BENEFITS OF HEALTH SERVICES

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I have attempted to analyze some of the benefits from the main service areas. The most important benefit from good primary care is, I believe, a feeling of general trust and security. The care should be organized to promote this feeling, and continuity is important. The acute hospitals already save most of the lives which can reasonably be saved and should devote more time and effort to quality of life and human concerns. In long-term care security, trust and human considerations are essential. Such benefits are difficult to measure - especially in economic terms - but society accepts this responsibility even without a demonstration of benefits. However, cost-effectiveness studies are important in this area. Medical prevention receives better priority, but other forms of prevention (life style, education, job security, etc.) are of equal or greater importance. The health services should therefore work in partnership with other agencies to promote health, life style and environment.

Evaluation is an essential part of good health services, but it may easily be corrupted to serve vested interests. Therefore, it should be developed as part of a general philosophy of medicine which strives for a balance between medical and human care.

My assignment is to answer the question: What are the benefits of the health services? This is one of those impossible questions, either so simple that it should not be asked, or so difficult that it cannot be answered. To present a personal view, I must first make a philosophical point.

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The reason for asking the question is, of course, a practical one. To evaluate health services, one needs a list of benefits which may serve as targets for the evaluation. Evaluation is the business of health services research, and there are two types of people in this field:

- Type A work with grand schemes. In my country, for example, the A-people feel that the problems in reality are quite simple. They see the health service as a black box. On the left side we take in 4 million Norwegians, we process them in the box, and on the right side we turn out health. Health services research is to investigate the box in order to optimize the process and maximize the benefits, which is health.

- Type B work with small schemes. They feel they do not really know much about the health service. Therefore, they concentrate on small and practical questions. Let me emphasize, however, that these people also need a general philosophy to guide their small steps in the right direction.

This description is demagogic but useful, I think. I belong to type B, and I want to break the end product, health, into pieces which I can understand and attempt to measure. In this lecture I will show what this reasoning leads to. My goal is to illustrate a concept, not to present a complete list of benefits.

1. Primary care

I shall start with primary care, that is, with the personal medical care which people receive locally. There are three kinds of benefits from this care.

The first and most important benefit of good primary care is a feeling of general trust and security. People know that the local medical services are adequately developed; they know the doctor, they like him, they feel that he is friendly, interested and competent, available to them and has time for them. Continuity of care is usually

necessary to achieve all of this. It is difficult to measure the benefits which flow from this security and trust, for example, by increased longevity, productivity and happiness and by reduced sickness and fewer days lost. Therefore, I define this feeling of security as a benefit in itself, and I believe most people agree with me, feeling that this is an essential benefit which they demand and are willing to pay for. In my country, security is present, strangely enough, in the rural areas, but less so in the cities. The presence or absence of this benefit can be studied. Availability can be measured by waiting hours and house calls, and one can ask people about trust. It is true that people are not able to evaluate their doctors critically (3), but they are able to judge availability, trust, etc. (6). For a feeling of security it does not matter much whether trust is justified. The point is whether it is there or not.

The second kind is a group of specific benefits. They result from an efficient health service which offers proper care and prevention. To study these benefits one must go into details. The doctor should be able to diagnose and treat correctly a number of diseases, he should be able to recognize difficult and dangerous conditions and refer them to specialists and hospitals, he should be familiar with certain drugs, and he should do no harm. It is possible to look for evidence. For example, Spitzer (11) studied the use of 13 drugs and the way the doctor dealt with 10 specific "indicator-diseases". Furthermore there should be no death due to medical error, no misuse of drugs, no overtreatment, no exploitation, etc. Again, it is possible to look for evidence.

A third potential benefit is economic, since good primary care - as compared to institutional care - often produces more health for less money.

It is often said that a modest increase in resources for primary care will decrease the need for hospital resources. I should like to believe that this is true, but convincing studies are still lacking.

