CHAPTER

1

UNDERSTANDING HEALTH CARE

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LEARNING OBJECTIVES

- To obtain an overview of health care as a concern in the U.S. and worldwide
- To appreciate the challenges experienced by health care consumers and providers
- To identify objectives and goals for heath care
- To highlight the importance of public trust and professional ethics
- To frame health care issues within three perspectives: a systems approach, critical thinking, and the public interest

HEALTH CARE AS A NATIONAL CONCERN

Health and health care are subjects in which everyone has an interest. When young mothers get together, talk soon turns to the health of their children. In search of health, men and women of all ages work out at the gym. Among elders, conversation inevitably involves aches, pains, and the merits and shortcomings of their physicians. Health and health care periodically become major election issues. But acute concern for health, health care, and associated costs are only a step away from each individual, who, if he has no direct concerns, almost always has a friend, relative, or neighbor in need of care.

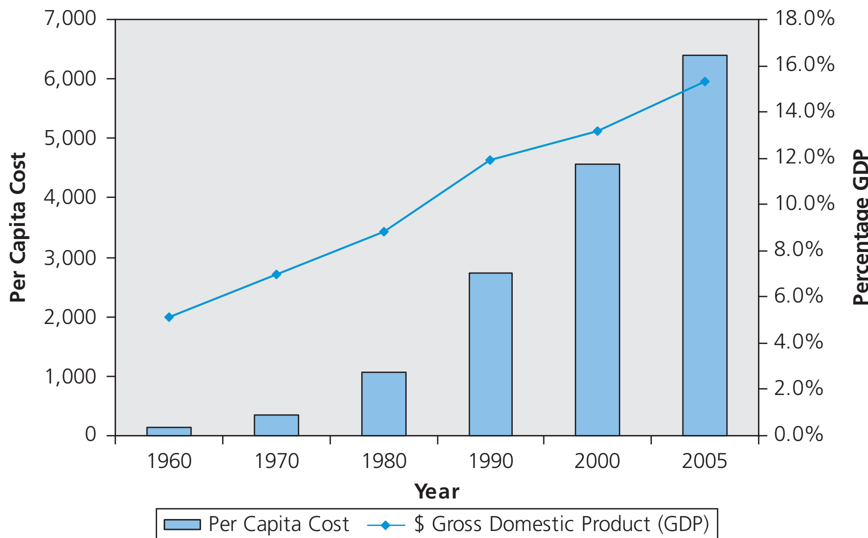
Health care in the United States is arguably the best in the world, and much evidence suggests that the health of Americans is today the best it has ever been. Only a few examples can convince most people that this is true. Children with leukemia, whose illness amounted to a death sentence only a generation ago, now often survive to live normal lives. Elders who at one time would have been confined to wheelchairs and nursing homes now live active, independent lives thanks to procedures such as cataract surgery and hip transplants. Effective drugs and widely available surgery are chipping away at heart disease, for generations America's leading cause of death. AIDS is now often controllable, whereas at a time still well remembered it invariably led to a miserable death. Life expectancy in the United States has steadily increased, from 69.6 years in 1955 to 75.8 years in 1995, and to 77.9 years in 2005.[1]

Health care, however, has become a major source of dissatisfaction and controversy in the United States. A challenge affecting the United States as a whole, and Americans as individuals, is that of cost. As Figure 1.1 indicates, the cost of health care increased markedly during the late twentieth and early twenty-first centuries. Despite public policy aimed at controlling costs, the upward trend appeared to be accelerating as the twenty-first century began.

Figure 1.1 takes on added significance when viewed alongside changes in the health insurance available to the American public. Most of the dollars paid for health care come from health insurance of some kind. As recently as the late 1970s, large numbers of Americans paid nothing out of pocket for their health care. Hardly anyone today enjoys such generosity. Now, both private and public insurers continuously seek ways to reduce insurance coverage for individuals. Not only are health care costs higher today, but Americans are more likely to have to pay them out of pocket.

