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PRESIDENTIAL ADDRESS*

LATENT AND OVERT SHOCK

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SUMMARY

Reference is made to the impact of unfamiliar political philosophies and new social attitudes on an unprepared medical profession, and it is suggested that the latter should prepare for even more profound changes in the future.

Recent years have seen the introduction to this country of a philosophy of health care which, though in evidence in other parts of the world for many years, had largely been ignored by the Australian medical profession, doubly complacent, perhaps, in its being both medical and Australian.

The new philosophy, embodied in the World Health Organization definition that " health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", implies a re-direction of emphasis towards preventative medicine, away from the traditional 19th century disease-orientated concepts under which most of us received our training. Moreover, this new philosophy suggests that health care extends beyond the mere relationship of patient and doctor to the active involvement of each citizen and the community.

During my period in office, which has fortuitously coincided with the ascendancy of a Socialist Government, the propagation of the new philosophy has been accompanied by an attack on the doctors, which was at times reminiscent of attacks which totalitarian governments elsewhere reserve for undesirable minorities in their midst.

The intensity of the attack shocked the medical profession, most of whose members, having entered Medicine largely for altruistic reasons, considered that they still acted for the purest of motives, with the patients' interests their chief concern. The doctors, seeing themselves as something in the nature of " beloved physicians ", and feeling that they were above and beyond politics, became involved in a political battle, in the course of which their opponents were able to tap an undreamed-of well of resentment which lay hidden in the general public, many of whom have been seen to regard doctors, not as individuals to be loved, but as a faceless, prosperous minority to be envied. As if this were not enough, the doctors have been confronted with yet another shock, in that the very value of their traditional, disease-orientated health care is being seriously called in question, and its actual contribution to human welfare is being compared unfavourably with the contributions made by other professions, in fields such as hygiene, sanitation and nutrition.

Rude though these shocks may have been, they have certainly served a purpose, for, having long regarded itself as the sole arbiter on the quality and quantity of health care to which the community is entitled, and being geared to the traditional concept of a concern with disease, the medical profession has been forcibly introduced to the new philosophy of health care, and to the realization that there are other bodies who consider that they, too, have a right to determine standards of health care. Just as governments have adopted the attitude that war is too important to be left to the generals, so they have decided that health care is too important to be left to the doctors, and in this attitude, governments are joined by the consumers of health care, the public. Society has given notice that

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it intends to seek full value for the money it expends on its providers of health care.

At the same time, the general public is looking for ever-higher standards in health care, for a number of reasons. Higher standards of education, together with a great deal of publicity, often initiated by the profession itself, have increased the public's awareness of the possibilities of health care. Politicians' promises that they can improve health care, coupled with their assertions that the public has not been receiving the best of such care, have fed this awareness. In addition, there are many in the community, and especially those who support comprehensive nationalization of the health service, who would extend the humanitarian concept that everybody is entitled to good health care to the point where this care should no longer be the responsibility of the individual, but the right of every citizen, and, moreover, a right with unlimited availability. In effect, health is to become one of the public utilities.

Public utilities require public money, and this involves the further intrusion of a government which is already involved in meeting part of the cost of health care, particularly when that government is possessed of its own sociological, if not frankly socialistic ideas on health services. While allowing the government some degree of altruistic motivation behind its interest in the health field, it is the cost involved which is bound to be its chief concern. Though politicians can make extravagant promises, governments, mindful of spiralling health costs, must question the amount of productivity that has to be utilized to support the health care system. To the avowed problem that health care costs are escalating out of proportion to the general rise in productivity within the community must be added the further problem that, if health is to become a public utility, it must compete with other community services, e.g. education, housing, transport, in its search for a share of the tax dollar. There will be no alternative but to place a limit on the health budget.

If, now, in line with the proposed greater emphasis on the preventative side of medicine, government expenditure on health must encompass provision for recreation, sport and other general measures designed to improve the so-called "quality of life" and to reduce psychological disorders, including measures, e.g. counselling services, to counteract the stress factors which seem to be contributing so much to ill health in over-developed countries, it must be envisaged that there will be within the health budget itself a limitation on the funds available for the familiar, traditional hospital and professional services. Certainly, with a limited budget, if every member of the population is to receive an equal level of traditional health care, and if the general level of care is to meet an adequate standard, it is implicit that the use of expensive drugs, unlimited investigations and costly, sophisticated procedures like organ transplants and prolonged intensive care will be restricted. As a consequence, in anticipation of these restrictions, the health planners responsible for implementing the new philosophy are introducing a new concept, that of reasonable, or adequate, health care.