It can be said against my analysis that it is too crude and that these benefits do not allow more detailed measurements and grading of practices. This is true, and I shall worry about that when we have developed primary care in the cities to the point where all people feel trust and security at all hours. We shall then have to develop a more sophisticated list of benefits to measure small differences in costs and benefits.

2. Acute hospital care

I now turn to the more complex benefits from acute hospital care. The first and most important comes from a correct diagnosis and therapy of an acute injury or episode of illness. Life and future health may be at stake, and the benefits may be large. These benefits should be constantly monitored, and methods should be checked by controlled clinical trials. There is a tendency to take these benefits for granted, but they are often doubtful. Some of these doubts can be confirmed or eliminated through proper trials, for example, the value of intensive care units in the treatment of acute myocardial infarction (8).

Some doubts are of a different kind and relate to quality of life. Sometimes, the burden of advanced medical care may become too heavy on the patient and his family, for example, following very extensive surgery (12), in near-complete burns, in chronic hemodialysis (7), or in advanced cancer. There is a need for a series of difficult studies to assess benefits and their limits in these situations. Such studies are important because we may get trapped in technical assessments of complex procedures, forgetting that the purpose of medicine is to ease man's suffering, not to prolong it.

I mention trust as a second kind of benefit, but it appears to be less critical than in primary care, simply because people, at least in Norway, generally trust their hospitals. They expect first rate care and believe they get it. When they complain, it is usually not about the level of competence, but about the human

aspects of care.

The hospitals are designed to cope with acute problems, but at least 50 per cent of the load is chronic illness and handicap, generally in old patients. The purpose of hospital care for such patients are sensible corrections and adjustments, not cure. This calls for long-term planning and careful cooperation with patients, relatives and the family physician. But the service is often fragmented and discontinuous, and old patients are often sent home with a battery of drugs which they fail to use properly, if they use them at all. Much study and improvement are needed here before we can judge the benefits. One way of assessing the benefits would be to have the practitioner judge the outcome of the hospital stay several months after the patient has come home. Such studies would probably point to wasteful uses of resources and suggest ways of improving the services for the chronically ill.

A special task of the hospital is terminal care. About half of the 40,000 people who die each year in Norway, die in the general hospital. The benefits of this service should be a peaceful and dignified death, a bliss which people value highly. In addition, the relatives are relieved of fear, stress and burden. This is the ideal, but reality frequently falls short of the ideal in this difficult area of medicine. At present, our group evaluates the terminal care in two hospitals in Oslo, looking into the details of every death and interviewing the closest relative five weeks later. The study suggests improvements which we hope will give a better balance between medical care and human care.

As hospitals get more resources, there is a tendency to refer ill defined problems to the hospital which in reality are not of a medical nature. Thus, in a recent study a chief of medicine at a local hospital concluded that up to 48% of his patients had problems for which the hospital had nothing to offer (10). Sometimes it may help the patient to learn that his problem cannot be solved by the hospital. Yet, these admissions usually represent expensive non-solutions, and it is important to study such cases more closely to

define the benefits not to be expected from a hospital.

Finally, I want to consider a benefit which is important, but usually tacitly overlooked. What I have in mind is the role of the hospital as a local employer and industry. In most small and middle-sized Norwegian cities the hospital is a major employer. A big hospital, over-sized or not, is a valuable asset to the city, since it is built and operates mainly on national and not local money. The local politicians therefore always join with the doctors in pressing for new wings, equipment and jobs. These are important driving forces and local benefits. Personally, I can think of worse ways of wasting public money, but it is essential to study and evaluate these benefits.

We should also look into the role of the hospital as a potential employer of handicapped and partially disabled people. Any large employer must accept his share of such people, and the hospital could lead the way.

3. Long-term care

The third area of the health services is long-term care, the most complex and the most neglected one. The common element is that care - not cure - is the goal, and this makes long-term care a useful concept. On the other hand, it lumps together extremely diverse problems, such as rheumatoid arthritis, alcoholism and mental retardation. This has resulted in low status, standards and spirits.

