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# EDITORIAL

## CRISIS AND CHALLENGES IN THE HEALTH CARE SYSTEM

*A Personal Point of View*

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## INTRODUCTION

Public health care systems in countries all over the world are confronted with increasing difficulties. The problems are mainly economic, but they also reflect difficulties of adaptation to changes both in society as a whole and within the health care services.

The atmosphere of a crisis results from internal struggles within the health care system and with other welfare and social services that face economical difficulties, while confronting accelerated demographical, social, technological, and cultural changes.

The situation is more acute because of the inability of modern society to provide the public health care system with resources (human and financial) according to the expectations that have developed in the welfare state since the end of World War II.

New welfare policy, adjusted to the changes that occur within the society, is needed. In this struggle, the public health services find themselves in the center of the discussion as one of the whole of public social services and in competition with other public welfare systems.

Economical and organizational problems are the most acute and attract a great deal of interest, and they are amply discussed in many articles and conferences. I shall not deal with them in this article.

## ACHIEVEMENTS AND LIMITATIONS OF THE PUBLIC HEALTH SYSTEMS

The greatest achievements of public health services have come in different domains at different times. Increased life expectancy and improvement of health status in the first half of the century—and today in many "developing countries"—are primarily due to improved nutrition and sanitation.

The first contribution of technology to public health was the development of vaccines that enabled the eradication or control of many diseases, including diphtheria, tetanus, whooping cough, poliomyelitis, and smallpox. The combination of improving

hygienic conditions and vaccinations also brought about the control of tuberculosis, typhoid, typhus, and many other diseases.

Other components of progress in medical technology include pharmacology (antibiotics, psychopharmacology, antineoplastic chemotherapy, immunotherapy, etc.), medical imaging (x-rays, isotope scanning, ultrasonography), anesthesiology, and resuscitation (including "intensive care"). These were followed by dramatic developments in cardiology, cardiac surgery, organ transplantation, in vitro fertilization, and other areas of medicine and surgery. Yet, this remarkable medical technological development is limited in its ability to increase life expectancy or improve the quality of life of the public. It is focused on *hospitalization*, while the concern of public health services is not limited to this area. Hospital services are the most expensive and require most of the human and financial resources. Yet the contacts of the citizen with health services are mainly with ambulatory, family, and community services and less with hospitals. The effect of hospitals on health is of short range and of limited scope in relation to the rate of its sophistication.

This situation has far-reaching effects on the health status of both the individual and of the public, as well as on the forces that operate within the health care system. Health care and welfare systems are facing changes that involve a different and new deployment of priorities and resource allocations. The most substantial changes are linked to the redefinition of health and illness. It used to be possible to relate to illness as a situation in which a person suffers from a disease, while a healthy person was one who was not ill, meaning that he or she had no disease. This unidimensional definition of health is no longer true. Today it includes a sense of well-being and the ability to live a meaningful life socially, economically, mentally, and in terms of intellectual productive capacity. This new definition expresses the views of the World Health Organization (WHO). Therefore, in addition to fighting disease, the meaning of health includes the development of capacities of individuals within the frameworks of the societies in which they live, while the mere existence of disease does not mean that people cannot conduct or contribute to their families and societies and achieve a state of satisfaction and health.

To illustrate the situation, we can use the following example. An amputee can be ill if he is bedridden with no ability to move around. However, if the same amputee has an appropriate prosthesis enabling mobility, occupation, etc., he or she can conduct a healthy and creative life and contribute to family and society. The immediate event, disease or injury, that caused the amputation was linked to hospitalization. On the other hand, the processes of recovery or rehabilitation, both vocational and social, take place outside the hospital at home and in the community. These include not only health services, but also other welfare services: housing, transportation, vocational training, and employment. In addition, the existence of recreational and cultural possibilities that suit the needs of the handicapped determine their health status!

The same is true with the *elderly*; appropriate housing and suitable community and social services may prevent morbidity and decrease the need for hospitalization. Thus, securing health for the public is more than securing health services. An analysis of current public health problems is the basis for the evaluation of the needs of public health within the national systems. There is a need to define national priorities within which the health care system shall find its proper place. We shall have to decide whether liver transplants or the development of new hospitals are of higher priority for the nation than prevention of traffic and work-related accidents, fighting drug abuse and

crime, prevention of air and water pollution, or sex education and parent education. This kind of policy should be discussed publicly on the political level. There should be no hesitation to present the subject for debate. We must realize that technological development and medical progress cannot be stopped in modern society, and they continue despite economic constraints. Therefore, the question that should be discussed is whether under existing conditions it is justified to implement a new technology and when, not whether, new technologies should be developed.

