and 1985--when she "was doing statistics." In 1987 she thought it may be about 60%. She

remembers when hernias and tonsillectomies were done in the hospital. Now they are done as outpatient procedures. Her hospital had about 20 outpatient surgeries a month in 1985; when interviewed, she said they did that many in a day.

She told me that the decreased occupancy rates could be dangerous for the hospital financially

if you didn't look to other things that you could provide. Services like the outpatient unit have really increased their staff and their capabilities to take care of those patients that now are outpatients that were inpatients. So, I think the hospital's recognized that and done some things in that area to beef-up their outpatient services.

SHORT-STAY OBSERVATIONAL UNITS

DRGs have meant it is impossible for hospitals to get reimbursed for patients arriving at the hospital needing care that are determined to be "non-acute" and, thus, treatable outside the hospital. In response, hospitals have developed short-stay observational units to provide needed services while maximizing reimbursement for patients whose hospital stay will not be paid by third-party payers. Most patients admitted to short-stay units do not get admitted to the hospital.

A director of medical records told me her hospital's short-stay unit was developed in order to deal more effectively with those "in-between patients" faced with a

myriad of non-acute problems. A vice president of operations told me

patients actually weren't allowed to come into the hospital or, you know, they didn't meet the criteria to be admitted anymore (laughter). So you have to, we've developed things like we call "the short-stay unit." Which, really, Medicare has no reimbursement for currently. But it was the only way we could treat these patients 'cause they're too sick to go home and they don't meet the criteria to really be admitted to the hospital so we put them into the hospital and don't charge them for inpatient stay (laughter), room and board. So you got an additional cost that you can't do anything, I mean, you get paid for the lab and x-ray and all the diagnostic tests. But, you know, in order to help the patients that can't manage on their own.

A director of utilization review told me:

Well what we do with those patients is that, you know, the physician admits them to the hospital and we'll look at them and we'll say to the physician the next day, "You know, your patient's still not meeting criteria. What's the plan here?" And he'll say, "Well, I've observed him for 23 hours and now I feel I can send him home." And we will look at that and say we don't have a hold area, but we can treat it as if we did and not bill it as an inpatient.

She was against hospitals having the units because she believed they supported federal policies aimed at cutting reimbursement.

The short-stay unit, or observation unit, concept came out of the feds. It came out of the regional offices for the PROs. What a great idea! If people could come into the ER, and if you can't get the congestive failure under control . . . and we can just observe them for maybe up to 24 hours they'll get better and then they can go home. And if this is all done as an outpatient, you don't get, have to pay that DRG, right? What a wonderful idea. And all the PROs,

and the PROs start pushing for this. . . . So the PROs forced us all to have observation units. They don't force us, but they send us notices saying, "This case could have been handled in the 24 hour observation unit."

The hospital gets reimbursed for their laboratory and x-ray expenses for patients in these units since they are billed as outpatient services. They receive no reimbursement for the other services they provide, the largest being the room charge.

OK. These people take a lot of time and effort in a short period of time. If they're truly sick and belong in the hospital, they are in the hospital and they belong there and it shouldn't be a make-believe they're not really here. They are here, and they are being treated as acute patients. The whole DRG system was built based on short stays and average stays and long stays. And the short stays included those people that stayed one, two, three days. Well, they want to carve out all those short ones. Which means that when we get paid the average, that we're really losing because they're still paying us the average for the longs but for the shorts we get nothing.

It may be workable if regulators would come up with a "short stay outlier payment" or a similar reimbursement scheme and readjust the average, she stated. In the meantime she believes "We're all being duped." The only patients she suggests for the short-stay unit are those that should not be in the hospital anyway--the "no-bills" (patients not billed for the care they receive because the hospital determines they will not be reimbursed by the third-party payer).

Hospital administrators like short-stay units since they decrease denials, but a UR supervisor told me this perspective ignores the long-term impact. She believes that hospitals support federal cost-containment policy when they utilize the units because it limits reimbursement.

In essence, short-stay observational units are a financial response on the part of hospitals, a means of providing inpatient care but billing for these patients services in a different manner. A vice president said:

Because of that opportunity, we, basically we have a whole new category of patient--in a billing sense, not in another kind of sense--and, yeah . . . a lot of patients, around three, four hundred a month, probably, go through that system.

The unit does not exist as a separate, physical entity in the hospital; patients are assigned to nursing units based on the type of treatment they need and the kinds of problems they have. This causes administrative problems associated with billing and keeping track of short-stay patients in the hospital. Tracking patients and following up on the care delivered by their physicians is crucial since a patient staying 24 hours or beyond must be admitted to the hospital, thus increasing the hospital's vulnerability for a denial of payment.

Tracking DRGs and Physician Behavior

As discussed above, all of the study hospitals developed ways to monitor their costs and payments associated with DRG-reimbursed patients. These efforts included the monitoring of physicians. Responsible for admitting and discharging patients and determining how much money is spent on them while in the hospital, physicians play a large role in determining how much profit a hospital makes.

During the study period, Medicare patients accounted for 20% to 40% of the study hospitals' censuses, approximately 20% were covered by Medicaid, and 40% to 50% were insured by the state's largest third party-payer. As discussed above, DRGs began with Medicare and soon spread to Medicaid patients. Though private insurances have not yet adopted DRGs or similar prospective payment plans to the extent the government has, they have begun to monitor admissions, procedures, and lengths of stay in ways similar to DRG-induced monitoring. As a result, hospital attempts to track DRGs and physician behavior are widespread as hospitals attempt to limit their expenditures and maximize profits.

Below, the ways hospitals track patients and monitor physician behavior are discussed, followed by a description of the educational efforts taken by hospitals to instruct their personnel, including physicians, about the new

regulations. The effects of these monitoring and educational efforts include decreased lengths of stay for patients and fewer patients being admitted to the hospital. A discussion of how hospital administrators view these and other changes brought about by cost-containment concludes this section.

GROUPERS

In order to chart performance under DRGs, hospitals use some kind of DRG "Grouper." These software programs allow hospitals to estimate their payments for the patients they treat. Groupers "roll in" primary diagnosis, secondary diagnoses (especially complications or comorbidities), surgical procedures, and patient age and sex in order to assign each patient a DRG. They also allow hospital personnel to add additional diagnoses found in patients' chart notes to see if it will increase reimbursement. The software has features prompting coders and physicians to look for things which are usually related--dehydration with gastroenteritis, for example--so that they may be added to the chart and increase reimbursement. It will also flag inappropriate admitting diagnoses.

By mid-1988 there were seven different Medicare Groupers that had been used since DRGs began. Medicaid began using the first Medicare version and stayed with it

until 1988 when they went to the fifth version. A director of medical records told me the Grouper is "one of best \$5,000 investments we've made." Though she said she had to "jump through hoops," she was eventually successful in getting each of her employees a personal computer with grouper software in 1986. She believes it has helped achieve hospital goals by being able to show physicians what their charting means in dollars and cents.

Information obtained from the Grouper can be used by hospital personnel, including the patient's physician, to alter the medical record to maximize reimbursement. Printouts are put on patients' charts showing what medical records has extracted from the record and how, if the physician agrees, it would affect the DRG payment. Physicians must sign an attestation agreement, signifying their agreement with the ordering of the diagnoses. The order in which the diagnoses are listed is important since reimbursement is determined by the principal diagnosis, listed first.

Most of the problems found by the Grouper relate to physician sequencing of diagnoses. A medical records director told me physicians still tend to think in terms of "primary diagnosis" (which diagnosis consumed the most services) rather than "principle diagnosis" (why the patient was admitted in the first place). She told me they

alter about four to five records every day to increase reimbursement.

TRACKING PATIENTS

In late 1983 and early 1984, the hospitals studied began entering financial data related to each discharge into computer files, predicting the DRG assignment for each case, and tracking the length of stay and charges for the patients of individual physicians. Physicians in all four of the area hospitals received statements informing them how they were doing relative to DRGs. These statements, individualized for each physician, compared the lengths of stays of their patients with DRG-associated lengths of stay (LOS) and noted physicians' expenses. A study by one of the hospitals in 1983-84 correlated individual physicians' discharge abstracts with bills that specified the services ordered for each patient. Analyses like this one, common in all the study hospitals, provided a clearer picture of individual physician practice styles and hospital services that result in above-average charges. One hospital changed its by-laws in late 1984 to more carefully define the requirements for staff membership and, in effect, permit withdrawal of hospital privileges for excessively expensive practice patterns.

Medicare patients come under the most scrutiny by hospital personnel because DRGs began with them and because

the federal government's monitoring capabilities are more organized and intrusive. Medicaid patients are also monitored, but with review criteria that are more lenient and less prone to deny payment: "We call them [Medicaid] very non-invasive, actually (laughter)," a director of utilization review reported. Medicaid has an eight day readmission guideline, with readmissions occurring over eight days subject to a "retrospective review" of "something like ten percent." Medicare reviews all readmissions which fall within their specified number of days.

At the beginning of my research, patients covered by third party insurances were not monitored at all in terms of costs or expected reimbursements. Since hospitals were guaranteed their costs plus a profit on these patients, they did not spend the time to track them. Over the course of the study, however, private insurers greatly increased their concern over costs and their monitoring activities. A controller reported in 1988 that the state's largest insurer had really begun to quibble over costs. She described them as "Nit-picky; every year it gets worse." She said trying to reach agreement with them "has become a real challenge, where you can't get an answer."

One of the complaints voiced by the administrators I interviewed concerned the lack of clarity regarding review or tracking criteria emanating from federal and state

regulators. The director of information systems I interviewed told me the rates for both Medicare and Medicaid patients were changing constantly. His hospital averages three DRG updates a year from the federal government. A utilization review supervisor voiced consternation regarding the way in which the hospital was informed about new DRG-related regulations. At the time of our interview, in mid-1988, DRGs were spreading to third party-payers and outpatient surgical DRGs. She complained one could never be sure when changes would take effect or what, exactly, the new regulations would be.

And then they change dates and they're not ready and, you know, just like they weren't ready for us to start submitting the codes so that they could start collecting the data when they were supposed to. We got an extension then from July to October. So you're never sure if it's really going to happen till it happens.

This keeps hospitals somewhat off-balance and continuously having to guess in which direction they need to go regarding monitoring patient admissions and treatments.

In response to this continually changing environment, hospitals are forced to focus their attention on those patients posing the largest risks to them. These include patients with very long lengths of stays or multiple admissions and those with diagnoses singled out by public and private insurers as foci of attention. A supervisor of utilization review described how the functions and scope of

her department had changed because of DRGs: "Before a chart was just a chart and all we did with it was code it," since a diagnosis was needed before payment would be made.

That was always the umbrella of utilization review, but it never was that intense. . . . A lot has changed. Even our coding. It's not changed, but we reassessed what it is and how it's to be used and the interpretation of it. Just like Medicare reassessed and reinterpreted, we've had to do the same with almost everything that we do in our department. Umm, they dictate to us, you know, that readmissions, umm, those are quality issues and we never focused on that as a quality issue before.

I asked her what readmissions were looked at closely:

Seven days for sure, 15 days most likely, and it can go to any time frame. So, um, we focus a lot on seven day readmissions, we adhere to 15 days and we look at them also, and, but, we don't exclude that if it's like 18 days or 20 days. That, you know, that might be a concern. And we're looking for, we're looking for the quality of care that the patient was provided on his first hospitalization: What was the status of the patient at discharge? Did he meet screens for discharge? Was social service involved appropriately? Did he go home with appropriate assistance? We look at those things. If those things are clean, and we did as much as we could for that patient on that first hospitalization and he's readmitted in 20 days or whatever, you know, that's, that's life. That, that will occur, but we, as a facility, provided him quality care on the first admission. You can't avoid readmissions. . . . then it's up to Medicare if they want to challenge it to challenge it, because we're saying that we did everything we could for this patient that's reasonable.

She said diagnoses like hypertension, diabetes, and chronic obstructive pulmonary disease (COPD) got automatic review.

It's been determined that those diagnoses in most situations can be managed in other situations. Like chronic COPD. If--this gets down to coding--if you just code COPD, then you've got a coding error, because if that person belongs in an acute care facility you shouldn't have a COPD code. You should have the "Acute Exacerbation," if it's a pneumonia or whatever that should be the primary code. So if you just have a COPD, then there's, then that person probably didn't belong there because what's different today with him? Why is he here today versus why wasn't he there yesterday? . . . If you're coding the COPD you're not demonstrating an acute process. So, you know, that flags them.

One of the biggest problems associated with DRGs, according to one of the hospital's utilization managers, were patients admitted for one diagnosis who suffered another illness while in the hospital. The DRG payment is based solely on the admitting diagnosis, with a little extra money added for complications and comorbidities. She reported that, on average, the extra payment totals about \$200. She used the example of a patient admitted because of a fractured hip. This patient's DRG is associated with a 12 day length of stay. If this patient has a stroke while in the hospital, this additional illness, depending on its severity, would require an additional six to eight days. With DRGs, the hospital gets neither the days for the fracture plus the days for the stroke nor the money for the fracture plus the money for the stroke. In this case, the hospital would get about \$4500 to take care of two separate problems, representing more than they would get

for just treating the fracture but not enough to cover the costs associated with treating both problems.

Another aspect of the DRG reimbursement system which negatively affects hospitals' profit-making capability is the restriction on the number of admissions reimbursable for one patient. A UR supervisor at one of the hospitals told me how her hospital was losing money because of this restriction. Since her hospital does not have a catheter lab, admitted patients needing this service must be transferred to another hospital for the test and then back to the original hospital for the remainder of their care. Because DRGs only pay the hospital which bills for the patient's care, and since only the hospital supplying the majority of that care can bill Medicare (since there can not be two service dates--at two separate institutions--in one 24-hour period), the hospital supplying the catheterization cannot bill the federal government for its services. The only way it can get its money is to bill the other hospital for the cost of the procedure. In October 1988, one hospital began billing another of the research hospitals for the catheterizations it performed on its patients. These bills average \$2,300. Since the DRG payment averages \$2,200, the hospital supplying the majority of care to these patients automatically loses money.

We're losing our shirt on that person when he comes in the hospital. It's costing us to have him come in the door.

Since the hospital supplying the catheterizations had just recently figured out this billing ploy to recoup their money, all the details had yet to be worked out. One option under consideration would be to discharge the patient to the hospital supplying the catheterization service. Another would be to meet the patient's care needs at the first hospital without having the catheterization done. The procedure could then be given later on an outpatient basis, thus forcing Medicare to pay for both the hospitalization and the diagnostic procedure.

I don't think the system needs to penalize us. I think we just have to figure out what it is that we can do within the system.

This quote highlights the extent to which cost-containment issues affecting patients are not medical issues, per se. Rather, they increasingly pertain to administrative and billing issues and hospitals are rising to the challenge. Hospitals are increasingly involving themselves in the monitoring of patient care and educating themselves about future policy and reimbursement changes in order to minimize their negative impact and maximize their ability to make a profit.

The implementation of outpatient surgical DRGs represents a case in point. A utilization review

supervisor, argued that DRGs for outpatient surgical patients was "a good move" because many patients do not belong in the hospital. She told me they also offer a way for hospitals to monitor their expenses associated with these types of patients.

Right now, we had the opportunity, and we realize that we have the opportunity, to influence what we're going to get reimbursed when we go under DRGs for the outpatient surgery. They're collecting the data, they're finding out what it is that the patients are having done for them. And based on that, they'll determine what the DRG [is]. . . . So I think now we're really aware what all that means and we're really payin' a little more, we're payin' a lot more attention to that and the importance of that. So I think, I think that's going to work out well. That system should work well for everyone.

TYPES OF REPORTS

In response to cost-containment, hospitals constantly run reports on the costs and profitability of their services. Reports examining outpatient surgical procedures were common in mid-1988 as hospitals geared up for prospective payment in this arena. Reports grouping physicians by specialty are also common. With hospitals supporting around 20 different specialist groups, it is in their benefit to be aware of which are profitable and which are not. A director of ambulatory services told me most of his hospital's reports are requested by the departments of quality assurance and medical records (to make sure charts are coded properly and that good care is given), the

planning department (to track certain diagnoses or patient types over time to monitor their marketshare), and marketing (to maximize efforts in beefing up profitable services).

To get an idea of the detail contained in some of the reports hospitals generate, it is useful to look at a few of them as described by one hospital's director of information systems. The data pertaining to the hospital's performance under DRGs contained in these reports and tape transcripts of the interview are illustrative of hospital efforts to get a handle on costs and the nature of their attempts to relay this information to those in charge of making decisions affecting profit margin.

Report No. 1 was last used in 1984. Given to each physician, it showed his or her Medicare discharges for the previous six months. The report listed each patient's discharge data, primary diagnosis, DRG, length of stay (LOS), and the average LOS for outlier patients with the same diagnosis. I was told a lot of consideration went into deciding *not* to show financial data on this report. It was left off because the hospital did not want physician treatment decisions to be explicitly linked to financial considerations.

Report No. 2 is a "gain-loss report," tracking Medicare, non-Medicare, and Medicaid patients for variable lengths of time. The report groups patients by MDCs (see

Table 6) and by physician or DRG. It includes the following data: total and average days; total and average charges; charge-to-cost ratio; costs and average costs; DRG weight; reimbursement; and gain or loss. Though it is possible to run this report for any patient in the hospital, I was told gains and losses for patients with third-party coverage are generally not shown around the hospital because of the possibility of reports "getting into the wrong hands." The hospital is not interested in letting it be known how much money they make from patients with third-party coverage.

Report No. 3 used to be done for individual physicians and showed how many patients, organized by diagnoses, he or she saw in a certain time period. It also displayed the lengths of stay for each patient, comparing these with national averages and the costs and reimbursement per patient and per DRG.

Report No. 4 assigns each patient a DRG and lists their diagnoses, surgical procedures, discharge status, charges, physician, financial class, sex and age, admitting diagnosis, and LOS. Variations of this report display data for different types of patients and for all insurance carriers. The report has a lot of options and is used "so much it's absolutely incredible." I was told the hospital has four years of patients in their computer files on which data can be analyzed.

Report No. 5 notes all physicians and diagnoses and gives a breakdown of costs by cost-center (e.g., laboratory, pathology, radiology) and the physician averages over time.

Report No. 6 was run as early as 1983 but had not been run "in years" because no one ever used it. It displayed case-mix composition, giving the number of patients for each DRG, each DRG's percentage compared with total patient population, number of patient days and percentage of total, and the average LOS compared with the geometric mean LOS.

Report No. 7 consisted of a set of reports listing breakdowns by insurance carrier and all diagnoses for the specialties in the hospital. A report of this type shown me displayed that the hospital had 22,951 patients in 1987, with charges equalling \$106,000,000. The average charge was \$4,000 per patient with a total cost of \$74,000,000. The average patient costs were listed, as was the charge-cost ratio. It showed that the DRG reimbursement for Medicare patients was \$21,800,000, compared with costs of \$21,200,000: "We made a little bit of money on Medicare patients in 1987 (laughter). . . . It's just a little bit. Compared with the volume of business that we've done?! Give me a break!" A different report of this type showed that the hospital "made \$500,000 here and \$600,000 there" on Medicaid payments for an unspecified time period. As with the reports discussed earlier, this report does not

deal with data from third-party payers. The administrator told me there is no way to show their reimbursement because there is no Grouper for them.

These reports are useful to the hospital in pointing out where they are making and losing money. Many of them are used solely by hospital administrators for planning purposes. With the knowledge gleaned from these reports, hospitals can take steps to increase some services or do away with others in order to maximize their earnings and cut their losses.

Another function the reports serve, however, is to help in the hospitals' efforts of educating physicians. Reports do this subtly, mainly by pointing out how a physician compares with his or her peers and with national averages. As mentioned above, financial information is rarely given to physicians, nor is information related to charges versus costs or reimbursement versus costs. This is usually shared only with planning and financial departments, though the hospital used to make such information available to physicians a few years ago and there had been recent discussion regarding making it available to them again in one study hospital.

But it's very, very sensitive information and there has to be a good go-between to present the information to the physician and be able to respond to their questions about what does this mean, you know, how did you derive--how did you get at the costs that you show on the reports and so on and so forth.

I was told it was important for someone to present the information in person rather than just sticking it into a chart or mailbox "so it has a meaning."

EDUCATIONAL EFFORTS BY HOSPITALS

Giving DRGs meaning--making cost-containment "real"--was the primary goal of the hospitals' educational efforts aimed at their employees and physicians. The reports discussed above, and others like them, were used as an on-going educational effort by the study hospitals. More short-term informational meetings were also sponsored to educate employees and physician staff members about cost-containment both from within and from without the hospital.

Soon after DRGs began, hospital administrations organized presentations to personnel and medical staff to familiarize them with the logic of DRG reimbursement and to highlight what would be needed from each group to help the hospital meet the perceived challenge. For example, when the outlines of the state's plans for changes in Medicaid reimbursement became clear in late 1984, one hospital arranged meetings between various hospital departments and the department of utilization review to discuss the changes with those most likely to be affected. Another hospital set up a series of meetings when a new accounting system was put in place. These training sessions aimed at educating the staff (especially department heads) about

different kinds of costs. Hospitals urged employees to look at how things were done, challenging them to be more cost-efficient. A utilization review supervisor at another hospital reported having been sent, with other hospital staff, to regional meetings set up to educate them about DRGs, "their impact, and what it is we should be doing." Occasional articles in hospital newsletters pointed out successful attempts at controlling costs and discussed strategies for coping with expected changes in reimbursement. The effort put into this and its effectiveness vary somewhat by site, but all hospitals made attempts, quite early on, to at least inform their staffs that cost-containment was now an important goal.

Though these types of educational efforts served to familiarize employees with the fundamentals of cost-containment and its theoretical underpinnings, policy most directly affected personnel when it impacted their daily activities centered around care-giving. Thus, formal educational efforts were generally seen as having limited value. A utilization review supervisor, echoing the sentiment of most of those directly involved with cost-containment within the hospital, said the informational meetings were "helpful" but

The reality of it is you don't know all those things and you can't apply all that stuff until you really start working with them and see where it's effective and where it's not. You know, really what it means. There's so much to learn about DRGs that

there's no way you could sit in front of a big group and teach them about DRGs. You really need to do it on an individual basis. It seems like every time we come across something we have a new situation that has a little bit different twist to it. There's just so many things out there that we find

Educating physicians, given their role in hospital costs and income, was a primary goal of hospital efforts. The aforementioned reports supplied to department heads and physicians about their performance were supplemented by sticker systems aimed at informing physicians of potentially costly patients.

Soon after DRGs began, all the study hospitals began placing DRG worksheets and stickers on the charts of Medicare patients. The worksheets specified the patient's projected DRG, LOS, charges to date, and estimated payment. Stickers, commonly a bright color, were placed on the outside of the chart and specified the patient as a "DRG patient." By mid-1988, stickers were appearing on the charts of patients covered by some third-party payers. These noted the number of days of hospitalization approved by the insurance company.

[It's] kind of controversial because--with the sticker--it says, based on diagnosis, we'll get reimbursed so much. Today your charges are this. And if it's more than what is reimbursed, it's unclear how the physician takes it. Is it intimidation? A tool for management? How does he use it? Some perceive it as if UR is "really after them" and they feel caught, in a sense, because the patient's really sick and what can they do? This isn't what it's for. It is

supposed to make them aware and help them with the management of their patients. (Utilization Review Supervisor)

The administrators I talked with stressed their goal is to educate physicians regarding "what they're supposed to do and to try to really have proper utilization within the hospital, regardless of the reimbursement issues." By mid-1988, physicians were conscious of the costs of the care they provide and new approaches had to be adopted, I was told. Rather than focusing on cost, hospitals began emphasizing appropriateness of care and proper utilization of resources. All of the hospital's UR managers agreed that their departments are instrumental in teaching physicians how to respond to these changes.

[We do] as much as we can. I mean, you know, you can't just tell the doctor, you know (laughter). You have to work with them, you have to suggest to him that, . . . [you] lead (laughter). I honestly believe the physician looks to us as their ally and help, you know, they think we can help them get through this thing. And that's fine. That's the role we like to play and I think we can.

The various reports given to doctors provide a context within which hospital administrators can approach physicians and attempt to educate them about cost-containment in face-to-face meetings. These types of meetings, usually centered around specific instances of care-giving, were generally perceived to be the most

efficacious in affecting physician change and compliance with cost-containment regulations.

One administrator told me this was the only way to effectively enlighten physicians about cost-containment. She reported that putting reports or stickers on patients' charts was less effective than face-to-face contact which "has meaning." A director of information systems expressed the same sentiment:

Sometimes, what good does it do to do all that monitoring? Can you really change the patterns of the physicians? Presenting that info to them? Yes, if you have adequate, you know, if you have good staffing to constantly interact with them, but throwing a report in a physician's mailbox is not going to do it.

Given this reality, hospitals relied on the departments of utilization review and medical records to interact directly with physicians and educate them about cost-containment. Over the course of this study physicians came to learn about DRGs and cost-containment. Physicians studied early, when DRGs were first beginning, denied they would be affected, that they were doctors and no "non-medical types" were not going to tell them how to practice medicine (see Notman et al. 1987). By 1991, though still not generally familiar with the details of DRGs (i.e., how they work, their history), most physicians have encountered problems they associate with cost-containment and have changed their behavior to appease hospital administrators. Reports, face-to-face meetings, and a general barrage of

information in professional and lay media all helped to clue physicians into policy changes and strategies they could use to help hospitals maximize profits. The next section details the functions of utilization review, including their interactions with physicians as hospital watchdogs and intermediaries for federal regulators (the PRO) and third-party payers.

*Utilization Review (UR) and the Peer Review
Organization (PRO)*

UR FUNCTIONS

Hospital UR departments are instrumental in tracking hospitalized patients, insuring that they need to be in the hospital and that they receive proper care. Though they existed previous to DRGs, the scope of their work and their presence within the hospital has greatly increased as cost-containment has come to the fore and with the establishment of state PROs. UR departments function as a nexus, linking local institutions with the federally mandated review organizations. UR's charge is to insure the hospital and its staff comply with federal regulations concerning admitting patients and the delivery of appropriate, "quality care." The emphasis is on whether or not the hospital is doing something medically for the patient and whether or not the patient needs it.

UR reviews all targeted admissions within 24 hours and periodically reviews charts to check whether the "Intensity of Service" (IS) is below Medicare or other insurer specifications. They manage the chart sticker systems, discussed above, informing physicians of DRG patients and approved lengths of stay; they encourage physicians to contact them for information regarding whether or not an admission is reimbursable; they explain the importance of thorough and precise documentation; they monitor the length of stay of each admission; and they confer with physicians when the length of stay for a patient is apt to lose money for the hospital. UR personnel routinely inform physicians over the phone or in person of patients that exceed their DRG's associated mean length of stay. When IS is too low, a UR staff member or physician representative contacts the attending physician or resident and encourages discharge of the patient. UR staff members often indicate what information must be recorded in the chart to justify admission and to ensure the highest paying DRG classification.

Though the specifics of how UR departments operate and their effectiveness vary somewhat by site, the function they serve as educators remains the same. Contact between physicians and UR officers (referred to by many physicians as the "DRG ladies") is the primary way physicians learn about cost-containment. UR's educational function is not a

mere accident of the bureaucratic structure. While utilization review for purposes of quality assurance predates DRGs, the UR officers have come to view teaching physicians about cost-containment as a primary part of their role. One chief UR officer, soon after DRGs began, summed up UR's relationship to physicians as follows:

We like our hospital full, and doctors are the ones who fill it. We need the doctors [in order] to survive. But doctors need to be educated. In the future they'll need to do it right, too, if they want to survive--at least if they want to get more money.

Utilization Review departments at the two smallest study hospitals review all charts within 24 hours of admission to make sure Severity of Illness/Intensity of Service (SI/IS) criteria are being met. In the largest study hospital a "focusing plan" is used with all pay sources, but not all patients, reviewed. Some patients never get reviewed, I was told by a director of UR. For example, obstetrical patients and newborns are not reviewed as a rule because it is widely accepted that these patients need to be in the hospital. Patients in intensive care units are also not reviewed on a regular basis because physicians do not put patients in these units unless they need to be there, I was told, and there is no history of denials for them. An exception to this occurs with patients who are covered by an insurance which requires approval or certification for admission or for a specified

hospital length of stay. Patients covered by these programs are looked at--"we have to"--regardless of which department they are in.

In general, hospitals now review all patients covered by Medicare and Medicaid as well as those of "problem" physicians. All the study hospitals' UR departments look closely at all the patients admitted under the care of these physicians, no matter where they are in the hospital or what they are admitted for. Physicians are determined to be a problem if they have three or more PRO denials in a one year period. None of the study hospitals had large numbers of these physicians. The largest study hospital reported having eight to ten in mid-1988, but the UR supervisor told me that when she began her job in 1986 there were two to three times that amount.

Over the course of the study, UR departments, reflecting changes emanating from the state PRO, began to focus more on quality and less on admissions. In some hospitals, the departments of quality assurance and utilization review were merged; at others they were urged to work more closely together. There was a general consensus that chart reviews done by the two departments were complementary and should be coordinated. Departments of quality assurance check every chart to make sure quality care was delivered.

They have criterias [sic] developed by the medical staff that they review each chart against, abstracting data from the chart, you know. You know, if the lab values were out of whack then it's kicked out. Umm, but it's based on criterias, only different kinds of criterias than what we [in UR] use. You know, they look at quality of care: Did that patient get the proper antibiotic? We [in UR] don't look at that, did he get the proper; we just say is he gettin' it? And did he need it? Utilization of hospital beds. Does he belong in this setting? Does he need to be here to get that IV antibiotic?
(Director of Utilization Review)

The utilization review supervisor at another hospital described to me why, in her hospital, UR was combined with the departments of QA and medical records and why they did "not just focus on utilization review":

we feel it's more advantageous to combine 'em since the person that does the review also does the coding. And, you know, you can't, you really cannot separate utilization review, coding, and quality assurance because they're so closely interfaced. Umm, what's a utilization problem most likely will be a quality of care problem most likely will be a coding problem.

DEALING WITH THE PRO

Besides conducting internal review of the appropriateness and quality of care provided within the hospital, UR departments also serve as an interface with federal regulators. To a large extent, UR activities now receive their impetus from the PRO as they interpret and act upon policy changes emanating from HCFA. As discussed in an earlier chapter, these organizations, mandated by 1983 Medicare changes, are under contract with the Health

Care Financing Administration (HCFA) to review Medicare hospitalizations for appropriateness, correct DRG coding, and level of quality. They can deny payment to hospitals for admissions deemed inappropriate and sanction both hospitals and physicians for care lacking quality.

