Is Medicine becoming too expensive?

The world economies are changing, and this is affecting healthcare. Numerous activities worldwide are experiencing financial constraints. Many countries that have enjoyed well-resourced health systems are no longer so well-resourced. Across the globe, there are staff shortages (a substantial part of health budgets). Consequently, services are being scaled down or curtailed to prevent additional strain on already stretched national and local treasuries, thereby avoiding further shortfalls.

The demands on health are also increasing. Populations are increasing, though not everywhere, and in many countries, populations are ageing. Older people are more affected by illness and place a greater strain on healthcare provision.

Another financial constraint for healthcare systems is the inappropriate diversion of funds – corruption. This takes many forms. In both developed and developing countries, this can be the deliberate purchasing of unnecessarily expensive products. In countries that lack a powerful press or civil society, this can be the direct transferring of money into individual's accounts without value or benefit to the State.

Medicine is driven by national and, particularly health politics. Excessive costs can be incurred to satisfy the popularity contest that is politics, ignoring the limitations of constrained budgets.

These issues may appear to be in the purview of politicians, journalists, and regulatory authorities rather than doctors. But doctors *are* involved in policy making and purchasing and provide advice to purchasing authorities, given their direct involvement in the actual use of medicines and medical products 'at the coal face' of medical practice.

A general surgeon enters the operating theatre after being called in by a gynaecologist who brought the case to the theatre. The surgeon was asked to be on standby. The patient has been experiencing nausea, vomiting and central abdominal pain moving to the right iliac fossa, with guarding and rebound tenderness localised to the right iliac fossa. There is tachycardia, pyrexia, a raised white count and no cervical motion tenderness. The general surgeon says: 'You made the diagnosis without a CT scan?!' And yet the diagnosis is obvious. This is not to suggest abandoning CT scans, but it demonstrates a lack of understanding of basic medicine.

A raft of expensive immuno-histochemistry stains is performed on a malignancy. The results, positive or negative, will not change the therapeutic outcome - the expensive tests are performed almost out of habit. In other examples, molecular markers *do* influence therapy.

Similarly, many confirmatory tests for polycystic ovarian syndrome(PCOS) do not alter the initial diagnosis of the condition or modify its management.

An inpatient, undergoing treatment for a pelvic infection, lies in a bed as their temperature and pulse show positive responses to antibiotics. The ward round is told that the C-reactive protein (CRP) and procalcitonin (PCT) levels are also decreasing. These tests have not contributed to the care of the patient and there is a financial penalty to be paid for their use. The patient lies in a very expensive hydraulic bed once considered exclusively for intensive care units.

Likewise, molecular-based chemotherapy agents are widely used as an adjunct to standard agents in gynaecological malignancies. But, in many defined circumstances, these expensive molecular agents increase life expectancy by only a few months and do not significantly affect the course of the disease; and yes, in other circumstances they may be beneficial.

During a gynaecological conference, a doctor asserts to the audience, 'Soon, *all* these procedures will be performed by a robot'. While there is no denying that some medical procedures can be effectively performed by robots, the issue lies in the absolute term '*all*'. Many local health systems globally lack the financial capacity to adopt such advanced technologies. Unfortunately, due to commercial coercion and corrupt practices, a small town may find itself with two costly 2-million-dollar robotic units sitting in a theatre complex, while struggling to provide basic medicines.

Healthcare systems across the world are subject to very powerful commercial interests that drive a perceived 'necessity' for both massive acquisitions and large-volume smaller purchases that are not always cost-effective.

We must all keep our critical faculties, be willing to challenge, and spend wisely for medicine to meet its basic obligation to care for a great number of people. Good science and good sense are easily abandoned if vigilance is lost. The vigilance must be constant.

Doctors cannot extricate themselves from politics, and we should know that Commerce is a wise poker player. It knows that access to commercial environments can be through national and supranational authorities, and we must guard against the type of regulations that appear to be in people's interests but are, in reality, shaped by poor science, ultimately tailored to maximize purchase and sale. Even in the face of evidence, which is often overlooked or unread, it seems the willing can be co-opted when interests align against what the evidence suggests.

Money is running out in the world, and we all have a responsibility to be alert, just as we must in the daily care of our patients.

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