Editorial

Resource Utilization in Cardiology

Lately, a great deal of effort is being spent on understanding what are the driving forces determining resource utilization, cost effectiveness and cost curtailment in the health care services of the western countries. Countries with both socialized medicine and those with insurance based systems are doing this. The implications for fields like cardiology are an eye-opener for the whole world, including developing countries.

Good scientific medicine is evidence based and must be relevant to the population being treated. It must be shown to produce the greatest good in the greatest number of this population. In addition, it must do this within the limits of available resources. While modern medicine particularly cardiology has a high cost, expensive treatment unfortunately may not necessarily translate into good and appropriate management. Add to that challenge the vastly different resources available to private versus public health care systems in Pakistan, and, you have the making of a challenge of increasingly unmanageable proportions. In the absence of organized health care systems and functioning regulatory bodies to oversee standards, and, with many practising both in the public and private sector, the physician is placed squarely in the eye of the storm.

How do we ethically and scientifically ration resources in the public sector? Should newer and extremely expensive medications be registered in the country only to be barred from the public hospitals who cannot even afford the basic life saving drugs? How much of the ruthless market forces ought to control what happens in health care? Who should regulate and quality control the seemingly runaway private health care services? These and many such questions will have to be faced squarely and answered by decision makers who have so far shied away from tackling the fundamentals.

It may be that given our economic crunch, the general deterioration and lack of leadership, there may be no answers for now. That in the foreseeable future, the day to day ad-hoc management and survival strategies to keep the system from total collapse seem like the only possibility. But, efforts must start to do at least what can be done within these constraints. Even if these efforts are at an individual level, they will help keep hope alive until better days arrive. At present what one sees and does involves very little science and mostly arbitrary choices. Out of fluke, good care may be given at low cost or free at a public health facility and horrible care at a high priced private health facility, or, vice versa. The public generally and perhaps correctly believes that private care is superior, certainly it is more comfortable. Chance and not standards are in the drivers seat. This has to change, but, should not have to wait for the country's lot to turn around. It must remain for physicians, even if they are not the final decision makers, to do what is right. The patients see us in the driver's seat and will justifiably hold us responsible for what happens to them. They do not see our problems, they see only us.

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