As already mentioned, PROs were preceded by Peer Standard Review Organizations (PSROs) of which there were ten in the study state. The PSRO in the study city was set up in 1976, responsible for ten hospitals in five counties. Though many PSRO regulations still apply to PROs, most generally agree that PROs are more intrusive and have more authority than PSROs. PSROs, for example, unlike the PROs, had no authority to deny *payment*. They could deny *cases* and hospitals could lose their "waiver of liability," but neither occurred too frequently. The waiver of liability was a clause in Medicare law stating that if a provider or beneficiary did not know services were not covered, patient care would be reimbursed even if the case was denied. The existence of the waiver essentially meant that all bills were paid under PSRO review. If a provider had an increase in the percentage of denied cases they could lose their waiver, but, in fact, this was rare because the threshold was so high. If a case is denied by the PROs, on the other hand, it will not be paid unless an appeal overturns the original denial.

Another difference between PROs and PSROs concerns who does the actual reviewing. With PSROs, hospitals were often delegated to do their own review with PSRO oversight. According to a UR supervisor, "it was almost a nightmare to perform review" under the PSRO system. She told me the PSRO would come in and look at a small sample of charts to see if they were reviewed properly. If not, a variety of steps needed to be taken before the hospital could be non-delegated and PSRO actually came in and did all of the reviews. It took a very long time to get to that point, but it did happen. Two hospitals in the study state--including one of the study hospitals--were non-delegated at some point, according to one hospital administrator. With PROs, there is no delegated review. PROs have the sole authority; they do the review and their decisions are binding.

Though stressing increased monitoring by the PRO and UR's beefed up operations have helped patient care, those administrators I talked with were also quick to point out problems associated with the system. One UR director discussed her department's relationship with the PRO:

We learn what it is that they're looking at and we look at it also on our own. They don't necessarily dictate to us that we do that, but we understand the need to do that. I mean, what they're saying to us is you need to provide quality care, and we don't want, need them to find that we're not doing quality care. We want to see in our own respect, by our own measurements, that we are doing quality care. And, so, I think in that respect, this whole thing has been

really good because it really makes you take a look at it. You know, peripherally we were doing quality assurance. Now we're really doing quality assurance.

No question about it. It's made the hospitals take a better look at themselves. And some of the things that kinda concern the hospital are that, you know, when this whole system was developed you had short-stays and you had long-stays and that's how you get your average. Well, now we think the short ones are being chopped off, because if it's one or two days Medicare looks at that automatically. And they are trying to say, well, if it's a one day stay, couldn't that patient's care [have] been met in another environment--an extended outpatient setting or whatever? So they're chopping all those off. So what do you have left? This here. The high, the low, not the lows anymore, but the mediums and the highs. And that's where, you know, you feel like your DRGs don't really reflect what's happening in today's society, because all these are chopped, this is what's left, but we're being paid on this whole piece right here. So, you know, and they're telling us that you need to beef up your outpatient setting, which we've really done. You know, more patients are done as an outpatient surgery and that kinda thing, so it's made us do some things that probably should have been done, but you still can't get away from, Do they really care about the individual? What about the 90 year old person that no one can take care of and the doctor can't put them in a hospital? They don't belong in a hospital, yet you can't get them into a nursing home from the home situation. So they've taken little pieces and said, "Hey, you can't do this," but they haven't provided what it is that you can do then. Make it easier for us to get a person into a nursing home! Have more nursing homes. Reimburse nursing homes better so they can provide the care the patients need.

The UR supervisor at another hospital saw the various regulations associated with review as a natural fact of life but wondered whether they really could be successful in containing costs.

But isn't that true of almost anything? You know, you create things and then, based on those, we

create more things, and, really, are we, you know, in the end, has it been cost-effective? You know, has [the PRO] really been cost-effective for all the billions of dollars that's gone into it and how many-- I read a report where they found 23 physicians or 26 physicians that they really sanctioned for not providing quality of care. In the whole United States! Now is that cost-effective? For 26 physicians? Does that demonstrate we really have a quality issue out there in this society if they've only found 26 physicians to have real quality issues? And those are only of the fragrant [sic] nature, meaning that the, there was a death occurred or some permanent damage to a patient or whatever. Course we're only talkin' about physicians that are determined to have not provided quality care for Medicare patients. There's a lot of other patients that, you know, you could probably hang a lot more physicians out on those, but I don't know, billions of dollars for 26 physicians?

Hospital personnel from medical records usually deal with the PRO when they come in to review a sample percentage of the hospital's charts for correct coding and DRG assignment. One medical records director told me the PRO reviews a three percent sample and the hospital is allowed about five DRG changes per quarter. The PRO disagrees with the coding by the hospital "a lot of the time," she said. This results in the PRO altering the hospital's payments, but the hospital does not

get into trouble, per se, and go into any intensified review that then they start monitoring, you know, higher percentages of records. It would just make tons amount of work. If we go above the threshold of five, then they intensify the review and then they will start requesting--I think right now they do about, uh, about 100 records every two weeks.

She stated the PRO can "yank the money" for a lot of different reasons and that she thought this was their goal. When I asked her if she thought they would admit to this, she replied:

If you ask them, they would say that recently, um, it was, there was an article in there [a local newspaper column], somebody had written in about something to do with, it mentioned one of our doctors on staff and there was a patient, and the patient was told that [the PRO] would deny this and so, therefore, the patient had to leave early and they thought it was too early. Something to do with that. And the executive director of [the PRO] wrote back [to the newspaper with a copy sent to the hospital] . . . and they came up with this wonderfully flowery thing that said, "No, no, no, we're not here to save money. We're here to protect Medicare patients and we're making sure that the hospital services are being utilized appropriately, and that you are not, you're not discharged too soon or kept too long because that can be harmful to a patient, too, to be in the hospital too long." And, you know, "We're here to help you." You know, one of those kinds of deals.

Who are they kiddin'? They want to save bucks. You know, it's, really, they're not, overall, I mean, they may be saving the government money, but all they're doing is passing more of the costs on to the hospitals so they're not, in the long run there's not really any money being saved because of all the administrative crap.

The UR manager at one of the hospital study sites knows top-level people at the PRO and feels she occasionally gets better treatment than most. She also, however, finds it difficult to get things accomplished at times. She said it depends on the day and whom she talks to. It is also dependent on the PRO's workload, which, according to her, is massive. They are swamped with more

work than their personnel can handle, she said, and they are also under corrective action by the federal government, with the continuance of their contract dependent upon meeting certain federally imposed guidelines. She argued this affects their special handling of any cases:

So anything that falls outside of this--to quote their director--this "big factory, this assembly line" they've got going, just doesn't get any attention. "We can't deal with it, it takes too much time to deal with it. Just keep the masses moving through here so that we can get caught up." They are very far behind in review.

She reported getting information regarding 1984 and 1985 cases in January of 1988. Her hospital began getting early 1986 cases in mid-1988. "Physicians don't want to hear what happened two years ago. Things are different now." She complained this makes it difficult for hospitals to deal effectively with these cases and the physicians who are responsible for delivering the care.

THE DENIAL OF CASES

According to the hospital administrators I interviewed, the PRO's main purpose is to deny cases, to not reimburse the hospital for care already delivered. The vice president of operations at one research site outlined the review process, assuming denials at every step. First, the case is reviewed by a nurse at the PRO. If denied, she contacts the hospital and the attending physician involved

in the case with a "pending letter." The hospital is allowed to give additional information supplied by UR, the attending physician, or other hospital personnel. This is usually done in writing. The case then goes to a PRO physician reviewer. If he or she denies it with a "final" denial letter, the hospital and the physician can once again respond. This sets in motion a second review by a different PRO physician. If the case is denied at this level, the hospital or physician must request a reconsideration of the case. A third PRO physician then examines the case and either upholds the denial or overturns it. This stage, like the other reviews by PRO physicians, often involves phone conversations between the physician that provided the care and the PRO-employed physician. Both hospital administrators and physicians told me a number of times this was the most effective way to deal with the denials because "doctors understand doctors" and the decision making process involved in a patient's care can usually be described verbally more easily than in written documentation. If denied again, only the patient can fight the denial by going before an administrative law judge or by assigning a physician or hospital to represent them. Physicians also are forced to talk to PRO physicians regarding "complaint letters" and "inquiries" they have received from disgruntled or questioning patients.

A UR supervisor at one hospital discussed what happens after the final denial and before the administrative law judge is brought into the case:

Then we have up to a year to ask for a "re-opening." And you can only ask for a re-opening if you feel that you've got information that was omitted originally, there was a judgment error on [the PRO's] part, or they applied rules that weren't in effect at that time. . . .

You know, sometimes they're right and we acknowledge it. But at least 90%--let me take that back, because I can only tell you maybe three cases that we've not appealed. And we really look at it, because we aren't going to just appeal 'em to appeal 'em, because that's not good for them and it's not good for us because we need to own up to it if we've made an error in judgment. But at least 98% of the cases we've asked for further review on.

Like the other directors of UR, this one told me her hospital has less than 20 denials a year "where they've said absolutely no way was that a proper admission." She reported that at least 60% of their cases are approved once additional information is sent to the PRO after their "final" denial. She told me that if the PRO reviews

fifteen charts I'll get two or three pending certifications. And they're for different things. Umm, of the three cases, maybe one will get challenged further. And, like I said, rarely do we get a denial. We do really well with it.

A vice president told me his hospital had, on average, about 4.4% of their Medicare discharges denied by the PRO, representing approximately one percent of their total discharges. This number is going down because "Everybody's

coming to the middle," he argued (though the decrease has not been remarkable, being only one or two percent since 1984). The PRO is denying less and the hospital is denying more internally, he said. As of February 1988, the PRO had denied only two cases out of the more than 3,000 discharges occurring in 1987. The hospital, on the other hand, denies about 2.3% internally.

Internal review of cases centers around target patient categories and "problem" physicians. When a potential reimbursement problem with one of their patients is identified, UR calls the physician and tells them why the patient should not be in the hospital. If the physician refuses to discharge the patient, the case is "referred" internally and they "go through a denial process" which entails a lot of phone calls with physicians: "So, they get a lot of discussions on their individual cases" (primarily by phone, sometimes in face-to-face conversations on the floor). She stated that physicians do not like it.

Yeah, they'll just say to you they want to be a doctor: "I want to be a doctor and why do I have to worry about all these things?" I don't blame them for saying that. Umm, that's why we're here to assist them to know what those rules are and keep within those rules. And there's gonna be that isolated person that, you know, he put 'em there with good will and good intention, but they don't belong there, and no matter how you documented, that person can't, you cannot demonstrate, it's just there's no other place for them.

The problem physicians have with the various considerations determining if patients get admitted or not, what treatments they receive, and their expected lengths of stay is that they are based on non-medical criteria: "If it's good medicine, it's good medicine. If it's not it's not." Some insurances do not challenge admissions, paying for them all.

But Medicare won't pay it, so how can they practice good medicine if everybody, if they're doing it based on insurances? Most insurances won't pay for T&As [tonsillectomies and adnoidectomies] in the hospital. Maybe one will. Is this good medicine?

When any case is denied by the state PRO, UR talks to the physician directly so they know, individually, which cases were not paid and which raised quality issues. UR then sends the physicians more information regarding the case "saying what this really means is this and this is what they mean by that and here's what your options are and the law says you can do this," according to one UR supervisor. It is about one-half a sheet "that's really condensed and says, you know, this is what you ought to do." UR gives the physicians about three days after sending this letter to respond, after which they call them on the phone to further discuss the cases that warrant it.

If physicians try to circumvent or ignore the suggestions of UR personnel the physician is "zinged" with an internal denial by the hospital. The PRO is not

notified of this process and remains in the dark because the patient's care is not billed to Medicare. By not billing Medicare, the PRO does not become involved in the case and the hospital avoids a federal denial and possible sanctions.

I was told that, in one study hospital, about 20 Medicare patients a month are "no-bills"--out of 300 Medicare patients on average per month. Before the hospital decides not to bill for a case, the physician has to agree with this decision. If they do not agree and are adamant that the case should be billed, the hospital will bill for it with the understanding that, if it comes back as a denial by the PRO, the physician will confer with the patient and have them file for a hearing with an administrative law judge. I was told that in 1987, 80% of the cases denied by one hospital's physician reviewer were overturned by the PRO. He believes this is because the PRO has to call attending physicians and their patients or family members and talk with them while the patient is in the hospital, intimidating PRO personnel.

We feel that it's because they're in the same boat we are. We can't deny a lot of cases either 'cause you're dealing with a physician who tells you these are the reasons and you're dealing with talking to a family and saying, "Do you really think your mother belongs in the hospital?" "Well, she's sick!" (Hospital Vice President of Operations)

In reviewing cases, the hospital uses the PRO's criteria "as a base," with physician judgment being the ultimate criterion. This is where inconsistencies arise, I was told, because the PRO is less apt, at least initially, to take into consideration "physician judgment." The vice president of operations said that the PRO denies cases which are "fuzzy," that is, based on a physician's medical judgment and not really supported by lab values or not meeting criteria. The fact that the PRO reviews mostly retrospectively, with the whole medical record in front of them, makes it easy--with hindsight--to see that the patient did not need to be admitted. I was told it is different, however, for a physician treating a patient one day at a time when he or she does not know what that patient will be like in 24 hours.

And, you know, that's some of the farce. That many of the reviewers try only to base it, they base it on what happened to the patient, the outcome. . . . It should be based on what they knew when the patient was admitted. If you're talking about length of stay, then you can use outcome, that they should have been discharged back here. But you find very few of those types of denials anymore, because [the PRO] doesn't care. Neither do the feds. Because there's no money savings to them on that unless they get to be day or cost outliers. And those are few and far between.

One set of concerns, expressed to me by hospital administrators centered around the Medicare waiver program. The waiver fund was established to pay for care retrospectively determined unnecessary but delivered in the

belief that criteria were being met. Prior to March 1986, the presumption was that hospitals did not know about criteria limiting care if the care was delivered. The burden of proof was on the PRO to demonstrate that criteria were ignored or intentionally circumvented. New regulations, however, allow for no presumption; waivers are now applied on individual cases by the PRO. If new regulations have been issued it is the hospital's responsibility to comply. One administrator told me this excuse for denial is now used 99% of time by the PRO: "That's where they hang their hat. That we do have a copy of their criteria and so we should have known." A UR supervisor complained this is hard for hospitals to deal with given the ever-changing regulations and their "reclarifications." It is hard for them to keep abreast of it all, yet they are held responsible.

Another complaint voiced was that even if a hospital is found to warrant payment under the waiver, the PRO has an unwritten blanket policy of not paying for overturned denials under the waiver. A UR supervisor told me she was told this by the PRO's director, a personal friend; "All hospitals have copies of the criteria and that is enough." She told me, however, there are cases that meet PRO criteria but still are denied. She thinks the waiver should apply to these cases because if a patient is sick

enough to be in the hospital (using PRO criteria) they should be paid.

A vice president complained about the PRO's retrospective denial of cases that had previously been approved while the patient was in the hospital. His hospital went to the HCFA regional office to get them to stop doing this, arguing that the PRO already had approved the case and unless they could prove the hospital was lying, the PRO should stand by that original decision. He told me the PRO's system is so bad they often did not even know they already had reviewed the case. He said his hospital has had five or six of these as of mid-1988.

They [the PRO] said we can overturn anything we want They don't seem to believe in the court system or justice, you know. And this is what we have big headaches with them. You know, they feel they can just randomly go back and open a case any time they want and deny it. After they've approved it. You know, that's like finding somebody innocent and then trying them again for the same crime (laughter). You can't do that!

HCFA agreed with the hospital and sent them a letter to that effect. They also sent the PRO a letter telling them to reverse all retrospective denials which were previously approved on concurrent review unless they could prove the hospital lied. The PRO now has to make a decision within 24 hours on concurrent cases and abide by it.

The vice president of operations I interviewed felt the biggest problem with the PRO is inconsistency between cases they review. Identical cases will be reviewed and one will be paid and one denied, he claimed. He blames this, to some degree, on the fact that physicians do the reviews and they are in the habit of making decisions on their own. It said it was difficult to really differentiate patterns of practice.

The cases we deal with, you know, it's great that there's criteria, you know, and you can get a book and you can write all the criteria you want. But everything has its exceptions and those are the ones that come up. You know, yeah, you know, if this person doesn't meet any of the criteria then they probably don't get admitted to the hospital, but if they meet some and, yet, there's some other extenuating circumstances that maybe they should be here, and you admit them, you got a 50-50 chance of winning that case.

A director of UR blamed part of this inconsistency on the PRO's disorganization.

But they still do really stupid stunts, like, um, if we have an in-house denial that our UR Coordinator and our physician reviewers have determined we think that this case ought to be denied. So we want to just do an internal denial on it. So the hospital has a "concurrent denial" and [the PRO] will say the hospital shouldn't deny the case; that they think it's OK. So the hospital doesn't deny it. When [the PRO] reviews the chart three months later, however, they may deny it. It's just a constant trial of, you know, they think they can do something and we disagree and we have to go around them and go higher.

Another category of complaints hospital administrators voiced about the PRO centered around that part of the

denial process relating to the activities of administrative law judges. This is the highest level a denial appeal can go. A UR supervisor told me that cases had reached that level "ever since this has been in process but it's been few and far between." She said few patients know how to take advantage of this option, or what to do, or why they should do it since there is no financial responsibility or gain for the patient. Physicians and hospitals have no rights to take it to that level though they can act as the patient's representative if appointed by the patient or their family.

A UR officer told me she believes that this step of the denial process is totally different than our entire system of government and, thus, unfair. She argued there is no due process, but the federal government gets away with it and the hospital industry has not fought for change. She thinks the industry will wake up eventually when they notice it hurting them financially. She argued that the whole denial process, at that level, was a smoke screen set up by the federal government to appear as if they are doing something. She told me she had never heard of a case that was lost when a patient has appealed: "I have no doubt that when they get to that level that they are won." When interviewed in mid-1988, her hospital just had its second case go before a judge. No one in the hospital believed this case should have been appealed, she

said; it was obvious the patient did not need to be in the hospital.

Everybody looked at it and said this lady did not belong in the hospital. But I knew if it went to the judge it'd get approved and, sure enough, it did. And, in fact, what they wrote about the case I almost believed she belonged here.

This denial, like the hospital's other case that went before the judge, was already paid by Medicare on waiver prior to the judge's ruling, supporting the notion that the hearing had little more than symbolic effect.

One UR officer told me in mid-1988 her hospital had 25 cases due to appear before the judge. Since April 1986 she feels the hospital has reviewed so well ("we have screened these cases inside, outside, upside down") that if they can get the patient or a family member to assign the hospital as the patient's representative they will take it to the highest level. If they cannot get this assignment, and the case is not paid under the waiver, they will file for it under the waiver anyway, saying there is no way they could have known it would not be paid. They have nothing to lose at this point since even those cases that get approved by the administrative law judge are non-binding and not recognized by the PRO. It is primarily a moral victory, she argued.

A vice president at the same hospital told me they win the cases going before an administrative law judge "90% of

the time. We've never lost one." He told me the docket is now one and a half years behind in getting cases heard because patients and providers have found out about this option: "So it's really useless." He complained that the rules are so badly set up that nobody knows how to reverse the financial part of the decision. Thus, if unsuccessful in obtaining a waiver for the case, there is no way for the hospital to get paid. He told me the PRO and the state's largest third-party payer have no way of reimbursing the hospital for overturned denial cases.

It's like you've been found innocent of the murder but we're gonna hang ya anyhow (laughter). We haven't figured out how to tell anybody that you're innocent (laughter).

The Treatment of Elderly and Other Patients

Hospital administrators' perceptions of cost-containment and the hospitals' responses to them discussed above have major effects on the care delivered to patients in general and elderly patients specifically. The administrators I talked to centered their complaints around decreasing lengths of stay and lowered censuses in their hospitals but they also complained about the new regulations ignoring the medical needs of elderly patients. How cost-containment is perceived by the elderly as they receive medical care will be covered in a subsequent

chapter. This section highlights how administrators view these effects on the patients treated in their hospitals.

SHORTER LENGTHS OF STAY

As has happened throughout the country, patients at the study hospitals are not staying as long as they used to. Though this trend was apparent prior to DRGs, there is no question that this and other cost-containment measures have accelerated the trend. As one administrator put it:

They're getting booted. . . . Even insurance companies are telling us how much they'll pay; beyond that we lose money.

A nephrology social worker stated: "UR is on our tails to get them out of the hospital."

A UR supervisor argued DRGs, coupled with a general push to contain hospital costs, have helped accelerate the decrease in length of stay (LOS). She said it is expensive to stay in the hospital.

This is a high priced hotel. Um, if you have surgery and you're gonna feel like crap, you can feel like crap at home in your own bed just as easy as you can here if that's your only problem.

In Michigan there was an 8% drop in LOS between 1980 and 1989, and a 20% decrease in the use of acute care. In 1981, the average LOS was 7.9 days. In 1987 it was 7.3 days (Hamilton 1989). The budget director of one hospital

told me in mid-1988 that the average LOS for medical-surgical patients at his hospital--traditionally one of the better paying groups of DRGs--was down from 8.5 to a little over five days in the last six years ("a dramatic decrease"). A discharge planner told me that patients with bone infections used to be in for six weeks, but now are hospitalized only as long as it takes to prepare them to do the IV at home. She told me she had a patient a month before our interview who needed three to four weeks of antibiotics for an infection. The patient came in, had a central line put in, and then was discharged the next day. A UR manager told me, at her hospital, patients receiving gall bladder surgery used to be admitted for seven days but now for only four. Hysterectomy patients stay four or five days, down from eight, and patients receiving Cesarean sections stay four days, down from seven.

Data collected at one study hospital in 1985 demonstrate the same trend (Table 8). At this hospital, the average hospital stay of patients on the medicine service dropped from 5.6 days in 1983 (before DRGs) to 3.6 days in 1984 (after DRGs were instituted). After adjusting for change in patient mix, the mean length of stay was 25% lower in 1984 than in 1983 ($p < 0.01$). The reduction was greater for Medicare patients (38%) than for other patients (15%), also after adjustment for patient mix ($p < 0.05$) (Notman et al. 1987). Studies looking at national data as

well as other regions in the country have found the same basic results (Day 1985a; Mayer-Oakes et al. 1988; McCarthy 1988; Schramm and Gabel 1988).

This shortened length of stay has affected hospitals and patients. Patients are having to leave the hospital sicker than in the past and more reliant on the services of foster care, home care, nursing homes, and support from family caregivers. These changes have put a new burden on the medical care delivery system in the country, including both its formal (i.e., institutional) and informal (i.e., familial) components. Hospitals have increased their efforts in discharge planning to insure patients receive the care they require upon leaving the hospital and, as previously discussed, hospitals have entered the home care business to help facilitate patient care outside the hospital.

Table 8: Means and Standard Deviations for Indices of Services
Predicted and Provided to Patients on a Medicine Teaching
Service

	Feb. - April 1983			Feb. - April 1984		
	Medicare Patients	Other Patients	All Patients	Medicare Patients	Other Patients	All Patients
Dis. ¹	43	60	103	45	78	123
LOS ²	6.6 (4.7) ³	4.8 (4.3)	5.6 (4.5)	4.0 (3.5)	3.4 (3.2)	3.6 (3.3)
DRG LOS ⁴	7.5 (2.2)	6.7 (2.2)	7.0 (2.2)	7.2 (3.0)	5.7 (1.8)	6.3 (2.4)
Chrgs ⁵	\$4300 (4800)	\$2700 (2300)	\$3400 (3600)	\$2600 (2400)	\$2200 (1700)	\$2300 (2000)
DRG Cost Index ⁴	1.10 (0.46)	0.91 (0.50)	0.99 (0.49)	0.96 (0.35)	0.77 (0.29)	0.84 (0.33)

1. Discharges.

2. Length of Stay.

3. Standard deviations in parentheses.

4. Length of stay and cost index assigned to each DRG taken from Table 5 of interim final regulation for DRG payment. *Federal Registrar*, 1 September, 1983, pp. 39,876-39,886.

5. 1984 charges have been reduced to take account of a 6% price increase on January 1, 1984.

A discharge planner at one study site told me the patients she deals with are coming to understand, but that a lot are angry: "They feel they paid their health insurance policies and that they should be in the hospital as long as they feel they need to be." Most of the patients she deals with are Medicare patients "because they're the ones that need the assistance at home." Her job consists primarily of finding home-based services for patients who need care but can no longer remain in the hospital. She said some patients feel kicked out early and blame the hospital even though it is really not their fault. Or they take out their anger on the doctors whose hands are also tied. Like others, she told me there are not enough services in the community to meet the need. She also mentioned that it is often difficult to get these patients into nursing homes because of a lack of beds or into foster care because they are "not up and about." Since Medicare does not cover custodial care, these patients are oftentimes sent home to recover with the help of family members and whatever home-based services can be arranged.

To initiate a discharge and home-based services numerous steps have to be taken. First, it must be documented that the patient requires additional, non-acute care. A discharge planner at one study site discussed the way her department gets notified about patients needing

their services: Since UR and discharge planning staff are on the units "most of the day," a lot of interaction goes on throughout the normal work day. If UR has a concern with a patient they will tell discharge planning, who then gets involved. In her hospital, the nursing department fills out a "Social Service Referral Form" that evaluates each patient's "risk factors." If a patient has two or more risk factors "we want a social service referral upon admission." Depending on the patient's needs, a social worker or a home planner will then see the patient. "Ideally, we get started on the patient as soon as they come into the hospital."

She said her hospital had been doing this since 1986. Before that, they needed a physician's orders for a social service referral. Now nurses do it, UR does it, and outside agencies can call social services and say they were following a particular patient prior to admission and ask them to follow the patient in the hospital: "So we can get referrals from anybody and it doesn't have to come just from the physician like it used to." She said her department likes to find out about them right away to have time to coordinate everything.

In order to receive home care, a patient's physician must fill out a referral form to a home care agency. The physician must document the patient's need for a nurse to assess vital signs, change daily dressings, or monitor

blood sugar levels daily in order for a patient to be eligible for home care.

DECREASED CENSUS AND RESTRICTED ADMISSIONS

Just as lengths of stay have decreased, so have hospital censuses (Davis 1987; Gage and Andrulis 1987:1943; Schramm and Gabel 1988). Current restrictions on reimbursement mean that fewer patients are admitted to the hospital. Administrators from all the hospitals told me their censuses had decreased over the past few years and attributed this to DRGs and other cost-saving efforts by third-party payers. Average occupancy rates in Michigan dropped from 76% in 1981 to 65% in 1987 (Michigan Hospital Association n.d.). In 1988, occupancy rates at the study hospitals were averaging around 50 percent. Some parts of the state have experienced rates as low as 43% (West Michigan Health Systems Agency Update 1986b:13). Nationwide, occupancy rates dropped 12% in the first year of prospective payment (Schramm and Gabel 1988:1681). Admissions for patients over 65 declined at an average annual rate of 2.2% between 1983 and 1985, compared to a 5.2% total decline from 1972 to 1982 (McCarthy 1988:1683). They dropped 4% in the first year of DRGs (Day 1985a). Arthur Andersen & Co. (1984:36) predicts a 20% reduction in hospital patient days per 1,000 population between 1982 and 1995.

One cause of the decreasing numbers of hospitalized patients is the increase in outpatient treatments that hospitals have facilitated in order to maintain (or increase) their marketshare. As Goldsmith notes, these trends reflect a major shift in the way hospitals are organized to carry out their business. He predicts:

The hospital of the future will be transformed into the critical care hub of a dispersed network of smaller clinical facilities, physician offices, and remote care sites that may stretch out as far as 200 miles . . . from the core facility, connected by air and ground critical care transport and integrated by clinical information and patient monitoring systems. (Goldsmith 1986:3371)

In Michigan, outpatient visits equalled 1.1 per 1,000 population in 1981 (7 per admission) and 1.3 per 1,000 in 1987 (11 per admission) (Michigan Hospital Association n.d.). Table 9 displays 1986 data from the three study hospitals, showing their decrease in admissions over a two year period as well as the increase in outpatient services experienced by each.

Table 9: Selected Characteristics, Hospital Research Sites, 1986

Site	Beds	Occupancy Rate	Inpatient Admissions	Change ('84-'86)	Outpatient Registration	Change ('84-'86)
A.	249	65%*	10,414	-8.4%	91,483	+14.4%
B.	200	57%	8,211	-1%	64,306	+20.4%
C.	502	59.5%	22,892	-3%	107,853	+18.2%

* Estimate

Source: Lansing State Journal, Feb. 15, 1987, p. 11A.

Though there always will be, as one administrator put it, an "inpatient chassis" needing hospital-based care and it appears hospitals have been successful in increasing their outpatient services, increased difficulty in getting into the hospital negatively affects patients used to being admitted for chronic conditions or without the social or medical support necessary to provide needed services outside the hospital. A social worker told me patients can no longer get into the hospital just because they feel sick. Everything treatable outside the hospital is now done on an outpatient basis.

So patients think they're terribly sick and patients' families think they're terribly sick, but they can't be admitted. So I see a lot of that.

More home care is needed to help support the family, she believes, but support is not available for non-skilled

care. Medicare never covers it, she said, and Medicaid only covers it when it is documented the patient cannot care for him or her self.

FAILURE OF CRITERIA TO MEET THE NEEDS OF ELDERLY PATIENTS

A few administrators I interviewed (as well as a number of physicians) told me cost-containment regulations are especially hard on the dying elderly and their family caregivers. They claimed cost-containment keeps patients who are dying out of the hospital. These patients usually have multiple chronic illnesses associated with multi-system failure and are ill-suited for treatment in an acute care hospital. A UR manager said these patients represented one group "someone needs to know about, hear about, do something about." She stated, hesitantly and confidentially--as if it were just too gruesome to describe: "[It] upsets me greatly. Um, dying is not a reason to be in the hospital." She told me that patients "actually in the process of dying--within 24 hours, two days, ten hours"--are denied payment.

One case related to me concerned a patient who died from cancer after having been treated successfully for some time. She had been taken care of at home by the hospice in the area. Just before she died, her husband could no longer take care of her and brought her to the emergency

room of one of the study hospitals. She needed oxygen and pain relief; there was no hope that she could be cured and the dying process averted. All the hospital could offer was support in making her comfortable while dying. According to the UR supervisor, it would have been inhumane to try to keep her living. The patient lived about 12 hours after admission. She told me that the care would have been reimburseable if they had tried to save her.

The PRO told the hospital this was a "social problem" and the patient should have been turned away to be taken care of by family caregivers and any other help they could arrange. The UR manager expressed disbelief they would not be reimbursed for the little care they gave her.

After this family has come to us and we have been there for them and we have billed and we have been paid. I mean, we have taken their money through this whole process and then we're supposed to say, "She's just dying, take her home." I could never do that. I mean I don't think we could ever do that.

She strongly stated that her (or any) hospital would never turn away patients such as these. She argued these patients usually have a long-standing relationship with a physician, and if the majority of their care was delivered at a particular hospital, it is only reasonable to assume the patient as well as the physician would expect the hospital to be there when they were needed at as crucial a time as death.

