Os Desafios da Medicina na América Latina

"Prediction is very difficult, especially if it's about the future."
-Niels Bohr

José Manuel Silva

Faculdade de Medicina de Coimbra / CHUC/ Ordem dos Médicos

40 anos após 25 de Abril de 1974
35 anos de Fundação do SNS

	1973	2014
Esperança de vida à nascença (anos)	67,6	80,4
Esperança de vida aos 65 anos (anos)	13,2	19,2
Taxa de mortalidade infantil	44,8	2,9 (2015)
Taxa de mortalidade materna (/100.000)	73,4 (1970)	7,3
Taxa bruta de mortalidade (/1000)	11,1	10,5 (2015)
Casos de Tuberculose (/100.000)	131,8 (1970)	22,9 (2013)

The 17 **Sustainable Development Goals (SDGs)** of the 2030 Agenda integrate **all three dimensions** of sustainable development (**economic**, **social** and **environmental**) recognizing that eradicating poverty and inequality, creating inclusive economic growth and preserving the planet are inextricably linked.

Health is centrally positioned within the 2030 Agenda, with **one comprehensive goal** (SDG 3) and its 13 targets covering all major health priorities, and links to targets in many of the other goals.

NEWS

Social prescribing could help alleviate pressure on GPs

Ingrid Torjesen

London

Social prescribing could help reduce pressure on health and care services by referring patients seeking help for non-medical issues to community based non-clinical services, says a report published by the Social Prescribing Network, a group dedicated to supporting social prescribing at local and national levels.[1]

It says that around 20% of patients consult GPs for problems that are primarily social rather than medical, and dealing with these needs is important because social and economic factors affect health outcomes.

However, many of these patients' needs are not currently met by the NHS. The report adds that social prescribing, in which patients are referred to a link worker who will work with them to design a non-clinical social prescription to improve their health and wellbeing, could help take pressure off overstretched GP and other healthcare services.

The network produced its report after its first annual conference funding from local authorities, Public Health England, or the UK National Lottery.

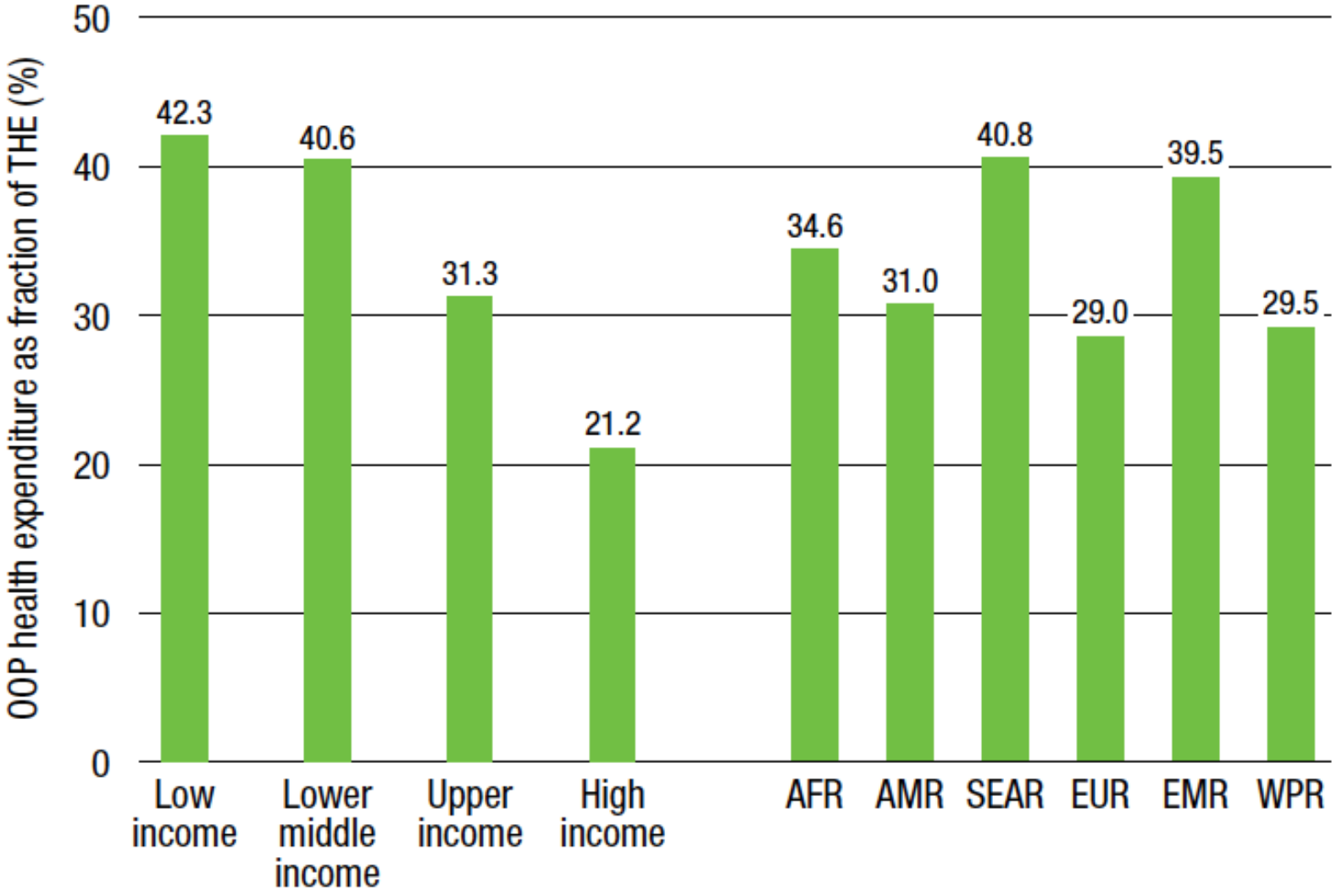
The network plans to create a set of standards and a commissioning framework outlining what good quality social prescribing provision looks like. In the longer term, it aims to map social prescribing's economic benefits and to build a research and evaluation toolkit to assess the effects of social prescribing approaches not only on health and wellbeing but also on social and economic health determinants.

