4 Encoding truths? Diagnosis-Related Groups and the fragility of the marketisation discourse

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Introduction[1]

Organisational reforms in healthcare are usually left to economists, public law scholars or social scientists. Intentionally or not, decision-making at the policy-level often converts far-reaching decisions into technocratic jargon. Theologians have been somewhat on the margins of these debates. This is perhaps no surprise, considering the seemingly neutral focus on empirical measures typical of the discourse. Moreover, theological ethics are frequently limited to neuralgic issues such as euthanasia or preimplantation diagnostics. Nonetheless, the marketisation of healthcare has a theological dimension, also at the policy-level.

This chapter will take as an example a particular change in healthcare financing at the meso-level: Diagnosis-Related Groups. DRGs marked a shift in the way hospitals were oriented and were the means to operationalise the market-logic in healthcare. The DRG system is a case classification system: each hospital case is related to a 'pre-standardised product' of treatment. Depending on how a patient's case is encoded, the hospital is reimbursed for the services provided. In this way, hospital care can be matched with pre-calculated resources. Case volumes can be predetermined according to the profit needs of a hospital and an economy's 'healthcare sector' as a whole. Developed in the early 1980s by Robert B. Fetter and John D. Thompson, a management and a public health scholar at Yale, DRGs were first introduced in New Jersey, and have become the key accounting system throughout Western and increasingly LMI countries' healthcare systems. (Mathauer and Wittenbecher 2013) Here I will particularly draw on examples from Germany, Switzerland and Scandinavia, but also to the NHS in England.

What follows is what one might call accompanying research, albeit in a counterpoint movement (Ramsey 2016). The aim is to critically illuminate the theological structures of (sub-)systems such as the DRG. Four constitutive claims will be contested. First, the claim that marketisation is theologically neutral, inherent in the 'clean' language of 'modernisation' reforms. Rather, I argue, it is theologically grounded and implies theological interpretations of how acts of care should relate to political-economic structures; theology itself is a critical heuristic for different systemic challenges. Second, the adjacent assumption that marketisation is a natural, impersonal and global evolution will be contested. In contrast, the meaningful

nature of human history makes both individual and systemic responsibility possible in the first place. Third, I will contest the claim that DRGs better represent care. The codification and thus distortion of care raises the question of whether and how to represent it truthfully. It will be suggested that meaningful representation has to *follow* the event, rather than quench it out. Finally, against the claim that DRGs do not touch the substance of medical care, DRGs have in fact challenged the integrity of the medical profession, because they institutionalised contradictory 'logics' of action – medical as opposed to managerial-economic. This invites reflection on the meaning of vocation as an irreducible aspect to the human being and medical practice. These four theological counterpoints to the DRG system – theological significance, historical-systemic responsibility, representation and vocation – destabilise the marketisation discourse exemplified by the DRG system, relocate it and raise the stakes of the debate.

1. *The patient follows the money*: marketisation as theological shift and transvaluation

DRGs classify clinical cases according to several variables: principal and secondary diagnoses, patient age and sex, the presence of co-morbidities and complications, and the procedures performed. Depending on how the clinical case is then coded, reimbursement for each delivered pre-standardised "product" is released to the hospital by payers such as statutory health insurances, Medicare, private insurers, or Clinical Commissioning Groups. In the NHS, for example, operations are coded using the Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) system. These operation codes, together with diagnostic codes such as the ICD-10, are then converted to generate Healthcare Resource Group (HRG) codes, the English version of DRGs. In the system of "Payment by Results" (PbR) they generate the tariff for reimbursement to the Trust (Department of Health 2013). In the NHS, as in other systems, DRGs have remained one hospital financing mechanism besides others such as block grants, per capita payments and public investment. And whereas block grants are arguably on the state end of the spectrum of financing mechanisms, DRGs or 'activity-based funding' are on the market end, putting a price on each activity (Marshall et al. 2014).

The great selling-point of DRGs was that they were to allow 'money to follow the patient' (OECD 2004; Kimberly et al. 2008; Busse et al. 2011). This almost mythical phrase alludes to the familiar idea that patients are ends in themselves, which translates into 'patient-centredness', 'patient choice' and focus on 'outcomes'. However, because of their *prospective* nature, DRGs pre-determine the categories into which both patients and doctors must fall. As a 'currency' they are used for budget projection and rationalisation to increase 'efficiency' and, or, profits. Targets for activities and volumes are set in advance; bonus payments to clinicians can be related to pre-agreed numbers of cases in a given time-interval, irrespective of patients' actual needs. In this industrial model of contracted 'instances of care', payment is released according to specific numbers of coded

cases. Unless the system is gamed to their advantage, the coding thus determines how patients are treated. In other words: *The patient has to follow the money.*