Part of the problem with the DRG system is with the type of patients it covers. At one hospital studied, the average stay for Medicare patients was 10.7 days while the average for the whole hospital, including Medicare, was 5.7 days. A UR manager told me that older patients suffer more than the young because they do not recover as quickly and they often lack the social support network younger patients have. She thinks it will take society time to adjust to patients going home sicker and needing services that used to be delivered in the hospital (total parenteral nutrition, naso-gastric tubes, and IV antibiotics). Nursing homes also have to adjust, she said, so that they will be able to take these patients. She then added:

But who's to say that's not good medicine for them to be in their own environment? But that's something that wouldn't have been happening a year and a half ago. Maybe two years.

She told me that patients need a lot of educating in order to learn that things have changed, oftentimes for the better.

A vice president described to me a "nightmare patient" who had been in the hospital for six months, the last three considered extraneous and unnecessary. I was told the patient's husband is "crazy" but leads a life normal enough (writing checks, taking care of financial concerns, shopping) so that the court will not declare him incompetent. In court, the hospital lost attempts to take

guardianship away from the husband and to have the husband labeled "uncooperative" because "he will not even approve of home care." He lives alone and refuses to take his wife out of the hospital to live with him, saying it is too difficult to care for her. The patient, continually going in and out of consciousness, does not need skilled care but needs care intensive enough that the husband cannot provide it alone. The husband will not allow his wife to be sent to a nursing home and no other family members exist. The hospital is "banging its head up against the wall" because it does not know what to do. At the time of the interview, the hospital was not being reimbursed for this patient. The hospital had talked with Medicaid (who in the past covered this type of case), but they refuse to pay under new regulations and the husband cannot get the home care he needs for his wife.

He continued to tell me the effects of cost-containment on an elderly person--"79, 75"--who falls in the middle of the night while at home.

Did she have a stroke or is she just clumsy? Given her condition, it is hard to tell. She has a couple bruises, but it is impossible to tell if more is wrong.

He said that ten years ago, this type of patient would probably get admitted for diagnostic tests to rule out a stroke or a blood clot and sent home in a couple of days. Now, they are afraid to send this patient home, he

reported, especially if a relative cannot be found. So they admit the patient to the hospital because there may have been a small stroke. He said the fear of malpractice plays into this, and also that it is not good for the patient to be sent home. The hospital uses its resources on a patient that they are not getting paid for, doing tests that normally would be done on an outpatient basis, and providing meals. The costs of the case "gets absorbed," he stated.

A UR supervisor told me there are two categories of patients that really need hospital care and need to be considered by regulators as exceptions: 1) Medicaid pediatric patients with "uneducated parents" that may need more frequent or longer hospitalizations because they do not know how to take care of the patient at home, and 2) elderly patients with multiple problems ("I don't know if age is an illness--I don't think it's classified as an illness--but, boy, our bodies sure fall apart. It's like an old car.") These groups are "being squeezed the hardest," she feels, and a real injustice exists. She told me young adults coming in for inguinal hernia operations can stay two or three days, but Medicare patients have to have the procedure done as an outpatient. The federal government, she told me, has decided those procedures can be done in outpatient settings.

And obviously they can, we're doing them that way. But I don't think that helps the patient out at all. Even an overnight stay in the hospital could be extremely helpful to someone 80 that can't see, that has other illnesses, that has to take care of themselves when they get home. When they're having a lot of pain. . . . You can't hardly stand up afterwards!

Another UR supervisor at a different hospital told me

I could probably apply that criteria [associated with DRGs] more easily to you than I could to a Medicare patient. If you come in this hospital for diabetes, I don't think that you probably have congestive heart failure or that you probably have COPD or any--chronic renal failure--or any of these chronic conditions that the elderly seem to have. And by the time you couple aging and chronic illness with whatever happens to be acute at that time, you have a whole different picture. You can't treat them the same as if the only thing that's going on with you is that the doctor discovered your blood sugar is 800 and you are out of it because of that.

There's no way to do that. . . . The criteria . . . never said that if you have this and you really don't meet this level, but you have congestive heart failure and you have this, then that's really good enough. That would be a phenomenal, um, it would be something that someone would have to definitely do on the computer that has a lot more brains than what I do or more, most people do. The trees and the branches and stuff would make the DRG system look like it was a piece of cake. And that was, that's a nightmare to try to figure out.

Yet she admitted that physicians are oftentimes faced with diagnosing and treating patients with a myriad of medical and social problems that make hospitalization a relatively easily decided--if not cheap or entirely warranted--option.

There was a widespread understanding that social factors could not be included in patients' charts in order

to keep them in the hospital. A UR officer complained about this:

Yeah, and they say those are social factors and they are irrelevant. Supposedly, social factors cannot be considered. I do not believe that for one minute. [The PRO] claims that the feds have told them that. If that is anywhere in the regulations I would love to have someone show it to me. I have read every regulation that has ever come out since this whole program began, and I do not recall anywhere. Now I know that you don't consider social situations such as he needs to stay in the hospital because his aunt Myrtle is coming in two days and that's when she'll be back to take care of him or they're painting grandma's bedroom. I mean, I've heard all those stories, too. Those aren't real reasons to stay in the hospital. But when you're debilitated from other things I believe those things should be considered.

Though hospitals attempt as best they can to minimize the negative effects of cost-containment on patients, there is no doubt the changes place some categories of patients at risk. Those without adequate insurance and those suffering from diffuse multiple conditions--often exacerbated by unresolved psychosocial problems--are especially vulnerable. The institutional response has been reactive; hospitals are faced with cutting back and do a relatively poor job of anticipating or effectively planning for the non-acute care needs of their patients.

INCREASED CONFUSION

Associated with the expansion of third-party reimbursement is the proliferation of paperwork with which

patients and providers must contend. It was a widespread conception among all the categories of people I interviewed that ill elderly patients may have a hard time with the numerous statements, forms, and bills they received from hospitals, physicians and other caregivers, insurers, and the PRO. One of the UR managers discussed the confusion occurring in insurance and reimbursement matters due to cost-containment which she believes are especially hard on Medicare patients. She helps her grandmother-in-law with the financial aspects of her care and told me it is "a nightmare."

I asked her if she thought the confusion was intentional or merely a by-product of the bureaucracy. She believes the confusion associated with Medicare regulations is a bureaucratic by-product but that regulations imposed by the state's largest third-party insurer create intentional confusion. When she was with the PSRO she attended a meeting with state and third-party insurance officials who stated the purpose of one third-party payer's program was

to create a roadblock. It's so that there will be problems so that it will take longer to process the claims and only those people that know how to get past the roadblock and what to do when you hit a roadblock will be able to move forward and get the same thing.

Confusion also surrounds how physicians get reimbursed for their services. If a physician is non-participating

(i.e., does not accept the Medicare reimbursement rate), then patients will often get a check from Medicare, made out to them, to cover the cost of the physician's services. Any difference between the physician's charges and the Medicare reimbursement sent to the patient is to be paid by the patient. A social worker told me patients often do not know what is going on because the forms are so confusing. They often cash the check and the physician does not get paid, often resulting in the physician turning the matter over to a collection agency. She said this is hard on sick patients and their families.

Another major problem, according to the UR manager, is that the statements from Medicare often do not make sense: "it purposely sounds as if they're trying to distort the truth sometimes." She said the forms occasionally do not show what parts of a patient's bill they have paid, and, when they do, oftentimes only a total unitemized payment is noted. Thus the patient does not have a clue regarding what the statement is about and is forced to call Medicare, often while still sick or recovering.

A final source of confusion for patients involves communication concerning the denial of cases.

The denial letters [from the PRO] that the patients get when you're up there laying in a bed and not feeling well says that you don't belong in the hospital, and if you really think you do belong in the hospital call these people and they'll do this, but if you don't call within three days then you have to do this and the letter's confusing enough itself. Um,

they don't know what to do. They're sick, they're oftentimes confused. Their families don't know what to do.

The hospital, too, must now send patients letters when the hospital determines that their care is not reimbursable. The patient only has financial responsibility if the letter is from the hospital. If the patient is in the hospital, UR sends a letter. If the patient has already been discharged or if he or she was never admitted and the PRO denies payment, then the PRO is responsible for sending one--usually a year or so after the patient received the care. These letters, either received while one is recuperating after the illness episode or months later, merely add to the documentation they must make sense of and do nothing to clarify what, exactly, is expected of the patient or what their rights are. The administrators I spoke with felt this added confusion was unnecessary and unfairly burdened sick people and their families with additional stress.

Summary: The Acceptance of a Sense of Threat

The preceding discussion points out hospitals' perceptions of cost-containment's effects on their business and highlights the responses they have taken to maintain their solvency. In general, hospitals have responded by adopting the principles of corporatism. They have worked

to increase the profitability of their businesses in a variety of ways, including monitoring the behavior of physicians and how they incur costs. There is a general acknowledgment that cost-containment threatens patient care--especially for the elderly. While everyone I spoke with was eager to denounce the changes, most believe they are here to stay and hospitals will have to continue to adopt.

Overall, administrators saw plusses and minuses associated with DRGs and the new medical care system. They were glad, in retrospect, that it forced them to get a handle on their costs, to become more efficient business operations. It has become accepted that the system needs to adjust to the new fiscal environment. What this will bring in the future was uncertain, though everyone agreed change would continue.

The vice president of finance at one study hospital denied hospital-focused DRGs would be the end result.

DRGs is not a payment system as much as a classificatory system and that will stay because it's handy. It's useful. Any payment system now, I think, will be based on that some way, but, you know, there's lots of talk about vouchers and all kinds of things. I'm skeptical that that will happen very soon. My suspicion is they'll leave the same payment mechanism in and continue to tinker with it. They have a long ways to go and they have to, the hospitals are pretty well settled into the system and then they have to start looking at other providers.

He felt the next step was to "squeeze the physicians."

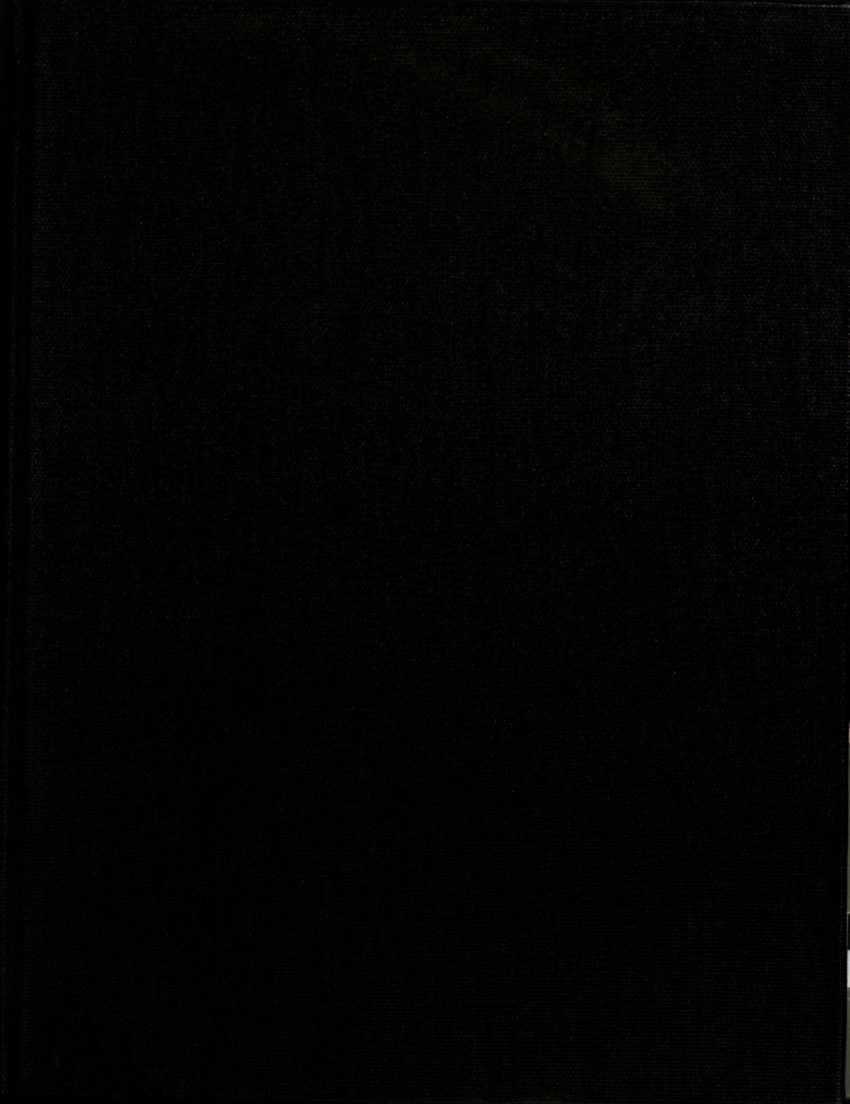
Well, this preapproval process really is an attempt to squeeze the physicians although the hospitals end up with a lot of the burden of that. . . . If they go ahead and do it [i.e., put the patient in the hospital without preapproval] they won't get paid. Which is the first time they've been penalized in that way, interestingly enough. Even if a patient's admitted and our UR or [the] PRO kicks them out, we don't get paid but the physician does.

That's about to change, I think. The physicians, they're trying to put some physicians, right now, under the DRG system. . . . And I think that's coming for outpatient surgeries. Right, limited and done on a DRG basis, and not just what reasonable and customary charges, which is what they've always gotten. That will, I think, have a profound impact and there'll be lots of political hassle about that, because of physicians' interest, obviously, in keeping their income stream. And they have some influence, or think they do. Declining, I think, but they still do have some influence in the legislative area. That's who they have to squeeze next. There's not much room to squeeze hospitals. They're, hospitals are being driven out of business, what, about 300 a year. And that was their intent. Couple more years, they'll have all the hospitals out they probably want, although maybe not the right ones, oddly.

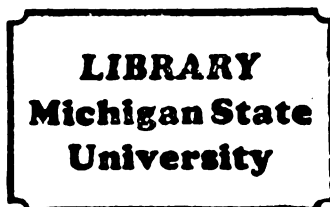
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**MEDICAL COST CONTAINMENT:
THE POLICY AND PRACTICE OF DIAGNOSIS RELATED GROUPS (DRGs)**

**PHYSICIANS AND DRGs
Volume II**

Introduction

By

Mark Edward Notman

From the perspective of the hospital responder to cost-containment, it is obvious that physicians are strongly impacted. Though recent cost-containment efforts have not been targeted directly at physicians, they have profoundly affected the delivery of medical care and, hence, the physicians' responsibilities for admitting and discharging patients and ordering services. As their illnesses are diagnosed and treated, their charges, as discussed, are influenced by various mechanisms related to the monetarization and delivery of medical care (Ginsberg 1984).

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of
DOCTOR OF PHILOSOPHY

(Culliton 1986b; McKinlay and Arches 1985; McKinlay and Stoesckle 1990; Steptoe 1987).

Department of Anthropology

Siegler (1984) argues that PMGs represent a revolution, with the "Age of Autonomy" being replaced with the "Age of Bureaucratic".

CHAPTER 6 How physicians are asked to balance the good of the patient against other goods such as the needs of the hospital, the needs of its employees, and the needs of society.

PHYSICIANS AND DRGs

Introduction

From the preceding discussion of hospital responses to cost-containment, it is obvious that physicians are strongly impacted. Though recent cost-containment efforts have not been targeted directly at physicians, they have profoundly affected the delivery of medical care and, hence, the physicians responsible for admitting and discharging patients and ordering services for them as their illnesses are diagnosed and treated. These changes, as discussed, are linked to other social processes related to the monetarization and bureaucratization of medical care (Ginzberg 1984). For physicians, the main effects have been a loss of autonomy and increased proletarianization as they inexorably become corporatized employees in a medical system driven by mechanisms altogether different from the "traditional" doctor-patient relationship (Culliton 1986b; McKinlay and Arches 1985; McKinlay and Stoeckle 1990; Steptoe 1987).

Siegler (1984) argues that DRGs represent a revolution, with the "Age of Autonomy" being replaced with the "Age of Bureaucratic Parsimony." Now physicians are asked to balance the good of the patient against other goods such as the needs of the hospital, the needs of its employees, and the needs of society.

The doctor-patient relationship in America is moving away from an individualistic model toward a bureaucratic and corporate model. This is a profound change. It is, in fact, the most radical change in the doctor-patient relationship in generations, and one whose consequences can only be guessed at. (Siegler 1984:25)

As discussed in the previous chapter, hospitals have instituted a number of changes in response to this cost-containment "revolution." These include a number of internal reorganizations and the adoption of new management techniques aimed at better understanding and controlling their costs. Since physicians account for such a large percentage of the costs hospitals incur (Grossman 1983), it is not surprising that hospitals have attempted to control physician behavior in order to save money. Their monitoring of physicians and methods of educating them regarding cost-containment were discussed above. This chapter deals with the ways physicians perceive cost-containment and their responses to the new medical care environment. Their perceptions and responses are organized effects of cost-containment (see Notkin et al. 1987), no one is apt to do so today. Cost-containment and its

under the analytical categories of Protecting the Hospital, Protecting Patients, and Protecting Physicians.

Protecting the Hospital

Over the course of this study, physicians have, to a large extent, come to embrace hospitals' efforts at containing costs. Faced with increased monitoring by hospitals and outside regulators and the expansion of cost-containment into all aspects of medical reimbursement, physicians are aware they need to practice medicine in a way which limits costs whenever feasible (Nowak 1983). Many do not necessarily agree with the changes forced upon them, but they have come to realize they will be held accountable for their actions. They also are well versed in the general negative effects associated with the last seven years of cost-containment (Keenan 1985) and believe hospitals must be protected so sick persons will be able to receive the care they need.

The physicians I observed, as well as those I interviewed at length, were quick to point out that cost-containment threatened hospital survival and quality of care. Though a sizeable percentage in the early part of the study--when DRGs were first beginning--denied their practice of medicine would be affected or played down the effects of cost-containment (see Notman et al. 1987), no one is apt to do so today. Cost-containment and its

effects are just too prevalent to ignore and deny. They have all witnessed the changes--from hospital closings, mergers, and reorganizations to the denial of payment for patient care and the increased inability to get patients admitted to the hospital. A study of 334 physicians in 38 states found the same concerns (*Modern Healthcare* 1985a; also see Keenan 1985:28).

Mirroring the complaints put forth by hospital administrators, physicians believe hospitals are inordinately affected by cost-containment. Many complained to me that the "Severity of Illness" associated with many DRGs (and linked with an "Intensity of Service" specifying "approved" treatments) is often "oversimplified." The result is that the hospital invariably loses money on these cases. Because of this discrepancy, one hospital administrator (who is also a practicing physician) described the 467 DRG categories as "hogwash." Physicians familiar with the particulars of DRGs also complained that "length of stay" is an inappropriate criterion, because it often fails to cover the expense of required and customary treatments, especially for elderly patients with multiple acute and/or chronic conditions. For example, I was told diseases whose standard treatment includes long-term administration of I.V. antibiotics commonly entail expenses above what DRGs allow. The critics claimed that the "Intensity of Service" judged appropriate by physicians

often exceeds what is reimbursable. This problem is exacerbated, according to one physician administrator, because DRGs "make us get rid of the healthy patients while we still have the sick ones" (who require higher than average amounts of care). One attending physician, an outspoken critic of cost-containment efforts, claimed the DRG system is self-defeating:

[With DRGs] you have all these personnel--nurses, UR people--spending time monitoring patient care. All of this costs money. You have a system set up to do one thing doing another which it wasn't created for. You have people who aren't involved with medicine getting their fingers into patient care. I've been here an hour documenting already. This costs money. The [DRG] system creates fixed costs. It actually increases costs!

It also creates a conflict of interest for physicians. They are now pressured not to admit patients while their medical training and the realities of the doctor-patient relationship lead them to admit if there is any doubt.

Physicians are very humanitarian and they like to get paid for their services. So there is a conflict. Some physicians don't want to use the short-stay unit because they can't bill for an inpatient H&P [history and physical exam]. They're worried about liability--so are prone to admit, even if the patient doesn't meet criteria, because their medical judgment says admit. And then the relationship of the physician to the family, as opposed to the hospital and the family: the hospital is a very generic-type relationship. The physician has a relationship normally with his patients This leads to pressures to admit as the family pleads to get a patient admitted that they can no longer care for. But Medicare rules say you can't die in the hospital; chronic deterioration is not a reason to admit. The physician has a burden here. They use the hospital as an excuse to keep

patients out sometimes because of the difference in relationship. We [hospitals] don't have that relationship. the man a medicine cost \$140 for the

required two-week regimen. Knowing that the patient did

Physicians have adopted practices to help protect hospitals from the possible harmful effects associated with cost-containment directives. Changes in charting and discussions regarding the use of certain antibiotics (types and method of administrations) based on their cost-effectiveness were the most frequent. Two of the seven senior residents I studied in 1984 carried price lists for medications and tests in order to save the hospital money whenever possible. Some of the teaching services employ pharmacists to round with physicians and impart information on drug costs and administration. Seminars on cost-containment-related issues are increasingly incorporated into residency programs. Physicians also commonly reported and were observed not admitting patients that would have been admitted in the past, discharging others "early," taking reimbursement rates into account in determining admitting diagnoses, and performing an increasing number of procedures (such as bronchoscopies, dialysis, and chemotherapy) on an outpatient basis due to new reimbursement schedules.

The above practices may be illustrated with case examples. In one case, the hospital administration and physicians worked together to bring about an "early discharge" for an indigent patient with tuberculosis. When

preparing for the patient's discharge, the resident learned inadvertently that the man's medicines cost \$140 for the required two-week regimen. Knowing that the patient did not have the money or insurance to pay for his treatments after discharge, the resident was faced with keeping the patient in the hospital to assure delivery of medication (and losing the hospital money under DRGs) or discharging the patient knowing he would not get the needed medication (but saving the hospital money). As a compromise the resident arranged, in consultation with hospital administrators, for the patient's discharge and for the hospital to pay for the medications without any reimbursement. According to the resident, this was equivalent in cost to one more day in the hospital. Since the patient's bill was already being paid by the hospital, the alternatives were to either absorb the cost of fourteen days of medication or absorb the cost of two weeks in the hospital plus the fourteen days of medication. The hospital opted to supply the medication on an outpatient basis and, thus, cut its costs dramatically.

A second case occurred in pediatrics. The resident felt the patient was a "social admission" in that the child was probably suffering from its mother's neglect, rather than from any urgent, acute medical problem. Prior to DRGs, such a case would have been labeled "Failure to Thrive" in the admitting notes, she said. Because of

discussion with UR about other cases, however, the resident had learned "Failure to Thrive" would only pay for three days of hospitalization under DRGs and be costly to the hospital. The resident labeled the problem "Malnutrition" which paid for a longer admission. She told me:

It's only a matter of learning to play the game--to learn the language. So I admit for "Malnutrition." And when I called to get the PACE [Medicaid pre-authorization] number they told me it had to be an "urgent admission" to be reimbursable. So I told admissions that it was an "urgent admission."

In a third case, an elderly alcoholic who periodically "dries out" in the emergency department had been admitted to the hospital because the emergency room was unusually busy. The next day, the senior resident spent approximately half an hour attempting to get this patient out of the hospital through a series of phone calls to hospital administration, emergency, social work, and the patient's relatives and friends. None of the friends or relatives who could be reached would come to get the patient, and none consented to have him sent to their house. Ignoring the issue of where the patient would go after discharge, the resident called a taxi, saying, "Either you eat the costs of his stay in the hospital or you eat the cost of the cab. I'd rather eat the cost of the cab."

Need to, perhaps, do everything for each patient in the most, the least costly way, not necessarily the best for the patient. So that becomes a real ethical problem, that type of arrangement, really.

Protecting Patients

Early observers and commentators were quick to point out that the desired but potentially opposing goals of cost-containment--cutting costs and providing quality care--would be impossible to attain: that the drive to improve efficiency is antithetical to providing adequate medical care. Some early analysts also pointed out that cost-containment had the potential to affect the moral climate of medical care delivery (Menzel 1983; Daniels 1985). If limited resources are one of the results, they argued, it may force choices on the part of physicians between providing, on one hand, less care than conventionally judged adequate and, on the other, fudging diagnoses to cover costs. A physician told me during an interview in 1986 that the situation physicians increasingly faced raised a new ethical dilemma for the profession. He argued that, as physicians increasingly become employees of health care corporations (as opposed to being private contractors) and come under the jurisdiction of various regulatory bodies, an ethical dilemma arises centered around monetary interests:

[A]nd, then, the ethics of that, of course, is the fact that there is, therefore, a built in quiet. And, ethically, the quietness, of course, is the worse part about it. Need to, perhaps, do everything for each patient in the most, the least costly way, not necessarily the best for the patient. So that becomes a real ethical problem, that type of arrangement, really.

responsible for denying admission to the five emergency patients. Though knowledge about the particulars of DRGs often tends to be vague, physicians are constantly faced with stiffened criteria for admissions. It is common knowledge that patients are no longer admitted for problems such as alcoholism, executive work-ups, rest and recuperation, diffuse psychosocial problems, and a myriad of pre-surgical and diagnostic procedures (Wrenn 1985). As I was repeatedly told, patients are not admitted "like in the old days."

The chief of the emergency department of one hospital reported stricter admitting criteria for his department emanating from the hospital's executive committee. It was common in emergency rooms at all of the study hospitals for certain patients (e.g., those apparently not suffering from acute medical problems but for whom a short hospital stay might uncover undetected problems) to be denied admission "due to DRGs." Of thirteen observed instances in which patients came to one emergency department for treatment in 1984, five patients were not admitted because of cost-containment considerations. Of the eight that were admitted, three engendered physician-led discussions of approved lengths of stay reinforced by the hospital. A nephrologist I interviewed and observed at work told me the reimbursement system and of ways in which the "Intensity of Service" could be kept high enough to meet admitting criteria and keep the patient hospitalized. The physicians information about patients they insured. In 1987 he

responsible for denying admission to the five emergency patients told us these patients would probably have been admitted as a matter of course in the past, if only for observation. According to one attending physician,

The loser will be the patient. Hospitals will make it [the DRG system] work eventually, but fewer patients will be hospitalized. [Doctors will] think about admitting three times instead of the regular two.

Physicians also perceive pressures to discharge patients quickly. Though many reported that pressure to discharge can be countered at times by increasing the intensity of care prescribed (for example, by starting an IV infusion), a common misconception among physicians is that UR has the authority to order patient discharges. I was told many times by residents early in the study that the "DRG stickers" placed on patients' charts meant "discharge right away." Others complained that UR, the PRO, and insurers of all kinds "kick people out of the hospital." The general perception is that patients' lengths of stay are the target of DRG reimbursement and, in general, cost-containment (see Wassersug 1986). Stickers on patients' charts and letters from insurers noting approved lengths of stay reinforced this perception. A nephrologist I interviewed and observed at work told me the state's largest insurer had written him "all kinds of letters" and then had one of their physicians call him for information about patients they insured. In 1987 he

claimed he got calls every two weeks, with the insurer asking him

really subtle questions, checking up on me. What they're gonna do is force all the doctors that take care of the complicated cases, the really good, experienced doctors, out of practice. That will leave only the young, inexperienced doctors who have nine to five mentalities to take care of these patients. That's what it's gonna be.

The physicians I studied believe that patient care has suffered because of cost-containment efforts. Sixty percent of those interviewed in 1984, including seven of nine attendings, volunteered negative aspects of patient care related to cost-containment that they had either experienced themselves or feared would happen. As one internist put it:

The insurance companies want one nice diagnosis, but with these kinds of patients--a lot of patients--there isn't just one diagnosis. They can't deal with patients with multiple problems or that just aren't right and have no easily made diagnosis.

Twenty-seven percent stated on their own that their practices were already compromised. Periodic letters to the editor and features in local and national newspapers decried the effects of cost-containment on the quality of care (e.g., Hough 1988; *Lansing State Journal* 1985; Pear 1984). A cardiologist involved with geriatric medicine described DRGs as "kind of a pain in the butt."

with DRGs. I think just in terms of making decisions, sometimes it seems to be more related to trying to keep the hospital solvent than what might be best for the patient. And it changes your decision-making, it changes your relationship with patients to some extent. For example, [that patient we saw today in the hospital who wanted to stay because he felt too sick to go home]: He's ready to go anyway, but, I mean, and he might have been ready to go even earlier, but you wouldn't have argued with him very much in the past. You would've just said, "OK, well we'll just keep you around a little longer." For old people, older people, who don't have a good, who are more debilitated than he, having to get 'em out of the hospital quicker I think is bad in the sense that they don't get a chance to recover and get back going again.

As a senior internal medicine resident put it: "All I can say is there's not much room for compassion." In 1990, all are able to voice fears or expound on experiences about the negative effects of DRGs.

The UR director at one hospital said

The internists have been infected, affected the most. "Infected," I don't know (laughter), whatever. . . . Because the biggest problem is with the aged population that they treat and with medical issues. Surgery is a cut-and-dry issue. I mean, that rarely comes up. It's usually medical cases. . . . And most of them are very upset. They have hard decisions to make. I mean, what do you do? What if it was your grandmother, what are you gonna do? You know, your grandmother falls at home and you can't get her up off the floor and she's having a lot of pain and you bring her to the ER and they say, "No, you gotta take her home." And you say, "But she lives alone." And they say, "She's got you, you got her here." "Well, I have to go to school. I have to go to work." "Then hire somebody to come in and sit with her." Um, "She has a compression fracture in her back." "Well, then keep her in bed for three days." "How am I going to keep her in bed for three days? Who's going to stay with her?" "You get somebody at home to stay with her." I mean this is a difficult, I don't know how you deal

"sub with this. I mean it does cost a lot of money to be in the hospital. It's a very difficult situation for them to be in."

She told me that before DRGs that type of patient would have automatically been in the hospital.

A major worry of physicians (blind to the present state of affairs) is the creation of a two-tiered health care system: For those who can pay, there will be a "better" system; for those who must rely on some sort of assistance, there will be another, "worse," system. Thirty percent of the physicians interviewed in 1984 spontaneously mentioned this possibility. It is a common subject of writings today in professional medical journals and the lay print media. The old, poor, and chronically ill are identified as the major losers in such a system. Discussing a patient with good insurance hospitalized to receive nutritional support and chemotherapy for her cancer, a resident told me:

We were going to put her in a nursing home, then we found out she has no intentions of going to a nursing home. That's why I'm beginning PT [physical therapy] today. If she was Medicaid she'd be out of here or she'd be paying the bill. A lot of them get right out when they're told they'll have to pay.

One attending, frustrated in his attempt to forestall a DRG-related discharge, reportedly exclaimed: "We're abandoning our elderly!" A resident referred to DRGs as "We're never be cured, but they're used to being admitted and can't stay unless it's an acute problem. Patients get hostile about this at times, wondering why it was O.K. in the past but not now—even though they feel as bad

"subtle violence against the old and poor, the oppressed."