In a foreword, the network's co-chairs, Michael Dixon and Marie Polley, said, "By facilitating the patients' access to a whole range of voluntary and local services, including becoming volunteers themselves, there is much potential to nurture local social capital and catalyse health-creating communities that strengthen their ability to care for themselves and each other."

They added, "Social prescribing recognises that the third sector

Weak health systems are a **major obstacle** in many countries, resulting in **major deficiencies in universal health coverage** for even the **most basic health services** and inadequate preparedness for health emergencies.

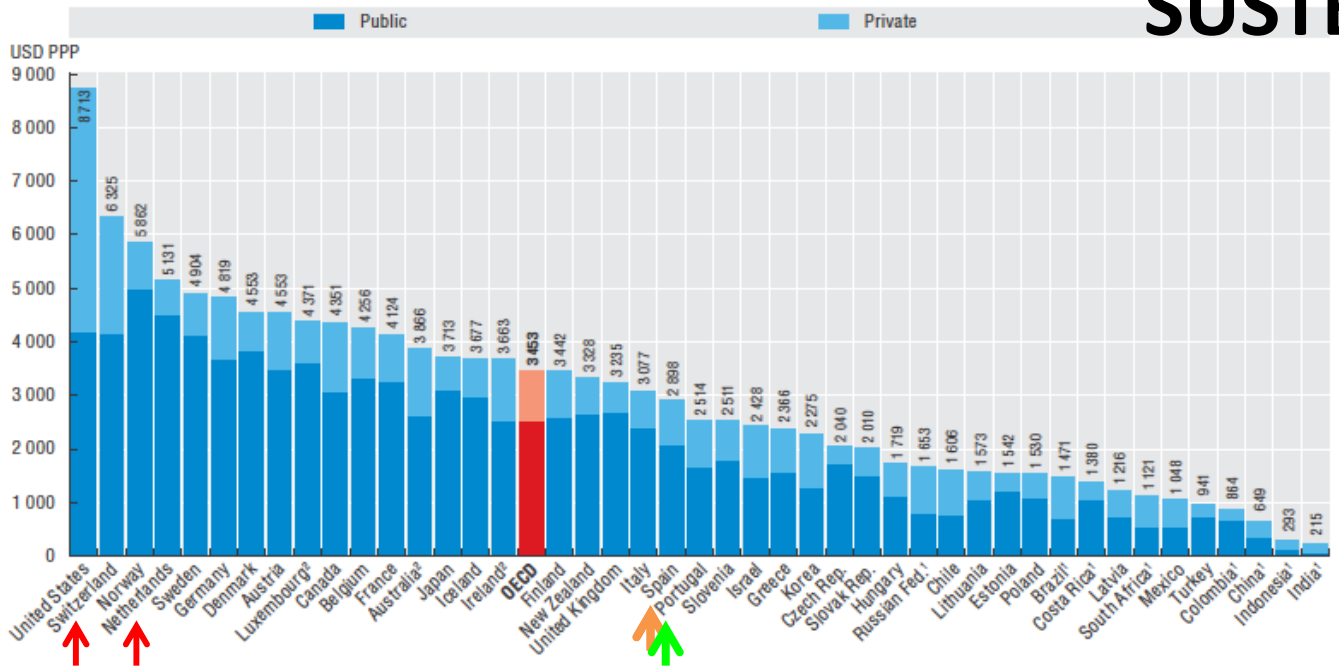
Figure 4.4
Out-of-pocket health expenditure as fraction of total health expenditure, by country income group[a] and WHO region, 2013



a Based on the World Bank analytical income classification of economies.

SUSTENTABILIDADE ?

