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The current forces acting on the U.S. hospice industry, and their likely future impact

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University of Hawaii, 1991
THE CURRENT FORCES ACTING ON THE U.S. HOSPICE INDUSTRY, AND THEIR LIKELY FUTURE IMPACT

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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IN

POLITICAL SCIENCE

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By

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ABSTRACT

The health industry in the United States is a system in the systems theory sense. Thus, it has periods of homeostasis during which large numbers of forces and actors interactively cause progressive changes within and without the system. However, the integrity of the system as such is preserved.

The system also has occasional perturbations and periods of heterostasis that cause major changes in the relativities of the forces and actors, and in the system's position in its broader environment.

Most forecasts for the health industry are offensive. They use techniques with poor theoretical justification. But, worse, they ignore the fact that the health industry is a fully integrated system, and they ignore the certainty that perturbations will occur.

This dissertation adopts a systems approach in musing on the future, deliberately eschewing the popular but flawed techniques that promise results that cannot be delivered. Instead, it identifies thirty major forces and a dozen major actors that have created today's system; and it examines the existing relationships between them.
It then recognizes five forces that are likely to promote perturbation, and for each provides a scenario that describes the likely outcome for the health industry. The hospice industry is embedded in the health industry, and each scenario is followed through to describe a likely future for the hospice industry.

For the health industry, the most likely future is that national and international "Seven Saving Sisters" oligopolies will quickly develop, and they will always subjugate compassion to profit. The oligopolies will control all service delivery points, services, and also the products marketed. Consumers' values will be changed; perhaps this is for the better.

The health industry will probably experience major upheavals stemming from arguments over euthanasia, from intergenerational economic warfare, and from discovering cures for a major disease. In all these cases, there will be big winners and big losers within the industry.

Hospice will be a big loser. It will go the way of previous movements of compassion; it will lose its identity; it will be coopted physically into the mainstream health industry; and its philosophy will be perverted by greater commercial considerations.
# Table of Contents

**Abstract** ................................................................. iv

**Chapter One** Introduction to This Dissertation

1.1 Introduction .......................................................... 1

1.2 Philosophy, Methodology, Assumptions .......................... 4

1.3 Four Processes of Modelling and Speculation .................. 24

1.4 Definitions; Contents of Later Chapters ....................... 29

**Chapter Two** Demographic Macro Forces

2.1 Introduction to Chapters Two Through Six ...................... 35

2.2 The Size of the Population ......................................... 36

2.3 The Proportion of Elderly in the Population .................... 42

2.4 Demographic Contributions to National Health Costs .......... 47

2.5 The Political Power of the Elderly ............................... 52

2.6 Intergenerational Conflict ......................................... 54

2.7 The Sex Ratio of the Elderly ....................................... 58

**Chapter Three** Political Economic Macro Forces

3.1 Introduction .......................................................... 61

3.2 Background Political Economic Forces ........................... 62

3.3 Aspects of the American Political Economy ..................... 65

3.4 The Argument for an Economic Crash ............................. 69
5.5 RESEARCH .................................................. 133
5.6 THE COST OF AN ENCOUNTER WITH THE HEALTH SYSTEM .................................................. 136
5.7 FORCES EMANATING FROM THE AIDS EPIDEMIC .................................................. 137

CHAPTER SIX THE HEALTH INDUSTRY ACTORS
6.1 INTRODUCTION .............................................. 141
6.2 THE HEALTH INDUSTRY ACTORS .............................................. 142
6.3 PHYSICIANS .................................................. 148
6.4 SOCIETY .................................................. 152
6.5 HOSPITALS .................................................. 154
6.6 INSURANCE CORPORATIONS .................................................. 156
6.7 TRADE UNIONS .................................................. 158
6.8 LARGE EMPLOYERS .................................................. 160
6.9 PHARMACEUTICAL INDUSTRY .................................................. 160
6.10 EQUIPMENT MANUFACTURERS .................................................. 161
6.11 GOVERNMENT .................................................. 162
6.12 CORPORATIONS .................................................. 165

CHAPTER SEVEN FIVE FUTURES FOR THE HEALTH INDUSTRY
7.1 INTRODUCTION .................................................. 167
7.2 A PETERSON-TYPE ECONOMIC CRASH .................................................. 170
7.3 IMMEDIATE ACTION TO AVOID AN ECONOMIC CRASH .................................................. 182
7.4 INTERGENERATIONAL ECONOMIC WARFARE .................................................. 188
7.5 A CURE FOR LUNG CANCER .................................................. 194
7.6 SOCIETAL CONFLICT OVER SUICIDE AND EUTHANASIA .......................... 199

CHAPTER EIGHT ASPECTS OF AMERICA'S HOSPICE INDUSTRY
8.1 INTRODUCTION TO CHAPTERS EIGHT AND NINE .......................... 204
8.2 THE HOSPICE PHILOSOPHY AND ITS APPLICATION ............................. 204
8.3 THE MARKETPLACE FOR HOSPICE SERVICES ....................................... 216
8.4 THE FINANCIAL VIABILITY OF THE HOSPICE INDUSTRY ..................... 221
8.5 CONCLUSION TO CHAPTER EIGHT .................................................. 226

CHAPTER NINE THE FUTURE OF THE HOSPICE INDUSTRY
9.1 INTRODUCTION ........................................................................ 228
9.2 A PETERSON-TYPE ECONOMIC CRASH ......................................... 228
9.3 IMMEDIATE ACTION TO AVERT AN ECONOMIC CRASH ................... 235
9.4 INTERGENERATIONAL ECONOMIC WARFARE ................................. 239
9.5 A CURE FOR LUNG CANCER ...................................................... 243
9.6 SOCIETAL CONFLICTS OVER SUICIDE AND EUTHANASIA .............. 245
9.7 CONCLUSION TO THIS DISSERTATION ......................................... 249

BIBLIOGRAPHY ................................................................................. 260
CHAPTER ONE: INTRODUCTION TO THIS DISSERTATION

1.1 INTRODUCTION

It is now only 23 years since the first modern-day hospice was opened at St. Christopher's in London in 1967, and only 16 years since the first U.S. hospice was established in New Haven, Connecticut, in 1974.

In the United States, hospices have packed a lot into those sixteen years. They have seen growth, they have seen schism, they have seen innovation, and they have seen opportunism. They have provided a better way of dying for many persons, and refused it to others. They have won forms of financial support that give them a level of security that threatens their independent existence. They have sold services that are considered humanistic in some contexts and criminal in others. They have become pawns, small but valuable, in wider societal and health industry battles that they cannot hope to influence. They are a product of compassion and greed, simplicity and politics, freedom and domination, the past and a vision of a better future.

The basic purpose of this dissertation is to conjecture on what that future will be over the next two decades. Other hospice writers have done this before me, though generally their approach has been to offer prescriptions rather than offer formal forecasts.
For example, Zimmerman (1986) expects that:

hospice programs are likely to increase in numbers and quality. Both the art and science will grow as experience is gained. Such care can reach its full potential as it becomes an integral part of our medical care system.

Paradis (1985) makes a similar type of prediction. She considers that:

hospice administrators, managers, planners and policymakers can ensure that the future of hospice is filled with promise. The essential ingredients for success are available and can be obtained if hospice advocates work towards consensus building and establish compatible relationships with the existing medical industrial complex. With good, strong leadership and a sense of public policy and patient needs, hospice developers can look forward to a rewarding future.

Behind these mixtures of prescription and forecast is the view that, as far as the hospice industry is concerned, the future will be a continuation of the present. There is an implication that there is a high degree of equilibrium among the industry forces and institutional actors, and that the future will produce only small adjustments to the status quo. There is an underlying confidence that if hospices can avoid a number of avoidable pitfalls, then their destiny rests in their own hands; if a number of fine tunings to the hospice system are made, then they can expect a future of guaranteed growth and prosperity.
In this dissertation, I present a number of possible futures for the hospice industry that are quite different from the one outlined above. Indeed, I argue that the industry will not be in the position to decide its own destiny, because it constitutes only a small, almost powerless, part of a larger health industry that will dictate its future. And, I contend, the health industry will itself be responsive to a series of macro forces that will certainly mandate large and chaotic changes for both the health industry and the institutional actors in it. I expect that, as a corollary of all this, a number of different futures are possible for the hospice industry; and the one thing they have in common is that they are all very different from those implied by Zimmerman and Paradis.

The remainder of this chapter describes the philosophy, methodology, assumptions, and processes I used in reaching my conclusions. Thus, the next section contains a discussion of the first three of these; after that there is a section giving details of the processes I used. In the final section of this chapter, I provide a number of definitions for use within this dissertation, and outline the contents and organization of the later chapters.
1.2 PHILOSOPHY, METHODOLOGY, ASSUMPTIONS

Health care for the population of America is delivered via a vast and complex system that extends into every city and town in the nation, and which provides services that are used in every building in the nation. It involves the efforts of a huge workforce, including 600,000 doctors, 1,600,000 nurses, 7000 hospitals, tens of thousands of nursing homes and millions of others in the actual delivery of services (Califano 1986). Behind these, there are hosts of suppliers of pharmaceuticals, drugs, equipment of all kinds including computers, buildings, and countless other products. The system is financed by an array of institutions that include governments, employers, banks and insurance corporations, citizens and society. Tens of thousands of persons are engaged in health-related activities in government departments, in universities, in volunteer organizations, and in legal firms and advertising agencies. Every person in the nation comes into contact with the system at some time, and a significant number depend on it every day to stay alive for that day.

This is a system in which dozens of major institutional actors are linked by a symbiotic dependence on each other at the same time as they are
competing among themselves for a share of the income that the system generates. Each of them is affected by the forces generated by any other actor. If, for example, government mandates that small businesses provide health insurance cover for employees, then it is not only those businesses and the employees that are affected. Large business will benefit from "cost shifting" or "load sharing" reductions in their insurance premiums, insurers will gain from their share of the increased cash flow that will pass through them, the health industry will expect to see an increase in the national expenditure on health, and other sectors of the economy might get a corresponding decrease.

For the purpose of analysis, this large number of actors and forces exerting pressures, and generating response, on each other cannot be regarded as somehow independent of each other. Instead, I have lumped them together into a "system" in the sense used by systems theorists as disparate as Bateson (1972), Boulding (1956), and Lazlo (1972). In terms of actors and forces, a system can be seen as a conceptual concentration of contiguous actors and forces acting on each other in such a way that any force, generated either within or without the system, in turn generates a reactive force from some, if not all, of the other
actors and forces within the system, and thereby changes the configuration of the whole system. It is a basic assumption of this dissertation that the American health industry is in fact such a system.

Under systems theory, the industry would be seen as being in a state of "homeostasis" for much of the time. This does not mean that the system is in equilibrium, since that would require that the forces within it are in balance, and that change did not generally occur. And it might mean that the health system was in some fixed and permanent relationship to the world around it. Homeostasis, on the other hand, expects that the forces act in such a way that changes within the system are constantly occurring, and that the conceptual relativities of the system to its wider environment are also constantly changing. Rather than requiring no change, it requires constant change, but with gradual push and shove in many directions so that the integrity of the system as a system is maintained.

In terms of the health industry, homeostasis means a creeping change in the relative strength of the actors, and of the forces, and a similar change in the positioning of the health industry within the national economic and social fabric. Many forecasts, probably a vast majority, within the industry are based on the
assumption of continuing homeostasis. For example, those cited above from Zimmerman and from Paradis assume the business-as-usual and the past-as-a-continuation-of-the-present approaches that systems homeostasis by itself suggests.

But systems theory also provides for "perturbations" to the homeostasis. These occur when one or more forces assume a form or intensity that materially changes the relativities between the forces and the actors within the system and may also change the position of the system as a whole within its broader environment. A major departure from the steady state or from trend in one force or actor causes similar departures in some or all of the others; this causes a period of heterostasis, and the ultimate result is that the combination of impulse and response cause permanent significant changes to the system. This is especially pertinent to the "halfway competitive markets and ineffectual regulation" (Altman and Rodwin 1988) of the unplanned American health system.

World War II provides an example of such a perturbation since it caused major changes in the social, political, economic and technological climate that surrounded the health industry, and allowed it to
move to a very different position in the American economy and in society (Starr 1982). This was a highly visible and dramatic perturbation. But there is nothing in systems theory that requires this. For example, in the early years of Medicare it was not at all obvious that it would encourage enormous growth in the consumption of health care services, and indeed this perturbator went unrecognized as such for several years (Marmor 1977). But despite the slowness with which it changed the health system, change it did; and all aspects of the system now have different forms as a consequence.

Under this approach, a perturbation will come only when one of the more powerful forces or actors experiences a relatively sudden change of state. For example, the force of self-interest among health care professionals is a very powerful force. However, I do not expect this to become a perturbator in the future, because I expect that force to remain steady over time. Likewise, the sheer size of the American population represents a considerable force, because it provides a huge market for health products. But the increase in population that I expect in the future will not cause a perturbation, provided it is a steady increase reasonably consistent with trend. In effect, the
system is set up to expect steady change and to accommodate it.

Perturbations will instead come from marked deviations from an established trend, and only provided the force concerned is powerful enough. Take two examples. Various forms of "holistic medicine" have, in the last decade, gained increased societal acceptance. Suppose in the next decade the number of acceptors doubles. Then this would be a marked change from trend; yet I expect this would not be a perturbator, since the initial power base from which this force emanated is quite small relative to that of mainstream medicine. The existing state of homeostasis might be excited but it would not be destroyed.

For the other example, suppose a complete cure for lung cancer were discovered. This technological force would have major effects for all the actors in the system; and since it combines a sudden change in trend with a high impact, it would qualify as a perturbator.

These systems theory concepts of homeostasis and perturbation are basic to this dissertation's study of the future of the American health and hospice industries. The first step in the study is to describe the health industry in a state of homeostasis. Then, the next step is to use the concept of perturbation as
the basis for conjecturing on the future. Both of these steps I will discuss later in this section. But first, I need to describe the philosophy that encouraged me to use the systems concept of perturbation as my vehicle for forecasting, rather than some of the many alternatives.

I start from the position -- which I argue at some length below -- that when it comes to examining the future of a complex system, methods used for other purposes are of little use. For example, the most common form of forecasting involves the use of some form of mathematical modelling. Even when used in their proper context, these models suffer from a lack of theoretical justification other than that provided under past goodness-of-fit criteria; and they suffer from the intellectual paralysis that inevitably stems from maintaining the pretense of objectivity that the techniques require.

Each technique also has its own additional weaknesses. For example, regression analysis requires the estimation somehow of the independent variables. Time series analysis demands choices. Should the model be Gompertz, inverted exponential, logistic? Should exponential smoothing be used; if so, what should the weighting be? Should some variables be lagged, should
others lead; if so, what time displacement is appropriate for each? Only a few of these decisions can be based only to a small extent on theoretical justifications. In the main, the justification for a particular set of choices is that, after intensive manipulation of the data, it maximizes on the day a number of correlations between past sets of data.

Multivariate techniques -- such as factor, discriminant, principal component, or cluster analysis -- suffer from a particularly weak theoretical justification based only on the inversion of a form of the variance-covariance matrix, and then the capricious naming of the so-called factors. And they suffer from the fact that they condense a wide range of variables down to one or two that purport to represent the original variables. Non mathematical techniques, even in their proper usage, have their own weaknesses. For example, other operations research techniques, such as physical simulation of recurrent events, also depend on predictions based on prior co-incidences in the past. Delphi techniques are faced with the difficulties of selecting the experts and getting their continued cooperation; and the problems that the experts themselves often rely on the techniques I mentioned above, often they push their own barrow, often they are really
talking about different subject matter, and often they end with inconclusive opinions and the call for further research.

But beyond these specifics, in the systems context, all of them are quite inadequate because they try to reduce complexity to simplicity by starting with a considerable number of variables, and seeking to explain or predict their collective behavior in terms of a few parameters. Such attempts are meaningless in the systems context. What happens there is that a perturbation to the system affects all the forces and actors, and they in turn react. The process is one of turning simplicity into complexity, not the reverse.

A basic premise of this dissertation is that the American health system is indeed a system in the systems theory sense; that analyses and techniques that ignore this are virtually useless; and that the systems concepts of homeostasis and perturbation do provide a theoretical basis that stands the crucial tests of being reasonable in the first place, and of possible utility in the second.

In carrying out this study, four processes were involved. Put deceptively simply, I firstly attempted to identify the actors and forces that are dominant in the health industry's (assumed, but see later) current
state of homeostasis, and to appreciate the relationships between them. Secondly, I searched among the actors and forces to recognize which of those were most likely to cause a perturbation in the future. Thirdly, for each of five such perturbators, I developed a separate scenario as to how the system would respond to it, and what the new system would be. Fourthly, I conjectured on how hospice would fare as the perturbation proceeded, and what its position would be as the health system returned to a new period of homeostasis.

This approach has a number of advantages:

* it obviously takes a systems approach. It says that here is a system with an established set of gradually changing relationships; here too is some force that substantially disturbs these relationships; and here is the new-look health system that develops and this is how hospice fits into it. The emphasis remains throughout on the system; not on some small part of it, nor on estimates of a few parameters that seek to represent it. In short, it treats the health system, correctly, as the system that it is.

* the model is consistent with history and with reason. It is arguably historically true that the health industry has gone through periods of homeostasis,
interrupted by occasional perturbations that have changed the course and position of the industry. And it is reasonable to expect that such a process will continue.

This is not saying that history will repeat itself. Rather, it is saying that a process that has persisted for decades and which is based on the supple relationships between actors and forces that have themselves persisted for decades, is likely to continue into the future. It could be that in fact it will not; and it could be that even if it does persist, it will not provide here or elsewhere descriptions of the future that come close to what does eventuate; it could be that other approaches also offer other reasonable ways to proceed, either with or without producing forecasts that prove to be reasonably accurate. But that is not the point here; what is pertinent is that the approach based on systems theory is indeed consistent with history and reason, and is right now a reasonable way to proceed.

* it allows for multiple futures. Few other approaches are conducive to this, and most end up with sets of figures that represent a single likely future of a number of variables -- not the system. Sometimes this is modified by forms of sensitivity analyses, but these
can only provide minor variations because they are based on a philosophy that requires a single best-fit model.

This is not part of my approach. Instead, I argue that it is not possible to know what will happen in the future, and that the best that can be done is to speculate on likely outcomes. Thus it makes little sense to look at a single future when the odds are that it will not eventuate; a better way is to look at quite a few futures, both because it increases the chance that one of those chosen will come to pass, and importantly because it should lead to the consciousness and the examination of a whole range of futures that all have a chance of occurring.

In terms of my systems approach, this means looking for perturbators that have the potential to disrupt the homeostasis, and also have a tolerably high probability of doing so. In fact, in this dissertation, I selected five likely perturbators and then speculated on what new systems would emerge if and when any of them disrupted the health system homeostasis.

* it provides a model that can be used by other interested parties. For example, it is likely that different readers of this document would want to conjecture on health industry futures deriving from
potential perturbators other than the five I have followed. Or some readers, who disagree with some of my conclusions in defining the existing homeostatic system, may choose to patch in their own conclusions, and then dwell on their personal vision of the future.

Further, it provides a basis for speculation on the future of other industries that are component parts of the health industry. For example, the pharmaceutical industry and electronic diagnostic equipment industries could well use this model for their particular speculations.

This is the approach I have taken in forming my futures for the hospice industry, though it will become obvious later that not everyone would agree that this is a reasonable way to proceed. They would argue that the philosophy of hospice is quite separate, and often antagonistic, to that of the health industry; and that its philosophy, its position in the marketplace, and its mode of financing are all unique to it. On this basis, they would argue that hospice should be seen as an industry in its own right.

But, I argue that, even though this might have been true in the past, and even though many persons would like to make it so now, it does not express the pragmatics of today. Most of today’s hospices are
clearly linked with the health system's major actors. For example, governments and licensing and accreditation bodies impose a wide set of rules; governments provide funding in one form or another to almost all of them; they are staffed by health industry professionals such as doctors and nurses; they buy equipment and drugs from pharmaceutical companies; they survive only through the financial and volunteer support of the society in which they are embedded; and so on. Every one of these institutional actors has the power to affect the destiny of the hospice industry; and on this basis, I have included hospice as just one more institution within the health industry.

* it is unashamedly subjective. Most, if not all, of social science writings are mainly subjective, whether the writers and readers realize this or not; subjectivities are an inevitable part of analysis and speculation. This dissertation is in no way exceptional in this respect. This is not to say that the writer is freed to base analysis on fairy tales and speculation on a form of unscientific fiction. Rather, it imposes a number of very definite restraints.

Firstly, the writer should acquaint the reader with the major subjectivities involved, and where applicable, the qualifications that then apply to any
conclusions thus reached. For example, in doing my historical review of the health industry, I synthesized the works of many writers. These were almost entirely "establishment" writers whose works were published in "establishment" books and journals. I did consider writings of a few fringe establishment authors such as Illich, Navaro, and Waitzkin, but these scarcely affected my later judgements. It could be that had I ranged wider for literary sources, then some of my conclusions would have been different.

In this dissertation, subjectivities abound. The list of them would start with the choice of topic for this document, and end with my final word in my final paragraph. It would probably contain reference to my selection of 30-odd macro forces -- not some different number, and not some differing set of forces. It could note that my expectations of the behavior of institutions under American capitalism are quite different from those expressed by many other writers. It might dwell on my obvious belief that government is only one among many powerful actors in the nation, and that major changes in society, and in the balance of economic and political power, will come from other sources. It would be a very long list; and it is worth
noting that its length and content would vary with the perception of the person making it.

Given this, in this dissertation I adopted the policy of specifically discussing major subjectivities as I came to them in the text. My earlier discussion of my attitude to forecasting provides an example of this. But there was a limit to the number that I could formally discuss; and I adopted the presentation device of moving from the third person to the first person when I moved from an analytical mode down to my subjective assessments of these analyses and their consequences. For example, in the chapters that identify the significant forces that have operated in the health industry in the past, I have presented the information and views from various writers in the third person; but when I come to express opinions concerning the future trends of these, I moved to writing in the first person.

Secondly, it places a responsibility on the writer to provide lucid and sufficiently detailed arguments to back up decisions made. For example, in my context, the description of the current homeostatic system and also of the likely perturbators involved a series of very subjective decisions. To meet my responsibility here, I have presented the arguments that back up these
decisions in considerable detail in Chapters Two through Six. My approach was that while the decisions should be subjective, they should not be arbitrary. Yet there is again a limit to how much material can be studied, and how much can be discussed in a dissertation. Every one of the forces and actors has had multiple tomes written about it, and to review these all here would have been impossible and not rewarding. The policy I adopted was to extract only the material from the writers that related directly to the argument I had in mind. By doing this, perhaps I missed material that may have been significant to my conclusions. I accept this as one of the shortcomings of this dissertation.

Thirdly, when it comes to studying the future, the philosophy and the techniques used need to be apparent. In my case, I have discussed my philosophy sufficiently above. The technique of scenario writing carries with it responsibilities for the writer. In the first instance, I sought to convince most readers that the future described in the scenario is at least likely or -- better still -- quite likely.

But more important was the responsibility to ensure that every prediction in every scenario was rooted in some part of the homeostatic relationships already
discussed. For example, I could not suggest that euthanasia will become legal under some circumstances, unless I had earlier established that a force of reasonable size is trending towards that outcome. Nor could I say that physicians under certain pressures will react by overservicing, unless I have argued previously that they have done so in the past under similar circumstances.

* it puts me in the good company of a number of leading philosophers and futurists who are also averse to many of the concepts and forecasting techniques that I am deliberately avoiding. For example, Birch (1988) talks about the "fallacy of objectivity" that asserts that subjectivity does not enter into scientific analysis; Amara (1989) considers that "the clearest winner in the methodological (futures) sweepstakes" has been the scenario, in keeping with the trend towards less formalism. Dror (1989) states that presently available forecasting and policy analysis methods are as a whole very inadequate and often misleading; and he advocates alternatives that include "macro-policy as the main focus, long-range and dynamic situation estimates as the main bases, thinking-in-history as a main mode."

These very nearly translate into a description of much of my own methodology.
Robinson (1988) sees the need to rethink some traditional views about forecasting; what is needed are not techniques that converge on likelihood, but those that reveal the possibility of alternative futures. Masini (1989) observes that a number of crises emerged in the last fifteen years, and they collectively produced an awareness of the complexity and interconnectedness of events and a sense that the future will not be a linear continuation of the past and the present. At the pragmatic level of technique, Amara’s (1988) advice is to look for breakpoints and discontinuities, and focus on underlying driving forces; Millett (1988) notes that scenarios are increasingly gaining acceptance, and are best suited for long range time spans of five to fifteen years, and to highly complex and uncertain situations; and Schnaars (1989) advocates avoiding any methods that include advanced mathematics, maintaining high suspicions of trend projections, challenging assumptions, and using multiple scenarios.

In all, there is a wealth of recent futurist literature that supports me in shying away from pretences of objectivity, and from mathematical approaches and forecasting. Equally, that same literature consistently advocates the use of multiple
scenarios as a means to the desirable end of exploring alternative futures.

Turning now from the advantages to the disadvantages of my methodology, I expect that the major complaint would be that it is too subjective, not precise enough, and not in any way quantified. My response to that is to repeat my earlier statement that all forecasting is subjective, and to add that techniques that promise precision through quantification are promising the impossible. To emphasize my position, I have throughout avoided terms that suggest I am forecasting or predicting, and the like; and have instead used terms that indicate I am speculating, conjecturing, and musing, to rightly describe the process of studying the future. In the same vein, my scenarios are deliberately vague when it comes to timing. Occasionally, I have used phrases to indicate specific periods of time, but the purpose of these is to separate different periods of activity from each other, rather than to suggest that I can somehow anticipate just when major eventful changes will occur.

A substantial disadvantage, however, would be apparent if the system were now, at the reporting point of my study, in a state of heterostasis. If that were so, then many of the forces and actors would be busily
engaged in deviating from trend in response to a current forceful perturbator, and I would have to somehow attempt to devise a model that started from heterostasis.

In this dissertation, I have assumed that the health system is currently in a state of homeostasis. Not everyone would agree with this, and the main arguments against it would come from those who consider that the energy with which larger corporations are entering the health industry is right now completely changing the full system. I have considerable sympathy with this claim; yet I will argue later that as far as this force is concerned, the changes it has caused are only minor compared with the others that might occur in the future. Thus while I recognize this force as a potential perturbator, and while I agree that right now it is pushing the industry towards a new shape, I consider that it -- as with other perturbators I will nominate later -- has not yet, to date, caused enough perturbation to generate heterostasis and a permanently new disposition for the health industry.

1.3 FOUR PROCESSES OF MODELLING AND SPECULATING

In this section, I return to the four processes of modelling and speculation that form the basis of this
dissertation, and provide more detail of each with the emphasis now on the process itself.

The first process involved creating a model of the American health system in its current state of homeostasis between many actors and many forces. The approach I used was to examine, collate, and synthesize a wide range of mainly secondary literature that described and analyzed the philosophies and events prominent in the American health industry over this century, and particularly those of the last two decades.

This process revealed that, say, one hundred forces have been found by the writers as having contributed to the current state of the health industry, and that, say, thirty different institutional actors had also played their part. I subsequently reduced these numbers for inclusion in my model of the health system to 30-odd and about a dozen respectively. In doing the culling, I dropped out those forces and actors that appear to have lost prominence or which seem likely to make little contribution to change to the system in the future. While this process was somewhat arbitrary, I expect that none of the writers that I considered would argue with the inclusion of any one of the forces, and relatively few would lament the exclusion of some.
For reasons of presentation and manageability, I described the remaining 30-odd forces as "macro" forces; and also placed them into a total of five categories that represent demographic, social, political economic, disease, and technological forces. For example, "the population of America is increasing" describes a population force. And "the political power of the elderly as a group remains substantial" signals a social force.

In selecting the forces in such a complex system, it is apparent that behind every force there are other forces that contribute to it. For example, the increase in population stems in part from technological advances, and in part from social forces that are demanding a high level of access to health care services. I had no problems in including all three of these forces in my systems model. But, for example, I could have also followed literature that asked where the demand for health care fits into Maslow's hierarchy of needs. I stopped short of that; and in general, I adopted the policy that if the source writers did not consider a background force important, then I would not include it. Likewise, I stopped short of discussing questions such as whether the forces have a common origin in technology, or perhaps in society. Such
philosophical questions, though not without pertinence to this dissertation, I treated as being beyond its scope.

The second process involved the search for potential perturbators. In doing this, I first culled those forces that I judged to be in a steady state or in a state of steady change. For example, I argued that while there are many forces seeking to extend access to health services to greater numbers of the population, there were also strong forces opposing this. From this I reasoned that there would be relatively little change in the level of access; and on this basis I eliminated this force from the list of potential perturbators.