No government bent on containing health costs within a budget limited by demands from other areas of community expenditure could afford the bald introduction of a term such as "reasonable health care". Consequently, as a politically acceptable means of controlling the escalation of hospital costs, the government sees the provision of lower levels of care which are capable of providing treatment "commensurate with the illness from which the patient is suffering", while the politically acceptable means of controlling escalation of medical costs is seen in the fixing of fees or, preferably, the inclusion of the doctors, particularly hospital-based specialists, in a salaried service. Though no-one would expect governments to show any concern for the financial status of the medical profession, they seem to have completely overlooked human nature and its need for incentives, for, while payment for services is in theory not supposed to be the moving force in the health field, the fact is that, for many doctors, the principle of extra financial reward for extra effort has been the incentive which has led to the provision of a high level of service to the public.

In realization of this, the medical profession, which is not alone in its beliefs that maximum effort is seldom achieved in any field without adequate reward, and that conscription to a salaried service would reduce incentive while not cutting costs, is seeking to ensure that its members continue to receive adequate financial reward, in the interests of maintaining the best possible service. At the same time, the profession is insisting that, whatever organizational changes there might be, the doctors should not be restricted in their right to advise whatever treatment they consider to be in the best interests of their patients, regardless of cost.

Unlike a commercial undertaking, health has traditionally lacked cost and profit sensitivity, and has operated under the premise that no expense should be spared for the sick. Now, with the disproportionate rise in the cost of health care and its extension along the lines proposed by government and sociologists, with the public's expectation of the best of care as a right, with the doctor's demands for adequate payment, with the introduction of more and more sophisticated treatments and the doctors' insistence that they should be entitled to a completely free hand in the initiation of these treatments, together with the costly investigations that go with them, it will soon be impossible to ignore the need to develop a system which will reconcile the many demands with the resources which are made available by society.

So far, both government and profession have been obsessed with the problem of how to pay for health care, when it is becoming increasingly apparent that the type of care as we know it at present, even without the newly-proposed extensions, is not capable of being paid for within the limitations of a budget. The basic problem to be faced is that of controlling costs and of controlling demands which initiate costs. The solution involves nothing less than a change in the very nature of medical practice and in the order of priorities now followed, which requires the development of a new set of attitudes by all parties concerned—government, public and profession—and each of these parties has a responsibility if a solution is to be reached.

The principal responsibility rests with the government who, having said that the cost of the present system of health care is too high, and that the cost is rising faster than the general level of productivity in the community, has proposed a scheme which enlarges the scope of health care.

If this scheme is to be kept within a limited budget, bearing in mind the many demands on the public purse, it will be necessary for the government to gain acceptance of the health planners' concept of reasonable health care, in the face of the public's expectation of unlimited care as a right. Incentives will have to be found which will encourage both providers and consumers of health services to be reasonable in their demands on the system, otherwise the system will be overwhelmed, both in terms of numbers of demands, and of cost.

Instead of devizing means of controlling doctors' incomes, the government has a responsibility to see that doctors receive adequate remuneration and conditions, along with the rest of the community. Society cannot afford to have a group of its most expensively trained professionals not put forth their maximum effort, and government must be realistic enough to appreciate the fact, already stated, that the monetary incentive, though perhaps not a noble one, has been one of the major factors accountable for the high incidence of maximum effort within the medical profession. In particular, a responsible government should cease portraying to the public the picture of a profession motivated only by self-interest and greed.

Lastly, if the government truly subscribes to the need for cost control, it will have to show responsibility in its own expenditure, especially in the establishment of the bureaucracy to administer the health scheme, and in the construction and staffing of the new centres of lower levels of care.