Another resident told me:

Patients are being sent home too early now. In the future it will only get worse. I have this patient who's 80-some years old and dying of gastric cancer. If she doesn't die soon, she'll have to go home to die--regardless of her social or family situation or what they want. It isn't that I'm against dying at home with one's loved ones and family members, but that the option of dying in the hospital is being lost.

I had another patient who was sent home by UR as soon as he began to recover. He was a little old man and they sent him home to be with a little old lady. A little old man and a little old lady! Can you believe it? You know, if you have young patients, there's not much problem, because they'll come in, get treated, and get out within the [DRG] time limit. But with old people you just can't do that. They don't always respond in the time given them.

Several physicians reported that many patients feel they are being sent home "too early," and noted this is especially a problem for chronically ill patients who are accustomed to longer stays. I observed instances of such patients "being kicked out of the hospital," as the physicians (and patients) put it. One physician explained how he had come to deal with affected patients through increased educational efforts:

A lot of chronically-ill patients are now sent home before they feel they're ready. As their doctor I have to talk to them and explain to them why they have to go home. Since they're chronic patients they'll never be cured, but they're used to being admitted and kept in the hospital until they feel better. Now they can't stay unless it's an acute problem. Patients get hostile about this at times, wondering why it was O.K. in the past but not now--even though they feel as bad

as they did before. They need to have explained to them that they're not acutely ill, no matter how lousy they feel. You have to impress upon them that you'll take care of them as much as if they were in the hospital and that there's no need for hospitalization.

In rare instances physicians were observed directly confronting the system and refusing to follow the regulations when they felt DRGs would negatively affect their patients. One instance was observed involving a chronically ill cystic fibrosis patient who was to be discharged after 18 days in the hospital (four days over the standard DRG-reimbursed length of stay). Because he was on oral medications and was receiving no regular intensive therapy, discharge was indicated on the basis of low "Severity of Illness and" low "Intensity of Service." The patient's attending physician (who views cost-containment measures as misguided and a direct threat to patient well-being) felt the patient needed to stay in the hospital at least a few more days, contrary to the senior resident, three interns, and the nursing staff. After a somewhat heated debate carried out in the hall outside the patient's room, the attending got his way and the patient remained in the hospital.

More common examples of direct confrontation are the phone calls physicians make and the letters they write to insurers and others about the perceived inappropriateness of a patient's approved length of stay. One physician in private practice drafted a lengthy letter in 1987

specifying instances of poor patient care caused by DRG regulations and outlining major problems he saw with the PRO's operations. He eventually testified before state and national legislators. Other physicians were observed intervening on behalf of patients who received threatening letters from insurers informing them they had already used up their authorized number of hospital days.

Much more common than directly confronting the system were a group of more indirect measures used to manipulate and work around the rules on the behalf of patients. These measures generally aimed at minimizing the impact of cost-containment on patients without "rocking the boat" or directly violating cost-containment regulations. Interventions were often employed--"to get around UR" and "to dodge DRG bullets"--that allowed physicians to keep patients in the hospital. A senior resident reported, for instance, that it is common practice to keep children with diffuse symptoms on oxygen, justifying continued hospitalization for the real purpose of observation. Others said keeping patients on IV fluids was enough to "buy a few days."

Admissions are also finessed by using certain admitting diagnoses or listing them in such a way that hospitalization and diagnostic testing are justified and the DRG-related length of stay maximized. Through the use of such techniques, many physicians believe their delivery

of care has not yet been compromised too severely by cost-containment. A senior resident related to me the case of one of his alcoholic patients with a "terrible social situation." The state threatened to take away his child if he did not get treated for his alcoholism. He would not go to a local hospital-sponsored treatment center because his insurance would not cover it and treatment required a three or four week stay, compromising job-related responsibilities. He said the patient did not really need to be in the hospital, but that "he had to go somewhere."

The resident "had the DRG people on [him] from the start," as soon as the patient was admitted to the hospital. The insurance company-approved length of stay was a "medically justified" three days, but in order to keep the patient hospitalized the resident had to "play up" the patient's medical problems in the chart--"impending DTs, alcoholic hepatitis, and alcohol-induced kidney problems." These conditions really did not meet admitting criteria, but the physician "played them up" to get the care he believed his patient needed.

Despite these attempts to protect their patients, data gathered from inpatient abstracts suggests that physicians have not been entirely effective in skirting the effects of cost-containment on behalf of their patients. As Table 8 indicates, the average hospital stay of patients on the medicine service dropped at one study hospital from 5.6

days in 1983 (before DRGs) to 3.6 days in 1984 (after DRGs were instituted). While part of the difference can be attributed to a shift in patient mix, the mean length of stay was still 25% lower in 1984 than in 1983 after adjustment for the change in patient mix ($p < .01$). The reduction was also greater for Medicare patients (38%) than for other patients (15%) after adjusting for the change in patient mix ($p < .05$) (see Notman *et al.* 1987).

Additionally, the total volume of services devoted to each patient, indexed by hospital charges, also decreased. Though the volume of services changed less markedly than length of stay (with much of the reduction in average bill related to a shift in patient mix), after adjustment for patient mix the average charge per patient declined by fifteen percent. The average charge for non-Medicare patients declined four percent compared with a 26% decline in average charge for Medicare patients. Although neither the year-to-year difference in charges nor the interaction with source of payment is statistically significant in the sample, the reduction in charges is consistent with the national experience. Thus, Medicare patients appear to be inordinately affected by cost-containment in terms of relatively shortened lengths of stays and reduced availability of services, realizing the fears of the study physicians.

Protecting Physicians

In addition to worrying about the welfare of hospitals and patients, physicians also expressed concern about restrictions on medical decision making associated with cost-containment. These complaints seem, in part, to express physicians' fear of losing autonomy. As one of the creators of DRGs stated in 1985, DRGs take power away from physicians and give it to insurers (*Physician's Management*, 1985:158). This fear on the part of physicians is not new. Cited in a 1979 publication--four years before DRGs started--a physician-attorney argued against outside influence on physician behavior:

You have to operate within the standards of care for your particular community. To hell with cost containment guidelines. Individual bodies and souls sometimes respond differently, and the man who is standing at the bedside is the only one who can make the decision.

Cost containment is a political football. It's popular right now because of the economic conditions of the country and it's only popular because of that reason. I think physicians are getting misled into lining up behind the cost containment program--we're being led like sheep to the slaughter. After all, when it comes right down to it, who is best qualified to decide whether or not a patient goes home? (*Legal Aspects of Medical Practice* 1979:23)

Many of the physicians studied reported on their own that they did not want to turn decision making over to a "medically unsophisticated bureaucracy" that is more

concerned with saving money than treating disease effectively. As one pulmonologist put it:

It's garbage. They don't know anything [about affort medicine]. People not familiar with medicine are responsible for determining if people need to be here [in the hospital] or not.

Physicians fear the "'circummedical' field" (Hahn 1985:60), made up of "non-medical types," will stress financial management over patient care and, in the process, usurp physician autonomy, cause doctors more work, and negatively influence patient care. An internist I studied was outspoken in his disregard for cost-containment efforts by all insurers:

The insurance companies want one nice diagnosis, but with these kinds of patients--a lot of patients--there isn't just one diagnosis. They can't deal with patients with multiple problems or that just aren't right and have no easily made diagnosis.

Many physicians perceive cost-containment as gross interference with the practice of proper medicine. Editorializing in a popular medical publication, one physician decried the many facets of cost-containment as "censureship."

Medicine The censorship being imposed upon the medical profession in the United States today exceeds anything ever placed upon any other profession or trade, except in wartime. What we see now with DRGs, preadmission screenings, PSROs, and quality assurance is the imposition of conformity and restriction that has been

They witnessed only in the governments of autocratic tyrants or in harsh Communistic regimes. (Wassersug 1987:109).

Another physician describes cost-containment's affront on physician autonomy as

Perhaps in time someone will be found that can see a multifaceted issue involving the degree of an individual clinician's control over patient care versus control by some organizational entity, local versus national and physician versus nonphysician ownership and management of those organizations, the degree to which the organization uses professional measures rather than bureaucratic manipulation (or bureaucratic stalling) to influence physicians' practice style, and the distribution of income to clinicians rather than to administration and overhead. (Kralewski et al. 1987:340)

A local academic physician involved with utilization review argued the main reason physicians do not like DRGs is because they limit their income:

No longer is it the case that your earnings are limited to the amount of work you want to do and the number of hours you put in. Now there's others who will tell you what you'll make. You know, a lot of doctors went into the business for the money and they don't like what these changes are doing.

Also threatened is the traditional doctor-patient relationship. Discussing increasing influential structures of accountability and regulation, the *Cecil Textbook of Medicine* (Wynngaarden and Smith 1985) argues

These measures were enacted to assure quality of care according to consistent standards; the hidden agenda was cost control.

patient lengths of stay (e.g., UB, the PRO, insurance companies) often have a strained

They support the notion that medical practice be open to public view and public accountability, but argue the physician-patient relationship should remain paramount and inviolate. Review, the FRG, and, increasingly, various

Perhaps in time mechanisms will be found that are less onerous and distracting than those currently in use. The federal role in medical practice will remain, although it may change. But the ultimate contract is between the patient and the doctor, and this relationship must be based on mutual trust and mutual respect. No amount of third party surveillance must be allowed to supplant that venerable tradition.

One resident I observed complained that he could not obtain an echocardiogram for one of his patients. Agreeing that the results would not change his management of the patient's care, he nevertheless contended that the echocardiogram would be "interesting" and "educational." He said cost-containment would increase the frequency of such occurrences to the detriment of residency training and, possibly, patient care. Others complained that various cost-containment policies infringe on physicians' freedom by restricting the tests available in hospitals and running them only at certain times. The perceived constraints on the utilization of laboratory tests and medical technology engendered by cost-containment efforts led one attending to remark, "It's back to thump and look medicine."

Groups who monitor patient lengths of stay (e.g., UR, the PRO, insurance companies) often have a strained

relationship with physicians expressing displeasure at someone looking over their shoulders second-guessing their care (Miller et al. 1988; Norstrand 1986; Zaslow 1980). Utilization Review, the PRO, and, increasingly, various third-party payers, as the overseers of costs, are commonly viewed as standing in an adversarial relationship to physicians. Physicians contend they are now required to think about "semantics" because of the demands of others. They perceive cost-containment in general (and, often, the above mentioned groups) as coercive and a threat to the exercise of their medical judgment.

One senior resident said UR does not discuss cases with doctors: "They grab us after they have hawked us out upon the admission of a patient." Another reported that "UR grabs us in the hall all the time. It's a hassle whenever they talk to us. They're always hassling us." Some physicians referred to UR personnel as "the grabbers," and one, in particular, as "Bloody Mary." Another reported that "It's all out war with UR." A medical student reported UR is viewed as "a specter looking over everyone's shoulders and not really contributing to patient care." An editorial in the *Journal of the American Medical Association* referred to them as "DOG analysts" (Wohl 1987:1801). Though the quality of the UR-physician relation varies by site based on such things as personalities and UR "visibility," the UR team, the medical

records be staff handling routines related to DRG classification, PRO officials, and the creators of DRGs are all characterized as "non-medical people" without adequate knowledge, affecting medical practice for the worse.

Though expressing fear for hospitals, their patients, and their autonomy because of DRGs, physicians have been slow in becoming acquainted with new regulations aimed at curbing costs and restructuring the medical care delivery system. In the early part of the study, many of the physicians appeared to have no idea where DRGs and their indices came from. Few were aware that DRGs are a statistical characterization of past medical experience, or that DRG indices and associated lengths of stay are based on observed patterns of care. For example, when two pediatric attendings argued (in 1984) over whether DRGs were based on amassed data or on theory alone, the chief of pediatrics expressed his skepticism about the very existence of any pertinent data. It was and still is a common misconception among physicians that DRGs are based on criteria totally disconnected from actual practice patterns. In 1991, a seasoned physician. The majority of physicians observed also appear to have a poor understanding of cost-containment mechanisms. Most talk among physicians about DRGs concerns patients' lengths of stay. Many have the misconception that the length of stay associated with a DRG category is a "cap"

not to be exceeded, and that DRG "outliers" (patients who stay beyond their particular DRG's length of stay or incur inordinate charges) "eat up all the profits" that the hospital would otherwise make.

Though it is more frequent in 1991 to hear comments linking treatment choices to cost-containment policy, many physicians are still unsure how the system specifically works. Their comments indicate they know that DRGs are imposed by the federal and state governments as well as third-party payers, that they require classification of each patient into one of a set of diagnostic categories, that each category has its own fixed rate of reimbursement, and that whether hospitals make or lose money depends on the management of the DRG system. However, few appear to know the details of the classification scheme. In the early part of this study, most physicians did not know what information was most critical to record from the administration's point of view. It is here that the efforts of UR have been instrumental in terms of teaching physicians how to chart their patients' hospital stays in ways maximizing reimbursement. In 1991, seasoned physicians are quite familiar with charting requirements and know that help from UR is only a phone call away, even if still unaware of how the system specifically operates. As DRGs and other cost-saving measures were instituted, a good deal of confusion about the new

directives and procedures was observed. Physicians--especially residents and interns--were not sure, for example, who was supposed to call insurance companies for admission preauthorization. A month after the admission pre-authorization policy for Medicaid patients went into effect, patients were still being admitted up to five days before preauthorization calls were made. The pediatric head nurse was unsure what the new Medicaid criteria "would be" after they had been formally issued by the state. Calls to UR regarding Medicare DRG patients and to third-party payers for "preauthorized" hospital stays are still a source of consternation for physicians.

On one level, confusion concerning cost-containment is understandable. A lack of concern about costs has a long history within the medical community (Cf. Applegate *et al.* 1983; Eisenberg and Williams 1981; Garland 1980; Martin *et al.* 1980; Schroeder *et al.* 1973). Physicians are much more concerned, as they go about their daily business, with making sick people well. During the thirty-seven morning reports and various types of teaching rounds observed in 1984, only five references to the larger social issues related to health care cost-containment occurred, and in only one case was the topic pursued. In this one case an attending physician urged his residents to think about the social allocation of health care monies, but the discussion quickly ended when a resident commented, "Social concerns

are nice, but I have to treat sick patients." The attending himself agreed that "costs should be ignored and things should be done medically." This sentiment prevails to this day.

Discussions among physicians at work typically focus on patients' medical problems and appropriate treatments. Few deal in any way with costs or cost-containment and, when they do, these issues are rarely the primary topic of the discourse. For example, of 151 physician-initiated discussions of individual patients' cases recorded in 1984 fieldnotes, only 36 dealt in any way with treatment cost considerations, 17 with cost-containment in general, and 24 with DRGs specifically. The majority of times such comments were directed at the researcher and probably would not have been brought up if someone interested in them had not been present. Notes kept by a physician colleague while he served as attending physician on a family practice inpatient service in 1984 revealed only five discussions related to DRGs or cost-containment in the care of 44 patients over a two-week period. Physician respondents in the Proxy Decision Making Study (see Chapter 7) overwhelmingly tended to base their treatment decisions on medical aspects of the case, though not denying that costs were of some importance. Though cost-containment is certainly more on peoples' minds now than it was when DRGs were first instituted, it still makes up a very small

percentage of daily discourse centered around the delivery of medical services. As one physician stated, summing up the general consensus:

Our [treatment] decisions are based on medical knowledge and medical priorities. Costs are not that important--if they enter in at all. We can sometimes choose a different antibiotic which is cheaper and has the same coverage, but cost doesn't enter in that much.

My observations, as well as studies examining the topic, have shown physicians generally do not know the costs of the services they order (Kelly 1978). Physicians, in general, decry the reduction of the practice and art of medicine to cost considerations.

Summary

Over the course of this study, the physicians I observed and work with have vigorously adapted to changes associated with cost-containment. They have changed the way they document the care they deliver, they readily admit they are not admitting patients they would have a few years ago, they discharge patients earlier than in the past, and they treat more things outside the hospital. Though these efforts to protect the hospital are currently widespread, the still increasing costs of medical care and remaining deficiencies in physician charting (General Accounting

Office 1986) underscore the fact that physician adaptations to date have not been adequate.

The physicians studied admit to dissatisfaction with the increased roles that the federal and state governments and third-party payers have in determining how medical care is delivered. They fear for the solvency of hospitals, their elderly and poor patients, and their loss of autonomy and economic privilege (see Kinsley 1986).

The climate is one in which physicians are generally hostile toward cost-containment, but they often find ways to cooperate with the hospital administration to protect hospitals' and their patients' interests. Though they feel unfairly scrutinized and constrained under the new system, they recognize they cannot ignore the costs of delivering care. As one resident remarked rather cynically, "We need to play the game and get the money."

Physicians do not see cost-containment efforts as something they can reverse or eliminate. They, as do hospital administrators, accept that cost-containment is here to stay. As one said: "It's a situation we're stuck with. We can't argue with the law or the federal government." Yet, physicians find themselves in what Jonsen (1983:1532) describes as a "professional moral paradox" comprised of "the two most basic principles of morality: self-interest and altruism."

[T]he self-interest of a licensed monopoly and the social promise of altruism live together in the profession's life. It is too easy to invoke one in order to dissemble about the other. Over and over again, the professional response to any changes judged inconvenient or unprofitable proclaims the monastic vow of altruism in order to disguise the Hippocratic concern for good business. (Jonsen 1983:1534)

Physicians have not yet been the target of major cost-containment efforts. To date, only minor changes have been made which affect physician reimbursement and these have, to a large extent, been restricted, with little effect, to relatively small and specific subgroups of physicians (e.g., pathologists and radiologists) (Kirchner 1985, 1986).¹⁹ Efforts to force all physicians to accept Medicare assignment and other cost-containment measures aimed at physicians in general have been squashed (Dentzer *et al.* 1985; Williams 1984) as they have come head-to-head with organized physician lobbying groups--the most powerful interest groups in the health care arena (Shenkin 1986:36; also see Krause 1973). Though the study state's largest private insurer recently enacted set fees for its "participating" physicians, these fees are, on average, 9% higher than normally would be the case due to concessions made to the state's practitioners (*Lansing State Journal* 1990). The AMA has continuously voiced its opposition to any sort of financial incentives for physicians to practice cost-conscious medicine (Egdahl and Taft 1986:60).

Though major changes in physician reimbursement are slated to begin in 1992 (*A.S.A.P. Update* 1990), to date physicians have remained relatively unscathed. It will be interesting to see how well cost-containment measures aimed at other sectors of the medical care system--especially hospitals--have prepared physicians for this eventuality, as measured by their resistance, organized opposition, and stalling tactics. Whether any efforts will be able to effectively reduce physician payments remains in doubt given the prestige this occupation has in the U.S., the wide range of "acceptable practice patterns" (Egdahl and Taft 1986:60), and the orientation many physicians are likely to take. A physician editorializing in a local newspaper argues that "physician fees are still one of the biggest bargains available to the American public" (James 1985). Shenkin, writing in 1986, expresses the sentiment well. Arguing that any future medical delivery system the U.S. devises--including a nationally-based one (Relman 1987, 1989)--would have to have as one of its components high physician incomes:

This is the cost to be borne by the late development of cost-containment in the United States and would be necessary to insure the willing cooperation of the profession. (Shenkin 1986:130)

There is no doubt medical care has changed drastically over the last few years. There is also no doubt it will change drastically in the future. How physicians will

respond in order to successfully impact these changes to protect their professional standing and prerogatives remains to be seen (American Medical Association 1986; Brailer and Nash 1986; Day 1985b; Goldsmith 1986).

PATIENTS AND COST-CONTAINMENT

Introduction

Both hospitals and physicians have responded to changes brought about by cost-containment in a variety of ways and fear the effects cost-containment will have on patients, especially the elderly. Critics advocate groups and some legislators are also fearful and have lobbied to counter cost-containment efforts (e.g., The Better Care 1986; DeLeon 1986; Miligau 1986). Services for the Aging 1987; U.S. Senate 1986; U.S. House of Representatives 1985). Most agree a real battle is being fought over the elderly's (and their families') health care costs. Policy, however, has focused on controlling costs over hospital and physician services, resulting in decreased access to hospital-based care and a shift in care giving to outpatient settings and understaffed, poorly organized, and inadequately funded informal care networks (primarily families).

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CHAPTER 7

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The majority of the patients encountered during this study had no difficulties and, thus, no concerns regarding cost-containment, primarily because they had adequate insurance and their illnesses were acute and self-limiting. There was a group of patients and their caregivers, however, who had inadequate insurance or other resources to deal effectively with their needs. They were either in need of extended convalescence after an illness or were quite ill, suffering multiple chronic conditions and needing on-going medical care and supervision. For them, the system often proved inadequate to meet their needs, even when they thought they had adequate insurance. It is these patients that were the focus of this chapter.

This chapter illustrates the effects of cost-containment on patients and their informal caregivers. First, an overview of values and norms associated with medical care in the U.S. is provided. Data also are presented from a study of proxy medical decision making for the elderly, illustrating the relative value patients, caregivers, and providers give costs compared to other factors influencing the delivery of medical services. Next are discussed the ways in which the elderly are a target for cost-containment measures, illustrated with data gathered from interviews with patients and their family caregivers. Their experiences receiving medical care and perceptions regarding DRGs and cost-containment highlight

contradictions inherent in our value system. At the same time that we espouse governmental responsibility for providing equal access to unlimited care, we foster an individualized approach to health and well-being and an ideology which blames victims for their illnesses. While we discount the importance costs should play in medical decision making, we face a variety of cost-cutting schemes which help serve to commoditize health and further inhibit the equitable delivery of services.

Changing Social Realities and Values Centered Around Medical Care

As discussed, hospitals are where most formal medical care is delivered in this country (Starr 1982:145-179). Following this trend has been an increased focus on the elderly as recipients of care and as the target for government policy. Increased life expectancy and increasing numbers of older Americans, technological advances in medical care, and social policy aimed at the elderly (especially Medicare), among other causes, have supported the growth of physician-centered, hospital-based, procedure-oriented, acute care and the "medicalization of old age" (Arluke and Peterson 1981; Estes and Binney 1989).

This has not always been the case. Before the late 1800s, the elderly, as all medical patients, were integrated into the medical care system based on

dependence, not age (Rosenberg 1986:235-6). Then, social class, more than pathology, determined the kind of care one received. The U.S.'s early medical system was arranged with voluntary and municipal hospital wards serving as repositories for the poor, while almshouses, general hospital wards, and outpatient dispensaries were reserved for the working and dependent classes (Strauss 1970). The wealthy traditionally received personalized home care from the private sector. By and large, only the poor received institutional care based on a bureaucratic model similar to today's hospitals. This has changed dramatically: our medical system is now centered around hospitalized care and the elderly are now a primary focus of government policy and medical and social resources.

These changes have fostered an expectation among the public that the government will be there when needed to supply medical care and support in the last years of life (American Board of Family Practice 1985:28 and 1987:154; Blendon 1988). The way in which this "entitlement mentality" (Shenkin 1986:42) became solidified is detailed in a passage of Shenkin's (1986:22-23) discussing the structures and institutions created by the medical establishment. He argues they have systematically removed market forces from the medical care economic arena, buffering people from the true costs of the medical care

population has access to hospital-based care Williams and

they receive, and, in the process, fostering the status quo of medical power. He writes:

Fifty years ago, after the onset of the great economic depression, the nation's hospitals found it difficult to meet their costs and turned to an insurance plan to broaden the base of their financial support. From the beginning, the operation of this plan was in the hands of the administrators and trustees of the hospitals contracting to provide services. This was the start of Blue Cross. The boards of trustees for the Blue Cross plans were and are composed of representatives of member hospitals and medical societies with so-called public members chosen by the board members previously elected by the hospitals and doctors. They are nonprofit and, thus, are pseudo-public agencies that are untaxed. The contracts between Blue Cross and hospitals are on a cost-plus basis, and thus in effect the "marketplace," as far as there are costs concerned, is markedly attenuated. In addition to being basically an accommodation for providers, Blue Cross plans favor the wealthier segments of society by providing partial and full service plans that cause poorer subscribers to spend a far larger percentage of their income for full coverage than the more affluent. In 1965, introduction of Medicare and Medicaid . . . broadened access to hospital care for the aged and poor. These measures further separated patients from the costs of their medical care and more fully eliminated the marketplace from the operation of hospitals. The inclusion of payment of the premiums of all health insurance plans in labor contracts, tax deductible to the employers and tax free to the employees, is another way government has subsidized the cost of health care, further relieving many consumers from this responsibility directly.

Assumptions centered around the expectation of government support are being directly attacked by cost-containment schemes like DRGs as the payers of medical care attempt to curtail their costs and limit their responsibility. Currently, approximately 80% of the population has access to hospital-based care (Williams and

Guerra 1985:188), but, due to cost-containment, an increasing number are finding hospital-based care restricted and adequate home care impossible to obtain. As in the "old days," the wealthy do not have much trouble finding quality home-based care. For a large majority, however, finding suitable care is oftentimes difficult and taxes social networks as they are forced to adjust their schedules and daily routines to care for sick relatives at home. Nursing homes offer an alternative for the sickest, but access is limited and the cost is very high and usually not covered by insurance. Medicaid covers home-care expenses but only after a patient's financial resources are liquidated. Furthermore, nursing homes are associated with negative values in this society. As Rosenberg (1986:237) notes about the contemporary situation: "Even now, there are relatively few nonstigmatizing institutions to care for the aged and chronically ill"--including nursing homes and family social networks.

The increased need for families to provide intensive care in home settings for their ill family members brings to the fore an ambivalence surrounding this situation. On the one hand, there is a strong cultural tradition of independence in U.S. society. Being able to "take care of oneself" is a cherished value for most Americans (Clark 1972). Dependency tends to be negatively valued. Associated with these values is the belief that, to a large

extent, people are responsible for their own health. A study by The American Board of Family Practice (1987:154) documents 36% of the American public believes getting good medical care is the responsibility of the patient or her family. Not unrelated, preventive medicine and health promotion have come to the fore in public policy orientation and with the general public at large. As DRGs commoditize disease, health promotion commoditizes health and makes it the individual's responsibility to remain healthy. Ignatieff argues (Will 1989) our nation's burgeoning "ideology of health" amounts to "the medicalization of American individualism." On the other hand, Americans are well-enmeshed throughout their lives in social networks which provide a variety of needed resources and services. Verifying the significance of these relationships, especially among family members, surveys demonstrate a majority of children believe their parents should reside with them when no longer able to live on their own (Peterson 1989) and that children should be economically responsible for their parent's medical care (American Board of Family Practice 1985:28 and 1987:154). As DRGs affect patients and their family caregivers, positive values associated with independence, negative values associated with dependency, and norms stressing familial obligations to provide custodial care will increasingly come into conflict as

families grapple with the reality of supplying a greater portion of medical care at home in the last years of life. The current lack of support and reimbursement for low-tech, home-based care exacerbates these conflicts and does little to assuage the collective needs of chronically ill elderly patients and their informal, familial caregivers. This orientation fits well with the government's and businesses' intentions of containing medical costs by commoditizing medical services and shifting an increasing share of the costs and responsibility onto patients and their social networks via restricted access to inpatient medical facilities and increased emphasis on home and self care (cf. Butler *et al.* 1979-1980).

A study I participated in while conducting the fieldwork for this dissertation examined proxy medical decision making for the elderly. The results of this study shed light on the values U.S. citizens hold toward health and the delivery of medical services. The study (Tomlinson *et al.* 1990) was aimed at discerning how well others could make crucial medical treatment decisions for incompetent elderly people. Though not directly focused on issues related to cost-containment, this research supplied data relative to the perceptions elderly persons, their physicians and potential proxy decision makers have regarding the costs of medical care and how costs may affect medical decision making. These data supply part of

the context in which recent cost-containment efforts occur, representing one variable affecting how people experience and perceive cost-containment. ~~set treatment~~ obtained from all. For the study, elderly people in the community, in seniors housing, and in nursing homes were presented with three medical scenarios. Each depicted a stark treatment choice--basically life or death. Respondents were asked to imagine themselves in the scenario situations and to tell us if they would or would not choose treatment. We elicited their main reason for their treatment choice with an open-ended question. Subjects then rated and ranked seven "Reason Statements" (supplied by the researchers) relative to their importance in guiding their treatment choice. One of the scenarios explicitly asked respondents to consider cost considerations in their decisions (see Appendix B, Scenario 3).

~~decis~~ "Related Subjects"--potential proxy decision makers for the elderly--were also interviewed. These included family, friends, and physician caregivers of the primary elderly subjects. "Related Subjects" were presented with the same three scenarios, asked to imagine "their" elderly family member, friend, or patient in the same sets of circumstances, and to state whether or not they thought treatment should be given. The primary reasons for their treatment decisions were elicited and they also rated and ranked the supplied "Reason Statements."

These interviews supply two data sets that will be used here. The first consists of the open-ended primary reason responses (for or against treatment) obtained from all the people originally interviewed for the study. These include 486 responses to the three scenarios by 45 elderly subjects, 61 family members, 29 friends, and 27 physicians and other formal caregivers.

Based on the participants' unprompted main reasons for or against treatment, financial costs seem to play a very minimal explicit role in deciding their treatment decisions. Of the 486 open-ended responses collected for all three scenarios, costs were mentioned in only 21, or 4% of the total. Fifty percent of these responses were secondary or tertiary comments, mentioned after the "main reason," and unrelated to it. The majority who mentioned costs used them as partial support for a "No Treatment" decision. Five of the comments (22%) came from those choosing treatment; two of these, however, explicitly discount the importance of the economic costs of the care in influencing their decision. Though the order in which the scenarios were presented was rotated, the relatively few times issues of cost arose they were mentioned in the context of Scenario 3, where the researchers had introduced the topic. When costs were brought up respondents overwhelmingly tended to down play their importance.

Based on participants' open-ended responses, it appears that what they took into account the most in reaching their decisions were the "health" and "social" costs--as opposed to financial costs--associated with the particular conditions outlined in the scenarios. If quality was seen as being too compromised and the chance of recovery too minimal--regardless of the scenario--people opted for no treatment, citing the hopelessness of the situation or the burden it would place on others. If, on the contrary, they felt life could still be enjoyed, that there was a reasonable chance of recovery, or that life should be preserved (for whatever reason), they opted for treatment. These results parallel those of The American Board of Family Practice (1985:7) who found that cost considerations play a minimal role in patients' right-to-die decisions.

The second data set consists of the study participants' main reasons for their decision in Scenario 3 and the weighted importance subjects placed on our provided Reason Statements, two of which explicitly asked subjects to consider the costs of care. Data include interviews with 43 elderly subjects, 95 related subjects (spouses, siblings, children, friends, and others), and 20 physicians treating the primary elderly subjects. This author tape recorded and transcribed interviews with a subset of these research subjects (See Table 4).