For the forces remaining, I eliminated those whose effects would not be felt within my timeframe. For example, it could be that if the nation en masse follows the urging of the Environmental Protection Agency to insulate all existing and new dwellings against cancer-producing radon in groundrock, then it could be that the incidence of cancer across the nation will reduce considerably. But this is unlikely to have much effect in my twenty year timeframe; and on this basis I eliminated it.
I then classified each remaining force in terms of its potential impact and its probability of causing heterostasis, and retained only those which were high-impact and at least moderately probable. My method for doing this was to start from the present set of system relationships and trends; then for each force, test whether I could construct a credible pre-heterostasis scenario that would end with that force causing perturbation.

In all, using the various culling and selection techniques that constituted the second process, I classified five forces as potential perturbators; and it is these five that I carried forward into the next process of writing heterostatic health industry scenarios.

The third process involved the writing of those five scenarios; and here I adhered to the rules cited above for doing this. Each scenario is quite separate from the others and was written on the basis that it alone had reached the level where it upset the homeostasis.

The fourth process conjectured on what the consequences of heterostasis and the creation of a new homeostasis would be for the hospice industry. In doing this, I had in mind that hospice is distinguished
from other health institutions by its philosophy, by
its method of financing and by its marketplace position
Thus, I created a hospice industry scenario for each of
the five health industry scenarios, and in doing this I
laid some emphasis on the three distinctive features of
hospice. It is the five scenarios thus developed, and
the conclusions drawn from them, that represent the end
product of this dissertation's deliberations.

1.4 DEFINITIONS; CONTENTS OF LATER CHAPTERS

In this section, I introduce a number of
definitions that I have used throughout this document.
Following that, I conclude the chapter with an outline
of how the subject matter of this dissertation is
organized into the later chapters. Firstly the
definitions:
* I have assumed that "the reader" is quite well
acquainted with the health and hospice industries.
Thus, for example, I have offered no descriptions of
commonplace health industry terms such as Prospective
Payment Systems and Diagnostic Related Groups.
Similarly, I assumed that the reader has a reasonable
knowledge of the history of the health industry in
matters such as Medicare, cost cutting efforts,
national health insurance proposals, and so on. Again,
I have kept the use of descriptive statistics to a
minimum, and mainly use them as one among many ways to illuminate the argument I am making.

Likewise, I have assumed that the reader is already familiar with the background of hospice and its philosophy and history, and will need only memory joggers on these; though when it comes to examining the three distinctive characteristics of hospice, I do provide a more detailed discussion.

* I have used the term "hospice" and "hospice industry" interchangeably. Some readers would not approve of this. A first group would say that hospice is not an industry, and that it is instead a "movement" of compassion. I argued above that such an attitude avoids the realities of today, and on this basis I remain comfortable in this usage.

* "political forces" is used here in two senses. Firstly, as in its most common usage, it refers to the forces exerted by the various governmental
institutions, and their attending politicians and their bureaucracies. Secondly, it refers to the forces generated by the host of institutions, including those in the health industry, that are struggling among themselves, and also against the government, to exercise control over the health industry.

* the presentation of my arguments concerning the macro forces is sometimes hampered by the interrelationships between forces. I discuss every macro force formally, under its own heading, within its appropriate chapter category. However, in reporting on some of the earlier forces, it is often necessary to call on material that relates to forces discussed formally later.

I have tried to accommodate such convolutions within and between the forces and actors in the next five chapters by a system of forward referencing. Thus, when I refer to a macro force that I have not as yet formally discussed, I print the name of that force in emphasis to indicate that I will discuss it in some detail later; and I continue to do this until I have formally discussed it. Thus, in the early chapters, many forces are printed in emphasis; but as I progressively discuss each macro formally in its own category, the use of emphasis is progressively reduced.
The same technique is used for the actors when they are acting in a political sense; but not when they are acting as service providers or suppliers. For example, I would write "the hospitals opposed this legislation" in the former case; and "the hospitals supplied these services" in the latter.

* the writing of this dissertation will be completed in 1990, and looks towards the year 2010 as the upper limit of its timeframe. Thus, "the next two decades" indicates that the two decades of the 1990s and the 2000s are under discussion. Similarly, anything "current" refers to events occurring in the year 1990. But in none of this am I being literal. For example, "current projections" may have been made in 1988; but I will use this term provided that there is no distortion in so doing, and that the reference in the bibliography makes clear the timing of the projections. This approach is done with the intention of saving the reader from a barrage of petty time-based qualifications that in no way affect the substance of the dissertation.

* the term "elderly" refers to persons 65 years and over; "old old" refers to persons 85 years and over.

* the term "government" means the American Congress and the Administration. The term "governments" means the
government together with state legislatures and administrations.

* population estimates from the Bureau of Census are taken from its Middle Series.

* "institutional actors" are individually discussed in Chapter Six. They include obvious groups such as government and insurance corporations. They also include doctors collectively and hospitals collectively. "Collectively" is used here to indicate that while some doctors and hospitals may differ from the collective line, I am concerned with the policy that is evidenced by their collective action or by the policy of their national association.

I also include society as an institutional force. My unqualified use of "society" indicates that I consider that, for a specific issue, there is enough cohesion in society for it to perform as a single actor. This, however, is not always the case, and I indicate this latter situation by appropriate qualifications and discussions as I proceed.

Finally, the organization of later chapters:
* the description of the health system in its current homeostasis is presented in Chapters Two through Six. The approach used was to sort the various categories of macro forces out into different chapters.
Thus, Chapter Two deals with demographic forces; and Chapters Three and Four respectively examine the political economic forces and the societal forces; and Chapter Five studies the disease and technological forces together. Chapter Six focuses on the actors; and the material in that chapter contains a lot that was discussed earlier, but this time from the actors' viewpoint. But it also includes extra material that is more or less specific to the actors. These chapters also include a discussion of the potential for each macro force to become a perturbator in the future.

* Chapter Seven contains the five scenarios for the post-perturbation future of the health industry.

* Chapter Eight discusses hospice in terms of its philosophy, its position in the marketplace, and its mode of finance; and for each of these it examines the extent to which it contributes to hospice's vulnerability within the health industry.

* lastly, in Chapter Nine, the five scenarios for the future of the hospice industry are presented, together with a concluding discussion of the implications of the findings of this dissertation for the health and hospice industries.
CHAPTER TWO: DEMOGRAPHIC MACRO FORCES

2.1 INTRODUCTION TO CHAPTERS TWO THROUGH SIX

This is the first of five Chapters that collectively examine the forces and actors that are currently significant in maintaining the homeostasis of the American health industry. In this Chapter, I look at demographic forces. In the next two, I consider political economic and then social forces. Then, in Chapter Five, I examine disease and medical technological forces together. Later, in Chapter Six, I describe the institutional actors and the roles that they currently play.

In each of the first four chapters, my sequence of presentation for each force is more or less the same. Firstly, using the first of the four processes described in Chapter One, I present some of the origin and history of the force, with emphasis on the effects it has had on the health industry in the last two decades; and at the same time, I identify how this force has interacted with the other forces and with the institutional actors. Secondly, I execute the second of the processes by conjecturing on how this force will develop under the period of homeostasis that will precede a perturbation. Thirdly -- and this too is part of the second process -- I judge from these
conjectures whether this particular force has itself the potential to in fact cause a perturbation.

My purpose in doing all this is to provide a description of the health system in homeostasis, and to identify the potential perturbators. Given these, I can then continue on to Chapter Seven to develop the scenarios that describe the reaction of the system to each perturbator separately, and to speculate on the form that the health system will take as it moves towards a new period of homeostasis.

2.2 THE SIZE OF THE POPULATION

In the past two decades, the population of the United States increased from 205 million persons in 1970, to a projected 250 million in 1990 (U.S. Bureau of Census 1990). This is so well known that it often passes without comment and as if there is something inevitable about population increase. The reality, however, is that population will increase only if the combined incremental effects of migration, fertility, and mortality exceed their decremental effects.

In the past, America has often been conspicuous for its open door to migrants. In the 1970s, it maintained an average net annual intake of 400,000 persons per year. In the 1980s, boosted by refugees, family reunions and amnesties for illegals, the annual average
rose to 670,000 per year (U.S. Bureau of Census 1990). Also, in the past, the nation’s fertility rate was always above the population replacement rate of 2.0 (Pifer and Bronte 1986). In particular, during the postwar baby boom in the two decades starting 1945, total fertility rate peaked at 3.7 in 1957 (U.S. Bureau of Census 1990).

After 1964, the fertility rate began to plummet, reaching a low of 1.7 in 1976, and then moved towards the projected value of about 1.8 in 1990 (U.S. Bureau of Census 1990). This meant that, for most of the last two decades, the effects of fertility changes on population size were negative. These effects -- of higher migration on the one hand, and low fertility on the other -- largely offset each other; so that over the 1980s, their combined effects were to make a moderate contribution to population increase.

Still, the population did increase, and the increase was more than moderate; in fact, total population increased by 28 percent in twenty years. A major contributor here was to be found in changes in mortality rates. These rates have fallen spasmodically but persistently throughout this century for persons of all ages, but after 1957 they left their temporary plateau of the previous dozen years, and began a rapid
decline that has continued until the present (Pifer and Bronte 1986).

There were two factors involved here. Firstly, there has been a series of technological achievements this century that have progressively reduced the incidence of various diseases through sanitation, clean water, inoculation, wonder drugs, diagnostic machines, surgical miracles, and on and on.

The result of this was that persons of all ages in the last two decades increasingly had available to them a wide range of public health, preventive, diagnostic and treatment services that, in earlier years, did not exist or were nowhere near as effective as they became over the last twenty years.

The other factor was that, as the usage of medical technology became more effective, it also became more widespread, and the benefits increasingly became available to a larger proportion of the population. Since World War II, access to health services has been progressively expanded, and indeed institutionalized, and while it is true that tens of millions of persons currently are fully or partially denied health services through cost considerations, some 86 percent of the population in 1987 had some level of insurance
coverage that allowed them at least minimum access (U.S. Bureau of Census 1990).

In summary then, both the range of efficacious services and the access to services have been improving throughout the century, with consequent current major declines in mortality rates for persons of all ages. This trend continued into the 1970s and 1980s so that, given that the moderate net population increase from higher migration and low fertility, these two decades saw the nation's population count increase by an extraordinary 28 percent (U.S. Bureau of Census 1990).

Looking to the next two decades, there is much to suggest that the population rise will of the same order, though this would represent a smaller percentage increase than in the last two decades. In saying this, I have accepted the Bureau of Census assumptions that fertility will remain slightly below replacement rate, and that net migration will be reduced substantially and quickly back to a level of 500,000 persons per year (U.S. Bureau of Census 1990). In looking at mortality rates, I have reasoned that the health advances of the preceding ninety years of this century will not go away, and there is every indication that they will be supplemented by new technological advances. Of course, many of them will not work, and many will be positively
harmful. But that is no different from the situation in the past. I expect that many of them will live up to their promises, so that the array of effective health services will continue to grow larger and more diverse, and there will be considerable marketing forces at work to extend them in all possible profitable ways.

When it comes to access to these advances, the picture is not so clear, but I argue later that, despite actors who will seek to reduce access, in the shorter term there will be a net increase of some millions of persons who will newly gain it. And in the longer term, the fact that access has become institutionalized for the vast bulk of the population will guard against any major reductions.

In all, I expect that medical technology will continue to provide an increasing range of efficacious services, and that access to them will continue to expand. One consequence of this will be that mortality rates, over the next two decades, will continue on at the low levels now prevailing (U.S. Bureau of Census 1990).

For specific forecasts, I turn to the Bureau of Census which estimates that mortality rates for all ages over the period to 2010 will remain at about the
same levels as in 1990. After providing for the trends in fertility rates and net migration, they predict that the population will continue to increase. In fact, they estimate an increase in total population from 250 million in 1990 to 283 million in 2010 (U.S. Bureau of Census 1990), and while this is a noticeable lower rate than in the previous two decades, it still represents an increase of the same order.

This disqualifies "changes in total population" as a potential perturbator. Granted, if it did vary significantly from trend, the ramifications would be felt in every sector of the economy, not the health industry alone. But I expect this will not happen; and on this basis, I exclude it.

Still, the very size of the population, and the fact that it will continue to increase at an appreciable rate, mean that the cost of health care to the nation is now enormous, and will continue to increase. Thus, two of the basic requirements of corporate capitalism are satisfied, so that the entry of megacorporations into the health industry will be encouraged. At the same time, the conspicuous size of the health industry's share of the national economic pie will guarantee that there will be mighty battles to
decide which actors -- inside and outside the health industry -- will benefit from it.

2.3 THE PROPORTION OF ELDERLY IN THE POPULATION

In the last two decades, the population of the United States aged. This means that the average age of the population rose, and that the proportion of elderly in the population was higher than ever before. One cause of this relative increase stemmed from the decline in birth rates following the baby boom, and so the number of youths and children now is relatively small. Another cause was that the advances in medical technology mentioned earlier were available to the current elderly for most of their lives, whereas previous cohorts of elderly only partially benefitted. In any case, the proportion of elderly in the population rose from 9.8 percent in 1970 to 14.3 in 1987, and the corresponding increment for the old old was from 0.7 to 1.3 percent (U.S. Bureau of Census 1990).

Several writers throw useful light upon these figures. Manton (1982), using epidemiological terms, points out that the average elderly person suffered a period of morbidity, then disability, prior to death; for a person aged 70 years, this morbidity to mortality period averaged something like 12 years.
He demonstrates that over the course of this century, and especially in the last two decades, there has been a movement of the mortality survival curve upwards and to the right. This is another way of saying that mortality rates have fallen for all ages throughout these periods. He goes on to point out, though, that the corresponding morbidity curve and the disability curve has scarcely moved over the two decades. This means that while life expectancy for those aged 65, say, rose 1.2 years in the two decades, the onset of morbidity occurred at much the same age as before, and that most of the extra months of life were spent in a condition of chronic illness.

In the next two decades, given the projected movement of the mortality survival curve, the question becomes what will happen to the morbidity and disability curves. Fries addressed this question initially in 1980. He claimed that there is a fixed biological limit to the length of human life, with an average of somewhere between eighty-five and a hundred years. He claimed that the major health problems that keep life expectancy down below the limits are the chronic diseases, but in most cases the onset of these diseases can be delayed through health-promoting behavior and disease prevention. The ideal strategy
then is to compress morbidity into a brief period before the end of life, and then achieve a "natural death." He estimated that under the most favorable assumptions, this compression of morbidity could halt the increase in health care costs, and indeed reduce them by 15 percent by the year 2010. Bezold (1987) goes further and sees this compression of morbidity as part of a package that could reduce the percentage of Gross National Product (GNP) consumed by health care, from the current (1987) 11 percent to as low as 6-9 percent.

Bezold includes the development of "fully decisive vaccines and cures for the major diseases" in his package. Fries, however, is not talking about reductions stemming from miracle cures and medical breakthroughs. He concedes that a final period of organ breakdown will still occur as a consequence of cancer, heart diseases and so on; but that the onset of these can be delayed many years during which the individual will continue to function without the disabilities now experienced. This means that the survival morbidity curve will be pushed upwards and to the right so that it almost coincides with the mortality curve. Clearly, if he is correct, and the onset of morbidity can be delayed for years and if the
period of disability can be reduced, then the reduction in the consumption of health services by the elderly would be of great importance.

Many writers present opposing views. For example, Colvez and Blanchet (1981) found that middle aged Americans, the elderly of the future, are showing significant increases rather than decreases in health-related disability. Manton (1987) argues that the greatest reduction in mortality rates since the 1960s have been among the elderly, and this hardly suggests some fixed natural barrier. Gruenberg (1977) suggests that, given the health system’s preoccupation with extraordinary life saving technology, medical advances may prolong periods of chronic disease and disability in old age.

On balance, I do not give much credence to Fries’ theory. I say this keeping in mind the contrary views mentioned above. Also, at the more theoretical level, I consider that Fries has taken one set of trends and argued his case from them. Other writers have taken other trends and come up with estimates of up to 130 years as the natural limit of life. Others have argued that the concept has no basis at all. So in fact, I simply do not know, and no one else does either, which of the competing theories might contain some truth.
Further, I can see a momentum in the current drops in mortality that will be difficult to reverse, at least within my timeframe; and, equally pragmatically, because ten years after Fries advanced his theory, there is little hard evidence to suggest he is correct; if anything, the reverse is true.

Yet, I am cautious in all of this. For one thing, Fries’s prescriptions for achieving delayed disability and compressed morbidity are very much a summary of the various formulae for prevention of illness through changes in lifestyle; and there is some literature that points to the efficacy of these. The point I made above, that the balance of current evidence is against his theory, does not mean that he is wrong; perhaps it means only that the lifestyle changes will take longer to show up at the population level than he anticipated. And, I am cautious because if he is correct, there will be a considerable reduction in average periods of morbidity.

In all, though, the points of interest here are that, firstly, there has been a large increase in the proportion of elderly in the population in the last twenty years; and that further increases can be expected. In the next two decades, I expect that the mortality rates for the elderly will continue to
decline along with the declines for the population as a whole. Again I accept the predictions from the Bureau of Census. They forecast that by 2010 the number of elderly will rise to 39 million persons, or 14 percent of the total population; and the number of old old will rise to about 2 percent of the total (U.S. Bureau of Census 1990). These numbers in fact represent an substantial acceleration in the build up of elderly as a proportion of the population.

Secondly, there is now a large morbidity gap of the order of twelve years; thirdly, that gap widened significantly in the last two decades; finally, perhaps it will, and perhaps it will not, widen further in the future.

I can make no argument that suggests that the aging of the population per se will act as a system perturbator. Nor can I do so in terms of the morbidity gap. But three forces that stem from this aging do have some potential; and I discuss these consequential forces below in the next three sections.

2.4 DEMOGRAPHIC CONTRIBUTIONS TO NATIONAL HEALTH COSTS

Since 1970, the health bill for the nation rose from 7 percent of GNP to 11 percent in 1987; in current values, this was an increase from $75 billion to $500 billion (U.S. Bureau of Census 1990).
There were a multitude of forces that contributed to this huge increase. For example, there was the increased access to services that I described above; along with this there were came a diversity of inducements to consume more. Thus, there was a stream of technological marvels and the promise of miracle cures; and there was a realization among an increasing supply of doctors that they could set targets for their personal incomes and achieve those targets by marketing and other profit making techniques. There was proliferation of new diagnostic techniques -- for example, as today's extreme, biological samples that have 300 tests applied -- many of which became standard procedure for clinical encounters; and there was the increased emphasis on intensive care units and emergency rooms in hospitals. And so on.

All of these went hand in hand with generally increased costs per unit of service. And they went hand in hand with the increase in total population, so that there were more people each consuming more than ever before and at higher prices than ever before. It is not surprising that the aggregate expenditures for health services rose significantly.

But what was true for the general population was also true for the elderly. Except that the elderly
contributed more than proportionately to the cost increases. They were more likely to experience serious illness and functional disability than those at younger ages. They saw the doctor more often, made greater usage of ancillary health services, accounted for a disproportionate share of prescribed medications, were more likely to undergo hospitalization, and occupied the vast majority of nursing home beds in the U.S. (Ouslander and Beck 1982). Among the old old, the need for health services was particularly high due especially to their extensive usage of hospital and nursing home care. To sum this up, in 1987, the average number of bed-disability days for persons under 65 years was 5 days, while for the elderly it was 14 days (U.S. Bureau of Census 1990).

The arithmetic of the period was that there was a steady increase in the relative number of the elderly, and since these elderly individuals spent more on health than other individuals did, the total health consumption of the nation was incremented accordingly. Thus, in 1987, the elderly comprised 12 percent of the population (U.S. Bureau of Census 1990), but accounted for 29 percent of personal health expenditures (Rice and Feldman 1983).
One consequence of this was that the nation and government experienced the high rates of growth of expenditure described above. Another was that the provision of high cost health services for the elderly was institutionalized via the various legislative programs, and via the strong public acceptance of support for the aged (Blendon and Altman 1987).

I have no doubt that the forces of the past will continue into the future to push the general population and the elderly towards greater consumption. As well as that, it seems that special forces, peculiar to the elderly, will also operate. For example, the recent moves of the medical profession towards specialization in various forms of gerontology; the recognition of the malleability of the health of the elderly and the acceptance of diseases of the elderly, such as Alzheimer’s, as being treatable; the proliferation of surgical procedures that are used mainly by the elderly, such as coronary bypass; the development of special forms of drugs that recognize the different metabolic processes of the elderly; and so on. In all, the very large, and very well insured, elderly population can be certain that the marketing pressures on them to consume will be powerful.
This is not to say that health spending for the elderly will be allowed to go unexamined and unchallenged. Calasanti and Bonanno (1986), for example, consider that as the State becomes more entwined in its fiscal crisis, the elderly will become an increasingly obvious target for cutbacks; and that while there is still strong public support for the cause of the aged, it is apparent that the ideological framework is also being laid to encroach on programs earmarked for this group. They quote specific examples of Medicare and Medicaid cutbacks; and if they had written in 1989 rather than 1986, they doubtless would have included the Federal legislation (now repealed) for catastrophic health insurance that extended the user-pays principal.

Thus, in summary, I expect that the total population will continue to rise in numbers, and so too will the number of elderly; in fact these latter will increment more than proportionately. These increases will make a large contribution to the huge lift in national health costs that can be expected under homeostasis; and indeed the cost to the nation will become so great that it must be considered a candidate for classification as a potential perturbator.
But, clearly there are forces other than population forces that need to be considered in making such a decision, and I defer further discussion of this to the next chapter on the political economy.

2.5 THE POLITICAL POWER OF THE ELDERLY

In the last two decades, the increase in numbers of elderly was accompanied by a realization, by them and by others such as politicians, that the elderly collectively had the potential to become a major political force. As the sixties and seventies progressed, and as other social movements addressed health and other so-called rights, this potential was turned into a reality.

In the next two decades, the political energy of the past will not dissipate with time, and it seems improbable that their collective power will diminish, and indeed the increase in their relative numbers should help boost that power. It could be, of course, that they have pretty much achieved their goals for health care, and that they will now fight for other types of services. Some evidence of this can be seen in their current demands for Federal long term care legislation, which do include health care provisions, but only incidentally. In any case, I expect that the elderly will continue to be conspicuous in their
efforts to at least maintain their current position, and also to ensure that health provisions for the elderly do not fall below those for the rest of society.

If this is to be achieved, it is likely that it will occur at the expense of other interests. For example, as the proportion of elderly persons increases, there will be a simultaneous reduction in the proportion of persons aged under twenty years -- in fact from 36 percent in 1989 to 32 percent in 2010 (U.S Bureau of Census 1990). This provides the opportunity for governments and society to increase health expenditures by diverting moneys -- say, education moneys -- from the young, while still maintaining current per capita allocations for this group. Such a trend started years ago when the system of grants for college students was replaced by a system of student loans.

A different type of diversion would involve the appropriation of moneys from other sectors of the economy. For example, it can be argued that the defense needs of this nation are not directly tied to the population changes that can occur within twenty years. And it follows that if the nation’s defense bill was kept at today’s level in financial terms, then
it would decrease as a percentage of government spending, and thus allow increases to the elderly, among others.

The point of these two examples is that, as the elderly increase proportionately in numbers, there will be a corresponding increase in their political pressure for the allocation of more resources, including health care resources, to them. And the arguments that they use will include, consciously or not, the diversion strategies outlined above. I cannot argue that the forces that they will generate will become perturbative; rather they will maintain or perhaps steadily increment their current positions. But whatever level of benefits that they receive, or that they covet and fight for, will be gained at the expense of other interest groups in society; and it is certain that their special position in society will come under increasing scrutiny.

2.6 INTERGENERATIONAL CONFLICT

In the last two decades, as the proportion of elderly in the population increased, there has been growing reference to the possibility of intergenerational conflict in the future. The basis for these fears rests on the gradual decline in the aged dependency ratio with the consequence that a
declining proportion of working-age adults are expected to provide goods, health care, and other services to increasing numbers of other persons, including the elderly.

There was a wide range of opinions here. For example, the government line was that the various Trust Funds, such as those for Social Security and for Medicare, will cover the costs for decades ahead. At the other end of the opinion spectrum, Wynne (1986) had no doubts about the looming crisis and raised the question of whether the young will support the old, and thought that for the younger generation "there may well come a point of rebellion."

In the next two decades, there will be many opportunities for that conflict to erupt. As mentioned above, the elderly will have power, and will clearly use it in their own interests, and often to the detriment of the young and to the detriment of any illusion of a social compact between generations. Further, there is little evidence of forces -- such as strong family ties, or widespread respect for the elderly -- that would serve to mitigate or soften conflict. Also, I expect that there will be a number of specific issues that will test the tolerance of the younger groups; the looming new crises in the Social
Security and in the Medicare Trust Funds could well provide the battle grounds.

I classify intergenerational conflict as a potential perturbator. My pre-perturbation scenario is based on the prospect of younger generations of America developing hostility towards the relative wealth of the elderly, and rising up to effectively take some of that wealth for themselves.

Under this scenario, parents of childbearing age will perceive that:

* their own standard of living is no better than that experienced by their parents 25 years earlier, despite many mothers having entered paid employment. The prospect will be for their children to have yet a lower standard.

* there has been a deterioration in the education system and in the physical infrastructure of the nation in the last generations; and again their children will be the victims.

* children with serious chronic diseases are refused health services, and sometimes die as a result, unless the parents strip away all their assets to meet the requirements of Medicaid.

At the same time, they will be conscious that many of the elderly have higher incomes than they themselves
have; that they are asset rich; they double and triple dip into pension funds and Social Security; they are supported by Medicare and reap enormous benefits through Medicaid (usually without genuine asset stripping); they sometimes cost taxpayers enormous sums of money to be kept alive for years in vegetative states; they are the ones who invented the social security scam, and the ones who will benefit from it. And, they are currently not productive in the workforce.

The result will be that these younger Americans will seek to gain a greater share of national resources for themselves, and will join battle with the elderly. This will be no easy battle to win, given the undoubted political power of the elderly under attack; and given also that the generations in between will be torn by regard for their own future welfare and by concern for their parents on the one hand; and on the other hand, by concerns for their children and grandchildren. In all, the issue will be terribly divisive of society for a decade.

It will be the younger generations who win. Progressively, society will come to see the current set of conditions as being over-indulgent to the elderly, and as inequitable in society at large. Government
will cut back its expenditure for all its elderly support programs; this will severely affect all parts of society, and will be sufficiently disruptive to the health industry to cause perturbation. Details of the cutbacks, and their likely effects, provide the subject matter for the third scenario in Chapter Seven.

2.7 THE SEX RATIO OF THE ELDERLY

In the past two decades, reductions in mortality continued their long term trend of benefitting females more than males. At every age, male mortality exceeded female mortality, and the excess became more pronounced at older ages. In 1988, the sex ratio (the number of males per 100 females) was 69 at for ages 65 and over, and only 39 for ages 85 and over (U.S. Bureau of Census 1990).

A number of factors can readily be identified as contributing to this situation. For example:

* the number of males killed and impaired in the various wars of this century far exceeded the number of females.
* more males died from motor vehicle collisions, and from diseases related to tobacco and alcohol and other drugs, and from murder and other forms of violence.
* males were much more exposed to death and injury in the workplace.
* despite recent improvements, males have been much more susceptible to diseases of the heart.

In the next two decades, there is some argument among experts as to whether the gap will grow or reduce. On the one hand there is current demographic evidence that the increase in the gap is slowing down. Some commentators put this down to increased numbers of females having adopted male usage patterns of tobacco and alcohol products. On the other hand, there are those who claim that females are biologically programmed to live longer than males. They argue that lifestyle changes have already shown up in the demographics, and that is indicated by the retardation in the size of the gap, and that no further change will come from this source. They also argue that the differential exposure to violence and toxicity will continue, so that the natural relative longevity of females will keep the gap at current levels or somewhat above them.

In any case, within my timeframe, all commentators agree that any change will be minor. I accept the Bureau of Census predictions that, by the year 2000, the ratios will remain steady at about 69 percent for the elderly, and 39 for those over 85 years (U.S. Bureau of Census 1990). But, of course, the numbers of
persons in those classes will have increased substantially by then, and will thereby magnify the associated problems.

The forces generated by the imbalance in the sex ratio of the elderly will not create perturbation in the health industry. Still, they are of considerable importance to the hospice industry. Low ratios, and the potential falls in these, mean that elderly females in particular will be denied access to hospice services because they do not have marital partners available as primary care givers. For the old old, this has always been a problem since it is rare that even a male aged over 85 has a partner healthy enough and strong enough to act in the caregiver capacity. The likelihood is that the situation will get worse in the future.