For this reason, DRG reforms were a fundamental, paradigmatic shift, 'the largest and most thoroughgoing reforms of financing, but also of perspectives, of working and acting in the healthcare system' (Braun 2014, p. 91, also Bode 2011). It consists both in the relocation of the patient into a market logic, and the simultaneous redefinition of the patient as consumer-citizen which *conceals* this relocation: we now talk of consumer-clients, healthcare "delivery", instances of care that can be traded, scaled up, etc. The new definition of healthcare, its logic and *telos*, amounts to a 'transvaluation' (*Umwertung*), to use a Nietzschean term.[2] This was operationalised, amongst others, through DRGs.

1.1 Theology and the nature of the healthcare system

There are several starting points for a theological consideration of this development. First, the *historical* project unearths the genealogy of the market as we know it (see also below). Max Weber and Richard H. Tawney recognised the religious presuppositions of industrial capitalism, but more recently also several theologians (Kidwell and Doherty 2015; Skidelsky 2015). Both with and against sociology they have pointed at the Calvinist heritage of 'inner-worldly ascetics', for whom making money was a *religious* vocation. In one contemporary Anglo-Catholic interpretation, the Reformation's emphasis primarily on a person's faith led to a 'dis-connection of reality' from God: bared of all intrinsic justice and good end(s), the world became 'an arbitrary set of disconnected things' (Milbank 2015) and the market an exchange of mere 'stuff'. Whether the Reformation is to blame in this way must be contested. Either way, the market is theologically conditioned.

Conversely, organisational structures of healthcare have been an intrinsic part of the Church's reflection on its service to others (*diakonía*) as a 'fruit of faith' (Turre 1991). In the Middle Ages an aspect of charitable endowments and the monasteries' work, care for the sick was significantly re-ordered in the course of the Reformation. And whilst the Lutheran strand increasingly tasked the state with the provision of public healthcare, the Calvinist tradition embraced a more entrepreneurial model. In the nineteenth and early twentieth centuries, besides the socialist movement, Lutheran as well as Catholic social ethics played an important role in the institution of the modern welfare state. These 'religious schemes of interpretation' continue to 'format what one can call invisible social policy' as well as 'the non-economic foundations of economic action'. They undergird the different models of healthcare provision until today. 'To put it poignantly,' writes Gerhard Wegner, 'neoliberalism then would be the Calvinists' belated revenge on the Wittenbergians' (Wegner 2015, pp. 18–19).

Second, in line with this historical-theological continuum, there is a persistent systematic-theological aspect to the relationship between care for the sick and the market. It touches upon the grounds of the welfare state as that which has traditionally mediated between the two. As Zimmermann-Acklin has pointed out (2010, p. 110), there is now a significant 'contextual gap' between theological reflection

and the modern welfare state, despite their shared history. Some theologians mediate this gap by adopting the language of human and constitutional rights or shared concepts of human dignity. Others have traditionally sought to corrode it by reference to natural law (the more Catholic approach) and its principles of solidarity, subsidiarity and personhood. Schnabl, for example, writes: '*Solidarity* transforms the content of neighbour love into the field of the structural and the institutional. With this, a central ethical content of the Jewish-Christian tradition is spelled out into a sphere which in modernity can precisely no longer be developed' (Schnabl cit. in Zimmermann-Acklin 2010, p. 113). This is an admittedly 'reduced theology', in which faith easily shrinks down to a mere individual motivation, but the religious substance remains latent.

Third, this invites a reference to the *sui generis* theological debate around the being and nature of God in relation to the world. This debate sets the premises for the considerations just mentioned. In the light of this meta-narrative, historical and systematic forms can be analysed. In other words, theology functions as a heuristic for the *logic* of healthcare and economics, their modern relationship, and the nature of that debate. Reference may be made to the divine economy of grace, which is presented as profoundly *uneconomical*. Creation, redemption and the new creation are acts of divine generosity (Exod. 3:7–8b). This economy is at work in the liberation both from economic slavery ("the house of bondage", Exod. 20:2; Deut. 5:6, 7–21) and from egotistical desires ("And he died for all, that those who live might live no longer for themselves but for him who for their sake died and was raised" [1 Cor. 5:14–15]).