Scenario 3 was constructed containing explicit references to a hypothetical patient's finances, insurance coverage, and the costs associated with a "Yes" treatment choice. The scenario outlines a situation in which a 60 year old widow has been in the hospital two weeks after suffering a stroke. The stroke is no longer life threatening, but her physical and mental abilities have not improved. Her left side is paralyzed, she is unable to feed or bathe herself, and she does not recognize her family. She requires total nursing care. The doctors cannot tell for certain how much she will recover from the stroke, but they feel that improvement is unlikely.

Prior to the stroke, the hypothetical patient had agreed to have a pacemaker inserted because of an unspecified heart condition. Her doctor had told her that, with the pacemaker, she could expect to live 10 to 20 years; without it she could expect to die of heart failure within a year. She was going to contact her physician to schedule the operation the day she had the stroke.

She has insurance coverage for her hospitalization costs, including the pacemaker insertion, but not for nursing home fees. If placed in a nursing home, her \$50,000 savings will be rapidly depleted, requiring the state to make Medicaid payments on her behalf. Her immediate family is described as being unable to offer

financial support because of the presence of college-bound grandchildren.

The situation described, then, is one where the patient will have to "spend down" in order to become eligible for state support if she gets the pacemaker. By choosing treatment in this case, her life span will very likely be increased, but her savings will be depleted, leaving no money to help with her grandchildren's education, and costing the state tens of thousands of dollars for a patient with questionable quality of life and minimal chance of rehabilitation.

As for all three scenarios, analysis of the study's findings underscore that patients, physicians, and family caregivers generally tend to discount the role of costs in treatment decisions. If care is needed and there is hope, treatment will more than likely be wanted. How the care is to be paid for is of less importance than that needed care be given. In the rare instance costs entered into treatment decision making, they were generally used as a mean to justify non-treatment.

For elderly subjects not choosing treatment, most cited decreased physical and mental functioning, lack of quality of life, and increased dependency as their main reasons for not opting for treatment (Table 10). Fifty-two percent (n=27) of the elderly cited something to this effect. An additional 22% explicitly stated they would not

want to be a burden. Only two (7%) of the elderly subjects spontaneously mentioned costs as their primary reason. One stated the expense was too high and the other said she would want to leave money for her relatives.

The main reasons among Related Subjects opting for no treatment were decreased functioning and low quality of life (52%), their desire for the patient not to be a burden (14%), and their belief that the chance of recovery was too remote (10%). Only six (2%) cited on their own any kind of financial reason for their primary choice.

For those elderly choosing to have the pacemaker inserted, 44% stated the chance of improvement from the stroke was the primary reason for opting for the treatment. Twenty-two percent cited the increased number of years the pacemaker would bring, and an equal percentage mentioned that life should be preserved.

For Related Subjects opting for treatment, the largest categories, as they were for the elderly subjects, were the chance of recovery--including the increased number of years the treatment would bring (29%)--and the notion that life should be preserved (28%), either because it is sacred or because they thought the elderly person would want to live. Eighteen percent believed the patient could still enjoy life and said this was their main reason for choosing treatment.

**Table 10: Elderly Subjects' Ratings of Reason Statements
For and Against Treatment (Percentages),
Scenario 3**

REASONS	Trmt. Choice	LEVEL OF IMPORTANCE				
		NO	LITTLE	SOME	MUCH	GREAT
1. Might Recover	(Yes)1	0	0	11.1	44.4	44.4
	(No)2	44.4	22.2	18.5	3.7	11.1
2. Increased No. of Years	(Yes)	0	0	11.1	38.9	50.0
	(No)	66.7	25.9	3.7	3.7	0
3. Cost to State	(Yes)	33.3	22.2	44.4	0	0
	(No)	44.4	0	11.1	11.1	33.3
4. Money to Children	(Yes)	50.0	22.2	22.2	0	5.6
	(No)	37.0	18.5	0	18.5	25.9
5. Better Not to Linger	(Yes)	16.7	33.3	44.4	5.6	0
	(No)	0	0	0	14.8	85.2
6. Life is Sacred	(Yes)	11.1	16.7	11.1	44.4	16.7
	(No)	66.7	14.8	11.1	3.7	3.7
7. Burden	(Yes)	22.2	5.6	33.3	16.7	22.2
	(No)	3.7	0	0	22.2	74.1

1. For Treatment: n = 18
2. Against Treatment: n = 27

In looking at the Elderly Subjects' ratings of our supplied Reason Statements for Scenario 3 the same general trends appear (Table 10). For those choosing against treatment, the statements rated highest were the belief that "It's better not to linger in such a condition" (100% gave this "Much" or "Great Importance") and the "Desire not to be a burden" (96% gave this "Much" or "Great Importance"). Though only two respondents spontaneously related costs to their decision for no treatment, when the two Reason Statements referring to financial implications of the treatment choice are looked at (Table 10, Numbers 3 and 4), we see that people will not say that costs are not important. Fifty-five percent of the elderly said the cost to the state for long-term nursing home care was at least of "Some Importance" to them in deciding against the pacemaker. A third gave it "Great Importance." Forty-four percent (the highest percentage) stated that the costs to the state were of "No Importance." The same percentage (44%) said the fact that they would want to leave money for their relatives was of "Much" or "Great Importance" in their decision for no pacemaker. A little over a third (37%) said this was of "No Importance."

For Elderly Subjects choosing the pacemaker, costs also appear to have entered their deliberations to some extent when forced to consider them with our Reason Statements. Two-thirds (66%) said the cost to the state

had "Little" or "Some Importance." Half said leaving money for relatives had "Some" level of importance (even though they would opt to spend this money for their care).

The Related Subjects' ratings of the reason statements parallel those of the Elderly Subjects. For Related Subjects choosing "No Treatment," the statement that "It is better not to linger in this condition" was rated as having the most importance; no one gave it "No Importance." The burden issue was also rated relatively highly, though family members, when compared with friends and physicians, were much more apt to give it "No Importance."

For Related Subjects choosing treatment in Scenario 3, the chance of recovery, the possibility of increased number of years, and the notion that life is sacred were the reasons rated highest (as they were for Elderly Subjects). Nobody gave "Great Importance" to the statements regarding the cost to the state or leaving money for the children, though a sizable group were unwilling to give it "No Importance."

Thus, when asked to consider the financial aspects of their treatment decisions, economic costs or savings appear to be more important than subjects' responses to the open-ended question would imply. Though they rank below the "costs" to the hypothetical patients in terms of decreased quality of life and the general burden their condition would be for "others," our respondents did not deny that

costs are important when asked to rate them relative to other factors (see The American Board of Family Practice 1985, 1987 for national surveys on the rated importance of health care costs).

The data presented here are secondary to the actual focus of the proxy study and to the dissertation's main emphasis. They also deal with hypothetical situations which gloss over the uncertainty and the countless factors entering into real treatment choices. They suggest, however, that costs are considered in making such decisions, even if only tacitly. When asked, people generally are incapable of stating costs should be of no importance in making medical decisions. Yet the research subjects were reluctant to explicitly link reasons for treatment decisions with economic considerations. They acknowledged that the costs of medical care do have some degree of importance--that as a society we should be concerned with them--but that, in most instances, medical decisions should be based on medical criteria. If a patient needs care they should receive it and the question of who will pay should be saved for another time. Though the patients and family members I interviewed for the Proxy Decision Making Study usually had not faced situations quite as stark as those depicted in the scenarios, for many of them the effects of cost-containment were obvious and generally negative in nature.

The Elderly as a Target: Causes Of And Changes In The System

With DRGs, the elderly were singled out for a major cost-containment "experiment" aimed at cutting the state's expenditures on hospitalized care. Utilizing more health care resources per capita than other segments of the population, expanding in numbers faster than other age groups, and because the public sector pays for a large portion of their medical care, the aged represent a particularly appropriate "rational" target for cost-containment efforts.

In fiscal year 1981, programs for the elderly comprised 25% of the federal budget. This is expected to grow to 32% by 2000 and to 63% by 2025 (Quinn 1980). Though those 65 years and older represent only 12% of the population, they account for 31% of the nation's medical costs (Parsons and Marzetta 1987:76). Medicare supplies 45% of the medical care for those over the age of 65 (U.S. Senate 1984:69) and almost 90% of the hospital costs for this population (Parsons and Marzetta 1987:76). In 1981, public funds (including federal and state monies) covered 64% of the health bill incurred by elderly Americans (Congressional Quarterly 1983:77) and, in 1984, 67% of their medical costs (Parsons and Marzetta 1987:76). Since

1970, federal medical outlays for the elderly have risen about 17% per year (Morreim 1985).

Though evidence exists that the elderly are not the primary cause of escalating medical costs, they, more than any other group, have been hit with higher deductibles, co-payments, and monthly premiums as the federal and state governments, insurance companies, and various financing bodies have attempted to limit their expenditures (Shenkin 1986:39; Storey 1986). Between 1965 and 1983, the Medicare hospital insurance (Part A) deductible increased from \$40 to \$260. Annual deductible payments for supplementary medical insurance (Part B) rose from \$50 to \$75. In 1965 the Part B premium was three dollars. This rose in July 1983 from \$12.20 to \$13.50. Co-payments for hospital services under Medicare rose from \$10 in 1965 to \$65 in 1983. The co-payment rate for 100 days of care in a skilled nursing facility (post-hospitalization) rose from \$5.00 to \$32.50 in the same period (Congressional Quarterly 1983:101). Medicare beneficiaries are responsible for 20% of the "reasonable costs" of covered medical services (and any costs over that amount) under Part B. They are also responsible for many other medical expenses that have never been covered by the federal program: routine physical exams, eyeglasses, hearing aids, and dental care (Congressional Quarterly 1983:101-102).

Projected 1992 budget negotiations in Washington plan for a \$60 billion increase in Medicare costs for the elderly (Morganthau *et al.* 1990). At the same time, the deductible for Part B will rise from \$75 to \$100 a year and monthly premiums are scheduled to rise from \$28.60 to \$46.20 by 1995. In all, over the next five years \$10 billion is to be trimmed from the projected growth of benefits for Medicare participants (Fram 1990).

Nationally, approximately 30% of medical costs are paid by patients (Lassey and Lassey 1985:83; Williams and Guerra 1985:172). In 1981, per capita expenditures for medical care for the elderly were \$3,140 (Congressional Quarterly 1983:77). By 1984, this figure was \$4,202 (Parsons and Marzetta 1987:76), representing about 15% of the average elderly person's income. By 1987, 25% of the elderly's medical costs were paid out of pocket (Parsons and Marzetta 1987:76; *Modern Healthcare* 1985b:64) and it was estimated that one out of every 20 elderly Americans and their families faced financial ruin due to long-term medical costs (Derry 1987). A study by The American Board of Family Practice (1987:18) found three-quarters of Americans would have difficulty paying the costs of a serious illness and twenty-five percent expressed difficulty in paying current medical costs.

When DRGs were created, it was hypothesized that they would cause early discharges and shortened lengths of stay,

fewer diagnostic tests and procedures, multiple admissions, and a general restriction in access to health services (Dolenc and Dougherty 1985; Morreim 1985; Siegler 1984), even for those with "adequate" insurance. That such major cost-cutting efforts would be directed at the elderly is especially troublesome when it is noted that Medicare generally has a higher share of high-cost cases than do other payers (Wennberg et al. 1984). Medicare patients also have higher average costs within specific DRGs (Martin et al. 1984:377), signifying the relative severity of their illnesses. The leading causes of hospitalization for this group are digestive and circulatory problems and neoplasms-conditions, many of them chronic, with numerous and varied etiologies. In addition, the elderly suffer multiple chronic conditions, multiple drug reactions, and poor nutrition more often than other age groups (Steel 1978). Their illnesses create presenting conditions often difficult to reduce to one of 467 discrete DRG categories or treat in a short hospital stay. Many do not require high-tech, hospital-based care. Thus it was likely the elderly would be disproportionately affected by DRGs, as shortened stays, limited treatment options, and diagnostic testing reduced the chance of receiving adequate care.

Even before DRGs, there was evidence the elderly receive less care than younger patients. Physicians are not well trained in geriatric medicine and have little

inclination or opportunity to learn such skills (Senger et al. 1985). Physicians, on average, spend less time with elderly patients than with younger ones (Sudnow 1970), experience greater difficulty in treating the ailments for which elderly patients seek treatment, and tend to assume that extensive care for the aged is economically unjustified and, ultimately, futile (Butler and Gleason 1985; Greene et al. 1987; Greene et al. 1989; Haber 1986; *Medical World News* 1986a). This, argues Haber (1986), is linked to a model of old age developed by early gerontologists relating aging to a nonreversible state of degeneration and breakdown, leading inevitably to death. It is also related to deep-seated and pervasive values in American culture associated with ageism and our system's inability to adequately deal with patients--especially the aged--suffering multiple chronic problems caused more by natural, evolutionary physiological changes and social, political, and economic processes than to pathophysiological changes in individual organisms. The elderly, as a group of patients, are difficult to "treat" adequately with a medical delivery system geared towards "curing" acute problems with high-tech, hospital-based interventions and super-specialized medical expertise. The elderly are often in need of non-acute care services due to the chronicity of their illnesses and lack of social and economic resources.

The poor elderly (like the poor in general) also stand to suffer restricted access to adequate medical care as states implement DRG-like payment systems for Medicaid (Fuchs 1984:1572; Harrington *et al.* 1986; Uehara *et al.* 1986). The poor suffer from more acute illness and disability than the non-poor (Victor and Evandrou 1987) and patients without insurance receive fewer services than those with insurance coverage (*Lansing State Journal* 1989; Mullan 1987; Wrenn 1985). Morreim (1985:32) argues that the poor, in general, are treated with a "hold-back approach," as opposed to the "order-freely" approach used for insured patients. Today, close to 40 million Americans have no medical insurance (Clark *et al.* 1988). Thirty-two percent of the general public and 41% of those aged 65 and over have no hospital insurance (American Board of Family Practice 1987:20). In 1984, less than 40% of those earning less than the poverty level were covered by Medicaid (down from 54% in 1980) (Gage and Andrulis 1987).

Because of their age, the types of illnesses they have, and the expense to those paying their medical bills, the elderly and poor often receive care different than that of other groups and they have been targeted for medical cost-cutting measures. The government argues that cost-containment helps insure appropriate, quality care. Critics argue otherwise. Though various cost-containment measures existed prior to DRGs (e.g., Certificate of Need

and various types of managed care), there is no doubt DRGs represent a more intrusive, all-encompassing approach, given their applicability for all hospitalized patients as well as outpatient care and physician services. Though a history of shortened hospital lengths of stays existed in the U.S. before DRGs took effect (Starr 1982:157-158; Moien and Liu 1987:64-65), they have dropped even further since they began (Notman *et al.* 1987). DRGs have also created a need for services outside the hospital due to increased numbers of outpatient procedures and fewer admissions to the hospital. Whether these changes are good or bad, of course, depends on one's perspective and interests, but the general consensus, as discussed earlier, is that they bode ill for the elderly unless viable options are created and supported (cf. Brody and Magel 1984). As Shenkin (1986:123) notes:

Since the DRG system has its focus exclusively on cost-containment, it will be a system fostering the complete hegemony of hospital and corporate managers whose overriding commitment will be to fiscal matters including profits, and patient interests will become a secondary matter. A prime motivation for introducing a nationalized health system in other countries was to broaden access to the entire population, recognizing health care as a basic right. The DRG system by its very nature and concentration on cost reductions will pay no heed to this tenet. More than likely this right will be impaired, or at least compromised, not broadened.

As pointed out, the acute, high-tech, curative focus of our medical system offers little to chronically ill

elderly patients with minimal social and economic resources. With DRGs restricting admissions, increasing the number of outpatient procedures, and decreasing lengths of stays, patients increasingly receive care outside the hospital. Hospitals responded by beefing up their discharge planning and social work departments to help insure patients receive the outpatient care they need (see Jacobs and Lurie 1984), but gaps in services and access still exist.

The trend away from hospitalized care existed prior to DRGs (Alter 1988; Brody 1977:76), but prospective payment has fueled an even larger need for home-based and other services. Sager et al. (1987) report that, by 1985, prospective payment systems resulted in a 10.3% decrease in hospital deaths (and a 26.2% increase in nursing home deaths) highlighting the reduction in hospital services. From 1971 through 1985 Medicare expenditures for home care grew at an annual rate of 20%, increasing from \$63 million in 1970 to over \$1 billion in 1981. This growth rate was expected to continue, averaging 12% to 20% annually, through 1990. Medicaid home care costs have increased from \$15 million to over \$400 million. During the same time period, home care visits to patients tripled and the number of certified home health agencies has doubled (Koren 1986).

Home care agencies, many of them owned and operated by hospitals, have become a growth industry since DRGs began,

both locally and nationally. In the study area, the number of home health agencies went from one in 1983 to five in 1988 (Kapusinski 1988). The 1990-91 study area telephone book lists 21 agencies providing such services. For fiscal year 1991, Congress added \$80 million to the budget for Support Services, Congregate Meals, Home-Delivered Meals, and Older Worker Programs (*Aging Alert* 1990b).

Despite this increase, there are increasing number of Americans without medical insurance (Michigan Department of Public Health 1986:3) and DRGs and other cost-containment measures have increased the burden of local networks of home care services as well as family caregivers. Area Agencies on Aging, for example, have been hard hit with a large increase in demand for their services since the passage of prospective payment legislation (Dolson 1985). Harlow and Wilson (1985) document that, after DRGs were implemented, case management services increased 365%, in-home skilled nursing increased 196%, housekeeping services increased 69%, personal care services increased 63%, and there were increases of over 10% in the areas of health screening, adult day care services, respite care, home delivered meals, and chore services--without adequate funding to support the increased need.

A shortage of trained home care professionals exists, their services are expensive, and many are not covered by insurance. Thus, members of patients' social networks--

families and, less frequently, friends--have to bear the burden of the elderly patient's home care needs. Despite the documented benefits of home care (Hopper *et al.* 1984), this creates social and economic stress among families as they attempt to provide the care needed by sick patients while simultaneously fulfilling the obligations associated with their other roles as parents, spouses, and wage earners (Stone *et al.* 1987).

Numerous studies have documented the importance of social support networks in providing services, including medical care (Blythe 1983; Brody 1977; Cohen and Sokolovsky 1979; Edelman and Hughes 1990; Fischer and Eustis 1988; Shanas 1979; Smilkstein 1988; Snow and Gordon 1980). This was true prior to DRGs. Brody (1977:65) reports that up to 80% of home health services are provided by families. Steinitz (1981:4) reports between 60% and 85% of all impaired adults receive significant family help. With DRGs, however, families have had to become more involved in the care of their *critically ill* family members. With patients being denied admission to hospitals and being discharged "sicker and quicker," informal social support networks are faced with managing much sicker patients than ever before, entailing increased expenses, more time and energy, and increased stress and strain on other roles and obligations. Edelman and Hughes (1990) have demonstrated that formal support mainly supplements informally provided

services, which tend to remain stable over time and are not replaced by formally provided care or services. Fischer and Eustic (1988:383) note:

Along with other trends in health care, DRGs have increased the importance of the managerial family. Families increasingly serve as mediators, supervisors, and planners for both in-hospital and post-hospital care.

Patients' Problems With The System

National and state surveys and numerous studies have shown the general public feels the effects of cost-containment (Citizens for Better Care 1986; *Family Practice News* 1986; *Medical World News* 1986b; Sager et al. 1989; U.S. Senate 1985). The patients studied who were having difficulties with the system have experienced stricter admitting criteria, earlier discharges, inadequate coordination of care, and increased pressure from insurance companies. Though a good number denied that cost-containment negatively affected the care they received, most noticed changes. Some have "horror stories" to tell which help illustrate the current system's weaknesses and those areas bound to be tested in upcoming years due to fiscal crises and changing demographics.

One interview subject was a 79 year old male providing home care for his bedridden wife disabled with a stroke and a broken hip. Although throughout their marriage he had

taken care of her numerous illnesses, she had only recently been sick enough to require extensive care. He was very bitter about his inability to get adequate support in caring for his wife. He had worked all his life, he argued, and had good medical insurance, but felt it fell far short of adequately protecting him from the expense and emotional and physical costs he was now forced to bear. Though he had savings, Medicare, and private insurance, he felt very threatened, vulnerable, and cheated by the costs associated with his wife's care.

As soon as I sat down, introduced myself, and explained the purpose of my study, he said:

Well, you might as well live before 65. Because after that you ain't gonna get nothing from them. They'll take it all. They're leaving out the senior citizens is what they're doin'. I just want my fair share, that's all.

He was especially bitter about the expense to himself, complaining about being saddled with the cost of his private insurance plus Medicare deductibles and copayments.

When I got to be 65, this is when it began. And with Medicare, you go in the hospital then and what [my insurance company] does is pay just 20% of what Medicare don't. And they're darn fussy what they pay. And how long they pay it. And it's just ridiculous. . . . Medicare just put a stop to everything. You, it's just like you outta get shot before you get to be 65. It's just the way you feel, they just don't care. They raise enough money. They just don't put it in the right places.

. . . They're doing it as a business, not sickness. And they're foolin' with our money, it's

insurance money should be doin' this. They're not payin' it. They're just spending their money--our money--on all services, or too much of it, and don't have anything left for us. They're managing our money pretty poorly. If it's an insurance wouldn't you think you're supposed to be insured? Everybody's not in the hospital. Just a few people. A lot of people die, are disposed [sic]. A lot of people have no insurance except Medicare, no insurance whatever. That's what it's all about. A lot of guys got the money has got to pay it until I'm down to 300-some dollars a month. Poverty!

. . . But politics has a lot to do with it when you get to be 65. This is Medicare we're talkin' about. It ain't worth a nickel. I mean it's the biggest hindrance I've ever ran into. And payin' for a service to get one. . . . No help. No nothin'. You gotta spend it down. Give it away. Charity or somethin'. As long as you got any assets you gotta pay. They won't allow you to have very much paycheck. They don't even allow you to have a decent burial. They run you down to poverty level on savings. You can have about \$2500 savings a piece. . . . That's not fair. It's discrimination from one end to the other.

He also complained about the costs associated with providing his wife the home care she needs: "Yeah, you take her home and you pay the bill!"

Many patients expressed a general confusion over billing and the reams of paperwork they receive from the hospital, the doctors who treated them, and their insurance companies outlining the services they have received, their charges, reimbursements, and any amounts still due. Even if patients owe nothing the paperwork comes, causing confusion about what to do with the information. Often, the services are covered by a patient's insurance company, but due to the time it takes them to reimburse the provider, the patient is billed for the service. In some

instances patients' names are given to collection agencies. If the patient does not have a complete understanding of his or her insurance company's payment procedures and which services they cover, patients will sometimes pay the bill unnecessarily. Recovering these monies is difficult.

A 72 year old female discussed her insurance coverage and the process used in paying her medical expenses. Covered by two private plans in addition to Medicare, by all standards her coverage is exceptional. She reported her insurances covered all of her hospitalization expenses but that it is confusing.

Yeah, they cover everything, but they're slower than molasses in January. Gosh, we don't get any Medicare time, you know, and then [the hospital], of course, they keep sendin' you bills. And I won't pay it because I got the insurance. And I paid [another hospital in a different city] one time and I never did get it back.

Concerning her hospitalization during the study, she claimed the hospital or her cardiologists turned her over to a collection agency five months after her hospitalization--even though her insurance covers all hospital medical expenses.

Another patient also expressed consternation that the bills she received from the hospital were confusing and put her through unneeded stress. In early 1987 she went, by ambulance, to a hospital in another city because of an insulin reaction. The bill was over \$200 for the three

mile ride. She received a bill from the hospital and a letter from her insurance company stating the emergency room (ER) services she received were not covered because her condition was not life threatening. She called her insurer and told them it was life threatening and then called the hospital's billing department, who checked the ER records and noted they did not specify her condition was life threatening. The hospital resubmitted a "more clear" bill to the insurance company, who ended up reimbursing the ambulance costs and ER services.

Later in the same year, this woman went to a hospital in the study area, again by ambulance, because of chest pains. This ride was immediately covered by her insurer because her physician ordered the ambulance. The patient, however, was still billed \$30 because she was taken "after hours" on a holiday. She was also charged a "loading fee."

Many believe costs are artificially high because of overcharging by physicians and hospitals to compensate for low reimbursement rates and high malpractice insurance charges. Some voiced concern that cost-containment threatened the special relationship patients are supposed to have with their physicians. One patient told me about the \$50 to \$75 charge she receives every time she goes to the dermatologist.

Every time I go he sprays me with his zap gun and charges me for surgery and an office visit. I get sprayed even if I don't need it. It's theft! This

hurts everyone--the needy as well as doctors who do deserve a decent income. The needy are due a certain level of health care.

One respondent told me this is extremely unfair to people who have insurance and pay their premiums.

I don't use it unless I have to, unless it's needed. And for the amount of premiums they're paid [I don't think the insurance companies should worry about it]. They discourage people from using medical facilities. It make's you wonder, should I go to the hospital or not? It stifles people from going to the emergency room in the middle of the night, maybe. Where I know that if I delay going to the hospital, it'll only get worse.

Patients also had concerns regarding reimbursement by insurance companies. One respondent felt physicians and hospitals were not paid fairly, causing patient care to be diminished.

I have no problem with the concept of cost-containment and I have no problem with accountability: That anybody who's accountable to pay for care, whether it's an individual, whether it's an insurance company, or whether it's a government entity, is entitled to some oversight for their money. Nobody . . . with any responsibility would want to write doctors blank checks. And we hear about things like fixed fees, and I say I don't hear doctors complaining about arbitrary fee schedules. I hear them complain a lot about fees that never get paid, period! . . . The point I was making is you set an arbitrary fee schedule at maybe 60% of the going rate, but if you'd pay it always and pay it in a timely manner that'd be the thing, but to pay it a year late, if at all [isn't fair].

He complained to me about delays in payments made to hospitals and physicians and his notification of these

payments. He also complained about the "nonproductive mishmash" caused by the need for prior authorization and cost-containment in general. He told me about a problem he had with obtaining "predetermination," or permission, for foot surgery his wife needed. Two years earlier, she had a bunion removed in the hospital. This was followed by a year of pain and swelling, caused, it was thought, by the deterioration of her big toe joint. She had the joint replaced with an implant, followed by one more year of swelling and pain. Her condition deteriorated until she would fall down if her foot landed a certain way while walking.

The insurance company demanded a second opinion and predetermination before the problem could be corrected. The physician offering the second opinion found bone chips in the ball of the foot remaining from the bunionectomy. The respondent applied for predetermination for surgery to remove these bone chips and also for a contingency procedure to replace the implant if it had deteriorated. They waited six weeks--"typical [insurance company] grind along." The authorization came back approving the implant replacement but not the removal of the bone chips: "Just totally out of whack with the priorities." "[The insurance company] policy when you're performing two surgical procedures within the same field at the same time, they only pay for the more expensive one."

Just as patients are monitored before they go into the hospital, patients already hospitalized find their stays under scrutiny for appropriateness of care and length of stay. A 50 year old female needing dialysis on a regular basis complained about the letters she received from her insurance company telling her how many hospital days would be covered. The letters arrived while she was still in the hospital after the approved length of stay, leaving it in question whether or not the rest of her hospitalization would be paid for. She complained that this intimidated her and probably other patients as well. She feared it meant some patients would not get the care they needed and felt the letters were uncalled for, coming from the state's largest insurer. Both her and her husband had "good policies" and she felt the intimidation and confusion the letters generated--while she was in the hospital dealing with a life-threatening condition--were just too much.

One respondent told me doctors are telling patients (as her physician told her) that they have to

hurry up and get you well so you can go home before the insurance company goes crazy. Insurance companies don't want people in any longer than they have to. We have to get you out before they start hollering.

A different patient related to me the terror she felt when told she would have to leave the hospital, needing 24 hour care. She did not have the finances to pay for this or

anyone at home to help her on a regular basis. Her physician told her, "they're sending you home."

I said, "I can't go home, I don't have anybody at home and I can't go home." Anyway, I hadn't even been outta bed enough to go to the bathroom. What could I do? Well, he said, "You can't, you shouldn't go home." He said, "Let me go see." Now it wasn't his job I gather, but he came back after awhile and he said, "Well, I talked to them and I got another day for you." I think that's what he said. And the one lady said something and so they got it stretched out to Wednesday. But, if it'd been a normal situation, I probably should have been there at least a week because I couldn't move.

Another respondent was upset and angry that his father faced an early discharge even though he still felt sick. He stated that hospital personnel were nice about pushing for the discharge--due to the necessity of good "public relations"--but he also pointed out the irony in discharging sick patients to family settings not equipped to deal with the situation.

But the Friday I couldn't see anyway in hell how he could go home and the help he would have needed. Course that's probably of little importance to them. Their job is to After he leaves there the burden is off their back. And if you're kinda hard headed about it, then it's certainly on our back. To some degree they gotta do that. They can't, everybody's gonna try to make you--or damn near everybody--stay there more days.

The respondent taking care of his ill wife at home claimed the hospital began "working on him" one week before his wife's discharge to get him to place her in a nursing home.

Oh, yeah, they harass you to death to put her in a nursing home or, and you go look at a nursing home and the first thing they do is start sendin' you financial sheets, you know, to make out how much assets you got. When they stick 'em out, I said forget it. They were all full. Couldn't get him in anyway. So they sent her home with me and I wasn't able to take care of her. It just run me right down ragged.

Though he believes people generally heal faster at home, he thinks many are going home too soon. He told me this was due to hospitals and doctors "overdoing it with hospitalizations earlier with rest stays and doctor fraud." "Now they're takin' it out on us. I can't believe it."

Many of the patients I observed in the hospital and interviewed had experience with home care and related a series of difficulties in arranging for this care. Their tales point out the added stress caused by the need for them to negotiate, with family members and formal providers, the logistics of who provides the care when and how it is paid for.

An 84 year old female I met in the hospital after an automobile accident had a long history of hospitalizations for diverticulitis, a rupture of her vaginal wall, a colostomy, and a bowel obstruction. Her main complaint was that the new rules of cost-containment added stress to patients already under a lot of tension due to their illness and hospitalization. She stated:

But even the first time around with the surgery, he was talking about my going home even before the 12 days [that were preapproved]. He began talking of it [laughter] and I was just petrified when he began talking about it. I said, "What to do?!" I had just barely gotten to the bathroom. I said, "I can't take care of myself." "No," he said, "you can't take care of yourself. You can't go home unless you have someone take care of you." I said, "Well, I live alone, you know, this isn't easy."

She told me: "They tried all over [the study area] finding home cares." Her daughter was willing to help her at home, but her son was seriously ill in Chicago, limiting her ability to care for her mother after hospitalization.