Clearly though, there are other forces that will affect this situation, such as family size, divorce rates, remarriage rates, workforce participation rate and population mobility. These are all considered, in the context of the availability of the primary care giver, in my final two chapters on hospice.
CHAPTER THREE: POLITICAL ECONOMIC MACRO FORCES

3.1 INTRODUCTION

In this chapter, I continue to describe the past and present relationships between the forces and actors within the health industry system; and I examine a number of forces emanating from the political economy to judge whether they are likely to throw the system into perturbation.

In the next section of this chapter, I list a number of assumptions concerning the American economy that I refer to later in this dissertation.

In Section Three, I look at the political economy of the nation over the last twenty years, and try to sort out rhetoric from fact, the shorter from the longer term, and the ephemeral from the real. My starting point for this is the description of the current state of the political economy presented by Peterson (1987, 1988), and this is supplemented by Havens' (1989) similar version.

Peterson's analysis and approach is attractive because it is based on well accepted macro economic principles, and because he carried the analysis through to make forecasts in a timeframe similar to my own. Havens' similar work (without the forecasts) adds supplementary information and also an updated analysis,
and carries the rigor expected of an Assistant Comptroller General of the Government Accounting Office.

Peterson's work suggests two possible forces that deserve consideration as likely perturbators of the health system. In Sections Four and Five, I examine these forces separately; and I conclude that, even though the forces are mutually exclusive, each of them does indeed qualify as a potential perturbator.

In Section Six, I turn my attention away from analysis of the political economy towards the examination of the health industry itself, with a focus mainly on attempts over the last two decades to reduce health care costs.

In the course of doing this, I identify four macro forces that offer promise of becoming system perturbators; and, over the next four sections, I question whether they do in fact meet the criteria.

3.2 BACKGROUND POLITICAL ECONOMIC FORCES

I provide below a summary of a number of assumptions about the American political economy that I have used in subsequent pages. All of them can almost be regarded as common knowledge, and I include them here with very few supportive references. Indeed, I take the precaution of listing them only because they
do become important briefly in a number of arguments that I advance later in this dissertation. These assumptions are that:

* America will remain a capitalist nation. This has two important relevant consequences. Firstly, the capitalist system demands that any industry or corporation must continue to expand if it is to survive. Secondly, it requires that profits must be close to the top of the hierarchy of objectives of any corporation. It can be that profit is in fact the principal objective; this is the most common view. Or it can be, as Galbraith (1978) writes, that profit-making runs third behind survival of the decision makers, and the avoidance of risk taking. But in any case, profit making must rank high; much higher than any motive that involves altruism.

* there is an imperative for corporations within major industries to ultimately form into an oligopoly. This is the famous economic argument of Stigler (1952), and it is backed up by performance. Witness the oil, steel, car, heavy equipment, shipping, soft drink, telecommunications, tobacco, pharmaceutical, and trade union industries. Look at the current moves towards oligopoly in the airline, computer, tourist resort, and retail industries. As Stigler puts it, the ultimate
end point under unrestrained capitalism is monopoly; but given that this is outlawed in America, the prior step of oligopoly development acts as the next best thing.

* in an increasingly capitalist world, the same logic applies to multinational corporations. Here, the restraints on establishing monopoly come from the powerful nations anxious to maintain their markets. But the observed effects are the same; vide the arms, aerospace, pharmaceutical, computer, media and propaganda, and satellite-placing industries.

* the medium for moving towards oligopoly in an industry is the takeover and the merger. As Stigler points out, the typical pattern is for a host of smaller operators to reduce their own numbers by such means of "rationalization"; then for the larger of these, and other operators outside the industry, to buy controlling interests in the larger units thereby creating even larger units. Finally, a war of attrition between the larger units reduces the number of actors down to an oligopoly.

* the planning, creation, management, and the general exploitation of crises is an instrument commonly used to create favorable business opportunities within the nation or a particular industry (Edelman 1977).
3.3 ASPECTS OF THE AMERICAN POLITICAL ECONOMY

There is no shortage of opinion and commentary on the current state of the American political economy, and how it got to be where it is, and what should be done next. Needless to say, not everyone is agreed about these matters, and indeed there is much disagreement as to whether the current state is one of prosperity or skillfully hidden disaster. There are some, often Republican politicians, who point with satisfaction to relatively low interest rates, low inflation, high employment with low industrial strife, and growing exports, to argue that things are good, and will get better. There are others, often Democrat politicians, who blame the Reagan and Bush administrations for impending problems caused by high budget and high overseas trade deficits, reductions in welfare provisions, and a crumbling infrastructure. They regard the position as not so good, but with the right management, things will get better.

Politicians aside, there is a wealth of comment and prescription. Eisner (1986) argues that there is no budget deficit, and that when allowance is made for the inflation-caused decrease in the value of the national debt, America had a "real surplus" of $20 billion in financial year 1988. Hamrin (1988), on the other
hand, takes the view that American people have been hoaxed into thinking that they are much better off than they really are.

Most macroeconomic analyses of the last two decades focus in the end on the overseas trade balance and on the federal budget, and have two interrelated lines of reasoning. The first -- which I have abstracted mainly from Peterson (1987) -- argues that America has experienced low productivity growth over two decades due to low savings rates and to the deterioration in the national physical and educational infrastructure; and also due to high consumption. As a consequence, there is now a growing foreign debt, and this is financed by the overseas sale of bonds; and not only is the interest bill on the growing debt a matter for concern, but so too is the prospect that at some point the overseas lenders will see the debt as being too large to warrant further investment; and this would produce a mixture of disasters and crises that would include the raising of interest rates to levels that would cripple American business. The solution is to increase savings, and to direct investments towards increasing the nation's productivity; and to reduce national consumption.
The second line of analysis (from Peterson and Havens equally) is that there is excessively high consumption at the personal and governmental levels, and that the government is locked into large social security and pension and entitlement programs, and into defense and other commitments, including interest payments on the national debt. The consequences of this are that it has accumulated so large a federal deficit that more disasters and crises are imminent, including the drying up of lendings from local as well as overseas investors as the specter of the printing press solution looms; and also including the continuing drain on national savings to finance government spending. The solution involves, in addition to that above for international trade, a number of specific measures such as cutting entitlements; and it also involves finding the social and political will to acknowledge that there are problems, and then facing up to acting to resolve them.

For the next two decades, Peterson presents two scenarios that cover his range of possibilities. The best that can be hoped for is the "bumpy start-and-stop" future that afflicted postwar Great Britain. If that occurs, the standard of living in America will drop, its national indebtedness will be little changed
(but no longer growing), its international responsibilities will be necessarily curtailed, and its economic fate will be hostage to the tenuous and nervous confidence of outsiders.

In the second scenario, a "crash" followed by a lengthy U.S. depression, the traditional policy responses of fiscal stimulation and of loosening monetary policy will be of limited use, and "Americans will service and pay off their debts through indefinite impoverishment."

The difference between these two scenarios comes back to their timing. If America can pull it all together rapidly, and soon, then it can escape with a soft landing, and then a decade of start-and-stop. If it delays, or responds not at all or in a piecemeal fashion, then the crash will come, and stay. The logic here is that the longer the nation ignores its poor economic performance, the more severe will be the consequences when some critical point is reached.

In the terminology of this dissertation, Peterson has offered two scenarios, one resulting from an "economic crash" force, and the other from an "economic soft landing" force. I agree with most of Peterson's analysis, and accept that both of the scenarios have a high probability of occurring, and that the economic
consequences from each would be considerable. Thus each of them, on the surface at least, has the potential to be a perturbator. The question I address in the next two sections is whether I should accept both, or one only, or neither of these as such.

Specifically, my task is to attempt to create two scenarios, the first of which argues that an economic crash is a likely outcome, and the second which does a similar job for an economic soft landing.

3.4 THE ARGUMENT FOR AN ECONOMIC CRASH

Here, I start from the Peterson proposition that the choice for the future is either a crash or a soft landing. In this scenario, I opt for the crash. My reasoning here is that the alternative for the American economy is to walk a financial national and international tightrope for decades. I listed above the changes in savings, physical and educational infrastructure, entitlements, consumption, political will, (and there are others), that must occur in order to reverse the long term deterioration in the economy. When I look at this list, and when I realize that a reversal requires that the changes must all occur more or less at the same time, and that that time must be soon, then I see no scope for such an event. And thus, I argue, America cannot stay on the tightrope.
Even if Peterson's solutions were adopted, and even if they were adopted fully and deliberately and with the full enthusiasm of the entire nation, the time lag in reversing unfavorable trends would be of the order of several years. But there is a great deal of evidence to suggest that "several" years might in fact mean "ten or more" because of the sheer size of the problems; and there is also much to suggest that the nation does not have the consciousness, and the political and social will, to work seriously and collectively towards the proposed solutions.

Take the economic indicators first. Writer after writer argues that a position of near calamity is at hand. For example, Peterson (1987) points to the drop in net national savings from 7 percent of GNP in the 1970s to 3 percent in the 1980s, and contrasts this present figure with Japan's 7 percent. There are serious problems everywhere; in crumbling infrastructure (Yoo 1989; Gordon and Richardson 1989); in education (Bullough 1988; Perelman 1989; Finn 1990); in agriculture (National Research Council 1989); in all sorts of pollution (World Resources Institute 1989; Postel 1989; Flaven 1989; Beach 1989); in the banking industry (Nash 1988).
My position is that if the problem lay entirely in the national economy, then the best-case scenario of a soft landing could happen. But that will not happen. The problem stems not from a lack of economic opportunity, nor know-how, nor capital and so on. Instead, it stems from the fact that society is not conscious that a genuine crisis is near, and from the fact that those who are aware of its seriousness and imminence have nothing to gain from alerting society to the facts, and from a lack of national will to address critical problems.

There is a multitude of evidence to back this up. For example, the national deficit is commonly cited as the nation's major current problem. Thus the Gramm-Rudman-Hollings Act was set in place to "balance the budget" over six years. The whole thing has, of course, turned into a farce. Firstly, the whole concept of automatic sequestration — as a substitute for the deliberate and public making of decisions by Congress — is a grand example of the lack of responsibility I am referring to. Beyond that, the time period for balancing the books has slipped three years, and to top it off, the actual budget deficit comes in well over the official cap. What we have here is a cap on the budget, but not on expenditure. And on
top of that, there is an annual Congressional and Administration circus of indecision and buck-passing when it comes to setting the final figures into the budget.

Take other examples, such as the increased tendency of government to move expenditure items "off-budget." The bail-out money for the current Savings and Loans fiasco has come from this source; and that simply means adding to the pile of bonds that need to be serviced in the future. Or look at who is always to blame for America's trade deficit; it is never, believe it or not, America.

Take another example that relates to the numerous Trust Funds that operate, under Federal government legislation, to hold various moneys earmarked for specified government programs in the future. The best known of these is the Social Security Trust Fund; the current largest (in term of accumulated balance) is the Civil Service Retirement Fund; the three that will come under public scrutiny in the 1990s are the Medicare, the Airport and Airway Development, and the Highway Trust Funds.

When the income of a trust fund is greater than its outlays, the excess is invested in Treasury securities as a reserve against future expenses. This is now
happening at an accelerating pace as the retirement funds accumulate the reserves needed to finance benefits when the baby boom generation retires in the 21st Century. And this accumulation has served to remove from the public agenda the discussion of just how well the government will meet its future obligations to the specified programs.

Put simply and correctly, however, the government is not accumulating the excess funds; instead, it is spending them. The device it uses is to take the money from the Trusts, and in return issue securities that the government will redeem with cash when called upon. The money it takes from the Trusts it incorporates into the unified budget as just another set of revenues, and it spends them in the same vein.

This, of course, disguises the true size of the Federal deficit by huge amounts. In 1988, for example, the reported budget deficit was $150 billion. But included in that was a surplus of $100 billion from Trust Fund surpluses. Thus the total deficit in general operations of the Federal government was in fact $250 billion, out of total receipts of $1040 billion (Havens 1989).

The temptation for the government to continue this deception will grow very rapidly from this time
onwards, mainly due to the increases in the payments into the Social Security Trust Fund. For example, by 1994 the Congressional Budget Office projects that the reported government deficit will come down to about $130 billion, but only after the taking from Trust Funds of $170 billion. Beyond that date, the rewards for continuing the scam will become greater as the Social Security annual excess of $100 billion in 1995 swells to $200 billion only five years later, and to $420 billion by 2010 (Havens 1989).

Of course, it is nowhere mandated all of this must happen. In fact, from the time of the last rescue operation of the Social Security Fund in 1983 up until the present there have been many voices raised warning of the possibility and the dangers of just this (Marmor and Mashaw 1988). But, since the Fund went into the black two years ago, the appropriation of its moneys has become very swiftly embedded in the system of financing the government.

The good part about all this, for politicians and society, is that in only a few years from now, the problem with the Federal budget deficit will go away. No wonder President Bush can say there will be no tax increases; he, and all Presidents for the one or two decades ahead, and all the Congresses, and society, can
expect a growing glut of ready cash taken from the Trust Funds. That is, provided the current system survives.

My prediction is that the system will not survive for the twenty years of my framework. Even now there are a few whistle blowers, but the image of the social security system "secure to the year 2050" is so popular that no one listens. But at least some people will listen in the 1990s, when liabilities of the three Trusts -- Medicare, Airways, and Highways -- become obvious.

Take the Medicare Trust for the example that will be the most conspicuous, because it involves the most money and will affect the most people. Holahan and Palmer (1988) argue that present government forecasts already assume considerable success in controlling hospital costs and physician payments. They point out, using their own actuarial calculations based on 1988 data and (I believe) reasonable sets of assumptions, that the Medicare Trust Fund will go heavily into the red within a decade, and probably sooner. They conclude that improvements from the government's Prospective Payments Scheme (PPS) and from imposing increased beneficiary contributions must be recognized
as reflecting nothing more than a postponement of Medicare's fiscal problems.

Of course, the day of reckoning can be postponed, by say, inching up the current Medicare payroll tax from 2.9 percent to 3.0 and then beyond, or by increasing co-payments. But, I agree with their statement that "sooner or later, steps far beyond those currently contemplated will have to be taken."

Somewhere in all this, the whole system of the Trusts must come under close scrutiny, and maybe the whistles will be heard then.

Failing that, I argue that at some time in the next twenty years, there will be a widespread realization in society that for many persons the Social Security Trust fund will run dry. Perhaps it is unlikely right now that the typical Baby Boomer, aged forty say, will be disturbed by the thought that when she turns eighty there will be no money in the Fund, and that benefits will need to come from the pockets of the then-working population. But, will she feel the same at fifty years, or at sixty in the year 2010? My answer to that is that somewhere in the next twenty years, probably between 1995 and 2005, she will realize that she is facing serious trouble, and even the government will be forced to agree.
Probably then the government will set up a proper Trust Fund; and perhaps it will finance this via increased taxation, or by inflationary and money-printing devices such as going off-budget yet again. In any case, it will become obvious to all -- not just those who now know -- that the American economy is not only naked, but has no clothes in the wardrobe. And then a drastic version of the Peterson scenarios will become a reality.

But the point here is that it will be only then, or at some other traumatic trigger point, that the government and society will confront the multitude of economic problems that are now festering unacknowledged.

Concerning a trigger point, I think that there is a multitude of other events, or accumulations of events, that might start the crash. There is the possibility of a slow process, such as the gradual withdrawal of Japanese money from the bond market, developing into a stampede. There is the possibility of dramatic wildcard events, such as the murder of a President, or an earthquake in California. The Economic Community in Europe could well use its new currency to replace the American dollar as the world standard, and then it would be in the Community’s interest to expose
America's economic vulnerability. And so on, singly or in combination. And there is still the near certainty that the collapse of the Social Security Trust Fund will act as a trigger of last resort if all other triggers fail to fire.

Of course, in the shorter term, it could be that all such triggers are not equal, and that the immediate turbulence caused by one would be different from that caused by another. However, I take the view that the macro forces that will operate after the trigger fires will be such that the source of the turbulence will be of little consequence in the longer term, and that by 2010 the nature of the specific trigger will not be important.

In any case, returning to the question of whether the force associated with a Peterson-type economic crash rates as a potential health industry perturbator, I argue that America is following a national economic path that is bound to reap a harvest of financial disaster at some time not too far away. I also argue that the nation's leaders and opinion makers are fully aware of this, and that the public at large is at least semi-conscious of it. But there is no national will to address it; and the resolve to fix the situation will come only after some system perturbator or crisis
shocks the nation into action -- too late to avoid a major economic crash. The health industry is a major part of that economy, and can in no way expect to escape the full brunt of the economic chaos and dislocation that will follow.

Thus, I argue, an economic crash is a likely event, with drastic consequences for the health industry if it does occur. Thus I recognize it as a potential perturbator. And I leave a description of how it will affect the health industry until the appropriate scenario chapter.

3.5 THE ARGUMENT FOR AN ECONOMIC SOFT LANDING

Here I argue that an economic soft landing is likely, and examine whether its occurrence is likely to cause perturbation of the health industry.

There is considerable evidence to support a soft landing scenario. Peterson himself included the soft landing as a viable possibility. Further, print media editorials are persistent in pointing out the dangers inherent in current self-indulgent policies. The fact that Gramm-Rudmann-Hollings legislation exists at all, and the amount of hustling that is done because of it each budget session, indicates an awareness in Congress and the Administration that action should be taken. In early 1990, Congress did make some distressed noises
over dangers apparent in the administration of the Social Security Trust Fund. And so on.

Many writers -- not the Jeremiahs of the Peterson school -- have provided opinions and prescriptions that indicate that they consider that all is not yet lost. For example, Janeaway (1989) confidently advances a formula that would "revitalize" the economy; Dertouzos et al (1989) similarly provide formulae for America to "regain the competitive edge"; Whicker and Moore (1988) offer a different way to achieve the same goal. Stein (1989) -- a former Chairman of the President's Council of Economic Advisers -- argues that balancing the Federal budget is not the real problem, rather the problem is one of making good use of the national output. Baumol (1989) says "there is no basis for a conclusion that the long-term growth rate of US productivity has fallen below its historical level, or that it is about to do so." Heilbroner and Bernstein (1989) suggests that "to worry about the present size of the (national) debt is to magnify a mouse into a monster. It is simply a false alarm."

Kiplinger and Kiplinger (1989) provide an upbeat summary of the situation. For them, U.S. strengths far outweigh the weaknesses; popular impressions of deindustrialization, the U.S. drowning in budget and
trade deficits, and worsening education, are erroneous and dangerous. America will lead the world in the 1990s because it is the most international nation and will become more so. "The 1990s will be a decade of solid economic growth, broadly shared in an increasingly interdependent world, and the U.S. will continue to be the most influential nation in technology, trade, and political leadership."

Still, these writers are unanimous that the current economic situation needs urgent attention; and while each of them offers a different solution that accords with her or his particular emphasis, they do agree that the general solution demands that the nation immediately redress the macro economic defects that Peterson highlights.

All of this points to the possibility that sometime relatively soon serious attempts will be made to address the problems and that a Peterson-style soft landing will result. In fact, though, I -- along with Peterson -- expect that the consequences for the economy will still be severe since it will impose significant reversals and restraints. And, I expect that these will inevitably flow through to the health industry.
Thus, given that there is a reasonable chance that the nation will consciously opt for the soft landing approach, and that this will still produce major upheavals in the general economy and in the health industry, I accept that health industry perturbation will result.

3.6 GOVERNMENTAL IDEOLOGICAL OSCILLATIONS; EFFORTS TO REDUCE NATIONAL HEALTH COSTS

This is the first of three sections that deal with political economic forces that are specific to the health industry. In all, I examine four forces:

* national health care costs, and government's attempts to reduce them.

* government's ideological oscillations in making those attempts.

* the health system's ability to frustrate the implementation of governmental policy.

* the entry of megacorporations into the health industry.

Here, as usual, I am attempting to describe each force's relationship with the other parts of the system, and then to evaluate its chances of acting as a perturbator in the future. The first two of these forces are so closely linked that I have discussed them together in a single section; though I have evaluated
their prospects as perturbators separately. The remaining two are each given their own section.

Turning firstly to government’s efforts to reduce national health care costs, the appropriate starting point in studying this self-inflicted injury is, according to Marmor (1986), in the early 1970s with the macroeconomic events that included the inflation of the Vietnam years, and the stagflation that worsened after the 1973-74 oil crisis. In terms of federal health expenditure, he argues that, even without those pressures, the growth of large programs -- such as Medicare and Aid to Families with Dependent Children -- could not have continued without imposing severe economic strains. But, he says, the U.S. overreacted to the various cries of "crisis" in medicine in the seventies, and thereby institutionalized the politics of restraint. The situation since then has been exacerbated by ideological hesitancy and by the budget deficits of the eighties. "The American polity was exceedingly ill-prepared for the strains of the 1970s. In the 1980s, we have been living with the debris."

The ideological hesitancy he refers to stems from the series of decisions that both Republican and Democrat Presidents, and both Republican and Democrat Congresses, made contrary to their ideological stances.
It would have been expected in this period, based on ideological commitments, that Republicans would have supported moves towards competition in the health industry, and Democrats would have sought to advance their various distributive goals through forms of regulation. But this did not happen.

Thus, the Nixon and Ford administrations, avowedly pro-competitive, made proposals to introduce an National Health Insurance scheme, to support but prohibitively regulate Health Maintenance Organizations (HMOs), to impose a general wage freeze in 1971 that singled out doctors and hospitals both in terms of severity of the freeze and its duration; and to curb doctor and hospital freedom of maneuver through the creation of community-involving Peer Review Organizations (PROs). They did propose laws that promoted competition, such as those increasing the future number of doctors through subsidization (and regulation) of medical schools, but their major health initiatives were aimed at curbing the current rising cost of national health care, and the means they chose involved interference in the workings of the free market place. Starr (1982) describes this process as the conservative assimilation of liberal reform.
The Carter years did nothing to dispel the image of ideological confusion. This liberal defeated the Kennedy drive for an NHI scheme, and improved the competitiveness of the HMOs by removing heavy regulations imposed earlier. But the ambiguity was not only Carter’s; it was the Democrat House that let the doctors off the 1978 Carter-hook of regulation by accepting their self-regulation proposals.

Despite Reagan’s obvious ideological commitment to competition and privatization, his terms in office also were marked by a mixture of regulatory and pro-competitive proposals. As if to make Marmor’s point about the symbiosis between regulation and competition, his 1983-84 proposals for the PPS and the Diagnostic Related Groups (DRG) systems on the one hand imposed a massive set of regulations, and on the other created an environment -- at least according to his rhetoric -- that would stimulate competition between hospitals. Then, other proposals were straight out pro-competition, such as the liberalization of HMO regulations in 1982. Then, other moves appeared ideologically contradictory; for example, he proposed a temporary freeze on doctors fees in Medicaid; and yet he campaigned every year in Congress from 1981 to 1984 to have restrictions on Medicaid lifted to allow states
to accept competitive bidding by hospitals for Medicaid business. Then again, some moves were plainly expedient, such as his attempts to reduce taxation exemption benefits for employers.

All of this brings me to the conclusion that, since the early seventies, Federal health policy has been responding more and more to the pressure of increasing costs, and that the various policy proposals were more a matter of expediency than of ideology.

The Presidents and Congress were not alone in tackling the cost problem. For example, at the federal level, Department of Justice and FTC officials have begun antitrust challenges to the merging of numbers of competing hospitals (Klingensmith 1988). Similar action is occurring at the state level (Lynk 1984). Also at the state level, for example, in Illinois (Salmon et al, 1988), compulsory competitive bidding for Medicaid contracts has been introduced with the purpose of shifting Medicaid business from high-cost to low-cost hospitals; in California, this has been taken further in that competitive bidding has been extended to include all insurers, and to include physicians supplying services under Medicaid (Bergthold 1984). In all of these it is hard to find ideological motivation other than the desire to reduce expenditure.
The question that now arises is whether, firstly, ideological forces of the future will perturb the health care system. My answer is that they will not. The discussion above suggests that they have made little difference to outcomes in the last two decades; and I can see no indication that the situation will change in the future. If anything, they could have less influence as American political party influence declines. In any case, I have ruled this force out as a possible perturbator.

The second question is whether the national cost of Medicare will become a system perturbator. There are, in fact, two parts to the question since it is conceivable that a fall in cost could be the culprit, and so too could be a rise.

Take first a drastic fall in the national costs. To suppliers and service providers, this would mean a fall in revenue, and if it were drastic enough, then perturbation would follow. But there are no signs of that happening. In fact, quite the opposite has happened over the last two decades, despite the strenuous opposition of a whole range of governments. I can see nothing that indicates that this situation will change in the current homeostatic system.
Granted, it could be that some other force will break the homeostasis, and that national cost will be drastically reduced, and that will in turn strongly affect the industry. Indeed, this is part of one of my later scenarios. But under these conditions, it is another force -- and not a reduction in cost per se -- that is the perturbator.

A drastic rise in cost shows distinctly more promise as a perturbator. The recitation above of governmental attempts to reduce or restrain them is evidence enough of the strains they are already putting on government. And it is easy to argue that they will continue to rise. For example, they will surely increase as the size of the population does, and as the population ages. Then there are a host of other cost-increasing forces mentioned earlier, such as increased access to health services, marketing inducements to consume more including the proliferation of seductive new products, and the increased cost per unit of service coupled with an increase in the number of services used in each encounter with the health system. Surely, under current homeostasis, the cost will rise.

Of course there is nothing inherently wrong with a rising national health bill. There are many who would prefer it to a rising military bill; and there are
those who ask why it should not rise to say 20 per cent of GNP. But that is beside the point here, since the question is whether further rises in health costs per se will perturb the system.

My answer to that is that it will not. This is a touch-and-go decision, since clearly if the costs become so worrisome to government that it does provide opposition that really works on a large scale, then the health system will clearly be perturbed. And there is a good chance that they will try increasingly to do this. But I expect that they will fail to be effective. This is because, under current homeostasis, every move they make will be frustrated by a wide range of other actors whose interests would be damaged if government did become effective. I discuss these latter actors in the next section.

3.7 THE HEALTH SYSTEM'S ABILITY TO FRUSTRATE GOVERNMENT POLICY

Government has spent twenty years trying to restrain or reduce health care costs. How effective has it been? Despite the millions of words devoted to that question, and the many thousands of studies that have analyzed the effects, the answer is that no one knows. Contradictions in data and in opinions abound.
For example, Anderson and Erickson (1987) found that the DRG and PPS systems have reduced hospital costs, and Evans (1986) calculated that in 1984 they have reduced admissions by four percent, and length of stay by five per cent. But Evans notes also that the costs of program administration and insurance increased to the extent that "if this trend persists, it may be that the U.S. experience after 1983 represents a transfer of outlays and incomes from hospital patient care staff to managers and investors, with no net saving to payers." And he adds, in terms of physicians fees, that no changes since 1980 have had any detectable controlling effect on physicians fees. In fact, the opposite was true; there was an average rise of 7.0 percent in 1984-86, compared to a 2.4 percent rise in the CPI.

Other writers argue that any savings via PPS and DRG systems are one-off and that the health care system is based on cross-subsidies, so that if one group such as the government gets a special advantage for itself, then it is inevitable that other groups will face extra costs (Sapolsky 1986); that physician, outpatient, and clinical testing and diagnostic services are substituted for hospital services (Anderson and Erickson 1987; Miller 1988); that if Medicaid Uniform
Customary and Reasonable rates fall far enough below fee-for-service rates, then doctors drop out of the Medicaid system (Miller 1988); that the various review boards are symbols only; that the success of the anti-trust legislation is evidenced by the fact that Humana and other corporations have merged hundreds of hospitals.

The point here is that for every reduction in hospital or other costs, there was a strategy for someone in the system -- including the hospitals -- to recoup for themselves the cost saving. This is borne out by noting that national expenditure for health rose to 11 percent of the GNP in 1987, and federal health outlay rose to 14 percent of all federal outlay (Bureau of Census 1990). By any yardstick, these figures mean that cost containment was not working as hoped for. For example, in 1977, the corresponding figures were 8 and 11 percent (Crozier 1984; Long and Welsh 1988). Or, as another example, the 11 percent for the U.S. compares with 6 percent in U.K., 7 percent in Japan, and 8 percent in West Germany (Schieber and Poullier 1987).

But to say that they did not work at all would not be correct. Collectively, they must have had some effect, either in increasing costs or decreasing them.
I choose to believe that they have reduced them from otherwise higher levels down to the levels quoted above. To support this, I might argue that costs would have been greater if the hospitals had remained on the cost-plus basis, and if hospices had not been included under Medicare and Medicaid, and if the number of doctors in the system had been constrained in recent years.

But overall, I regard any cost gains as uncertain, temporary, often illusive and as of little consequence in terms of magnitude. Long and Welsh (1988) say it well -- the current process of cost-cutting is akin to pushing on a balloon.

