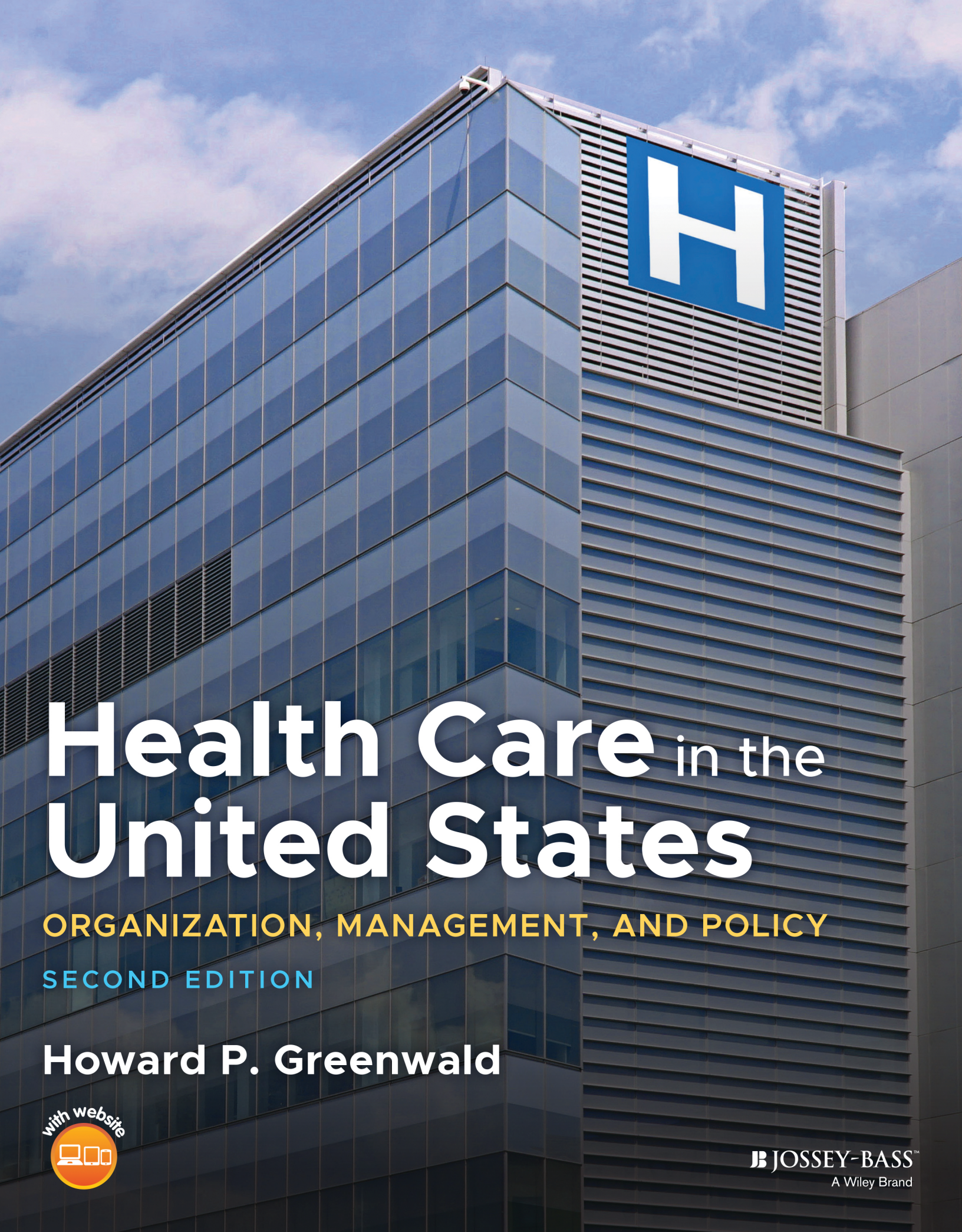
Health Care in the United States
ORGANIZATION, MANAGEMENT, AND POLICY
SECOND EDITION
Howard P. Greenwald
with website
JOSSEY-BASS
A Wiley Brand

Health Care in the United States

Health Care in the United States

ORGANIZATION, MANAGEMENT, AND POLICY

Second Edition

Howard P. Greenwald

JOSSEY-BASS™
A Wiley Brand

This edition first published 2022

Edition History
John Wiley & Sons, Inc. (1e, 2010)

Registered Office
John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, USA

Editorial Office
111 River Street, Hoboken, NJ 07030, USA

For details of our global editorial offices, customer services, and more information about Wiley products, visit us at www.wiley.com.