The lady in the hospital that looks after that kind of thing finally found [a home-care agency] and they would give me some home care. But that's \$11 an hour, that's what they told me. First they said nine [dollars], then they said it was 11 [dollars]. I needed 24 hour duty because I couldn't be here alone. I couldn't, I would be afraid to try to get to the bathroom with nobody in the house. But, anyway, they came for, that was the only way the hospital would let me go home was that there was somebody here. Now what they would've done if they didn't get anybody, I've never figured out. But they said, "We have to get somebody that'll be in that house when you come home." They knew that much, that I couldn't be alone. They knew that, but they also knew they couldn't keep me because they couldn't get paid for me. You're in kind of a rock and hard place.

Dealing with the insurance company was also difficult and the patient was not sure her home care expenses would be covered. She had to keep in touch with the company providing the services because "there was no arrangement who was going to pay [them]." She refused to be responsible for an \$11 an hour bill for 24 hours a day.

When she first called the company on the phone they said they were "almost positive" her automobile insurance company would pay for the home care since her injuries were the result of an car accident. The next day she was told ("after calling all day") that they were "pretty sure they'll pay." On the third day out of the hospital--after she called the insurance company and "kept bugging them about it"--she was told the headquarters in Florida was unavailable but that the local branch of her auto insurance company would "go out on a limb and pay for three days." The patient informed them that the day nurse left at 3:00 P.M. and asked them what she was to do until 6:00 P.M. when her daughter arrived; she doubted she could be alone for three hours. The company asked her if she wanted "to split it up--get some today and some tomorrow." She told them that did not help, because there would still be a stretch where she would be alone. The insurance company got the afternoon provider to stay until 6:00 P.M.

When the home care stopped, her daughter took her into her home for a month so she could recuperate in bed.

It was the only alternative or else at a nursing home. . . . And my granddaughter didn't want me to go to a nursing home. These are real health problems that you don't know what to do about.

The patient's daughter came periodically after her mother returned home and cooked for her occasionally. An aide

came twice a week: "She was like somebody walking in and out."

A patient receiving home dialysis discussed how her illness had affected the social roles within her household. Because of her illness, her husband was forced to take over many of the household maintenance tasks she had traditionally done such as managing the check book, paying bills, shopping, and assorted chores. These types of changes in role status are brought about because of increased dependence on the part of one member of the social network. Given negative values associated with dependency in this society, the need for informally provided home care services will call our values into question as we increasingly face readjustments in social roles and obligations as growing numbers of ill people are taken care of at home. Policy should adequately recognize the integral part informal care networks supply in providing resources and services to the elderly and facilitate their efforts rather than impeding and penalizing them.

According to those instituting, running, and monitoring the system, cost-containment regulations have a major responsibility in assuring the delivery of quality care to needy patients. Numerous safeguards are in place, they say, that protect the patient and the providers of care from inappropriate admission denials. The process of

appealing denials was discussed in a previous chapter; there it was pointed out that the results of going before an administrative law judge to appeal a denial of payment are ambiguous at best: Patients do not seem to lose these cases, there are no mechanisms to force insurers to pay, and hospitals are often paid for denied cases before the judge holds a hearing. Policy makers express interest in creating policy heedful of constituents' needs, but current cost-containment regulations--and the policy making process which creates them--are overwhelmingly driven by financial considerations rather than a true desire to provide appropriate and equitable medical care to all Americans. The regulations themselves and the process by which policy is created has the appearance of patient/constituent accountability but little effective means to assure fiscal considerations are adequately balanced with patients' needs.

A respondent with an extensive history of involvement with the medical system related to me his experiences in testifying before the State Senate and in hearings held by national senators concerning PRO monitoring of hospital and physician performance. His family's physician (who also is the primary provider for a state senator involved with medical issues) is adamantly opposed to the PRO meddling in medical affairs, believing that cost-containment unduly restrains physicians and causes a decrease in the quality

of care for elderly patients. After my respondent's mother-in-law's hospital stay had been denied reimbursement by the PRO, the physician arranged for state-level hearings in which both he and the patient's son-in-law (my respondent) would testify.

And I approached the idea that he [the Congressman] and I were both less than 20 years away from Medicare, and I hoped there was a system there to deliver to us when we reached that point. And that we wouldn't get a birthday card on our sixty-fifth birthday from our doctors saying "It's been nice knowing you these last thirty years, now go somewhere else." That was the whole point I wanted to make. I didn't feel that this case with my mother-in-law was one of these catastrophic-fall-through-the-cracks-of-the-system-unique situations. I testified I felt it was commonplace. And that's what made it wrong. It was happening *all* the time to a lot of people and the effect was harassment on providers. I mean it didn't cost my mother-in-law any money because it all happened after she died. It didn't cost us anything but a little bit of time.

Those monitoring Medicare costs, he argued, attempt to make their job easier by throwing up a maze which shields them from responsibility. In discussing the denial letter he had received from the PRO concerning his mother-in-law's care, he stated:

I call it the "divide and conquer technique." The doctor's judgment is being impugned. The hospital, as the agent of the doctor, is getting the punishment by not being paid. The doctor's fees are not denied in this case! But the hospital's fees are denied and the patient, or . . . the patient's surviving family, are the only ones with appeal rights. And the letter they send you makes it very plain that as a patient you're under no obligation to reimburse Medicare or pay the bill! That your doctor is wrong and, therefore, you're innocent to that

action and you're not required to pay. It's a real apathy creator.

The whole foundation of the Medicare system is delivering the service by the provider. That no matter who pushes papers where, if doctors and hospitals aren't delivering the service the whole system is for naught. And if we're going to harass these providers with arbitrary decisions not to pay them every time a computer burps or some RN screens a file six months after the patient's died and decides that according to some arbitrary rule book it doesn't meet the criteria, then providers are going to simply say we've been harassed to the point where we won't deal with this kind of patient anymore. We'll deal with 40 year olds with ingrown toenails and leave the elderly to fend for themselves. That's the position I've taken: That the best intentions of the politicians and everyone else to deal with their constituents are going to come to naught if the providers can't provide without undue harassment.

He told me the case was originally denied because the

PRO

felt the issue could have been dealt with in the ER. It didn't require an admission of three days. They refused to look at the illness in retrospect, in total context. The woman was dying of cancer. It took them longer to deny the payment than it took her to die after she initially sought medical attention. And we didn't argue it on that basis. We argued it on the basis of, hey, we don't care what caused the problem. The problem had to be dealt with--and the way it was dealt with--and was done successfully; the immediate emergency: primarily dehydration due to prolonged vomiting and extreme abdominal pain. Anyway, we thought we presented a good case and the judge agreed with us.

There were actually two denials on this case for two separate admissions. The family's physician was successful in getting the first admission denial overturned, but the second was still denied after review by a PRO physician.

The first admission was for a needle biopsy of the pancreas which took seven attempts before it was successful. The physician was able to convince them this could not have been done in an outpatient setting. Upon hearing that this denial had been reversed, the son-in-law called the PRO and gave them his arguments why the second denial should also be reversed. The PRO physician told him that he would take everything into consideration and get back with them. Later, my respondent was notified by the PRO that the first admission denial was reversed but the second one still stood. In a letter they were informed of their appeal rights.

My respondent filed an appeal and received correspondence that the case was assigned to an administrative law judge. Soon after receiving the letter, he received a phone call from the judge's office. They wanted to know if the hospital was pressuring him for the money. When he replied the hospital was not a party to the appeal, the judge's office expressed confusion regarding why the patient's family would complain since they had no financial stake in the case. "Talk about getting your fuse relit!" He told her they were pursuing it "because it's wrong" for the hospital to "eat" the bill and that this will result in the public paying the tab for his mother-in-law's care.

And the people who would deny these admissions and turn around and cry about increasing health care costs are talking out of both sides of their mouth. And if the government wants to say we can't afford this program so we'll only pay for broken legs but not broken arms and be up front about it, I got no problem with that. But to say we're gonna have this big program, but we're gonna steal 10% of it back under the table, to me, is a real, I have a terrible problem over that. That, to me, is totally dishonest and I think that's the whole motivation of the PRO system: Let's steal some back, rather the criteria's valid or not.

As the appeal date approached, my respondent learned that the PRO might not appear at the hearing. Upon hearing this, he called the judge's office, stating, "Hey, then I've won." They responded that was not the case. "Hey, defend themselves or I win by default. This is an adversary proceeding." They informed him that they did not consider the proceeding to be adversarial, despite the fact that \$1,500 would or would not get paid to the hospital.

When the hearing began, my respondent began to present "his act." The judge, however, only wanted to hear from the doctor, stating that he had already "three-quarters made up his mind which way he was going to rule." The family's physician spoke for about ten minutes after which the judge told him they had won their case. He stated that they had it won before they even got there, and that the hearing was held only because the judge had heard from his staff that my respondent was making it obvious he wanted a hearing. The PRO did not send a representative to the hearing. Their involvement consisted of supplying the

judge, the physician, and my respondent with documentation concerning the case.

The case was won, which overturned the PRO denial, but my respondent was frustrated because nothing was changed. He told me that in

Title IX of the Social Security Act, there's nothing in the administrative rules which allows a PRO to be overruled. Once they've gone through the reconsideration process, you're entitled to seek a hearing. We won our hearing, but later we found out there's nothing there that gives the judge any power to overrule the decision [the PRO] made.

As far as I know, [the hospital] has never been paid for the admission in question. We find that kind of deplorable because we played the game by their rules and beat 'em at their own game and yet there's no way to beat them. And that was our big complaint, that we played their game their way and beat 'em and still had no recourse. I mean it isn't the case of expecting [anyone] to be sympathetic to what was wrong with the denial in the first place. The burden of proof was on us and we prevailed.

He felt that nothing had been accomplished: "So what?"

Another aspect of the case "flabbergasted" my respondent. He approached the hospital to see if they were interested in helping him with the case. He assumed they would be since they would benefit should the denial be overturned and payment made. He assumed they would take the position of the physician who supported and helped them with the appeal: "Good grief, here we have a family willing to fight for us!" He met with one of the hospital's vice presidents who "almost yawned in our face." He cannot understand this because his "approach to the

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whole case was that hospital utilization review was on top of the case and saw nothing inappropriate from the beginning."

Though expressing consternation regarding the review system, the lack of remuneration by the federal government, and the hospital's disinterest, he believed his actions helped bring about a symbolic victory of sorts: Michigan's Congress had ended up "condemning DRGs."

They condemned them. They named a specific case that a colleague of [my physician] had: the dying patient in the basic care nursing home who was admitted to their hospital to make him more comfortable while he died, providing with certain treatments he could not have available in the--even with a doctor's supervision--in the nursing home itself (such as pure oxygen, morphine drip, a few other things of this nature). The patient expired approximately 18 hours after admission and [the PRO] denied it on the basis that he's dying anyway, and what difference does it make where he was? And this specific instance was mentioned in that resolution. . . . That doctor testified at both hearings same as I had. So that, and the general problem that they're denying admissions for invalid reasons, et cetera, was added to the DRG concern which the House had no problem concurring with.

Most of the patients and family caregivers I talked with believe the elderly are especially targeted by cost-containment. One respondent told me: "Well, anything that's gonna cost 'em is gonna get singled out." They also generally felt the government was at fault for the negative impact on patients. The man providing home care for his wife told me:

I think probably everybody'd get along better if they didn't have government in it. The government gets their fingers in it, they spoil it. Well, in fact, I don't know what the person's gonna do that don't have any insurance. That's what you gotta look at. I'm not deprivin' them, but it's discrimination the way it is right now. . . .

I'd feel terrible if I had to go down to poverty level after trying to save to live comfortable without worryin'. That's all I wanted. I don't want to be a millionaire. I didn't want to be a man with lots of money. But I was fortunate to save a little, and I hate to have to spend it all before I can have any comfort. I've never had a vacation. We've always worked. I started workin' when I was 11 years old. Bought my own clothes since then, helped with our big family. All I've ever known is work.

A different respondent, with an extensive history of hospitalizations over the past ten years, blamed compromised care on Medicare cutbacks:

it's caused the hospitals to cut their care. To cut their expenses. And because they cut their expenses, it's also cut their care. The care--and many people that are my friends have been in the hospital, and I have been in [two of the area hospitals] just in the last few months--it's the same thing: You do not get the care you got before. . . . But, you see, all are in a bind. The hospitals are in a bind. The doctors are in a bind. Now the patients are all in a bind And the doctors don't want to take all the grief and the hospital doesn't want to take all the grief, so I don't know what they're gonna do.

Summary

Patients experience changes related to cost-containment as recipients of medical care. Patients are concerned about the care they receive and about cost-containment. Although the majority I came into contact

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with had adequate insurance and relatively good experiences with the medical system, some had been negatively affected by cost-containment constraints and shifts in the focus of medical services. Though cost-containment is not the sole cause of the shift in this country's medical system away from its traditional hospital-based focus (Kinston 1983:1165), there is no doubt that it has affected the care received by the elderly and other patients, changing their options regarding how, where, and by whom care is delivered. Almost all were fearful of what continued cost cutting would mean to them, as well as to those without adequate insurance coverage.

With cost-containment, medical care is increasingly "steered" by imperatives removed from traditional values centered around care giving. The norms and values patients and providers hold toward the formal medical care system in this country are being challenged. The positive value of equal access to care is contradictory to the efforts expended by federal and state governments, corporations, and third-party payers to contain medical costs. Assumptions about the "right" way to provide and receive services are being altered due to contradictions inherent between capitalism and social equality.

In general, the medical system in this country serves more to support a status quo of hospitalized, high-tech care and the centrality of physicians in controlling the

allocation of medical resources than it insures meeting the needs of patients requiring long-term, low-tech care and services. Keeping physicians at the center of the system maintains their general hegemony over medical decision making and, specifically related to geriatric medicine, over a sphere in which they often have little direct control and about which they know relatively little (Koren 1986). As Brody and Magel (1984:677) state:

[Physicians] are . . . reluctant to mobilize and coordinate services beyond the medical model, particularly if those services are outside the hospital walls.

Centering medical services around physicians serves to increase the costs associated with providing care and minimizes the usefulness of non-physician providers in managing and coordinating formal home-based medical and social services.

Despite the increased need and push for non-acute home care (both legislatively and among seniors' advocate groups), the government has continually delimited its involvement in providing these services via a series of cutbacks in its reimbursement (Eastman 1985; also see Wisensale and Allison 1988). Furthermore, informal care networks are penalized by the current system. Steinitz (1981:1) notes:

Informal providers . . . labor under a lack of recognition and compensation from most other

distributors of social and medical care in this country. Their voluntary role is virtually ignored in Medicare, Medicaid and disability insurance reimbursement mechanisms and in the planning and coordination of local service systems. In many arenas, strong economic and social disincentives work against the continuation of informal supports, to the detriment of both the individuals involved and the general taxpayers forced to pay the bills for unnecessary or premature institutionalization.

Today, on average, almost one in ten Americans is hospitalized each year and the average American sees a doctor in his or her office four times a year (Williams and Guerra 1985:23,16). The elderly patient, on average, makes six to nine visits to his or her physician's office annually (Koch and Havlik 1987:56). It is important to note, however, that over 86% of those aged 55 to 64 years and close to 75% of those 75 years or older are not hospitalized during any given year (Koch and Havlik 1987:56). The five percent of Medicare recipients that die every year use 25% of all Medicare expenditures (Lubitz 1985). Twenty-five percent of Medicare Part B beneficiaries receive 79% of the payments (Shenkin 1986:60). Expenditures are quite disproportionate among various categories of Medicare beneficiaries, just as they are among Americans in general.

The facts are that most elderly do not need acute medical services in any given year; old age is not, for the majority, necessarily disabling (Cape and Henschke 1980); Americans of all ages positively value independence

and negatively value dependency; and most long-term care and services received by the frail elderly are provided by family members and other informal providers. A small percentage of the aged at any time require and consume the majority of medical services. Our health care system is centered around these individuals with a reductionistic medical model focused on "killer diseases" and patients suffering significant impairment and activity limitations (Von Merring and O'Rand 1981).

Von Merring and O'Rand (1981) argue our medical policy is based on an over-reliance on national, aggregate mortality statistics related to the delivery of medical services and consumer patterns. A macro-level needs assessment approach dominates, rather than one more sensitive to sub-regional and local variations in medical service needs. This represents a contradiction in policy relative to practice when it is realized that the focus of medical practice is on the sick individual in need of medical care. "Needs" derived by macro-level analyses often do little to provide the care required by a particular patient with a unique illness history, network of available social resources, and cultural tradition (see Clark and Sparks 1976).

Our medical system is currently "out of control," according to Samuelson (1989):

Chaotic? You can't describe our system, let alone control it. It's not socialized medicine. It's not private medicine. We want the security of welfare without the invasiveness of government control. Our health-care system is a jumble of groups (doctors, hospitals, government agencies, health-maintenance organizations, private insurers) working under a bewildering array of regulations and pursuing different objectives. No one is in charge. Power is fragmented.

He argues these structural characteristics result from basic contradictions in public attitudes about medical care: We want good care regardless of ability to pay, we want free choice, and we want to keep costs down. Together, these wants are unobtainable. Until we deal with these contradictions there will be no solution to the medical care crisis.

Von Merring and O'Rand (1987) argue for an "ethno-medical" approach in delivering medical services which would recognize life-cycle variations in health and disease, focus more on chronic, degenerative and regulatory afflictions (as opposed to acute medical illnesses), and be better able to address aging-related patterns of "ill-being" (e.g., intermittent patient-hood and dying by degrees). This, they argue, would provide more adequately the services needed by the nation's ill, especially the elderly. It would also help break down the "major medico-cultural features" of the U.S. medical care enterprise characterized by: 1) A focus on institutionally-based diagnosis and treatment; 2) The growth of medicine as a

science of tests and mechanical measurement (rather than a "bio-cultural art"); 3) The proliferation of medical subspecialties and differentiation of paramedical skills; 4) The functional separation and distancing of personal care away from home and community; 5) The rapid spread and complexity of diverse private and public hospital and medical reimbursement plans; and 6) The bureaucratization of clinical services. Though these trends would not be done away with entirely, the focus would be shifted to an integrative, wholistic approach which would better serve the medical care needs of ill patients.

Brody (1986) has argued that we need to fully recognize that health care is really chronic health care; we need to create and maintain a "health system" rather than a "medical system" and focus on people's quality of life. The public is ready for equal access to adequate, quality formal medical care; they are not against the nationally-planned rationing of medical services (American Board of Family Practice 1985:59). Policy needs to address this by expending appropriate medical care coverage to all Americans. There appears to be a slowly growing understanding of this within policy-making spheres (cf. Goldsmith 1986). The question is how long before reality adequately shapes policy and is able to reorganize and restructure the groups which currently control medical knowledge and services.

Numerous studies have attempted to measure the relative cost-effectiveness of home-based and institutionally-based care, with mixed results (cf. Vandivort et al. 1984 and Walsh 1981). What appears to be the case is that cost is a direct function of the degree of patient disability (*Patient Care* 1985). It is cheaper to treat relatively less impaired patients at home and the more severely disabled in institutional settings. What is not measured in these studies, for the most part, are the social costs families accrue as informal caregivers to patients of any disability level.

The elderly need medical services more attuned to their needs. They need to have a sense of control (Rodin 1986) and they need to be allowed to face death in a way that does not negate this inevitability. They need care which allows their death to occur with minimal disruption of self-esteem, well-being, and social/familial harmony. Today's market-dominated medical system fosters patients as consumers and providers as income maximizers (Thurow 1984) rather than partners in wellness and well-being. Health becomes a commodity rather than remaining a person's inalienable right. DRGs serve the status quo by commoditizing the patient's illness, reducing it to a reimburseable commodity within the medical system and failing to recognize the individual's illness episode's uniqueness in terms of disease history and medical needs.

We need to reconstruct our knowledge and beliefs about old age and medical care. Only then will medical services fall in line with the reality of human existence.

Marcel Proust wrote, "Old age perhaps of all the realities is the one we preserve longest in our life as a truly abstract conception." We continue to associate morbidity and mortality with age; therefore we assume that the increase in life expectancy will increase disproportionately the costs of health care and income maintenance. The last illness has always been the most expensive. It is not that longevity has extended the period of incapacity; rather, it is our inability to adjust our expectations and environments so as to encourage and allow elderly people to exercise their capacities. (Butler and Gleason 1985:3)

Policy today serves to destroy what it should attempt to foster and preserve. Initiatives like DRGs create dependency on the part of the elderly. Gratton (1986:19), citing Graebner (1981), notes it is "the fate of the elderly to serve the economic and social needs of other age groups." He argues the conclusion of writers looking at the current crisis of the Western welfare state is that "the capitalist state uses welfare systems to balance the demands of the monopoly sector against the demand of political constituencies" (Gratton 1986:19). Thus it is that the poor and the old have been laid out upon the sacrificial table of medical cost-containment and benefit cuts, leaving the most vulnerable exposed to a harsh and unforgiving system.

CHAPTER 8

SUMMARY OF FINDINGS

Previous chapters have detailed recent changes in the reimbursement of medical services and their effects on hospitals, physicians, and elderly patients. Though the long term effects of various cost-containment measures, including DRGs, remain an unanswered question, this research makes clear that hospitals and other providers are being forced to adjust to the changes in order to remain solvent and provide what they consider adequate care. It also demonstrates that, for some of the elderly, receiving necessary medical care is difficult because of cost-containment.

Hospitals want to provide care and yet remain economically viable, physicians want to deliver care they feel is medically necessary, and patients want to be cared for until they feel better. Medical cost-containment threatens these goals. Providers have responded to cost-containment to protect their interests. Hospitals have become "smarter" businesses to counter financial restrictions and, in the process, have become increasingly enmeshed with corporatized structures of finance and

services. Physicians have protected their interests by trying to minimize the effects of cost-containment on hospitals, their patients, and themselves. To a large extent they have been successful. They have, however, begun to lose autonomy to the financiers of medical care who exert increasing control over the means and mode of production of medical services. Patients have been affected to the extent they lack the financial and social resources necessary to deal effectively with the changes brought about by cost-containment. Shorter and fewer hospital stays have resulted in larger burdens being placed on patients' informal caregivers and the disjointed and underfunded outpatient medical care system.

This chapter summarizes this study's major findings. Unlike many anthropological and other social scientific studies examining social policy and process, which aim to address social problems with practical recommendations and solutions, this dissertation is not meant to "solve" the crisis related to medical cost-containment. It does not offer recommendations for its alleviation or solutions to dilemmas uncovered by its analysis. Rather, it describes the effects of DRGs on providers and patients and the perceptions of those affected by it. It is argued that DRGs represent one aspect of pervasive changes occurring in the United States' medical sector as well as the culture at large. DRGs, as one form of cost-containment, are part of

larger, state level processes associated with the welfare state in advanced industrial capitalism and its mechanisms for survival, control, and legitimacy. The study of cost-containment serves to uncover and highlight long-standing social and cultural contradictions associated with historical trends linked to capitalism. Cost-containment, in general, and DRGs, in particular, represent major efforts to further corporatize the delivery of medical services and have, as a direct result, the continued commoditization of medical services and illness itself.

DRGs and Cost-Containment

DRGs are the culmination of many factors associated with the state's involvement in medical care (Congressional Quarterly 1983; Quadagno 1986). They represent one attempt, of many, to balance the state's increasing role in the delivery of medical services with the containment of its costs. As state support has broadened, largely through Medicare and Medicaid, numerous strategies and policies have been undertaken to solidify governmental control of resource use. DRGs, like Health Maintenance Organizations, managed care plans, Certificate of Need programs, and reorganizations within the local agencies supplying services to the elderly, represent state attempts to dictate how care should be delivered so that resources are maximized and costs limited.

DRGs are a form of cost-containment begun in 1983 by the federal government for all hospitalized Medicare patients. They are monitored and regulated by state PRO organizations that oversee physician and hospital medical practices. PROs have the authority to impose sanctions (usually the denial of payment) on physicians and hospitals for cases they deem inappropriate. Over the course of this study, DRGs have spread to state Medicaid programs, outpatient procedures, physicians' radiological and pathological services, private third-party payer plans, and legislation has been enacted to make all physician reimbursement DRG-based. They classify patients according to their primary diagnosis and other characteristics, assigning each patient a DRG number linked to a prospectively-set reimbursement rate and projected length of stay. These figures are derived from national data (taking into account regional variation in labor costs and practice patterns) and reflect what the government has determined to be adequate reimbursement and length of stay for the average patient. It is assumed costs will vary by patient, with hospitals losing money on some patients and making money on others. DRGs place the burden on the hospital to realize a profit through judicious use of resources. Their goal was to decrease the number of hospital days for Medicare patients, thus limiting state expenditures for the elderly. The state argues they

improve quality of care by limiting unnecessary hospitalizations, stopping ineffective treatments, and forcing more appropriate regimens outside of hospitals. Critics argue they result in increased bureaucracy, loss of hospital income, and shorter lengths of stays and restricted hospital admissions for patients (especially the elderly).

DRGs serve these goals by standardizing and commoditizing medical services as never before. They standardize care by reducing patients' varied, and oftentimes multiple, symptoms to a numbered category associated with a relatively fixed rate of reimbursement and length of stay. Treatments for individual patients become standardized as physicians attempt to match state-issued "Intensity of Service" and "Severity of Illness" criteria.

Medical care is commoditized because DRGs explicitly measure hospital work as a "product" and view patients as "outputs" of a system producing "health care" (Fetter 1984). Individual, unique patients become numbers in a bureaucratic system geared toward maximizing profit.

At the heart of this cost-cutting revolution is the assumption that health care is a commodity like any other, and therefore when regulatory adjustments force efficiencies, the unproductive elements in the economy will "shake-out" and the result will be cheaper, high quality care for all. (Dolenc and Dougherty 1985:27)

DRGs serve to operationalize illness, reducing a constellation of individual historical and social processes involved with sickness to discrete biomedical entities linked with specified levels of reimbursement, hospital lengths of stay, and treatment protocols. This rationalization of medical care may be viewed as a natural continuation of the Industrial Revolution and the spread of managerial authority (Freidson 1971) resulting from modernization and the state-sponsored imperatives of money and power (Habermas 1981 and 1987).

As one of the most intrusive forms of cost-containment to date, DRGs represent an unparalleled attempt to restructure the delivery of medical services in the United States. Though short- and long-term results are debatable, DRGs have had profound effects on hospitals, physicians, and patients as they have responded to the changes brought about by prospective payment.

Hospitals and Cost-Containment

Hospitals were the first target of DRGs. Those unable to adjust rapidly went out of business. Fewer patients were admitted to the hospital because of cost-containment, and those that were had shorter lengths of stays. Outpatient services, including home care, burgeoned. Elderly patients were affected disproportionately relative to other sectors of the population. These trends are not

solely the result of DRGs, but there is no question prospective payment reinforced, hastened, and expanded them.

The hospitals studied all expressed a mixture of concern and optimism regarding DRGs, reflecting the national consensus. Though arguing that DRGs (and other cost-containment measures) stifle a hospital's attempts to realize a profit, benefits associated with DRGs are also recognized. The literature is full of contradictory statements regarding the effects of prospective payment schemes on hospitals' ability to realize profits (Horn et al. 1985a, 1985b, 1986; Jencks and Kay 1987; Russell and Manning 1989; Schramm and Gabel 1988). As discussed in Chapter 5, the comments of hospital administrators and others regarding the effects of cost-containment are also contradictory, with people relating the horror stories associated with underpayment as well as the ways DRGs have helped--or at least not harmed--hospitals' quests for profits. While voicing dissatisfaction with restricted ability to make money and increased monitoring by governmental and private regulators, hospitals have adopted many cost-containment strategies as a means of understanding and controlling their expenditures and to become more efficient, "smarter" businesses. Though complaining of having "no control" and being forced to react to imposed regulations, most agreed on the necessity

of some system of regulation and viewed incentives to increase efficiency positively.

Techniques adopted by providers of medical care, as discussed in Chapter 5, include the centralization of medical organizations to better exploit economies of scale, the creation of management structures able to provide close oversight of hospital expenditures, the development and implementation of aggressive planning and control systems, and the introduction of human resource policies aimed at improved use of hospital personnel, including physicians (Ginzberg 1988:758; also see Donlan 1985; Shenkin 1986:119, 25-26; Salmon 1977). The study hospitals reflect these adaptations through vertical and horizontal integration (cooperative agreements with other hospitals and expansion into non-acute medical services); consolidation of departments and administrative reorganizations aimed at streamlining managerial structures; computerized analyses of hospital costs and expenditures; reductions and reorganizations of the labor force to better monitor employee productivity and minimize costs; and stepped-up physician monitoring to better control the utilization of medical services. These responses represent the hospitals' perspective that they are "in deep woods, . . . on a teeter-totter, . . . in deep trouble with big financial problems."

These trends within medicine represent responses to specific cost-containment strategies such as DRGs as well as a general orientation in this country toward the organization of medical institutions along the lines of corporate enterprise. As pointed out in Chapters 4 and 5, the role of the hospital has changed dramatically in the United States: From its early beginnings as a place where primarily the poor were cared for charitably, it has become the center of our medical care system, subsidized through private and governmental programs aimed at broadening the scope of medical coverage. Though hospitals have retained an orientation of public service to the needy, cost-containment has facilitated the development and elaboration of other goals centered around profit maximization. From 1978 to 1983 (when DRGs began) the number of facilities owned by for-profit hospital chains increased 72% (Shenkin 1986:25-26). Though these privately owned chains experienced economic downturns after an initial period of extensive economic expansion, the entire medical care arena has become increasingly structured along similar lines. Publicly funded medical services have adopted the assumptions and strategies of for-profit medicine to maximize their profits (Navarro 1975 and 1984; Salmon 1990a). The nature and extent of state and corporate influence has fostered continued standardization and reductionism within medicine and a supporting

bureaucratization of the medical delivery system as a means of effectively monitoring the new system. The distinction between "for-profit" and "not-for-profit" hospitals has been blurred:

Issuance of . . . hospital bonds to the public bring the nonprofit hospitals closer to the privately owned for-profit hospitals with shareholders. Whether a hospital has bondholders or shareholders, both are primarily interested in a return on their investment, and, sooner or later, the principle of community service will be subordinated to this financial consideration. . . . I suppose this is no different from any other large U.S. enterprise; hospitals are only joining the mainstream of American capitalism. We tend to think that health care providers should somehow be different from Exxon or General Motors. (Shenkin 1986:28-29)

This has tended to make explicit the long-standing dilemma hospitals have faced in attempting to balance the goals of service and business (Smith 1958).