The cost of health care has raised significant concern on many levels. Employers complain that high employee health care costs have strangled international competitiveness. Recipients of health care feel increasingly uncomfortable about increases in out-of-pocket expenses. Some researchers have reported that health care costs contribute to a majority of personal bankruptcies in the United States.[2] Programs that provide health care to the elderly and poor consumed a percentage of the federal budget far in excess of defense. Because of their responsibility to provide health care to the poor under Medicaid, individual states have experienced severe fiscal stress, forcing some to cut infrastructure maintenance and education to meet their health care obligations.[3]

FIGURE 1.1 *Growth in the cost of health care in the United States, 1960–2005*



Source: National Center for Health Statistics. 2009. *Health, United States, 2008.* Table 123. Hyattsville, MD: National Center for Health Statistics.

Often, the text to follow uses the term *consumer* in preference to *patient*, the traditional designation of a seeker or user of health services. The term **consumer** recognize the health care user as someone capable of making free choices and exercising economic power. Traditionally, the term **patient** has signified a suffering, dependent individual.

The economic downturns of the early twenty-first century sharpened the issue of health care costs for many individual Americans. At that time, a majority of Americans received health insurance through their employers or those of their parents or spouses. But by 2009 it was estimated that 3.7 million working-age Americans had lost their health care coverage as a result of unemployment.[4] Millions more, though still employed, worried that they might lose their health insurance if the economy continued to slide.

Despite the resources allocated to health care in the United States, observers have expressed doubts regarding the value Americans get in return. Although the United States ranks highest in the world in per capita expenditures, it has an infant mortality rate higher than most other wealthy industrialized countries. Singapore, the top-ranked country in preventing infant mortality, recorded two infant deaths per 1,000 live births in 2004; the United States recorded 6.8.[5] In 2003, the United States ranked sixteenth in life expectancy worldwide.[6]

Concern over the quality of services received by the public is growing. A great deal of attention has focused on patient safety. A highly influential 1999 report by the Institute of Medicine estimated that between 44,000 and 98,000 Americans die each

year due to preventable medical error. According to the report, more people die from such error than from motor vehicle accidents, breast cancer, or AIDS. The authors estimated total national costs (lost income, lost household production, disability, and health care costs) of preventable adverse events (medical errors resulting in injury) to be between $17 billion and $29 billion. The expense of additional health care required by the victims of medical error accounted for over half the total. In the opinion of the report's authors, health care is a decade or more behind other high-risk industries (such as aviation) in its attention to ensuring basic safety. Medication errors alone are estimated to account for over seven thousand deaths annually.[7]

The quality debate has also addressed the basic efficacy of medical procedures.[8] Strong scientific substantiation is lacking for many interventions widely used in medicine today. Consequently, patients do not always receive the most effective treatments available and may receive treatments that are ineffective or whose adverse side effects outweigh beneficial ones. Awareness of this problem has led to a movement called *evidence-based medicine,* whose goal is to develop standards of care validated through both new research and synthesis of existing studies.

Great variability has been reported in both the cost and content of medical care across geographical areas, suggesting the absence of accepted standards of care. As recently as the late 1990s researchers reported that appropriate application of scientific evidence in practice occurred only 54 percent of the time.[9] According to one observer, "most clinicians' practices do not reflect the principles of evidence-based medicine but rather . . . tradition, their most recent experience, what they learned years ago in medical school or what they have heard from their friends."[10]

Recently, health care in the United States has come under increasing criticism owing to issues of social justice. The health care system serves the nation unevenly. Inequality prevails among racial groups and economic strata in use of health services, health status, and life expectancy. People who earn high incomes, have advanced education, and are nonminorities tend to use more services, have better health status, and live longer than their less advantaged counterparts.

Table 1.1 provides an illustration of this disparity. Male African Americans have a higher mortality rate than men of any race. Women in all racial groups have lower death rates than men. But within both gender categories, people who have not graduated from high school (less than twelve years of education) have death rates roughly three times that of people with one or more years of college (thirteen or more years of education).

The differences in death rates apparent in Table 1.1 are mirrored by other indicators of well-being (or lack thereof). Similar disparities are apparent in infant mortality, likelihood of death in diseases such as cancer, and disability due to illness. Although researchers and social critics have increased their attention to these facts, public programs in the United States have long made major commitments to care for the disadvantaged. The disparities evident in Table 1.1 suggest that the billions of government and private dollars allocated to care for the poor have not yet produced the desired results.

