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The changing face of health care: Implications for counseling

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Abstract

The intent of this paper is to examine the effectiveness and the costs of the health care system in America today. Recent analyses by health care writers will be reviewed to provide an overview. The orientation and role of health care will be compared and contrasted with the role and orientation of counseling.

THE CHANGING FACE OF HEALTH CARE: IMPLICATIONS FOR COUNSELING

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The intent of this paper is to examine the effectiveness and the costs of the health care system in America today. Recent analyses by health care writers will be reviewed to provide an overview. The orientation and role of health care will be compared and contrasted with the role and orientation of counseling.

THE ISSUES

Writers in the health care field have begun to respond to the rapidly rising cost of health care in the United States. Data compiled by the Health Care Financing Administration on gross national product and national health expenditures for the United States for selected years 1929-1980 (1981) show a substantial increase in the amount of money spent on health care. In 1955, America spent 17.77 billion dollars on health care, or 4.4% of the gross national product. By 1965, this figure had risen to 41.7 billion or 6.0% of the gross national product. In 1980, only five years later, the amount spent on health had almost doubled again, rising to 247.2 billion or 9.4% of the gross national product. As of 1984, costs had risen to 387.4 billion, 10.6% of the gross national product.

As a result of these rapidly rising expenditures and the

large percentage of gross national product expended on health care, writers in the field of health care have taken a close look at the current health care delivery system and have identified some significant problems. Carlson, Illich, and Mechanic have identified factors contributing to rising costs as including the fact that the current health care system is focused on providing cures and alleviating symptoms that have already developed.

According to Carlson (1975), modern medicine removes problems, fixes on undesirable symptoms, and tries to eliminate them rather than addres their causes. He notes that vast sums are being poured into research for new cures and the development of high technology equipment to effect these cures. Relatively little effort is devoted to determining the causes and preventions of symptoms of illness.

A primary reason for the orientation of the current system is thought to be the attitude of those who use the system. Many individuals who utilize the health care system seem to have the attitude that they are not personally responsible for their own health. Illich (1976) believes that as a culture, we are dependent upon and addicted to medical services. We are not taking responsibility for our health, but instead have turned it over to the health care delivery system.

Carlson blames the health care system in part. He believes that because medicine has failed to encourage the patient to assume the responsibility for health, the public craves more and more

services. As a result, medicine has fostered a profoundly dependent public which searches for cures that do not exist. It is apparent that many Americans who are using the health care system are not taking personal responsibility for their health. They have developed lifestyles, that is, consistent behavior patterns, that are ineffective in terms of health.

Ryan and Travis (1981) note that what they call the current "illness care" system deemphasizes the role played by lifestyle in determining one's state of health; they, in contrast, believe that most illness results from choices about lifestyle rather than from lack of access to health services.

Lifestyle behaviors can include factors such as dietary habits, physical activity patterns, sleep patterns, and work-life. Certain patterns of lifestyle behavior are classified as ineffective when they are detrimental to the overall health and well-being of an individual. Examples of ineffective behavior patternsare smoking tobacco, overconsuming high fat foods, abusing alcohol and drugs, and failing to resolve negative emotional conditions such as boredom, depression, anxiety, and resentment. Ineffective lifestyles may also lack such health-maintaining and health-enhancing behavior patterns as proper nutrition, rest, recreation, and exercise.

The current health care system in the United States focuses on treatment of the symptoms of illness rather than on the development of healthy lifestyles. Present practices are a cycle

which can be described as follows: people adopt unhealthy lifestyles and develop symptoms of illness; they turn to the health care professionals, demanding treatment for these symptoms; now "cured", they resume their previous ineffective lifestyle, which in turn leads to the redevelopment of symptoms, and once again they return to the system to be cured.