This uneconomical logic recurs in scriptural passages on material wealth. Proverbs, for example, appreciates wealth, albeit in the context of wisdom (Prov 11:4). Ezekiel meets the market in the context of critical suspicion to the point of hostility. The prophetic thread continues in the New Testament, where the impending divine kingdom engenders an acute, if not disturbing, rejection of material goods and economic considerations (Mark 10:25; Mt 19:24; Lk 18:25). Salvation through the cross would be interpreted as an uneconomically economic event: according to Anselm of Canterbury's theory of atonement, Christ made a restitutive 'payment' to God. The infinite debt owed as a result of human transgression against an infinite God, so the understanding, could only be paid with the sacrificial death of a God-man. Through faith, infinite divine judgment would be avoided. Thus the participation of faith in this divine plenitude was to overcome the economy of transgression, debt and repayment (Bell 2005; Benjamin 1991).

Over against the logic of the market – managing scarcity in the light of conflicting interests – divine plenitude, existence as such, suggests a strong logical, and possibly ontological primacy of nurture and care; reconciliation is understood as *healing*. Not least the parable of the Good Samaritan indicates compassion in principle encompasses everyone rather than a merely contractually founded society (Zimmermann-Acklin 2010, p. 117). Hence the market requires significant boundaries, reorientation and redefinition; it cannot determine its own ends. In every case, the above juxtaposition avoids, and even polemicises against the absolute conflation of the late capitalist market logic and that of healthcare. Even

more so since this conflation effectively amounts to the *separation* and *silencing* of genuine healthcare from the managerial health economy. Care for its own sake becomes a subjective motivation, a 'black box' (Powell cit. in Bode and Vogd 2016, p. 9) or an ideologically imposed fiction, threatening with its 'moraline-acidic' paternalism (Patzen 2010; Savulescu and Schuklenk 2017).

Since the early nineteenth century the main churches have continuously wrestled with their relegation to pure internal subjectivity. Recent scholars have set ecclesial practice as a counter-corporation against managerialism and market corporations (Long et al. 2007). This does not necessarily suggest the uneconomic logic of gift may fully replace economic systems. But a horizon of plenitudinous gift that is existence as such is the ground for solidary, diaconic forms of healthcare here. It also inserts significant *doubt* into any healthcare system that is a) based on the maximisation of individual utility, b) is oriented towards – or happens to result in – the mere upwards-moving extraction of profit, and that c) redefines all aspects of healthcare to that effect. Such doubt is particularly strong in healthcare, which addresses the loss and scarcity of physical suffering, often correlated with economic disadvantage and loss.

In the U.S., Scandinavia and Germany, increasingly privatised hospitals certainly have used DRGs to maximise their income, often at the cost of patients. Strategies associated with DRGs include e.g. the 'cream-skimming' of patients with particularly lucrative conditions. This has resulted in unnecessary invasive procedures, but also multiple re-admissions after "bloody" hospital discharges (i.e. before patients had recovered), as well as the relative neglect of patients with chronic diseases. Setting targets through DRGs for particular treatments allowed for an artificial increase or decline in the number of financially rewarding cases. DRGs have also been used to generate hospital income by either making use of the codes' flexibility ('DRG-creep', upcoding or upgrading) or by straightforward fraudulent coding at large scales (Neby et al. 2015; Balleisen 2017, p. 365). The Payment-by-Results system in the NHS 'relies on honesty and transparency between commissioners and providers of clinical services, both working on behalf of patients and in their best interests' (Chambers et al. 2010). But there are no grounds for romanticising the NHS: like others, it is under 'pressures to cook the books' (Cooper 2016, cp. Brennan et al. 2012).

2. Marketisation: 'natural evolution' and systemic (ir)responsibility

A previous point – the possibility that marketisation is just something that happens – is particularly pertinent to the global narrative of New Public Management (NPM) reforms in general and the DRG in particular. This narrative makes frequent reference to impersonal, naturalistic images: the new 'landscape' of healthcare, the organisational 'environment' that is 'emerging'. The OECD consistently presented DRGs as a global development, the natural thrust of progressive modernisation in the face of objective necessities. This language also pervades critical assessments, e.g. when Ingo Bode talks about a 'maelstrom of

evolutionary processes' (Bode and Vogd 2016, p. 6). Such imagery chimes with neoliberal thought, which the late Duncan B. Forrester (1997) explored in a useful study of Friedrich A. von Hayek's work. Forrester's analysis illuminates the ahistoricity and the ensuing lack of political responsibility inherent in marketisation, which also explains its resilience in the face of countervailing evidence. This will prompt the second theological counterpoint: history as meaningfully structured.