## THE CRISIS WITHIN THE HEALTH CARE SYSTEM

Professional developments and their influence on health professionals are at the basis of what might be termed the internal crisis within the health system that includes physicians, nurses, administrators, and technicians. For the sake of brevity I shall refer only to physicians, although the problem of the nursing profession may be even more far-reaching and merits another presentation.

There are important considerations involving salaries and work conditions, but the main problem is the lack of professional satisfaction for doctors and the decline in the social status of physicians. There are two reasons for this—first is the immense increase in the number of physicians. Since the 1970s, the number of practicing physicians in Israel has almost doubled, from 6,500 to 11,500. Israel is not unique, since similar phenomena have been observed in other countries in Europe and elsewhere. This growth is accompanied by an increase in the proportion of medical students coming from social and ethnic groups that in the past were rarely represented in medical faculties. There is also an increase in the number of women in the profession. These developments, welcome as they may be, are nevertheless symptomatic of a change in the social status of physicians.

The second reason for dissatisfaction among the professionals stems from an inherent process. Since the 1950s, we have been caught in the trap of overspecialization that is based on technological developments. The result is fractionation of medicine, multitude of authorities in the care of the patient, and the loss of the central authority in diagnosis and care. Instead of the treating physician who is responsible for the patient, we now have a collective responsibility of the institution, which really means dilution of responsibility. The end result of these well-known processes is damage to the self-confidence of the physician in his or her ability and right and obligation to cope with the totality of the problems of the patient. It is not only the physician who is hurt by this process, but also the patient who has lost the treating physician to whom he or she could always turn.

This phenomenon is aggravated because of developments in society, in the media, and in the legal system. Physicians are now concerned with protecting themselves from legal suits by using a complex system of tests and consultations, thus dividing ultimate responsibility for the patient.

### Impact of Technology

Technological development, especially in pharmacology, has seen great progress, bringing with it new risks to the public. The sensitivity of the public to human experimentation has brought the blessed result of safeguarding individuals as well as the general public from unethical human experimentation in the form of Helsinki Committees or review boards. Now, however, we observe technological developments in

equipment (medical technologies) that are growing even faster than pharmacology. We face questions of risks versus cost-benefit, meaning assessing the real benefit to the patient versus costs and risks associated with new technologies. We must find an arrangement similar to the Helsinki Committee for medical technologies.

The admiration by physicians and the public of technological progress has created a status of super specialties among physicians, especially among those who use more equipment and technologies, with a simultaneous intolerance of the possibility of failure. Modern society is technologically minded and believes that we should be able to solve problems with the appropriate technology. Society does not accept medical failures. The physician who tries to stand up to such expectations soon loses confidence and the outcome is anxiety and dissatisfaction over an inability to cope with the patient's problems and expectations.

## Alternative Medicine

The lack of satisfaction of the public exists at the level of the direct contact between patient and physician, but it is also expressed by disenchantment with medicine in general. We observe an everlasting search for alternatives to medicine – and of course, there are always those who are ready to offer such alternatives.

Alternative medicine is a phenomenon that grows out of the anxiety of the patient and the patient's inability to maintain confidence in physicians. This anxiety serves as fertile soil for all sorts of doctrines and healers, all of which share an approach towards mysticism, remote exotic and ancient cultures that dates from medieval times and beyond: acupuncture, natural diets, homeopathy, reflexology, etc. The patient's genuine need to resort to such treatments exists not only because of personal anxiety, but also the anxiety of physicians.

Physicians too, turn to such practices in the hope of being helped by something that is beyond their understanding. There are, of course, charlatans who with pseudo-scientific jargon confuse not only the public, but also public leaders. It is our duty as physicians to protect the society against the deterioration of public health services, and the public withdrawal to redecorated medieval medicine. The solution lies not only within scientific debate; no less important is the need to cultivate anew the status of the treating physician who has the professional authority to assume total responsibility for the patients' physical and psychological problems. This has ramifications for the organization of health services in hospitals and in the community, and even more so for programs for the education and training of physicians. The pendulum that for 30 years moved towards overspecialization must go back to comprehensive medicine. It must stop in a position that will guarantee technical and scientific expertise while securing patient care that is simultaneously authoritative, safe, sure, and comforting. This is the main challenge for medical education – in medical schools, hospitals, the community, and wherever a physician is in contact with the public. Therein lies the challenge for the medical profession. Can we meet it?