Wiley also publishes its books in a variety of electronic formats and by print-on-demand. Some content that appears in standard print versions of this book may not be available in other formats.

Library of Congress Cataloging-in-Publication Data

Names: Greenwald, Howard P., author.
Title: Health care in the United States : organization, management, and policy / Howard Peter Greenwald.
Description: Second edition. | Hoboken, NJ : John Wiley & Sons, [2022] | Includes bibliographical references and index.
Identifiers: LCCN 2021041609 (print) | LCCN 2021041610 (ebook) | ISBN 9781119812210 (paperback) | ISBN 9781119812579 (pdf) | ISBN 9781119812227 (epub) | ISBN 9781119812234 (ebook)
Subjects: LCSH: Medical policy--United States. | Medical economics--United States. | Medical care--United States.
Classification: LCC RA395.A3 G74 2022 (print) | LCC RA395.A3 (ebook) | DDC 362.10973--dc23
LC record available at https://lccn.loc.gov/2021041609
LC ebook record available at https://lccn.loc.gov/2021041610

Cover image: © Spiroview Inc/Shutterstock
Cover design by Wiley

Set in 10/12 and STIX Two Text by Integra Software Services Pvt. Ltd, Pondicherry, India

10 9 8 7 6 5 4 3 2 1

To the great doctors in my life,
Romalee A. Davis, MD, and Phoebe L. Greenwald, MD

CONTENTS

Part 3 Paths Forward

Tables

Figures

PREFACE TO THE SECOND EDITION

The chapters to follow have been written as a textbook in health care management and policy. The book may serve as an introduction to problems and issues in U.S. health care for people entering related professional fields. It is also intended for use by people already experienced in a specialized area of management, policy, or patient care for attaining perspective on the system as a whole.

Every day, millions of Americans encounter challenges in locating and paying for services and obtaining care of the highest quality for themselves or their loved ones. Many are led to wonder how health care operates "behind the scenes," why an essential service should involve such difficulties, and what steps might be taken toward the system's improvement. This book is intended primarily for students. But it is also a factual resource for citizens, clinicians, and officials seeking to better understand and improve health care in the United States.

For no reader will the material presented here be entirely new. Without exception, everyone reading these pages will have experienced health care as a consumer. It is hoped that this book will help readers of any background see their experience as part of a large, complex, and ever-changing system. An improved view of where the reader's experience fits within this firmament will enable her or him to better render direct service, manage human and material resources, influence policy, and utilize health care for his or her own needs.

The second edition of *Health Care in the United States: Organization, Management, and Policy* places long-recognized issues in the context of the twenty-first century's first decades. The COVID-19 pandemic ranks as a historic challenge; yet much has been learned from this episode for future encounters with emergent health threats. The Affordable Care Act (ACA), widely controversial after its enactment, has shown clear signs of achieving its objectives and attaining public acceptance. Heightened public attention to diversity, equity, and inclusion (DEI) promises commitment to new policies and interventions to reduce health and survival disparities among Americans.

Although pundits and policymakers have predicted revolutionary change, many basic features of health care in the United States have remained remarkably stable in the 2000s. Innovations hailed as system-changing—prospective payment, managed care, the ACA itself—have had limited overall impact. The U.S. health care system has long been and remains predominantly private, decentralized, and employer-financed. For this reason, the challenges addressed in the chapters to follow appear likely to remain well into the future. It is important to understand that challenges visible in the U.S. health care system are not unique to this country. Throughout the world, health care is highly personal in nature, depended on for survival by many, widely viewed as a "right," and steadily increasing in cost. These basic features of health care ensure continuing controversy perhaps everywhere over access to care, quality of services, responsibility for payment, and reliability of outcomes.