Hayek distinguishes between two kinds of orders: first, 'contrived orders', devised by humans to serve their purposes. This is what the Greeks called *taxis*, and is illustrated by a line of battle in which the individual is no longer free but under orders. Contrived orders are distinct from 'spontaneous orders', organic growths that are not the result of human planning, decision or calculation. Hayek (1982, cit. in Forrester 1997) calls these the *kosmos*, 'orderly structures which are the product of the action of many men but are not the result of human design' (p. 143). Forrester points out: 'A spontaneous order has no purpose, no *telos*; it has not been brought into being by an outside agency . . . it has "just growed"' (p. 143). Hayek understood the market as such a spontaneous order, the only one in which individuals could freely pursue their interests, goals and purposes. The market, according to Hayek, is '"an impersonal process which brings about a greater satisfaction of human desires than any deliberate human organization could achieve"' (p. 143). Forrester highlights that Hayek adopts the term *catallaxy* for the market order. The word certainly invokes a form of exchange, but Hayek also welcomes connotations of 'to admit into community' and 'to turn from enemy into friend'. He effectively mirrors, and partly parodies, Hobbes' *Leviathan*, the powerful state that stifles the civil war always lurking just under the surface. However nuanced their collusion, then, market and state remain profoundly at odds with theologies of plenitude and teleology.

The ahistorical nature of Hayek's market warrants further attention. It is no coincidence that marketisation gained steam from the 1990s onwards, when Francis Fukuyama famously declared the 'end of history'. From a systematic-theological perspective, the God that acts in history markedly contrasts with the idea that a spontaneously emerging *catallaxy* remains unaffected by conveniently pluralistic human values. The nature of God's interactions with Israel as *historical* is already part of early Israelite faith. Though now virtually impossible to historically reconstruct, early biblical 'original stories' are repeatedly commemorated: biblical narration itself largely consists of repetition, remembering and retelling earlier material. Historical political events are *theologically* interpreted throughout later writings (e.g. the fall of Judah as divine judgement on Israel's sin in the prophets). In the New Testament, the events around Jesus of Nazareth are located in a specific time and space, i.e. first-century Palestine. 'Here history becomes serious, without being sanctified' (Bonhoeffer 2009, p. 104). Up until the Enlightenment, the Bible was a key to world history; the differentiation between profane history and salvation history dates from that era. Their relationship certainly resists homogeneity both in the Bible and contemporary debate. Yet whilst the Bible without history is prone to become simplified and ideologised so any human, culturally meaningful institution requires the horizon of history (Frey et al. 2009, p. xxii). Put differently,

for any institution to be legitimate, history itself must be meaningful; this sense is perhaps a residue of history-as-salvation history (Schaper 2009; Milbank 2015). Retelling the history of marketisation, and DRGs in particular, is to understand it as part of our social, political and cultural negotiations, which are hardly bound by the determinism of a brute nature.

As for the DRGs, before they were introduced, hospital financing was largely framed by political structures. Whilst negotiation skills were certainly required of hospital managers, elected politicians were held accountable for budget decisions. Hospitals received their funding for the treatment given to patients, covering *retrospectively* the costs incurred. A frequent complaint about this system was that it led to lengthy stays in hospitals for lack of incentives to discharge patients swiftly, longer waiting lists and, consequently, altogether fewer hospital admissions. The argument was that this keeps "activity" low. But already this argument was part of the cultural drive to (re-)turn healthcare into an economic 'sector' and, in the U.S., to reverse the post-war settlement (Gaffney 2014; Chilingerian 2008). DRGs spread with the varying political champions of healthcare marketisation, such as Reagan in the U.S., Thatcher in the UK, or the Social Democrats in Germany. In Greece and Ireland, they were adopted as late as 2013 and 2014 as part of the European budget discipline (under German oversight) in the wake of the financial crisis (Burke et al. 2016). Yet these events require interpretation, locating the interpreter and his future possibilities. Hence, *history* marks a significant counterpoint to the natural-evolutionary imagery accompanying marketisation. In the remembrance of alternatives, history functions as a depository of freedom.

2.1 Systemic (ir)responsibility

On the back of the market as an ahistorical order, Hayek effectively limits systemic, political responsibility for a just social order, which makes Petratos' (2018) neat allocation of responsibilities in the present volume difficult to sustain. Hayek does assume that justice exists as an objective reality, which is why Forrester thinks there is an ontology at work here. But as a minimal set of rules or procedures, justice 'has nothing to do with aiming at just goals or attempting to bring about a just situation' (cit. in Forrester 1997, p. 145).[3] In the Great Society Hayek imagined, justice is minimised to individuals and families seeking their own private goods, again chiefly in the market. Meanwhile, questions of human purpose are relegated to the private realm. Procedural justice has no common good, shared goals or neighbourliness in view. Indeed, for Hayek such terms smack of the stifling, not least moral collectivism, the 'teleocracy' (cit. in Forrester p. 150) he discerned in fascist and socialist totalitarianisms. Rather than heeding a just order, 'interpersonal transactions are a "game" in which the behaviour of the players, but not the result, can be just or unjust, and the behaviour includes the intentions of the players'. Hence it may be unjust to *intend* to damage another person or their interest, but 'justice is not concerned with those unintended consequences of a spontaneous order which have not been deliberately brought about by anybody' (p. 147).