TABLE 1.1 Age-adjusted deaths per 100,000 U.S. residents, by gender, race, and education

	Gender		
	Male	Female	Both
All	994.3	706.2	832.7
Race			
African American	1,319.1	885.6	1,065.9
Caucasian[a]	984.0	702.1	826.1
Asian	562.7	392.7	465.7
Latino or Hispanic	748.1	515.8	621.2
Native American	797.0	592.1	685.0
Years of education			
Less than 12	826.8	496.8	669.9
12	650.9	349.4	490.9
13 or more	252.5	171.0	211.7

[a]Excluding Latino or Hispanic.

Source: National Center for Health Statistics. 2006. *Health, United States, 2005*. Tables 29, 34, and 35. Hyattsville, MD: National Center for Health Statistics.

The issues raised here merit the serious concern of Americans. The paradox of abundant resources alongside unmet needs in the United States is striking. Basic problems in health care do not result simply from conditions that prevail in the United States. Many challenges and dilemmas regarding the objectives and delivery of health care are universal and timeless. Although many of these challenges may never be resolved, effective management and policy can do much to ensure greater benefit from health care for individuals and society as a whole.

HEALTH CARE OBJECTIVES AND GOALS

An understanding of health care requires examination of both objectives and goals. **Objectives** are short-term, measurable, and often individual in scope. **Goals** represent broad aspirations for the future, reflecting the well-being of an entire nation or society. Recognizable goals are necessary for assessing performance of any system as a whole.

Most objectives sought by consumers of health care are obvious. These include prevention of illness, relief of symptoms, restoration of function, and extension of life. Beyond these basics, though, people today seek a wide variety of health care objectives that are relatively new. Many who are biologically normal, for example, desire to improve how they look, feel, and relate to others, and look to health care for solutions. The popularity of cosmetic surgery and lifestyle-enhancing medication illustrates this development.

Objectives proposed for health care include some that are far beyond the traditional concerns of doctors and healers. Physicians today are legally required to report evidence of child, spouse, or elder abuse. Doctors crusade against youth violence in the name of protecting individuals' health. On a global scale, physician organizations have taken stands to reduce the threat of nuclear war, characterizing such action as "the ultimate form of preventive medicine."[11]

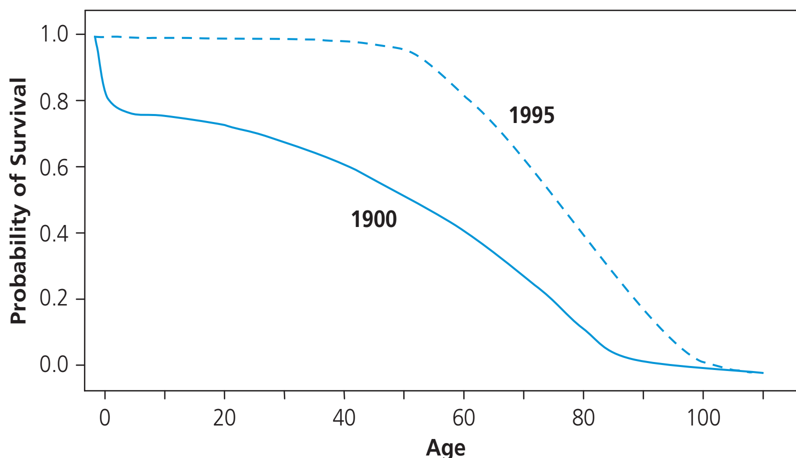
Goals of health care depend on fulfillment of a multitude of objectives, but go beyond any of those specified above. A goal of extreme breadth is implicit in the conception of health adopted by the World Health Organization (WHO), a unit of the United Nations. According to this conception, health is characterized as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."[12] Although this conception was formulated in 1947, it is still widely cited today.

An equally ambitious, though more concrete, goal of health care is the *rectangularization of survival.*[13] This concept refers to concentration of deaths in a population within a particular age range, presumably one approaching the natural limitation of the human lifespan. Under such a scenario, nearly everyone might live to a particular age (perhaps eighty, ninety, or one hundred years) and die rapidly thereafter.

Figure 1.2 illustrates a trend toward rectangularization of survival among U.S. women between 1900 and 1995. This graph indicates a decreasing probability of survival with every passing year in 1900, but a steady rate of survival until about age sixty in 1995. Thus, the 1995 survival curve begins to look like a rectangle. Were the trend to continue over the following century, the 2100 curve, it might be speculated, would fall off even more sharply at some natural limit. In a variation on the rectangularization concept, the goal of a health care system might be maintenance of a "wellness span," to a point where nearly everyone remained fully functional until a particular and very old age.