In order to see the implications of this for the future of the health industry, I must ask why these policies have fallen short of their goals. And here I have a moment of doubt. Perhaps the policies have worked better than I indicated. After all, when you have an increase in population, an aging population and marked increases in the number of old old within those populations, then it is inevitable that national and governmental health costs will rise. Is it perhaps true that demographics alone are responsible for the increasing costs? The answer to this is that the unit cost for physicians’ services increased fourfold
between 1970 and 1988; the cost of a hospital room increased sixfold; but the Consumer Price Index increased only threefold (Bureau of Census 1990). It was not only demographics that caused increased national expenditure. It was also the greater unit costs, and greater individual consumption. Why, given the attempts to curb rising costs, did this happen?

The answer to this question lies in the resistance to most forms of change from physicians and their Associations, from the hospitals and their administrations and boards, from the medical schools and teaching universities, and from the drug companies; it lies in the support that employers and unions give to their concessionary taxation treatment; it lies in the vast political power of the aged, and of the rapidly increasing number of non-physician medical professionals, and of the newly arrived megacorporations; it lies in a system of bureaucracy and of law that allows contenders for power to eviscerate legislation and to postpone and frustrate effective implementation (Wohl 1984; Califano 1986).

And it lies with the up-till-now lethargy of commercial insurers in seeking to encourage cost savings (Gabel et al, 1987). Add to this the strong desire that Americans have for treatment, and for high
technology treatment; and also add the increasing efforts of a seductive advertising industry. In short, while government sees advantages in reducing health care expenditure, there is a vast array of actors and forces that thrive on the current situation of high and increasing expenditure.

There is nothing to suggest that any of these actors will change their behavior in the future. Indeed, it will become apparent as I examine the actors separately in Chapter Six that, if anything, the trend is that many of them will become even more effective in frustrating government policy.

As usual, I must ask here whether this force will cause perturbation. My answer is that it will not. Collectively, the actors are a very conservative force; they are currently reaping major benefits from the gradually expanding system, and they will act deliberately to preserve the current system for as long as they can.

3.8 THE ENTRY OF MEGACORPORATIONS INTO THE HEALTH INDUSTRY

Since 1970, the health industry has progressively moved along the rationalization path described by Stigler (1952). First, in the 1970s, the backyarders in the nursing home industry were consolidated into
larger units; and later in the decade, hospitals started along a similar path.

But the momentum of consolidation picked up early in the new decade, and has accelerated persistently since then. Wohl (1984) and Califano (1986) describe the massive changes in control of the industry, as the process of consolidation of local delivery units has gone on simultaneously with the development of ever-larger national chains, and the process of vertical integration coupled with within-industry diversification.

Virtually every type of service delivery has been affected: hospitals, nursing homes, pharmacies, physicians, free-standing pathology and other testing units, radiology and diagnostic imaging businesses, computing systems for accounting and record-keeping and other uses; and so on, right down to the suppliers of paper towels.

Some of the predators had their business origins in the health industry; some, such as the insurance corporations, have been on the fringe; others have had no previous involvement (Wohl 1984). What they had in common is, firstly, they possessed the capital that is increasingly needed to buy more and more expensive
equipment; and then the capital to buy out those other operators who cannot meet the new capital requirements.

Secondly, they shared the capitalist’s need and desire to invest in an expanding industry where there is a reasonable chance of satisfying corporate profit-making requirements. The health industry, with a guaranteed market, a demonstrated capacity to resist regulation, a high level of government underwriting, and delivery units that had themselves done some of the rationalization, suited their purposes very well.

I do not classify the force generated by the entry of the corporations as a potential perturbator. I do expect that, under homeostasis, the processes of rationalization will continue apace, and that the industry will move progressively towards an oligopoly. But this process is already moving along an established trend line, and it can continue thus without perturbing the system. But that is not to say that the force will not be disruptive to the industry; it certainly will be. But not until some other perturbator destroys the homeostatic system that now exists. Then, as I discuss in later scenarios, the ensuing chaos in the system will unleash all the opportunities that crisis situations provide; and then the prospect of oligopoly will change to a reality.
CHAPTER FOUR: SOCIAL MACRO FORCES

4.1 INTRODUCTION

In this Chapter, I examine eight societal macro forces. The first six of these relate directly to the health industry, and I present them spread over four sections. The last two forces are pertinent specifically to the hospice industry; thus I do not need to scrutinize them for their possibly perturbative effects on the health industry.

These social macro forces are:

* access to health care services, and also the institutionalization of health insurance -- both in the same section.
* the attitude of society towards suicide and euthanasia.
* the medicalization of society; and the dominance of scientific medicine -- both in the same section.
* changes in individual lifestyles.
* the supply of primary care givers for hospice.
* trends in voluntarism.

4.2 ACCESS TO HEALTH CARE; INSTITUTIONALIZATION OF HEALTH INSURANCE

In the last two decades a significant social force, initiated in the 1970s, was what Starr (1982) called "the generalization of rights" that took the form of
dozens of movements each marching through the courts with its own catalog of demands. In terms of health care, there were demands for equality of care, which meant equality between the poor and the rich; and meant that health care was a right, not a privilege; and it meant flirtation with various forms of national health insurance, and with variations on prepaid group practice, and so on. And there were demands for equality in care, which meant greater equality between professional and client; it meant the right of informed consent, the right to refuse treatment, the right to see one’s own medical records, the right to participate in therapeutic decisions, the right to death with dignity; and as a consequence, it meant a change in the public perception of doctors. "Once a hero, the doctor has now become a villain... and the medical profession (is seen as) a dominating, monopolizing self-interested force (Starr 1982)."

In the 1980s, some of these demands disappeared or went into limbo. For example, the National Association of Social Workers still lobbies vigorously for a national health scheme, and Senator Edward Kennedy has not given up on the idea. Still, they have only sporadic support from other sources, so that in a period when privatization is much favored, and when
cost containment is the order of the day, there is little scope for them to succeed.

Other demands, however, have become persistent parts of the health care scene; some because they were accepted and institutionalized; and others because they are highly regarded by society but have not as yet been accepted. It is these persistent demands, fulfilled and unfulfilled, that constitute major forces for the future; and it is forces such as this, and their consequences, which are discussed immediately below.

The societal struggle for universal access to health care, from the cradle to the grave, has been enduring; and many more persons now have access to health care than twenty years ago. An initial impetus for this came from the passage, in 1946, of the Hill-Burton Act that started a huge program of community hospital construction that continued on for almost thirty years (Starr 1982).

More recently, access has been improved by a wide range of measures. For example:
* there was a big increase in the number of persons covered by some form of health insurance. The increase emanated partly from the 1950s accords between the government and the employers and the unions, and partly from the implementation and incrementation of Medicare
and Medicaid coverage, and partly from increasing numbers of persons taking private insurance, or taking gap insurance; and partly from membership in a HMO or some other form of prepaid practice, and partly via some form of service with the military.

* in the 1970s, there was a large increase in the supply of doctors, and this was accompanied by a more even geographic distribution of these throughout the nation; there developed an attitude in society that increasingly saw access to health care as a right; there was a limited increase in number of community health centers with their emphasis on the provision of "one-stop" ambulatory services; Medicare was extended to cover persons with kidney diseases; and so on.

* in the 1980s, there was the introduction of employee choice options for group insurance schemes sponsored by the Federal government, and by many of the larger corporations; there was the extension of Medicare to cover hospice patients, and of Medicaid to cover AIDS patients; there was increased availability of hospital outpatient services and of walk-in clinics; and so on.

In any case, by 1987, some 87 percent of the population was enrolled for some level of care (U.S. Bureau of Census 1990), whereas twenty years previously, only 74 percent were enrolled, and then
often for a lesser range and depth of services (U.S. Bureau of Census 1968). But the push for yet more access did not stop then. Currently, for example, in Congress:

* there are a number of proposals to mandate group health insurance participation for small businesses. The Kennedy scheme would provide health insurance coverage for an estimated 25 million persons, while at the other end of the range, the Hatch proposal would cover 8 million, though it is true that many of these millions are already covered by personal or other insurance schemes.

* all the various proposals for long term care contain provisions relating to care and treatment of the ill, not just the elderly, and not just from the point of morbidity onwards.

At 1990, then, I can point to long term forces that have worked persistently for increases in access, I can say that they have succeeded in achieving much of their goal, and can add that they are still there pushing hard to incrementally finish off the job. It would be easy to blithely assume that they will readily do so.

But there are a number of forces and actors working to prevent this. If 87 percent of the population are covered by some form of insurance, there are 33 million
persons who are not. Califano (1986) adds to this; he estimates that, in 1985, the coverage of 16 million additional persons was quite inadequate. Even those who are insured in one way or another are often crippled by encounters with the health care system. For example, Medicaid patients, including those in nursing homes, need to "spend down" their assets to very low levels to qualify for assistance. Others with private insurance face similar problems when their caps are exceeded. For many others, the co-payments are beyond their means.

The cost of bringing all of these persons fully into the insurance system would be very great, and it is a fact that it is this body of people who are least able to themselves contribute towards this. The cost would need to be borne by others.

Thus, the strong support for increased access is being met by formidable opposition. For example, the small business lobby is resisting their cooptation into the compulsory insurance schemes, and suggestions -- that big business is supporting the legislation only as a means of shifting their own burdens (Cohodes 1987) -- are probably true. Further, many major employers have introduced quite reduced benefit plans to new
employees, and have moved with occasional effectiveness to reduce benefits to current and retired employees.

Also, there are those who see the cost reduction attempts of government over the last two decades as having deeper significance. Cohodes (1987), for example, sees the cutbacks in Medicare and Medicaid in the early 1980s as evidence of a retreat from collective responsibility, and the incremental repudiation of the Great Society Programs. He predicts that "to the extent it can, Congress will rewrite these programs, and view the passage of Medicare and Medicaid as an albatross enacted by a guilt-ridden society." He expects that Medicare programmatic re-design will occupy the Federal legislative agenda, while at every possible opportunity the private sector will be encouraged "to substitute the invisible hand of Adam Smith's marketplace for the prescriptive actions of government." In the run up to the 1990 budget, there was some speculation that Congress might choose to accelerate the policy changes of the 1980s by imposing Medicare upper limits on doctors' charges (as opposed to hospitals') for each unit of service.

For the future, then, I expect that the supporters of increasing access will be met with opposition from those whose economic interests will be damaged by this.
On balance, I expect the supporters to have something the better of the battle. Firstly, in the short term, Congress will eventually legislate to approve some of the proposals listed above, and many millions of persons will thereby be given new access. None of the proposals and ruses suggested for reducing access would have impacts in any way comparable, and I expect in the short term the net effect of the various efforts will be to increase access.

Further, in the longer term, every past extension of access has quickly become institutionalized, and efforts to reverse this have been made only at the margins, and have generally been of little success; I expect that this pattern of successful resistance will continue. There can be no doubt that the people of America want access to health care, and while it will be possible to reduce it for the well known groups of politically powerless and fringe minorities, I cannot see that the government or any other actor will achieve much reduction for the rest of the population.

In all, though, there is little to suggest a major change from current trend; and I do not classify access to health care as a likely perturbator. During homeostasis, I expect that somewhat increased access will have the effect of decreasing mortality.
marginally; and at the same time it will provide greater revenues for the health industry, and this will in turn increase the incentives for megacorporations to enter the industry.

The second force in this section is the institutionalization of health industry insurance; and here I include all forms of insurance schemes including Medicare, Medicaid, group insurance, pre-paid plans including those of HMOs, private insurance, gap insurance, and so on. My argument here is that, since World War II, access to health care has become increasingly identified with coverage under insurance, so that now access and coverage are seen as almost synonymous. Indeed, in the paragraphs above, this is the approach that I have clearly adopted.

At 1990, there is good justification for this. The cost of an encounter with the health system has risen to the extent that few persons in this nation can afford it except on a risk sharing basis. Most persons without coverage have dubious entry to the health system at all, and also have severely limited options once they are in it. Yet all persons want the full services that the system can provide; and the widespread and persistent and growing quest for these
services has led to the *institutionalization of health insurance* as the means to this end.

But the fact is that access and insurance coverage are different. And the distinction is important for the future. Take the Federal government for example. At the same time as it presided over the institutionalization of Medicare, it also created a reimbursement system where it is firmly established that the user will pay if government mandates this. For example, Medicare Part B is voluntary and requires an annual up-front premium; so too did catastrophic health insurance; co-payments of various types are almost standard; Medicaid often involves spending down; and so on.

Currently, government premiums and co-payment rates are fixed at levels that allow mass participation; but there is no guarantee that they will remain at these levels. If government chooses, it can change these rates and -- still maintaining correctly that Medicare is a protected institution -- thereby reduce access to services for large numbers. The same is true for other insurers.

In the future, I do not expect this to happen under homeostasis, and so I do not regard institutionalization of health insurance as a likely
perturbator. On the other hand, it is worth pointing out here that there is considerable scope for this to occur under various states of heterostasis, and that I will return to this in some of my later scenarios for the future of the health industry.

4.3 ATTITUDE OF SOCIETY TO SUICIDE AND EUTHANASIA

In the last two decades, there are many who claim that the attitude of society towards dying and death has changed substantially.

Proponents of this view offer a host of supportive arguments. For example:

* the written and the spoken words of Mitford, Kubler-Ross, and Saunders -- in their respective fields of funeral abuses, dying and death approaches, and hospice care -- gathered enormous public interest that led to major changes in philosophy and practice in those fields. Kubler-Ross's book, "On Death and Dying" had sold over a million copies by 1976 (Paradis 1985).

* hospice has so quickly become institutionalized in America. Further, many aspects of hospice care have been adopted in other parts of the delivery system. Paradis reports that hospitals and home health agencies have begun advertising their "hospicelike services"; nurses, health professionals, and society are learning
about palliative care and the differences between palliation and cure.

* the concerns and debates over use of life preservation equipment, in cases such as Quinlan and Sackowitz, caused a revulsion in society against prolongation of life in the vegetative state and in a hopeless pain-ridden state. The consequence of this has been that the use of living wills and durable powers of attorney has become widespread in society at the same time as there has been a proliferation of States' legislation that legitimated these instruments for death with dignity.

* a level of openness developed in hospitals concerning decisions in matters such as resuscitation codes and life and death decisions for impaired infants.

Paradis (1985) sums it up. She writes that:

public awareness of issues related to death and dying is at its peak. Heightened awareness is due, in part, to the increased incidence of cancer, improved longevity, and growing concerns over rising health care costs. These reasons aside, public pressure on established practitioners and institutions has risen and consumers demand more and different types of medical care.

Dying persons, Paradis claims, want to be treated as a real persons, made comfortable, coherent until the end. "Take me off the respirator" is an increasingly
voiced cry. "Let me die at home, I want to be somewhere familiar."

There are some counter indications. For example, doctors are just as reluctant as ever to give up hope on a patient. Patients and families share this attitude as witnessed, for example, by the fact that patients entering hospice have an average life expectancy of some 30 days, which usually signifies that they have continued with aggressive treatment long after a terminal diagnosis has been made. It is also true that 68 percent of deaths in 1987 occurred in hospitals, and 25 percent in nursing homes (Mor 1987), so that for all the changed attitude to death and dying, in practice only a handful of persons did die outside the now dominant system.

Aries (1974) sees the momentum of attitudes as being against change. He studied the dying and death process over the last 800 years of Western civilization, and considers that the fourth and current stage started about 1800. At 1980, he writes that man is no longer master of his death and the circumstances surrounding it. Today, nothing remains either of the sense that everyone has or should have of his impending
death, or of the public solemnity surrounding the moment of death.

He states that:

What used to be appreciated is now hidden; what used to be solemn is now avoided; modern society deprives man of his death, and allows him this privilege only if he does not use it to upset the living. In a reciprocal way, society forbids the living to appear moved by the death of others; it does not allow them either to weep for the deceased or to seem to miss them.

At 1990, it is too early to proclaim that the events and attitudes of the last two decades do indeed signal the end of a two-century trend and the beginning of a new Aries-type stage. What is obvious though is that technology has now made it possible to prolong human life in a vegetative state almost indefinitely; and technology again has made it possible for people of all ages in states of severe disability and distress to live longer than in the past. These are two strong forces that will progressively impact the personal lives of more and more persons. They raise a myriad of death-and-dying ethical and practical issues that will force society to re-think many of its attitudes; and, I expect, in the forefront of society's re-thinking will be the attitude that it currently has towards suicide and euthanasia.
Over the last two decades, according to Weisbard and Siegler (1988), the powerful rhetoric of "death with dignity" has gained much intellectual currency and increasing practical import. So much so, that the movement supporting it has now advanced to the new frontier involving the termination or withdrawal of fluids and nutritional support from the dying patient.

They point to the acceptability in respectable forums of proposals to permit avoidable deaths by dehydration and malnutrition -- a step further than turning off a machine -- and that a few years ago such proposals would have been repudiated by the medical community as medically objectionable, legally untenable, and morally unthinkable.

Daniel Callahan (1988) argues that the matter emerging for public discussion now is:

we know in our bones that we are going to be faced in the future with a growing number of cases of the biologically tenacious, those whom we think ought to be allowed to die but who simply will not die unless we apply the extra and exceedingly effective mode called forgoing sustaining food and water.

He believes that there will be a substantial increase in the number of chronically ill elderly who will not die, and that "many, many lives will be at stake." He welcomes the suggested guidelines laid down
by writers such as Lynne and Childress (1986), but sees three dangers emanating in practice from them.

Firstly, he asks, what will happen to practices when they are taken from the hands of the first thoughtful and deliberate pioneers, and are put into the hands of large numbers of people who may not approach them with the same care. He fears that implementation could become thoughtless, careless, and incorrect, and easily create another form of abuse such as those periodically reported in nursing and chronic care centers.

Secondly, he worries about the so-called scandal factor, wherein decisions to terminate are made well in accordance with guidelines, yet the press react with "Black Man Starved to Death in Hospital" headlines.

Thirdly, he argues that in our society we have a solid history of seeing things that were initially introduced as possibilities for choice or discretion turned into matters of mandatory behavior. Thus:

The way we usually change free choice into a coerced choice is not by direct command. Instead, we just tell people what would count as morally responsible choice, applying general social pressure in its behalf. Given the number of people who are a social burden, it is easy to imagine such pressure.

Other opportunities for social dissension arise. For example, there is the dilemma faced by the criminal
prosecutor in deciding whether to press murder charges on doctors who deny nutrition. There are a series of financial problems; for example, the consequences of making a patient more comfortable may reduce the level of care that third party payers will support. There is the symbolism of giving food and water, and the psychological stress that denial brings to both patient and caregiver. There are the many arguments that arise when a competent patient refuses nutrition.

I expect that these writings are the first signs of a conflict that will soon engulf society and the health industry. The gaps between the conflicting philosophies will be vast and durable, and society will be split no less than in the current battle over abortion. The philosophy of the movement for change will be based on the supremacy of the individual over the state in the control of her or his own body. Its arguments will be that the terminally ill should have a means of death which does not torture themselves and their watching family; that all sufficiently stressed persons should have the right to escape from a hopeless and painful life; that, for those doing so, there must be a legal and painless alternative to malnutrition and starvation; that the financial cost of keeping the suffering persons alive is a great burden on the
individual and the state; that in a highly technological and automated society, the capitalist state need no longer preserve its workforce by placing a blanket ban on suicide.

Opponents will contest all these, and will add that there is a god-given sanctity to human life; that the movement's proposed system would be impossible and expensive to administer; that there would be great scope for abuses, including murder; that precedents would be set that allow the extension to more and more categories; that an attitude would develop that places an obligation on certain persons to suicide; that all persons who are participants in a given death would be psychologically damaged permanently; that as various states compete for the available business by introducing new sets of persons into their categories, it would become possible for almost anyone to "shop around" for a category that suits them, and this includes persons in states where the innovation is not legal.

In all, I consider that there is a high likelihood that conflict along these lines will develop; and that if it does, the consequences would be sufficient to disturb current homeostasis. Thus, I classify
society's attitude to suicide and euthanasia as a potential perturbator.

4.4 THE DOMINATION OF SCIENTIFIC MEDICINE:

THE MEDICALIZATION OF SOCIETY

Starr (1982) pointed out that the medicalization of American society goes back for more than a century in history; and he traces its progressive growth since then. He records a number of conspicuous developments; for example, governmental support for the 1911 Flexner report; the growth in public health disease prevention techniques that scientific medicine has adopted as their own; the dramatic advances in drugs and surgery during World War II; the surgical miracles of the last decade; and so on. But, apart from these highlights, he also records a history of steadily increasing acceptance of medicine, and in particular scientific medicine, by society.

Other writers, describing aspects of the last few decades, have reported on the depth and width of medicine's penetration into everyday life (Friedson 1970; Zola 1983; Knowles 1977; Mechanic 1979, 1986). Many others have done more than report; they have waxed strong against it for its detrimental socialization effects (Illich 1973, 1976; Waitzkin and Waterman 1974). Others have extended their attack beyond
medicalization to rail against scientific medicine in particular (Weil 1983; Carlson 1975).

Other criticisms abound. Treatment is often iatrogenic (Illich 1976); medical practitioners are self serving (Illich 1973); patient-doctor contact is increasingly depersonalized (Banta and Gelijens 1986), it suffers from poor cost-effectiveness, erratic quality and misguided marketing efforts (Abramson 1990). Bailer (1987) typifies criticism of research; there has been little or no success in reducing overall cancer death or incidence rates, or improving case survival rates; we have had 35 years of unfulfilled promises; there is a need for greater objectivity from senior program managers at the National Cancer Institute as they report on progress, or lack of it, to scientists and the public.

Inlander et al (1989) provide an imposing list of faults; drunk and doped-up doctors, widespread laboratory errors, wrongly-administered anesthesia (killing up to 10,000 persons a year), unnecessary operations (perhaps 5 million to 35 million performed per year), flaws in medical education, hospital-originated infections (afflicting one out of every five patients), medication errors, loopholes in the medical licensing process, and insufficient disciplinary
measures for malpractice. Califano (1986) complains about the coronary bypass "epidemic." And so on.

I expect, that despite all the faults of medicine and the health system, society in the future will become even more medicalized. Part of the lure lies in the value that Americans place on technology generally, and the fact that it will become more technological adds to the attraction; part of it lies in the demise of alternatives, especially in traumatic and death-approaching situations; part of it lies in marketing; and in the obstructive power of entrenched expansionists; and so on. But, whatever the multitude of causes, I can see no sign of any reversal from the current trend towards greater medicalization.

This does not mean that it will become a perturbator. It will not. It will continue along its current path of steady increase, and will not in itself perturb the health system.

4.5 CHANGES IN INDIVIDUALS' LIFESTYLES

In this section, I conjecture on whether changes in lifestyles will generate forces that will cause system perturbation. In doing this, I selected three habits of society that clearly do contribute to deterioration of health or to death. Then I asked the question of
whether there is any chance of a significant change away from the current behavior patterns.

Firstly, motor vehicle collisions. These are a major killer and maimer. By whatever set of statistics used, the incidence of collisions and the average effects of collisions have remained stable for a decade, and there is little sign that they will change. Granted, American alcohol consumption has fallen significantly from 1980 (New York Times 1989); granted that the Reagan administration tied some state aid to increasing the minimum legal drinking age; granted that manufacturers are marketing (the word is chosen here deliberately) so-called safer cars; granted that groups like Mothers Against Drunk Driving make valiant and sometimes effective attempts to change behavior.

But surrounding these changes is an environment that does anything but promote reform. Cars are marketed for their power; laws mandating the wearing of seatbelts are poorly enforced; random breathalyzer testing is a rarity; legal blood alcohol limits for driving are generous to the driver. The idea of mandatory tachometers on heavy vehicles is scarcely heard; the concept of mechanical limits on the maximum speed of all vehicles would be anathema if it were heard. America is a decade behind the rest of the
First World in all of these matters. As well the car clearly remains dominant over other means of transport; and I expect that the suppliers of oil, vehicles, highways, and health services will be powerful enough to at least maintain their current levels of benefits. This will not be a perturbator.

Secondly, tobacco consumption. According to Surgeon General Koop (1988), smoking is America’s foremost public health problem, killing an estimated 350,000 Americans in 1986. The U.S. pays $54 billion each year in health care costs and income lost by sick smokers and those who die (White 1988).

In the last decade, males on the average have consumed less tobacco, and females have consumed more; but average female consumption is still well short of that of males. This suggests that the a new lower national level will be reached. As part of this, there has been a wider acceptance in society of the dangers of smoking, as evidenced by the creation of smoke free zones, extending even to airlines; by the concern in some quarters over the effects of secondary inhalation; by restrictions on advertising; by death threats on packets; and so on.

But there are plenty of indications that White’s (1988) "Merchants of Death" are a long way from the
wall. He points out that the growing awareness of tobacco's threat to health has paradoxically helped the industry in some respects. It has kept competitors away, and has thus created a classic oligopoly; and it has led to greater consumption of filter tips, thus reducing the cost of each cigarette and adding to profits. He also points out that tobacco price supports are as prevalent and as strong as ever; that cigarettes are still the most advertised product in the U.S.; that such advertising has tax deductible status; and that government has the unused option of raising excise to the point where consumption really falls.

I consider that tobacco consumption will progressively be reduced but only at a slow rate; and certainly the consequences will not be sufficient to destroy current system homeostasis.

Thirdly, alcohol consumption. As mentioned above, national consumption has fallen over the last decade. However, males have provided the basis for the reduction; and in fact, female consumption has steadily increased. This is despite the fact that two separate government studies (Schatzin et al, 1987; Willett et al, 1986) done in the last decade have concluded that a moderate consumption of alcohol (say two drinks a day) was correlated with an alarming increase in
breast cancer in women. These were huge, apparently valid studies, by reputable agencies. Yet no one pays any attention to them.

I could conjecture on why this is so. For example, it could be that society does not want to hear the message. It could be that powerful business interests disseminate alternative information. It could be that public health agencies are so far down the pecking order that they do not have the funds to take the studies’ findings to the public in a way that will have an impact. But all that is beside the point. What is pertinent here is that important messages about the ill affects of alcohol have not been heard, discussed or heeded. I argue that the widespread reduced drinking of alcohol could indeed perturb the health industry. But it will not, because whatever the cause, society in general is not ready to reduce consumption that much.

In summary, I expect that none of this section’s three forces will be perturbators. Nor do I expect that forces emanating from jogging, or from reduced cholesterol intake, or other lifestyle changes will be. Perhaps the cumulative effects of these latter will benefit individuals in due course; perhaps they have done so already. But in any case, not to the extent to throw the health system into heterostasis.
4.6 THE SUPPLY OF PRIMARY CARE GIVERS FOR HOSPICE

I indicated above that two forces have developed that pose a threat to the supply of care givers for hospice patients. The first of these was the possibility of increased intergenerational conflict; and the second was the shortage of male partners stemming from the demographic forces.

Now I add three other forces. Firstly, high divorce rates reduced the potential for partner support; and, because males re-married more than females, it was again the elderly female who suffered on this score. Secondly, the potential for support by children was reduced by divorce and remarriage so that fewer children had allegiance to the parents that raised them; by high levels of residential mobility of children and parents; by more women entering the workforce. Thirdly, the closing down of old industries, and the disintegration of job-based stability, has separated family members (Lusky 1986).

The consequences of these social developments for the health care industry have been that the nursing home and home care industries have boomed; and they have become valuable prizes for the forces of rationalization and aggregation. For the hospice industry though, it has created problems. That is
because pioneer hospice philosophy in the U.S. almost mandated that primary care be provided by a family member. Yet it is clear that that can not always happen; and that probably the numbers thus excluded from hospice care will increase. This in turn provides a problem, since it is foreign to hospice philosophy to exclude anyone. But this is just one of the dilemmas facing hospice in philosophy and practice; and I will return to these in the final two chapters.

4.7 TRENDS IN VOLUNTARISM

Voluntarism is an institution in its own right in American society. And it is fundamental to the survival of hospice under present homeostasis. From the point of view of hospice, there are four trends in voluntarism in society generally that are important.

Firstly, the pattern of the last century has been for voluntarism to progressively give way to professionalism, and for movements of compassion to be absorbed by professional service providers, increasingly under governmental auspices. More recently, in the last two decades, an ever increasing number of health industry providers have fallen prey to various forms of professionalization, but now at the hands of private entrepreneurs. This is not just to say that various agencies have been taken over; what it
adds is that the basic motivation of the persons in the agencies has moved from compassion towards self-service and profit.

Secondly, the supply of volunteers over the last two decades has fluctuated, but seems to have remained fairly steady; though fashionable charities have come and gone.

Thirdly, over the last two decades, the per capita monetary contributions to charities has risen and fallen with economic prosperity; but with a long term trend towards a decrease as people see welfare as being more in the domain of government.