The first kind of benefit is the specific relief of a problem; less pain in arthritis, better care of the old, less burden on families, etc. These benefits must be evaluated in clinical studies, often designed as controlled studies. Such studies would reveal examples of widely used therapies with limited benefits, but also examples of useful therapies, which are not generally available (for example, surgery in rheumatoid arthritis). These studies are difficult and costly, but should be given higher priority.

Many benefits, however, cannot be measured. The health services are asked to provide many of these services solely on the basis of general value judgements which are accepted by society. Thus, an individual in need has a right to get care, irrespective of the reasons for his need. Furthermore, the care should be of a reasonable standard, protecting his dignity, and be given with warmth, kindness and compassion. Some benefits can be singled out and measured, such as the relief of the family. But most of the benefits are soft and unmeasurable; we take care of old people, not because we have documented the benefits, but because they belong to us and are our common responsibility. The benefits of this concept itself are large, because it gives people security. The health service should insist, therefore, that this job is important, even if benefits are difficult to measure.

Nevertheless, economy should be recognized as a second-order benefit. Society does not take care of all these individuals because economic benefits have been demonstrated. On the contrary, in many cases there are no economic benefits, only costs. Therefore, the cost-effectiveness of the entire operation is important, and some methods of care have the simple benefit of being less costly. Economy is not a primary goal, but the health service should give value for money. Research in long-term care should therefore be strengthened. It is necessary to collect data on the needs, organize controlled clinical trials and do cost-effectiveness studies. Such practical studies are more important than analysing benefits, since society accepts the responsibility irrespective of benefits.

4. Preventive work

The benefits of curative medicine are often highly controversial (5). Yet these controversies are only pleasant discussions compared to the larger issue of the overall contributions of medicine. Many doctors believe that medicine deserves the credit for decreasing infant mortality, increasing life span, eradication of infectious diseases and the elimination of malnutrition. Some critics feel that medicine deserves hardly any credit at all and is often harmful (4).

It is important to analyse the benefits of special programmes, such as vaccination, mother-and-child clinics, and screening. These benefits vary with the epidemiological situation and should be monitored in a running programme.

However, it is more important to analyse the entire work of prevention. Such an analysis will show that medical prevention plays only a modest role, because so much depends on individual life style, housing, job security, occupational and environmental hazard, food prices, education, road safety, social climate and other factors. Some important conclusions should be drawn from this. Medicine should provide leadership, because the object is to improve health, but it should invite partnership from all the other areas which can contribute tools, skills and ideas. This concept of partnership requires an understanding that investment should often not be made in the health services, but in the other areas of prevention. The benefits of such programmes must of course also be evaluated.

5. Education and research

Any health service should include education and research. Unfortunately, these two activities are often too far removed from the service.

Education of medical personnel has a decisive influence on the goals, values and performance of the service. Frequently, the professional schools are not sufficiently responsive to the needs of the service. For example, the medical schools have overemphasized the acute hospital services and neglected the needs of long-term and primary care. Furthermore, health education must be given to the entire population to influence life style and habits. Thus, education should be considered one of the most important activities of the health service, and its potential benefit should be analyzed and the performance evaluated.

In most countries medical research is not a responsibility of the service, but of the medical schools, research councils, funds and institutions. There is a complex relationship with mutual benefits

between research and service, and many services feel an increasing need to use research more directly in an attempt to improve performance and use of resources. This may lead to a shift in research priorities to achieve a better balance between basic research and health services research. A well conceived research policy requires a study of the benefits of medical research.

6. Global indices of benefit

So far, I have avoided the concept of over-all indices of health. Indices may serve as yard sticks for benefits produced by the service, and they can be constructed to reflect health, social and economic benefits. They can also be used to compare populations, institutions and programmes (2).

This important work needs to be developed further before we have a single global measure of the benefits from the health service. It will also take time before the service is ready to accept such a measure. In the meantime, good work can be done using more modest measures of benefit, for instance in the field of primary care.