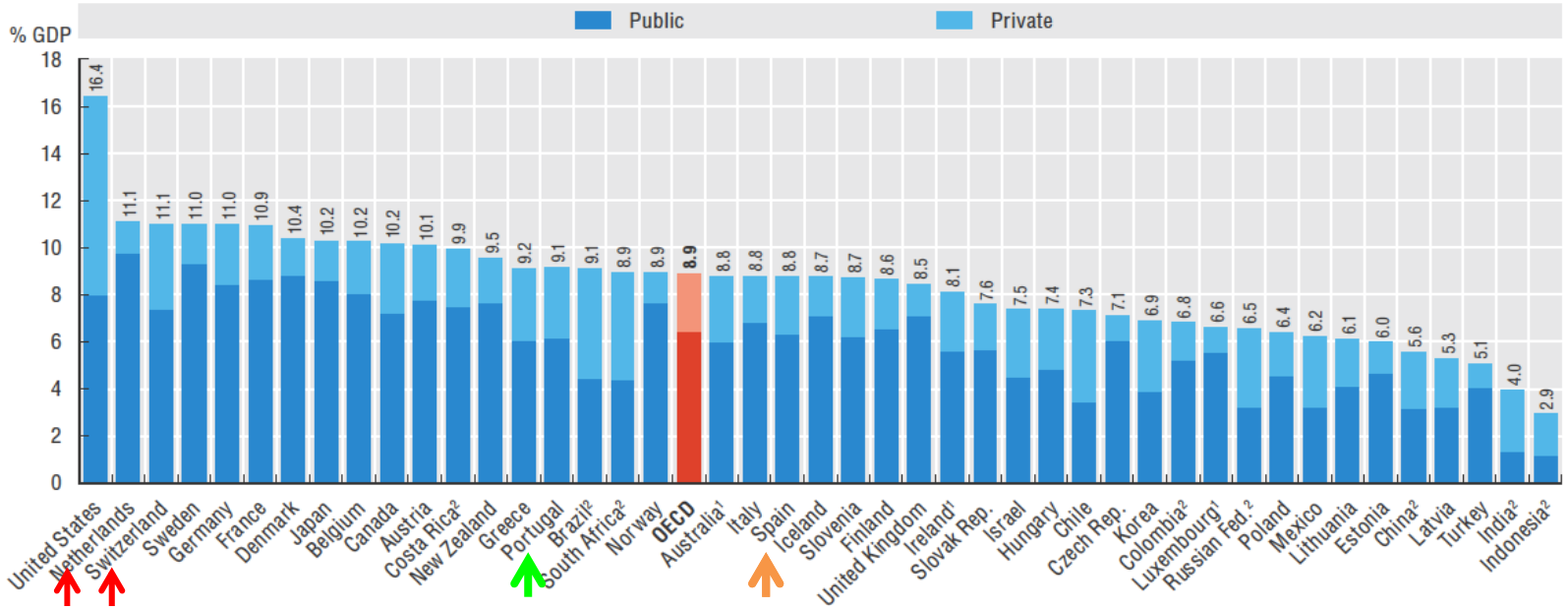
9.1. Health expenditure per capita, 2013 (or nearest year)



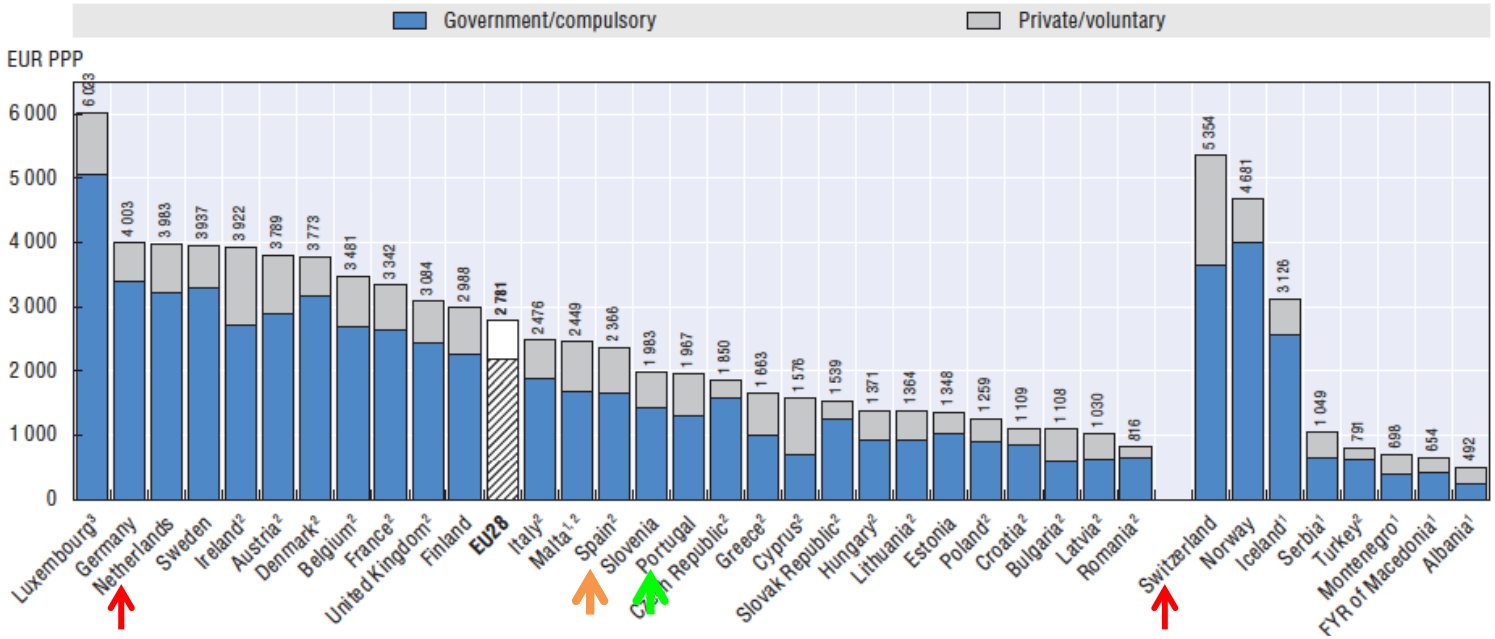
Note: Expenditure excludes investments, unless otherwise stated.
1. Includes investments.
2. Data refers to 2012.

