EDITORIAL

A health care system versus a virus

Un sistema sanitario contra un virus

Antonio Juan Pastor

To write about an unprecedented health crisis[1] while it is happening and to analyse the behaviour of the health system in relation to it is a very difficult task. First of all I would like to clarify that the content of this editorial does not intend to be critical of the actions carried out during the crisis[2]. There will be time to make the appropriate analyses, but I believe that at this time we can only congratulate all the professionals who have faced unusual situations that will surely leave a mark on many of them for a long time to come. But this does not mean that we cannot make an assessment of the state of our health system, which I believe cannot be assessed simply by the actions taken during this crisis.

I have always avoided using the term breakdown, because I believe that it can lead to confusion when we use it to describe our conditions of common saturation and I believe that the events experienced during this pandemic prove me right because we have just known what a real breakdown is. The system, this time, has indeed crashed. Areas that had never been used before have been used for care, we have seen patients being cared for in hotels, field hospitals have been set up. Frankly, I do not believe that any health system is prepared to withstand an increase in demand such as that which has occurred, but the problem has taken on this dimension because it has particularly affected the axis of emergency services and critical care units. And this axis is one of the weakest links in the system, because it is permanently saturated[3,4]. And if this axis obtains the results it usually does, on the other hand excellent, much has to do with the daily management that the professionals themselves make of scarce resources[5,6].

For this reason, it would be advisable that after this crisis, we are not left alone with the impressive response of the professionals and do not continue to be settled in the self-congratulation that we have one of the best health systems in the world[7]. The reading we should make is how we can improve the saturation of the system at its key points and how we can make it more flexible so that, in the face of increased demand, supply can be increased if necessary[8]. And I do not refer to the situation we are experiencing, but to the annual epidemic crises, winter crises due to influenza and summer crises in tourist areas, the latter often forgotten in emergency plans.

Saturation of any service, not only the health system, is caused by an imbalance between supply and demand[9]. Supply can never be unlimited, even if politicians mislead the public by promising to increase services and benefits. This means that demand must be controlled[10]. We already control part of the truly urgent demand, through emergency systems, codes, etc.[11]. However, when demand is mostly spontaneous, as in the case of urgent care, control measures are difficult to implement. Different formulas have been proposed, all of which are unpopular and which the health authority is not willing to apply[12,13]. Light measures, such as health education, are a total failure. Let's face it, the citizen uses easily accessible public services without reasonable criteria. Let us note that one of the hardest decisions in recent decades taken in relation to this crisis, a measure that infringes on individual freedoms and that is confinement, was aimed at regulating this demand. It was not only a matter of the number of people affected decreasing in absolute terms, but also of the transmission of the infection occurring in a more staggered manner, giving the health services time to adapt[2]. In other words, to reduce the imbalance between supply and demand. In any case, we should not forget that regulating the spontaneous demand of hospital emergency departments (ED) would have an impact especially on their waiting rooms, since the adjustable demand would especially affect non-urgent consultations, which are not the main cause of saturation. However, there is one exception to the regulation of spontaneous demand that would clearly contribute to alleviating ED saturation and that is to improve the care of the elderly population in non-hospital settings. Let us finally recognise that healthcare in residential and social healthcare settings is deficient, and in this crisis there have been signs of this. Better care for the elderly in non-hospital settings could contribute to fewer ED visits and lower hospital admissions for this growing population group[14].

Therefore, if demand is not going to be regulated

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with actions that limit citizenship, the supply must be increased, up to reasonable limits. And increasing supply means improving financing and investing that money properly[15]. If money is injected into the system to do more of the same, we will not fix anything.

We must ensure adequate care for our elderly and chronic patients before they develop complications and exacerbations. It has been said repeatedly but, for the time being, specific programs are falling short. This means improving the financing of primary care and making it accountable, through an appropriate incentive system, for its results. Experiences with funding improvements without linking them to results are disastrous. Let us not fall into the trap again. In fact, one of the roles of the specialties most concerned with care for chronic and elderly patients, such as geriatrics, internal medicine, pneumology and cardiology, would be to get out of the hospital a little more and move closer to primary care.

But above all, the hospital for acute care must be reinvented and its management improved[4]. Beds in acute hospitals have two main gateways: the surgical block and the emergency department. From the first comes a surgery-bed resuscitation axis or intensive care unit (ICU)-conventional high bed and control. This process must be excellent and requires correct dimensioning - structural and professional - in each of the phases and must seek excellence. The more talented the surgeon and the better the nursing care, the fewer complications, the shorter the stay, the earlier the discharge, and the less expenditure. The other axis is that which makes up the emergency systems - ICU bed or semi-critical bed or conventional bed - discharge and control. Well, that is where we have the biggest problem, because we start from clearly under-dimensioned and permanently saturated EDs. First of all, the staff must be adequately equipped, both in the emergency services[16] and in the EDs, and to do this it is necessary to train specialists. We have been proclaiming our specialty for 30 years[17]. Perhaps the administration, even as a reward for the services provided, will make up its mind at once. The role of the emergency services must be reinforced, especially in the coordinated management of critical care beds. In addition, the spaces in the EDs need to be adapted. Most continue to have obsolete structures, with absent or insufficient observation units, with a distribution of spaces that encourages inefficiency. On the other hand, the critical care units, in addition to being correctly sized, must break down their borders, facilitating the control and monitoring of patients not necessarily admitted to a bed in their unit. Let's stop thinking about beds, and think about patients. The more patients who really need to be monitored, the more adverse events can be prevented. As for conventional beds, in addition to ensuring the correct adequacy of the number of beds required, average stays should be adjusted, with stays as short as possible, without undermining patient safety, improving control at discharge and avoiding safety problems in hospital-home transitions[18]. Doing all this would intervene in the main cause of ED saturation, hospital drainage, with the aim of immediate admission from the ED to the destination bed.

I hope that this crisis has not been in vain, and that the health authorities will look a little further ahead when they analyse what has happened. ED professionals do not work to be heroes or to be applauded, although they are moved and grateful, but to be able to give the best possible care to people and, if there are no profound changes, I am sorry to say that this can never happen.

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