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Healthcare In the U.S.A.

E. Paul Kirk, MD, Professor and Chairman, Obstetrics and Gynecology, Oregon Health Sciences University

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Abstract

The twentieth century has been the century of quite remarkable progress in Western medicine. To try and list the components of that progress is an almost endless task, but includes an appreciation of the scientific basis of health and disease, an explosion of potent pharmacologic agents, the evolution of 'new' disciplines in genetics, molecular biology and immunology, an expansion of the surgical horizon, aided by improved anesthesia and blood transfusion, into new areas such as organ transplantation, the development of the intensive care units which have been particularly effective in neonatal care and much more.

As medicine has developed so has the public's attitude toward medicine changed. When the family doctor could offer little more than TLC (tender, loving care) that was all that was expected. Now expectations are, not unreasonably, far greater. Life spans have been extended, the relationship between societal problems and illness recognized, health care is subject to quality control and legal scrutiny, a new and sometimes seemingly confused or disconnected discipline of biomedical ethics has evolved, and government has become involved in health care, more or less.

This presentation will attempt to report on health care in the U.S.A., now, at the end of the 20th century. This is not a public health report with statistics of mortality rates and causes, infectious diseases, etc. It is a brief glimpse at an enormous industrial complex, a phenomenon that is unique to the U.S.A., where more than any other country in the world, health care is talked about in industrial terms and health is seen as a commodity.

The story essentially starts in the 1930's where health insurance was first offered, and the 1940's when during the war and a time of a wage freeze and labor shortage, health insurance was provided as an employment based 'fringe' benefit. As the second half of the century played out, the industry developed enormous capacity, consumed increasingly vast resources mainly on a fee for service basis, predicted a physician shortage so created many more medical schools, and the government was generous in its support of research activities. Initially, insurance was affordable and employers paid; in the 1960's, the government stepped in to help the elderly with Medicare and the poor with Medicaid and "charity" care was provided to the uninsured.

By the mid-1980's, the system was beginning to unravel, the nation was spending vastly more of the gross national product on health care than any other nation in the world, costs were soaring, more and more employers were not offering the fringe benefit of insurance, and as the numbers of uninsured rose, the ability and willingness to shift costs so as to

cover non-reimbursed care dwindled and there was a widespread assumption that "something had to be done."

While action was needed, it was much less clear as to what the action was to be and who was to direct it. Alternative suggestions included a move to a single payor system, leaving it to the states to develop their own individual initiatives such as the Oregon plan, government led reform (the Clinton plan), or leaving it to "the market place," to sort the problem out. The principles of the Clinton plan, security, simplicity, savings, quality, choice and responsibility were fine principles and difficult to challenge, but the strength and resistance of the industry together with the deep American distrust and suspicion of government and the style with which the reform was attempted doomed the plan to failure.

So, by default, reform is occurring but as a consequence of failure, not as a result of the success of federally legislated reform. The essential motivation is to reduce costs and this is being achieved by reducing capacity, avoiding fee for service, shifting responsibility and reducing choice.

The pace of change is rapid and there are marked regional differences, but the trend is the same across the nation. As "markets mature," there is a greater number of patients enrolled in managed care, and the costs per 1,000 enrolled population fall as do the length of hospital stays and the costs per day of hospital stay.

Integrated systems have developed that provide a full range of services from insurance coverage through the hospital with a closed medical panel and community services. Physicians have responded by moving away from independent single-handed practice to specialty groups or multi-specialty groups, some with tight relationships to integrated systems, some without.

More than ever before, Wall Street has an interest in health care, systems are bought and sold, mergers and acquisitions occur on a daily basis, and "for profit" organizations are much more common than they were in the past. Advocates for the competitive market place see the profit motive and the returns to the shareholder as ways to increase efficiency, and promote quality and customer satisfaction; skeptics see the money taken off the top as money that would be better spent directly on patient care.

The role of the primary care physician has changed so that he/she is assuming a more central role, carries more weight, and is seeing salaries rise and job opportunities increase at the same time as there are fewer or no job openings and failing salaries for the subspecialists.

All of this is occurring while medicine continues to advance, technologies develop and new modalities are introduced. The recent attention and all the action has been directed to cost cutting, and yet the central question is still being avoided. That is, "how do we allocate limited resources now that our expectations and abilities are greater than our resources can support; should/how can we, ration health care?"

This is a much easier question to pose than to answer, and American society has not been willing to tackle it at a political level apart from a limited experience in Oregon. The

ethicists help to frame the debate which on the one hand considers and respects the principle of autonomy and on the other wrestles with concepts of justice and equity. What seems best for the individual does not always seem best for society and vice versa.

It seems unlikely that in the current political climate-there will be any further attempts at federal reform in the foreseeable future. As managed competition reduces costs to the barest minimum and the government also cuts back in Medicare and Medicaid, there is great concern that three features of the American system that have been valued in the past may not be valued in the future. These three features, medical education, research and charity care do not fit comfortably into the bottom line as the benefits are remote, indirect and altruistic and are not immediate and visible.

What the 21st century holds for health care in the U.S.A. remains to be seen.