Physicians and Cost-Containment

Increased monitoring and regulation by government bureaucracies and hospital administrators in response to DRGs and other methods of containing medical costs has, necessarily, resulted in increased surveillance of those providing medical services. Physicians have come to perceive cost-containment as threatening hospital survival, physician autonomy, and the care delivered to their patients, especially the elderly. Physicians have acted to protect hospitals by working with departments of

utilization review to insure that admissions are justified and to maximize reimbursement. They know they "need to play the game and get the money." Physicians have attempted to protect their interests by complaining about regulations which change the delivery of medical care, lobbying national and state legislatures, and trying to limit others' (UR's and the PRO's) efforts at controlling medical decision making. The physicians I studied feel their autonomy is being usurped by non-medical regulators working for the government, insurance companies, and hospitals--Hahn's (1985:60) "circummedical fields."

It's garbage. They don't know anything [about medicine]. People not familiar with medicine are responsible for determining if people need to be here [in the hospital] or not. (Pulmonologist)

Physicians attempt to protect the interests of their patients by trying to maintain control of medical decision making and insuring that their patients receive the highest quality care possible.

You have to operate within the standards of care for your particular community. To hell with cost containment guidelines. Individual bodies and souls sometimes respond differently, and the man who is standing at the bedside is the only one who can make the decision. (*Legal Aspects of Medical Practice* 1979:23)

Despite these defensive postures taken by physicians, the extent to which they have been successful is questionable. During the period of this study, physicians

have come to accept cost-containment as part of their work environment and the practice of medicine has been increasingly altered in ways dictated by federal, state, and private payers of medical services. Legislative efforts creating HMOs, managed health care plans, and DRGs are representative of an organizational plan whose goals are to save money, control hospitals and physicians, and rationalize medical care. Legislation to extend DRG-like reimbursement to physicians in 1991 is an extension of this trend (Hsiao 1988; Roe 1985).

It is increasingly clear that physicians will continue to be under the surveillance of those who pay for patients' care.

The probable success of the DRG system in containing hospital costs and its probable eventual application to physicians' fees, together with the rise of the corporate ethos in medical care, will mean private regulation, not public regulation, and not a free-market system. It will mean more corporate planning, not public planning. There will be much less equity in access to medical care than even at present, and physicians will have their autonomy completely eroded. (Shenkin 1986:122)

Though this has been warned for some time (Mechanic 1980) and physicians have been successful in minimizing the impact of many government-sponsored programs (Krause 1973), new ways of thinking about the organization and delivery of medical services abound and physicians have done little effective blocking of the creation of structures capable of controlling their behavior. This threatens the status of

physicians as professionals. Though highly successful, to date, in maintaining the privilege and autonomy associated with their profession, physicians have seen their ability to survive as independent entrepreneurial practitioners limited by state-sponsored policies fostering group and corporatized models of medical care delivery (Engel and Hall 1971; Feinglass 1990; Freidson 1971; McKinley and Stoeckle 1990; Salmon 1990b). Physician autonomy is threatened by their increased proletarianization and the increased monitoring of their medical practice by governmental, hospital, and private insurance regulators. Federal funding for medical education, service, and research is shifting away from supporting hospital-based, high-tech, subspecialty medicine controlled by physicians and towards less expensive low-tech, long-term, primary care in outpatient settings (Zola and Miller 1971)--"thump and look medicine," as one physician referred to it.

These changes threatening the profession of medicine, as mentioned, must be seen as part of larger processes associated with the development and expansion of the state and its attempts to gain control of productive processes. Giddens (1981:222), explaining the causes of class struggle in contemporary societies, discusses the increased "scientific management" of the work world as state-level systems implement control. Extending this argument to the realm of medicine, federal and state regulatory bodies have

increased their influence in medical care via cost-containment with expanded monitoring of medical resource utilization and supporting the establishment of new, more cost-effective, structures and organizations delivering medical care. It is, as Siegler (1984:25) argues, a shift toward a bureaucratic and corporate model for the doctor-patient relationship.

DRGs especially epitomize and mirror state-level processes of bureaucratization, corporatization, and control of medical services. Increased governmental influence, based on "scientific management," directly compromises physician autonomy. Reflecting analyses of national Medicare patient data, DRGs "scientifically" specify disease categories and average payments and lengths of stay for individual patients, commoditizing their illnesses and abstracting them from the particular social and individual historical contexts in which they arose and exist. They help commodify illness, furthering Western medicine's "thingafication" of disease and the rationalization of the commodity production of medical care (Taussig 1980). This allows and facilitates the management of illness episodes by those standing between, so to speak, physicians and their patients. What were once decisions made exclusively by physicians for and in conjunction with their patients are now decisions made on the basis of "scientifically derived" notions of efficaciousness and

effectiveness which may or may not reflect physician knowledge of any one particular patient and his or her unique illness history, manifestations, and social realities.

Habermas (1981:217), drawing from Weber, points out this general evolutionary trend in looking at correlates of modernization:

From an organizational point of view, what is characteristic of both capitalist enterprise and modern state administration is "the concentration of the material means of operation" in the hands of the rationally calculating entrepreneur or leader.

The rise in power and scope of the activities undertaken by the PRO and hospital UR departments charged with monitoring physician behavior and the use of medical resources epitomizes this trend within medicine (see Chapter 4). As the state extends its control over the allocation of medical resources, decision making increasingly is centralized and, thus, removed from the control of individual physicians.

Just as citizens of states must "commit themselves, at least in principle, to a general willingness to obey those who hold office," physicians must abide by rules established by those paying for medical services: "They relinquish the right that participants in simple interactions can claim for themselves: the right to orient their actions only by actual agreement with those present"

(Habermas 1987:170). What were once private decisions between patients and physicians supported by unquestioned reimbursement from public and private third-party payers are now decisions which must take into account the parameters of "good" medical practice as dictated by those paying for it. In this sense, physicians are experiencing a "crisis" since they, as a social group, are experiencing "systematically induced structural changes as critical to their continued existence and feel their identities threatened" (Habermas 1987:292).

This perceived sense of threat on the part of physicians relates to traditional assumptions and practices of medical care now under attack by corporate-modeled, state-driven processes aimed at control. These trends, along with the increasing number of salaried, employee physicians (Relman 1988), insure additional standardization of care and the "depersonalization" (Shenkin 1986:24) of physicians. They also insure continued commodification of medical services (Rodberg and Stevenson 1977) and loss of physician autonomy. Physicians are not happy about these changes. They fear the future, arguing that medical decision making should be kept in their hands and that further commoditization of health care does a disservice to the type of social interactions it entails. It leaves little room for compassion on their part, they believe.

Habermas (1981:251-252), quoting Weber (1946:144-145), points out the difficulty in applying state-driven goals of rationalization to behaviors centered around healing:

The general "presupposition" of the medical enterprise is, stated trivially, that it has the task of maintaining life and diminishing suffering as such to the greatest possible degree. Yet this is problematical. By his means the medical man sustains the life of the mortally ill man, even if the patient implores us to relieve him of life, even if his relatives, to whom his life is worthless and to whom the costs of maintaining him grow unbearable, grant his deliverance from suffering. Perhaps a poor lunatic is involved, whose relatives, whether they admit it or not, wish and must wish for his death. Yet the presuppositions of medicine, as well as the penal code, prevent the physician from relinquishing his therapeutic efforts. Whether life is worth living and when--this question is not asked by medicine. Natural science gives us an answer to the question of what we must do if we wish to master life technically. It leaves quite aside, or assumes for its purposes, whether we should and do wish to master life technically, and whether it ultimately makes sense to do so.

In this passage, jurisprudence, standing for the sphere of law in general, is represented on the model of an order of life that, like the economy or the state, can be rationalized formally--that is, in terms of means-ends relations--from a particular value standpoint. Of the examples mentioned, however, this model applies unambiguously only to medical care. Here we have a case of the value-oriented application of natural-scientific knowledge, that is, of the rationalization of services in the framework of a professional practice that, as the practice of healing, is directed to a specific value content--the health of patients.

Physicians generally argue that, because medicine deals with the "health" of patients, it is not a commodity in the usual business sense.

In some ways, it is difficult to find fault with a corporation's focusing on the bottom line to increase profits. Such is the nature of business. Such is also the crux of the problem. The ethos of medicine and the nature of its primary concern--human health and emotions--make medicine a commodity less amenable to harsh business realities than other economic goods such automobiles, hair spray, or lumber. (Brock 1988:786)

Health care is not a commodity, but the most complex personal service provided in the US economy. Industrial models of organization seem unlikely to have the same powerful impact on market structure in health care. (Goldsmith 1986:3374)

Physicians appear to be denying the obvious. When one looks at the history of legislation created to develop networks of rationalized medical services it is evident that, even though physicians have won battles, they appear to be losing the war as the medical sector becomes increasingly organized explicitly around business principles. Though largely successful in minimizing their loss of autonomy and privilege (McKinley and Stoeckle 1990; Zola and Miller 1971), to date, it is doubtful they will remain as powerful a force as in the past.

Patients and Cost-Containment

It is a common perception that DRGs negatively impact hospital care for elderly patients, limiting admissions and lengths of stay and restricting access to diagnostic and therapeutic regimens. They are also held responsible for

increased costs to the elderly and added burdens on informal social support networks to supply medical care outside of hospital settings. Comments made to me by policy makers, hospital administrators, physicians, and patients reflect these perceptions. Governmental officials involved with monitoring the DRG system argue their efforts help improve the quality of care by facilitating more appropriate treatments and better utilization of services.

Studies demonstrate that physicians and hospitals, forced to treat Medicare patients differently because of DRGs, alter the ways they treat other patients as well (Schramm and Gabel 1988). Furthering this trend is the fact that DRG-like reimbursement strategies have been adopted by a variety of private and public third-party payers and are spreading to other realms of reimbursement (e.g., physicians). The standardization of care this implies is worrisome despite the fact that there is little documentation supporting the claim that prospective payment systems have negatively affected the quality of care (Schramm and Gabel 1988:1682). Though detractors argue cost-containment has hurt quality, they have often based this assumption on ill-defined or absent definitions of "quality." As Steffen (1988) points out, "quality" has never been well-defined by the medical establishment. He argues it never will be adequately defined until medical charting includes data on patients' social situations,

values, and wishes centered around medical decision making and until audits of such variables are routinely included in studies of the "quality" of medical care. Given the individual trajectories and "stories" illness episodes entail (Brody 1987), it is imperative medical decision making takes into account patients' social situations in deciding upon treatment and management protocols.

This is an extremely important point. Western medicine is typified by a reductionistic biomedical approach which tends to ignore or minimize the social correlates of illness and its unique experiential dimensions for individual patients (Brett and Niermeyer 1990; Engel 1977; Freidson 1961:175,227; Hunt *et al.* 1990; Kaufman 1988:399; Kleinman *et al.* 1982; Reid and Reynolds 1990; Scheper-Hughes and Lock 1986; Taussig 1980). As Scheper-Hughes and Lock (1986:138-139) argue,

while illness symptoms are biological entities they are also coded metaphors that speak to the contradictory aspects of social life, expressing feeling, sentiments, and ideas that must be otherwise kept hidden.

Kaufman (1988:349-350) points out the inability of Western medicine to adequately deal with the existential needs of patients suffering chronic illness:

much of the patient's response to the long-term ramifications of chronic illness is fundamentally beyond the scope of medicine's interventions, no matter how broadly that medicine is construed. Profound dilemmas regarding disruption of body- and

self-image, impotence, and change that individuals face following a stroke (and other illnesses as well) have their source in cultural understandings of individual autonomy, control, and will and the contrasting reality of illness experience. For patients and families I observed, "failure," "vulnerability," "anger," and "humiliation" characterize that experience. What threatens them is not the disease alone, as it is medically defined and treated, but rather the existential awareness of loss, distortion, fear, and entrapment that emerges sometimes long after the patient's condition is medically stable.

Medicine did not adequately deal with these dimensions of sickness before DRGs, and their implementation makes it even harder for it to do so. DRGs further remove illness from individual experiences by pigeon-holing patients in preconceived slots associated with their diagnosis, their medical condition. Medicare benefits are determined solely in medical terms (Kaufman and Becker 1991). They ignore individual variability in terms of relative health, disease trajectory, social support, and likely prognosis. Scheper-Hughes and Lock (1986:140) argue that the meanings patients attach to illness experiences are

unstable, negotiated, and contested. They are not reducible to fixed diagnostic categories. Insofar as medicine and physicians fail to recognize the secret indignation of the sick they act as custodians and harbingers of sick-making social institutions and arrangements.

DRGs exacerbate the reification of disease--its commodification or "thingification" (Taussig 1980:3). They deny "the human relations embodied in symptoms, signs, and

therapy" and, thus, "mystify them [and] reproduce a political ideology in the guise of a science of (apparently) 'real things'--biological and physical thinghood" (Taussig 1980:3). Taussig argues the general trend toward the rationalization of medicine (continued and expanded with DRGs, it is argued here)

amounts to an attempt to wrest control from the patient and define their status for them by first compartmentalizing the person into the status of patient-hood, then into the status of thing-hood as opposed to that of a mutually interacting partner in an exchange, and then into the categories of Objective and Subjective, working through these reifications by an Analysis and a Plan. The analogy with the rationality of commodity production is complete. As with automobiles on the assembly-line, so with patients and with health itself, the difference, the pathos, and the occasional problem bearing mute testimony to the fact that unlike automobiles, patients do think and feel, and that sickness is as much an interactive human relationship as a thing-in-itself. (Taussig 1980:10)

DRGs, like other aspects of Western medicine (e.g., medicines themselves) objectify illness; they make illness concrete and, "as things, they allow therapy to be disengaged from its social entanglements" (Van der Geest and Whyte 1989:345). At the same time DRGs help separate illness experience from its social realities, it throws patients needing care into their informal networks and a poorly organized and underfunded system of home-based care. Data presented in Chapter 7 underscore the problems a small, but significant, number of patients and their family caregivers are experiencing because of cost-containment--

lack of access to hospital and home-based services, increased costs, and added burdens placed on familial networks for care. These problems have been noted at both national and state levels. Seniors advocate groups have protested loudly and have offered recommendations to alleviate its negative effects on the elderly and to help insure equitable and adequate care for all Americans (League of Women Voters 1985; Michigan Office of Services to the Aging 1986, 1987; U.S. Senate 1985).

Despite these pleas, federal and state legislation has simultaneously increased the need for home-based care and limited the financing of such services. Goldsmith (1986) argues that health policy, as it pertains to elderly Americans, focuses on removing government responsibility by stimulating a private insurance market for long-term and chronic care and by encouraging private capital formation for payment of these services. A review of recent federal and state legislation reveals that although the state has increased the absolute amount of dollars allocated for home-based services, they have also set up many limitations to state involvement (Aging Alert 1985, 1986a, 1986b, 1987a, 1987b, 1988, 1990a, 1990b, 1990c). For example, as part of the legislation putting prospective payment schemes in place, HCFA redefined the term "intermittency" as it applies to patients needing care on a part-time basis outside the hospital. These new regulations cut funds for

patients needing home-based care and increased the burden of informal care networks. The regulations did not appear in the *Federal Register* for public review though they limited home health services to the extent that HCFA's Northeast Region began denying all homecare Medicare payments to patients receiving any supplemental care by family members (U.S. Senate 1985:15-16).

Despite attempts to counter the effects of such legislation on elderly patients, large gaps in services still exist and the neediest informal caregivers receive the least tangible assistance (Clipp and George 1990). Policy has not taken full account of the needs of elderly patients and their family caregivers though the majority of U.S. citizens believe it is no longer the prerogative of families and patients to worry alone about their medical needs (American Board of Family Practice 1985, 1987). Myles (1984:26), quoting Mills (1959:8), points out:

[A]ging and old age have long since been a source of "private troubles." Faced with declining capacities and resources on the one hand and confronted with the threat of impending death on the other, men and women throughout history have been preoccupied with discovering the secret to a happy old age. But now old age has also acquired the status of a public issue, one that transcends the localized environment of self, family, kin, and community.

What this means to patients and their family caregivers is that "traditional" normative contexts of receiving and giving medical care have been supplanted by

imperatives emanating from the public sphere. The state is increasingly seen as responsible for providing medical and social support for elderly patients; yet, cost-containment forces the elderly and their families to absorb more of the costs (both social and economic) of this care and to deal with exposed contradictions centering around familial responsibility for sick relatives and the various costs associated with this responsibility. All of the patients and familial caregivers I interviewed discussed these contradictions eloquently. They expressed a general dissatisfaction with the lack of formal medical and social support and the difficulties faced in balancing the demands of caring for a sick loved one with other demands in their lives. Many wanted to do all they could for their ill relatives but the social costs are high and it was felt they were owed support by their employers or the government, regardless of their particular social situations and potentially available informal support. The majority of elderly persons interviewed strongly believed their children (or other relatives) should not be burdened with the costs of caring for them. People in the Proxy Study expressed a desire for whatever medical care was necessary for the *hypothetical* patients--including the notion that parents, if necessary, should be kept and cared for at home--yet they were uncertain and unclear about who,

exactly, was to provide this care and how it was to be paid for. Kaufman (1988:349) discusses this dilemma at length:

Patient or case management, with its institutionally created rules and regulations, has stepped in to fill an apparent void. The extended family, with its mandate to care and its knowledge about what is right, appropriate, and natural for its infirm members, has vanished as an institution for many groups in American society. Furthermore, there are no explicitly shared standards or values regarding the quality of interpersonal relationships that accompany intimate, essential interactions between an able-bodied and an impaired individual. Yet patient management is not simply imposed on an unknowing or unwilling clientele. [People needing home care] (and there are thousands) desperately want to be recipients of a paid service, delivered by strangers who are supposed to be trained, screened, and available through the health care system. Families can only hope that the paid strangers will behave in a caring, humane way and that they will not be abusive. No viable alternatives present themselves or, in fact, seem to exist. (Mrs. Chapman has two loving children and four grown grandchildren who all live nearby and see her and her husband regularly. Yet nobody assumes that any family member would or could aid Mr. Chapman.) Instead, there is growing consensus that patients, families, and their chronic conditions should be managed by health care professionals and that paid workers are the appropriate "experts" in such situations.

Offe (1984) argues that legal-bureaucratic and professional forms of state intervention weaken the state's clients (including patients') capacity for self-help by continually redefining and monitoring their "needs." Patients, like citizens of the nation-state, are "expected to assume the role of passive objects of administrative care and surveillance" (Keane 1984:17-18). This trend was well underway in the United States prior to DRGs but

prospective payment systems further the trend and, to a large extent, exemplify it.

Patients are at the mercy of a corporatized set of institutions and professional groups controlling the means of production (the delivery of medical services) whose goal is to increase profits regardless of the negative effects on patients. As Salmon (1985:401) notes:

Whereas health needs among the underserved were previously given at least lip service in policy circles, the "health cost crisis" [of the Reagan administration] now overshadows issues of access, quality, and equity in a health system geared for profit maximization.

Habermas' (1981, 1987) concept of "lifeworld" and his thesis of its rationalization, technicization, and colonization by state-level processes may be applicable here. This is not the place for a detailed analysis of Habermas' theory. In general, however, he argues that the state supplants traditional social processes involved with cultural maintenance and renewal--rooted in immediate and grounded face-to-face social interactions--with impersonal state-level imperatives which increase the rationality of the system. This helps solidify state control and legitimacy and brings with it a variety of changes occurring at the most fundamental levels of social interaction. Habermas (1981:342-343) argues the rationalization of the lifeworld entails a "disintegrative effect." This occurs because

The transfer of action coordination from language over to steering media means an uncoupling of interaction from lifeworld contexts. Media such as money and power attach to empirical ties [T]he lifeworld contexts in which processes of reaching understanding are always embedded are devalued in favor of media-steered interactions; the lifeworld is no longer needed for the coordination of action. (Habermas 1987:183)

This process, resulting in a "technicizing of the lifeworld," causes conflicts at the most basic level of social interaction.

[C]onflicts within the lifeworld [occur] chiefly as a consequence of the expansion and the increasing density of the monetary-bureaucratic complex; this happens, first of all, where socially integrated contexts of life are redefined around the roles of consumer and client and assimilated to systemically integrated domains of action. (Habermas 1987:351)

It is suggested here that DRGs, embodying issues of state control (power) and financing (money), are instrumental in conflicts centered around a tension between familial and state responsibility to provide care. Habermas argues this general process of conflict creation is a by-product of the welfare state and its associated juridification and bureaucratization (here epitomized by DRGs).

In connection with social-welfare law, it has been shown repeatedly that although legal entitlements to monetary income in case of illness, old age, and the like definitely signify historical progress when compared with the traditional care of the poor, this juridification of life-risks exacts a noteworthy price

in the form of *restructuring interventions in the lifeworlds* of those who are so entitled. These costs ensue from the bureaucratic implementation and monetary redemption of welfare entitlements. . . .

. . . [T]he individualizing definition of, say, geriatric care has burdensome consequences for the self-image of the person concerned, and for his relations with spouse, friends, neighbors, and others; it also has consequences for the readiness of solidaric communities to provide subsidiary assistance. . . .

In the end, the *generality* of legal situation-definitions is tailored to *bureaucratic implementation*, that is, to the administration that deals with the social problem as presented by the legal entitlement. The situation to be regulated is embedded in the context of a life history and of a concrete form of life; it has to be subjected to violent abstraction, not merely because it has to be subsumed under the law, but so that it can be dealt with administratively. The implementing bureaucracies have to proceed very selectively and *choose* from among the legally defined conditions of compensation those social exigencies that can at all be dealt with by means of bureaucratic power exercised according to law. Moreover, this suits the needs of a centralized and computerized handling of social exigencies by large, distant organizations. These organizations add a spatial and temporal element to the social and psychological distance of the client from the welfare bureaucracy.

Furthermore, the indemnification of the life-risks in question usually takes the *form of monetary compensation*. However, in such cases as reaching retirement or losing a job, the typical changes in life situation and the attendant problems cannot as a rule be subjected to consumerist redefinition. To balance the inadequacy of these system-conforming compensations, *social services* have been set up to lend *therapeutic assistance*.

With this, however, the contradictions of welfare-state intervention are only reproduced at a higher level. The form of the administratively prescribed treatment by an expert is for the most part in contradiction with the aim of the therapy, namely, that of promoting the client's independence and self-reliance. (Habermas 1987:362-363; emphasis in original.)

DRGs (and their resultant restructuring of the medical delivery system) thus abstract unique individual illness experiences and replace them with bureaucratically-defined, "legal situation-definitions" linked to monetary reimbursement and treatment protocols. They commoditize illness and medical care, prescribing limited treatment options not geared toward the individuality of patients' illness episodes and the realization that the core of healing is symbolically, not scientifically, derived (Stein 1983). They also help place the state (which is generally ill-prepared for adequate intervention) between patients and family caregivers, limiting independence and self-reliance at the same time as they limit care. The situation of the patient is thrust back on the lifeworld which has inadequate resources to deal with it.

The ambivalence of the last juridification wave, that of the welfare state, can be seen with particular clarity in the paradoxical consequences of the social services offered by the therapeutocracy. . . . The more the welfare state goes beyond pacifying the class conflict lodged in the sphere of production and spreads a net of client relationships over private spheres of life, the stronger are the anticipated pathological side effects of a juridification that entails both a bureaucratization and a monetarization of core areas of the lifeworld. The *dilemmatic structure of this type of juridification* consists in the fact that, while the welfare-state guarantees are intended to serve the goal of social integration, they nevertheless promote the disintegration of life-relations when these are separated, through legalized social intervention, from the consensual mechanisms

that coordinate action and are transferred over to media such as power and money. (Habermas 1987:363-364; emphasis in original)

Habermas argues this process represents a "colonization of the lifeworld," characterized by "the subsystems of the economy and state [becoming] more and more complex as a consequence of capitalist growth, and [penetrating] ever deeper into the symbolic reproduction of the lifeworld" (Habermas 1987:367-368). Whether or not cost-containment represents an example of the colonization of patients' and their family caregivers' lifeworlds is not the purpose of this dissertation. Data presented in Chapter 7, however, suggest this may be the case for a (as yet) relatively small number of cases. Patients with multiple chronic medical problems experiencing the new DRG-oriented medical system's inability to deal adequately with them are forced to face the fact that long-held assumptions and expectations about such things as growing old, being ill, and who has responsibility for providing care are now challenged by new expectations and assumptions on the part of policy makers and providers. The two sets of assumptions often appear to be in conflict. On the one hand, as Gordon (1988) points out, biomedicine is instrumental in reproducing cultural ideas about personhood, society, morality, and religion and for perpetuating the ideal of autonomy. On the other hand, as Kaufman (1988:350) argues,

subjective individual dilemmas are reinforced, supported, and informed by belief in the power of the American health care system to restore, manage, and order. Awareness of limits to therapeutic intervention and medical management calls into question patients' assumptions about the scope and nature of that power and contributes to their suffering.

This paradox suggests Habermas' thesis may have some credence. Future research should focus on the ways in which traditionally mediated means of understanding and normative consensus centered around patient care are being altered because of the intrusion of state-level steering media into the medical decision making of providers and recipients of medical services.

Policy in the 1990s: Will Cost-Containment Work?

There is no doubt that Medicare and Medicaid (and other) reimbursement strategies supported high costs prior to DRGs (Holahan et al. 1979), stimulating "excessive medical intervention, superfluous medical services and products, and the duplication of health institutions, while discouraging population-based prevention" (Himmelstein and Woolhandler 1986:444). These trends resulted in the widespread adoption of a variety of cost-containment strategies. Kimberly and Rodwin (1984) note that health policy in a number of Western industrialized nations has followed similar trends based on similar themes; most

countries experienced periods characterized by the expansion of medical services followed by attempts to contain this expansion. Though variations exist among nations, the role of the state has increased and the rationing of services has become more explicit. In the United States there has been a general infusion of private capital into the health care sector, the establishment of an ideology of managerial efficiency, and a growth in corporate strategizing. These trends have been adopted by the providers of medical care in imitation of successful nonmedical corporate models. The result has been "the introduction of a productivist logic" (Kimberly and Rodwin 1984:272) geared toward defining production functions for medical care (DRGs are a prime example), alternative organizational forms of medical practice (e.g., HMOs), controls over the supply and certification of physicians (e.g., the recent shift in emphasis within federal funding agencies toward primary care), and alternatives to the medical model (e.g., community-based services, holistic health, and primary prevention). These changes point out the revolution medical care has undergone and is still experiencing throughout the West in the latter part of the Twentieth Century.

DRGs have strongly influenced how medical services are paid for in this country. More and more financing schemes are based on some sort of prospective payment system and

they have spread to the states via changes in Medicaid reimbursement, commercial carriers, and Blue Cross. Seven years after DRGs were instituted, however, the question is whether or not they have achieved the goal of helping to contain medical costs while improving, or, at the least, maintaining quality. McCarthy (1988:1685) argues that DRGs have "slowed considerably the current and future diffusion of many medical advances" and decreased expenditures from the Medicare trust funds, thus significantly delaying the fiscal crisis touted in the late 1970s and early 1980s.

Thus, the government can declare victory in its attempt to control Medicare expenditures. It can also declare victory in its less global goal of reducing inpatient use of hospitals and directing Medicare beneficiaries to less costly settings. (McCarthy 1988:1683)

Evidence suggests that prospective payment has reduced Medicare's hospital costs (mainly through decreased admissions) and these reductions have not been offset by increased outpatient expenditures (Russell and Manning 1989:442). But, since hospitalized lengths of stay were decreasing well before DRGs began (Myers and Schroeder 1981), it remains unclear what the full effect of their implementation has been. There is evidence to suggest that cost-containment measures taken by public payers of medical services (e.g., Medicare and Medicaid) have merely served to shift the costs of care to the private and long-term care sectors and, hence, to individuals (Ginsburg and Sloan

1984; Harlow and Wilson 1985). The question is difficult to answer because of the federal government's failure to monitor and publicly report on DRGs' effects on expenditures and patient care. The only reports generated regarding prospective payment's impact are used internally by HCFA and contain no references to "quality of care" (U.S. Senate 1985:2-3, 19).

A major question is whether DRGs provide a solution to the costly organization of our medical system or merely add costs because of the increased need for monitoring and its correspondent bureaucracy.

Health policy reforms that leave . . . basic structures intact can attain savings only by lowering the incomes of physicians and health workers or by limiting the volume of clinical services. In practice, most cost-containment programs in the United States have involved either hiring more administrators to ensure delivery of less care or giving providers financial incentives to ration services. For example, the Medicare payment system based on diagnosis-related groups has resulted in the creation of a federal enforcement bureaucracy that costs millions of dollars (Bureau of Program Operations, Health Care Financing Administration: unpublished data); the loss of 60,000 jobs in hospitals; the hiring of 6000 new fiscal personnel; the purchase of hundreds of millions of dollars of administrative computer equipment and "outlier insurance"; and the threat of premature discharges, slow adoption of useful new technologies, and inadequate care for the most seriously ill patients. All such programs have eliminated some of the wheat of needed care along with the chaff of excess services. (Himmelstein and Woolhandler 1986:444)

Shenkin (1986:90) points out that even New Jersey's demonstration project--which led to national Medicare DRGs--did not reduce that state's medical bills.

Part of the problem in measuring the success of DRGs is that a uniform definition of "cost-containment" has not been developed (Ginzberg 1983) and it has proven difficult to measure "cost effectiveness" (Doubilet et al. 1986). Because of the way cost-containment has permeated the delivery and financing of medical services, Ginzberg correctly points out that "cost containment in health care is an elusive concept; it is difficult to define and even more difficult to apply" (Ginzberg 1983:1223). He points out that cost-containment, as it is currently used, pertains to at least five different spheres involved with medical services: 1) government policies dealing with expenditures; 2) government regulatory policies; 3) medical insurance and other prepayment mechanisms; 4) medical care delivery systems; and 5) the practice of medicine (1983:1220). He calls for a definition of cost-containment taking into account "outputs as well as inputs, total as well as unit costs, and long-term as well as short-term results" (Ginzberg 1983:1223) and provides the following as a useful, practical definition of "true cost containment":

a reduced inflow of real resources into the healthcare system without a diminution in useful output that would adversely affect the satisfaction of patients or their health status. (Ginzberg 1983:1223)

This is a definition with which few could argue and appears to be the federal government's approach as exemplified by simultaneous efforts to reduce hospital services and maintain quality care. Whether or not they have accomplished these goals, the general approach of prospective payment in its many guises works well enough that the federal government is unlikely to change it radically for some time. As Robinson and Luft (1987 and 1988) point out, the economic and technical issues associated with cost containment have been explored and documented to the satisfaction of those in charge of them. They argue it is now time to examine the social and political ramifications of these cost-saving strategies (also see Melnick and Zwanziger 1988).

The problem in answering these questions and in solving the contradictions inherent in medical care are compounded not only because of the financial implications of its practice but also because of its nature. Those that subsidize medicine are demanding greater accountability over the use of resources and have set in place many structures facilitating compliance on the part of providers. Yet, the practice of medicine involves much more than simple economic cost-benefit analyses. It

involves the treatment of ill patients by an influential and powerful set of professional groups attempting to balance what is good for the patient with other considerations centered around notions of quality of care and appropriate utilization of resources. This is a result of money, as a state-driven steering mechanism, forcing its way into the doctor-patient relationship and medical decision making. As Habermas (1987:264) notes:

Money has the properties of a code by means of which information can be transmitted from a sender to a receiver. The monetary medium makes it possible to produce and transmit messages with a built-in preference structure. They can inform the receiver about an offer and induce him to accept it.