Fourthly, over the last decade, there has been uncoordinated but persistent reference to the privileged taxation status that voluntary organizations have as non-profit organizations. While it appears that status is secure, these references are a reminder that all organizations might not be secure for all time from a different level of taxation.

These are all important social trends that might well affect hospice even under current homeostasis; but I expect that in periods of heterostasis such as I describe later, there will be rapid changes in these trends, and that they will materially affect the fortunes of hospice.
CHAPTER FIVE: DISEASE AND MEDICAL TECHNOLOGICAL FORCES

5.1 INTRODUCTION

In this chapter, I discuss disease and medical technological forces. For the latter, I used the Office of Technological Assessment's definition of medical technology as the drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided.

Thus, I have included here sections on forces emanating from public health and prevention; from testing and diagnosis; from treatment including surgery; from research; and from communications and information processing. Also, I discuss the cost of a unit of service. And I conclude with a section on the forces generated by the AIDS disease.

5.2 PUBLIC HEALTH AND PREVENTION

The earliest conspicuous success of the prevention industry goes back to the decades just before and after the turn of the Twentieth Century. In this period, emphasis turned towards the implementation of germ theory, and the now discredited miasmatic theory, into the practice of public health. The methods used were to improve sanitation, drainage and water supplies and personal hygiene. When these were joined with a long
term improvement in the standard of living, and the better diet and living conditions that accompanied this, the way was opened for the first widescale triumph for the public health industry.

The benefits from these early programs have been built into the framework of our society; they are often unnoticed, except in the breach. The credit for them has passed, not to public health, but to scientific medicine.

This typifies the position of public health in prevention today. It is a poor second cousin. For example, the Occupational Safety and Health Administration has always been understaffed and under-supported; environmental protection bodies are usually outmuscled; programs to reduce alcohol and tobacco consumption are underfunded; change-of-lifestyle programs are coopted so as to place blame for poor health onto the individual; funds for the prevention of AIDS are meagre and reluctantly given. And so on.

Apart from the poor political standing of public health, Walker (1989) points out that much of the public health system was in the past associated with communicable disease control. The decline in some infectious diseases and the disappearance of others has led to the erroneous assumption that public health
problems have been solved. He delivers "an urgent message" that U.S. public health activities are in trouble, characterized by lack of clarity and agreement about the mission of public health, the role of government, and the means necessary to accomplish objectives.

Given the weak political standing and the lack of mission, I do not expect public health prevention to perturb the system.

5.3 TESTING AND DIAGNOSIS

The last two decades have seen a boom in the businesses of testing and diagnosis. As Anber (1987) puts it, "there is hardly a physical property of matter that has not been applied to clinical diagnosis". Califano (1986, 1989) points to the enormous increase in the range of tests, the number of tests per encounter with the health system, the number of encounters with the system, the number of tests done on a bodily sample, the number of radiographic procedures performed, and so on.

For diagnosis, the patient can now enjoy a day-after test for pregnancy; a wide range of electronic imaging technology; fiber optic non-surgical invasion; DNA-based tests for fetal abnormalities (Holtzman 1989); the choice between 4000 single gene disorders
for their children (Institute of Medicine and Nichols 1988); and a whole range of new diseases, many affecting the elderly, that were unheard of a decade ago.

Reiser et al (1984) notes that we already have machines programed to question patients about illness and monitor physiological functions, and to analyze the data generated by these activities. He considers their use will be ubiquitous in the future, and that more and more medical activities now performed by persons will be possible to capture and simulate using machines. Anbar (1987) believes that we are witnessing only the beginning of technological diagnosis. Bezold (1987), Banta and Gelijens (1986), and a host of other writers agree.

Testing and diagnosis have definite potential to cause system perturbation. Take, for example, the field of life technologies. Holtzman (1989) argues that in the quest for perfect babies and lower health expenditure, prenatal diagnosis and abortion could be widely used.

Weiss (1989) points out that biomedical cartographers have already located more than 400 genetic "markers" or signposts of genetic disease, on all 46 human chromosomes. Then, Rothstein (1989)
suggests, that "20 or 30 years from now ... life insurance policies will be essentially accident policies, because everything is foreseeable". Andrews (1989) takes up the argument from there. If one's genome is seen as a template for future disease, premiums for some persons will become prohibitively expensive. Insurance will thus lose its social value of spreading risks across groups. I add that this would cause enormous disruption to the health insurance industry. Nelkin (1989) adds the advantage that it will become possible to protect especially vulnerable workers from harmful substances.

But these examples are taken from only one of many fields. Taking the fields together, there is a reasonable likelihood that they could cause perturbation. I do classify them as potential perturbators. But, anticipating my conclusions in the next section, I expect that forces emanating from treatment will also be potential perturbators. Rather than develop scenarios round both of these similar futures, I have chosen the latter, since it appears that it is more likely to produce greater disruptive effects within my time range.
5.4 TREATMENT

It is hardly necessary to say that, right throughout this century, there has been a huge increase in the number, range, and efficacy of treatments available. This has been particularly true in the last two decades. As memory joggers only, keeping in mind that they are a minute part of the whole set of developments, I mention:

* World War II saw the development of penicillin and the sulfanamides, the insecticide DDT, and better vaccines; and these all but conquered yellow fever, dysentery, typhus, tetanus, pneumonia, meningitis and malaria.

* in the 1950’s, Salk produced the polio vaccine.

* in the 1960s and 1970s, the use of expensive "prestige" technology in hospitals grew rapidly. For example, open-heart surgical procedures of all kinds grew from about 14,000 procedures in 1967 to over 38,000 in 1971, and the first programs of long-term renal dialysis were also implemented in the 1960s. Coronary care units were introduced in 1962, and by 1976 most larger hospitals had adopted this service.

* the use of intensive care units also grew rapidly during this period, and many metropolitan hospitals
also adopted technologies involving as disparate as respiratory therapy and the usage of radioisotopes. In the 1980s, surgical procedures involving organ transplants and immunosuppressant drugs entered the production stage, as did major advances in prosthetics and palliation.

For the future, most writers expect that the development of new treatments will continue. For example, Peck (1987-88) details the future directions that geriatric drug treatments will take; Chase (1988) examines the prospects for "anti-sense" medicine; Bezold (1987) outlines the possibilities of telematics; Mathieu (1988) examines the issues involved in the expected future expansion of natural and artificial organ substitution; Segall with Kahn (1989) argues the possibility that cyromedicine has the potential to expand life indefinitely.

These again are a small sample of the possibilities. And doubtless, as in the past, many will not get to the market place, many will not be efficacious, and some will be positively damaging (The Wall Street Journal 1989). But, I expect that these decidedly futuristic treatments, together with extensions through research of the already existing treatments, will together mark the 1990s as yet another
decade of significant advance in the number and range of efficacious treatments.

The question then becomes whether this advance will cause health system perturbation. Given that there is already a strong trend in this direction, perturbation would require that some major treatment breakthrough. Is this likely?

There are those who would argue against this. Reiser and Anbar (1984), for example, consider that there will be no quick fixes as in the past to deal with the spectrum of chronic diseases. They point out that Thomas's 1970's list of half-way technologies was advanced only a little in the ensuing ten years; and, despite some clear cut breakthroughs (for example, in some childhood leukemias), the list of not-cured diseases remains very long. Bailer (1987) demonstrates that despite a vast research effort, the age-adjusted U.S. cancer mortality rate actually rose almost ten percent between 1950 and 1984. He says that 35 years of unfulfilled promises is a sufficient period to raise questions about the promises of today.

Of course, no one knows if there will be a breakthrough against a major disease. But my position is that there is a reasonable chance that there will be. To take the opposite view would be to say that all
the current vast sums of money and manpower now being poured into research will yield nothing for any one of dozens or hundreds of major diseases. I do not think that is true. Accordingly, I have accepted the forces emanating from treatment as a potential perturbator.

When it comes to selecting a particular disease for a treatment breakthrough, I adopt the approach that a cure for one of the major forms of cancer seems as likely as any other. Indeed, it is probably more likely than most, given that a vast amount of information on it has been accumulated over many years; that cures for some forms of cancer have been found; that extensive research is also being done on it all over the world; and that the sums of money spent on it in the U.S. are second to none. Further, any such cure would surely bring perturbation to the health industry. And, of course, it would be of particular significance to the hospice industry.

Thus, I accept a cure for a major form of cancer as a perturbator; and provide a scenario for its effects on the health system in Chapter Seven.

5.5 RESEARCH

In the last twenty years, health research has stemmed from two sources. Firstly, there has been research that has been directed specifically at a given
disease problem. Secondly, there has been research in non-medical areas that has produced results that can be applied to medicine.

Concerning the first of these, Eden (1984) makes three points:
* basic biomedical research is done almost exclusively by funds provided by the government (via the National Institutes of Health, and foundations such as National Heart and National Health), and nonprofit foundations.
* industry, including the medical technology industry, the health insurers, and health providers, such as hospitals, provide virtually no support for basic research. Most of their resources go to product and prototype development; and indeed this latter is true for the federal government also.
* there is little prospect for increases in basic research in the next twenty years.

Concerning the development of health products as a spin-off from other areas of research, Rettig (1987) says that the major advances in generic technology flow from national and international investments in research and development, public and private, civilian and military, having little to do with health. They generate a burst of technologies that ramify from the primary area application to a number of unrelated
domains. Such generic advances -- in materials, telecommunications, computing and imaging -- invariably impinge strongly on health, penetrating the practice of medicine in various ways. Continuing investments in Research and Development, broadly directed as well as focused on medicine, ensure that the supply of new scientific and technological concepts for application in medicine will not greatly diminish.

On the demand side, he considers that the number of disease problems on the unfinished agenda of clinical medicine is such that powerful incentives will always drive the search for more definitive medical interventions.

I accept the views of both of these writers. I note that Eden (1984) considers that there will be no increase in the quantity of basic research done in the future, and that this might be seen as running counter to my expectation of a breakthrough in cure for a major disease. But that is not so; I expect, as does Eden, that the level will remain as it is now; and this is massive. Indeed, it could be that there is little point in throwing more money into the fray, since there is no guarantee that the marginal gains from expenditure, already measured in tens of billions of dollars, would be worthwhile. In any case, I consider
current levels as being consistent with the proposition that a breakthrough is likely.

The consequences that stem from research could cause perturbation; indeed, I have indicated above that I expect this for a cancer cure. But, research per se will not be a system perturbator.

5.6 THE COST OF AN ENCOUNTER WITH THE HEALTH SYSTEM

Banta (1981), argued that technology had increased the unit cost of health care service, and led to more encounters. Schramm (1987), six years later, reached a similar conclusion. Rettig (1987) demonstrated that it was still true that technology had not in general reduced the cost of encounters with the health system, nor the number. For the future, he warned of technological determinism under which the march of medical technology is inexorable, and lies beyond policy control, and inevitably leads to higher costs regardless of whether benefits are marginal or substantial. Reiser (1988) takes another tack; he points to the recent rapid growth in the health force; and says that they will contribute to higher unit costs.

I agree with both these writers. I add that I have made the case earlier that there is a host of providers and suppliers, with a great deal of political clout,
who will do everything they can to keep unit costs up. And, there are few forces that seriously oppose this -- certainly no forces of any moment. So, I expect unit cost to continue to rise in real terms, and so too will the cost of the average encounter. But, clearly, these are not perturbators in their own right.

5.7 FORCES EMANATING FROM THE AIDS EPIDEMIC

In less than a decade, AIDS has moved from being medically unknown to the stage where it is one of the most dreaded diseases ever known to mankind. In the U.S., it will claim the lives of at least 200,000 victims by the end of 1992 (Fauci 1988).

As well as that, there is a much larger pool of persons rated as HIV positive who have strong chances of succumbing to the AIDS virus. Numerical estimates of the size of this pool vary. For example in 1988, Surgeon General Koop highlighted the difficulty in gauging the extent of the problem by placing the number in the pool at somewhere between 400,000 and four million persons. Later that year, estimates were lower, and with a smaller range of uncertainty. For example, Heyward and Curran (1988) -- from the Centers for Disease Control (CDC) -- thought the accumulated total would be between 1 million and 1.5 million by 1992 end. By early 1990, the New York Times (1990)
reported that the CDC had reduced this estimate to a range from 800,000 to 1.3 million. Without agreeing with Fumento (1990) that AIDS has been the most exploited disease in history, and that a supposedly great threat turned out to be a dud, it does seem that early estimates of infection have given way to smaller figures.

Still, the toll of the disease will continue to be great; and the social, political and ethical controversies that it has spawned can only grow. Likewise, the cost of financing health care treatment will continue to grow, and will continue to generate financial problems for individuals, insurance companies, governments and welfare agencies.

But I do not classify the forces generated by AIDS -- in its current manifestations, and in America -- as a perturbator. This is because it has already provided a shock to the health system that the system was able to accommodate, no matter how imperfectly. If I am right that the numbers of diseased persons will be less than forecast a few years ago, I expect that the more mature service system will be able to cope without perturbation.

That does not mean that I dismiss AIDS completely as a possible perturbator. The virus has been known
for only ten years and clearly has scope to attack mankind in other ways. Weiss (1989) sees the possibility of mutations that would allow infection by respiratory droplets; even Fauci (1988), who argues broadly that it is very, very unlikely that AIDS will spread to the general population in the U.S., admits that there is a chance of a different mode of transmission -- though the chances of this are small. Here is another situation where no one knows the answer. All I can say is that if such new modes were to occur, then perturbation of the most serious kind would be a possibility.

Another possible source of perturbation comes from outside the United States. For the Less Developed Countries (LDC), the estimates of the rate of infection are again unreliable, but there is unanimity that the problems there are serious and growing.

Mann (1988) estimates that between 5 and 10 million persons worldwide are infected by the AIDS virus, and that one million new AIDS cases can be expected over the next five years. Tinker (1988) considers that regions of Africa will have population reductions over the next decade; Lewis (1989) provides a long list of reasons why disease incidence in the LDCs will continue to increase. And so on.
These writers indicate that the future for these nations is placed in jeopardy by these developments. They expect that they will suffer from the disease itself and from its financial costs, from reduced manpower, and from drops in tourism, and trade. For America, the cumulative commercial aspects of this could prove to be severe; and the fact that there is an unfettered source of the disease not far away will be a cause of ongoing concern. I do not class this currently, however, as a perturbator for the United States; it is more of a timebomb.

In summary, I see that AIDS could still perturb the heath industry here; though I rate its potential lower than other forces I have chosen for my scenarios of the later chapters. But I should add that AIDS does have the capacity to impact and change the future of the hospice industry specifically; and I will discuss this further in my final two chapters.
CHAPTER SIX: THE HEALTH INDUSTRY ACTORS

6.1 INTRODUCTION

In this Chapter, I turn my attention to the actors that have helped make the health industry what it is today. In the next section, I introduce the major actors of the last twenty years by, firstly, reviewing the works of three prominent "politics of health" writers of the 1970s: and, secondly, by reviewing those writers of the 1980s who emphasized the growing importance of the medical industrial complex in that decade.

In later sections, I take the major actors in turn, and examine how the macro forces have affected each of them over the last two decades, and conjecture on what their relative political and economic strengths are now, and how they might perform in the battles looming in the future. In making this latter judgement for each actor, I deviate a little from the formula used in discussing macro forces. Thus, instead of discussing whether a given force is likely to cause perturbation, I ask whether a given actor should be considered as conservative in the sense of trying to maintain the present system of industry homeostasis; or whether it is dynamic in the sense that its actions are likely to contribute significantly towards creating heterostasis.

141
6.2 THE HEALTH INDUSTRY ACTORS

Among the "politics of health" writers, Alford (1975), Krausse (1977), and Brown (1977), all drew attention to the fact that power groups did exist in the health field, and that the conflict between them was endemic and bitter; and each of them defined the various groups that hold the power and described the ways they sought to retain it.

Alford found that a dominant structural interest was apparent in the professional monopolies as represented by biomedical researchers, physicians in private or group practise, salaried physicians, and those in other health occupations holding or seeking professional privileges and status. These interests benefitted from the system precisely as it was; and they did not have to exert power to influence particular decisions, except to block proposals for change. Battles did occur between segments, but these were conflicts of interest groups within a dominant structural interest. None of the conflicts of this type challenged the principle of professional monopoly; rather they argued over who was to have that monopoly. But, that apart, these interests were quite prepared to act together when challenged by outside groups.
There were, however, challenging interests. These were the so-called rationalizers, made up of the medical schools, public health agencies, insurance companies, hospitals, and health planning agencies. These interests contradicted and challenged the fundamental interests of the professional monopolies, and this contradiction accounted for much of the sometimes muted, sometimes blaring, conflicts between doctors and hospitals, between fee-for-service practitioners and prepaid practices, and between health planners and health market advocates.

And there were repressed structural interests, namely those without any social institutions or political mechanisms in society to ensure that their interests were served. They included rural and urban poor, the lower middle class, those occupations affected by job-related diseases, ghetto blacks and many others. They constituted a set of potential interest groups which were internally heterogeneous with respect to their health needs, ability to pay, and ability to organize their needs into effective demands. Enormous political and organizational energies would need to be summoned up by these interests if they wished to offset the intrinsic disadvantage of their situation.
Brown basically accepted Alford's model, but he added the state, with all its various attempts to control the professionals, into the challenging class. And, with his eyes specifically fixed on the 1970s, he saw that the capital needs engendered by high technology were making the physician class increasingly dependent on the government and the rationalizers, and thus that Alford's designation of the professionals as "dominant" was losing its pertinence.

Brown differed further from Alford in that Alford left the impression that his three classes were quite stable, and that while battles between the two upper groups occurred, "the differences between them should not be overemphasized." Brown, on the other hand, saw a much more politically dynamic situation. He reported the weakening of the professionals; he added that "the unity among the rationalizers is fragile now that their victory is in sight." He added "that the medical care system has evolved into a glut of interest groups, none of which has the power to prevail by itself."

Krause, in 1977, saw four power groups in health -- corporate power, the state, organized health-field groups, and the (repressed) citizen. He saw the role of the state as being quite forceful, and as being especially necessary to control corporatism. He too
talked about the falling political power of "storekeeper" medicine, and claimed that the change towards a more centralized industrial technological organization of health would favor the rise of a new owner and controller class, namely the professional hospital managers, who would have their own set of loyalties.

The impression that the reader in 1980 would have gained from the three writers was that while the once dominant medical professionals were under increasingly effective challenge from other groups, including corporate interests, the state, and other self interested parties, these challengers were themselves divided.

Starr, writing in 1982, captured both the spirit of conflict and change, and the emerging importance of corporate power. He wrote that:

when I began work in 1974, it was widely thought that medical schools, planners, and administrators, were emerging as the chief counterweight to private physicians. Governments seemed to be assuming a major, perhaps dominant, role in the organization of medical care. Decisions that had formerly been private and professional were becoming public and political. Eight years later this is no longer clearly the direction of change, but neither is the status quo ante being restored. Private corporations are gaining a more powerful position in American medicine; if leaders in the Reagan administration have their
way, the future may belong to corporate medicine. However, the origins of this development precede the current administration; the force behind it is more powerful than the changing fashions in Washington.

Wohl, in 1984, described in detail the extent to which larger corporations were buying up and rationalizing the fragmented health industry -- particularly the hospitals -- and considered that this would become the dominant theme of the future. Califano, in 1986, continued with this theme, and pointed to the fact that all parts of the industry, not just hospitals, were being rationalized.

Evans (1990) argued that the health industry had settled out into three forces. The first (the stressors) contained service providers and suppliers, the insurance corporations, and society. They were fully supportive of increasing the quantity and range of all aspects of health services. The second (the compressors) aimed to curb increases. The third (the shearers) were aiming to move the cost of services from themselves to others. These were groups such as employers. What is conspicuous in his classification, is that most actors fell into the first group, including the shearers. These latter were happy with expanded services, provided they did not have to pay for it. Also conspicuous was that government as an
institutions was the only genuine compressor; but a large part of government -- the politicians -- was personally sympathetic towards the goals of the stressors. And, government too was to be often found among the shearers.

By 1990, there seems little doubt that, over the two previous decades, there had been major changes in the relativities of the major actors. The power of the government had increased, clearly at the expense of the doctors and the hospitals. The power of the corporations -- which included insurance companies, pharmaceutical and other suppliers of health products, as well as the new breed of entrepreneur not previously associated with the health industry -- had also increased. And also, the power of society, and of the woman in the street (with some 33 million exceptions), had increased in that access to services was much more available than it had been twenty years earlier.

In all, there have been considerable shifts in the relative power of the different actors. This, I expect, would continue into the next two decades, and even under current homeostasis the system in twenty years would be very different from now. But homeostasis will not last for that period and, in an ensuing period of heterostasis, I expect that the
current low key battle among actors will be replaced by an all-in fight-for-life. In the remainder of this chapter, I conjecture on how the various actors are poised now to join the battle.

6.3 PHYSICIANS

Before looking at the actors individually in the context of the macro forces, I will point out that over the last two decades, the increase in supply of health care meant that all suppliers and providers in the industry benefitted from the vastly increased economic pie that was generated. This is true for physicians, hospitals, suppliers, and insurance companies. It is also true for minor actors such as other health professionals, lawyers engaged in malpractice suits, and the advertising industry; it is even true for suppliers of non allotropic medicine, such as homeopaths and holistic practitioners. Regardless of what happened to the political power of these actors in the last two decades, their earning power generally increased substantially.

Turning now to the physicians, all of the writers from Brown to Califano pointed to the relative decline in their power within the industry and to their concomitant loss of political power.
Many factors contributed to this. For example:

* part of the decline stemmed from the medical successes that technological advances allowed; because these successes stimulated societal demands on a huge scale for access to the health care system. When the unions and employers and then the government (through Medicare and Medicaid) and the insurance companies satisfied this demand, the way was opened for the introduction of controls onto the professions via a huge range of third party funding regulations and via governmental policies such as those establishing peer review committees, and even fee freezes.

* the ever increasing capital costs of the new technologies strengthened the relative positions of the hospitals, and more recently the HMOs, since they were better able to find large amounts of finance.

* at the same time, the efforts of physicians to amalgamate into various forms of collectives, while they sometimes allowed them to acquire big-ticket technology, introduced a degree of anonymity into the doctor-patient relationship. This often replaced the traditional confidential and intimate relationship that Americans persistently say they want, and which in the past has provided a popular underpinning for the political power of the physicians.
* the detailed operating procedures for the new technologies encouraged the entry of a wide range of technologists into the health industry; and this, coupled with an increased militancy among the nursing profession, stripped away some of the power-through-mystique that the physicians previously enjoyed, and simultaneously exposed them for the first time to public criticism from within the medical establishment.

* the rationalization of the industry certainly created positions of power for those physicians who moved into administration; but for many more, who had previously been in private practise, it meant that they became employees of corporations. This in turn resulted in high mobility and, again, anonymity with the patient, with the same decline in political persuasiveness.

* the various societal demands for greater access to health care, described in Chapter Four, had a strong component of criticism of medical professionals; widespread public discussion of cases such as Quinlan and Sakowitz called into question the right of doctors to unilaterally make life and death decisions; and the organized political power of the elderly has been increasingly used to frustrate the political wishes of physicians.

* many physicians now in positions of managerial and
administrative power have been coopted into basically profit-making, rather than service-providing organizations. The distinction becomes obvious at times of tension or drama when conflicts of interest arise; but more importantly, in the day-to-day working of such persons, their orientation inevitably favors the policy of the organization that employs them; and that policy is designed primarily for the organization's financial benefit. And such cooptation, rather than enhancing the collective power of the doctors, reduces it by splitting the administrators from their still-practising colleagues.

* the American Medical Association in the last decade has seen its membership drop to the point where only 43 percent of eligible physicians are members (JAMA 1990); and it has seen the growth of alternative, and often opposing, non-establishment Associations. It has also seen the number of specialists groups grow to 23, and again their Associations' policies have often varied from that of the American Medical Association.

Having said all this, it is necessary to point out that while the political power of doctors has been substantially reduced, their residual power is still considerable. For example, at the national level, they have recently been successful in restricting the entry
of Foreign Medical Graduates into American practice; and indeed they are still able to control and limit the number of new graduates that American universities produce. At the state and local level, they hold much power through their various positions on boards and executive committees in hospitals, licensing boards, review committees, and the state Blues, and so on.

Also, in the long run, it is they who provide the services to the patients, and this gives them the often-used power to manipulate public opinion, or to go so far as to refuse or frustrate government policies (Starr 1982), and to mount politically damaging support against these policies.

However, because of their loss of widespread unquestioning community support, and the splintering of their solidarity, and the emergence of the government and the corporations as serious threats, I consider that they collectively have lost significant political power. Still, they started from a very powerful base, and they remain a very substantial conservative force.

6.4 SOCIETY

Society, on the other hand, has gained a little of the power that the doctors lost. The most obvious forces working here were those generated by the "rights" demands of the 1970s, and by the political
activity of the increased numbers of elderly in the population. But the call for greater access was common to all elements of society, and there can be no serious doubt that, over two decades, society has gained a great deal of what it sought.

It can be pointed out that large numbers of persons still have no access, and that many more still have inadequate access. This is true. And there also can be criticisms of the accuracy of diagnosis, and of the efficacy of treatments, and of the quality of doctor-patient relationships, and of the exploitation of society by many actors; and so on. Many of these criticisms are justified.

But the fact remains that society sees the current health system as something it does not want to be without (Mechanic 1986); and, generally, it supports the eventual extension of the system so that all citizens have access to it. Certainly it is true that those currently without access are those with the least political power, and it may take some time before many of them do get access. But, this is not to say that those who now have it will accept any reduction; and any government or any other actor that threatens this will face the full opposition of a society in one of its rare periods of (almost) unanimity.
I agree with Mechanic that the public wants more health care services and easy access to them. Much of the demand is contrived by the professionals: come back for a check up in three months; if the pain persists, see your doctor; but don’t start this exercise program until you’ve checked with your doctor; do you know your cholesterol count? And much of it does not work or is iatrogenic. And physicians are not able to deal effectively with the most common presenting problems, namely those related to stress and mental disorders; or to prevent death ultimately from chronic illnesses. But all that is beside the point -- the public does want more health care services, and will use its power to progressively get more of them. I consider, though that society is now a conservative force, very intent on retaining its current position. If it can expand its position a little, then well and good. But there is no real dynamism to do that.

6.5 HOSPITALS

The hospitals in the last two decades were under attack from both the government and, especially in the 1980s, from the corporations. Despite all the ideological oscillations of the Democrats and Republicans in government, they managed to persistently
harass the hospitals via a constant barrage of financial legislation and regulations.

At the same time as the consequential squeeze on their easy and guaranteed profits occurred, the hospitals were faced with large capital demands to expand their services and also to extend them so as to provide very expensive forms of new technology. Their financial vulnerability, together with the rewards that would likely flow from the rationalization of this small-scale industry, attracted the takeovers and agglomerations described earlier.

At 1990, the various types of hospital agglomerates, and also the remaining small-scale hospitals, are in positions of considerable power. Financially, they are collectively secure. Granted, some few of the small-scalers have been recently forced to close; and some few of the chains are overburdened with debt. Still, they have generally developed techniques -- such as cost shifting, hiving off new subsidiaries, promoting new services -- that not only will benefit them financially in the future, but also demonstrate that the new breed of hospital administrator can stay one step ahead of the government in the future.
Politically though, they are weakened by the split between the predator and the prey; the chains on the one hand and the community hospitals on the other have different histories and different basic reasons for existing; they have very different levels of popular local support (or often antagonism in the case of the agglomerates); they can expect very different futures.

Overall though, they are collectively still absolutely vital as centers for acute medicine and for concentrating big ticket technological machines. This leaves them today with a great deal of security, and at the same time, invests them with a considerable measure of conservative power.

6.6 INSURANCE CORPORATIONS

The last two decades have seen incredible growth in the involvement of the insurance corporations in the health industry. In 1970, the commercial insurers collected premiums of $8 billion, while the Blues received $7 billion. By 1987, the combined total for these insurers had risen to $157 billion (U.S. Bureau of Census 1990).

In any industry, the combination of rapid growth and huge turnover and large cash payments in advance provides the basis for the participants to increase
their power relative to other actors; and here, the health insurance industry was no exception.

Fortune smiled on it. It won the lottery -- which it itself had done much to create -- when it became the intermediary between the government and the providers in the running of Medicare and Medicaid. It became the de facto body that approves or rejects new surgical procedures and devices. It showed in the "insurance crises" of the mid-seventies and the mid-eighties that it was in a position to prosper, despite large increases in the value of claims, by passing on costs to providers, and hence the consumers, simply by making hikes in premiums. It is the second largest industry in the United States; its accrual of real property and also its year-to-year profit is enormous. It enjoys low concessional rates of taxation, and is free from many anti-trust provisions. It has become one of the principal predators of the health industry; not only through the financial clout it carries through its lending power; but also as a direct purchaser of providers, and also its growing interests in the newer forms of providers such as HMOs; Kaiser is the classic example.

