Introduction

The End of an Illusion

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In Western society, everyone wants to live "normally" as long as possible. We ask physicians to do whatever they can to prolong life, be it only for months, or days, in the case of terminal illness. The arsenal of medical technology deployed to keep aging political leaders alive is but one example of this tendency. Physicians merely perform their duties and respond to the demands of the majority of people. Though the belief is widely held that health is the most precious thing a person has, most of us are loathe to analyze the collective consequences of this belief.

The most costly diseases are those for which there are presently no cures and which therefore require multiple diagnostic procedures, symptomatic treatment, and long-term care. Though the biomedical industry naturally invents and markets new machines and new drugs to improve diagnosis and treatment of these diseases, diagnostic and therapeutic procedures have only marginal effects on mortality rates. Nevertheless, hospitals have been built, new machines are purchased, and personnel continue to be trained and hired. All of this accelerates the rate of health care expenditures.

Such growth was easily tolerated when total health expenditures were well under ten percent of gross national product and when national economic growth proceeded at a rate of roughly five percent. Today, however, health care costs in many countries are increasing more rapidly than GNP, thus claiming an increasing share of the national product. As a result, new questions are being raised. Will it be possible to continue to remunerate the growing number

of physicians at the levels to which they have become accustomed over the past two decades? Can health policies continue to encourage diffusion of new medical technologies? Will it be possible to support the biomedical industry and at the same time contain the growth of health care costs and achieve more equitable access to medical care?

The answer, we think, is that what was once believed possible may no longer be. The notion that the welfare state can provide an abundance of health services for all of its citizens is an illusion. In the future, social policy is likely to veer from idealism to realism, from opportunity to constraint. Difficult choices must be made. Our objective in this book is to identify the issues and themes around which debates about health policy will focus in the 1980s and beyond.

One has only to open a newspaper day after day to see that health and health policy revolve around questions of life and death, problems of suffering, and the ways Western societies have responded to these issues: through science, technology, bureaucratic organizations, professionalization, social security, health insurance, biomedical industries, and management. Rarely do we discuss suffering except where these responses are inadequate, as with the elderly and the physically or mentally handicapped. More typically, discussions of health policy focus on economic issues. Representatives of industry or of a ministry of finance argue that health care is too expensive, while physicians argue that government regulation of costs jeopardizes quality of care. Sometimes the discussion is political: some claim that a free enterprise system is more efficacious and more equitable than a nationalized system, while others argue the reverse. Sometimes the debate is technological: some claim that esoteric new technologies drive up the costs of health care even before there is solid evidence of their effectiveness. Others argue that new technology is essential for the practice of effective medicine.

This book contains three parts. Part 1 examines the recent

past: the expanding role of the state in the health sector of Western industrialized nations. In health systems of the 1980s the state defines the rules of the game and is also the principal actor. The state finances—directly or indirectly—a large part of the cost of health care. It also shapes policy in several critical domains: medical manpower and biomedical research, the purchase of equipment, the development of innovations, and the construction and modernization of hospitals. Curiously, it plays this public role while preserving, by and large, the notion that the practice of medicine is a very private affair—that the only obligation of the physician is to his patient. The state supplies funds, the ill demand care, and physicians command resources.

This highly individualistic conception of medicine is unlikely to survive during the present period of economic retrenchment. Retrenchment will force alternative conceptions of medicine. It is likely that, at first, as cost savings are sought, they will be found in the slack that has accumulated during the period of growth. Cost savings of this sort are not unlimited, however. When the fat has been cut away, it will be clear that the best way to save is not to spend.

Not to spend may involve questions of life and death. For example, should a child with a rare blood disease who requires transfusions costing in the neighborhood of \$2,200 weekly be kept alive? Should pacemakers be made widely available to the elderly? Should renal dialysis be available to everyone who needs it? To raise these questions in a time of abundant resources would be—and has been—considered sacrilegious. Until social values have caught up with economic realities, it is likely that the medical profession can use deeply held beliefs about the value of life to great advantage; and as long as public opinion reflects a belief in the possibility of unlimited economic growth and infinite progress, these questions will provoke resistance of the most intense sort.

As the illusion of abundance wanes, however, the functioning of health systems, as well as the role of technology

and the power of the health professions, will come under increasing scrutiny. The state is likely to extend its power. It will no longer merely finance and regulate the provision of goods and services in the health system; rather, it will be an arbiter in a debate about what is good, equitable, and right in the business of life and death. This debate will go beyond the domain of medicine, for well-being is not simply a byproduct of our health systems. Moreover, the debate will produce different results in different countries, as a consequence of historical, cultural, and institutional differences.

Part 2 of this book (chapters 2–5) elaborates on a number of these themes. Chapter 2 considers contrasting perspectives—radical, conservative and liberal—on the proper role of the state in society and explores their implications for health policy. The liberal perspective has dominated health policy in the West since World War II, but the conservative perspective now appears to be gaining ground. History has taught us to be modest, however, where prediction is concerned. We are therefore more inclined to indicate probable tendencies than to make predictions.

Chapter 3 discusses the state in relation to prevention policies. It begins with a historical analysis of disease prevention programs and the rise of clinical medicine and raises some of the key issues that have fueled health policy debates for years: Should disease prevention programs intervene largely at the individual level, or is there a case for collective action? Must they compete with curative medicine or are there new areas for growth (for example, in health education)? And, how can renewed interest in disease prevention avoid encouraging either victim-blaming, directed at individuals who fail to take responsibility for their health, or authoritarian state intervention to avert all potential risk factors? In resolving these issues it is helpful to distinguish between risk-taking and risk-imposing behavior and between strategies of health promotion versus health protection.

Chapter 4 analyzes the evolution of medical technology and its social impact. The precise nature of the medications,

drugs, and equipment that will exist in the future is impossible to predict. What seems probable, however, is that research and development will be worldwide, and no one country will be able to control the development of new technology. A moratorium on technological development is therefore unlikely. Instead, each country will have to control access, which will raise a host of very difficult ethical issues.

Chapter 5 raises the specter of health care rationing as a mechanism for controlling access to health care and examines the ethical implications. There are already changes in doctrines relating to professional ethics and “the right to health.” The concept of clinical freedom is unlikely to survive in an age of medical austerity. Physicians are increasingly aware that they must work in teams, accountable not only to their professional values and to individual patients but to a new public morality and new social and economic constraints. One common response to pressures for health care rationing is to advocate medical decision making based on a comparison of outcomes. One example is a utilitarian calculus that two years of additional life for an elderly person is less valuable than a longer period for a younger person. But such criteria for allocation of scarce medical resources are seriously deficient. This chapter explains why and proposes alternatives.

How will Western industrialized nations devise health policies in the future? Part 3 examines the recent past and probable future in three nations—France, Britain, and the United States—and in the Canadian province of Québec. Although each case is different, together they provide some indications of how current problems in the health sector may eventually be resolved. In a sense, these case studies are the heart of the book, because they demonstrate, singly and collectively, the range of alternatives before us.

Part 4, like Part 1, consists of a single chapter. We identify the common themes and variations in the case studies and speculate about emerging trends and the future of health policy.

Western societies are seriously questioning current assumptions about health, medicine, and individual and collective well-being. Our hope is that this book may help to explore the pathways that lie ahead and to avoid the quixotic jousting that tends to permeate the field of health policy.