Source: *OECD Health Statistics 2015*

9.3. Health expenditure as a share of GDP, 2013 (or nearest year)



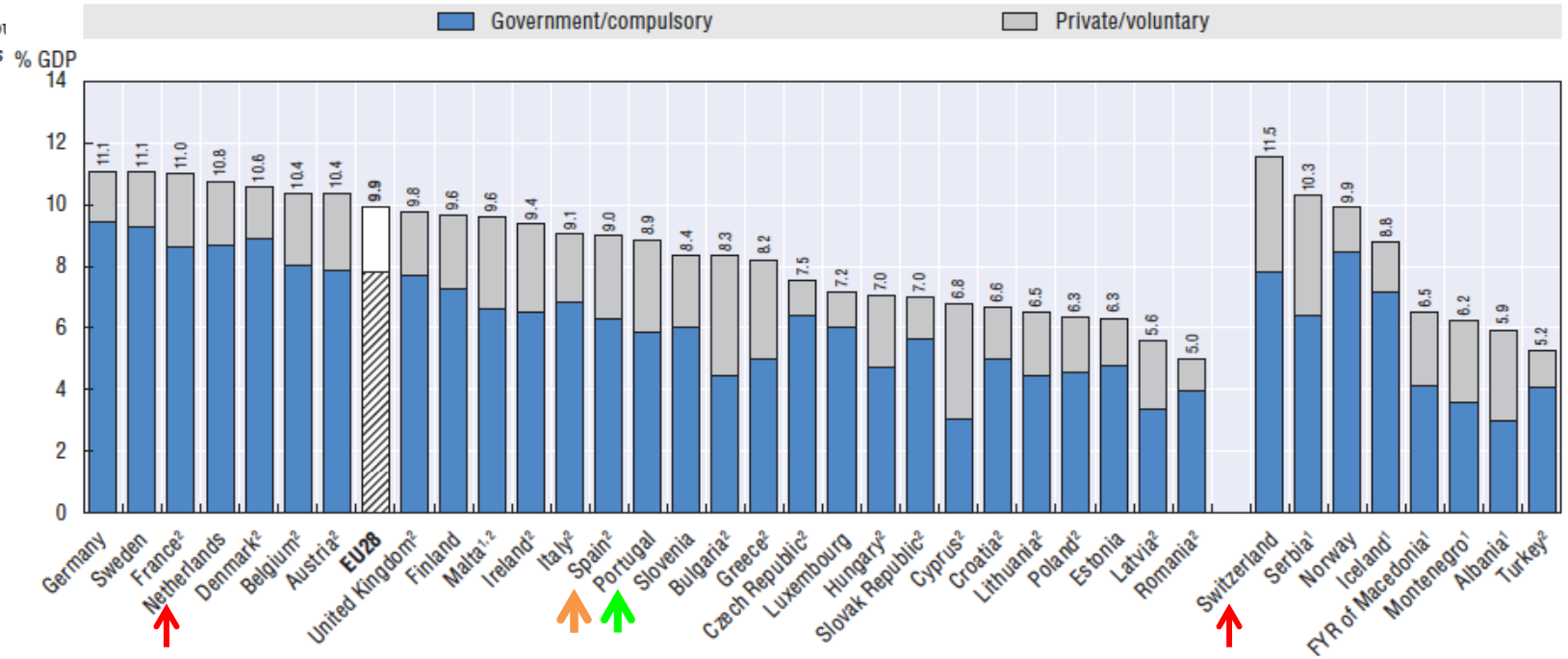
5.1. Health expenditure per capita, 2015 (or nearest year)



