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A BRAVE NEW WORLD OF HEALTH CARE

*Sister Rosemary Donley**

We are witnesses and perhaps partners in a major reorganization of health care delivery. New expressions have developed such as vertical integration, capturing the market, and spreading the risk. Some believe that access to health care is a limited right and that available, albeit costly, technology should be rationed.¹ Although I am cognizant of the models which are used to describe the care of the sick, my personal and professional orientation leads me to conceptualize the new health care scene as a Brave New World. When I read *Brave New World* as a college freshman, *in vitro* fertilization seemed bizarre. I could not imagine a civilization where class was determined by adding chemicals to test tubes or social conditioning was accomplished by playing instructional tapes to nursery school children during rest periods. Today *in vitro* fertilization and subliminal conditioning are part of our experience.² When I read Huxley's book again this summer, I was surprised to learn that his work is not classified in the genre of fantasy or science fiction. It is considered to be utopian literature. The Huxlian utopia is a society where perfect integration and control yield maximum quality of life for all. Nicholas Berdiaeff, a Russian philosopher who wrote the introduction to the text, noted that Brave New Worlds are, indeed, realizable.³ He commented that there may be inherent problems with utopias because freedom may be sacrificed for perfection.⁴ Berdiaeff's hope for the new century was that intellectuals and the cultivated class would be able to avoid utopias and opt for a less perfect and a more free world.⁵ A new sense of the literature is the basis for expanding my ideas about the Brave New World of Health Care, to include the role of the intellectual and the cultivated classes in reshaping our future.

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1. See H. AARON & W. SCHWARTZ, *THE PAINFUL PRESCRIPTION* (1984).

2. Tiefel, *Human In Vitro Fertilization*, 247 *J. A.M.A.* 3235 (1982).

3. A. HUXLEY, *Brave New World* (1932).

4. *Id.*

5. *Id.*

I.

Demographic data indicate that within the past two decades the number of older people has increased twice as rapidly as the rest of the population. The fastest growing sector of our population is over eighty-five; in fact 5.2 million people will be over age eighty-five by the year 2000.⁶

Traditional caregivers, families and women, are less able to assume care of elders. By 1990, sixty percent of all women will be in the work force.⁷ These social forces have more meaning as prospective payment systems encourage early discharge of medicare beneficiaries and the stimulation of home-based care. Women and children should not be discounted in this cursory discussion of clients. Data indicate that children constitute forty percent of all poor Americans.⁸ Women, children and the chronically ill are more than represented in the uninsured fifteen percent of the population.⁹ They are the medically indigent, the sick, poor, and the recipients of uncompensated care. If Pearce is correct in her assertion that poverty has been feminized,¹⁰ women and children will require more health care in the future. The health of women and children is an international measure of a nation's health and well being. The documentation of poverty in a vulnerable population highlights the tragic consequences of public decisions.

Acute care hospitals and the status of acute care in the spectrum of health care services change daily. The community-based hospital may be in greatest jeopardy as for profit conglomerates organize small hospitals into national systems. It is interesting to note that five companies, unknown in 1968, now own or manage one of every seven hospitals in the United States.¹¹ In many cities, there are circles of two or three not-for-profit institutions.¹² Religious communities, who founded hospitals to promote a belief system, once operated them as separate institutions. Now groups like the Sisters of Mercy and the Holy Cross Sisters have gathered their institutions into corporate folds and also joined newly organized super systems owned by religious and secular groups.¹³ These patterns of ownership, expansion and

6. Munding, *Health Service Funding Cuts and the Declining Health of the Poor*, NEW ENG. J. MED. 44 (1985). See also *Poverty* in PASTORAL LETTER ON CATHOLIC SOCIAL TEACHING AND THE U.S. ECONOMY, ch. 10, Washington, D.C., National Conference of Catholic Bishops (draft November, 1984).

7. Personal Communication, Health Policy Alternative, Inc. (1985).

8. CHILDREN'S DEFENSE FUND, AMERICAN CHILDREN IN POVERTY (1984).

9. Wildowsky & Berk, *Poor, Sick and Uninsured*, 2 HEALTH AFF. 91 (1983).

10. D. PEARCE, WOMEN AND CHILDREN: ALONE AND IN POVERTY (1986). See also FAMILY PLANNING PERSPECTIVE 14 (1982).

11. See P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

12. *Id.* at 432.

