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OPINION ARTICLE

Should Minor and Benign Cutaneous Lesions Be Treated by the Health Service?

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Although the question posed in the title of this article rarely figures on the programs of dermatology meetings and conferences, it is often the subject of conversations during breaks and lunch, and for some time it made for a lively forum on the web site of the Spanish Society of Dermatology and Venereology. These exchanges show just how heterogeneous the criteria applied by academics are and how attitudes can vary not only between the different Spanish autonomous communities, but also between members of the same hospital or health care area. Even the number and characteristics of the range of entities covered by the term "minor and benign cutaneous lesions" is vague and open to discussion, and the reader's own interpretation is equally valid.

The first point to be taken into consideration before addressing the controversy surrounding the treatment of minor cutaneous lesions in the Spanish national health system—much as it may seem paradoxical—is whether this can really be considered a significant problem. In other words, is there really a growing demand among the general population for treatment of minor and benign lesions? What is the impact of the management of these lesions on the daily activity of a dermatologist in the public sector? In this sense, and in line with the fundamental premiss of health care administration that "what cannot be measured cannot be determined, and what cannot be determined cannot be improved," we can state—with a few respectable exceptions—that dermatologists have done little to turn a mere impression into a tangible reality that enables us to appreciate the magnitude of the question.[1] Therefore, from here on, we have no alternative but to deal mainly in impressions and opinion.

There can be no doubt that there is growing interest and investment by the general public in cosmetic and aesthetic treatment, a circumstance that has placed Spain first in Europe and fourth in the world in the total number of plastic surgery operations (first in patients aged under 21).[2] In this context, it seems likely that the continuous flow of advertisements will eventually get through to the average person, who will tend to see as abnormal and worthy of treatment lesions that were once considered part of the ageing process or of the normal development of the skin. This, combined with a reasonably satisfactory health system, which has evolved from an old-fashioned civil service structure to one of well trained professionals willing to meet the demands of the user, means that the user–client sees the Spanish health system as an adequate framework for his or her aspirations.

This greater perception of the relative importance in dermatology of minor benign lesions and their treatment is affected by the already advanced—almost complete in some cases—disappearance of the second level of health care.[3] Its daily role as a filter of the most routine and unimportant queries, once blindly criticized for reasons of personal interest and often with no academic recognition, has somehow been restored by the huge direct demand for the only level of specialized care that brings together outpatient clinics and hospitals. If I may be allowed to digress, it is worth adding that this absorption of the second level has generally not been accompanied by a corresponding increase in the hiring of specialists. Rather, institutions have hoped that their part of the work will be absorbed by the constantly expanding primary care sector.

Faced with this problem, public health managers often behave with an ambiguity not observed in other areas. Given the apparently low cost of these lesions—more details are given below—the modern concept of business quality could be applied. This is understood to be the act of satisfying client needs and expectations by supplying the products and services that clients need, when they need them, and at the lowest cost.[4] However, and even from a management viewpoint, it is worth pointing out some specific aspects. First, we must consider whether users of the health service really "need" treatment of minor benign lesions to improve and promote their level of health. In a strict sense, and given their prognostic insignificance and universal prevalence, they cannot be considered diseases as such; therefore, they could remain outside the objectives of the health service, which does not finance procedures it considers as having no relationship with accidents, disease, or congenital

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malformation.[5] Second, unlike private companies, the health service has limited resources that depend on public funding and political pacts, not demand, with the result that the second premiss of business quality—receiving timely health care—is inexorably postponed in the same way as for patients suffering from significant skin conditions, whose health care is a health service priority. Finally, it is also known that, if client satisfaction is improved, the client will consume more—the benefits brought by a satisfied customer are generally repeat purchases and consumption. This circumstance, which is suitable in private companies, must be evaluated with caution in a capitation system, where health care is supposedly free and universal in the case of visits for lesions that account for 25% of all normal visits to the dermatologist in a primary care center.[1]

Those dermatologists willing not only to treat but also to take on the management of minor benign lesions claim that this would lead to an increase in the number of visits with a subsequent increase in the number of dermatologists hired and, therefore, greater importance and negotiating power for dermatologists. Furthermore, and as a collateral effect, the ever-scheming primary care sector does not then have to take charge of these lesions. The first scenario, that is, hiring more dermatologists, could be true if the health service depended on market forces, as is the case with private health centers or multiple specialty clinics, where dermatologists are much in demand due to the large number of visits and interventions they generate with respect to other specialties and to their lower overall costs. However, and despite the exceptions, health care plans follow strict criteria that are often based on political trends or imported models and were designed many years ago in offices a long way from the clinic. In this sense, the dishonest attempts to show greater efficiency of dermatologists in the management of visits for skin complaints compared with primary care professionals have failed dismally because of the inertia and duration of health plans.[6] With this state of affairs, and while waiting for managers to become more sensitive to the needs of the population and of primary care, greater demand leads directly to an unacceptably long waiting list that sooner or later becomes a greater number of daily patients with the fallacious premiss of "urgent" or "nonelective." The easy solution for the manager is a progressive, inexorable, and, sometimes, scandalous reduction in the time allotted to each visit, with the subsequent deterioration in health care. This does not take into account the restriction—unthinkable in other areas of health care—in the right to attend conferences or in the request for days off to deal with personal business, which must be arranged months in advance and are often only granted in exchange for overtime during the following days. Given the rigidity involved in providing public offers of employment, the dreaded waiting lists take effect in the form of unfair part-time and low-paid contracts that offer the worker few rights, often in return for taking on the least stimulating part (from the professional viewpoint), namely, dealing with a huge number of patients during interminable working days. We dermatologists probably underestimate our capacity and strength when demanding suitable working conditions to enable us to provide high-quality health care, independently of the demand generated by the health service.