1. Includes investments.
2. OECD estimate.
3. For Luxembourg, the popu

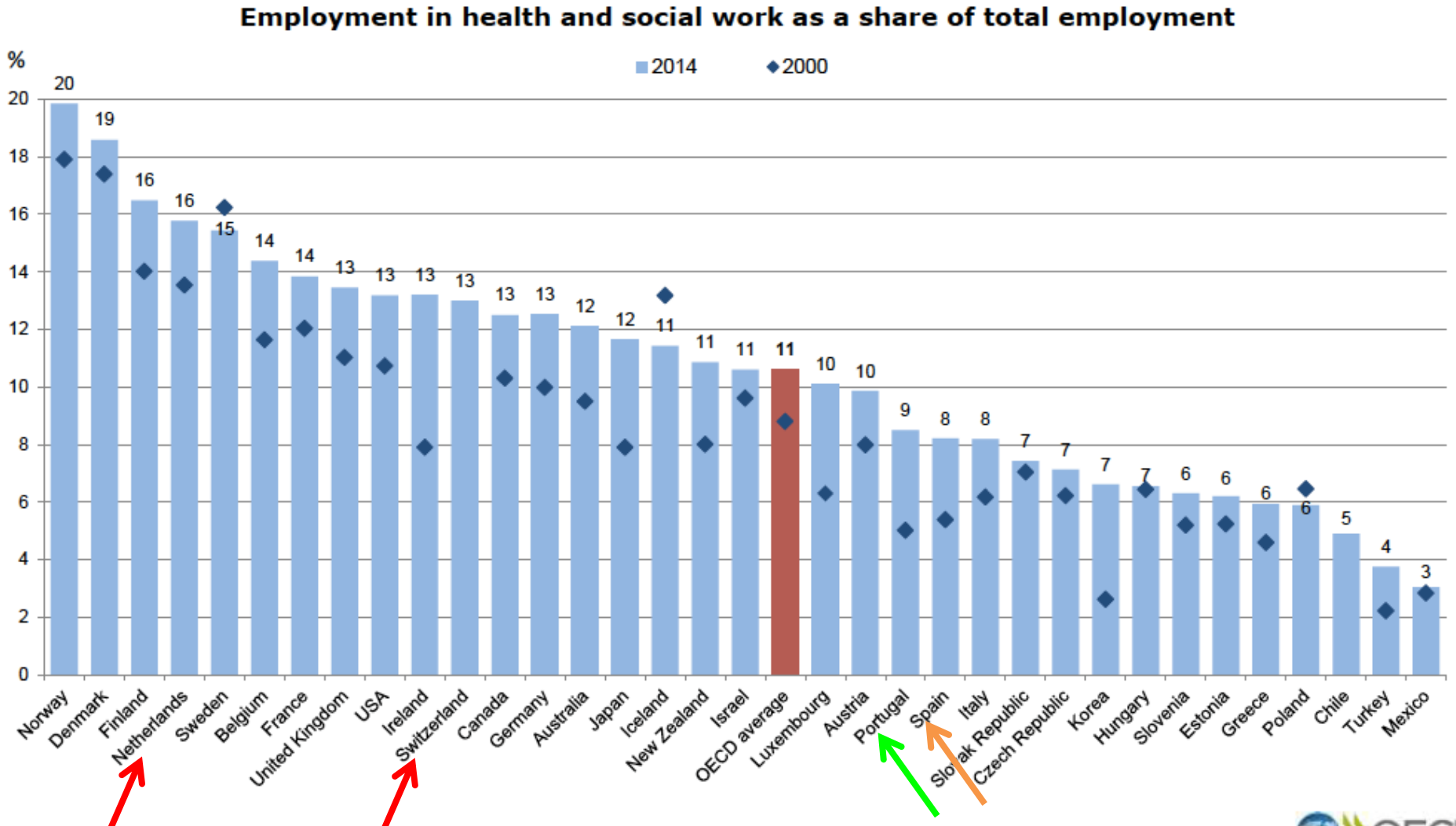
Source: OECD Health Statistics

5.3. Health expenditure as a share of GDP, 2015 (or nearest year)



EUROPE

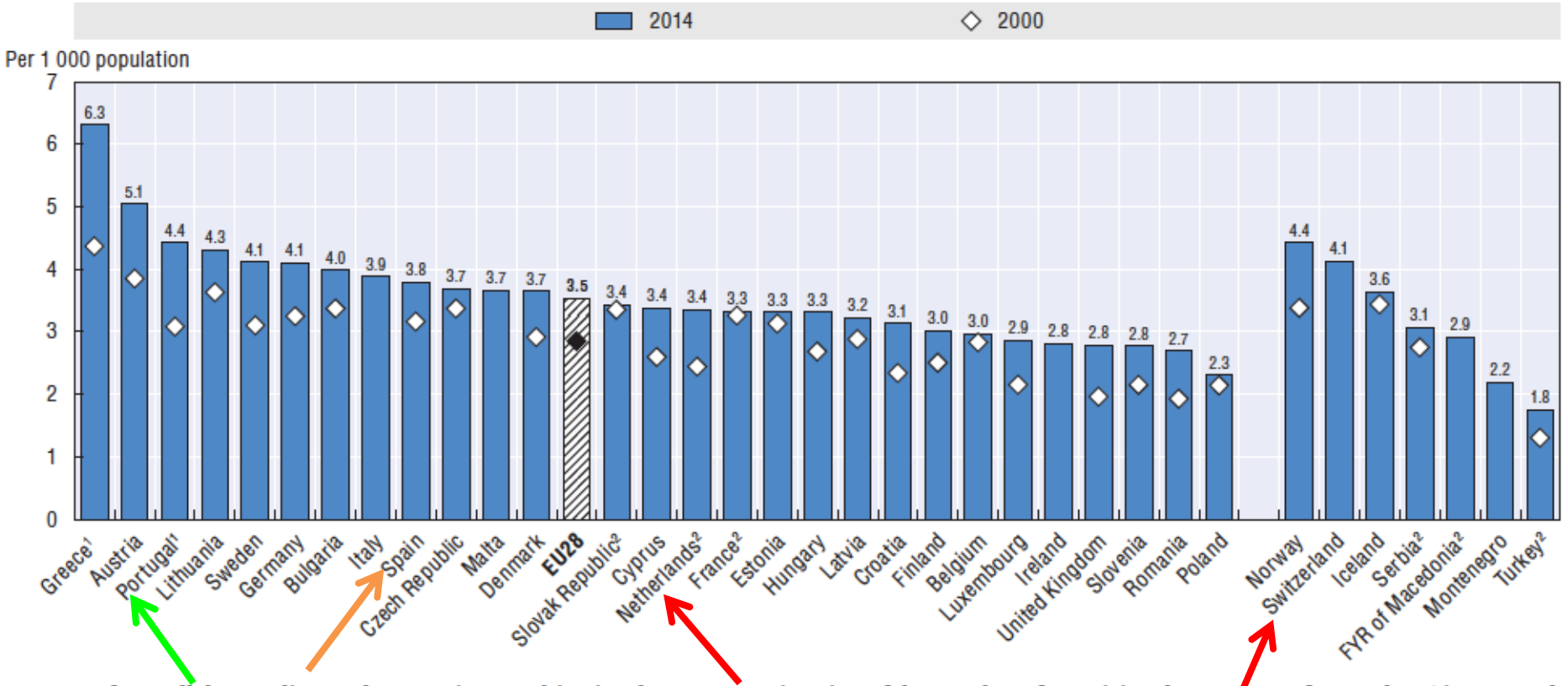
Jobs in the health and social sector now account for more than 10% of total employment in most OECD countries