Why do people continue this dangerous and repetitious pattern? They may be unaware of the impact of lifestyle on health, or they may be aware but lack the knowledge or motivation or skills required to effect changes of lifestyle. When we consider that health care spending has increased without improving the health of the public, it becomes apparent that there are problems somewhere. The health care system, with its focus on the removal of the symptoms of illness, has not educated the consumers of health care about the effect of lifestyle on the development of symptoms of illness. As a result, a cycle has been established which has contributed to the rapid rise in the cost of "health care" without improving health.

REVIEW OF LITERATURE

The intent of this review is to survey recent studies of problems in the health care system; the focus will be on the impact of the system on health-related aspects of behavior.

A writer who has taken one of the most radical stances on health care issues is Ivan Illich (1976). Illich believes that

Americans are not taking responsibility for their health, having become dependent upon the health-care delivery system to effect cures of illness already developed. He argues that our current system creates more illness than it cures, because it does not encourage people to be responsible for their own health. He notes that by abdicating personal responsibility for health, people do not effectively regulate health-related behavior. The result is a decline in health.

A writer who has taken a less critical position is David Mechanic (1979) who acknowledges the role of the health care system in creating dependence on the part of health care consumers. He discusses attitudes contributing to the problem of increasing health care expenditures and suggests that a major way to reduce expenditures for medical care is to limit the needs of patients for medical care. Reducing needs involves preventing illness and diminishing the psychological dependence of patients on the medical encounter for social support. Mechanic asserts that patients have unrealistic expectations of physicians, believing that the physician can cure whatever goes wrong. The result is that it becomes easy for people to think of themselves as patients and thus take less responsibility for their own health.

In discussing approaches to this lack of personal responsibility for health, Mechanic points out that encouragement of effective health behavior as part of a national strategy is widely discussed but there has been little serious effort to design

and implement programs. Apparently, the major problem in developing health promotion programs is to motivate people and to involve them in changing health-damaging habits, increasing health-enhancing behaviors, and maintaining the new behavior patterns.

Mechanic discusses the difficulty of behavior change. He notes, "behavior is the result of a long period of socialization and from the contextual demands of the environment in which we work and play. Good or bad health practices are most typically integrated into our daily routine, our patterns of work, family life, and social demands and expectations" (p. 29). He suggests that, "to the extent that healthful patterns of behavior are programmed into our daily routine, they are more likely to be practical than if they require continuing conscious efforts." Mechanic suggests that Americans need to learn new health-promoting habits and behavior patterns. However, in order for these new habits to develop, broad changes in societal attitudes towards health must occur. These changes will result from education, including awareness of need for change, knowledge of techniques for implementing change, and skills to motivate change. Making changes in current attitudes and behavior patterns is a difficult task, because these attitudes and behaviors have developed over a lifetime and are firmly ingrained in the culture. Mechanic believes that such difficulties can be overcome only through the systematic application of behavior change principles.

He notes that behavior change can be facilitated by developing a clear plan of action and incorporating it into usual routines.

David Richards (1975) also believes that awareness is not enough. Writing about health education, he shows how education of the public has been concerned primarily with the dissemination of information and has therefore faced inevitable limits. Richards believes that the field of health education has only begun to examine seriously the implications of its own practice, and that it rarely makes use of existing knowledge of behavior change techniques.

Rick Carlson (1975) has also addressed problems associated with increasing health care expenditures. He views the present health care system as one in which health is sought principally in the form of services delivered by a system designed to treat symptoms of illness. He describes a cure-oriented system which has little impact on health, believing that social and environmental factors have a greater impact on health than medicine, and that medicine has reached the limits of its effectiveness and its impact is declining. Carlson asks, "Should we indenture our health in the future to the existing medical care system when better health might be insured though other means? The answer should be no" (p. 3). He contends that we must start over in our efforts to achieve health. "If it is health we care about and not medical care, we must look for improvements in the life setting of the unhealthy, not simply the provision of ser-

vice designed to cure them once they are sick" (p. 3).