Both the WHO-inspired goal for health care and the rectangularization of survival present practical difficulties. Neither lends itself to straightforward measurement of progress. Documentation of "complete physical, mental, and social well-being" would require assessment of numerous features of the lives of a multitude of individuals. Though more readily expressed as numbers, rectangularization of survival is no less

FIGURE 1.2 *Survival curves by age for U.S. women in 1900 and 1995*



Source: Wilmoth JR, Horiuchi S. Rectangularization revisited: variability of age at death within human populations. *Demography*. 1999;36(4):475–495. Table 1.c.

definitively measured. Scientists do not agree that there is a natural limit to human life. According to some, there is little evidence that achievable human life expectancy, having increased steadily over the past century, is reaching a limit.[14]

Though important for assessing progress, widely acceptable goals are difficult to both formulate and measure. In addition, pursuit of individual objectives may undermine achievement of overarching goals. Effective treatment of chronic, heritable diseases—diabetes and certain kidney ailments, for example—increases the presence of people with such conditions in today's population and in generations to come. Antibiotics may provide prompt relief of pain from minor infections, but limit the remedies available to the seriously injured due to development of antibiotic-resistant pathogens. The goal of health care cost containment is widely endorsed in the United States. But denial of potentially useful services for reasons of cost is strongly resisted by those whose individual service needs are affected.

ESSENTIAL CHALLENGES IN HEALTH CARE

As suggested earlier, health care involves features that create challenges and dilemmas wherever it is practiced. Health care directly involves the client's body; she cannot walk away from the health care provider as readily as from a provider of other goods and services. Health care addresses the most profound of human experiences, including pain, suffering, life, and death. Across national boundaries and through the ages, healers have held special but not entirely honored status in society. As consumers, the sick seldom seem entirely satisfied. On several dimensions, tension and dissatisfaction may be universal.

Negative Demand

It is safe to say that few, if any, individuals *desire* health care in the normal sense. Except possibly for hypochondriacs, no one *wants* to see a physician or be admitted to a hospital. Even when people get sick, most would prefer to treat themselves or hope the illness would resolve on its own. People seek care—however negatively they may view it—when they feel they have no choice. In this respect, obtaining health care resembles the purchase of a casket for a deceased loved one or coughing up tuition for the feared finance or accounting course required for a management degree.

In consequence, consumers are often predisposed to viewing their encounters with health care providers and organizations negatively. The wait time at a doctor's office is experienced as more onerous than a similar delay for a table at a fine restaurant. Reasonable fees may be viewed as exorbitant. Paradoxically, some consumers seem to enjoy complaining about their health care. These individuals thus obtain some emotionally positive returns from what they perceive as a negative encounter with the system.

Uncertain Costs

Traditionally, charges to consumers are more variable in health care than they are in other areas of trade. For centuries physicians have accepted payment on a sliding scale dependent on the consumer's resources. In nineteenth-century literature, the husband of Madame Bovary, a physician, receives payment in gold from a wealthy patient, but forgets to collect the meager debts owed him by the common people. In the mid-twentieth century, physicians in the United States expected that a goodly proportion of their bills would never be paid. Traditionally, hospital administrators have referred to their receivables as *spongy*—never fully solid in terms of eventual collectability. Well into the late twentieth century, health care managers practiced various forms of *cost shifting,* in which higher charges to well-insured patients were used to subsidize lower receipts from the poorly insured, uninsured, and indigent.

It is no accident, then, that payment for health care is viewed by the public as less obligatory than payment for nonhealth goods and services. Many consumers feel a sense of entitlement to health care. A bill is seldom paid entirely out of pocket. Few patients ask a doctor how much a procedure will cost or shop for the lowest-priced practitioner. An unpaid medical bill represents less liability to the consumer than a neglected car payment—repossession of items such as pacemakers and prostheses takes place rarely if at all.

Unpredictable Outcomes

An essential unpredictability prevails in much of health care. Many standard interventions, preventive or curative, are available for a wide range of frequently encountered diseases. But the human organism is variable, and many factors—both internal and external to the individual—contribute to resistance versus expression of disease. In some cases, diagnosis is complex and inconclusive, adding to uncertainty of cure. In instances where diagnosis is evasive, physicians may treat a suspected disease in hopes that diagnosis and treatment will be accomplished in the same step.

