Reconciling 21st century temptations with 20th century resources and problems

Healthcare systems in many developing countries face a major challenge: how to meet the demand for 21st century standards of health care and technology with funds that, as a percentage of gross domestic product (GDP), remain lower than what developed nations were investing in health in the 1980s. And, furthermore, how can developing countries meet such expectations when they are still dealing with health problems that rich countries had overcome 40 or 50 years ago?

Take my country, for example. In recent years Brazil has been spending some 7-8% of its GDP (both public and private sector investment) on the health sector. Over the past few decades developed nations have been progressively increasing their spending on health. In the 1960s countries such as Canada, France, Switzerland, Australia, Italy, and the United States spent some 4-5% of their GDP on health. By the end of the 1980s this figure had increased to 8-9%. The United States now leads the world: in 2004 it spent some $1.7 trillion, or 15.3% of its GDP, on health. In absolute terms this amount is more than three times the entire Brazilian GDP.

Thus, in terms of percentage of GDP Brazil spent the same in 2005 as developed countries were spending in the 1980s. The situation is similar if we look at absolute amounts spent per person in the population. The US spends some nine times more per inhabitant than Brazil does—Switzerland six times more, Germany, Norway, and Canada five times more, and Britain 3-4 times more.

Resources in Brazil are far too scarce even to think about giving in to the temptation of investing in today's technology. Such spending cannot be justified, given the number of other areas that require investment for health to be improved. Basic sanitation, education, food, and security are just some that come to mind. Another reason for not spending more on modern technology is the current inefficiencies in our health system. It makes no sense to invest in the latest equipment when the infrastructure isn't in place to support it.

As in numerous other developing countries, in Brazil we have all the typical health problems of developed nations (cardiovascular diseases and cancers, among others) but have not yet dealt sufficiently with the sorts of health problem that richer countries resolved 40 or 50 years ago. Diarrhoea, diseases of the respiratory tract, and infectious diseases continue to be major problems, despite the fact that well known and effective preventive measures exist. Some of Brazil's health indicators—infant mortality, low birth weight, life expectancy at birth, and the proportion of the population aged over 60—are still at levels that prevailed in developed countries 40 or 50 years ago.

The demand for new technology is understandable, given the plethora of available information and increasing awareness. We all want access to the best practices, especially when we are working with what we hold as most precious, human life. However, in the health sector we deal with biological phenomena. No matter how much evidence we have to support our decisions, the possibility always exists that we may have got them wrong. Medicine is an inexact science in constant evolution, and some of its "truths" are transitory and require caution.

Members of the public, who fund the health system, have every right to want access to a good quality service. But we need to recognise that our health system, whether public or private, has limited funds, a limit delineated by what society as a whole can afford. Given these special circumstances of healthcare systems in developing countries at the moment, it is important that all stakeholders—the public, service providers, managers, suppliers, and policy makers and regulators—share responsibility for the stability and continuing viability of health care.

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The public is responsible for raising questions about the appropriate use of the health system. After all, they are funding the system. Funding and risk managers, along with service providers, are responsible for the appropriate use of the available funds and for the system's quality and efficiency. And finally, the policy makers and inspectors—a small but important group—are responsible for deciding on and implementing health policies, with a view not just to the short and medium terms but also to the long term.

The challenge is great, but the opportunities for improvement are even greater, as there is currently much waste of resources in health systems in developing countries. A more efficient health system, with focused policies and transparent and justified decisions, must be our goal. Only then will we be able to demand additional resources.

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SOUNDINGS

Medicine is not a club

There is a small hospital in Drogheda in Ireland, where, between 1974 and 1998, 188 peripartum hysterectomies were performed, most of them caesarean hysterectomies, and most by the same doctor; most obstetricians would carry out less than 10 in their whole career.

That a doctor should deviate from normal practice is not exceptional; we can all get set in our ways, and nowadays change occurs so rapidly that it is easy to fall behind. But in this case the practice adopted at the hospital was so unusual that surely it should have been noticed. The other obstetricians, the midwives, the anaesthetists, the paediatricians, the registrars, the physicians, the surgeons, the local general practitioners, surely one of them should have noticed that something was going on. And yet the Royal College of Obstetricians and Gynaecologists inspected the unit as recently as 1992 and found it suitable for training.

A complaint was eventually made (courageously, it must be said) by a newly appointed midwife, who obviously didn't understand that rocking the boat was not what the doctor ordered. This complaint was then investigated by three Irish obstetricians, who found that there was no case to answer.

A later and highly critical government report dismissed this finding as motivated by "compassion and collegiality," and this is what I find most disturbing. Who most deserved the compassion, the obstetricians' colleague, or the women who had this unnecessary procedure, with all its implications?

And what does "collegiality" mean? It implies a "them and us," that doctors and patients are mutually exclusive groups. But they aren't; every one of us will be a patient sooner or later.

We are slow to criticise each other because we understand that humans are frail, that mistakes are easily made, and that we could be the next to make one; we don't want to cast the first stone. We also know that often bad things happen and it's nobody's fault, that we manage uncertainty every day and sometimes the gamble comes unstuck, that medicine has its limitations and that patient expectations are often unrealistic.

But none of these should translate into a misplaced loyalty to our profession when we can see that something is clearly going wrong.

When I became a doctor, I didn't join a club.

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