Furthermore, it may be a tactical error to take more visits as meaning greater consideration and representation in hospitals. This can be seen clearly in the fact that medical services have no means of managing the money hospitals charge the different managers of the autonomous communities for their work. Once again, we have the impression that dermatology services are last in line for new equipment, facilities, or staff, despite the fact that they offer a highly profitable service for institutions. Managers, by contrast, prefer to boast of "elite" hospital units which, although very expensive and offering services to very small groups, increase prestige both at home and abroad. There is no doubt that dermatologists can provide a similar service through the specialized clinics proposed in the range of services offered by the Spanish Society of Dermatology and Venereology, although this will only be possible if we are not expected to do so after seeing 40 to 50 patients per day in the primary care center. In this sense, we can see how—albeit paradoxically—the apparent decrease in the number of consultations in some medical specialties as a result of the development of primary care, far from damaging their interests, has nourished them and enabled them to extend their specialty and gain prestige, a situation that would have been impossible under the weight of excessive health care duties. On the other hand, some authors feel that the process of trivialization leading dermatologists to spend most of their time dealing with relatively unimportant lesions can jeopardize their very role as a specialty within the health service.[7]

A second, important argument defended by some dermatologists states that the treatment of minor benign lesions—we can assume that the user has the right to receive a correct diagnosis from the dermatologist or from the primary care physician—is within the remit of the specialty and that there is no justification for it to be otherwise. Nevertheless, it is not a question of whether dermatologists should not treat these lesions, rather whether they should decide if they are to be treated within the health service. A more blatant example can be seen in the case of dental fillings—the fact that these are not covered by the health service does not mean that a dentist does not know how to apply them. Moreover, the user knows that this service can be obtained from private centers or health care companies. As mentioned above, this is clearly legal, and users are not deprived of a worthy service in terms of health, as long as we leave to one side the psychological aspect, which is difficult to define and is different in every case. However,

in the coming years, Spanish dermatologists might have to face the following paradox: if suitable training is to be guaranteed in the increasingly popular area of cosmetic treatment, and to do so medical residents have to rotate in institutions specialized in this field and this circuit becomes part of medical training, health service managers could ask dermatologists to treat not only minor lesions, but also carry out different aesthetic medical-surgical procedures. And all covered by the health service. Criteria such as those of the World Health Organization that are part of its Constitution, which defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" would be of little help when attempting to restrict these objectives.

We must not forget the respectable opinion of some colleagues, who feel that if dermatologists do not treat these lesions, then primary care physicians will take on the responsibility. The now old and still growing preference of all health care administrations in recent decades for primary care as the mainstay of the health service has led to numerous controversies in medical specialties both at home and abroad.[8-11] Thus, the apparent ease with which primary care obtains resources and means that are denied to or have to be bargained for by specialists creates anxiety, even despair. Today, to attempt to struggle against this trend is a task as enormous as it is fruitless. However, it seems unlikely that primary care physicians—with the exception of the few professionals who are particularly interested in this field—will give themselves over to treating these lesions when they already have their own problems managing the growing list of duties demanded by the health service.

We must also take into account that, despite the disciplined efforts of our administration to keep physicians' salaries among the lowest in the UE—they are higher only than those of Lithuania, Poland, and Hungary—the cost of these procedures is high, greater than that paid by insurance companies to independent professionals.[1,12] Thus, the interesting report by Macaya et al[1] estimated that a single dermatology outpatient office invoices for more than €300 000 a year for the diagnosis and treatment of minor complaints. There can be no doubt that projects aimed at producing an accurate profile of the real costs of these complaints by introducing concepts of health care management would make it easier for us to marshall our thoughts in this area.[13]

Finally, we have the barely rhetorical although nonetheless understandable reasons of those dermatologists who simply desist from seeing their patients, backed by a system in which the physician, whose role is merely technical, can decide the best way to meet the client's request satisfactorily.

I have observed that dermatology is not the only area faced with problems. Many specialists are asking themselves how to deal with an exponential increase in demand within the health service, which, paradoxically, coincides with a reduction in resources as a result of their theoretically consultative role for a robust primary care system thought to be almost self-sufficient.

Given the different arguments put forward—no doubt there are many more—concerning this question, I feel that dermatologists would do well to stop attending minor benign lesions within the health service. The time they take up in routine practice explains the extremely long daily waiting lists with only a few minutes per patient. Such lists would be unthinkable in other specialties and do little for the prestige of our specialty. The importance given to these lesions distorts the waiting list by hindering the access of patients with genuine skin complaints and requires the investment of material and human resources in objectives with little added value for the health of the nation. An agreement on restricted access to this service in the health service would not only not be a risk for health care demand, but it would strengthen the development, positioning, and prestige of dermatology in public health through the development of its different subspecialties.

The reasons and arguments set forth in this article in search of consensus and the controversy they generate may seem excessive in a seemingly insignificant area of little academic import. However, as the reader may recall, this type of complaint takes up 1 of every 4 minutes of the daily activity of a health service dermatologist. First, we should ask whether dermatologists as a group are willing to decide what their role in the health service should be—in strictly professional terms and once they have resolved their own contradictions—and transmit this to the health authorities. A collective success in uniting efforts and criteria and getting their message across to the government could, at the least, augur well for more ambitious projects, and may even change the way the administration views the specialty.

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Conflicts of Interest

The author declares no conflicts of interest.

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