Other relevant points made by Carlson are that today's medicine has become so specialized and highly technical that the physician is no longer trained to treat the patient as a whole person. Medicine has failed to encourage people to develop self-responsibility for health, and the public requires more and more services, however specialized and fragmented, becoming more profoundly dependent on medical cures. Because medicine focuses on symptoms rather than causes, and because it has assumed that it can treat the human organism in isolation from its society and environment, the American medical system has reached its limits to effectively treat and reduce disease. Carlson emphasizes that society needs to place a high value on health if people are going to change their lifestyles.

Ratcliffe, Wallack, Fagnani, and Rodwin (hereafter, Ratcliffe) (1984) define an important classification system for the role played by our current health care system: primary, secondary, and tertiary prevention. Primary prevention refers to measures which prevent the outbreak of disease by reducing exposure to the causal agent or by altering the susceptibility of the individual at risk. Secondary prevention refers to the detection and diagnosis of disease at an early stage, accomplished usually through screening procedures. The focus is on individuals at risk, and it provides remedial action so that the health problem will not worsen. Tertiary prevention refers to the amelioration, treat-

ment, or cure of clinical disease. Its goal is to prevent impairments and handicaps and to readapt patients to their social contexts.

A brief history of our health care system reveals a gradual shift from a public health prevention orientation (a primary prevention approach) towards a more treatment-oriented system (a tertiary prevention). A growing demand for medical care by people is attributed to the internalization of values on which clinical medicine is based by broad segments of the population. In the space of a century, the medical profession has persuaded the population to believethat life is not possible without regular recourse to medicine.

The current tertiary prevention system is described as the "disintegration" of disease prevention, characterized by 1) the emérgence of professional and institutional bondaries between curative and preventive medicine, 2) the lack of clear differentiation between services rendered by traditional, primary, and secondary prevention programs and those of the helping professions that claim to provide information, resolve personal problems, and promote well-being. A variety of primary prevention procedures have developed outside the medical profession in areas such as insurance, job training, physical therapy, counseling, and other "personal" psychological and pedagogical services.

Ratcliffe proposes that the leading policy issues today

concern the role of primary prevention efforts. There are two contending strategies of primary prevention: health promotion, which involves altering individual behavior, and health protection, which involves altering sociopolitical and economic structures. Advocates of health promotion argue that the major killers of today--heart disease, cancer, and stroke--are primarily the consequences of an unhealthy lifestyle. According to this view, such personal factors as stress, improper nutrition and exercise, and the abuse of alcohol and tobacco are the primary causal agents in the development of disease. The emphasis is placed on the personal responsibility of the individual in the disease process. Advocates of health protection hold that our major chronic diseases are the consequence of social organization and economic structure. They believe that because disease is socially caused, prevention requires social change. The health protection approach places responsibility for disease prevention on the state and industry, and the focus is on population groups rather than on the individual.

The medical model has generated two principal strategies for health improvement: the curative hospital-based strategy (tertiary prevention), which consumes ninety-five percent of health sector expenditures in America, and the public health approach, which relies on environmental modification or on reducing the risk of population groups through programs such as vaccination.

It is noted that medical care does not contribute much to national levels of health, although its importance is acknowledged.

Ratcliffe argues that the most successful programs in improving national health levels are primary prevention programs; however, the primary prevention strategy of health promotion has been ineffective for two reasons: most factors of illness lie outside the control of individuals, and lifestyles are powerfully influenced by the social organization. Any major imporvement in national health levels will come as a result of health protection policies which regulate "risk-imposing behaviors". Risk-imposers include those who market the legal drugs alcohol and tobacco and those who pollute the environment with carcinogenic waste products. To take action to raise national health, the authors identify four principles: 1) disease can be understood fully only within the context of the social structures, 2) the treatment of illness is an important moral responsibility, and "casualties of the social system" cannot be abandoned; the moral responsibility for prevention of illness is at least as great as the responsibility for treatment, 3) research concerning the social, political, and economic links to health and illness is vitally needed, and 4) the principal mechanism for instituting primary prevention is social policy.

