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# PARADIGM SHIFT IN AMERICAN HEALTH CARE: ARE WE READY FOR A COMPREHENSIVE SYSTEM?

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## INTRODUCTION

**T**HE METAPHOR OF the competitive market has governed our understanding of the complex social institutions which serve our needs for health care since the early 1980's. Whether we recognize this social metaphor as correct or appropriate, all of us who work within health care or are served by health care institutions must come to terms with the many consequences of the widespread belief in this image. The purpose of this paper is to suggest that we are currently undergoing a major shift of social metaphor in health care to a significantly different image—a paradigm shift, if you will, in the sense that Thomas Kuhn describes in his work *The Structure of Scientific Revolution*.

## THE PARADIGM SHIFTS

### From Paternalism to Science

If we were to review the history of health care in the U.S. since the Second World War, we would find several paradigm shifts. During the immediate post-war period, while the spectacular success of the new antibiotics began preparing the ground for the first major shift, paternalism prevailed within the context of the professional relationship where the physician cared for and looked to the best interests of the patient. However, with the establishment of Medicare and Medicaid programs, the paradigm shifted such that health care, especially medicine, came to be understood as a science.

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This period saw the rise of major research institutions, the massive increase in size and influence of medical schools, hospital construction and expansion, and a disproportionate increase in physicians' earnings as well as the size of the health care sector of the GNP.

The benefits of this "medicine as a science" paradigm have been prodigious. Major infectious diseases have been conquered or controlled through the development of new pharmaceuticals. Disabling conditions are now manageable in many cases and even preventable in some. Chemotherapies combined with radiation and/or surgical interventions now offer hope to patients who would previously have received death sentences with their diagnoses. The application of various engineering and industrial technologies to surgery have expanded the success of direct manual intervention within the body itself and spectacularly improved our capacity to diagnose diseases and conditions previously hidden. We seem, even, to be on the threshold of direct genetic manipulation of our own species, hopefully to improve our species health.

Most of the successes of scientific medicine, to a great extent stimulated or at least facilitated by the availability of federal funding, were accomplished with little or no attention to their costs. It is important to note that the predictable inflationary character of the "medicine as a science" paradigm was of little concern, as long as the benefits of that science were extended to the great majority of us regardless of ability to pay, and as long as the expenditures represented did not jeopardize other social goals and needs. The benefits to all of us, especially the sick, have been viewed as justifying almost any use of resources.

In a subtle but powerful sense, the paradigm of "medicine as a science" has also supported the general social expectation that any form of human grief or limitation, all human sickness, even our mortality, is a phenomenon available to the explanatory and effective processes of science and hence, manageable.

It should not be surprising that the role of the physician and other health care providers also changed, taking on more of the qualities of an expert technician and losing much of the traditional interaction of the professional paternalism of the pre-Medicare era. It was predictable that some patients and commentators would criticize the delivery of care during this era as lacking in humanity and caring and that physicians and other professionals would lose some of their caring skills.

While some counter-cultural institutions (such as hospices, herbal medicine, acupuncture, etc.) began to appear during the mid-

seventies in response to this decay in the caring aspect of health care, it was not until the costs of health care reached proportions threatening to other social goods that forces appeared to cause another paradigmatic shift.

### Health Care in the Competitive Market

In response to the unexpected and severe recession of the early 1980's and the new Administration's commitment to increase defense spending regardless, the White House and Congress began a concerted effort to curtail runaway inflation in the costs of Medicare benefits. The introduction of prospective payment schemes, first in Medicare financing, and later in the financing of Medicaid, contributed to the new paradigm of health care within the competitive free market. Following the federal lead, most private insurers instituted programs to control the costs of claims and to encourage the premium payers to behave as informed and prudent consumers within the market for health care services. These measures included increasing deductibles, instituting co-payments, offering differential premiums for use of managed care programs, developing utilization review, and requiring pre-authorization for surgeries.

While each of these mechanisms can be shown to have reduced the inflation in health care costs for a brief period, nothing seems to have definitively stopped the upward trend in costs. Paradoxically, the hegemony of the market metaphor has simply added consumer behavior to the previous paradigm's inflated expectations of scientific medicine. Americans now believe that there really is a cure for everything and it can be bought. We further seem to hold the belief that the purchase of that cure should be a matter of individual consumer choice. The marriage of the "medicine as a science" metaphor with the image of the competitive free market in health care services may have created a monster which neither individually could have predicted.

### The Marriage of Market and Science

There are many commentators who would argue that the benefits of the market metaphor are yet to come and that we can reliably predict that further competition will increase efficiencies in the delivery of care. Whether this argument turns out to be true, the unacceptable consequences of the current *modus operandi* are moving public consciousness toward another shift of paradigm with remarkable speed. It is important for us to note that inefficiencies in

the system of health care delivery do not seem to have stimulated the raft of proposals for reform. Rather, it is the demonstrable inequities in the current arrangement which provoke reflection and response. From the perspective of the ethicist analyzing the foundational values informing whatever new paradigm we shall have, it seems that we are quickly entering into a period when health care will be conceived of as a basic, entitled human need which will have to be met within the constraints of community commitment and available resources.

Whether we can agree that the value of medical need within constraints will serve as the basis for our new paradigm, I suspect that few of us would disagree that the current system of care is not adequately serving most of us. While we utilize more than 12% of our GNP for health care—more than any other industrialized country—we have less impressive efficacy statistics in many areas than most of our European allies. Indeed, especially when we control for social class and race, we find that the U.S. underclass, in spite of the federal commitment to Medicaid, have health outcomes which would be unacceptable in other parts of the world. We can also document 37 million Americans who do not have any form of health insurance, as well as 24 million who, because of long-term illnesses or conditions, are underinsured. These gross statistics and demographics hint at the reality of a health care “system” which is not really a system at all.

