Modern medicine reflects deep cultural traditions and needs

The Nation's Health

complex "industry". A million persons worked in health services in 1929; there are now seven million: an army of professionals, support staff, and technicians.

Hospital budgets alone rose from $2 billion in 1946 to $71 billion in 1978, and in the last decade, hospitals have added more than a million people to their payrolls.

Private health insurance coverage, through non-profit Blue Cross and Blue Shield plans and through commercial insurance companies, grew rapidly from the 1950s. Today well over 80 percent of the population has some kind of private insurance coverage, although typically it covers only part of an individual's medical bills. Most Americans buy their insurance through group contracts negotiated with their employers. The availability of insurance has both increased the effective demand for health services (and thus the costs of care), and shored up the traditions of private institutions and practitioners.

MEDICAL MARKETPLACE

The fee-for-service system has undoubtedly encouraged the idea that physicians and hospitals have something tangible to sell — from a prescription to an operation. American medicine is more like a commodity to be bought in the marketplace than a social service guaranteed by government, as is more typical in European countries. Americans, for instance, have long been enthusiastic drug takers, and they undergo twice as much surgery as patients in Britain.

When expectations are not fulfilled, the American patient is much more likely to sue the physician or the hospital than is his European counterpart. Such attitudes are not new; indeed, complaints about Americans' indulgence in malpractice suits can be found in the medical literature of the 1870s.

The financing of medical care, as it has developed in the last forty years, has focused on the purchase of medical care rather than on the provision of comprehensive services, enshrining the position of the patient as a consumer in a pluralistic, competitive industry. Even Medicare, a federal program of medical payment for the elderly, covers expensive hospital procedures, but not dental services, eyeglasses, or hearing aids. By paying for medical bills incurred with private physicians and in private hospitals, nursing homes, and other facilities, Medicare leaves relatively undisturbed the traditional patterns of medical organization.

GOVERNMENT INTERVENTION

But if the assumptions of medicine in the United States have been toward pluralism and private enterprise, the rapid rate of growth of the health care industry since World War II made government intervention inevitable. Federal programs for the sponsorship of biomedical research and hospital construction were followed, in the days of the New Frontier and Great Society in the 1960s, by a host of government programs: subsidy of medical education, neighborhood health centers, hospital construction, programs for needy groups, as well as Medicare and Medicaid.

Government financing of medical care grew from less than $10 billion in 1965 to almost $50 billion ten years later. With increased subsidy has come increased regulation: planning agencies, medical audit systems, federal and state financial audit, and inspections of facilities, programs, procedures.

Paradoxically, while the United States continues to have a largely private enterprise medical care system, most physicians and health care institutions are now more highly regulated than in countries such as Britain, which have government-run health care systems.

At the same time, the scientific emphasis of American medical education for much of this century has focused on identifying and understanding disease, with little intellectual interest in common complaints or preventive medicine. While the economics of American medicine have made this country rich in medical resources and the scientific emphasis of American medicine has made us a leader in diagnosis and technology, profound questions remain as to how well the full range of medical capability is actually extended to the whole population.

It remains to be seen whether a commitment to scientific and technological excellence can be translated in the future into equitable service for all Americans, and whether a pluralistic medical system, inbued with the ideology of private enterprise, can adjust to government intervention.

NEXT WEEK: Stephen M. Shortell, director of the Center for Health Services Research at the University of Washington, describes our health care system.