Many countries share health care challenges with the United States. The wealthy democracies of Western Europe, which all have national health plans of some kind, for example, experience socioeconomic disparities in health and life expectancy akin to those observed in the United States. Sweden, a country as strongly committed to the welfare state as any on the globe, still reports overcrowding and delays in its hospital emergency facilities and widespread dissatisfaction with health care. The health care system in Canada, to which Americans have looked for generations as a model for the United

States, today faces severe challenges due to increasing costs and uncertainties about how delivery of care should be organized.

This book is intended to help readers see their own specialized area of the health care system in the perspective of the whole. It covers a broad spectrum of health care–related subject matter, including such diverse areas as epidemiology, health behavior, the health care labor force, hospitals and ambulatory care organizations, and health care finance. The chapters to follow may not necessarily provide information that is new to specialists in the relevant area. But even for experts in a particular dimension of health care, the book will contribute to a comprehensive understanding of the system and its issues.

Within practical limits, this book attempts to be definitive and comprehensive—and to be definitive in this case requires a highly factual approach to each area addressed. Many unsupported assertions characterize management thinking and policy debate. The field of health services research, however, has produced a tremendous volume of relevant, high-quality studies. This book makes extensive use of such research.

The text attempts to adequately address the essential tasks of the health care system, the features of each system component, and issues relevant to the future. Truly comprehensive treatment of the U.S. health care system, however, would require many more pages than those in this volume. The more closely one examines any dimension of health care, the more complex and multifaceted it reveals itself to be.

Rather than attempting to be exhaustive, the book concentrates on matters with the broadest implications for the delivery of health services. Consistent with this approach, hospitals receive more attention than long-term care organizations or public health departments. The social and economic issues arising in long-term care are by no means unimportant. But services delivered in hospitals predominate as drivers of health care costs. Similarly, the labor supply and contributions of physicians and nurses receive more attention than other health professionals. None would dispute the importance of persons outside these fields. Physicians, however, exercise more control over the delivery process, and their decisions crucially affect health care utilization and costs. Nurses comprise the largest single component of the health care labor force and provide the most visible and immediate care in many places. In addition, adequate supply of these professionals has at times been highly problematical.

This book is divided into three parts. Part One, "The System and Its Tasks," provides an overview of the U.S. health care system's components and challenges. Chapter 1 addresses the characteristics and dilemmas of health care as experienced by human beings everywhere and across historical eras. The chapter points out that although health care in the United States may be poorly integrated and decentralized, it is indeed a system, each of whose components is interdependent with several others. Chapter 2 identifies characteristics of the U.S. health care system that distinguish it from those of other countries, explains why these features exist, and raises questions about the type and degree of change acceptable to U.S. citizens. Chapter 3 presents a brief summary of the field of epidemiology and the health issues that lead Americans to utilize health services. Chapter 4 identifies patterns of human behavior, including individual acceptance of risks to health, that help determine both need for and utilization of health care.

Part Two, "Means of Delivery," addresses actual operations of the system. Chapter 5 highlights the importance of formal organizations—such as ambulatory care practices, hospitals, and managed care firms—as the system's actual operating components. Chapter 6 addresses the supply, demand, distribution, and management of health professionals, placing special emphasis on physicians, nurses, and health care administrators. Chapter 7 covers the ways in which Americans pay for their health care and the implications of insurance for consumer behavior and costs. Chapter 8 treats research as a sector of the health care industry, with special implications for the future of health care. This chapter covers basic questions regarding the validity, usefulness, and potential misuse of research in the health field. It highlights the challenge of making decisions that are crucial for health care efficacy and cost on the basis of research findings.

Part Three, "Paths Forward," examines approaches Americans have taken to improving the system, its output, and the means that will be required to put innovations into effect.

Chapter 9 covers the effects of key innovations in U.S. health care delivery over the past generation and assesses the impact of these measures. Chapter 10 addresses the contributions that prevention can make to the well-being of Americans and the control of health care costs. Chapter 11 concentrates on government and the political process as potential agents of progress or, alternatively, causes of stagnation and backsliding.

Finally, Chapter 12 examines alternative routes that Americans have considered toward an improved health care system. This chapter pays special attention to non-U.S. health care systems as potential models for improvement in the United States. The chapter concludes by highlighting controversies that are likely to continue into the future and identifying reforms that are feasible in view of American public opinion and potential industry opposition.

