Health care systems — the seven sins

FIGO World Congress
Rio de Janeiro, 1988

HEALTH CARE SYSTEMS

A DEFINITION
Health care systems trace their origin to the mystical beginnings of medicine. Throughout recorded history, societies have sought relief from physical and mental suffering through the institutionalization of roles, the functions of which have been to minister to the suffering. Health personnel and health facilities operate within the context of a ‘health care system’. The health care system can be defined as the mechanism in any society that transforms or metabolizes inputs of knowledge, manpower and economic resources into outputs of services relevant to the health concerns in that society.

From an economic standpoint, one can make a distinction between the three major inputs into the health care system: knowledge (science), manpower (education and training) and economic resources. Science is not as easily quantifiable as the other two. It is, however, a non-finite resource, once it has been generated. Once knowledge is there, it is there to stay. The dividend on the investment in training, on the other hand, is limited by what one may call the professional’s ‘half life’. Economic inputs are the most finite resource.

The health care system should be put in proper perspective within society. Whether we like it or not, we are not at the exclusive center of social interest. We are one system alongside several other differentiated systems that serve other society needs. The health system competes with these other systems for scarce resources. The competition is not only at the national level when a country allocates resources to the different sectors but also at the level of the family and individuals when they make decisions on how much to spend on health.

Health is not solely the domain of the health care systems. Other systems (or sectors) in the society have a hearing on the health of the population which may be, in fact in many cases is, more important than that of the health care system. Agriculture (nutrition), education, housing, transportation and the general economic level, among others, all have their bearing on health. In spite of their importance to health, they are not by definition a part of the health care system. The health care system, however, has the mandate to play the leadership role in health concerns.

Organized health care systems are diverse in nature. Three basic patterns are currently in existence, generally associated with and corresponding to the basic economic systems: public assistance, health insurance and national health service. There are many variations on the basic patterns and more than one system may exist in the same country. A survey in 1980 found that the public assistance system is dominant in 108 countries, covering 49% of the world’s population, mostly in developing countries in Asia, Africa and Latin America. The health insurance system is dominant in 23 countries, with about 18% of the world population, mostly in industrialized capitalist countries. The national health service is dominant in 14 socialist countries, with about 33% of the world population.
Society grants the health care system the ‘legitimacy’ to function and the resources to operate. For that, the society expects a return. Society expectations from the health care system do vary and are affected by the value system of the society. The highest expectation was expressed in the constitution of the World Health Organization, as adopted by all Member States:

‘Health is a state of complete physical, mental and social well-being, and is not merely the absence of disease or infirmity.’

‘Enjoyment of the highest standard of health is one of the fundamental rights of every human being without the distinction of religion, political belief, economic or social condition.’

Whatever the level of expectations may be from the health care systems, there is a growing frustration about the growth in inputs without a corresponding increase in output and an impact on the health of all people. The loudest noises are made by those who are responsible for the economic resource inputs, be they a government, an agency or the consumers themselves. Those responsible for the two other inputs (science, education/training), should also be concerned.

Why are our health care systems failing in meeting the expectations of their social contract? Various explanations can be made and the issues can be seen from different angles. In this lecture, I have selected one angle to look at this important concern. Health care systems are human institutions and mechanisms. They are subject to the same weaknesses, to which mortal humans are vulnerable. I have opted, therefore, to look at the weaknesses of the health care systems from the angle of human weaknesses or human sins.
The traditional catalogue of the seven deadly sins:

1. Vainglory or pride;
2. Covetousness;
3. Lust;
4. Envy;
5. Gluttony;
6. Anger;
7. Sloth.

A sin was classified as deadly not merely because it was a serious offence morally but because it gives rise to others, especially in the manner of a final cause or motivation.

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- A health care system too proud to ‘care’
Throughout human history, medicine has been recognized as a profession for both care and cure. This was the way it was when the medical man or woman was also the priest and/or the magician. This was also how it continued to be when the medical profession diverged from religion and from magic. A reader of the history of medicine would realize that our physician ancestors, for the major part of human history, had really so little in their hands to influence the process of disease or to prevent deaths. Their treatment had an equal chance, in many cases more than an equal chance, of being more harmful than useful. Let us consider how King Charles II of England was treated by our noble ancestors in 1685.