The public's responsibility lies in not demanding too much, but its acceptance of this restriction will be dependent upon the extent to which the community can be persuaded to reduce its expectation of unlimited care to that of reasonable care. In the simplest of terms, the health planners hope to be able to convince the public that, just as the majority must be content with a reasonable standard of living, a reasonable standard of education, a reasonable standard of housing, and so on, so they must come to accept a reasonable standard of health care. The problem is to determine what is reasonable, and a solution to this problem will not be possible without the acceptance by the medical profession of this new concept of reasonable care.

While, at this stage, doctors might be unable to accept such a concept, involving as it does the need for taking part in helping to change the public's attitudes, they should be prepared to give some thought to regulating the initiation of costs. It should not be difficult to reconcile high standards of care with some form of economic self-regulation.

In the first place, it might be worthwhile giving a little less emphasis to the question of status, and for each section of the profession to see itself as merely a contribution to a good health service which, in turn, along with other essential services, e.g. education, is only a contribution to the running of the community. After all, the status of Anaesthesia is largely in the minds of anaesthetists, and the true place of the specialty in the scheme of things was suggested by a recent survey in the United Kingdom, which revealed that, of all the people

in the community who seek medical attention, the number who require the services of an anaesthetist is something less than 0·3 per cent.

In place of the current preoccupation with income, there is a need for moderation with regard to demands for over-remuneration, and a need to ensure that the service is truly commensurate with the fee, with which is incorporated an obligation to increase efficiency. There is much talk of the coming necessity for militancy in negotiations over remuneration, an attitude which is blind to the fact that high incomes, expensive cars and a super-abundant standard of living are inconsistent with the current pattern of life throughout the greater part of the world, and, indeed, with the likely future pattern of life in this country.

With regard to regulation of costs, it is largely for disciplines other than Anaesthesia to look to the real necessity for ordering, not only expensive drugs and sophisticated treatments, e.g. organ transplants, but all drugs, operations, pathological tests and X-rays. Investigative medicine in particular appears to have got out of hand, and it is often hard to see any improvement in morbidity or mortality as a result of the vast numbers of expensive investigations which are being performed to-day.

In the field of Anaesthesia itself, there are two broad areas of cost regulation, i.e. efficient use of trained personnel, and economical use of resources.

For instance, it should be possible to correct some of the inefficiencies which have been partially responsible for the current fee structure in private practice, e.g. the incompletely filled operating lists, the mid-session changeover of anaesthetist, the time spent in travelling in order to anaesthetize or premedicate perhaps one patient, the long hours on call for emergencies.

Concerning the efficient use of trained personnel in the broader view, there is at present much discussion throughout the world as to whether the ideal of providing a fully-trained specialist for every anaesthetic is attainable in the foreseeable future and, indeed, whether the ideal itself is a legitimate one.

It has been suggested by many world leaders in the specialty that the ideal is set too high, both from the point of view of the expense and time involved in training specialist anaesthetists, and from the point of view that realization of the ideal would give Anaesthesia more than its fair share of the doctors available. It is felt that the concept of adequate care in the field of Anaesthesia will most quickly be achieved by a three-tiered structure of fully-trained specialist, partially trained general practitioner and nurse-technician.

There is undoubtedly a requirement for some anaesthetists to be highly trained, to be possessed of a store of academic knowledge, if possible to be of sufficient originality of thought and intellect to be able to advance the specialty by conducting useful research, and to broaden their scope to the point where they become anaesthetist-physicians. There is a need for such people to be available in all the major centres where complicated procedures are carried out, and to be available for teaching and consultation. However, there is equally a need to have sufficient numbers of people capable of performing in competent fashion the vast amount of straightforward, largely technical, anaesthesia that is required every day.

It has been pointed out that the large part of Anaesthesia which is routine and which often leads to boredom and frustration on the part of the specialist could be performed by people with less training, whether these people be general practitioners who have had, say, a year's training in one or two basic techniques, or nurse-technicians, several of whom could work under the supervision of a fully-trained anaesthetist. For many, this concept will not be easy to accept, but even in Australia the three-tiered structure is already in existence in Obstetrics, particularly since the recent introduction of the Diploma of Obstetrics for general practitioners. Perhaps the all-but defunct Diploma of Anaesthesia could be revived and put to use in a similar fashion.