Each chapter ends with a series of discussion questions. These questions focus not on review of principles or facts appearing in the chapters, but are a means of encouraging the reader to develop her or his own synthesis of the facts and principles. The questions are intended to serve as the basis for personal reflection and group discussion.

To the Student

Everyone using this textbook should consider it one of many resources that can promote an understanding of the U.S. health care system. Students especially should note that any observer of this system, its operations, and its components will inevitably apply his or her individual experience and point of view. For this reason, students should feel encouraged to challenge material they encounter in these pages. Everyone has ample opportunity to find updated facts and competing points of view in the many specialized journals concerning health care available today and from high-quality mass media sources. Most important, students should form their own opinions and outlooks in conversation with peers.

To the Instructor

Several resources will be available to instructors as companions to this textbook. These include PowerPoint slides, lecture outlines, and suggested topics for class discussion. Instructors are encouraged to select among these for materials that best support their own outlook on the health care field and the topics that they believe deserve the greatest emphasis.

No textbook can anticipate the character and impact of major changes at the policy level. This textbook addresses challenges and choices regarding the U.S. health care system likely to remain important far into the future. Unanticipated developments, however, are sure to occur, driven by technology, policy, emerging health challenges, and changing public concerns.

THE AUTHOR

Howard P. Greenwald is professor of management and policy at the University of Southern California Price School of Public Policy. He is a specialist in program evaluation, organizational performance, health services research, and chronic disease epidemiology. He holds a PhD in sociology from the University of California, Berkeley. He has served as a faculty member at the University of Chicago Graduate School of Business, research scientist at Battelle Memorial Institute, chairman of the Network for Healthcare Management, director of the Health Services Administration Program at the University of Southern California, and commissioner on the Accrediting Commission for Education in Health Services Administration. He has received successive awards from Fulbright Canada to study the Canadian health care system. His current research focuses on innovation and change in formal organizations, socioeconomic effects on long-term cancer survival, and evaluation of multisite interventions to improve the quality of life in disadvantaged communities. He has written four books in addition to the first and second editions of *Health Care in the United States: Organization, Management, and Policy*. These include: *Organizations: Management without Control* (Sage, 2008), *Health for All: Making Community Collaboration Work* (Health Administration Press, 2002), with William L. Beery, and *Who Survives Cancer?* (University of California Press, 1992). He is author alone or in collaboration of over fifty peer-reviewed articles in journals such as the *American Journal of Evaluation*, *Journal of Clinical Epidemiology*, *American Journal of Public Health*, *Journal of Women's Health*, and *Milbank Quarterly*. His opinion pieces have appeared in the *New York Times*, the *Wall Street Journal*, and the *Sacramento Bee*.

ACKNOWLEDGMENTS

Many people directly involved in caring for patients or managing health care systems have contributed to both the first and second editions of this book. Notable among these are Romalee A. Davis, MD, Marlene M. Mirassou, MD, Susan J. Dirks, MD, Helaine B. Pleet, MD, Karen Kremer, RN, Rebecca Kang, PhD, RN, and Barbara K. Uenaka, Pharm D. I am indebted to many at the Group Health Cooperative of Puget Sound for providing direct contact with the health care industry. Bill Beery, director of Group Health Cooperative's Center for Community Health and Evaluation, was an outstanding and forthcoming colleague. Through the Health Service Administration Program at the University of Southern California I have enjoyed the privilege of learning from highly knowledgeable students, of whom Dr. Richard Ikeda and Chris Van Gorder are only two among many. I appreciate the time taken by working epidemiologists Drs. Dennis J. Bregman and David Dassy to acquaint me with their field. Dr. Ruth McCorkle of the Yale School of Nursing encouraged my interest and acquainted me with issues regarding chronic disease.

I acknowledge the core faculty of the University of Chicago Center for Health Administration Studies, which, beginning in the mid-1970s, introduced me to the field of health administration and policy. From outstanding figures in this field, including Ronald Andersen, Odin Anderson, Theodore R. Marmor, and Selwyn W. Becker, I was privileged to receive an incredible volume of facts and an understanding of the discipline. Emory B. ("Soap") Dowell, a preeminent member of the Sacramento policy community, deserves my gratitude for many conversations regarding the politics of health care legislation. William Richardson and Doug Conrad alerted me to the importance of health insurance and finance through their writings, lectures, and informal comments. Louis P. Garrison and Suresh Malhotra helped acquaint me with health economics.