13. Grant, *The Enemy Within: Sponsorship After Vatican II*, HEALTH PROGRESS, 45-54

governance represent a new social order, somewhat like Huxley's utopia. The governance of the new corporations, the super systems, is vested in professional decision makers who do not live or work in the cities where the health care institutions exist. Corporate boards are objectively removed from the ethos of the communities and the clients whose interests they represent. It is easier to consider the good of the whole, the utilitarian principle, when the plight of the individual is hidden in statistical reports.

Amid the trends to merge and consolidate, several images come to mind. One is a vision of the steel barons who built Pittsburgh and organized independent companies and mills into U.S. Steel. Small neighborhood grocery stores disappeared when 'supermarkets' developed. Independent, family-owned grocery stores changed hours, revised stock, and used their windows for advertising. They closed when the 7-11 chain opened.

There is something to be said for standardizations and Big Macs and 'Big Boys'. However, the "not so perfect" hamburger stands kept income in the communities while they added color, diversity, customer choice, and a human touch to neighborhoods. Community hospitals provided employment, neighborhood solidarity, and pride. They also gave expression to the communal beliefs about human dignity and the treatment of illness. Berdiaeff would have preferred the older systems.¹⁴ They were less perfect, but more free. Will community hospitals go the way of family owned stores as the business motif gains ascendancy in health care? What effect will the disappearance of the community hospital have on grass roots advocacy and consumer choice?

II.

If this trend continues, community hospitals will close, merge, or lose their identities in corporate systems. Even if hospitals do not really survive on the corporate scene and fail to be listed in the Fortune 500, the organization and control of institutionalized health care delivery will have changed irrevocably. This factor will continue to influence patterns of care and the behavior of health care professionals.

In Berdiaeff's view responsibility for historical development lies with the educated and the elite.¹⁵ What role has the academic establishment played in our Brave New Health World? Did the Academy help bring our new health care system into being? Is this the end desired by those who wished

(September, 1985). The September, 1985, issue of HEALTH PROGRESS addresses multi-hospital systems.

14. HUXLEY, *supra* note 3.

15. *Id.*

to change the fee-for-service, cost-plus system of reimbursement; close down underused hospital beds, and rationalize the system? Did we prepare too many people who could "fit in" to treatment styles and operating modes? Have our aims been distorted by technological imperatives and federal financing policies? Did greed, an obsession with autonomy, or quests for power cause us to forget the goals and oaths of our professions? Does anyone remember that we once promised that the good of the sick would be our primary concern?

Berdiaeff states that the cultured and elite bear unique responsibility for world order.¹⁶ What has been the historic position of educators about the superfluous hospital beds, the over-supply of health care providers, (especially physicians) high technology medicines, financing incentives, and cost containment? How are we responding to newly reorganized health care systems, de-institutionalized health care services, insurance in general and malpractice insurance in particular, and the new ethics of care?

Has the creative tension between schools of business and schools of health care administration disappeared? How have changes in the industry influenced classrooms and laboratories of clinicians? My review of the literature suggests that our thinking is dominated by fear and frantic efforts to expand the Diagnostic Related Groups (DRGs), "game" the system, and protect autonomy, income, and institutional turfs. Have we become so obsessed with utopian structures that we have neglected ethical concerns? Computer models in clinical decision making enable young physicians to know the cost as well as the logic of their treatment protocols. Nursing students have clinical instruction in home care settings as well as in intensive care units. Health care professionals are not alone as they capitulate and explain away the new system of health care. The thrust of the August, 1985, articles in the Hastings Center Report: "AIDs: The Emerging Ethical Dilemmas,"¹⁷ "Making Laws About Making Babies,"¹⁸ "The Case Against Unused Frozen Embryos,"¹⁹ and "Why Britain Can't Afford Informed Consent,"²⁰ sounds more like the concerns of a Brave New World than the agenda advanced by an ethical think tank.