John McKinley (1979) agrees that the current health care system devotes most of its resources to tertiary prevention or what he calls "downstream endeavors." His analogy likens health care to the effort to rescue people drowning in a river. It is

more effective to look upstream to discover who is pushing people into the river and to determine why they cannot swim than to try to rescue them one by one downstream, as our current health care system does by treating illness after it has developed. He believes we should analyze how and by whom people are being pushed into the river and prevent illness at the causal level. McKinley identifies the "manufacturers of illness" as political and economic entities which include individuals, interest groups, and profit-oriented corporations; he contends that they create artificial needs that habituate people to risk-taking behaviors which can lead to illness. Health workers arrive and begin to work only after the damage has been done, or people have 'been pushed into the river'. Corporations make better use of the knowledge of behavioral science to induce unhealthy behavior than the health professions do to prevent it. McKinley accuses 'manufacturers of illness' of inducing unhealthy behavior through 'piggy-backing' risktaking behavior on values, beliefs and norms that have been accepted in the culture, citing familiar advertising strategies that use the supposed endorsements of products or activities by 'doctors', 'choosy mothers,' attractive women, masculine men, or celebrities.

McKinley observes that current health intervention is often based on the assumption that people are themselves responsible for their health behavior, but it fails to take into account the

social context in which behaviors are influenced by the "manufacturers of illness". Health professionals have assumed a mandate to determine the morality of various behaviors, and they have access to knowledge and resources that can be utilized for change or alteration of behavior; thus health intervention is also a part of a pattern of social regulation. However, illness prevention programs and "downstream" endeavors because they are preoccupied with the individual who practices at-risk behavior and neglects the activities of those who 'manufacture' illness and foster the at-risk behavior.

McKinley's solution is legislative actions which would tax the corporations that manufacture illness at a ratio of risk-to-benefit; the higher the risk imposed or the lower the benefit of a product, the higher the tax. He also recommends educating the public regarding the at-risk behavior promoted by these corporations.

Thus analysts of health care--Illich, Mechanic, Richards, Carlson, Ratcliffe, and McKinley--are critical of current contributions to health by the health care industry. Another set of writers considers the possible alternative health strategies which can be discerned in certain areas.

There are positive developments in the directions recommended by McKinley and other writers. Fielding and Breslow (1983) surveyed health promotion programs sponsored by California employ-

ers. A surprisingly high seventy-eight percent of companies surveyed offered health promotion programs for their workers. Included were accident prevention, CPR training mental health counseling, drug and alcohol treatment, smoking cessation, weight control, nutrition training, exercise and fitness, and stress management. The programs ranged from primary to secondary to tertiary prevention efforts. For example, accident prevention is primary prevention since it looks to causes and attempts to prevent occurrence; drug and alcohol treatment can be considered tertiary prevention because it treats a disease in process.

McCann (1981) describes the Control Data Corporation's "Stay-well" program which is based on the premise that lifestyles has a major effect on illness and life span. With appropriate counseling, people can change their habits; the workplace is the most effective place because people spend many consecutive waking hours there. Companies have a major stake in promoting a healthier lifestyle for employees because of the potential benefits of reduced insurance costs, decreased absenteeism, improved productivity, and better morale.

Among reasons cited for engaging in such programs are the escalating costs of sickness-oriented health care system and a changing value system that places emphasis on fitness, good appearance, and moderation in many aspects of behavior. It was also noted that society in general and employers in particular are

bracing the concepts that to stay well is less costly than to get well, to prevent is more rational than to cure, and that a healthy lifestyle enhances the chances for improved health, longevity, and quality of life.