Source: Source: OECD.Stat, Annual Labour Force Statistics (ALFS) and National Accounts, OECD (2016)

OECD

7.10. Practising doctors per 1 000 population, 2000 and 2014 (or nearest year)

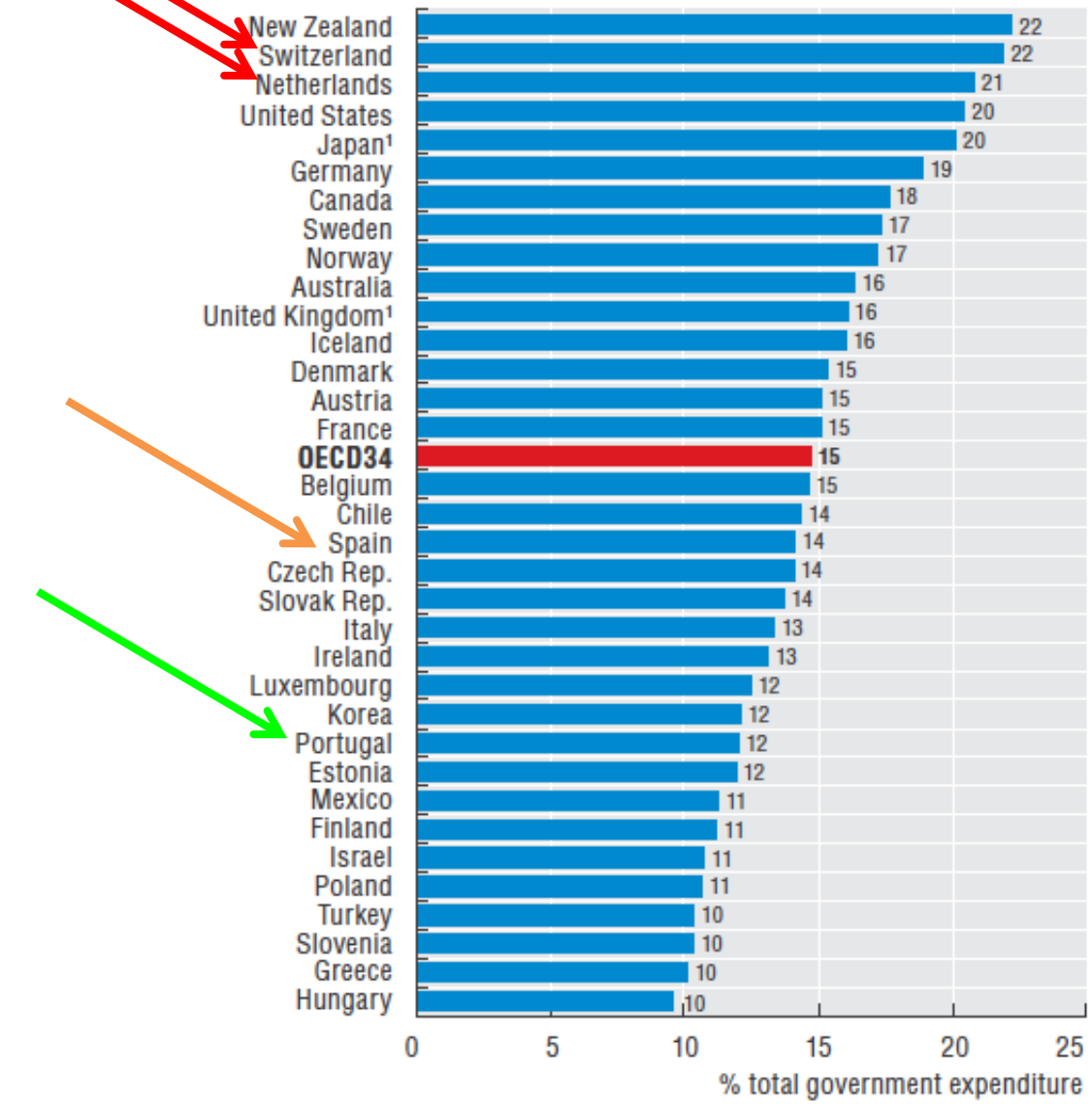


1. Data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30% in Portugal).
2. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).

Source: OECD Health Statistics 2016; Eurostat Database.

