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A view from the USA

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This issue of *Work* highlights Swedish models of health care, particularly in the area of rehabilitation. It is natural, for one whose cultural and clinical experience has been concentrated in the United States, to compare and contrast the underlying assumptions of the approaches taken in the two countries.

Larsson, in this issue, outlines what Paulsson, in her article, terms a 'holistic' view taken towards vocational rehabilitation in Sweden. While the term connotes somewhat different concepts to the American health care provider, the meaning for Swedish citizens is clear: the societal powers-that-be (government and social services) understand that medical and socioeconomic consequences of trauma and other accident-induced infirmity are related, and virtually co-equal, parameters in the prognosis for return to productive life. The assumption is that "man is basically active and needs to find aims and meaning in life" (Larsson, S., 1995) [1]. Included in this view is the recognition that the attitude of the individual matters in the likelihood of early return to work, and that both the medical and social systems involved in rehabilitation need to overtly recognize this factor and use it directly and positively in the process. This in turn leads to the realization that often, the best results in re-establishing employability require "a process of modification aiming at accommodation between work and the individual, in which changes can be brought about on *both* sides" (Larsson, 1995) (my italics) [1].

Although the above is incontrovertibly a *professionally* recognized verity in the United States, reflection on the practical experience of the clinician in the U.S. would, in general, yield a conclusion that the primary goals of the socioeconomic system are ones that include keywords of 'cost shifting' and 'evasion of responsibility.' These terms apply as much, indeed more, to insurance and governmental agencies as to individuals seen as avoiding gainful employment and seeking entitlement, or heath care practitioners looking to profit from churning 'the system.' In truth, there is very little objective evidence that the latter two cases are root causes of the disarray in which rehabilitation has fallen where medical and personal goals conflict with issues of cost.

A somewhat unexpected finding occurred in a

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search of the literature (medical and business-oriented) via several electronic resources (CompuServe and BRS Colleague): there seems to be great difficulty in extracting any significant objective or scholarly discussion of the underlying assumptions involved in the workers compensation system in the United States; namely, cost-shifting and assessing blame. In one unique article, a comparison of costs in treating injured workers via contracted HMO — vs. fee-for-service care — disproved the null hypothesis that such an arrangement might predispose to over-diagnosis in order to maximize income stream to that HMO [2]. The expected finding, however, is that there is an obsession with viewing cost containment as the major issue in defining the future of medical care in the U.S., with lip service offered as to access to, and quality of, that care. There are few references made to the humanistic cost of defining the debate in this manner; these tend to come from medical sources, or those outside the arena of direct management and oversight of the medical care system [3–5]. Exceptions seem to represent situations where broad coalitions of participating sectors (e.g., business/industry, labor, insurance companies, physicians, hospitals, government agencies and politicians) are formed to focus on practical aspects of this pressing issue [6]. This latter circumstance appears to remarkably mirror the appealing system described by Larsson which is evolving in Sweden [1].

Clearly, there are issues of scale and diversity that make treatment of the health care conundrum in the United States an order of magnitude more difficult than in those of the relatively homogeneous and smaller societies of Europe. Still, it is recognized that state-level, even regional, solutions under an umbrella of common national guidelines is a reasonable process to pursue. Problems still exist with this approach, in that for more than 30 years, the balance between perceptions of entitlement and privilege on the one hand, and responsibility on the other, have favored the former to such an extent that multiple sectors of the nationwide society have measurably suffered: education and public safety, the cost of a generally litiginous society, not to mention scapegoating in the discussion of the medical care situation leading to one source of deterioration in the doctor–patient relationship. This appears to leave open the probability that, if left completely to its own devices, a state-level system may foster new, if different inequities. A case in point [7] is the recent system legislated in Minnesota, where essentially otherwise unfunded mandates extended (low) fixed prices for medical care to 25% of the treatment population at the same time that it directly assessed the same medical care providers 2% of gross revenue, and increased licensing fees (to fund this extension), to boot!

Insofar as workers compensation is concerned, it appears that the insurance industry is foremost among critics of including such medical care in a truly comprehensive care system and thereby completely eliminate cost-shifting. This is despite increasing micromanagement of health care providers, and multiple layers of bureaucracy at insurance companies, to ostensibly reduce costs in the current system — which factors are arguably among the worst offenders in dragging out proper medical care to injured workers and thereby contribute directly to the *lowering* of likelihood of return to work. There is additionally a curious reluctance among labor union and academic health system analysts to favor such '24-hour coverage' — in part because of cynicism about the intentions of health care providers, and in part because of fear of the cost to the system [8]. An analysis of the likely consequences of truly comprehensive health care on business, however, appears to indicate an effect similar to that of raising the minimum wage — which in turn has been shown to only marginally affect the availability of jobs [5]. The legal implications concerning risk of increased suits by injured workers directed at employers now protected under workers compensation provisions is yet another deterrent to change in the system, yet small business in particular seems to favor at least a trial of '24-hour coverage' and such legislation has been enacted for pilot projects in several states [6].

To my mind, addressing the specific issue of worker's compensation, medical benefits and re-

habilitation, along with the larger issue of comprehensive health care access and affordability for the general population, must start with a revision of the basic assumptions and parameters of the debate in the U.S. We must go beyond arguments of potentials for abuse of the system and/or avoidance of responsibility. In particular, the societal bias here, in contrast to that in Europe, towards viewing medical care as a commodity rather than as a compassionate enterprise must be reversed. I submit that re-focussing efforts to the perspective of an individual's ailment and its effect on the self-image and functioning of that individual within society will accrue tangible economic benefits (i.e., cost-containment) more efficiently than fostering an economically punitive and micromanaged system upon providers and, ultimately, patients. It may even begin to erode the tendency towards litigation with every imperfect end-result, regardless of the presence or absence of malpractice, if patients feel themselves valued as the central factor in the health care system, rather than as a statistic to be minimized.

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