Uncertainty of success accompanies many treatments for cancer and other chronic diseases. Standard chemotherapy and radiation protocols cure some patients and not others. Trials of new interventions are, from the patient perspective, instances of chance taking. A physician can honestly tell his patient that there are no guarantees.

Whether associated with mild or life-threatening illness, uncertainty differentiates health care from other goods and services. On the patient level, uncertainty may raise issues of trust in the provider's capability. Uncertainty may be humbling for the provider. But acknowledgment of uncertainty underscores an essential element of clinical practice. No two cases are identical. Good medicine cannot be practiced cookbook-fashion.

An Evasive Diagnosis

Baffling even the most experienced physicians at a university medical center, the case of a nine-year-old girl illustrates the evasiveness of clinical success. For six months, the patient had been chronically nauseated, vomiting, unable to eat, and losing weight. Extensive blood work and imaging failed to detect intestinal obstruction, lactose intolerance, and the autoimmune syndrome Crohn's disease. Thinking they had ruled out gastroenterological causes, doctors considered the possibility of a brain tumor and ordered an MRI.

The evening before the scheduled MRI, a family practice intern examined the girl. He examined the girl's hands—eating disorders are often revealed by calluses caused by chronic self-induced vomiting—and, finding no calluses, ruled out an eating disorder. Although there were no calluses, the intern noticed a darkening of the skin. Darkened skin can be a clue for Addison's disease, an adrenal gland disorder. Measures were taken of sodium, potassium, glucose, and cortisol, which, abnormally low, confirmed Addison's disease as the correct diagnosis.

Low levels of sodium, potassium, and glucose had been detected earlier. But other features of the girl's illness seemed to explain the low concentration of these blood chemicals, and the possibility of Addison's disease was not pursued. A simple observation of darkened skin led a physician still in training to make a diagnosis that had stumped others for months. Within hours of starting treatment for Addison's disease, the patient began to recover.[15]

Emotional Involvement

Health care is often given and received in an atmosphere inflamed by human emotion. Anxiety and fear follow hard upon injury, illness, and the possibility of death. Medical uncertainty—along with the ever-present possibility of failure—fosters disappointment, frustration, and anger at health professionals and institutions. The role of patient

is the most powerless that many people ever experience. A story is told by a distinguished obstetrician about President John F. Kennedy watching as doctors struggled to successfully deliver his son. Even the most powerful man in the world could do nothing but watch in this situation.

In few, if any, societies, then, do people live in complete comfort alongside those who treat their illnesses. The uncertainty of success, unpredictability of cost, aloofness of providers, and emotional overlay—along with the fact that few, if any, individuals desire to be patients—inevitably promote fault finding. An essential discomfort with medicine throughout the ages is evident in mythology and literature as early as ancient Greece. Century after century, storytellers and commentators have connected health care with excessive expense, inexcusable error, calculated self-interest, and potential injury.[16]

Aloof Providers

In contrast to the emotional involvement of patients is a seeming aloofness of medical professionals. Many patients perceive emotional detachment on the part of their providers, particularly physicians. Researchers report that low-income and minority patients are most likely to sense absence of a caring attitude on the part of their providers.[17] A vast gulf in income, education, and privilege is evident between physicians and most patients.

Some aloofness, however, may be necessary for clinical practice. Even a practitioner who is skilled at communicating and emotionally secure requires a degree of detachment from the challenges facing her patients. According to one physician, factors conducive to detachment include fear of adverse outcomes and consequent criticism, and "an instinct to separate oneself from another's suffering."[18] Training and mutual support within a closed community of peers helps the practitioner accommodate the emotional challenges encountered in practice.

Health professionals of all types receive privileges and responsibilities allocated to few others. Practitioners are allowed to see patients naked, ask personal questions, pierce flesh with needles, and insert hands into bodies through surgical openings. The symbolism and ritual of medicine, still represented today by the snakes and staff of the caduceus, help maintain the provider's paradoxical combination of presence and absence.