Several Canadian universities deserve special thanks for giving me the opportunity to conduct in-depth research on Canada's health care system. I am grateful to the University of British Columbia Center for Health Services and Policy Research (CHSPR) for hosting me as a visiting scholar. I thank the University of Alberta Faculty of Law and the University of Ottawa Centre on Governance for enabling me to join them as the holder of successive Fulbright Canada Research Chairs in Governance and Public Administration. I gratefully acknowledge Fulbright Canada for awarding me these positions.

Martin G. Gellen and Deborah A. Dickstein deserve special thanks for reviewing drafts of the first edition. Heidi Merrifield produced many of the graphics appearing in the text. Robert B. Broadbelt IV, then a Master of Public Policy candidate at the University of Southern California, contributed significantly to the preparation of the manuscript for the second edition.

ABOUT THE COMPANION WEBSITE

This book is accompanied by Instructor and Student Companion Sites.
Instructor Site: www.wiley.com\go\greenwald\ushealthcare2e
This website includes:

- Test Banks
- PowerPoint Slides
- Lecture Videos

Student Site: www.wiley.com\go\greenwald\ushealthcare2evideos
This website includes:

- Lecture Videos

PART 1

The System and Its Tasks

Health care serves a basic human need and for this reason is one of the oldest specialized human functions. Perhaps even before the recording of history, specialized personnel in the human group acquired some degree of healing art. Imperfect understanding, and even magic and mystery, characterizes healing from the layperson's point of view. Still today, the layperson views health care with varying degrees of awe, uncertainty, and suspicion. As experienced by many in the modern world, the outcomes of health care are uncertain, the cost unjustifiable, and the practitioners aloof.

The U.S. health care system shares many of the essential characteristics of health care throughout history and across the globe. But the U.S. system is unusual in the degree to which it is privately owned and operated and lacking in direction by a central authority or agency. Values central to the American mind such as belief in the private sector have helped maintain these characteristics. Beliefs among Americans in meritocracy, the right to unrestricted choice, and maximization of personal advantages also help maintain the system as it is. Values such as these led many Americans to oppose the Affordable Care Act (ACA), the first major health care reform to be enacted in generations.

The health care system's basic tasks are to prevent and remedy illness and injury. Chronic, noninfectious disease represents today's principal threat to health and survival. Diseases of this nature tend to have multiple causes, both behavioral and environmental. They require close collaboration between clinician and client for control. Because of the need for repeated treatment, such diseases tend to be expensive to care for.

Until recently, infectious diseases were relegated to historical accounts of epidemics and plagues. But the COVID-19 pandemic reminded the world of the continuing importance of infectious disease. COVID-19 was not the first pandemic of modern times. It followed, for example, the human immunodeficiency virus (HIV), which, by early in the twenty-first century, killed over 30 million people worldwide. Fatalities of this magnitude are reminders of the continuing importance of public health institutions from the local to the international community.

Health is often an outcome of human behavior. Individuals vary significantly in the taking of health risks. Similarly, people differ in their perceptions and acceptance of illness. Demographic factors strongly influence the tendency of people to seek health care even when they perceive the need.

Major disparities in race and class now exist in both health and longevity. The degree to which health care itself contributes to these disparities is uncertain. Broader social forces, such as systemic racism, contribute to these disparities and must be addressed both along with and separate from health care. In the realm of health care, development of cultural competence among providers and health literacy among consumers constitutes immediate challenges.

CHAPTER 1

Understanding Health Care

Health Care as a National Concern

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 health 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 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 are major election issues. Acute concerns for health, health care, and associated costs are only a step away from each individual, who, if he or she has no direct involvement, almost always has a friend, relative, or neighbor in need of care. The COVID-19 pandemic raised health concerns to the top of the news and made once-arcane terms such as "virus variant" and "herd immunity" into household words.