This narrative certainly accompanies the DRGs. The problems we noted earlier are not identified as result of the intrinsic logic of a coherent political-economic agenda (which requires deliberative re-conception). Rather, they appear as a collection of 'unintended' consequences that can be fixed – not without a sense of naïve progressivism – if only all diverse 'stakeholders' were to procedurally collaborate (Cots et al. 2011; Bystrov et al. 2015; Numerof and Abrams 2016). Various forms of tinkering, so the hope, will minimise the 'unintended consequences' and 'maximise the intended consequences'. Again, even critics of DRGs repeat this interpretation.

The effect of this Hayekian understanding can be seen not only medicine. Despite – or because of – the increased focus on the individual as object of concern and subject of responsibility, responsibility for *systemic* decisions is diffused and untraceable, and that responsibility effectively evaporates in a field of impersonal forces. Attributable intentions together with systemic agency disappear, replaced by omission and oblivion. A single actor may be reactively picked out and sanctioned (individual cases of fraud in finance or medical institutions), which functions mainly as a deterrent. Yet the systemic question is muted. Representative political responsibility for marketisation is relegated to administrative re-organisation in the face of necessity, 'replacing the government of persons by the administration of things' (Engels cit. in Berlin 1998, p. 191).[4] Not least for this reason the marketisation of healthcare progressed slowly over decades, largely unaffected by party-political divisions. In Germany, for example, networks around the Bertelsmann Foundation since the early 1990s were particularly active in directly short-cutting to administrators. As Tanja Klenk (2011) noted, the de-politicisation of structural reforms was welcomed by left parties too. It allowed them to blame politically sensitive hospital closures on impersonal market mechanisms.

In contrast, as we saw, historically grown healthcare systems are *always already* the result of (implicit theologically grounded) truth commitments. Their form at the macro, meso- and micro-level both reflects and is challenged by these commitments. Understood as the field of decision and systemic responsibility, history is the opposite of the amoral luck of 'winners' and 'losers' in the anonymity of marketised public administration. Hence the DRGs, like other 'structural reforms' must be re-included in cultural, philosophical and political negotiations. Not because they have been excluded, but because they are *already* part of them (cp. Bode and Vogd 2016).

3. The representation of care – codification and distortion

Health-economic discipline and efficiency demand the translation of medical work into quantifiable units, especially in hospitals. And by grouping 'an almost infinite number of patients receiving in patient care into a finite number of groups of comparable patients', it became possible to 'characterise more precisely the "output" of hospitals – besides "cases" – and to represent it internally and externally transparently in a way that allows for comparison between hospitals and periods' (Busse et al. 2013, p. 57). DRGs, and similarly QALYs and DALYs (Quality- or Disability-Adjusted Life Years) in England, thus suggest representation of care

through repetitive identification ('A QALY is a QALY is a QALY') and codification with a distinct utilitarian drift.

Once connected to marketisation (budget projection, revenue and profit creation, competition between hospitals), this codification frequently distorts rather represents care as it is actually given:

> The system today rewards complications more than it rewards treatment without complications; it creates diagnoses instead of representing them by setting incentives that promise plenty of income. The system deters expensive treatments if they cannot or cannot adequately be coded.
>
> (Baehr 2014)

Similarly, Bartholomeyczick (2010 cit. in Bode 2016, p. 212) criticises the 'invisibility of care in the systematics of DRG-based hospital financing', where actual differences between patients' concrete needs cannot be taken into account. And because the main diagnosis is the key economically, doctors 'must only look at the diagnosis; why the patient is here, and everything else besides, plays no role. And so the patient is treated like a disease, unfortunately, not as a person' (Braun et al. 2009, cit. in Maio 2014, p. 32).

As part of the transvaluation mentioned above marketisation has created what one might call an aporetic, 'unhappy' simultaneity of total representation and non-representation. On the one hand, ever more "transparency" suggests increased measurement and control. On the other hand, this coincides with a kind of *utopianisation*: the increased non-representation of real care. It remains a 'black box' (Bode and Vogd 2016), even if not *necessarily* to the detriment of patients. For a long time, this problem was tacitly acknowledged as mental health was exempt from the DRGsystem. In this area, 'success' is particularly unpredictable and untranslatable. Even if diagnoses are identical, the length of hospitalisation depends on the doctor, the psychiatric institution, on patients themselves and their personal circumstances (Meyera and Holzer 2015; Pfister Lipp 2014).