StatLink http://dx.doi.org/10.1787/888933429793

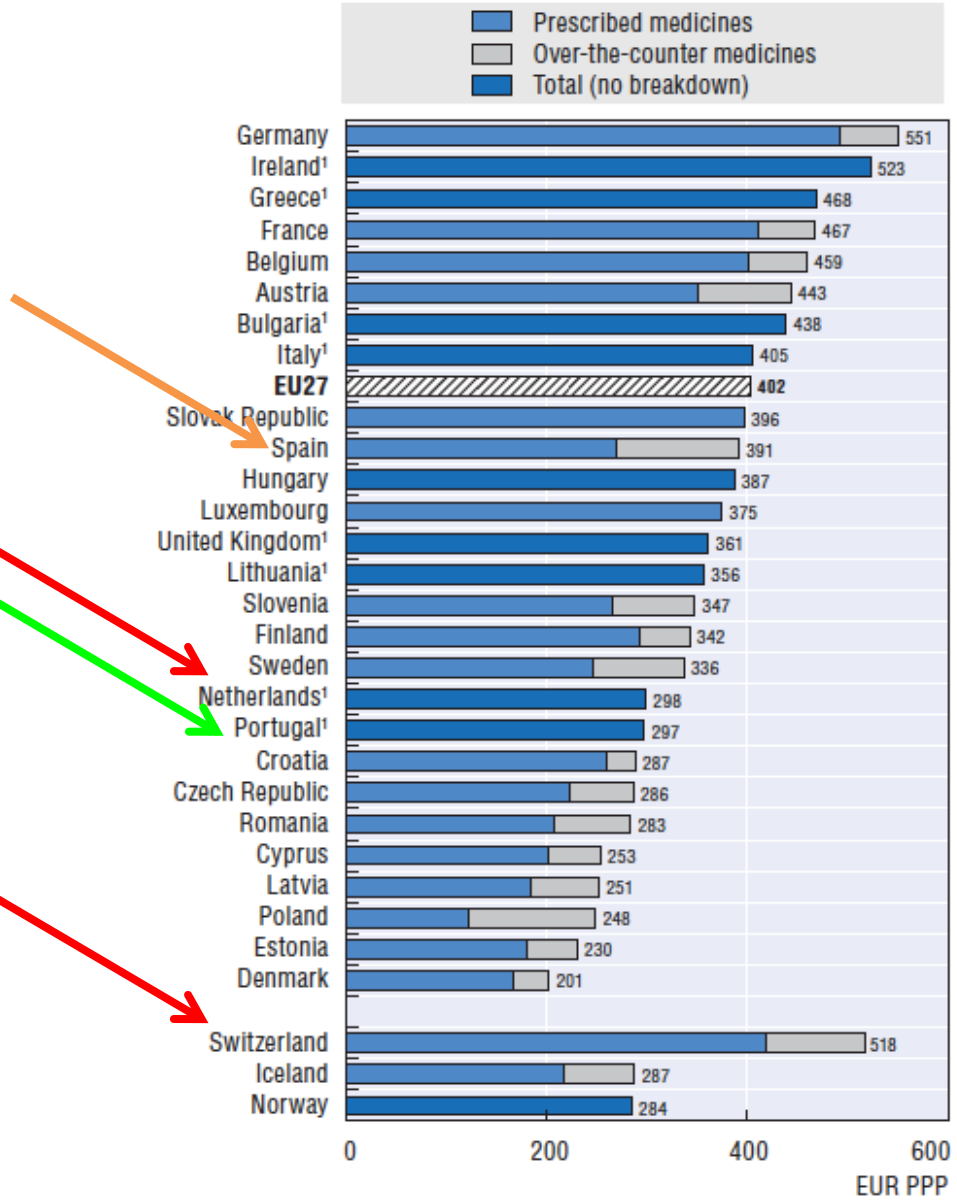
9.9. Health expenditure as share of total government expenditure, 2013 (or nearest year)



1. Data refer to total health expenditure (= current health expenditure plus capital formation).

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en; OECD National Accounts; Eurostat Statistics Database; IMF World Economic Outlook Database.

5.8. Expenditure on pharmaceuticals per capita, 2014 (or nearest year)



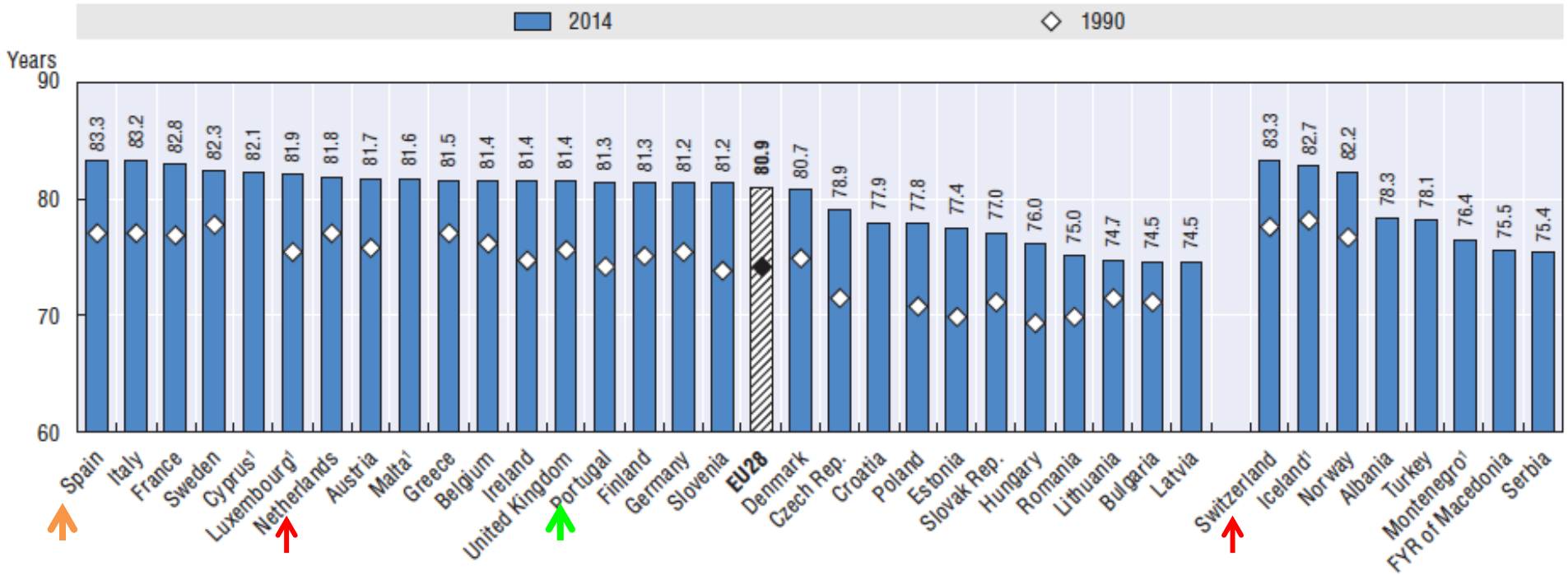
1. Includes medical non-durables.