The king, while shaving, fell unconscious in his bedroom. The following were among the treatments employed by the royal physicians. A pint of blood was extracted from his right arm; next an emetic and an enema. Then his head was shaved and a blister raised on the scalp; to purge the brain a sneezing powder was given. A plaster of pigeon dung was applied to the royal feet. Several substances were given internally including 40 drops of extract of human skull. As a last resort, hçzoar stone (hard lumps of material formed in the intestines of goats and other animals, highly prized throughout Europe for centuries for their supposed medicinal values and commanded high prices) was employed. But the royal patient died!

In spite of the clumsy performance of our ancestor physicians in the function of care, they continued to command respect and prestige in the societies they served, and the societies continued to invest in their activities. This was because they did so well in the function of care. This pastoral/supportive function may be described as the provision of psychological help and ‘tender loving care’ to the anxious patient. This psycho-emotional support and reassurance more than compensated for the shortcomings in treatment.

In spite of our greatly expanding knowledge, there are still many diseases and conditions for which the best we can offer is tender loving care. For other conditions, for which a scientifically based treatment is now available, tender loving care is still needed and can play an important role.
Unfortunately, the supportive pastoral aspects of medical care tend to be squeezed out by one of our human sins, pride. The Oxford English Dictionary defines pride as ‘high or overweening opinion of one’s own qualities, attainments, or state, which gives rise to a feeling and attitude of superiority over and contempt for others’. Our pride in the application of scientific knowledge and biomedical technology is now creating an ‘emotional’ gap in the care of patients. Machines now stand between us and our patients.

If scientific physicians, out of pride, are increasingly unable or unwilling to meet this need, then society may have to create a differentiated category of humane physicians, specialists in generalities whose mandate will include also the emotional aspects of patienthood and the co-ordination and integration of an increasingly specialized narrow and depersonalized service. That would be a sad day for health care systems. The loss of the caring function is no more evident than in our obstetric practice. Women in normal labor need care more than cure. They are getting instead a depersonalized, mechanized, mystery-clouded medical service. Women are objecting to being objectified in one of their fundamental physiological roles\(^5\), and they are right.
Medical professional liability can lead to a serious crisis for the health care system. The problem is escalating in the USA and it has the potential to infect other health care systems. Although a recent phenomenon, its roots can be traced to one of our human deadly sins: covetousness or greed. In the words of the chairman of the American Bar Association Section of Litigation ‘What has caused this crisis...? Greed; greed of contingent fee lawyers, greed of hourly rate lawyers, greed of the insurance industry...; greed of the American public...; greed of the medical profession...’ We may disagree on which party is more greedy than the other, but we have to agree that medical professional liability can harass the health care system and that the sin of greed is at its roots.

The professional liability crisis has an impact on the health care system. There can be one potential positive aspect: to improve quality of medical care. Otherwise, it certainly has an adverse effect on the quality of physician-patient relationship, it increases the cost of medical care and it leads to the practice of defensive medicine including increased consultation, increased testing and diagnostic procedures and increased monitoring, procedures that are frequently only justified on a legal basis. Physicians become also less inclined to take on difficult cases or risky procedures. Physicians may even change specialty or opt for an early retirement.

Although professional liability is a problem for the medical profession as a whole, it is by far more serious for our profession. The American Medical Association Center for Health Policy Research published figures of average annual claims per 100 physicians. For all physicians in 1985, the figure was 10.1. For surgery it was 16.5 and for obstetrics and gynaecology it was 26.6.
The crisis of medical professional liability in the USA is unusually complex. It is prudent, however, for health care systems in other countries to take prophylactic action. The health care systems should police themselves before being policed by others. Quality assurance should be a primary responsibility of the health care system.

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- The health care system harassed by greed: the medical professional liability crisis
- Lust for technology

Lust is considered one of the deadly sins. The Oxford English Dictionary defines it as ‘lawless and passionate desire of or for some object’. The health care system is being bedeviled by a lust for technology that is impeding our ability to fulfill our social contract.