DRGs prescribe what is acceptable care (because it is reimburseable) and include incentives (the lack of payment) to help insure compliance. Habermas notes, however, that there are inherent limitations in the "media code" which limit its ability to insure its message is received and appropriately acted upon. Such is the case with DRGs and other cost-containment schemes, given the nature of medical practice and the long-standing autonomy physicians have had in dictating what is acceptable medicine and in controlling its means of production. Physician control of expenditures has been hard to limit, and restructuring the medical system has proven difficult because of its size and the amount of political influence it has. (The health care industry is the largest employer in the United States.

Hospitals are the third largest employer in this country, and the fifth largest in Michigan [Hollister 1987].)

The difficulty in restructuring the system is supported by Offe's (1984) analysis of the contradictions engendered by the welfare state. Because of the system's tendencies toward "anarchy" and "ineffectiveness,"

the administrative apparatus [becomes] dependent upon powerful and organized social interests . . . , whose co-operation is vital for social order and effective administrative planning. . . . [T]he effectiveness of welfare state policies comes to depend increasingly upon informal and publicly inaccessible negotiations between state planners and the elites of powerful social interest groups. (Keane 1984:22)

Though physicians and other institutions of medical care are the target of (somewhat successful) cost-containment schemes managed by corporate and state interests, these interests remain reliant and dependent upon those controlling the allocation of medical services (and, thus, in a sense, subservient to them). This is true because of the structural position held by the controllers of medical resources and the power they wield. The theoretical approach taken in this dissertation--one which incorporates the notion of agency--argues the groups providing services influence policy as social actors realizing it. Friedson (1986:xi) states that policy is "transformed and modified by the activities of those participating in its use."

Physicians, as "gatekeepers" (Freidson 1986:166-68), are responsible for distributing health care monies and resources as they deliver care. They thus play an important role in determining the costs of medical services. As they deal with policy attempting to alter the practice of medicine, physicians also have the potential to affect the outcomes of policy directives by ignoring or manipulating any new system put in place. As "lower order participants" (Mechanic 1968b:415-32), they are capable, to a degree, of affecting or impeding (i.e., transforming) health care policy. Thus, in actuality, they determine what cost-containment policy is; they make it a "real" entity through their everyday actions influenced by the generative rules and resources inherent in policy-driven structural constraints.

DRGs have occurred within an historical context of ever increasing standardization and bureaucratization within the medical system, associated with the expansion of the capitalist welfare state (see Wilding 1986) and its attempts to deal with the contradictions its organization entails. State power in this country, however, is derived from the varied lobbied interests that express themselves competitively through the mechanism of the state. It is these interests which DRGs support. As Salmon (1985:401-402) points out,

The corporate class as a whole is concerned with rationalization of the delivery system and reallocation issues, while segments of capital groups who divide the over \$400 billion of health care spoils in 1985 oppose this overall interest--or work their best within the constraints set. Most specifically, "purchasers" versus "providers" clash over cost containment policies, and "suppliers" and "insurers" often resist overall class policies also. As with all aspects of capitalist development, the entire process over time yields many short-term contradictions to the larger corporate class interest.

This dissertation reveals that medical care has increasingly become formalized and penetrated by corporate and state-level prerogatives, including increased bureaucratization, corporatization, and rationalization. The lifeworld of patients and the work world of physicians are being drastically altered as the delivery of medical services becomes increasingly directed by interests linked to money (financing) and power (regulation). Patient-provider interactions, are increasingly being shaped and constrained by system imperatives related to the capitalist structures dominating U.S. society (Habermas 1981, 1987).

Though many have argued for reforming Medicare and the medical care system to counter these trends (Blumenthal et al. 1986; Meyer 1987; Shortell and McNerney 1990), few suggest totally throwing out the old and starting anew. Policy makers and patients alike agree the government should retain a large role in the management of medical services and help ensure equitable access. The public is in favor of revamping our medical system but, given the

strength of the interest groups in control of this system, it is unlikely that major changes will happen in the near future.

Opinion polls in the United States have indicated strong public support for an egalitarian national health program, even if this program entailed increases in expenditures. In contrast, enthusiasm for such a program has been notably lacking among policy makers and physicians. Politicians have been reluctant to back reforms that challenge both traditional and powerful private interests, and doctors have viewed a national health program as a threat to their independence. (Himmelstein and Woolhandler 1986:445)

As Keane (1984:26) notes:

[S]tate policies are viewed as dependent upon the existing matrix of *social* power, which in turn is seen to be constantly subject to transformations by the activity of *social* power groups and movements.

It is reasonable to assume that, to a large extent, the providers of medical care will continue attempting to forestall threatening policy initiatives and, at the least, shape them to minimize their impact and maintain medical control.

The state's approach to medical policy (as towards other large public issues) supports this result with its strategy of "disjointed incrementalism" (Kinzer 1990). This approach increases the number of separate organizations providing, financing, and monitoring care and the layers of bureaucratic intervention and involvement entailed in delivering and receiving medical services. It

also creates a separation between the needs of patients (especially the elderly) and those of the corporate class dominating the control of medical services at the same time as it promotes the latter's interests. This approach epitomizes Medicare and Medicaid policy, DRGs, and the recently failed Medicare Catastrophic Coverage Act.

A quick examination of President Reagan's attempt to expand services with the Medicare Catastrophic Coverage Act of 1988 illustrates that the overall approach served to maintain the status quo while appearing to address the deficiencies in our medical care system. Though the Medicare Catastrophic Coverage Act represented "the largest expansion of the Medicare program in the 23 years Medicare has been in existence" (Commerce Clearing House 1989:4), it also represented no added expenditure and minimal commitment on the part of the federal government. Current and future funding requirements were to be paid by Medicare beneficiaries through increased taxes. The state attempted to play down the notion of a "tax" by calling it a "supplemental premium" (Commerce Clearing House 1989:28).

Those supporting the act pointed to services it added to already covered Medicare benefits: outpatient prescription drugs, home intravenous drug therapy, mammography screening, and respite care. Increased coverage was also mandated for care delivered in hospitals, skilled nursing facilities, patients' homes, and hospices.

With these measures, the administration pointed to the beneficence of the system and their wisdom in successfully carrying out the political maneuvering and compromise necessary to create such a "bipartisan effort." They tended not to point out that most routine health maintenance services were still not covered, that the program was subsidized with increased premiums and taxes for the elderly, and that the increases in coverage fell far short of providing true and total coverage for catastrophic medical care needs.

For example, increased monthly Part B premiums were scheduled to increase over 100% in three years (from \$4.90 in 1990 to \$10.20 in 1993). The "supplemental premium" paid by those eligible for Medicare was scheduled to increase almost 90% in the same time period (from \$22.50 to \$42.00). The Act did remove limitations in the number of covered hospital days per year, but this represents a token addition to coverage because of the prevalence of third-party insurances and Medicaid and the success of DRGs in decreasing hospital lengths of stay. The Act increased the number of days covered in a skilled nursing facility (SNF) from 100 to 150 per year; since, however, Medicare pays such a small portion of the costs associated with stays in SNFs--about one percent per year nationally (Russell 1989)--adding fifty days of coverage per year is, likewise, meaningless for all practical purposes. In general, only

minimal provisions were proposed to safeguard against impoverishment for patients faced with long-term medical or nursing home costs.

The Act's repeal in late 1989 (Holstein and Minkler 1991) amid widespread public outcry against increased taxation and the plan's inability to substantially revise the medical system (especially by seniors groups) signifies the government's growing difficulty in foisting its financing schemes on the public and their disenchantment with the lack of support for comprehensive medical care insurance. It may also signify a growing reluctance of the public to be duped by the government's ideological ploys which serve to maintain the system.

Much of health planning and policy in this country may be viewed as ideology, used by the state to legitimize and support the current system and, at the same time, provide the appearance that it is responsive to the needs of its citizens. Krause (1973:460) points out how health planning at the national level has used ideology to legitimize the system.

Although the earlier targets of the ideology were in part specific subgroups in the population, the general public has always been the main target. The theme of citizen participation in planning grew with each program, while its actual absence remained constant. In short, the increasing demands for public accountability, participation, and control of health services planning is being met with the increasing use of ideology as a symbolic, not real, response to the demands. This process is the inevitable consequence of technocratic rationalization within a system where

the inside technocrats work in mutual cooperation with, or as agents for, outside interest groups primarily concerned with the perpetuation of profits and the maintenance of their existing power and control over the system.

It is argued here that DRGs are an ideological ploy in that they are presented as a system geared toward increasing the quality of care delivered and reducing medical costs, but they can demonstrate neither. They have impacted how and where care is delivered but they have not yet seriously affected the primary source of medical control and costs--physicians--or the factors contributing to quality care for patients.

If Offe (1984:13-14) is right, and "welfare state systems generate more policy failures, political conflict and social resistance than they are capable of resolving," then DRGs may not work in containing medical costs. They may, in fact, as many of their critics argued early on, ideally represent the type of policy intervention which increases conflict and social resistance to the extent that the system itself is threatened. Though, to date, this has not been apparent, that something must be done is clear; expenditures for medical care in the U.S. continue to rise at an alarming rate. Over the course of this study, the percentage of the United State's Gross National Product (GNP) used to pay for medical services went from under 11% to 12.2% (*Lansing State Journal* 1991a). Other countries provide medical services as effectively as the United

States (or better) and spend less money, per capita. For example, administrative costs for Canada's universal public insurance system average about 2.5% of costs, one-fourth the overhead of private U.S. insurers (Himmelstein and Woolhandler 1986:443). Cost-containment has been successful in lowering medical costs throughout the European community and they are now focusing on controlling public spending in general (Blaupain 1988).

It is important to recognize the implementation of cost-containment is an on-going process and that its effects are still being realized. As Offe (1984:108) notes:

The material effects of social policy innovations will be forged only in the course of their social implementation, and the ambivalence of new measures and agencies will be resolved into unambiguous "impacts" only when the socio-structurally conditioned relations of power and conflicts have bestowed this unambiguity upon them.

And:

[T]he function of "shaping society" of state social policy is limited to the definition of the themes, times and methods of conflict and, thus, to the establishment of the political-institutional *framework*--and not the *outcome*--of processes of social power. (Offe 1984:108-109)

This dissertation has described the *framework*, or context, of the "social implementation" of DRGs--their themes and the types of conflict they engender among providers of medical care and the recipients of medical

services. This process is ongoing and far from complete. DRGs have altered how medical services are delivered and the existential experience of patients and their caregivers as recipients of medical care. I have attempted to shed light on some of the changes within a U.S. community brought about by DRGs and what they mean for providers and patients. The effects of DRGs and other cost-containment strategies have been outlined and the ways providers and patients perceive and respond to these changes has been discussed. It is unlikely these trends will abate in the near future. Increased involvement of state and corporate interests in the delivery of medical services will certainly impact long-standing traditions in the future more than has already been the case. An analysis of the "ultimate" outcome or impact of these endeavors, if even possible, must await future study of the dynamic social structures and processes constantly being forged via social interactions involved with the delivery of medical services.

APPENDICES

APPENDIX A

INTERVIEW GUIDES

APPENDIX A

INTERVIEW GUIDES

Policy Interview Guide

1. Title
2. Length of time in position (Background, training)
3. Mission of agency (department, committee, society)
 - Functions
 - Funding
 - Hierarchy
4. What is cost-containment to you? What do you think about it?
5. In what ways has your agency been involved with cost-containment over the past few years?
 - Steps taken
 - Groups, people dealt with (legislators, hospital administrators, doctors, other providers, families, nursing homes, insurance company, elderly)
6. Who is most affected because of cost-containment?
 - Who else is affected?
 - Elderly singled out, affected disproportionately?
7. What are the effects? Main problems? Main benefits?
8. Why cost-containment/DRGs? Whose interests are served?
9. What will future cost-containment efforts look like?
10. What would you change about cost-containment if you could? How would you make it a better system?
11. Who else should I talk to?

Administrator Interview Guide

1. Title
2. Age
3. Number of years in current position
4. Previous positions in same (and other) organization
5. How do you feel about cost-containment/DRGs?
6. How has hospital (clinic) been affected by cost-containment in general? Who is affected the most? In what ways?
7. What have been the responses of the hospital (clinic) to cost-containment/DRGs?
8. Who is involved with cost-containment (Federal & state)?
9. Who is involved with cost-containment within the hospital (clinic)?
10. What are the major problems associated with cost-containment/DRGs?
11. What are the benefits of cost-containment/DRGs?
12. What will be the future effects of cost-containment/DRGs? What will future efforts look like?
13. What would you change about cost-containment/DRGs if you could?
14. Hospital census
15. Hospital lengths of stay
16. Who else should I talk to?

Provider Interview Guide

1. Job title
2. Number of years in practice (job)
3. Specialty (certified?)
4. Proportion of practice (service, ward) over 65;
Medicare; Medicaid
5. What is cost-containment/DRGs to you? Why does it exist?
6. How do you feel about cost-containment/DRGs?
7. What have been effects of cost-containment/DRGs (on patients, hospital, providers)? Who has been most affected?
8. What steps has the hospital (clinic) taken in response to cost-containment/DRGs?
 - Who is involved?
 - How does it work?
 - How has it changed since DRGs began?
 - How do the changes affect you?

(Discharge planning, UR, education, limited services)
9. What will be the future effects of cost-containment/DRGs? What will future efforts look like?
10. What are the major problems related to cost-containment/DRGs?
11. What are the benefits of cost-containment/DRGs?
12. What would you change about cost-containment/DRGs if you could?
13. Who else should I talk to?

Patient Interview Guide

1. Reason for admission
Length of Stay
Attending's name
Specialists used
2. Ever been to hospital (doctor) before for the same reason? When?
3. Is this stay/visit different from previous ones?
How?
Why do you think it's different?
Who/what caused the changes?
4. How often hospitalized in past 5 years?
For what?
Which hospital?
Length of Stay each time
Attending's name
Specialists used
5. Major procedures (inpatient)
6. Discharge Planning experiences
Who involved?
Changed from admission to admission?
Who went to live with (support network)?
7. Outpatient procedures
8. How did you pay for this care?
9. Do you have medical insurance? What kind?
Does it cover your needs? Why/why not.
10. How often do you generally see your physician over the course of a year? How long have you been seeing him/her?
11. Have you ever heard about DRGs/health care cost-containment?
What do you think/feel about it?
Why does it exist?
Who is responsible for it?
12. Would you say cost-containment/DRGs affected the health care you received over the past few years?
How?

Patient Interview Guide (cont.)

13. What do you think are the major problems related to cost-containment/DRGs?
14. What are the benefits of cost-containment/DRGs?
15. What do you think will be the future effects of cost-containment/DRGs?
16. What would you change regarding cost-containment/DRGs if you could?
17. Age
18. Highest school grade completed
19. Living arrangements
How often see children/other relatives/Friends?
20. Who else should I talk to?

APPENDIX B

PROXY DECISION MAKING SCENARIOS

(FOR ELDERLY SUBJECTS)

APPENDIX B

Proxy Decision Making Scenarios (For Elderly Subjects)

Scenario 1

Presentation order (1,2,3,4) _____

Interviewer Name _____

Date _____

First name _____ Last Name _____

Subject No. _____

Mr. Jones is 70 years of age, and has had a severe head injury caused by a fall. The injury is not longer life-threatening, but it caused extensive damage to his brain, and his doctors hold out little hope that his mental condition will improve. He often cannot remember the names of close relatives. Mr. Jones has lost basic toileting skills, and requires assistance in the bathroom. Sometimes, he is frightened by ordinary objects (the shower, for example). At other times, Mr. Jones takes delight in events around him, such as watching TV or listening to swing-era music.

Mr. Jones has a lung condition which is unrelated to his head injury. The condition is not immediately life-threatening, but does cause repeated bouts of pneumonia and high fever. The pneumonia can be treated with antibiotics, but each episode leaves him a bit weaker than before. The treatment is not painful, but in the past he has become agitated and frightened by it (especially the intravenous tubes), and his nurses have had to restrain him with cuffs around his wrists.

If Mr. Jones wasn't given the antibiotics, it is very likely that he would die from the pneumonia, after gradual loss of consciousness. Death from pneumonia is usually peaceful; pneumonia used to be called "the old man's friend."

Scenario 1 (cont.)

Imagine that you were in a situation like the one just described. Would you want to have the antibiotic treatment? (check one)

_____ Yes _____ No

How sure do you feel about this choice? (check one)

_____ Very sure _____ Sure
 _____ Some doubts _____ Very unsure

What is the most important reason for your decision?
 (describe)

Here are some factors that some people might consider in reaching a decision. In your own thinking about your decision, how important is each of these considerations?

This is how the ratings are used:

"No importance"

- . You believe the statement is not true
- Or . You believe the statement is true, but it has nothing to do with your decision.

"Little importance" or "some importance"

- . You believe it had some influence on your decision, but it was not one of the main reasons.
- Or . You believe the statement is true, and gave it some consideration, but it was outweighed by other factors.

"Much importance" or "great importance"

- . You believe the statement is one of the main reasons for your decision.

Scenario 1 (cont.)

	No	Little	Some	Much	Great
	Importance			Importance	
— I could seldom remember family or friends.	—	—	—	—	—
— My life is sacred, no matter what its quality.	—	—	—	—	—
— I would have no control over myself.	—	—	—	—	—
— I would still have some happiness in living.	—	—	—	—	—
— I would be a burden to others.	—	—	—	—	—
— I could still live a long time with treatment.	—	—	—	—	—
— Antibiotics are a simple and effective treatment.	—	—	—	—	—

Which consideration is the most important one for you?
 Which is the 2nd most important? What is the 3rd?
 Identify each of your top three reasons by writing its
 number (1,2, or 3) in the space to the left.

Scenario 2

Presentation order (1,2,3,4) _____

Interviewer Name _____

Date _____

First name _____ Last Name _____

Subject No. _____

Mr. Harmon is a 75-year old cardiac patient who has had 2 previous heart attacks, and now has congestive heart failure, which is under control with medications. He lives with his wife in the home they have owned for 30 years. His only child, a son, lives in California. His wife is in generally good health, and she and her husband are active in community affairs, despite Mr. Harmon's heart condition.

Mr. Harmon is admitted to the hospital when he suffers a third heart attack. After his heart is revived and stabilized in the emergency room, he is transferred to the cardiac intensive care unit. One week after his heart attack, he remains in a coma, with the doctors giving him a 50-50 chance of regaining consciousness. Should he regain consciousness, his physical activity will be quite restricted, because of the damage to this heart. Chances are he will spend the majority of his time in bed, only getting up to walk short distances or sit for brief amounts of time, before he becomes physically exhausted.

Because of his heart condition, his doctor believes he may have another heart attack while in the hospital. Therefore, a decision must be made regarding whether or not Mr. Harmon should be resuscitated, if he has another heart attack. If he is resuscitated, there is a strong possibility he will not survive to leave the hospital. Furthermore, any heart attack he suffers will leave him more physically debilitated. There is also the chance that the resuscitation efforts by the medical team would cause injury, such as fractured ribs or a punctured lung.

Imagine that you were in a situation like the one just described. Would you want to have the antibiotic treatment? (check one)

_____ Yes

_____ No

Scenario 2 (cont.)

How sure do you feel about this choice? (check one)

_____ Very sure _____ Sure
 _____ Some doubts _____ Very unsure

What is the most important reason for your decision?
 (describe)

Here are some factors that some people might consider in reaching a decision. In your own thinking about your decision, how important is each of these considerations?

This is how the ratings are used:

"No importance"

. You believe the statement is not true
 Or . You believe the statement is true, but it has
 nothing to do with your decision.

"Little importance" or "some importance"

. You believe it had some influence on your
 decision, but it was not one of the main
 reasons.
 Or . You believe the statement is true, and gave it
 some consideration, but it was outweighed by
 other factors.

"Much importance" or "great importance"

. You believe the statement is one of the main
 reasons for your decision.

Scenario 2 (cont.)

	No	Little Importance	Some	Much Importance	Great
— My physical activity would be severely restricted if I survive.	—	—	—	—	—
— My condition will probably get worse.	—	—	—	—	—
— I may suffer other injuries, such as fractured ribs or a punctured lung, if I survive.	—	—	—	—	—
— I may regain consciousness.	—	—	—	—	—
— I may be able to enjoy life with my wife, despite my medical problems.	—	—	—	—	—
— There is always the chance that therapy could be more effective than the doctors think.	—	—	—	—	—
— I would be a burden to others.	—	—	—	—	—

Which consideration is the most important one for you?
 Which is the 2nd most important? What is the 3rd?
 Identify each of your top three reasons by writing its
 number (1,2, or 3) in the space to the left.

Scenario 3

Presentation order (1,2,3,4) _____

Interviewer Name _____

Date _____

First name _____ Last Name _____

Subject No. _____

Mrs. Lake is 60 years old and is in the hospital after suffering a stroke two weeks ago. She is no longer in danger of dying from the stroke, but her physical and mental abilities have not improved since it occurred. She requires total nursing care. Her left side is paralyzed, and she is unable to feed or bathe herself. She is mentally confused, and she does not recognize her family.

Prior to the stroke, Mrs. Lake had agreed to the insertion of a pacemaker for a chronic heart condition she has. She was going to contact her doctor to schedule the operation the day she had the stroke. Mrs. Lake had been told by her physician that without the pacemaker, she would die of heart failure within a year; with the pacemaker she could reasonably expect to live ten to twenty years. The doctors cannot tell for certain how much she will recover from the stroke. It is likely she will remain in her present condition; but there's always the possibility that she might regain some of her physical and mental abilities.

Since her husband's death five years ago, Mrs. Lake has worked part-time. She has \$50,000 in a savings account. She uses the interest from this account to supplement her wages. The combined income has been enough to meet her living expenses. She has a small private health insurance policy. This policy will cover most of her hospital expenses, including the pacemaker. But it will not cover the expenses of long-term nursing home care, which will have to be met if the pacemaker is inserted and she remains physically and mentally handicapped from the stroke. Medicaid would pay for her nursing home care, but only after most of the \$50,000 saving account is used up. Her children cannot provide any financial help. With several of their children ready to start college, their family budgets are stretched very thin. They certainly cannot afford \$17,000 a year, which is what it would cost the state if her savings were used up and she was put on Medicaid.

Scenario 3 (cont.)

Imagine that you were in a situation like the one just described. Would you want to have the antibiotic treatment? (check one)

_____ Yes _____ No

How sure do you feel about this choice? (check one)

_____ Very sure _____ Sure
 _____ Some doubts _____ Very unsure

What is the most important reason for your decision?
 (describe)

Here are some factors that some people might consider in reaching a decision. In your own thinking about your decision, how important is each of these considerations?

This is how the ratings are used:

"No importance"

. You believe the statement is not true
 Or . You believe the statement is true, but it has
 nothing to do with your decision.

"Little importance" or "some importance"

. You believe it had some influence on your
 decision, but it was not one of the main
 reasons.
 Or . You believe the statement is true, and gave it
 some consideration, but it was outweighed by
 other factors.

"Much importance" or "great importance"

. You believe the statement is one of the main
 reasons for your decision.

Scenario 3 (cont.)

	No	Little	Some	Much	Great
		Importance		Importance	
— It's just possible that I might recover from the stroke.	—	—	—	—	—
— The pacemaker will greatly increase the years I have left.	—	—	—	—	—
— \$17,000 a year is too much for the state to spend on a person in this condition.	—	—	—	—	—
— I would want to leave some money for my children and grandchildren.	—	—	—	—	—
— It's better to die in a short while than to linger for years in this condition.	—	—	—	—	—
— Life is sacred, no matter what its quality.	—	—	—	—	—
— I would be a burden to others	—	—	—	—	—

Which consideration is the most important one for you?
Which is the 2nd most important? What is the 3rd?
Identify each of your top three reasons by writing its
number (1,2, or 3) in the space to the left.

APPENDIX C

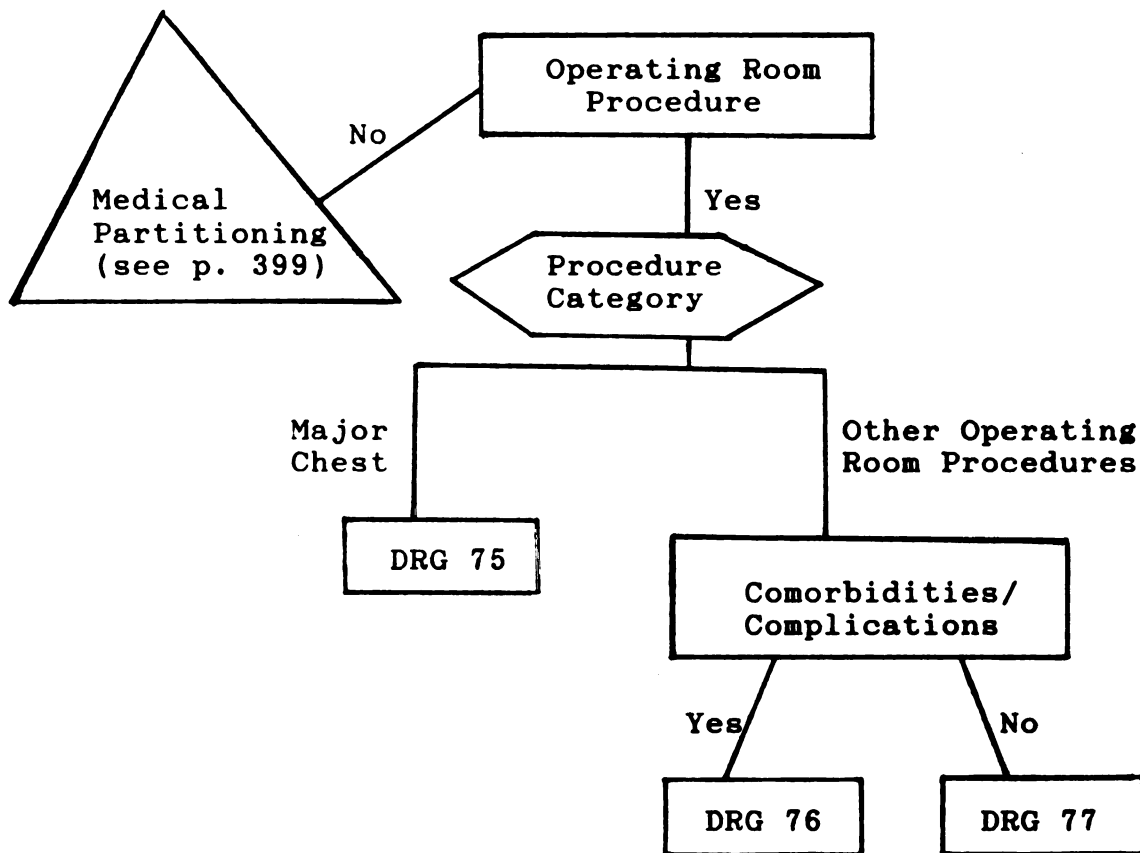
DRG CLASSIFICATION TREES

APPENDIX C

DRG CLASSIFICATION TREES

MDC 4: Diseases and Disorders of the Respiratory System
(Grimaldi and Micheletti 1983:228-229)

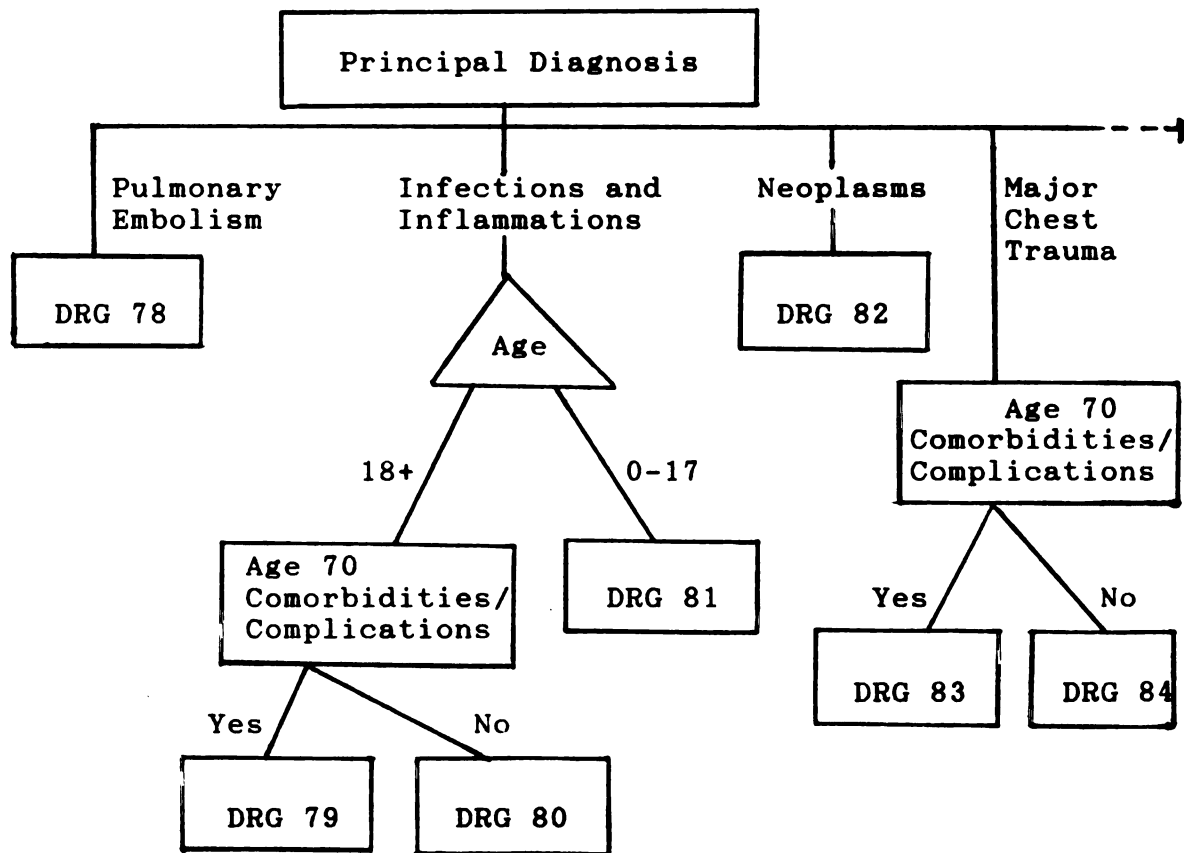
Surgical Partitioning



DRG Classification Trees (cont.)

MDC 4: Diseases and Disorders of the Respiratory System
(Grimaldi and Micheletti 1983:228-229)

Medical Partitioning



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