Challenges on the Front Lines

Like consumers, people in the health care industry experience confusion, frustration, anger, and feelings of powerlessness. Those at the front lines most directly experience the impact of increasing demands, limitations on resources, and challenges raised by advances in biomedical science. Following are some examples:

> Reacting to a reduction of compensation under the federal Medicare program, a Brooklyn physician commented, "My expenses go up and up and up every year. For the government to lower what it pays me when my expenses are rising—that doesn't make sense. It's an insult."
>
> Also commenting on Medicare compensation changes, a doctor in Texas asserted, "I have a hard-and-fast rule. I don't take any new Medicare patients. In fact, I don't take any new patients over the age of sixty because they will be on Medicare in the next five years."[19]

Rationing, or withholding potentially useful services because of resource constraints, is a reality today. Clinicians and managers at the University of Texas Medical Branch (UTMB) must choose which indigent patients may receive potentially lifesaving care for cancer. UTMB uses a detailed playbook to help determine who gets treated and who doesn't.[20] Following are more examples in a similar vein:

> Despite a federal law prohibiting patient dumping, a Chattanooga hospital dispatcher told an ambulance crew not to bring in an unconscious man found in a poor neighborhood to the hospital because, he said, the administrator "would kill us if we took another indigent."[21]
>
> A change in federal policy regarding lung transplantation brought grievous reactions from patients moved from high to low priority. "We tried our best to educate and communicate, but many felt they had been cheated," recalls the director of a university transplantation program.[22]

PUBLIC TRUST AND PROFESSIONAL ETHICS

As suggested earlier in this chapter, health care everywhere involves elements of detachment and mystique. Consistent with the uncertainty of diagnosis and cure is an essential independence of health care providers, particularly physicians. This independence is justifiable on technical grounds. Because of the uniqueness of each case, only a large fund of knowledge and experience enables the provider to recognize the range of possibilities that may be involved. The variability in the ways that human illnesses manifest themselves and respond to treatment precludes development of formulas—or so physicians have long argued.

Still, good health care requires partnership between providers and the public. Trust constitutes a key element of this partnership—and trust depends on a widespread belief that principles of honest public service prevail in health care. Patients must feel confident in the trustworthiness of their providers to seek care, reveal sensitive information, submit to treatment, or participate in research.[23] Trust is also crucial for the operation of health care at a societywide level. Citizens will support expenditures for

programs such as research and indigent care only if they believe that human beings will benefit and funds will be used appropriately.

Means of ensuring trustworthiness in the health care industry include government oversight and professional ethics. From the point of view of many in the industry, codes of ethics established by peers are a preferred means. **Ethics** may be thought of as obligations of an individual to act toward others in a manner consistent with socially reinforced values. Widely accepted principles of health care ethics include duties to help all patients in need, maintain the confidentiality of any information obtained, obtain informed consent for procedures used, avoid conflicts of interest, and apply medical skills and technology only in a competent and appropriate manner.[24]

As with other matters addressed in this chapter, resolution of issues in health care ethics is often not straightforward. Deliberately or consciously unethical behavior is rare in health care. But clinicians and managers often encounter issues that cannot be resolved via formula and whose resolution, whatever it may be, is subject to criticism. Refusal of care, examples of which were cited earlier (see box titled Challenges on the Front Lines), may be seen as unethical; however, such refusal may be necessary to preserve the operation of a health care unit. The principle of confidentiality would seem inviolate. But the need to protect the public from harm via disclosure of hazards represented by a patient's positive HIV status or homicidal intent may contradict the confidentiality mandate.

The lack of certainty in medicine itself creates ethical challenges, as the following example illustrates:

> A physician believes a course of chemotherapy using a newly licensed agent may benefit a desperately ill cancer patient. Other doctors of equal competence may consider such treatment to be of marginal value to patients with this malignancy and presumably so close to death. The physician orders the chemotherapy; the patient experiences discomfort due to the treatment and dies soon thereafter. The doctor submits a bill and receives payment.

Multiple ethical issues may be seen in this episode. Treatment with the new chemotherapeutic agent might be viewed as misapplication of medicine because it caused discomfort and ultimately failed to extend life. Some might charge that the physician's ordering of a newly developed treatment was inappropriate. The indications for newly licensed pharmaceuticals are often revised as experience is accumulated. Yet the patient and her family may have requested aggressive intervention. Since the physician will ultimately receive payment, conflict of interest may be suspected. Multiple motivations and trade-offs are made in situations such as the one described here. As in other domains of life, it may be impossible to determine whether or not an ethical transgression has occurred.

