NEW ERA IN MEDICINE

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Budgetary restrictions have become a determining factor in our health care system. This has fundamental consequences on medical practice.

INTRODUCTION

To date, three reasons have been put forward to explain the deficiencies in the French health care system, namely lack of transparency in our care organizations, mishandling of incentive measures and waste combined with lack of productivity.

The complexity of the system is such that no one expert can follow the evolution of all its component sectors. The hospital specialist has very little idea of developments in the fee for service system, while the subtleties involved in the rate of exchange between outpatient surgical beds and classical hospital beds largely escape those who work in the field of medication. In reality, nobody has an overall view of the situation. A global view is however an absolute necessity to determine the impact of policies implemented and to understand the reactions of the professionals concerned. Without this general view, we quickly become the prisoner of the information provided by existing pressure groups and the vocabulary they use.

For a long time, this complex system worked like the agricultural common market. It guaranteed prices for everyone working in the sector with no productivity ceiling. A posteriori reimbursement and per unit payment removed responsibility from those active in the field and was an incitement to increased spending.

Now, and this is the third and last observation, it is not at all sure that more is always better, the law of diminishing returns applying in medicine as elsewhere. The quantity and the quality of care are not necessarily the same thing.

Today, the system no longer works on an open basis, but behind closed doors, in the hospital since the adoption of what we call the global budget (1983) and in the fee for service system since the agreements between physicians, sickness funds and public authorities on the medical regulation of health expenditure. These agreements are more or less respected. Budgetary restrictions may be increased or relaxed, but everyone recognises that it is no longer possible to do everything for all patients with the best resources. There are costs that can no longer be considered acceptable. All sectors of economic life function under budgetary constraints and health care organizations are no exception, even if the official line is to deny their existence. The specifically French third way that we claim to have invented and named "medicalised regulation" is a political and strategic expedient rather than a reality. The aim is to give the impression that we can achieve technical effectiveness before being blocked by economic considerations and that eliminating waste is sufficient to give the health system the margin of freedom that it needs so badly. This is not the case and the need for a selective approach is becoming clearer every day. The result will be a change in medical practices, a new way of delivering health care and a new division of responsibility between those involved in the health system.
1. Changes in medical practices

In tomorrow's world, medicine will have to change its outlook, its logic and its ethics.

1.1 Changes in outlook: from a narrow short-term vision to a global prospective approach

Instead of concerning himself solely with clinical results obtained in the here and now, tomorrow's physician will have to interest himself in what is going on outside his immediate field of activity (his cabinet or his department) and in the long-term fate of his patient (prevention and prospective care). The transformation in the structure of pathologies and the passage from acute infections to degenerative diseases requires that patients be followed throughout their lives. This is the domain of decisional analysis.

1.2 Changes in logic: from a logic of conviction to a logic of responsibility

Changes in logic are just as predictable. Until now, the quantity of health care accorded to a patient has been the sigh of the physician's interest in him. Failure to use available measures to their fullest was seen as refusal to help a person in danger. Tomorrow, the simple evocation of a potential benefit will no longer be sufficient. We will see a transition from the desire to "do everything possible" for the patient to the desire to "do nothing at all" unless it has been scientifically proven. Therapeutic interventions will be subordinated to proof of their effectiveness. The patient is still at the heart of this new outlook, but we have passed from a medicine of conviction or belief to a medicine of responsibilities supposing documented exercise of the medical arts. The requirement that the daily practice of medicine be based on established scientific facts will have the force of law. This raised the question of the quality of scientific evidence required to legitimise the therapeutic approach. Medical teaching will have to integrate the new dimension as students will have to learn to distinguish between good and bad evidence and to regard the medical literature with a critical eye.

1.3 Changes in ethics: from an individual approach to a population-based approach

Up until now, the physician was exclusively responsible for defending the interests of his patient in the framework of the singular colloquy. In future, he will also have to consider the interests of the population to which he is responsible. No business, even the health care business, can spend more that it earns, and this is true whatever the methods of functioning of the health system, whether it is public or private, whether the organization's resources depend on market dynamics or are provided by the authorities as a budgetary allocation. It is important to change our reasoning to forget the macro-economic accounts of the 1970s and even the micro-economic concept of effectiveness that followed in the decade 1980-1990. Professionals must ask questions concerning the resources mobilised and the benefits obtained when they accept that they have duties and responsibilities to groups of patients, whom they consider they serve. It is no longer possible to ignore what economists term the opportunity cost, i.e. the value of what could not be done because of what was done. To do utmost for one patient, is to deprive the others of the resources mobilised to treat the first. The virtual benefits sacrificed are the real cost of treatment. To judge whether it is worth the price, it is necessary to consider the benefits expected. The goal is not to cut costs blindly but to save more lives within the financial budget allocated to the department or the establishment. High cost is not a synonym of condemnation, withdrawal or prescription refusal, but it is impossible to meet the objective (defence of the interests of a community of patients) without having first studied the cost-effectiveness ratio of the different therapeutic strategies available.
2. New system of health-care delivery

2.1 Limits of isolated practice

Health is no longer merely the absence of diagnosed and diagnosable diseases. It is also the absence of risk factors such as anxiety, smoking, obesity and the presence of positive factors related to personal behaviour and way of life. This **globality** of health requires **complete** management of the individual and supposes that all health care professionals, whether or not they are physicians, contribute to its defence. In the current system, every doctor has a network of contacts and enjoys privileged relationships with laboratories or hospital structures. This set of fraternal links or informal relationships defines the health care path the patient will follow as a function of the decisions made on his behalf. There is therefore a real "chain" which covers the totality of needs of the population. However, the large number of members compromises the continuity of care and prevents close links between the fee for service and the hospital sectors. There is a **co-ordination** problem between the actors in the health care system. Due to the complexity of the medico-social problems, the physician cannot solve all health problems by himself. He must be surrounded by all the professionals involved, whether they belong to the medical or social sector. The introduction of networks is an institutional response designed to solve these problems.