The insurance companies increasingly put out the propaganda that they are all for cutting health care
costs. But here they are talking about their own costs. After all, they sell health care on a pre-paid basis, and after the sale of each policy, the smaller the cost to them, then the greater their profits. The more money that flows through the system, the bigger their take home pay. They have no interest at all in reducing the usage of services in the longer term.

They represent now a very significant power, and one that will surely grow; and that power will be directed towards increasing the money that flows from the consumer to the provider through them; and, increasingly, towards increasing the benefits they receive from their own direct provision of services. They also represent a strong force towards conservatism and no one will easily wrest power from them. But they are also dynamic; they have the cash, and the capitalist desire and the long term strategic planning capacity to become major players in the race towards oligopoly.

6.7 TRADE UNIONS

During World War Two, the trade unions -- working hand in glove with the large employers -- frustrated governmental efforts to hold real wages steady by accepting substantial benefits for union members in the form of employer-paid health insurance cover. In the
thirty years following the War, all facets of the early
coverage were expanded; more persons, more providers
and services, greater percentage of costs paid, and
extended to families, and carried over into retirement
(Califano 1986).

Since 1975, there have been attempts to cut back on
these benefits, and given the weak current state of
unions, some of the larger corporations have had some
success in doing this. But despite the success stories
that abound -- Chrysler's cutback has risen almost to
the status of folklore -- the reductions for the bulk
of current beneficiaries and future is negligible.

I expect that this situation will continue. Given
that the benefits are both "free" and tax free to
recipients, and that they are somewhat
institutionalized; and given that the federal
government has made no effort to cut the tax free
status; and given that government is seeking to extend
mandatory cover (and tax exempt status to recipients
and employers) to many small businesses; then it seems
that the status quo will in effect be preserved.
Unions will however continue to live under this threat,
and their energies will be spent in fighting just to
maintain their current position.
6.8 LARGE EMPLOYERS

The large employers also gained from the above deal with the government because their provisions for health benefits for employees were -- and are -- tax deductible. Despite their recent attempts to cut back, and despite some successes, it is unlikely that they can roll the clock back too far because the unions are not that weak, and because government and society would then have to pick up an increased tab. In all, the deal between the unions, large employers and government has strong support -- and reductions in access from reversals of employers policies will be hard to achieve. Large employers will be only powerful in the conservative sense; their main efforts will be to shift their payment burdens to others.

6.9 PHARMACEUTICAL INDUSTRY

The pharmaceutical companies in U.S. are already effectively an oligopoly. They are protected from new entrants to the industry by an the excessive costs of developing new drugs and by the extraordinary precautions that the Food and Drug Administration imposes on the initial marketing of new drugs. At the same time, once they get a drug approved, they can sell it for any purpose, not just the one it was approved for. They are protected almost completely from
overseas competition. They earn huge and increasing profits. They are increasingly moving into health equipment manufacture. And they already have massive overseas markets.

In all, wealthy and protected at home, oligopolistic, vigorous in promoting new applications, aggressive overseas, they are powerful and will influence changes in the future. They will be secure from invasion of their existing territory and are in the position to be quite dynamic when the occasion arises.

6.10 EQUIPMENT MANUFACTURERS

Here I am talking about manufacturers of big ticket items. Again, entry is restricted to this industry by the large capital costs required; and again the industry is protected by de facto protection from overseas competition.

The current participants have in fact had a number of lean profit years this decade for their health industry products; and their numbers have been halved. For those remaining, they are subsidiaries of much larger electronics corporations who can afford to finance loss leaders. Further, many of the products marketed are spin offs from more general research, and this reduces their real Research and Development costs.
They collectively have large and growing overseas markets, though in a competitive world.

Those in the industry are secure from new entrants. There is a big market for their products, and with the number of suppliers recently reduced, profits commensurate with capital can be expected. Under homeostasis, the industry can thus be expected to prosper and gather financial strength; and they already have considerable political strength through their parent companies. They have a strong interest in moving their equipment to the forefront of diagnosis and treatment; and in all must be considered as a dynamic force.

6.11 GOVERNMENT

In Chapter Three, I described some aspects of government cost-cutting activity in the last twenty years. My conclusions there were that ideology in fact played little part in government decision making; the efforts of government were directed at cutting costs and at the same time providing an environment where costs were certain to rise; and that their efforts to cut costs were, at the most, successful in reducing them from what would otherwise have been a much higher total.
In all, the focus in that period was on cutting costs, with very little concern to cut consumption, except through the possible flow on from decreased spending. In fact, few persons of any significance in government opposed increases in consumption. Why would they? America was, and is, a wealthy nation that could afford to spend a great deal of money on what has clearly become of great value to it, namely better health care. Whether this money was always wisely spent in the short term, might be a point for argument. But equally it could be argued that sitting round thinking about the wiser way might also not be foolproof; and that the American way of blundering about and muddling through was appropriate while the resources were there to allow it. In any case, the opposing voices raised were hardly heard. It is true to an extent that twenty years of harassment from the governments paid off by 1990 to the extent that they had reduced health care expenditure below what it would otherwise have been. But to say that they reduced real per-capita consumption to only double what it previously had been is scarcely cause for applause.

More importantly, the fact that the voices were so muted points to a basic fact that is rarely stated among policy makers and by governments. That fact is
that Americans collectively want more and more of today's health care, be it razzle dazzle, sleight of hand, or efficacious. If that meant that, over the last ten years, national health care rose to 11 percent of GNP, there were no demonstrations in the streets fighting against this. What they wanted then, and now, is more of the same and better. If that means that national expenditure rises to 15 or 18 percent, then there are few who will seriously oppose it.

Granted there will always be politicians who will grandstand on reducing waste and duplication, preventing corruption and fraud, and driving tough bargains with one and all. But behind this is the realization that their constituents want to have available the "best health care system in the world."

The trend is for government to go on responding to the wishes of every powerful interested health group; and, because times were relatively good, it was not necessary to extend the health care system at the expense of powerful non-health groups.

The trend is for government to go on responding to the powerful health forces. Individual politicians will not cry out for less consumption, nor will presidents. Huffing and puffing will continue, but
government will respond to the concerted pressure from consumers and producers alike. Under homeostasis, then, I see government as flowing with the tide; after 20 years of vain effort, they will not suddenly become a major force. It has been conservative in the past, and it will not readily change.

6.12 CORPORATIONS

The corporations I am referring to here are those who in the course of this last decade have advanced the process of industry rationalization by means of takeovers, amalgamations, chaining and vertical integration of existing units. In some cases, they have also created new units. These non-traditional predators grew larger and larger as the decade proceeded and as they progressively extended their appetites to their fellow predators. Wohl (1984) provides a description of some thirty that at 1984 were conspicuous for their successful aggression.

Still, the industry remains fragmented. Granted, within-industry agglomerations are forming to maintain existing groups, but in the longer run this will make takeover more possible -- it is easier to mop up groups than individuals. But the fragmentation remains, and the predators can only hope that small units will continue to amalgamate.
The root reason behind the corporate rationalization is that the health industry is proving to be a safe, profitable place to invest capital both in America and overseas, and has the added advantage of offering decades of profitable expansion in the future. I expect that as the opportunity presents, the corporate actors of today will be replaced by megacorporations who will simply devour today’s corporations.

These megacorporations are dynamic actors; they are long term players, opportunistic, rich and powerful and are well placed to be the major actor in creating havoc in any state of heterostasis that develops from the existing delivery system, and in writing its own ticket in creating a replacement system.
CHAPTER SEVEN: FIVE FUTURES FOR THE HEALTH INDUSTRY

7.1 INTRODUCTION

In the previous five chapters I have discussed the first two of the four processes involved in this dissertation. In the first process, I created a model of the American health system in its current state of homeostasis between many forces and many actors; and in the second, I identified a total of five forces which have the potential to perturb the system into a period of heterostasis.

In this chapter, I consider the third of the processes. That is, I take each of the five forces in turn, and develop for it a scenario of what will happen to the health industry after it causes system perturbation. In this way I develop five likely futures for the industry. Subsequently, in the next two chapters, I concentrate on the fourth process. This involves the creation of a hospice industry scenario for each of the health industry scenarios developed in this chapter.

In creating the health industry scenarios, I conformed to the rules I nominated in Chapter One. Thus, I sought to construct scenarios that the reader would accept as quite likely outcomes from the various perturbations; and at the same time, I ensured that
every prediction in every scenario was rooted in some part of the homeostatic relationships already discussed.

Further, in the earlier chapters I drew a number of conclusions, concerning some forces and actors, that now apply to all five of the scenarios. Thus, to avoid repetition in presentation, I have listed these immediately below, prior to moving on to the presentation of the five.

These conclusions are that:

* some forces are basic to the American way; if they changed, then the whole structure of American society and politics would change. To avoid speculating on this improbable event, I have assumed that America will remain a capitalist country; in America's major industries, the trend towards the maintenance or the development of oligopolistic control will continue; and, in the major industrial Western nations, the trend towards control by transnationals will also continue.

* similarly, if the trends for some demographic forces are not maintained, then America must suffer pestilence, or an increase in fertility or in migration of such magnitude that certainly the social systems, and probably the political systems, would move outside the range of speculation that I could attempt. Here
then, I have assumed that the population of the nation will increase more or less in accordance with the figures quoted in Chapter Two; and the population will continue to age along the lines I suggested earlier.

* America will continue its love affair with technology, and this will become more and more apparent in the health field as technology progressively becomes more esoteric. In line with this, I have assumed that allotropic medicine will continue supreme. I argued earlier that most challenging forms of health care delivery would at most get small and peripheral shares of the business, and that any challengers who did better than that would be coopted into the mainstream. I continue to take that position here.

* all actors will continue to act predominantly out of self interest; and while this might not always be true at the individual level at all times, I am assuming that it is true under the stressful conditions I am considering and certainly always true at the collective level.

The scenarios that I developed stem from the five potential perturbators that I identified earlier. These scenarios are that:

* among the political economic forces, a Peterson-type economic crash will occur.
* among the political economic forces, government and society will take strong and effective action to avert a major economic crash.

* among the societal, the political economic, and the demographic forces, the younger generations in America will develop hostility towards the relative wealth of the elderly, and will be successful in taking some of that wealth for themselves.

* among the disease and technology forces, an effective cure for lung cancer will be developed and marketed.

* among the societal forces, society will be split over whether suicide and euthanasia should be legalized under a wide set of circumstances.

7.2 A PETERSON-TYPE ECONOMIC CRASH

This scenario is based on the prospect of the macro forces following their trends for about five years until a Peterson-type economic crisis is somehow triggered; and from then, the ensuing economic crisis for the nation will flow through to the health industry.

Under this scenario, consumption of health care will increase greatly over the next five years. Here, the demographic forces will play a large part. The rise in the total population will increase national consumption, while the aging of the population will
increment average personal consumption as the elderly consume proportionately more.

Over and above this, everything will be there to promote greater demand and consumption by the entire population, including many of those who currently cannot afford services. Technological wizardry will surge. And with this wizardry will come the urgings -- from the professionals, the other providers, the marketers -- to an uncritical society to use it. The medicalization of society will accelerate.

Supply will meet this demand. There will be an increasing number of products, at an increasing unit cost, to an increasing number of patients having an increasing number of encounters with the system. If the government creates some obstacles to maintaining and increasing the supply, the system will find one way after another to dodge the obstacles. If old medical procedures become discredited, or if some diseases fall out of fashion, then new products and diseases will be found to replace them. As new technologies are developed and marketed, new and old specialist professions will promote and supply them to the public.

The cost to the individual and the cost to the nation will continue to rise, reaching the current trend figure of $3300 per person, compared to $2000 now.
(in constant terms). In national terms, the bill would then represent 18 percent of GNP, compared to 11 percent in 1987.

Consumers in general will be happy enough with this. There will be still some who will have no access to the system; but these will be fewer than now, and will have no political or social clout. Some others who are reasonably well covered will be denied access to the most expensive services. Most, however, will have the perception that, even though their standard of living might not have risen, their standard of health care has.

The providers of all sorts will be in much the same frame of mind as they have been over this last decade. The professionals will still be perplexed by the structural changes that are happening, yet at the same time pleased with the financial returns that they are receiving. The suppliers will be in the midst of a creative technological and marketing boom that they will relish. Insurance corporations will see their turnover increase fifty percent in real terms in much less than a decade; no genuine complaints here.

Politicians will be uneasy in their dual role. As agents of government, they will stress the necessity to cut the nation's health bill. Yet, as elected
representatives who wish to stay elected, they will recognize the strong popular demand for health services, and will be loath to stand in the way of increases. Real cutbacks will be out of the question. In all, it will be a replay of the 1970s and 1980s; with much protesting, often on ideological grounds, about the cost of health measures, but with constant acquiescence in health expenditure incrementalism.

The losers in all this will be found in those industries which might otherwise get the monies that will increasingly be spent on health. There can be no doubt that they will do everything possible to get their share of the national economic pie. At the same time, however, that pie will be growing larger and larger in the Peterson pre-crisis era; and that will go a long way to compensate for their loss of sector share.

The rationalization of the health industry will continue apace. The current trends towards local integration and towards nation-wide chains will continue. For the prey, at the local level, much amalgamation will be done to protect against predators. For the predators, seeking to build nation-wide chains, all such amalgamations will make their task easier in the longer run. That is because, when the right time
comes, they will buy out a host of service delivery units that have already been consolidated into local operating units that can readily be managed by nationwide corporate policies.

Eventually, a Peterson-type economic crash will occur, in less than a decade from now. As I indicated earlier, the particular trigger is of little importance; and probably the longer it is delayed from now, the more severe will be the immediate consequences for the nation.

Government will be hard hit. Revenue from all sources, including its social security scam, will be cut; it will be saddled with large debts accumulated over a period of two decades, and with little prospect of rolling this debt over; it will be confronted with the political pressure to keep faith on its many entitlement programs. It will face a crisis more severe than anything since the Depression.

But with this crisis will come opportunity for the government. It will raise all sorts of taxes, cut expenditure across the board, extract itself from many financial commitments, and generally regain some control over its budget and expenditure. Here at last will be an opportunity to cut entitlements, break promises and change whole systems.
Within the turmoil that ensues, the health industry, for all its size, is not well placed to compete with the other sectors of the economy. There is no single locus of power; indeed, within the industry there are a multitude of interests competing against each for whatever share of the health sector pie that they can get. When it comes to competing against other well organized sectors of the economy -- many of them oligopolies -- and when it comes to a real showdown against entrenched sector oligopolies, for a share of the national pie, then the health industry is currently out of its league.

Thus the health industry will in no way be excepted as government reduces its bills. Initially, it will try to do this within the existing delivery system. For example, moneys paid by employers for workers' health insurance will no longer be tax deductible to employers nor to workers; copayments on Medicare will be increased, and means testing for Medicaid payments for nursing home care will become severe; many persons will find that they no longer have access to the more expensive surgical procedures.

But these measures will generally fail. Once again, all the devices of defiance will be used to frustrate government as its programs are met by
bureaucratic delay, court challenges, public campaigns from doctors and hospitals, and opposition from corporations, unions, and states.

Government will ultimately be forced to respond with changes away from the system that has not only persistently written its own tickets but has also done this at the expense of government popularity.

The new system will avoid these two evils by introducing some form of health care rationing and by moving responsibility for the new system into corporate hands.

The system of rationing might be based on restricting usage by the queuing approach used in Australia's National Health Insurance scheme, or queuing coupled with professional disinterest as in the British National Health Service; or passing the rationing buck to the states as in Canada; or a simple coupon system; and so on. Whatever the form, it will have two features. Firstly, it will be universal and will set a maximum level of service that an individual can claim at government expense. Secondly, it will encourage individuals and institutions to take out insurance coverage for above-quota usage.

Placing the new system into corporate hands has two components. Firstly, the major insurance corporations
will handle the financial flow. This is basically an extension of the current system for Medicare and Medicaid. This will suit the insurance industry, since the governmental system they manage will now be universal but still with the certainty of above-quota business.

Secondly, the delivery of services will be managed by an oligopoly of corporations who will use the crisis to gain control of virtually all points of service delivery. Granted, the physicians and specialists and hospitals who now deliver services will continue to do just that. But they will be managed and financed by the oligopoly, and will adopt the policies and marketing strategies dictated by them. Some providers will opt to stay outside the governmental system by servicing only those clients with private insurance. But they will have great difficulty staying independent from the oligopoly, because of their need for access to big ticket technology that the corporations will control. They will stay independent for as long as it serves the oligopoly’s purposes. There are now very few independent petrol service stations.

The oligopoly will be made up of those corporations that survive the violent struggle for control that will follow the economic crash. Prior to that, over the
next decade or so, the situation will hardly be benign as today's health corporations increase their size and influence through progressive acquisitions. After the crash, however, truly major national and transnational corporations will dust off their plans, and will seize the opportunity to buy into the industry at crisis prices. The current predators will then become prey, and at the same time the major corporations will battle amongst themselves until they reduce to a Seven Saving Sisters oligopoly, probably over a period of two decades following the crash.

Few if any of the current predators will be part of the oligopoly. Instead, some members will come from the insurance industry; others from banking; one or two from the IBM-style electronics manufacturing corporations; perhaps a few from the oil, or defense, or soft drink industries. The criteria for survival into the oligopoly will in no way depend on knowledge or current position in the industry; rather, what will count will be financial muscle, competitive ruthlessness, and pre-crash planning. In the longer term -- outside my time frame -- a transnational oligopoly will develop, and a few corporations within the American oligopoly will join this more illustrious group.
The main opponents of the drive towards the American oligopoly will be the physicians. But this time, instead of battling against a government that depends on electoral support for its own existence, they will be pitched against the major corporations. The government will in fact claim that it has struck the perfect ideological balance; on the one hand, it will provide the money to allow basic health services for everyone; and on the other, it will create a favorable legislative background for the forces of capitalism to run riot.

In this climate, the physicians will be no match for their corporate opponents. All of the forces of the then-past will be massed against them. They will have lost their political support at the grassroots level; they will have moved themselves into collectives that make them consolidated targets for takeover; they will have, in the collectives, bought expensive capital equipment that will add to their financial undoing as the crash eviscerates their cash flow; many of them will already be working as employees and have already given in on the long-held ideal of independence; the public will already be largely weaned of its illusion of a warm doctor-patient relationship; and so on.
What the doctors will do is reluctantly bow to the wishes of the larger corporations, but at the same time, retain their status at the local level. The corporations will provide them with financial and training incentives to retain and encourage their interest in their job; just as the HMOs are currently doing; but the reality of anomie among patients will grow more apparent.

But, amidst all this, and despite the inevitability of defeat by larger corporate actors, the physicians will fight tooth and nail to maintain their independence; it will take decades to finally subjugate them, and in the interim they will contribute much to the period of disruption that will accompany the consolidation of the oligopoly.

The hospitals will fare no better than the physicians. They too will be weakened by a lack of popular political support, financial stress from ongoing repayment obligations at a time of reduced income, divisions amongst themselves, and so on. In particular, community hospitals as such, and the governing boards, will disappear off the face of the American earth.

The pharmaceutical industry will suffer least during the immediate aftermath of the crash because
individuals in a medicalized society will be most reluctant to cut back on medicines they have become addicted to. In the longer term, they will be able to maintain their protected status from overseas competition, and maintain the closed shop that they currently enjoy.

The manufacturers of advanced technological machines will have a terrible time, because not only will U.S. institutions cancel or postpone their big ticket purchases, but so too will buyers in other economically depressed nations. Still, in the aftermath of the crash, the survivors will have available to them a real growth market, and those who can and do take a long term perspective will be well placed to share in the future spoils from the industry.

In all, during the three to five years of heterostasis, all actors will suffer from reduced income as the whole nation tightens its belt. Beyond that, as the nation expands from its depressed economic state, the health industry will also benefit. In particular, it will retain its 18 per cent share of GNP, since none of the underlying forces that raised it to that level will have gone away. And now a powerful developing oligopoly will strain to keep expenditure high.
What will have changed is the ownership of the industry, and with that will come the mixed benefits of oligopolic control of policy coupled with an unambiguous acceptance of the dominance of market forces in a government subsidized industry.

7.3 IMMEDIATE ACTION TO AVERT AN ECONOMIC CRASH

This scenario is based on the assumption that, in the next two or three years, government and society will realize the dangers involved in following the current economic course, and move successfully to avoid any economic crash. Following that, the nation will enter a period of muted but sustained economic prosperity.

During the crisis-avoidance years, taxes will be progressively raised, import restrictions in various guises will be imposed, the governmental trust fund abuses will be reversed. As a consequence, national debt and corporate and personal indebtedness will be reduced to sustainable levels, government will balance its budget, and the nation's current account will be somewhat in the black.

As this belt tightening proceeds, the growth in the health industry will gradually lose its momentum, and the proportion of GNP spent on health will settle at 15 percent, just four percent more than now. Given that
GNP during this period will fall in real terms, the total national level of health services delivered will remain at about today's level until the crisis has clearly been avoided.

Within this environment, the year-after-year expansion of the national health pie will cease, with the consequence that the competition among health industry actors for the available dollar will become acute. Providers of all types will be faced with, on the one hand, pressures from consumers and the advance of technology to provide an ever-increasing array of services; and on the other hand, pressures to be financially prudent at a time when their incomes will be difficult to maintain.

Government will be at the forefront of national cost cutting, and it will create a mess of consumption-reducing measures and new regulatory bodies. But here it will face the problem that no real crisis exists, and the drastic options available in that latter situation will not be politically possible. Instead, it will scrimp and save; it will extract its saving from the politically impotent, and that means that progress towards universality of health entitlement will be set back; it will concur with revitalized professional groups so that entry into the professions...
will be further restricted; it -- together with commercial insurers -- will reduce access entitlements to the more expensive medical products, and thereby slow down development and marketing of the newest of these.

The progress of rationalization within the health industry will continue, not much different from that of recent years. Society will still continue to demand technology's best, and the population will inexorably grow and age. Yet, the total health pie will remain constant. Inevitably, the weakest will go to the wall; and now that weakest will be those providers with the lowest profit margins; and that in turn will lead to the survival of those providers with some form of economy of scale. The prey will thus continue to be the small scale provider, and the predator will be the corporate rationalizer with nationwide affiliations.

At the end of the period of national economic prudence, the nation will settle into a time, rather similar to the 1980s, of gentle growth with periodic ups and downs, but this time with a sound economic base. For the health industry, however, this will not be a period of gentleness. Rather, it will become a period of intense competition at the national level as
the truly major corporations begin their scramble for a place in the oligopoly.

Again, in this scenario, the oligopoly will emerge, though the background circumstances now will be different. There will be no genuine crisis, so government will not efface itself from the system; instead, government will emerge with a flotilla of intrusive policies and regulatory bodies. There will be no universal health entitlement and rationing scheme; instead there will be a retreat from universality, and the form of rationing that will emerge will be a version of the devil take the hindmost. None of these conditions will facilitate the entry of the major corporations into the health industry.

Still, they will enter. There is an inevitability about this. Here will be an industry, fragmented yet already partially consolidated; rich in terms of proportion of GNP; protected from competition from abroad and with restricted entry from within; sophisticated and rationalized enough to know that profit is all that really counts; supported by public demand; subsidized by government; boosted by a vast development in new technology; capital hungry and starved. In capitalist America, the seizure of such a
prize can only be delayed by circumstances; each major
corporation, relieved from the financial prudence
imposed by the belt tightening, will use its power and
finance to grab as much of the industry as it can as
quickly as it can.

But the task of the emerging oligopoly will not be
as easy as in the previous scenario. In the first
place, the providers -- notably the hospitals and
physicians, chained or unchained -- will have been
through harder times and will have developed emerge
much more cohesion for fighting external predators than
they have now. But in the longer term, they will still
suffer from the same collective weaknesses as under the
previous scenario, and they will again be picked off
one by one as the oligopolies create or seize
opportunities.

The emerging oligopoly will have more problems with
government, since the latter have accumulated a host of
control mechanisms that it and its bureaucracy will be
loath to surrender. At the same time, government will
be under societal pressure to restore the access to
services that had been reduced during the problem
years; and as well, the nation and government will not
have found an accepted ideological basis for social
support policy. The end result will be a mishmash of
new expansionist policies embedded in a system of archaic and new restraints. None of this will deter the major predators permanently; they know from their rise to dominance in their maiden industries that the process can take decades, even a century. If there is a genuine crisis as under the first scenario, then the task of the oligopolic forces will be made that much easier; if there is no such crisis, then the only real consequence for the oligopoly will be that its rise to dominance will be delayed a decade or two.

Throughout the years of belt tightening and afterwards, the consumers will get a deal that increasingly deviates from their current expectation of service. In the years of restraint, government will set the trend by cutting back on services financed; the insurance companies will follow suit in writing policies and in deciding claims; employers will force powerless trade unions to backtrack, and to accept lesser benefits than previously. As the profit motive progressively becomes more dominant, remote areas and the inner city areas will be deemed unserviceable; and competing medical tests and treatments will be chosen, not because of their efficacy, but because of their contributions to profit.
Even after the difficult years have passed, there will be no turning back. The service to customers will have become highly depersonalized; it will be more technical and mystifying than ever; the national marketing of products and techniques will mandate packaged solutions. After all, why should the patient actually see a doctor, when a paramedic can help the patient to transmit symptoms to a corporation's national computer in Nebraska, and have the diagnosis within seconds, and the curative drugs air freighted that day. If the customer does not like approaches such as these now, then national marketing is there to fix such deviance. Whatever forms of new service that do develop, every one of them will be directed towards profit first and foremost; none of them will be devised with the customer as prime benefactor; and the customer will suffer greatly, at least by today's values.

7.4 INTERGENERATIONAL ECONOMIC WARFARE

This scenario is based on the prospect of younger generations of America developing hostility towards the relative wealth of the elderly, and rising up to effectively take some of that wealth for themselves.

Under this scenario, parents of childbearing age will perceive that their children's standard of living is falling; their education is poor; the physical
infrastructure is decaying; vital health services may be denied them; and so on.

At the same time, they will be conscious that many of the elderly have higher incomes than they have; they are asset rich; they double and triple dip into pension funds and Social Security; they are supported by Medicare and reap enormous benefits through Medicaid (usually without genuine asset stripping); they sometimes cost taxpayers enormous sums of money to be kept alive for years in vegetative states; they are the ones who invented the social security scam, and the ones who will benefit from it. And, they are currently not productive in the workforce.

The result will be that these younger Americans will seek to gain a greater share of national resources for themselves, and will join battle with the elderly. This will be no easy battle to win, given the undoubted political power of the elderly under attack; and given also that the generations in between will be torn by regard for their own future welfare and by concern for their parents on the one hand; and on the other hand, by concerns for their children and grandchildren. In all, the issue will be terribly divisive of society for a decade.
It will be the younger generations who win. Progressively, society will come to see the current set of conditions as being over-indulgent to the elderly, and as inequitable in society at large. Government will respond with a series of cutbacks to all its elderly support programs.

For example, it will reduce the benefits from multiple dipping, and will apply normal taxation schedules to incomes from social security and all other pensions; it will create a number of regulatory bodies with the mission of reducing consumption by the elderly of the health care services for which it pays; it will drastically increase copayments for Medicare beneficiaries, and will introduce an additional voluntary Medicare insurance plan that covers expensive procedures only for those within the plan; it will devise Medicaid regulations that do in fact strip assets and incomes from nursing home beneficiaries of Medicaid. Insurers and employers will get on this bandwagon, and they too will reduce their health care payouts for the elderly.

In all, there will be a major diversion of funds from the elderly to other persons, and from the health industry to other sectors of the economy. The proportion of GNP going to the health industry will
fall, from the current eleven percent, down to nine percent over the course of a decade, and will then remain at that level. The elderly alone will bear the brunt of this reduction, and their average annual consumption will drop by a third; and most of this of this will be spent on increased services for other age groups.

All actors connected with the health scene will suffer. In particular, elderly consumers will be dealt the double blow of a reduction in their income together with reduced and more expensive access to health care services; and the range of services will be so curtailed as to deny them to many who currently could receive them. Hospitals, doctors, specialists, pharmacies and other providers will cut their services to fit the dollars available, and while this will mean some reduction in overservicing, the result will be that the physical health and the mental wellbeing of this group will deteriorate significantly.

In some individual cases, feelings of hopelessness, rejection by society, and unrelieved physical suffering will lead to suicide. In other cases, persons loyal to a family or to society will arrange suicide or euthanasia so as to spare others the cost and the stress of sharing their prolonged, degrading death.
Others will simply die because they cannot afford health services or housing or nursing homes. In any case, the mortality rate of the elderly will rise sufficiently to arrest the average age of death for the whole population at its current level.