There is nothing wrong with technology; what is wrong is the lust. ‘Health technology’ has been defined in the Alma-Ata declaration as ‘an association of methods, techniques and equipment which together with the people using them can contribute significantly to solving a health problem’. Technology is good as long as it is appropriate. For a technology to be appropriate it must be scientifically sound, acceptable and affordable. The lust for technology leads us to associate ourselves with technologies that are not appropriate.

Our lust for technology may lead us to associate ourselves with a technology that is not scientifically sound. A technology that is not scientifically sound may be harmful, and could even be disastrous. Our profession has learnt several hard lessons. These include among others, the diethylstilbestrol story, the thalidomide tragedy and neonatal retrolental fibroplasia due to oxygen concentrations recommended for newborn children.
A technology does not need to be harmful to be scientifically unsound. It may offer no additional advantage over what can be equally achieved by more simple measures. Or it can be scientifically sound if selectively applied and scientifically unsound if it is advocated for universal application. The issues of electronic fetal monitoring and ultrasound examination in obstetrics need to be settled on such grounds.

After a technology is judged to be scientifically sound, which is a universal judgment, it has to be considered again in the light of local circumstances. A technology should be acceptable both to the provider and to the user and to society at large. One area in our profession where this judgment is sorely needed is the field of fertility regulation technology. The most scientifically sound technology may he completely inappropriate if it is not culturally acceptable.

If a technology is scientifically sound and culturally acceptable, it has to pass a final judgment before it is considered appropriate. This is the test of affordability. Affordability is not just a matter of price. It means that the technology should be sustainable by the local human and material resources. Trained people must be available. Maintenance should also he taken care of. Affordability has also to be judged in terms of ‘opportunity cost’; if resources are used in one way, an opportunity to provide some other benefit has to be renounced. Possible alternative uses of the resources should always be considered. It follows that the physician specialist only interested in offering his patient the best quality of care cannot be a judge on whether a technology is appropriate or not. The individualistic medical ethic will be in conflict with the social ethic of economics.

The lust for technology has other serious consequences for the health care system, apart from the use of inappropriate technology. Excessive indulgence means soaring costs. Physicians become too dependent on machines. Last, but not least, the physician—patient contact and relationship could change.
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- Envy among specialties: fragmentary responses to a totality of health needs

Herodotus (describing Egypt 2400 years ago) stated:
‘Each physician treateth one part and not more. And everywhere is full of physicians, for some profess themselves physicians of the eyes and others of the head, others of the teeth, and others of the parts about the belly, and others of obscure sickness.’

Specialization is a feature of modern scientific medicine. With the expansion of knowledge and technology, specialization is the only way to provide services of the highest medical quality. We are now getting into the era of sub-specialization, which some of us may argue for and some of us may wish to resist as long as they can, but it is probably inevitably coming. Specialization, and even sub-specialization are not sins, they
are virtues. What is not a virtue, and what could amount to a sin, is when the specialties and sub-specialties are not integrated together to develop a coherent response to the totality of needs.

Specialization and sub-specialization tend to narrow our focus. It could lead to ‘envy’, and to competition between the various health needs. ‘Envy’ within the health care system could confuse the policy makers. It could also be exploited by the policy makers to promote a disproportionate response to one health need at the expense of another.

Let us consider the totality of needs in reproductive health. Reproductive health is a positive status that means for women, ability, success and safety in the process of reproduction’. It means that women should be able to reproduce, able to regulate and control their fertility and able to practice and enjoy sex. It means that reproduction should proceed to its successful outcome of child survival, growth and development. It means that women should be safe in going through the reproductive process of pregnancy and childbirth, should be safe in having sex, and should be safe in regulating their fertility. This is reproductive health as conceived by women and as it should be conceived by the health care system. The health care system should be able to respond to this totality of need, in a coherent rather than fragmented way. It should be able to mobilize all the specialties and sub-specialties involved for an integrated approach to reproductive health.

A review of the health care systems reveals the tendency to respond to this totality of need in a fragmentary way, and with the accent frequently placed on only one element at the expense of, and occasionally total neglect of, other elements. Family planning is a case in point where health care systems tended to take extreme positions. In some systems, it was completely left out, if not discouraged or prohibited. In other systems, it was vigorously promoted to the neglect of other basic elements in reproductive health.