2.2 Need for networking

The Co-ordinated Care Networks (Réseaux de Soins Coordonnés, R.S.C.) are groups of health care professionals, led by a general practitioner and chosen by the patient, who offer a **complete**, homogenous and co-ordinated system of health care management to a quantitatively determined population of subscribers for a set annual fee. In this new system, a contract exists between users and health care professionals to ensure complete and co-ordinated management of individuals: the client agrees to be treated exclusively by the R.S.C. for a limited duration, while the R.S.C. guarantees that he will receive all treatment he may need whatever its nature. Therapeutic decisions are made by teams in the R.S.C. whether they concern care, prevention or re-adaptation. This means that the effectiveness of the medical decision is increased in a logic of responsibility. The fundamental structures of the social security system are maintained and it conserves its monopoly. Insurance deductions are still made pro rata of salary. The employers and employees share of the contributions does not have to be changed, nor do the mechanisms of compensation between regimes.

Financing of the networks is assured on the basis of a global annual fee whose amount is up to the directors of the organization. The sickness funds participate in the costs by means of a fixed annual health payment (forfait annuel de santé, F.A.S.) whose amount is identical for all networks but whose value depends on the age and sex of the managed population. The insured person, whose contribution is limited to the difference between the overall fee and the amount of the sickness fund payment, is given more financial responsibility but on the whole solidarity is maintained; solidarity within a risk class as the social security contribution is independent of the personal vulnerability of the individual; solidarity between risk classes in a particular network as the personal contribution of all members is the same; solidarity between the rich and the poor on a community level, as social security deductions remain a percentage of salary.

2.3 Need for an information system

It is important to create reference data on cost and performance in the outpatient and hospital domains. Medico-economic evaluations should be aimed at assessing the overall net cost of the entire sequence of health care measures. The existing information must therefore permit calculation of costs incurred by each therapeutic attitude and the complications it gives rise to, as well as the
costs avoided through, its use. Generally, the heaviest weight is the cost of hospitalisation linked to complications. The approach should therefore by systematic from the outset so as to evaluate the impact of the entire set of professional behaviours, taking into account all the repercussions of the initiatives taken, which implies longitudinal information covering all goods and services dispensed to the patient together with the results obtained. Decisions should be made in full knowledge of this data.

3. **Emergence of new responsibilities**

3.1 **Re-introduce a collegial dimension into medical thinking**

Medicine has become too complicated a science for a physician to master all its intricacies in the secrecy of his cabinet. Collective reflection in learned societies or subsets of professionals organized in a network permits all data in the national or international literature to be used to make the decision most appropriate at the local level and to arbitrate the best service to be given to the population when the resources available are limited. Prevention and care activities must be re-examined as a function of the overall benefits to the population.

Extension of mammography for the prevention of breast cancer to women under 50 mobilises considerable resources for very small returns. The medical community must reflect on this problem and accept to renounce case finding in women of this age group in favour of improved and truly effective prevention campaigns by mammography in women over 50. (This is the domain of medical reflection).

3.2 **Re-adjust the singular colloquy**

There are four concepts of singular colloquy. The most traditional is that of president Portès, the most utopic that of informed consent but between total paternalism and the sovereignty of the consumer, there is room for a pro-active relationship between the physician and the patient, the physician being the one to either reveal the patient's value judgements or to educate him. Louis Portès ès' position is clear : "a patient is and should be a child in the eyes of his physician, a child to be tamed, a child to be consoled not abused, a child to be saved".

It is therefore up to the physician to make all decisions in the patient's name and in his place. Guessing at individual preferences and his greater knowledge of disease are not sufficient. Often, with the best of intentions, truying to protect the patient from his irrational and poorly informed self, the physician can go against his preferences. B. McNeil has clearly shown the danger of such behaviour. Two strategies can be used in the treatment of lung cancer surgery and radiation. The first has a 5-year survival rate of 33% but is associated with a per-operative mortality risk of 10%. The second is risk-free but is associated with a less favourable 5-year survival rate of only 22%. Confronted with the choice, the patient prefers safety. How can the surgeon be justified in suggesting that the first strategy is preferable to the second when the patient is positively repelled by the risk ? It is therefore necessary to bring patients to express their preferences clearly with regard to a range of health states integrating the various dimensions of their negative effects on quality of life.

This vision corresponds to the theory of informed consent in which the physician presents the range of technically possible therapeutic measures to the patient, and the latter chooses among these solutions as a function of his own value judgements. Whilst, from the technical viewpoint, the physician is informed and the patient is not, from the viewpoint of value judgements, the position is reversed, the patient knows his own set of values but the physician does not. Between these two extremes, a third route may be opened where the physician does not substitute his own value judgements for the patient's but forces himself to bring the patient to realize his own true priorities. Tomorrow's goal is therefore to put the patient in the centre of the singular colloquium again by
introducing his preferences into therapeutic decisions. (This is the domain of quality of life indicators).

3.3 Increase the rights of the insured

Arbitration will be necessary given the budgetary constraints and it should not be left entirely to medical experts or administrators. Health choices are never dictated entirely by scientific considerations. They are explained by a certain idea of "good" and are based on a hierarchy of values. The general population should be able to participate in defining these values. This implies that patient-consumer representatives are involved in the decision-making process concerning health issues at a regional and national level. In an open pluralist democracy, it is normal that there should be debate about the goals, but the interested parties should be allowed to express themselves. (This is the domain of collective priorities).