

Chapter XII

DRGs and the Professional Independence of Physicians

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ABSTRACT

This chapter examines the effects of diagnosis related groups (DRGs) on the professional independence of physicians in three distinct types of healthcare systems: the U.S. private insurance system, where DRGs were first developed and subsequently implemented in the public Medicare program in 1983; the British National Health Service (NHS), which adopted an analogous version of DRGs referred to as Health Resource Groups (HRGs) in 1992; and the German social insurance system, which adopted its own DRG version (G-DRGs) based on a refined version of the Australian model that is to be fully phased into the hospital system by 2009. By examining these three cases, the present contribution asks (a) whether it is possible to identify any effects of DRGs on the professional independence of physicians; and (b) whether these effects are specific to the respective healthcare system and/or DRG version at hand.

INTRODUCTION

Since its earliest stages of development at Yale University in the late 1960s, the patient classification system referred to as 'Diagnosis Related Groups' (DRGs) has seen far reaching, worldwide applications as a hospital financing tool which relates the *case mix* (i.e. types of patients treated,

classified by diagnoses) of hospitals to their costs (France, 2003). This system, devised to increase the transparency, efficiency, and cost containment measures of hospitals, operates in the US (but also in Japan, Italy, Portugal, and Scandinavia) on the basis of a prospective payment system in which patients' primary and secondary diagnoses defined at the time of their discharge, together with

the procedural and surgical care performed during their stay, determine their patient categorisation and, subsequently, the fixed amount of compensation that hospitals may demand for their services. However, DRGs have also been adopted elsewhere for the purposes of fixing hospital budgets (e.g. France), as well as for controlling the length of stay for inpatient care (e.g. Belgium and Ireland) (Rochell & Roeder, 2001). Thus, although representing in principle a more technical means of categorising patients according to cost and illness related groups, an array of DRG applications has emerged in international perspective, ranging from mere documentation to a tool for managing clinical care. Depending on the specific DRG system under consideration, a particular set of healthcare objectives can be linked to their application (Leister & Stausberg, 2005).

The wide range of adaptations of the original US-DRG system can be found in various national versions such as that of the Australian National DRGs (AN-DRGs) and the French Groupes Homogenes de Malades (GHMs). Interestingly, while the widespread dispersion of DRGs has raised numerous questions regarding the actual utility and efficiency of this tool (Donaldson & Magnusson, 1992), as well as its implications for quality of care (Draper et al., 1990; Forgione et al., 2004; Kahn et al., 1990a, 1990b), issues concerning the system's effects on the professional independence and clinical decision making of practitioners have yet to be addressed in a systematic and comparative fashion.

Accordingly, the present chapter seeks to explore this question by identifying the precise procedural and institutional arrangements under distinct DRG versions that condition doctors' diagnostic and therapeutic choices, as well as their autonomy as professional actors within three highly dissimilar cases of healthcare systems: the US private insurance system, where DRGs were first developed and comprehensively implemented in 1983; the British National Health Service (NHS) which adopted an analogous

version of DRGs referred to as Health Resource Groups (HRGs) in 1992; and the German social insurance system, which adopted its own DRG version (G-DRGs) based on a revised version of the Australian AN-DRG model, the Australian Refined-DRGs (AR-DRGs), that is to be fully phased into the hospital system by 2009. By examining developments within these distinct systems, it is possible to identify whether the influence of DRGs on professional independence depends, at least in part, on the nature of the healthcare system at hand, as well as on the version of the DRG system applied.

This chapter will proceed by first giving an overview of DRGs, as they were originally created in the US and as they continue to operate worldwide. In a subsequent section, we then describe the key features of the three healthcare systems of interest here and make the case for the utility of their comparison. We then move on to examining the specific effects of DRGs on physician independence in the US, Great Britain¹, and Germany. We focus in these sections on physician independence understood in terms of two distinct aspects: (1) the ability of doctors to make independent clinical and diagnostic choices in treating patients; and (2) the autonomy exercised by doctors in demanding fees for their services, as well as the nature of their professional status in hospitals. We conclude by drawing our findings into comparative perspective.

THE DRG SYSTEM IN REVIEW

Worldwide, DRGs are increasingly regarded as a key classificatory tool to assist in the definition of hospital financing in order to contain public (but also in some cases private) healthcare spending in the face of growing demands brought on by aging populations and the soaring costs of medical technology (WHO, 2007). When reviewing the objectives of DRG introduction in greater depth, however, in addition to pure cost containment,

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