At the same time, society in general will develop a much more tolerant attitude to suicide and euthanasia at all ages.

Providers will suffer a considerable drop in income. In fact, the drop will be more severe than that felt during the belt tightening period of the previous scenario, and will continue on without the benefits from a subsequent recovery in the national economy. The same measures described in that scenario will again be in evidence, but more severe because of the actual drop in real income for the industry, and because of the lack of relief at some time in the near future.

The industry will again follow the route of providing services that maximize profits, and will do this while moving their service focus away from the elderly and more towards the other age groups. The current trend towards development of gerontological services will be reversed, and instead diseases of middle age will be defined and exploited along with the
growth of a huge prosthetics industry for providing miracle devices for the physically impaired and damaged.

In all, there will be massive chaos inside the industry; large numbers of providers, large and small, chained or not, will make wrong decisions and will go to the wall.

No part of the industry will be suffer more chaos than the nation’s nursing homes. The number of patients will drop, the available income of those remaining will be reduced, but the local pressure on the homes to continue service will remain. This situation is incompatible with the process of maintaining a sufficient profit level. The homes will work their way out of this by gaining government approval of reduced services and care for their customers; and by engaging in a wholesale selloff of small operators to those larger units and chains that will provide the efficiency that the backyard industry now often lacks.

Hospices will be in a position to increase their numbers of patients, as physicians, hospitals and nursing homes rid themselves of unprofitable patients and seek alternative placements. Whether hospice will
take in these patients remains a matter for discussion in a later chapter.

None of the events outlined under this scenario are at odds with the earlier scenario that the industry will eventually come under the control of an oligopoly. Granted there will be less money in the pot, and to that extent the industry will be less attractive. On the other hand, an industry that has some nine percent of GNP tied up is still a worthy prize; and in fact, the drawn out period of chaos will provide ample opportunities to buy in at the right price. Beyond that, the prospect of an eventual transnational oligopoly makes a few percentage points of American GNP seem insignificant to genuine long term strategists. The development of the oligopoly is an integral part of this scenario; and indeed, the same applies -- without further mention -- to the remaining two scenarios.

7.5 A CURE FOR LUNG CANCER

In developing this scenario, a number of options are available for exploration. For example, the claims made a decade ago for interferon by the American Cancer Society were that this was indeed a wonder drug that had the potential to stop existing cancers in their tracks and could be used to prevent their appearance in the first place. A different example comes from recent
works of the Environmental Protection Agency, who blame the accumulation of radon in dwellings for many cancers; and they claim that adequate specialized ventilation in dwellings will reduce the incidence of cancer nationally to one half of the current level.

A different example can be found among many researchers and medical practitioners who, stressing that cancer is not one but a huge variety of diseases, claim that cures need to be found one at a time, with one cure for one disease. The recent advances in apparently permanent cures for some forms of leukemia support their approach.

Then again, in looking at the options for this scenario, there is the fact that many cures will likely bring with them side effects that, over a period of time, replace the remittent cancer with other organ failures. A further consideration is that, especially among the old old, the onset of cancer occurs concomitantly with other disease, and it could be that a cure for cancer in these cases would scarcely prolong life at all.

In this scenario, cures will be found for the most prevalent form of cancers in the population, namely lung cancers. The cure will be in the form of drugs that will halt the cancer growth immediately and
permanently, without material side effects. It will not provide some form of an all-preventive immunization, but will be used to stop a specific cancerous growth after it has commenced. The development, manufacture, and marketing of the drugs will be done by an American corporation that is part of the existing pharmaceutical oligopoly. The products will be available at a price that everyone can somehow afford.

The consequences will be widespread for all actors in the health industry. Conspicuously, among the population, the incidence rate of lung cancer will drop to almost zero. Given that cancer is the second most prevalent cause of death in America, and that lung cancer is the most common of all fatal cancers, society will benefit from the demise of the specter and the reality of a major dread disease. The average age of death will increase substantially. And the high costs associated with the final months of life for lung cancer patients will be replaced with the much lesser costs of the drug itself.

Among the suppliers, the big winner will be the corporation that controls the curative product. Granted it will have some problems. In the first instance, its competitors will bring out the full array
of obstacles to marketing until such time as they have caught up. And it, along with the many other suppliers, will suffer from losses of sales of its current cancer-related products. But these will be short term annoyances. Overall, it will market its product with a handsome profit margin; it will do so free from serious competition for perhaps five years until the other pharmaceutical corporations find ways round the patent laws; during that time, it will develop profitable marketing arrangements with health care providers that will continue after its product does have competition. In all, it will be very well placed as a contender within the developing American health industry oligopoly, and indeed the same is true for the transnational oligopoly.

The other suppliers and providers will all be losers. There will be drastic drops in consumption of all forms of cancer-related products and services. For example, medical gatekeepers, cancer specialists, diagnostic and treatment machine operators, and surgeons and anesthetists and nurses, will find that much, if not all, of their income has disappeared; and the value of the practices involved will fall accordingly. No matter how much they might rejoice at
the removal of this scourge to society, they will be in
the forefront of the consequent industry turmoil.

Hospitals, suppliers of equipment and products for
diagnosis and treatment, the unsuccessful
pharmaceutical corporations, and hospices, will all
experience large losses of customary income.

The response of these actors will be that some
will, initially at least, make up for lost income by
overservicing for the other diseases still in their
realm. But of more significance will be the argument
that if cures for lung cancers can be found, then it
will not be long before cures for other forms will
follow. The ensuing movement out of the cancer
industry will be formidable; and will lead to greater
industry focus on the health problems, real or soon-to-
be-created, of the other age groups.

National and governmental expenditures on health
will decrease, perhaps by as much as the four percent
of GNP expected in the previous scenario. In any case,
the drop will be sufficient to trigger that scenario,
and the course of the health industry will follow along
its lines. But with the two notable additions that
firstly the weakest who go to the wall will be those
now deeply involved in the cancer industry; and
secondly, for the first time in these scenarios,
society at large will be a substantial winner in terms of improved health.

7.6 SOCIETAL CONFLICT OVER SUICIDE AND EUTHANASIA

In Chapter Four, I presented arguments that say that, over the last two decades, society has substantially changed its attitude to death and dying, and that this could result in numbers of persons moving towards the earlier acceptance of their own deaths in clearly defined terminal situations. I also pointed out that there has been considerable discussion, in respectable forums, of proposals to permit avoidable deaths by dehydration and malnutrition, and that this goes one step further than the much-accepted turning off of machines.

In this scenario, a movement will demand -- successfully in some states -- that individuals who fall into defined categories must have the right to legal death either at their own hands, or those of appointed agents of the state. The categories will include persons who are medically defined as terminally ill; but they will also include, for example, individuals who have chronic illnesses or functional failures of various types, the elderly over a specified age, malformed infants, and those permanently crippled or deformed by automobile collisions and other forms of
violence. Death will be caused by the administration of a painless drug; permission to die will be gained through the courts, which will also enforce proper supervisory procedures of the occasion of death.

Many professionals will benefit from this innovation. Notable among these will be lawyers, who will stand to gain right through the legislative process, and from court challenges to the legislation, from the court proceedings attached to the permission-to-die process, and from subsequent litigation at a number of points. Doubtless other suppliers and providers will also see their fortunes change. But, for once, in this scenario, my focus is more on the societal conflict that will be generated, and on the health institutions that will become the battlefields for the opposing factions.

The gaps between the conflicting philosophies will be vast and durable, and society will be split no less than in the current battle over abortion. In Chapter Four, I outlined the arguments that protagonists would use to support their positions. It is worth repeating them here.

The movement’s philosophy will be based on the supremacy of the individual over the state in the control of her or his own body. Its arguments will be
that the terminally ill should have a means of death which does not torture themselves and their watching family; that all sufficiently stressed persons should have the right to escape from a hopeless and painful life; that, for those doing so, there must be a legal and painless alternative to malnutrition and starvation; that the financial cost of keeping the suffering persons alive is a great burden on the individual and the state; that in a highly technological and automated society, the capitalist state need no longer preserve its workforce by placing a blanket ban on suicide.

Opponents will contest all these, and will add that there is a god-given sanctity to human life; that the system will be impossible and expensive to administer; that there will be great scope for abuses, including murder; that precedents will be set that allow the extension to more and more categories; that an attitude will develop that places an obligation on certain persons to suicide; that all persons who are participants in a given death will be psychologically damaged permanently; that as various states compete for the available business by introducing new sets of persons into their categories, it will become possible for almost anyone to shop around for a category that
suits them, and this includes persons in states where the innovation is not legal.

The divisions that such arguments create will result in a series of violent physical demonstrations and confrontations right across the nation, and extending for a period of years. In the early years, these will occur in the vicinity of the legislatures, and then later, the courts. But once the new system has stood up to the various legal challenges, the physical violence -- as in the current abortion conflict -- will be directed at locations that are perceived as points of administration of the system. Thus, a selection of hospitals, nursing homes and hospices will be subject to varying degrees of violence that will range from picketing and the invasion of premises, through the harassment of staff, through violent demonstrations, and right up to the physical destruction of their premises through arson and explosives.

Within the three institutions caught in this situation, the professional and volunteer caregivers will be subject to extreme divisions among and within themselves, as well as, sometimes, the physical fears and social rejection that will come with the violence. The internal cohesion of the institutions will be
damaged, the mission will become confused, and many of
the humanitarian influences -- both those supporting
and those rejecting the new system -- will be reduced.
This is the scenario that faces hospices in particular,
since every bit of their business falls into the death
arena; it is a scenario that could well be fatal to the
institution of hospice as we currently know it; and it
is the scenario that I will take up in the final
Chapter that specifically addresses hospice's future.
CHAPTER EIGHT: ASPECTS OF AMERICA'S HOSPICE INDUSTRY

8.1 INTRODUCTION TO CHAPTERS EIGHT AND NINE

In the previous seven chapters, I discussed the past and present of the American health industry, and also created five scenarios for its future.

In Chapters Eight and Nine, I adopt a similar approach for the hospice industry. In Chapter Eight, I start from the proposition that the three features that collectively distinguish hospice from other health institutions are its philosophy and the application of that philosophy, the marketplace for hospice services, and its manner of financial survival. I then examine the past and present of each of these, and how they are trending at 1990.

In Chapter Nine, I return to my predictions and scenarios for the health industry. For each of the five scenarios, I create a new hospice-specific scenario which anticipates the changes that will occur within that industry as the more general scenarios develop.

8.2 THE HOSPICE PHILOSOPHY AND ITS APPLICATION

The inspiration for early American hospices came from the establishment and success of Saint Christopher's Hospice in London in 1967, and then from the first Canadian hospice at Royal Victoria Hospital,
Montreal, in 1975. The first U.S. hospice program was opened at New Haven, Connecticut in 1974.

As defined by Flexner (1979), hospice in America is a medically-directed, nurse-coordinated program providing a continuum of home and inpatient care for the terminally ill patient and family. It employs an interdisciplinary team acting under the direction of an autonomous hospice administrator. The National Hospice Organization (NHO) adds that it provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. The NHO also stresses quality of life and adequate choice for the patient and family, and also the importance of volunteers (NHO 1979).

Proponents for the hospice philosophy make many claims for the ideal hospice:
* it dispels psychic pain and suffering, and reduces anxiety and fear of death in the dying person, as well as reducing physical pain and suffering (Paradis 1985).
* it is a place, a people and a philosophy. It is a system of care that seeks to restore dignity and a sense of personal worth to the dying. The focus is on the patient and the family, rather than on the disease,
and the aim is not to extend life, but to extend the quality of life that remains (U.S. Senator Randolf 1982).

* it provides an option for a patient to leave the sacred confines of a highly praised, technologically intense health care system and retreat to a place of his or her choice (Torrens 1985).

* it enables a patient to live to the limit of his potential in physical strength, mental and emotional capacity, and social relationships. It offers an alternative form of treatment to the acute care of a general hospital, not in opposition but as a further resource for those for whom the usual acute hospital care is no longer appropriate (Saunders 1977).

The actual institutional forms for these programs deviate considerably from the community-based, free-standing London prototype. Thus, in America, many smaller hospices are community based and provide services only in the patients' own homes; many larger ones supply only hospital based services; others work in accordance with the home health agency approach; others work under a number of combinations of all these. America has also introduced for-profit hospices, and nationwide chains of hospice (Paradis and Cummings 1986).
Some hospices rely almost exclusively on volunteers and others use scarcely any. Some have accreditation by Medicare, some require that a patient have a primary care giver, some accept charity cases, some accept only cancer patients, some have sophisticated business management; some do not. 

But these same hospices also have many things in common. At the operational level, they all operate under the same sets of regulations that licensing and accreditation demand; they fight the same types of battle for financial survival; they suffer equally from rejection from those parts of the community that see hospices as so-called death houses; and so on. But all of these would not be sufficient to bind together the disparate groups operating under the name of "hospice." What does bind them is their shared adoption of the hospice philosophy, and their common goal of serving dying patients in accordance with that philosophy.

The question that arises here is whether, given the disparity of the institutional forms that hospice operates under, the affinities stemming from the acceptance of the same philosophy are strong enough to withstand the pressures that are threatening to split hospice into separate and warring institutions. And if such a split occurs, what will be the outcome.
There are three threats apparent. The first, already manifestly divisive, is witnessed by the different operational forms that hospice works under, and by the many different practices that each form adopts.

At one extreme, the pioneer-type hospices of the American movement were mainly small, home-based, and all-volunteer; always they were fiercely independent, and accepted the burden of financial survival as the price of independence. Often they were openly antagonistic towards established health institutions and health professionals. Some of them have now, to varying degrees, been forced towards professionalism and regulation; and some others have staunchly remained uncorrupted. But they all see themselves as the custodian of the true hospice philosophy.

Their current fears are that the initial philosophy of hospice will become corrupted by the combination of professionalism and bureaucracy, and that hospice will go the way of so many other institutions of compassion that lost their initial inspiration. They argue that professionals are basically self seeking, and that members of the medical establishment, even though they support the hospice concept (and many in fact actually oppose it) will make decisions that support the
establishment rather than the hospice philosophy when these two are in conflict. They see bureaucracy as negating their own local control, as stifling their initiative, and as subjecting them to regulations and unnecessary standardization.

They are able to point to a host of developments that bolster their fears. For example, they lament the fact that hospice boards have moved towards domination by health professionals and suppliers to the health industry (Zimmerman 1985); they threatened schism when the NHO elected a president who is also president of a major foundation; they refused to participate in the Medicare hospice reimbursement scheme because it demanded they sell out their principles; and so on.

To the hard core pioneer-type, the arch enemy is the for-profit hospice, which clearly places profits ahead of patients; but since the for-profits are limited in number and geographical spread, they are seen as dangerous more for their potential than their reality. The real enemy, for these pioneer-types, is the pervasive hospital-based hospice. Here is an institution that has been conceived, directed, managed and staffed by professionals from the beginning; it has been in the forefront of moving the industry towards government dependence and regulation; it is only one
more profit center among the other profit centers that make up a hospital.

They are also found wanting in the services they provide. They do not have the training and approach to palliation that they need; the use of heroic medicine can unnecessarily delay the transfer of patients to hospice; profit motives push the patients back into mainstream medicine off and on, despite the weak attempts of Medicare to prevent this; hospice is only used as a bed-filler, and will ultimately give way to other, more profitable, services; much of the benefits of hospice are denied the family where the hospice bed is in the hospital; the patient is subjected to the cold and impersonal routines and disciplines that characterize a hospital; and so on.

Hospital-based hospices, on the other hand, are not apologetic in the face of these criticisms. Quite the contrary; they pride themselves on their professionalism; their submission to bureaucratic badgering is the price they must pay for third party funding, without which they could provide no services; and the hospice services they provide are filling various needs that the pioneer-type hospices do not fill.
In fact, they claim superiority in a number of ways. They provide a continuity of service right from the time of diagnosis until death; the problems of the curative-palliative interface are eased; they offer on-site access to equipment such as x-ray machines; they can move patients to appropriate sites as their physical condition changes; they minimize the patient's feeling of isolation; patients do not suffer from the "death house" stigma; staff are more effective since their rotation in and out of the hospice prevents the burnout that comes with specialization in dying patients (Zimmerman 1985).

In between the two extreme forms of hospice, there are those pioneer-types that have reluctantly accepted Medicare and professionalization and bureaucratic interference as a strategy for financial survival. These "hybrid" hospices have an uncertain foot in each camp; on the one hand, accepting the financial benefits that derive from losing independence, yet still deploring the practices that have come with the benefits.

Clearly the extremes and differences are not uppermost at all times, and many in the hospice industry see the two institutional forms as necessary in order to provide a coverage that neither of them
alone can provide. For example, most pioneer-type hospices have arrangements with hospitals to provide hospice services for patients while the primary caregivers gain a respite. On the other hand, many professionals in hospitals welcome both the emphasis on timely palliation that hospice demands, and also the philosophy towards dying that accompanies it; they claim that these are both regrettably absent in hospitals.

At 1990, it could be that the various hospice forms will continue in their uneasy alliance. They all subscribe to a common philosophy, albeit it is not always paramount in motivation; they have a history of a decade of some level of mutual tolerance and joint effort; they are aware that their lobbying at federal and state level is enhanced by a united front, and that any split among them would also reduce the effectiveness of their fund raising efforts. But the alliance is vulnerable; the differences stemming from bureaucratic intervention, from professionalism, and from different practices in the delivery of services are real and deeply seated. As various pressures develop that put increased stress on the alliance, it seems likely that the current alliance will not be maintained.
One such pressure, the second of the three threats looming for the hospice philosophy, comes from the increasing involvement of hospices in providing services for AIDS patients. Just like other terminal patients, these persons need relief from physical and psychic pain, a sense of personal worth, a refuge from technological intensity, and access to social relationships. Hospice is, on paper, the institution chartered to provide all these, and is doing so in an increasing number of locations across the nation.

For hospital-based hospices, there is no conflict at all in doing this. It is completely consonant with hospice philosophy; and in practice, it conforms to their aim of providing continuity of service throughout the full course of an illness, providing diagnosis and then heroic medicine for cure of derived illnesses, and the freedom to move patients to different sites as warranted by their current state of health. Further, these hospices argue that no other institution can provide such extensive services. Indeed, they have been so successful in arguing this that, at 1990, over half the states have approved Medicaid payments to them for these purposes, and Medicare has relaxed the restrictions that would ordinarily have prevented this.
All of this places the pioneer-type hospices, and the hybrids, in a dilemma. On the one hand, their compassionate instincts are to provide the services that they can. And there is the financial incentive to do so -- though the specters of bureaucracy and professionalization are again present. On the other hand, at the practical level, there are serious objections. For example, hospice nursing staff are mainly required to service patients, primary care givers and "families" who are homosexuals or drug addicts. Similarly, volunteers are confronted with a different population of people; and so too are grief counselors. These are very different from the cancer patients that they are accustomed to, and can place great stress on the service providers.

Medically, the hospices need to move from the familiar medical treatment of cancer to the treatment of AIDS and a host of secondary diseases they are not accustomed to. Financially, they are faced with the proposition that they are raising funds from the community, and spending it on a group of people that not every one in the community wants to support. Managerially, hospice boards are as divided as the community in the extent to which they should deprive
their envisaged clients in order to service the socially dubious.

Hospitals have been faced for decades with the treatment of persons known to be homosexuals or drug addicts, and at 1990 their policies and attitudes show a pragmatic detachment from judgmentalism. This is not so for the pioneer-types and the hybrids, and as the pressures generated by the AIDS epidemic increase, they could become more and more vulnerable to splits among themselves that are really deeply based on their own moral values.

The third threat looming for hospice philosophy would become a reality if society moves towards accepting euthanasia and suicide as practical and legal alternatives to living in hopeless pain for long periods of time. In Chapter Four, I discussed evidence that indicated such a trend is developing; and in Chapter Seven, I developed a scenario for the health industry around this theme; and in Chapter Nine, I extend this scenario specifically to the hospice industry. So, here, I will only record my expectation that, if it does become a major issue for American society, then the contradictions posed for the hospice philosophy will be greater than it can currently bear,
and the movement will be split hopelessly in all directions.

Summing up on the threats emanating from the hospice philosophy and its application, at 1990 it appears that the hospice movement is right now quite vulnerable to serious disruption from within, and there are a number of latent internal forces that could add to that vulnerability in the future.

8.3 THE MARKETPLACE FOR HOSPICE SERVICES

Fifteen years ago, the number of hospices and the number of hospice patients in America was nil. Since then, as the number of hospices increased, and as the average size of hospices grew, the number of patients serviced rose to 80,000 in 1988. In that year, in fact, less than 10 percent of all persons dying with cancer entered hospice programs, but, given that cancer is the second ranking cause of death, this still meant two out of every hundred American deaths occurred in hospice care (Mor et al, 1988).

From its inception in England, the users of hospice have mainly been cancer patients and their families. In America, patients have been predominantly white and not poor, aged over fifty, and have suffered from some form of cancer. Some hospices do cater to non-cancer patients, such as certain forms of heart disease; also,
there are a few specialized pediatric hospices; and recently, AIDS patients have increasingly been allowed into the system. Overall though, the number of non-cancer patients is small, less than 10 percent of the total hospice intake (Mor 1987).

Admission into a hospice program generally requires that the patient must be medically certified as being in a terminal condition, usually with a prognosis of less than six months to live. Further, patients are admitted mainly by the referral of an outside physician; and they and their families must formally accept that the patient is terminal, and that heroic medicine will no longer be used.

The families of patients must also be considered among the users of hospice. More often than not, family members act as primary care givers in the final months of life. Most hospices require that the primary care giver be a close family member of the patient; and there has recently been some elasticity in this to allow partners and "buddies" to act for AIDS patients.

All of these operating rules and conventions limit the number of persons eligible for hospice services. The concentration on patients that suffer from cancer and are clearly terminal, imposes medical restrictions on the potential intake. Other pragmatic limitations
stem from the lack of willing or suitable care givers; from the restricted geographical spread of the hospice system; and from the inability of patients to pay for hospice care; and so on.

Importantly, the level of intake is also reduced by lack of acceptance of the hospice alternative by much of society. There is plenty of evidence of this. For example, there are medical practitioners who will not refer patients to hospice under any conditions. Similarly, Asians, Hispanics, and blacks have low participation rates. Even for white patients, it is often not possible to get the referring doctor and the patient and her family to all accept the imminence of death and the rejection of further curative attempts; in those cases, the patient can not expect a referral to hospice. And always close at hand is the "death house" tag.

This reluctance of the majority of society to accept the hospice philosophy in practice is consistent with Arias' statement that western society currently "deprives man of his death, and allows him this privilege only if he does not use it to upset the living." There is, indeed, much evidence of something of a popular revulsion against this attitude in the last two decades. But, in the first place, this has
occurred only for a fraction of society; and in the second place, while individuals may have developed a changed attitude, it is very often difficult to put this into practice when doing so involves numbers of other people who have quite different attitudes.

At 1990, the looming increase in the total population and in the proportion of elderly will provide more patients for hospice, and part of the increase could result in an enhanced geographical spread of the system. Also, it has been consistently reported that hospices do provide care of a high quality; that their palliation programs are more effective than those in non-hospice settings; and that their claims for psychological and social benefits are generally well met. This too augers well for a gradual increment in the hospice industry.

At the same time, there is nothing to suggest that there will be an increase in the proportion of available primary care givers; and in fact, if anything the proportion could be decreased as more women enter the workforce, and as cohorts from divorce-affected families become elderly. Further, many of the old-old will face the difficulty that their marital partner is dead, or that not only is their surviving spouse
physically incapable of rendering consistent care, but so too are their children.

Further, for all the fanfare given to society's supposed changed attitude to death and dying, I consider it unlikely that society's attitude towards hospice will change quickly in practice, and this will be a considerable barrier to any major growth in the number of hospice patients.

Summing up, it is true that in its first decade in America, the hospice industry grew at a very rapid rate. In the next five years, the rate of growth gradually slowed. This pattern is the familiar one for most new products, and at 1990, the trend is for growth to continue at a diminishing rate as the hospice product gradually reaches its permanent level of market penetration.

But all of this is artificial in the case of hospice. The marketplace here is quite perverted from the normal business viewpoint. It is the suppliers who are limiting intake by placing restrictions -- archaic restrictions to my mind -- on who they will accept as patients. At 1990, this looks unstable, even under homeostasis. What we have now is a group that has been institutionalized, given government permission to spend public money, and protected increasingly from new
entrants. This is a privileged position; and with this usually come some controls on what must be done. Here, in a growing market, with genuine increasing public demand, the hospices have set up a system of patient selection that could easily be tagged as discriminatory.

I expect that hospice will need to face up to this problem soon. There are deep philosophical issues involved here, and it can be expected that there will be no easy solution and no unanimous solution. There is once again the potential to split the movement, even under homeostasis.

8.4 THE FINANCIAL VIABILITY OF THE HOSPICE INDUSTRY

In the 1970s, the financial needs of hospice were met mainly by the vigorous efforts of inspired committees and other supporters of the hospice philosophy. These disciples got their money through a mixture of fund raising events, from United Ways, from community donations, and later, from bequests from deceased patients and their families.

Other financial support came as seed money from foundations, often for capital purposes; the hospitals also had their own sources of funding from their general revenue, and their capital costs were reduced
because they had spare bed capacity which they used for inhouse hospice patients.

These early hospices also benefitted financially from the free gift of volunteer time for service delivery. In many of the community hospices, all functions were initially conducted by volunteers; and for perhaps a decade, most of them had no full time professional staff. Likewise, they received much volunteer support for non care-giving functions such as helping patients with shopping and travelling to medical appointments.

Equally important, the services of the primary care giver were free, and since this cut out the requirement for professional staff, it too was a financial boon. Had it not been given, the movement would have been stillborn.

The hospices have further benefitted throughout by being given non-profit status. This has protected their profits from year to year, and at the same time, made them a suitable place for charitable giving since donations earned tax deductions for the donor.

The change point to some of this was with the granting of Medicare funding in the early eighties; and this, as part and parcel, saw the growth of professionalism in management and in the actual
provision of services. This simultaneously raised the operating costs, and set standards that made entry into the industry much harder; and this is one cause of the reduced number of new hospices that have been founded since then.

The reimbursement formula set by Congress in granting Medicare reimbursement is complex, but in all respects the compensation is miserly compared to the actual costs of hospice care and compared to the rates paid to hospitals. So much so that some 50 percent of hospices have chosen not to become certified for Medicare reimbursement (NHO 1987), arguing that the moneys received were insufficient in terms of their costs, and in terms of probable loss of volunteers, community support, and autonomy that could come from accepting government funds.

The battle to get Medicare funding was won, over the body of the Reagan administration, on the ticket of cutting government costs, and hospice has tied its reimbursement rates to an automatic CPI formula that guarantees only parsimonious government support.

On the other hand, while their financial victory continues to haunt them, they did have a genuine victory in the Congressional battles of 1983, because they took all their opponents head on, and ultimately
vanquished them. So much so that in 1987, when their performance came up for legislative review, the opposition to the continuation of government support was virtually non existent. In effect, this signalled that the movement had become a recognized health institution, and that for competitors, the appropriate policy was now cooptation rather than direct suppression. Hospice was here to stay.

At 1990, the pioneer-type hospices which continue to reject accreditation with Medicare are vulnerable to financial pressures over which they have little control. Granted, they have shown that under the conditions of the 1980s they know how to provide a level of services appropriate to their finances. But they remain reliant on donations from the public for their independent survival, and these cannot be guaranteed in the future. On top of that, even if they stay out of Medicare, they cannot avoid state licensing and they usually choose to be accredited with NHO; and both of these bring pressure for increased professionalism, which leads inevitably to greater operating costs.

So their financial position remains precarious. Their main exposure lies in the possibility that public donations will be curtailed by factors outside their
local control, such as controversy over euthanasia or AIDS. In that case, there is the possibility that they will be taken over by other hospices; or that they will go out of business entirely; or will reluctantly be forced to join the other hybrids which participate now in the Medicare system.

The hospital-based hospices are in a much stronger financial position. They have behind them the backing of their host hospital, and are thus usually a small part of a much larger business. Medicare provides them with rates of reimbursement that are much higher than those for home-based units; their ability to roster non-hospice staff for hospice duties as the need arises helps them pool their labor costs to their advantage; they have greater access to capital through their patron; they can open and close beds to hospice patients as demand varies; and so on.

It appears that hospitals will continue to carry such units while they remain profitable. At the present time, when hospital occupancy rates are down, hospice patients provide a source of income, and that income exceeds their costs. But all of this is comparative in the sense that if hospitals can obtain patients that provide a greater level of profit, then hospice patients will no longer be attractive and
in-house hospices will be curtailed. Herein lies a conspicuous danger to such hospices.

