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What Medicine Will Look Like in the Year 2000

by Harry M. Oliver, Jr.

What American medicine will look like in the year 2000 will depend on the tradeoffs made between quality and availability on the one hand, and cost on the other hand. Two extremes can be envisioned. Both have important implications for business and industry, employers and employees, and others. Ultimately, the degree to which medicine moves towards either extreme will be determined by the wants and needs of the people.

One Extreme

One extreme would involve a pre-occupation with the cost of delivering care with an attendant need for its rationing. Some older patients could be denied high-cost procedures such as open heart surgery and kidney dialysis, as is presently done in some European nations. Decisions would be based on the quality of life as well as age.

The cost of medical and health services would be strictly controlled, and bottom lines would be predictable. Public and private insurers would set precise annual maximums on spending for beneficiaries and policyholders. Patients would pay larger deductibles and copayments when care is received. When coverage maximums are reached, no additional services would be provided unless patients pay out-of-pocket; but the total amount of care available would be largely controlled by private and public insurance mechanisms.

Every diagnostic procedure and payment would be approved in advance by insurers. Reimbursement of hospitalized patients also would be stipulated, as well as the length of patient stay. Everything would be based on norms for severity of illness. The theory would be that cost would "average out"; i.e., earlier recovery of healthier patients would make up for those less healthy. The system would be as much statistical as medical, with predictable illness and death rates. Wealthier patients would be able to pay for whatever care they need. Poor patients and those without insurance coverage would seek welfare or charity care.

Insurers would no longer help subsidize medical research, medical education and development of new technology. In some areas, patients would be on waiting lists to see one of the dwindling number of doctors available. There would be fewer hospitals. The pace of medical advances would slow down; with fewer discoveries, there would be fewer new techniques and medications. Technological innovation would be reduced. The quality of patient care would remain basically the same.

The Other Extreme

The other extreme would make the best kind of care available to those who need it, but it would be provided in more cost-effective ways through pluralistic financing and delivery systems.

Physicians and other providers would continue to diversify into more efficient, economical and convenient forms of practice. This would include the single practitioner's office, hospital-based or sponsored ambulatory care and ambulatory surgery centers, free-standing surgery centers, shopping mall and residential area urgent and routine care centers, and other, not-yet-developed forms of "custom medical care" to meet the needs of patients within necessary financial constraints.

There also would be a continuation of combined financing and delivery systems, such as health maintenance organizations and preferred provider organizations, all of them aimed at greater efficiency and the containment of cost—containing the real cost of providing care, not just the price or the payment for it.

Beneficiaries of both private and government insurance programs would assume more responsibility for the cost of care through premium sharing, deductibles and copayments for actual care. Those with little or no resources would be cared for through government programs and private health insurance risk pools.

All payers would contribute a fair share of the cost of medical education, medical and scientific research and technology development so that the quality of care—and its beneficial results—would continue to rise to meet the needs of the people.

Very probably, medicine in the year 2000 will fall somewhere between the two extremes, with a continued emphasis on quality and availability. The American people have become accustomed to the best of care and are not likely to abandon that for dollars and cents.

Progress/Problems

Medical progress has been of immense benefit to the health and life expectancy of the American people. Average life expectancy in this country is now about 75 years, up from 47 years at the turn of the century. And the number of Americans aged 65 and older now surpasses the entire population of Canada. Between 1970 and 1984, the number of people aged 85 and over jumped more than 90%, from 1.4 million to 2.7 million. But progress has a habit of creating its own problems.

Medical cost problems are bound to increase with the disproportionate growth of the elderly segment of the population. Medicare and Medicaid patients already account for more than 43% of total hospital admissions.

A National Center for Health Statistics report predicts average life expectancy in this country will reach age 80 just after the turn of the century. The same report estimates the number of people with chronic health problems will increase to 46 million. The number of doctor visits per year will jump by 318 million to a total of 1.4 billion; hospitalization will increase 48% to an annual total of 407 million days; and the number of nursing home residents will more than double, as will costs for their care. During this same approximate period, the number of Americans over age 75 will more than double, and the number over age 85 will more than triple.

Medicare is basically a payment transfer system, with the payroll taxes of four workers funding services for each Medicare recipient. This will shrink to just two workers. One recent government report predicts the Medicare program will be bankrupt by the year 2002 unless additional funding is provided.

Even so, given the social, political and medical philosophies of the United States, it is likely that the quality and availability of needed care will continue to take precedence over its cost.

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