THREE PERSPECTIVES ON MANAGEMENT AND POLICY

The issues raised in this chapter are likely to appear wherever health care is practiced. Some will likely remain important in the United States, even if the mechanisms of financing and delivery fundamentally change. Practitioners involved in the delivery of health services will continue to deal with intractable dilemmas and irresolvable public debates. Within these limits, the United States can achieve maximum benefit from its investment in health care through effective management and policy. Both high-quality management and policy require a broad and accurate understanding of health care as an industry and its relationship to the society it serves. Three perspectives are presented next as tools for achieving such understanding.

A Systems Approach

A systems approach views the situation of an individual—whether a consumer, a manager, or a policy maker—in terms of his connection to the multiple and interrelated components involved in health services delivery today. Health care delivered to a single individual is the joint product of numerous individuals, organizations, and institutions. Administration of a single dose of medication, for example, is made possible only by the participation of numerous entities and individuals: the medical school at which the basic science needed to produce the drug was developed, the private foundation or government agency that funded the medical school's research, the pharmaceutical firm that produces the drug, the physician who prescribes the medication, and the technician who administers the dose.

The systems approach involves realities outside the medical field itself. Consumers must be motivated to spend money on health care. A favorable political and economic environment is required for health-related goods and services to be provided. Congressional action (often spurred by interest groups and lobbyists) may be needed to fund research agencies. Capital markets have to be sufficiently generous to enable the pharmaceutical firm to develop and test a drug. A climate of public opinion sympathetic to science is needed to permit research to take place involving human beings, animals, or cell lines of human origin. For the patient to ultimately thrive, a safe and healthful physical and social environment is essential.

The importance of a systems approach for understanding health care issues increased in the last decades of the twentieth century. In earlier generations, participants in the health care system could work in substantial isolation. Today, however, a physician ordering blood must take the blood bank's costs and safety assurances into consideration. A nursing supervisor must understand telemetry and the structuring of liability insurance. A hospital administrator must understand capital markets.

According to some observers, the United States does not have an actual health care *system.* These observers have argued that many parts of the system work at cross-purposes. Hospitals and insurance companies, for example, are viewed as adversaries, at best communicating inefficiently with each other. Acknowledging the absence of

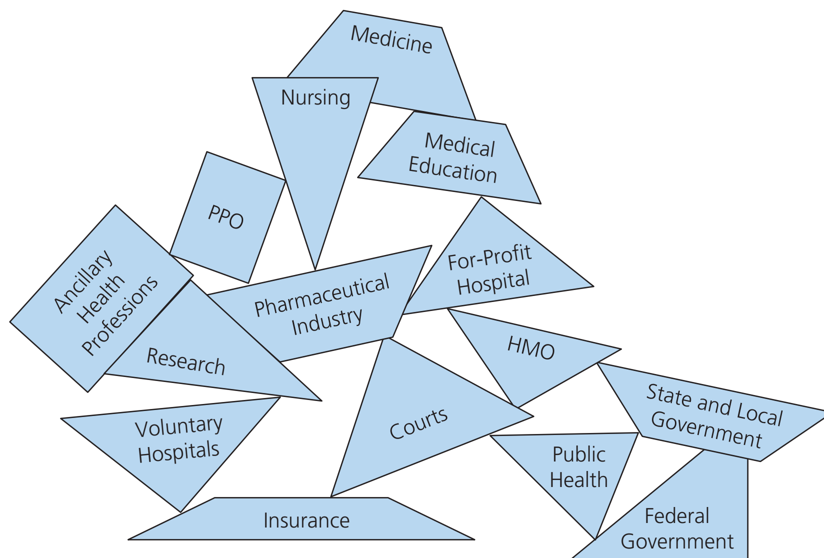
a tightly run system, this text interchangeably uses the terms *health care system* and *health care industry.*

However, it makes sense to think of health care in the United States as a *poorly integrated system.* Patients do move from community physicians to specialists, though often with delay. Physicians do receive insurance payments, although hassles may occur along the way. Newly trained health professionals do receive an education that enables them to help patients, although the relevance of some of their educational requirements may be difficult to establish. Figure 1.3 illustrates an array of organizations, institutions, and individuals whose actions ultimately produce what is needed in health care, but connection, communication, and coordination among the units are far from perfect.