7. Side effects of concern for benefits

I cannot end this lecture without raising an important concern. So many of the issues in modern medicine are related and share a basic problem of human values. I will give a few illustrations.

In curative medicine a doctor should have reverence for life, but medicated survival may be too great a burden on patients and relatives. In terminal care a peaceful death may be a better alternative than a few added days of costly and stressful treatment. In intensive care, heroic efforts may prolong the lives of patients who are too exhausted to be heroes. In the care of children with congenital disease treatment may overshadow the psychological and social needs of the child. Thus, we must recognize the problems related to quality of life. However, quality is a matter of subjective judgment. Even if

we could agree about whose judgment should prevail, quality is so difficult to measure that it is easier to settle for quantity alone.

In the battle for priorities it is easier to argue for acute hospitals than for geriatric care. Intensive care can save lives, but it may require so many resources that other services may suffer, and it might be a better policy to give good service to many, rather than maximum service to a few. In principle, all priority problems should be considered together, but in practice they come up for consideration one at a time. Thus we are asked to say yes or no to a piece of new equipment, not to weigh it against a series of other alternatives for an improved service.

So many of these issues end as a conflict between hard medical facts and soft human concerns, as drugs against kindness, as people against institutions, as time for patients against time for tests. Medicine itself is heavily weighted towards scientific facts, hospitals, tests and cure. Human considerations and time for kindness and care carry less interest, prestige and money. Evaluation has a tendency to select hard facts and quantifiable benefits. Furthermore, health economics often evaluates the costs and benefits of a single procedure, frequently selected from advanced medicine. Such studies usually come out positive, since few procedures are totally useless, and the studies therefore further promote already strong fields. Similarly, studies of service quality are used to support claims for cost increases from the acute service. The point of all this is that a preoccupation with benefits and evaluation may easily push medicine further off balance and lead to "progress in the wrong direction" (see also 1, 9).

Hard medical facts about life and death are of course important, and preventive medicine should be evaluated by such facts. In curative medicine, however, we are beginning to approach a new situation as the health service saves more and more of the lives which reasonably can be saved. Further progress, therefore, must be evaluated more by soft human concerns than by hard medical facts.

The purpose of health services research should be to improve over-all quality, equity and use of resources. It should be a means of preserving the balance in medical care. Therefore, it is important to understand these inherent dangers of evaluation. To succeed it is necessary to develop a philosophy of medical care, its goals and its priorities. This philosophy should not be a private concern for doctors, but a public issue, and health services research should help to clarify and present the issues.

8. Conclusions

Coming back now to the question of benefits, I will conclude with three points:

1. The over-all benefits of health services are still too difficult to define and measure. It is more useful, therefore, to study limited benefits from each service area. Controlled clinical trials are an important method for such studies.

2. Many of the benefits are difficult to measure, such as a feeling of trust, security and fellowship. I believe that these benefits are vital in a modern society.

3. Research on benefits is a powerful tool for better care, but it may be corrupted to serve vested interests. Therefore, this research must be developed as part of a more general philosophy of medicine.