In times of both crisis and normality, health care in the United States is arguably the best in the world. By some measures the hopes of Americans for long and healthy lives are brighter than they have ever been. 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 replacement. Effective drugs and widely available surgery are chipping away at heart disease, for generations America's leading cause of death. Acquired immunodeficiency syndrome (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 increased from 69.7 years in 1960 to 78.7 in 2018.[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. Figure 1.1, which includes a projection to 2028, demonstrates how markedly the cost of health care has increased in recent decades. National health expenditures grew by 4.6% between 2018 and 2019 alone, to 17.7% of the United States gross domestic product (GDP). National health spending is projected to reach $6.2 trillion by 2028.[2]

Figure 1.1 takes on added significance when viewed alongside changes in the health insurance upon which nearly all Americans depend. Most of the dollars paid for health

Health Care in the United States: Organization, Management, and Policy, Second Edition. Howard P. Greenwald.

Companion Website: http://www.wiley.com/go/greenwald/ushealthcare2e

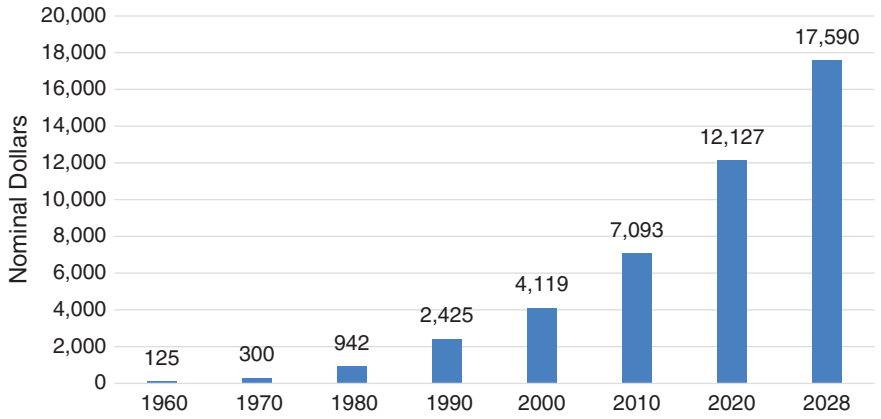

FIGURE 1.1 Growth in Per Capita Health Care Costs, United States, 1960–2028.

Sources: Data to 2010: National Center for Health Statistics, Health United States 2019. Estimates 2020 and 2028: NHE Fact Sheet, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

care come from health insurance of some kind. As recently as the late 1970s, a large number 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 the extent of coverage. Not only are health care costs higher today, but Americans are likely to have to pay a greater proportion from their own resources.

The cost of health care has raised significant concerns 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.[3] 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.[4]

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* recognizes 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. Casting the user of health services as a consumer also recognizes movement of health care away from its traditions of selfless public service. More and more today, health care is better characterized as an *industry*, including many dimensions better recognized as those of large-scale business.

The economic downturns of the early twenty-first century sharpened the issue of health care costs for many individual Americans. At the beginning of the century, a majority of Americans received health insurance through their employers or those of their parents or spouses. But unemployment in the "great recession" (2007–2009) caused an estimated 3.7 million working-age Americans to lose their health care coverage.[5] Research suggests that 10.1 million lost employer coverage in the recession accompanying the COVID-19 pandemic, although many of these were able to obtain insurance through family members or opportunities made available through the Affordable Care Act (ACA).[6] For decades, millions of employed Americans have worried about losing health insurance coverage in downturns to come.

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. Among eleven such countries, the top-ranked in preventing infant mortality, Japan, recorded 2.1 infant deaths per 1,000

live births in the century's second decade; the United States recorded 5.8. In this same comparison, the United States ranked last in life expectancy.[7]

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 died in 1997 due to preventable medical error. According to the report, more people died 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 was a decade or more behind other high-risk industries (such as aviation) in its attention to ensuring basic safety. Medication errors alone were estimated to account for over 7,000 deaths annually.[8] As late as 2018, observers identified patient safety as a continuing concern, steps toward improvement challenged by the complex interaction between technology and human behavior that characterizes health care.[9]

The quality debate has also addressed the basic efficacy of medical procedures. 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 their benefits. 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 the appropriate application of scientific evidence in practice occurred only 54% of the time.[10] 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."[11]

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 the 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.

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.