16. *Id.*

17. Relman, *AIDs: The Emerging Ethical Dilemmas*, 15 HASTINGS CENTER REP. 1 (August 1985).

18. Singer, *Making Laws on Making Babies*, 15 HASTINGS CENTER REP. 5-6 (1985).

19. Ozar, *The Case Against Thawing Unused Frozen Embryos*, 15 HASTINGS CENTER REP. 7-13 (1985).

20. Schwartz & Grubb, *Why Britain Can't Afford Informed Consent*, 15 HASTINGS CENTER REP. 19-25 (1985).

III.

What will be the structures of the Brave New World and how will they influence decision making? It remains to be seen whose ethos will influence the new breed of "supply side" health care providers. It is certain they will treat or refuse treatment to the poor, the chronically ill and the elderly. They will work in a redesigned health care system whose corporate policies will be standardized, legal, and somewhat homogenized. Will the new demography and organizational patterns simplify professional practices? The Brave New World of Health Care has an inherent problem, however. Corporate conglomerates cannot codify responses to questions about whom to treat, how to treat, and where to treat. Pressure to judge rightly will intensify because decisions will be made in a climate where costs continue to be exaggerated by technological advances. The success of medical science will require more clinical judgment. In the former days, patients died during therapeutic heroics. Lack of science and the virulence of disease were fatal combinations. Today, the level of science requires not a painful prescription but rather an informed judgment about the merits, efficacy, benefits, and desirability of available and experimental treatments. The power of our knowledge has advanced to the point where the treatment might work. Modern clinicians balance not only the cost to the client (and the system), but also the risk to the patient (and the system). Clinicians must make decisions based on the probability that treatment might restore life and health, albeit compromised. We have given clients new, more painful, and more costly ways to live and die.²¹ Justice mandates that decisions about access to health care should consider benefit as well as cost.²²

The problem is illustrated by Garrett Hardin as a "Crisis on the Commons."²³ He postulates that we have exhausted the resources of the health care commons.²⁴ He calls for restraint and a re-evaluation of the long-term effects of our traditions (e.g., need equals right) and our greed.²⁵ His discussion causes us to re-examine our assumptions: Need for care assures the right of care; treatment should yield positive results; patients should be isolated from cost and price; physicians have primary decisional roles. Cost of care was ignored in traditional therapeutic equations. It is the significant and overriding variable in the Brave New World. Return on equity is the

21. See generally Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 Wis. L. REV. 239.

22. See also Smith, *Triage: End Game Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143 (1985).

23. Hardin, *Crisis on the Commons*, THE SCI. 21 (1985).

24. *Id.*

25. *Id.*

outcome, and management of costs is the strategy that drives the new system.

Health care professionals need to include cost in their decisional paradigms. Failure to use the best available information, an irresponsible use of power, has brought us to the place where health care is a commodity to be purchased and professional judgment is mediated by arbitrary financial standards.

The question of quality care has yet to be addressed in the Brave New World. Current measures of quality are mortality and morbidity rates, the number of infections, accidents, untoward events, malpractice citations, and the ratio of professionals to patients.²⁶ Concern with quality has often been a euphemism for control, dominance, and preserving the flow of dollars into individual and corporate pockets.²⁷ The Brave New World may give us the opportunity to re-define quality of care and re-examine our notions of health care.

Unlike Huxley, we cannot bring back the old days. Our option is to take hold of the present. In many countries primary care is the norm.²⁸ High technology medicine is reserved for the influential and the wealthy. In the future, color TVs and wine with dinner will no longer differentiate patients who can afford health care from the under- or uninsured. When health care becomes a commodity, only first class care will offer unlimited access to high technology medicine. Utopias are realizable. The intellectual and cultivated classes may yet be able to design a less perfect, more humane and more free system of health care.

26. See the classic study by R. BROOK, *QUALITY OF MEDICAL CARE ASSESSMENT USING OUTCOME MEASURES: AN OVERVIEW OF THE METHOD* (1976).

27. Hardin, *supra* note 23.

28. M. ROEMER, *SYSTEMS OF HEALTH CARE: INTERNATIONAL HEALTH* 4-13, 16 (1977).