Marcotte and Prince (1983) write that employers show an increasing interest in health care itself as well as the cost of health care. Industry is beginning to realize the most efficient mode of cost containment would be a shift from the curative philosophy to a preventive philosophy. The authors cite companies that have begun health promotion programs such as hypertension screening, exercise, substance abuse treatment, stress management, nutrition, weight control, and other programs. Health promotion is in its infancy and many companies have not yet developed programs, they observe. They recognize that health promotion is not a panacea for our health care woes, but if properly developed and used in combination with other programs, health promotion can make contributions toward better health and cost containment.

In summary, health care costs in the United States have been rising rapidly over the past decades. In response, writers in the health care field have taken a critical look at the health care system. They have found a cure-oriented system which has more or less reached the limits of its effectiveness; they have made recommendations for alternative strategies, the most widely endorsed being towards prevention-oriented systems which take the form of "health promotion" and/or "health protection".

There is evidence that some of these strategies have recently been put into practice in certain geographical areas.

IMPLICATIONS FOR COUNSELING

In the final section of the present study, the intent is to discuss the implications for counseling of specific comments made by health care writers whose work has been reviewed. It will be useful at the outset to establish some definitions of counseling. Nugent's (1981) survey of definitions includes two which are particularly apt for our purposes. Shertzer and Stone (1981) see counseling as an interaction process which facilitates meaningful understanding of self and environment and results in the establishment or clarification of goals and values for future behavior. Pietrofeso (1978) says that counseling is a relationship between á professionally trained, competent counselor and an individual seeking help in gaining greater self-understanding, improved decision-making and behavior-change skills for problems resolution and/or developmental growth.

These definitions describe counseling as a helping process. It is clear that the orientation of counseling is different from the orientation of much of our health-care system. As noted above, the current health care system is primarily interested in removing symptoms and curing illness. Shertzer and Stone describe counseling as a process that results in establishing and

clarifying goals and values for future behavior (emphasis added). The concern with future behavior is clearly a preventive orientation when contrasted with the focus on present symptoms of illness by the health care system. Pietrofeso implies a concern with the future in emphasizing the goals of counseling as being self-understanding, decision-making, and behavior-change skills for problem resolution and developmental growth. If we interpret 'problem resolution' to mean problems which have already developed--a tertiary approach similar to that of the current health care system--then it would seem counseling has little to offer to resolve the shortcoming of the medical system. However, the concern with 'developmental growth' implies that people learn to resolve current problems and can also develop to the point where they can prevent the occurrence of problems.

The counseling profession seems to have the preventive orientation called for by many writers critical of the current health care system. The writers call for behavioral lifestyle changes, noting that our most common illnesses and diseases are related to lifestyle. The primary concerns of counseling as defined above are values clarification and behavior change, and at the same time, values and behavior are also the major determinants of lifestyle. It would therefore seem that the profession of counseling has the potential to play a major role in improving levels of health nationally.

With this in mind, the remainder of this study will focus on implications for counseling of some of the specific comments made by the writers. Ivan Illich maintained that individuals are not taking enough responsibility for their health and related this at least in part to the failure of the current health care system to encourage responsibility on the part of consumers for their health-related behavior. A potential role for counseling in health care is helping persons move towards greater self-responsibility both before and after they have had to make use of health care services.

As an example, for people who have been treated for heart disease, post-treatment counseling can emphasize self-management techniques which can be utilized to integrate rehabilitative, preventive, and health-enhancing behaviors into lifestyle. Counseling can provide important benefits in developing new, healthier lifestyles. An approach such as this is admittedly a tertiary one; however, it goes further because one of the long range goals is preventing the development of further problems in the future. This type of post-treatment counseling will also address the issues raised by Illich. Individuals will be taking more responsibility for themselves by learning to engage in healthier lifestyles. In addition, institutions which encourage self-responsibility by incorporating post-treatment counseling can reinforce this new behavior.