Health care systems are about to commit the same sin as regards AIDS: a fragmentary response that does not take into full consideration the totality of health needs.
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- Medical over-consumption: gluttony and inequity

Gluttony (the vice of excessive eating) is the equivalent human deadly sin to medical over-consumption. It is not justified. It can be harmful. It also means that others will not get a fair share. Medical over-consumption is relative. It is related to what is available and what can be made available. What we would consider medical over-consumption in developed countries is different from that in developing countries. It is also related to the condition of the patient. A patient at high risk needs to consume more medical care. A patient, who is not at such a risk, for example a woman in normal labor, should not consume excessive medical care.

It is now 10 years since the Alma—Ata Conference declared that: ‘The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore of common concern to all countries’. The statement is as valid today as it was 10 years ago.

Our concern here is not primarily with the inequity of health which has several determinants outside the health sector. We are concerned more with inequities in health care systems and within health care systems. Tremendous disparities exist among countries and within countries.

To highlight the extremes: in the rural areas of some least developed countries, there is only one doctor to serve more than 200000 people, whereas in the
metropolitan areas of some developed countries there is one doctor for only 300 people. Moreover, extremely inequitable distributions of health personnel are often found within the same country. For example, in many countries there are ten times as many people for every doctor in rural areas as there are in metropolitan areas.

If we consider maternity care coverage, pregnancy and childbirth attended by trained personnel show such wide diversity.

The proportion of the Gross National Product (GNP) spent on health ranges from far less than 1% in many developing countries to more than 10% in many developed countries. This implies an average of a few dollars per person per year in the developing countries as compared with several hundred dollars in most developed countries. Even if low income countries were to increase the amounts they spend on health at the rate of 10% per annum, in the year 2000 they would still be spending only about 5% of the amount now being spent in most developed countries. Moreover, in most countries, the overwhelming proportion of resources for the delivery of health care is concentrated in the large cities. In addition, these resources are devoted to expensive highly sophisticated technology serving a small minority of the population, to the neglect of the basic health care needs for the majority.

The problem of inequity in health care needs to be addressed by the society at large, and by the international community in the name of social justice. Within the health care system, however, the approach should be to ration health care, allocating one basic level of health care for all, and more for those at risk, according to the degree of risk,
This is the concept of the risk approach in health care systems. It would also imply that physicians should delegate all those responsibilities that can be undertaken by less qualified personnel, in order to be able to do more of those tasks for which they, and only they, are qualified.

If one considers the contribution of medicine to health from a historical perspective, one has to conclude that the first and major contribution was in the field of public health, through the application of general measures that affect large numbers of people and often many diseases at the same time. Examples of classic public health methods have been sanitation, water purification and food inspection. The next contribution was made by preventive medicine. As distinguished from public health, preventive medicine is usually defined as the use of specific intervention techniques to prevent the occurrence of particular diseases through protection of individual persons. Immunization is probably the best known method of preventive medicine. Prevention programs do have to reach individual persons but this can be done on a mass basis (as with public health) since the approach to different patients does not have to be particularized by sophisticated diagnosis to meet individual circumstances and conditions.

Curative medicine could only have a significant impact on the pattern of mortality in a society after scientific developments made that possible. It was between 1930 and 1960, that for the first time in human history, medical intervention could make a significant difference in the outcome of an illness. The health care system raises the slogan that prevention is better than cure. But it is difficult to say that we practice what we preach. About 95% of health care expenditure goes to support curative services. Whether within or outside the health care system, preventive medicine and public health always take a
second seat. Preventive medicine and public health lack the “priestly charisma” associated with the magic of healing. Successes of curative medicine are visible, personal, and often dramatic — real suffering, already in progress, is visibly alleviated thus lending a strong humanitarian appeal. One additional reason is that public health and preventive medicine have now come face to face with human behavior and this is not easy to change.

This unforgivable attitude in our health care systems can draw a similarity to one of our human deadly sins: anger. Health care systems are reacting to disease in ‘anger’, and not with a cool calculated response. A calculated response to disease is first to try to prevent it. If not, then to try to detect it at an early stage when it can be more easily conquered. This would also include detection of those at risk of the development of the disease.