The hybrid hospices are those smaller home-based hospices that have joined the Medicare system, and are torn between their pioneer-type philosophy and the pragmatics of financial survival. In 1983, it was argued that acceptance of Medicare reimbursement would create the twin disasters of decreasing donations from the public and increasing salary to new professional staff. It seems that both of these did in fact happen, but at the same time the payouts from Medicare offset this sufficiently to keep these hospices in business.

Financially, they too are exposed to drops in public donations. But they are cushioned by the guaranteed payments from Medicare, and provided they adopt a policy of financial prudence, seem set to continue along as they did in the 1980s.

8.5 CONCLUSION TO CHAPTER EIGHT

In the last fifteen years, the hospice philosophy has been accepted by a large lumber of Americans, and a significant proportion of these have been prepared to overcome a range of difficulties in putting the theory into practice. An industry has developed that provides services consistent with its lofty ideals, and this
industry has been institutionalized by its acceptance at all levels of government and by most other health institutions and professionals.

Still, there are many threats apparent to the industry, stemming from all three of hospice's distinguishing features. At 1990, it seems that, in the absence of major external stressful forces, it is only a possibility that the industry can survive the next two decades without major splits developing. When such forces do develop, then clearly the odds of disruption will increase. I leave it to the next chapter to conjecture on what hospice-specific scenarios will then develop.
CHAPTER NINE: THE FUTURE OF THE HOSPICE INDUSTRY

9.1 INTRODUCTION

In this final Chapter, I return to the five scenarios for the health industry; and for each of these, I develop a new scenario describing what will happen to hospice as a result. Then, I look at the range of possible futures for hospice, and conjecture on the prospects for the survival of the hospice movement. I then present some conclusions from this dissertation.

9.2 A PETERSON-TYPE ECONOMIC CRASH

In this scenario, there are three distinct periods. In the first, the nation's spending on health will increase towards 18 percent of GNP. In the second, a Peterson-type crash will occur; in the ensuing crisis, the government will introduce a universal health quota system, and will give control of the delivery system to an emerging oligopoly that will come to dominate all points in the system. In the third period, the nation will stage a sound economic recovery, and the oligopoly will prosper from its lion's share of the nation's health care expenditure that will be still set at 18 percent of GNP.

In the first period, the current unfettered growth in researching, producing and marketing of new medical
wizardry will continue and accelerate. Some of these will bring more customers to hospice doors, and some will keep them away. For example, the technique of Patient Controlled Palliation allows patients to administer their own palliation using a drip implant, thereby reducing their level of pain; and importantly, it also reduces the great apprehensions that some caregivers have about giving injections and also about overdosing. This advance is moving rapidly from mainstream medicine towards hospice, and can be expected to encourage more patients, and the earlier entry of patients, into the system.

On the other hand, miracle cures for cancer will come thick and fast, and while each one is in vogue, the numbers of patients entering will be reduced, and so too will be the lengths of stay. In all, the technological factors promoting more business, and those reducing it, will cancel out.

While this is going on, the hospice industry will force government, and also insurance companies, to increase considerably the reimbursement rates for hospice care. This will not simply be the fact that, in the continued growth of the national expenditure on health, hospice will take its share. Nor will it be simply that the political power of the elderly will
force an increase for the hospice services that growing numbers of them are using.

These will be contributing factors, but what will decide the issue will be the removal of two sources of opposition that forced hospice into a bunker mentality when they first approached Congress. At that time, payments for hospices were opposed every inch of the way by the Reagan administration that wanted absolutely no new spending programs, and by the powerful Home Care Association, who saw hospice as invading their territory. By 1990, Reagan himself has gone, and government has now before it the results of the five year study ("The National Hospice Experiment") which it commissioned for the purpose of examining the workings of hospice. This study shows that hospice does indeed save government money, and that it delivers the emotional support to individuals that its proponents claim. Also, by 1990, the Home Care Association has joined the hospice system, partly by members running hospices in their own right, but mainly through providing contract services to other hospices. In any case, the opposition has gone away, and Congress has before it its own evidence that the expansion of hospice services should reduce its overall health expenditure. When all that is added to the expansive
financial environment for health, and the political pressure generated by the elderly, considerable increases in the reimbursement rates will follow.

This will be good for the hospital-based hospices. It will provide them with more revenue with no offsetting disadvantage. If other forms of care become more profitable, as well they might in this period of industry prosperity, then they can still move beds away from the hospice system and into the more profitable alternative. But the overall effect will be to keep more hospital beds open for hospice services.

For the pioneer-type hospices, the increase in reimbursements will not help them financially, and will in fact reduce their revenues because community giving will be reduced as the public sees that government is at last paying a reasonable rate. On top of that, the internal philosophical debates associated with the temptations of Medicare will be intensified. Overall, many of the pioneers will succumb and join the hybrids. There, they will be plagued with philosophical doubts, but financially comfortable as professionals and bureaucracies gradually move them from a compassionate to a business perspective.

The number of pioneer-type hospices will drop quickly. They will become hybrids, or for those who
get into real financial difficulty, they will be taken over by hospitals. No new pioneers will take their place. Overall, though, the size of the industry will grow as new hospitals and hybrids join and as they take over the pioneers; and as for-profit hospices move into a number of areas that are currently financially unprofitable for them.

In the second and third periods, during the crash and in the subsequent recovery, hospice will be hit on all sides. This will be a period in which the government hands over the control of the health system to the corporations and agrees to pay the bills, subject to some form of rationing of the total usage by each individual. Under these circumstances, the contenders for the oligopoly will not be impeded at all by social or political forces emanating from power groups such as the elderly, and will make drastic changes to the hospice system.

Most of the artificial restraints on hospice usage will go. This includes requirements that patients must have a life expectancy of less than six months; that patients must have a primary caregiver; that at least five percent of all services must be provided by volunteers. These restraints are indeed artificial; there is nothing in the hospice philosophy that demands
them. They arose in the first place from idealistic notions of the beautiful death, and were enshrined in practice when it was necessary to convince Congress that hospice was indeed a separate form from other existing health institutions. Other restraints will go as well; for example, in individualistic America, with all the looseness of family ties, there will be little need to consider the emotional comfort of the family; nor is there a need for restrictions on moving back and forth freely between hospice care and aggressive treatment.

In removing restraints, the oligopoly will emphasize what is in fact the truth: that these restraints reduced considerably the number of persons eligible for hospice services. They will claim that hospice will now be open to everyone, and they will sell the idea that the essence of hospice is a continuity of appropriate treatment across all stages of a disease, coupled with readily available expert palliation. The one place where the patient can get this will be in the hospice beds within the hospitals and nursing homes that the oligopoly will progressively own.

The pioneer-type hospice has no future in this environment. For the oligopoly, community boards and

233
other volunteers are not acceptable to a profit-making business; the care of patients in their own homes involves costs and, importantly, a loss of control that can not be accepted; the operating units are too small to be profitable; the ban on movement between treatment modes costs the hospitals too much revenue, and underuses their staff and facilities; and so on.

The oligopoly, then, will do everything it can to destroy all hospice units that do not fit into their overall locality and national plans. They will adopt a number of tactics in doing this. For example, society will be educated to realize that pioneer-type hospices are fringe organizations with a dubious zealous mission that denies dying patients the services they need and want. Society will be encouraged to realize that pioneer-type hospices concentrate their services on middle class affluent whites, and that donations to hospices are racist and discriminatory against the poor. And so on. In the long run, the oligopoly will rig the new rationing system so that pioneer-type hospices will not qualify under the quota system. This latter provision will spell the end of the hybrids who will have become fully dependent on government money for survival.
In all of this, the pioneer-type hospices will be powerless. Their contributed funds will drop sharply as the public is turned against them; as the financial crunch comes, they will split on just how long they can hang out, and whether they can retain some level of local control if they bargain while they are still somewhat solvent. But, the permanent devastation from within will come from the realization that, with all the good will in the world, they have set up a system that does restrict their services to a very small and narrow part of society, and denies it to the majority by far.

In all, then, the oligopoly will take over pioneer and hybrid hospices, and incorporate them into hospital-based and nursing home units; and these will become part of nationwide chains. Clearly, the motivation of all units will be the oligopolic desire for profits, and the nationwide policies and local practices will accord to this. Pioneer-type and hybrid hospices, and their philosophy, will disappear entirely.

9.3 IMMEDIATE ACTION TO AVERT AN ECONOMIC CRASH

In this scenario, two periods are involved. In the first, government and society will realize the dangers involved in following the current economic course, and
move successfully to avoid the crash; national health expenditure will be curtailed at today’s level. In the second, the nation will enter a period of muted but sustained economic prosperity during which an emerging oligopoly will fight among themselves, and with a vigorous government, for control over the health industry.

Major differences between this scenario and the previous one are that here the government remains fully involved. It does not introduce a health quota system, and it does not roll over and hand control to an oligopoly. Instead, it remains as susceptible as it currently is to the democratic processes in society, and that allows scope for powerful pressure groups to influence policy.

During the crisis avoidance years, hospice will be one of the few health institutions that escapes real cuts in expenditure. In fact, armed with the results of the National Hospice Study, and backed by the brute political power of the elderly, they will move away from their cap-in-hand approaches to Congress, and demand that their proven cheaper mode of care be given sufficient financial recognition to not only survive but expand.
Congress will see the economic and political sense of this and will grant generous increases in reimbursement rates. At the same time, it will remove many of its artificial controls that have acted in the past to restrict the usage of hospice. All types of hospice will benefit from these two measures. But the pioneers and the hybrids will gain extra benefits because they will point to the Study's additional findings that they were more cost effective than hospital based hospices. Congress will respond by giving them additional increases in rates that raise them effectively to the levels that the hospital units will then enjoy.

These moves will usher in the golden decades of the pioneer-type hospice. They will widen the range of persons that they accept as patients, move into new geographical areas, and accommodate diseases other than cancer. They will have not only the financial support of Congress, but also its blessing as a favored institutional form. They will be freed from the current battle to make ends meet, and encouraged to return to the innovative ways of their first few years. They will be removed from many artificial controls, and the level of bureaucratic intervention will be reduced to tolerable levels. Membership of their boards will
show a reduction in corporate and professional control, and chief executives will be selected on their delivery of service capabilities, rather than on their fund raising potential. And so on.

In this environment, hospital based hospices will become absorbed into the general environment around them, and while they will continue to be sold as hospice, their services will devolve towards mainly palliation control. The distinction between pioneer and hybrids will disappear, since the Medicare restraints and regulations will be benign enough to allow hospice participation without compromising its philosophy. These latter two types, relieved not only of their financial pressures but also of their philosophical tensions, will combine to create a renaissance in hospice philosophy and practice that will stand in sharp contrast to the current confusion.

In due course, the oligopoly will come to dominate the health industry, though probably not for two or three decades from now. The best tactic that hospices could develop in the meantime would be to create the impression and the reality that hospice is not a part of the health system, and that it is a system of care, and not cure. If they can do that well enough, they might escape the attentions of the corporations.
If that does not happen, and they go the way of other health institutions into the corporate fold, then the fact that they have experienced their golden years and their renaissance will give them a solid enough popular base that they will come to stand within the oligopolies as distinct hospice units. Granted, they will be chained, and their policies will be dictated by the national considerations of profit making corporations. But, these policies will be directed at hospices as such, and not at hospices as minor parts of large institutions. To the extent that hospices can be accommodated into the world of the oligopoly, this is the best possible result.

9.4 INTERGENERATIONAL ECONOMIC WARFARE

Here, younger generations of America will develop hostility towards the relative wealth of the elderly, and rise up effectively to take some of that wealth for themselves. There will be a major diversion of funds away from the health care of the elderly, and towards other persons and other sectors of the economy; so much so, that the proportion of GNP going to the health industry will fall from the current eleven percent down to nine percent, and will remain at that level.

As this scenario develops, the political power of the elderly will be progressively sapped. Hospice will
gain no political credits by quoting the favorable results from the National Hospice Study since the dominant view in society will be that the elderly already receive too much government support, so that any increase in hospice outlays will be out of the question. The best that hospice will achieve will be that Medicare reimbursement rates will remain as they currently are, with the exception that payments to hospital based units will be reduced to those effective in the pioneers and hybrids.

These latter hospices will then be faced with the genuine problem of having more patients than they can handle as hospitals, doctors, hospital based hospices and nursing homes rid themselves of elderly patients who become financial burdens as their various entitlements are used up.

Even worse, these patients will seek admission to hospices only because they are being dumped by other care providers, and because of the cheaper place to die that hospice might provide. They will have no regard for the hospice philosophy; any family that they have will make poor care givers; they will enter hospice at the later stages of their diseases, and thereby threaten hospice with an influx of short-stay patients that would add to the financial burdens that hospice
already faces. And so on. In all, they will place great strains on hospice's capacity to deliver services of today's quality.

Pioneer and hybrid hospices will agonize over the extent to which they will accept such patients. On the one hand, there will be very obvious financial and operational disadvantages in doing so; and these will strain their ability to provide satisfactory service for their traditional patients, as well as those dumped on them. On the other hand, the compassion that forms a part of their philosophy will push them towards opening their doors. For the most part, philosophy will overcome business sense, and many extra patients will be accepted. As well as this, a large number of all-volunteer hospices will be newly created; these will be small backyard operations that make no financial sense; but they will be symbolic of the genuine concern that large parts of society will feel for the fate of the dying elderly.

The outcome will be that hospices will labor on for a decade or more under the most distressing financial conditions; these will be the asbestos years of hospice. The one factor that will mitigate this somewhat will be that society will see their plight and the plight of the otherwise forsaken patients, and will
give donations and volunteer time more generously than ever before. These will in turn have the effect of turning hospice back towards the original pioneer models, and that will give considerable satisfaction to those who now fear their demise. But, overall, these hospices will continue to grind on, desperately short of money, and maintaining quality of service at the expense of burning out their staff and volunteers; and at the expense of burning the hospice philosophy right out of the hearts of proponents who can only continue fighting for so long.

For those proponents, when the oligopoly arrives at hospice’s door, it will not matter then whether hospice is absorbed into other health institutions, as in the first hospice scenario; or whether it retains its identity as a chain of hospices, as in the second scenario. All that will matter will be that the battle for survival is mercifully over; the fact that the battle was lost, and that society dictated this by its rejection of the elderly, and the fact that hospice philosophy has been destroyed in the process, will be a matter for agony in the future; but for a brief period, simply the release from the conflict will be all that matters.
A CURE FOR LUNG CANCER

In this scenario, a drug that cures lung cancer is developed by an American corporation, and sold at a price that everyone can afford. While the supplier of the drug will benefit enormously, there will be a drastic drop in demand for all other forms of cancer-related products and services.

Hospice will be at the forefront of those most affected. In terms of donations, community expectations will be that other new cures will soon be found, and so donations from all sources will dry up. This will be particularly true for longer term bequests. In terms of revenue earned, some 30 percent of its revenue currently comes from lung cancer patients, and all of this will be lost.

On top of this, patients with other forms of cancer will live in the hope that they too might be saved at the last minute by new miracle drugs, and will be reluctant to enter an institution that formally requires patients to forsake aggressive treatments. In fact, if such a drug did emerge, patients could probably move themselves freely back on to curative treatment, and enjoy the drug's benefits. But the hope that a cure will come, coupled with the fear of missing out in a lower level institution, will cause many
non lung cancer patients to avoid hospice altogether, and many to delay entry until much later than they currently do. Both of these tactics will add to the drop in hospice revenues. Of course, some of this will be offset by reductions in operating costs, but still the net result will be that hospice will continue to operate on a tighter shoestring than before.

Hospice will also suffer from continued high turnover in professional staff as a result of the uncertainty as to whether hospice will continue to offer good career prospects. The professionals will see that thirty percent of business has gone away; that there is the prospect that other sizable parts will go likewise; and that professionals and institutions in the cancer industry are preparing to backtrack out of the industry. The full time professional with an eye to her career will see hospice as a dead end industry, and move out of it. For hospice, this will mean a change over to part time, short stay, professionals; this will add to its training and operating costs, make it difficult to maintain quality standards, and introduce an upsetting discontinuity for patients, families, and volunteers. Volunteers too will react to the possibility of new cures, and will move into new
activities, and this will add to the threat to quality hospice services.

Hospital based hospices will dilute the effects of all this across their whole establishment and will maintain their hospice units with fewer beds earmarked for hospice care. For the pioneers and hybrids, times will be difficult, but not hopelessly so. They will respond by removing some of the artificial constraints that reduce their current market share; and they will move to attract patients other than cancer patients to use their services. They will continue on in this way until the oligopoly decides their institutional fate. In the meantime, their move into other diseases will do much to spread the philosophy of hospice away from the narrow confines it now fills, and this will stand them in good stead when the oligopoly is deciding whether to maintain hospice as a separate and identifiable form of health care delivery.

9.6 SOCIETAL CONFLICTS OVER SUICIDE AND EUTHANASIA

In this scenario, individuals who fall into defined categories will have the right to legal death either at their own hands, or those of appointed agents of the state. The gaps between the conflicting philosophies will be vast and durable, no less than in the current battle over abortion. As a result, a number of
hospices, nursing homes and hospitals will be subject to a range of intimidation and violence extending up to the destruction of their premises through arson and explosives.

Within the states where the new system is legalized, the individual hospices will be split asunder. At the philosophical level, proponents of the new system will argue that it is the essence of hospice's being that they allow persons the freedom to choose relief from pain and indignity. The opponents will say that the system is simply legalized murder.

At the pragmatic level, there will be a host of divisive issues. For example, can a terminal patient, diagnosed with three months to live, demand the death-inducing drug. If the answer to this is negative, then what about the patient in agony with two days to live. If the answer is then affirmative, where is the dividing line. If the answer is still negative, is this in fact fulfilling the hospice philosophy of a better way of death.

Or, as another example, can a hospice demand that a staff member administer the drug against their conscience. Or can a permanent endowment be withdrawn if its trustees object to a hospice moving to the new system. And so on.
There will be no compromise possible here. The faction with the most power in each hospice will take control of the hospice; and the losers in most cases will establish their own hospice to implement their own ideals.

Hospices outside the participating states will not be able to stay aloof, because the battles at the local scene will be refought at the national level. Every hospice will be forced to take a position, and will quickly become designated as being in one or other of the camps.

The practical result will be that the total number of hospices in the nation will increase greatly, not because of any increased demand or because hospices will widen the groups for which they cater; rather, the increase will be an expression from both sides of their determination that their point of view will be reflected in hospice practice. Two new national hospice organizations will emerge, and the bitter local fights will continue at that higher level.

Both camps will find that their professionals and volunteers alike will suffer from the physical fears and social rejection that will accompany the violence; and they will leave in droves because of this, and because they too will be torn apart on ideological
grounds. As well, community giving will all but vanish. High staff turnover, poor morale, low level of funding will be the order of the day; and these would be sufficient in any organization to cause a marked deterioration in quality of services. In this case, however, the quality will be worsened further because the energies of all will be sapped by an ongoing, unwinnable, vicious battle against an evangelical opponent.

And so war between the two camps will rage on. The emergence of the oligopoly will not see a merciful peace, any more than the emergence of hospital chains in the 1980s saw a truce in the abortion battle. What is involved here are fundamentally different views on the value of human life, and when large numbers of people become involved in battles over these, only gradual evolution of society's values over decades will see some form of exhaustion and compromise emerge. The oligopolies will recognize this and, as they take over the industry, will merge the pro-drug hospices into their larger hospital based units, and create anti-drug chains for the others. In both cases, the years of conflict, and of poor service, and of concentration on the battle, will have eroded the initial philosophy of hospice to the stage where it has become synonymous
with palliation, with the free option of death through drugs or through natural deterioration.

9.7 CONCLUSION TO THIS DISSERTATION

In this dissertation, my nominated task was to study the future of the hospice industry. In fact, what I have done is develop a number of possible futures for the health industry, and for each of these I have described a likely future for the hospice industry.

The approach I used in doing this was based on the argument that the health industry consists of a set of actors symbiotically linked to each other by a number of forces. This matrix of forces and actors represents a system and, as such, responds to changes in a way that maintains its identity and its integrity relative to its encompassing environment. It is subject to changes both within and without the system at all times; but at times, the normal state of homeostasis is disturbed by perturbation, with the consequence that relativities between actors and forces are markedly changed, and a new system configuration and position develops.

Starting from there, I performed four processes. The first involved the study of numerous actors and forces in terms of their history and their current
apparent potential to influence the future. The second process required a search among these actors and forces to seek out those with the potential to perturb the system in the future. The third resulted in the writing of five scenarios for the health industry, one scenario for each of the perturbators chosen earlier. The fourth process concluded with the writing of five scenarios for the hospice industry, one scenario for each of the health industry scenarios.

A number of results and implications are apparent, and I shall discuss these now in terms of my methodology, then my expectations for the health industry, and finally my scenarios for the hospice industry.

Firstly, in terms of methodology. The approach I adopted is not commonly used; indeed, I have not encountered any writings that come even close to it. This meant that I had to find my own answers to the myriad of methodological questions that came up before and during my writings. For example, could I take a system of forces and actors -- which, by definition of the system, are intimately related -- and isolate them sufficiently to examine their separate histories and trends? Could I make reasonable arguments that some forces could become perturbators? What would I do if I
found too many of these to present effectively? How could I respond if forces I had already studied were to constantly change their relativities within the system? And so on.

Other matters of very different natures came into question. For example, the drawing of the boundary between the American political economy and that of the rest of the world; the decision that the health system is currently in a state of homeostasis; my basic philosophy that individual and institutional behavior are predictable enough that it is possible to create post-perturbation scenarios based on behavior prior to perturbation; my a priori contention that the only way to study a system is to treat it as one. And so on.

Other questions were more practical. Could I really link every statement in a scenario back to some event or actor or force in the past? Could I compress the study of a vast system down to a size where it would remain readable? Would that mean that I must compress complex ideas down to slogans that missed some of their essence? Could I create and present a system model that would allow it to be used to study the future of other sectors of the health industry; and could it be patched and used by other persons with some views different to mine? And so on.
In retrospect, I consider that I found satisfactory answers to all such questions; that my end product meets my original criteria of being both reasonable and of utility; that the philosophical basis and logic of my method stood the test of application to the health industry; and that the method stands ready to be used in other similar systems contexts.

This has implications for other writers who make forecasts or prescriptions for the health industry. For all such writers, I believe they should abandon their ideas that the future will be a continuation of the past; that there is a single possible future; and that they can somehow predict what that will be.

For those writers who take innovative technological advances and predict widespread, drastic and wonderful (or dire) consequences, I would remind them that history is full of episodes where technological advances did not live up to their theoretical promise; and that there are a multitude of forces and actors that are quite capable of diverting any technological wizardry away from a simple path.

For those economists and political scientists who work inside their disciplines using models peculiar to their discipline, I would argue that any such model is
worthless unless it takes into account the type of systems relationships that I have concentrated on.

For those hordes of political scientists who endlessly advocate their own brand of tinkering with the health system to achieve some form of better system, I would suggest that they firstly ask themselves what really would be a better system. I would hope that they decide on one that does not simply mirror small changes in current government policy. Then, I advocate that they take a systems approach that recognizes that years of tinkerings will soon enough be replaced by an avalanche of change. And importantly, I would urge them to reject their naive belief that major changes that do occur will come through government action; and instead realize that government is only one actor among many, and that there are powerful forces in the health industry that dwarf the action -- now or in the future -- of government.

The second theme relates to my conclusions for the health industry. I found that both of the political economic scenarios that I developed pointed towards a health industry oligopoly emerging over the next decade or so. Independently of this outcome, I created three other scenarios. In the first, intergenerational conflict will ultimately grow to the point where the
current emphasis on elderly care -- particularly that provided by nursing homes -- will be reversed. In the second, a cure for lung cancer will be found and marketed, but at the expense of the suppliers and providers who currently benefit from the disease. In the third, a great social rift will develop over the issue of euthanasia, and will prove to be no less disruptive than the ongoing controversy over abortion.

There are three implications, related to the emergence of the oligopoly, that I will now address. Firstly, both of my political economic scenarios assume that the nation cannot continue to defy the generally accepted principles of macro economics. But, there are those -- including the current Administration -- who would argue that the nation will do just that.

The point I wish to make here is that, even then, I would still expect a health industry oligopoly to emerge. The logic I use here is the same as I expressed earlier in more detail. The pots of gold are there, and an oligopoly will develop in the American way, and will take the gold and the pots in the American way. The fact that the process for doing this has been gaining momentum for this last decade adds credence to this argument; and I add that the prospect
of a transnational oligopoly developing will spur on the prospective American protagonists.

The second implication is that there is nothing in any of the scenarios that suggests that this can be averted. The corporations which will move into the oligopoly will collectively be the most powerful actor on the scene; and I can mount no argument that says they will lose out to less powerful actors.

The third implication is that perhaps control by oligopoly will not be all that bad. Granted, there will be a completely different locus of control inside the industry; and this will lead to painful disruptions along the lines I mentioned earlier. And, the consumer will need to accept that there can be no personal relationship between herself and her medical gatekeeper. And so on.

But control by oligopoly might well bring gains that exceed the losses from the consumer's point of view. For example, oligopolistic competitive pressure will hopefully force scrutiny of the efficacy of the treatments that each corporation markets, and of the doctors and hospitals that deliver them. Again, oligopolistic collusion should force government to keep its spending on health care high, and the likely spin-off would be that all persons would have a guaranteed
minimum level of access to the system. Yet again, collusion at the transnational level might destroy the protective regulatory environment that now delays the entry of proven life-saving drugs into this country. And so on.

My point here is that there is a host of glaring deficiencies in the current system; and the fact that they are not widely recognized in no way diminishes their severity, or the fact that many of the actors are getting away with murder. Perhaps an oligopoly will interfere with some pleasing and comfortable aspects of the current system; but there is plenty of scope for huge improvements in that system. My only politically realistic scenarios that promise such improvements are those that see current systemic abuses ending under a system of oligopolistic self regulation.

But in any case, virtually all aspects of the new health system will be controlled by the megacorporations. At the point of delivery of services, the customer might have some say; about as much as a car owner has with her mechanic. And the health professional too will have some influence; about as much as the mechanic has in deciding the fate of the auto industry. Granted, the oligopoly will make gestures that purport to respond to consumer and
professional needs; but their marketing efforts will steadily and surely change the needs perceived so that they meet corporate objectives. If it so happens -- as it always must -- that these objectives can be met only at the expense of compassion, then that is too bad. It is just the way it has to be.

My third and final theme relates to my conclusions about the future of the hospice industry. All my scenarios for hospice end up in the virtual destruction of the "movement" that developed in the nation in the 1970s. Granted, one scenario looks golden for a while, but shows a precarious longer term reliance on oligopolistic tolerance.

But let me turn this dismal picture round; can I argue somehow that the movement will prosper? My answer is that I can not. Firstly, I can point to lots of precedents where movements of compassion have been destroyed or coopted by commercial victors. Secondly, I consider that the oligopoly will surely be as commercial as other victors in the past, and "movement" hospice is scarcely a match for that. Any advantages that I saw above stemming from the oligopoly do not apply to the hospice industry; and in fact, it will be seen as one of those pleasing and comfortable aspects of the current health system that can be done without.
Thirdly, even if the oligopoly does not develop and come to dominance, the commercial forces and pressures now becoming so obvious in the health industry are certain to increase; and the fact remains that at some time, compassion and commerce must come into conflict, and I expect that commerce will always win in the long run.

So the best future I can see for "movement" hospice is under the second scenario. This allows for a conditional acceptance by the oligopoly. All other futures offer no real hope of survival, other than as adjuncts to larger institutions with their ideology repressed. But, of course, the odds are that the second scenario, just one among many possible scenarios, will not occur.

The regrettable consequence of this will be that hospice will lose all vestiges of their independent identity, and will instead become physical and philosophical adjuncts to parent institutions, with their evangelical zeal burned out and bought out. They will leave behind some wonderful gifts to the nation. For example, the wider and wiser use of palliation, the notion that death need not occur in depersonalized environments, the reality that family and friends need support at the time of death; and so on.
But hospice in America had potential for more than that. This is a nation that has the capacity and freedom to innovate, to adopt new ways, to make changes with vigor and speed. Hospice here started out that way; and it might have continued on in that vein; and it might have moved the whole nation towards a better way of death. But the last few years have seen it forced to scrimp and save and barely survive, or to sell out to others with different, though still compassionate, missions.

Now the future is that it will have no option but to sell out. This time, though, it will be selling ultimately to the oligopoly, and there can be no thought that compassion will rank highly in its objectives. The end result will be that true hospice will be strangled and die; and what will be left will a few wonderful ideas and practices from the past, that will gradually be effaced from consciousness or coopted into marketing strategies as part and parcel of oligopoly policy.
BIBLIOGRAPHY