The use of counseling can also be developed in the area of

secondary prevention. Screening procedures can identify people who are at risk of developing disease or illness as a result of lifestyle behaviors. Counselors can develop educational programs to teach the relationship between behavior patterns and the development of disease. Such programs can be recommended to at-risk patients by physicians to provide alternative behavior patterns which help to prevent illness and enhance levels of health and well-being. Counselors can then teach behavior-change techniques which will enable people to incorporate new behaviors into a healthier lifestyle.

These approaches to health improvement also address issues raised by David Mechanic. In the long term, they are a way to limit the need and desire of patients for medical care. While tertiary prevention should probably be hospital-based, secondary and primary prevention will be most effective if they are based in school and industry. Ideally, if primary and secondary efforts were so placed, issues relating to the difficulty of behavior change raised by Mechanic could be addressed. The "contextual demands" of the environment could be engaged in illness-preventing health-enhancing lifestyles, as opposed to encouraging behaviors which are health-damaging. Fitness counseling in the workplace or school can provide a motivating environment. Self-managed behavior-change techniques can be offered by counselors to give people the skills they need to "systematically implement

desired behavior change", as called for by Mechanic. Self-managed behavior change is emphasized because clients direct their own behavior change. By learning how to apply behavior-change techniques to their health-related behavior, people can be less dependent and more self-responsible. Counseling can initiate the very important early stages of self-managed change.

If counseling programs based on the general outlines which have been described above can be implemented in the educational and employment systems, we can "start over in our efforts to achieve health", as recommended by Carlson. Such a system will emphasize health rather than medical care and will encourage our culture to put a high value on health and health-promoting lifestyles. Counselors are appropriate professionals to implement this level of health behavior.

Counseling has an opportunity to strengthen its role as a health-related discipline. As such, counseling can probably be most effective when used as a primary prevention approach. Medicine has become almost exclusively a tertiary prevention approach. The current tertiary technology has been highly developed; however, as Ratcliffe has pointed out, there has been a "disintegration of disease prevention within the medical care system". As a result, a variety of primary prevention programs are developing outside the medical profession. In part, this seems to occur because much of what constitutes primary prevention lies beyond the

scope of the current medical system. The types of changes which need to be made--behavioral and attitudinal changes on the part of individuals--are the primary focus of the counseling profession.

Ratcliffe argues that "health promotion" programs which emphasize working with individuals will not have significant effects on the various health levels, and what will be most effective is "health protection". In certain areas, health protection has high potential to improve national health levels. When large organizations dump health-damaging toxins into the environment or manufacture products which damage the health of large population groups, appropriate legislation can be very effective.

The potential of health promotion is probably much greater than implied by Ratcliffe. What seems to be most effective is the initiation of both health-protective and health-promoting measures. Health-promotion programs have the potential to affect large segments of the population, if they are incorporated into large-scale systems such as business and industry and education.

Ratcliffe has said that many factors affecting health and illness are beyond the control of individuals, yet many factors are within that control. The type of diet, the amount of exercise, the means of coping with stress and negative emotional states, the amount of rest and recreation one gets, the avoidance of alcohol and drugs are all within the control of the majority of people.

They can learn how various behavior patterns affect their health and well-being in both positive and negative ways. Counseling can provide techniques which will enable people to make changes in behavior patterns and lifestyle. They can see how their choice has been influenced by the social organization in which they live. And organizations which affect people can come to realize the value of health promotion, as some already have. All of the above are factors which are within the control of persons or groups and which point to the great potential of health promotion.

The counselor who is interested in developing health promotion needs to make use of behavioral science as much as the 'risk imposers' to 'manufacture illness', as McKinley has suggested. It would seem that a minimum role for the counselor is to help individuals and groups make informed choices about lifestyle and then provide the skills needed to make changes. The counselor can bring people to the moment of making a decision to change and can assist in planning the strategy to implement the decision.

For the health counselor, the emphasis will be on enabling people to be as responsible as possible when making choices about lifestyle. Within the larger context of a social system which encourages health-promoting lifestyles, the counselor can help people select patterns of behavior and implement their choices.

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