An angry’ reaction to disease would lose sight of the disease foundations and its early beginnings and would just be eager to get into a fight. Frequently, it is not a well-matched fight. We do not often have the capability to conquer the disease at this stage. Let us take few cases in point: infertility, cancer and family planning. The treatment of infertility is not widely available, can be unduly costly, and is often time consuming and frequently unsuccessful. There are preventable causes of infertility, notably pelvic infections as a result of sexually transmitted diseases. Infertility is a problem of public health dimensions in several countries of sub-Saharan Africa. The expenditure on curative services, with all their shortcomings, is far more than expenditure to prevent sexually transmitted diseases which cause infertility.

The treatment of gynaecological cancer, as with other cancers, is disappointing. Early detection is possible for several gynaecological cancers, notably cancer of the cervix. Screening for cancer of the cervix has proved its success through lowering of mortality rates in national statistics. Data from 28 developed countries (representing 75% of the population of the developed world) showed a dramatic decrease (30/o) in mortality from cervical cancer between 1960 and 1980. It was virtually the only common tumour showing a substantial decrease in mortality. Reductions in mortality were seen in countries that had clear screening policies and a well organized cytological screening system. A study in Campinas, Brazil, suggested that the cost of screening for cervical cancer is almost ten times less than the cost of curative therapy for invasive cancer when cost per case is calculated (J. A. Pinotti, personal communication). How many countries are investing in curative services in cancer of the cervix and how many are investing in screening programs for early detection?

Family planning is one of the most effective preventive medicine measures available in the field of maternal and child health, through prevention of unwanted and high risk pregnancy. Yet, family planning had to fight for recognition. In many areas, it still has a long way to go.
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- Medical overconsumption: gluttony and inequity
- A health care system that reacts to disease in anger: overemphasis of curative clinical medicine
- Sloth: indolent attitude to social problems

The Oxford English Dictionary defines the word sloth as: ‘disinclination to action, exertion or labor; sluggishness, idleness, indolence, laziness’. In theological teaching, ‘sloth’ is listed as the seventh deadly sin. Sloth, as a word, may not be widely used nowadays. But sloth as a sin is definitely widely prevalent in all walks of life, and it can be committed by the health care system with deadly consequences.

Our health care system tends to be active, sometimes even over-reactive, in health concerns of individual patients. It is less active, sometimes even indolent in health issues of the society as a whole. One reason for this is that social health issues need to be addressed through social action that involves other sectors in the society whose role may even be more effective than the role of the health sector. But that should not be a
justifiable reason for our absence. It should be a reason for our taking a leadership and coordinating role in our societies for health issues of social concern.

Let us consider one case in point, the issue of maternal mortality. The issue was left without action until it assumed dimensions of a global neglected tragedy. We woke up to the figures of the World Health Organization estimating that about 500,000 women are dying in the world each year because of complications of pregnancy and childbirth. True, maternal mortality should be looked upon as the final blow in a long chronic process that probably starts at the time of birth, with the discrimination against a child, born to be a female. To address the issue of maternal mortality, action is needed in the society at several levels and for different stages in the life of the woman.
For all women, social actions are needed for advancement of the status of women. Concerted action is needed to promote the concept and practice of birth planning for all women in the childbearing period. Community-based prenatal care services should be made universally available for all pregnant women. Delivery by a trained birth attendant
should be ensured for every woman in labor. Essential obstetric functions should be made accessible at the first referral level for all cases of high risk pregnancy. Finally, facilities for the emergency transport of emergency cases should be readily available for all cases of life—threatening complications of pregnancy and childbirth.

Maternal mortality is a case where the health care system needs to be active and to take a leadership role in the society, playing the advocacy role for women’s health, and stimulating inputs from all sectors of the society. Sloth will only aggravate further an already grave tragedy.

RESPONSIBILITY OF OBSTETRICIANS AND GYNECOLOGISTS

The health care system is a concern for all of us, whether we are service providers, educators and trainers, or scientific researchers. The health care system filters our inputs and modifies the output. There are issues which, admittedly, we cannot change as individuals. There are issues, however, for which we are responsible and which we must change.

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God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.