Theologically, the situation describes the nature and possibility of images. In the Old Testament (OT), the well-known injunctions against images of God (Ex 20:4; Dtn 4:16) deny the possibility of an 'object'. God – who is who he is (Ex 3:14) – is exempt from all representation. He is a 'black box' too, who only reveals himself in words. There are images, e.g. outside the Jerusalem temple, but they are restricted to human and other creaturely forms. The main point of the injunction was to avoid the conflation of object and divinity (i.e. magic). But already in the OT this is somewhat "upset" by the idea that human beings are made in the 'image of God.' *Their* adequate representation consists in treating them with justice and mercy, especially the weakest. In the New Testament, however, with the Incarnation the divine unseen becomes seen and manifest in word, image and body. The non-representable has been represented in Christ. Conversely, Christ 're – presents' humanity to God. The human being is now partly already participating in divine plenitude – and, in turn, *its* non-representability.

What follows from this for human representations or images of the divine has generated controversy. Broadly speaking, for Eastern interpreters, images of e.g. Christ function as an index that points towards the divine; they are iconic, both hand-made paintings and divine. In Western churches, representing the un-representable results in 'profane' art as the hand-made suggestion of the plenitudinous. Art then becomes also indicative for other forms of representation – political, administrative, economic – which concern what cannot be fully captured even in the human. These areas of social life must be re-thought from and towards the non-representable, yet again without conflation (as in "politics as art"). By the same token, any reductionism is 'iconoclastic' once it comprehensively blots out its own object, the human being. And it becomes 'idolatrous' once it mistakes the image (or 'code') for the thing itself – as seen in the DRG system.

More often than not, health economists and policy-makers are well aware that DRGs, QALYs and DALYs are not the whole picture, and that every patient is different. The point of economic vehicles of calculation was never a true knowledge of the object, Vogd (2016) points out. Nonetheless, some have sought to address the gap between care and calculus by introducing 'quality measures' into the DRGs (cp. OECD 2017). But effectively this exacerbates the problem. To quantify quality means to accept the Wittgensteinian dictum that 'there is nothing beyond the text', that compassion and mutual recognition could be measured, converted and cashed in on. It 'delegitimises the non-measurable' (Maio 2014, p. 80) more emphatically. Hence, insisting that there *is* something non-representable that escapes the current system remains preferable to expanding that system: 'Every feedback and learning loop of the DRG system will only lead to a more complex representation, which prompts new adjusting movements on the provider side with the aim to even better exploit the DRG system' (Vogd 2016, p. 291).

An alternative, more 'representative' coding system would have to participatively *follow* and *respond to* actual healthcare, that which cannot be 'coded', in a way that assures its continued possibility. Every representation of an act must be a response that allows for a renewed instantiation of the act (Williams 2014, p. 67). In other words, *retrospective* systems are more adequate, and as mentioned, continue to exist alongside prospective systems. Retrospective representation in that sense is more 'iconic': a constant process of adjustment between clinical and managerial logics (and staff), albeit under the umbrella of communal, regional and national common goods (*pace* Albach et al. 2016). Consequently, health-economic considerations, financing systems and management systems need to be short-circuited with hard questions about justice for every polity, which includes hospital ownership, anti-fraud mechanisms, waste, etc. This collides with the 'market'-claim that justice consists in every individual getting what they want at any point in time, a promise transported by the 'ethical' formulas of 'patient-centredness' and 'money follows the patient' (cp. Epstein in this volume). These imply that all allocative decisions are ultimately based on arbitrary 'lines in the sand' and suggest justice presupposes wealth – which is to put the cart before the horse and hence, defer it indefinitely.[5]

4. Economic logic and vocation

The final point then, frequently made in connection with the DRGs, concerns the responsibilities of those working *within* the marketised healthcare system. As healthcare has been relocated and redefined in market terms, those interacting with patients remain standing and working at the borderline between the market system's logic and their actual responsibilities towards patients. Giovanni Maio (2014) recently described the 'overgrowth of medicine by economics' in the clinical setting by what he calls 'structural patronising'. He observes a

> mental appropriation of doctors, as they are subtly introduced to the idea of distancing themselves from their own ideals. Or at least they are implicitly taught that those are at least as important as the economic demands of the business. The danger here is that this new hierarchy of values is not explicitly mandated, but rather that doctors are subliminally guided to internalise this hierarchy, now presented as an objective necessity, so that in the end it looks like a *voluntary acceptance*.
>
> (Maio 2014, p. 29)

That includes the internalisation of time pressures, which leads to self-exploitation (burn-out) and the individual, moral internalisation of what are, in reality, structural deficits. Hence, healthcare workers have a permanently bad conscience about their putative failures. (Maio 2014, pp. 55, 86)

Maio also describes the different ways in which the 'medical logic is turned onto its head' by economic considerations: over- and under-diagnosis go hand in hand, the patient as a whole person falls out of sight; there is a lack of time and engagement as patience, conscientiousness and exchanges with colleagues are devalued under the 'dictat of time efficiency' (Maio 2014, p. 53). Indifference is legitimised.