### PROPOSALS FOR REFORM

Whether or not we will be able to propose a new paradigm for health care in America within this symposium, we certainly can contribute an analysis of which fundamental social values are primary to the issue. The central case study for this debate is the Oregon plan. The evaluation of this concept will be based primarily on the report from the initial dry run project, called the Oregon Medicaid Prioritization Project, and the Oregon Senate bills which provided enabling legislation for the current efforts in that state to provide insurance for all citizens. While of national importance in themselves, they contain most of the elements which seem to be appearing around the country as states, large corporations, insurers, the federal government, and provider organizations begin to struggle with the issues of need and equity.

First and perhaps most important, many proposals for reform attempt to speak to the fundamental incoherence of our present sys-

tem. In a real sense, such schemes attempt to take very seriously the value of universal right or entitlement by proposing a unified single-insurer or single-payer mechanism. Whether such proposals will improve efficiency at all or be able to deliver increased availability of health care to all remains to be tested empirically. Nonetheless, the very existence of such proposals indicates a shift in consciousness about health care where human need and equity are moved to the head of the priority list of values.

A second element which is explicit in the Oregon plan and implicit in many others is the notion of prioritizing what will be provided from the universe of possible benefits and services. The Enthoven and Kronick plan begs this question when it identifies a "decent minimum" and then refers to the benefits requirements of the HMO Act. Once a commitment is made to the provision of basic health care services to all citizens, then that commitment will only be accomplished within the context of other basic human needs and the community's ability and willingness to allocate resources. This reality will necessitate an explicit, concrete description of benefits, repeatedly adjusted in light of changes in experience and perception of efficacy.

A third related feature of the Oregon model is the development of an open participatory process for determining the specific social values which will identify the prioritizing of benefits within the system. Whenever a governing body makes a budget decision regarding the funding of such a program, the political process also involves some debate about social values. The Oregon plan addresses this need through town meetings and a parliament which offers citizens a direct means to participate in prioritizing benefits. But, it is only one possible form for such a participatory process.

It seems clear from the Oregon plan, as well as from several other proposals for reform of the health care delivery system, that some restructuring of the mechanisms for payment will occur. Of particular interest to me as a clinical ethicist is the debate heard in the corridors of hospitals about the disparate economic incentives between physicians in the fee-for-service sector and physicians who work in prospective payment managed care organizations. Both the Oregon and the Enthoven and Kronick plans propose forms of capitation for payment. Acceptance of this reversal in incentives will have predictable effects in the clinical arena, especially in the treatment of the terminally-ill and those who are so impaired as to be incapable of participation in decision-making.

Fear of malpractice litigation is most frequently identified by

physicians as the central reason for overuse of marginally-effective therapeutic interventions, for routine continuation of life-support measures which are medically futile, and for grossly redundant use of expensive diagnostics. While the enticing economic incentives are probably at least as responsible for these inflationary factors, it certainly is true that outrageous awards in malpractice cases tend to chill physicians' enthusiasm for responsible professional judgment in these cases. Thus, most of the proposals for national health care reform suggest an associated tort reform. For our purposes, both the financing and legal reform suggestions reflect the beginnings of a shift away from the nearly complete centrality of the value of individual patient autonomy toward a more communitarian perspective.

Finally, it is difficult to imagine that we will be able to guarantee all citizens access to health care services without increasing the efficiency of the system and controlling the spectacular rise in costs associated with the introduction of new technologies (devices, procedure, and pharmaceuticals). New technology assessment has begun to appear around the country but is not yet carried out in any sense other than evaluations of safety, efficacy from a medical stand-point, and comparable efficiency. Social value trade-offs are not yet constituent to the process. We can probably expect to see social value choices included in the assessment process in the near future and we can also probably expect to see old technology assessment begin as we develop more comprehensive outcomes and efficacy research.

## CONCLUSION

Let me for a moment step out where angels fear to tread and suggest that we may be seeing a new paradigm emerge from this conceptual soup. Many of the elements appearing in proposals and efforts at reform around the country, when assembled together, begin to look like a *public utility*. Public utilities are organized to provide for basic human needs through regulated monopolies where both efficiency and equity are important goals but equity is esteemed as the more important. Throughout the period of the free market metaphor, many of us and many of our colleagues have argued that it is inappropriate and destructive even to consider such a structural metaphor when talking about such an unpredictable yet undeferrable need as health care. The concept and structure of the public utility offers us precedents within our public life for addressing basic levels of human need while allowing for some of the effi-

ciencies of market forces. The debate would shift, within this paradigm, from whether health care is an entitlement to what level of services and benefits is right, just and possible within our real resources.

It is probably too soon to propose a specific metaphor for our paradigm. This public utility paradigm may be unacceptable simply on aesthetic grounds, but it does seem to me that many, if not most of the elements emerging from the proposals for reform coalesce to look much like a public utility. Whatever metaphor we find comfortable, I suggest that we look below and behind the specific proposals and reform packages for what social values shift is occurring in our country in relation to the real human need for health care. If my preliminary view bears any resemblance to reality, we are entering a period when the hegemony of professional paternalism, medicine as a science, and the competitive market will be assimilated and transformed into a further metaphor. Hopefully, this time around we will not lose the human, caring qualities of medicine, nor the real constraints of limited resources (both monetary and human), nor the community's legitimate and necessary responsibility to decide what goals and values take precedence.