From the point of view of economical use of resources, the chief concern within the orbit of the anaesthetist is the modern major hospital, where the greatest single area of potential cost savings is said to be in the area of staff utilization. By adopting a policy of delegating some of the routine tasks to nurse-technicians, anaesthetists would be contributing towards the more efficient use of this resource. Attention might also be given to the criticisms that huge increases in medical staffing have not been accompanied by concomitant increases in productivity, and that high cost hospital facilities are being used frivolously or irresponsibly, as with the performance of " trivial " operations which could equally well be conducted in less sophisticated surroundings.

Certainly, the affluence of the last few years has accustomed many of us to the ways of

extravagance, to the point where there is rarely a thought given to the cost of drugs and materials. Economics which are minor in themselves but which would lead to considerable saving overall, could be achieved by teaching ourselves and our trainees not to use the expensive drug when the cheaper one would do as well, not to use unnecessarily high gas flows, not to use more syringes and needles than necessary, not to use intravenous therapy indiscriminately, and so on.

Apart from considerations of the most efficient use of personnel and resources, there are certain other areas where anaesthetists can regulate the initiation of costs. In spite of the vast increase in activity in recent years, much of what passes as research work, involving time and money, together with a large amount of the published work with which the practising anaesthetist is afflicted, to say nothing of the increasingly expensive and recurring congresses, have not been accompanied by advances in anaesthetic practice remotely in keeping with the outlay involved.

Lastly, in the cost-intensive fields of organ transplantation and prolonged intensive care, there is a need for anaesthetists to join with their colleagues in other disciplines in order to answer questions of cost-benefit. Professional people have never been good at tackling such responsibilities, but it is likely that coming events will make it imperative that they become involved in considerations of this nature. In fact, people are already voicing their thoughts on this matter, and in the United Kingdom it has been estimated that, in a five-year period, 250 times as many lives would be saved if the money spent on artificial kidneys were to be used for a successful campaign for the wearing of seat belts in cars.

Having developed the theme that the way health care is moving appears to be in conflict with the community's ability to pay for it, with the corollary that cost control is likely to intrude to an ever-increasing extent, this dissertation has raised more questions than answers.

Why should politicians who are antagonistic towards the medical profession acknowledge that the profession's stance is motivated by anything other than greed ?

How can the public be expected to reduce its demands on the system, to understand that health care will only be as good as the community is prepared to pay for, and to accept the suggestion that the achievement of even a reasonable level of care for everybody might involve foregoing benefits in other areas ?

Why should doctors not look for continued increases in income, in common with the rest of the community ? How can they be expected to give their maximum effort if they feel that they are not being rewarded adequately ? How can doctors in general be expected to be influenced by the cost of operations, investigations and drugs, when they have the responsibility of doing the best they can for every individual patient ? Why should anaesthetists adopt any of the measures which have been suggested ?

Who will grasp the nettle of deciding which patient is going to receive the benefits of organ transplants and prolonged intensive care, and which patient is going to die ?

To suggest that there is a need for everyone concerned to develop a sense of responsibility in the initiation of costs, and to point to a few areas where cost regulation might be achieved is a long way from showing how these suggestions are to be accepted and put into practice. The solution to the many problems involves a radical change in thinking on the part of every member of the community, in that it implies our ceasing to look for improved standards of living in every sphere, health along with the rest, and our ceasing to pursue every new development in medical technology, even to the point of going backwards in certain areas for a time.

In our society, the provision of incentives, or the appeal to a sense of responsibility are the only means available for changing an individual's course of action. Since it is difficult to imagine what incentives could be offered or how successful would be any appeal for responsibility which would overcome the pressures involved, one is forced to the unpleasant conclusion that it is unlikely that the health care dilemma will ever be solved within the framework of the type of society in which we live.

Just as we appear to be witnessing the inability of our social system to cope with its economic problems, with its problems of law and order, education and urban transport, it is conceivable that we are about to witness its inability to come to terms with its health requirements. With so many people in the world suggesting that our society's ills will not be solved short of submission to authoritarian control, it may be that the shocks which our conservative professional sensibilities have received to date will be as nothing by comparison with those which the future holds.