> Now there is no longer a standardisation that puts together symptoms as one clinical picture, but a standardisation according to a purely industrial credo. Standardisation is no longer done in order to understand what is general in the particular personal history of a patient and how it can be treated effectively according to general rules and laws, but rather standardisation in order to go into a serial production with patients, and to achieve an industrial increase of efficiency. [. . .] now humans, like objects, are subjected to an industrial production process.
>
> (Maio 2014, p. 63)

Maio sees the subsequent 'moral dissonance' as going to the substance of the profession: 'As doctors are more and more deprived of their spaces of free decision and hence the possibility to identify with their profession, patients are also indirectly deprived, because they can only be well cared for if doctors practice their profession out of a deep commitment and with joy' (Maio 2014, p. 84). This clash for professionals between the economic and medical logics, ranging from

subtle to stark, has been observed since the early days of DRGs (Flintrop 2006, Braun 2010). Bode (2010, p. 203) notes the system imposes a 'double reality', so that professionals have to '"serve two masters"' (Bode 2016, p. 255).

This clash of logics also has a theological dimension. It crystallises the relationship between work and enjoyment, between law and gospel. Martin Hengel (2008) has traced the notion of work as it developed in early Christianity before the backdrop of the OT and aristocratic Greco-Roman environment. The latter despised work altogether in favour of *theoría*. Although still done joyfully in paradise (a point Luther for some time underplayed), work becomes a chore after the Fall: 'Cursed is the ground because of you; in toil you shall eat of it all the days of your life' (Gen 3:17; Hengel 2008, p. 465). But this is not unambiguous. At least fruitful work is praised as a divine gift, and frequently blessings are sought for it (Qoh 3:9–12; Ps 90, 128:2). A moral duty to work is a later rabbinic development, but there's a duty not to be idle. At the same time, work is interrupted by the Sabbath for all of creation 'to participate in God's rest' (Hengel 2008, p. 437). In the NT, work is then altogether *transvalued*: Jesus' proclamation of the divine kingdom is a 'great and final "interruption"' (Hengel 2008, p. 442). Work has a double meaning now: it is a service for the divine kingdom[6] and done selflessly for the neighbour in need. The daily job for a living (Paul was a tent-maker) takes the back seat. It shouldn't be dropped though, as some of Paul's enthusiastic audiences thought.

Yet details matter in how these pairs of work and rest, and then work and worship, are interpreted. Karl Barth, for example, not only contrasted the 'idolisation' of modern industrialised work with Sabbath rest, but thought all work finds meaning in the Sabbath: 'it points [man] away from everything that he himself can will and achieve and back to what God is for him and will do for him' (cit. in Hughes 2007). The late John Hughes critiqued this Barthian differentiation between the 'active life' of worship-in-*diakonía* and employment-work as overly stark, even though that prevents the 'glib liberal celebration of capitalism and its work-ethic' (Hughes 2007, p. 15).

Esther Reed somewhat counters Barth by insisting on the redemption of work. In her view, proclaiming the hoped-for future of transfiguration and eternal resurrection, Christians are freed from the ultimacy of everyday work. Reed also insists that the resurrection means work has eternal significance because nothing included in God's future will be lost. (Reed 2010, pp. 100–104). Nonetheless, her heavy-heavenly significance of honesty, good quality work, 'respect for clients' lacks transformative implications. Especially in hospitals where a clash of the standardised-industrialised logic with the medical logic is not without victims, Reed's curious insistence on the presence of God even 'in the darkest and most cruel workplaces' seems to bridge the Barthian gap less effectively than expected. This is similar to Maio (2014), it should be added, who suggests a 'dialogue' between the economic and medical – after he has shown that the premises for such a dialogue are no longer given.

Hughes, for his part, combines the critiques of the Frankfurt School with Romantic and Catholic strands of thought. He also notes that 'labour whose only end is efficiency and functionality, free of responsibility, intellect and delight, is

sub-human work'. Unlike the Frankfurt School's hope in the negative power of critique, however, he suggests work depends on a vision of true labour, i.e. the creative work of God. The artist is his best analogy:

> God creates purely for the sake of the thing being created, gratuitously, out of sheer delight. He does not create out of any need or lack in himself, nor instrumentally for any other purpose. God works for no other reward than his love for the thing made.
>
> (Hughes 2007, p. 226)

Hughes then thinks human work should be analogical participation in that divine labour, a 'liturgical offering to God', and hence indistinguishable from the contemplation of God.