Critical Thinking

Critical thinking reflects the perspective under which people question assertions made by others—peers, "experts," or administrative and political superiors. A perspective of this kind is particularly important in health care for a number of reasons. As closely as health care is tied to emotional and economic interests, ill-conceived and self-interested recommendations are likely to abound. A consultant with a new system for managing information in a hospital gains financially from adoption of that plan, just as does a physician advocating for a procedure in which she excels or a pharmaceutical

FIGURE 1.3 *U.S. health care (greatly simplified): an imperfectly integrated system*



company promoting a new medication. An organization lobbying for increased research funding for a specific disease claims that the entire public is at risk, directly or indirectly, from its consequences.

The history of health policy in the United States illustrates the importance of critical thinking. **Policy** can be thought of as an approach taken by government in response to a public concern. Many vigorously promoted policies and innovations regarding health care have been adopted, only to be found less effective than first hoped or abandoned when the political climate changed. Examples of concepts whose popularity has come and gone (or at least dropped from the policy discussion) include regional health planning and public support for health maintenance organizations. It is important for leaders in health care management and policy not to let themselves get swept up in the passions of the moment.

The Public Interest

A third perspective important for today's health care leadership is that of the public interest. This term refers to the relevance of health care far beyond those directly involved as provider and recipient. Because it affects the quality of the labor force and thus the performance of the overall economy, health itself has implications for society as a whole. The general quality of life in a society is marked by the health of its members. The truth of this statement is easy to grasp by the experience of an individual from a rich country traveling in a poor one. The traveler, for perhaps the first time in his life, is likely to regularly observe people with missing teeth, clouded eyes, club feet, and open lesions.

Health care should be recognized as a *public good.* No individual, profession, or agency can claim "ownership" of health care. Medical education enjoys large public subsidies in the form of tax mitigation for universities and hospitals, as well as direct aid through guaranteed loans to students and grants to faculty. Much biomedical research is supported by government or foundations, which in turn receive direct or indirect support by the public. Service by patients as teaching cases or experimental subjects also constitutes a contribution to the health care enterprise.

Everyone is ultimately a consumer of health care. Thus, everyone has an interest in availability, quality, and affordability of health care. No matter what system a society uses to allocate health care, it more closely resembles publicly recognized necessities such as drinking water and police services than discretionary items such as automobiles, clothing, or ice cream.

KEY TERMS

Objectives
Goals
Consumer
Patient
Ethics
Policy

SUMMARY

This chapter provides a basic framework for understanding health care and taking action toward its improvement.

Health care is an issue of concern for people everywhere, particularly in the United States. U.S. health professionals are arguably the world's best trained, and U.S. health care technology is the world's most advanced. Health care in the United States is also the world's most expensive, said to bankrupt American households and hamper America's economic competitiveness. Health care is difficult to obtain or prohibitively expensive for millions. For many, the health care system seems inaccessible, culturally hostile, and emotionally cold. Many solutions have been proposed and several important ones implemented. However, none has proven sufficient.

This chapter emphasizes several themes to promote a broad-based and accurate understanding of health care. As advanced by statespersons and scientists, the goals of health care reflect large-scale social aspirations. But objectives of actual services focus on individual and immediate needs. Health care requires a balance between independence of providers and their acceptance of social obligations as manifested in public expectations and professional ethics.

This book aims at promoting effective action in developing and operating a health care system that serves Americans well. Three principles are proposed for achieving this goal: (1) seeing individual roles, interactions, and institutions in health care as parts of a broader *system;* (2) taking *a critical approach* to widely shared views among policy makers and the public; and (3) viewing health care as linked inextricably with the *public interest.*

DISCUSSION QUESTIONS

1. Making your best guess, would you say that health care today seems less "mystical" to the average consumer than it did in the Neolithic world? In medieval times? One hundred years ago?
2. How much more predictable are the outcomes of health care likely to become in the future than they are today?
3. African American men have an age-adjusted death rate over four times that of Asian American females. How much of this disparity can be explained by differences in the health care the two groups receive?
4. Should control of costs be adopted as the principal goal of the U.S. health care system at this time? Explain why or why not.
5. How widespread do you believe ethical transgressions in health care are today? In which segment of the industry are they most likely to occur?