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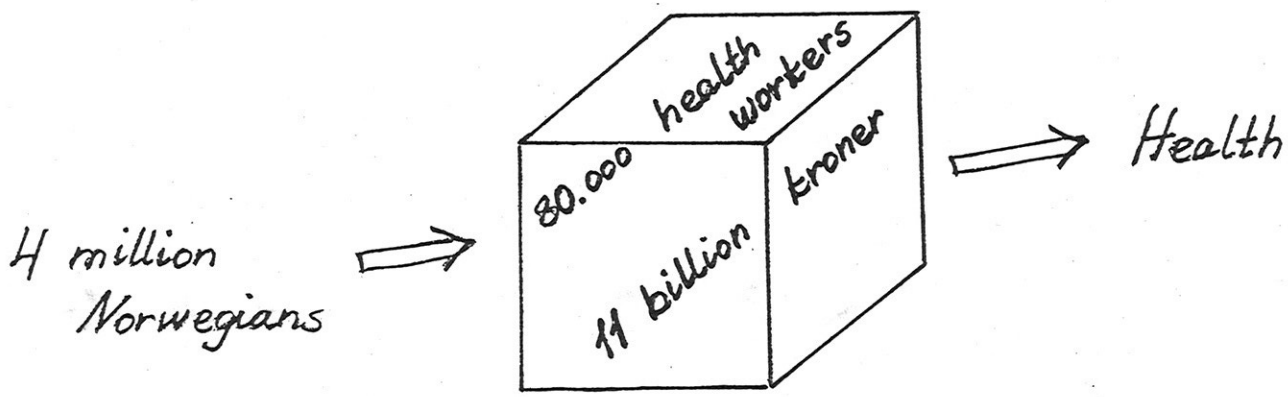
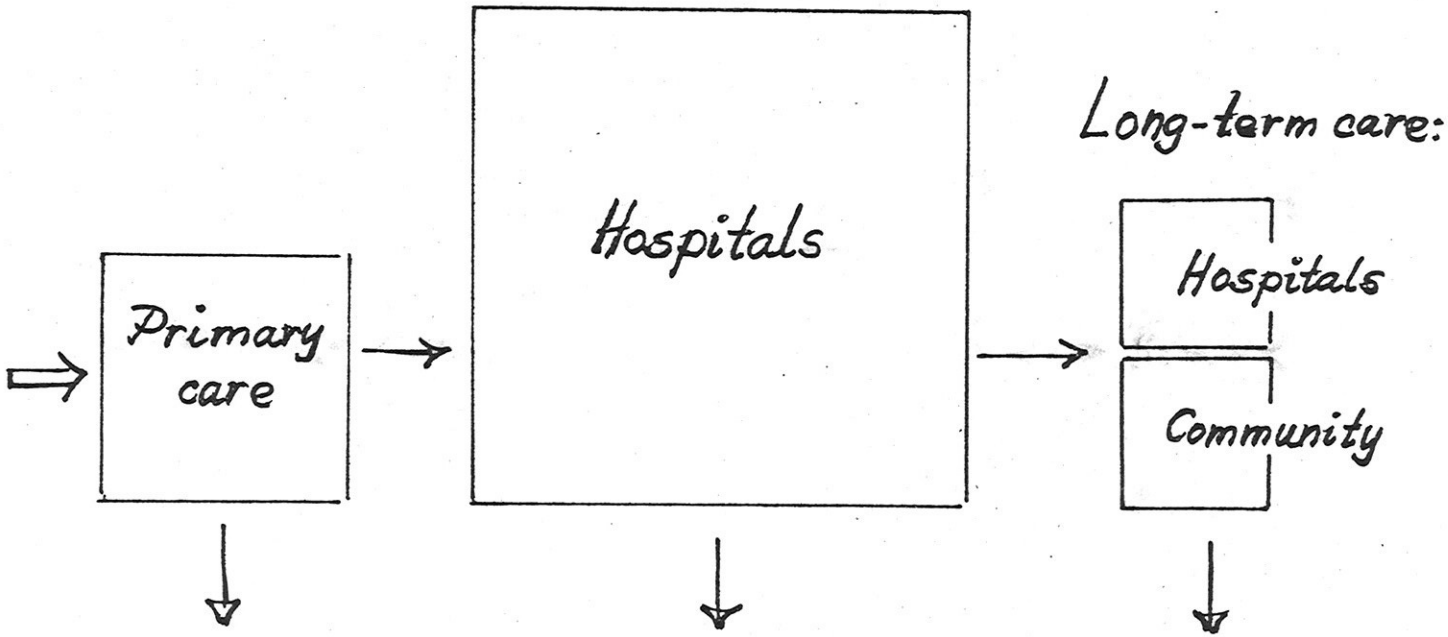
Health services: a simple model



System of medical care



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