Hughes thus somewhat drops the notion of vocation, which in the Protestant tradition recognises even the most profane work as a service to God, indeed quite so whilst remaining 'profane'. He thinks it over-exalts mere employment and under-rates the creative, beautiful aspects of work as *vita activa*. Keeping in mind the dangers that come with such a notion of vocation, however, it retains two important aspects. First, vocation is the form and being of human freedom that cannot be exhaustively explained or justified (e.g. "Why do you want to be a doctor?"). Economic expertise can also function as a service – and vocation – to this end. Second, precisely because of its correlation with freedom, vocation has a transformative potential. Care depends on a notion of freedom that transcends different immanent logics as such, as Hughes is aware. Again, the genuinely political form can hardly be subtracted, since corporate solidarity, justice and power in healthcare is *eo ipso* structural. Hence, more than a 'dialogue' between medicine and economics in Maio's sense is needed. A substantial rethinking of marketisation as a comprehensive intellectual paradigm entails relocating the political-economic in the service of medicine as an irreducible practice of solidarity-in-suffering. This implies both rethinking the economic order, and flanking critiques such as Maio's or Hughes' with political and managerial responsibilities for healthcare workers.

5. Conclusion

Theology, says Paul Ricoeur, emerges at the intersection between 'a space of experience' and 'a horizon of hope' (cit. in Gutierrez 2009, p. 323). In this sense, marketisation of healthcare is brittle in terms of its conceptualisation and invites sharp critique. Such critique is always already taking place on the theological territory briefly mapped out here.

Marketisation, exemplified by the DRG discourse, re-defines healthcare and covers up this redefinition. This transvaluation can be demasked as historically and theologically conditioned; its grounds are up for scrutiny. As shown in the first section, systematic theology provides not least a key critical heuristic for this challenge, the opposition between political economy and the notion of care and healing. The welfare state as one specific mediate institution between medicine and market is an occasion

at which this theological mediation moves into institutional forms. In concrete cases, this can lead to state-bureaucratic and managerial distortions as well as different kinds of complicities. Equally, non-state forms of care provision such as social entrepreneurship and diaconic organisations can function as such mediate institutions.

With reference to Hayek, we have also seen how the market paradigm generates ahistoricity as well as a lack of political responsibility (and imagination), exemplified in the way DRGs were implemented. Against this I have emphasised both the significance of history for any institution to be legitimate; and for marketisation to be re-embedded into political responsibilities, not least grounded in the interpretations of the past.

The problem of representation through coding systems such as the DRG was raised: they distort and re-direct care away from its *sui generis* task. An adequate representation of care, however, has to be truthful in that it neither distorts nor blots out its own object, but rather furthers its continued re-instantiation. This connected to the final point: problematic contradictions *within* the profession created by marketisation, which will also be dealt with in more detail in Part III of this volume. Here different theological approaches find ways to conceptualise and resolve the present fissure between the economic and medical logic. Granular differences matter; Protestant/Reformed emphases on vocation eschatologically shift perspectives, or transformatively re-orient structures; the Catholic emphasis, more integral, emphasises dialogue and a creative-artisan fulfillment of work.

For all their differences, these approaches imply that healthcare's corporate-personal responsibility cannot be absorbed into a jargon of 'hybridisation' or 'balancing' contradictory tensions within a grid of maximising personal utility. Marketisation is not complete, as an intellectual paradigm, a jargon or a practice. The various critiques over the years have shown that a continuous exercise of freedom, politics, creativity and care *can* reverse the transvaluation of healthcare, and reorient it towards its genuine end.

Notes

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2 Pfister Lipp (2014, pp. 59–64) identifies four areas of concern: justice of care provision, quality of care, vocational ethos and work conditions.

3 Hayek's parallels with Rawls explains their simultaneous success in the late twentieth century.

4 The irony of this twist – that marketisation engenders systems comparable to Soviet administration – should not be lost on the reader (see also Bevan and Hood 2006).

5 See Margaret Thatcher's infamous quip that the Good Samaritan needed money to pay for the victim's care. This obvious point becomes problematic if she meant to say: *first* he needed to make money, *then* he could help.

6 Mk 1:17 "Follow me, and I will make you fish for people."; Matt 9:37f; Lk 10:2. Matt 10:7–8 "As you go, proclaim the good news, 'The kingdom of heaven has come near.' Cure the sick, raise the dead, cleanse the lepers, cast out demons. You received without payment; give without payment" Cp. 1 Cor 3:9.

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