TABLE 1.1

Age-Adjusted Deaths Per 100,000 U.S. Residents, by Gender, Race, and Education

	Gender		
	Male	**Female**	**Both**
All	864.5	619.7	731.9
Race			
African American	1083.3	728.0	881.0
Caucasian[1]	885.1	642.8	755.0
Asian	470.1	336.4	395.3
Latino or Hispanic	631.8	434.2	524.7
Native American	943.9	674.0	800.2
Years of education			
Less than 12	673.8	406.1	551.2
12	695.2	423.5	568.6
13 or more	245.9	165.6	203.0

[1]Excluding Latino or Hispanic.

Source: National Vital Statistics Reports 68, No. 9, June 24, 2019. Tables 1 and 1–6. Data are for 2017. Years of education based on individuals ages 25–64. Total U.S. deaths in 2017 were 2,813,503.

Health Care Objectives and Goals

An understanding of health care requires an 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 the 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 actions as "the ultimate form of preventive medicine."[12]

Goals of health care depend on the fulfillment of a multitude of objectives, but go beyond any of those specified above. A goal of extreme breadth is implicit in the concept of health adopted by the World Health Organization (WHO), a unit of the United Nations. According to this concept, health is characterized as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."[13] Although this concept 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*.[14] This concept refers to the concentration of deaths in a population within a particular age range, presumably one approaching the natural limitation of the human life span. Under such a scenario, nearly everyone might live to a particular age (perhaps eighty, ninety, or one hundred years) and die rapidly thereafter.

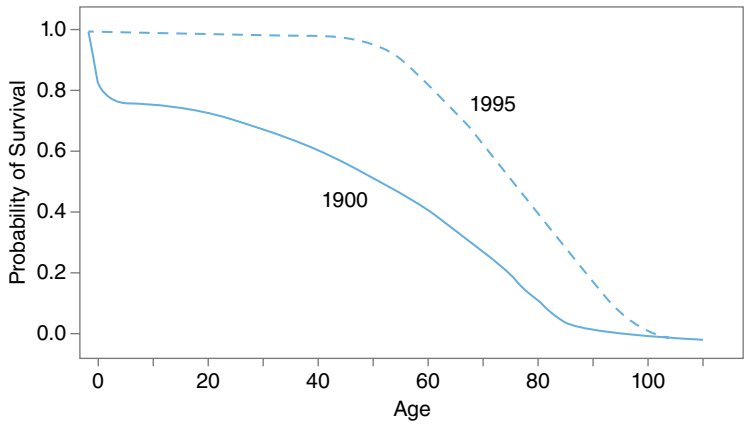

FIGURE 1.2 Survival Curves by Age for U.S. Women in 1900 and 1995.

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

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 60 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 the 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 more 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.[15]

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 collectibility. 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 non-health 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. As recourse, health care providers and hospitals may assign unpaid bills to collection agencies; even when such agencies are successful, however, the provider may receive considerably less than was initially billed.

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's 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.

An Evasive Diagnosis

Baffling even the most experienced physicians at a university medical center, the case of a nine-year-old girl illustrates the elusiveness of clinical success. For six months, the patient had been chronically nauseous, 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, being 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.[16]

But the acknowledgment of uncertainty underscores an essential element of clinical practice. No two cases are identical. Good medicine cannot be practiced cookbook-fashion.

Innovations made possible by computer technology and genetics may reduce this uncertainty in the years to come. *Medical expert systems* utilize analyses of big data to generate rules for improving diagnoses. *Personalized medicine* applies knowledge of the patient's molecular and genetic profile to increase the efficacy of treatment. But the degree to which these innovations ultimately reduce uncertainty in treatment and diagnosis is unknown.

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 the 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, the 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.[17]

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

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."[20]

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.[21] 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."[22]

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," recalled the director of a university transplantation program.[23]

are most likely to sense absence of a caring attitude on the part of their providers.[18] 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."[19] 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.

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.[24] Trust is also crucial for the operation of health care at a society-wide 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 received, obtain informed consent for procedures used, avoid conflicts of interest, and apply medical skills and technology only in a competent and appropriate manner.[25]

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 an organization delivering health care. The principle of confidentiality would seem inviolate. But the need to protect the public from harm via disclosure of hazards represented by a person's exposure to contagious diseases such as COVID-19 or human immunodeficiency virus (HIV) 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. A 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.