Source: OECD Health Statistics 2016.

StatLink http://dx.doi.org/10.1787/888933429302

EUROPE

3.1. Life expectancy at birth, 1990 and 2014

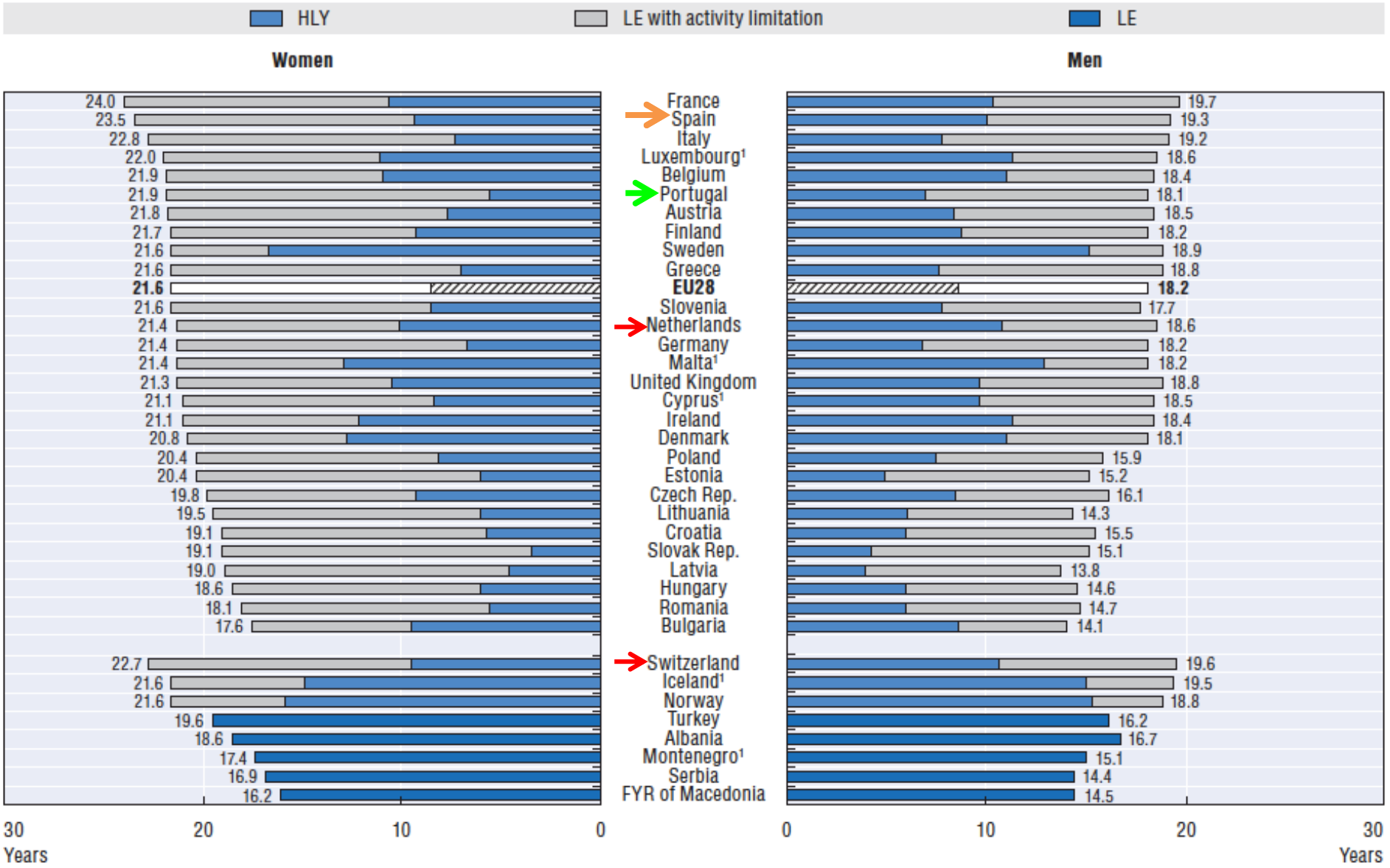


1. Three-year average (2012-14).

Source: *Eurostat Database* completed with data from *OECD Health Statistics 2016*.

EUROPE

3.3. Life expectancy (LE) and healthy life years (HLY) at 65, by gender, 2014



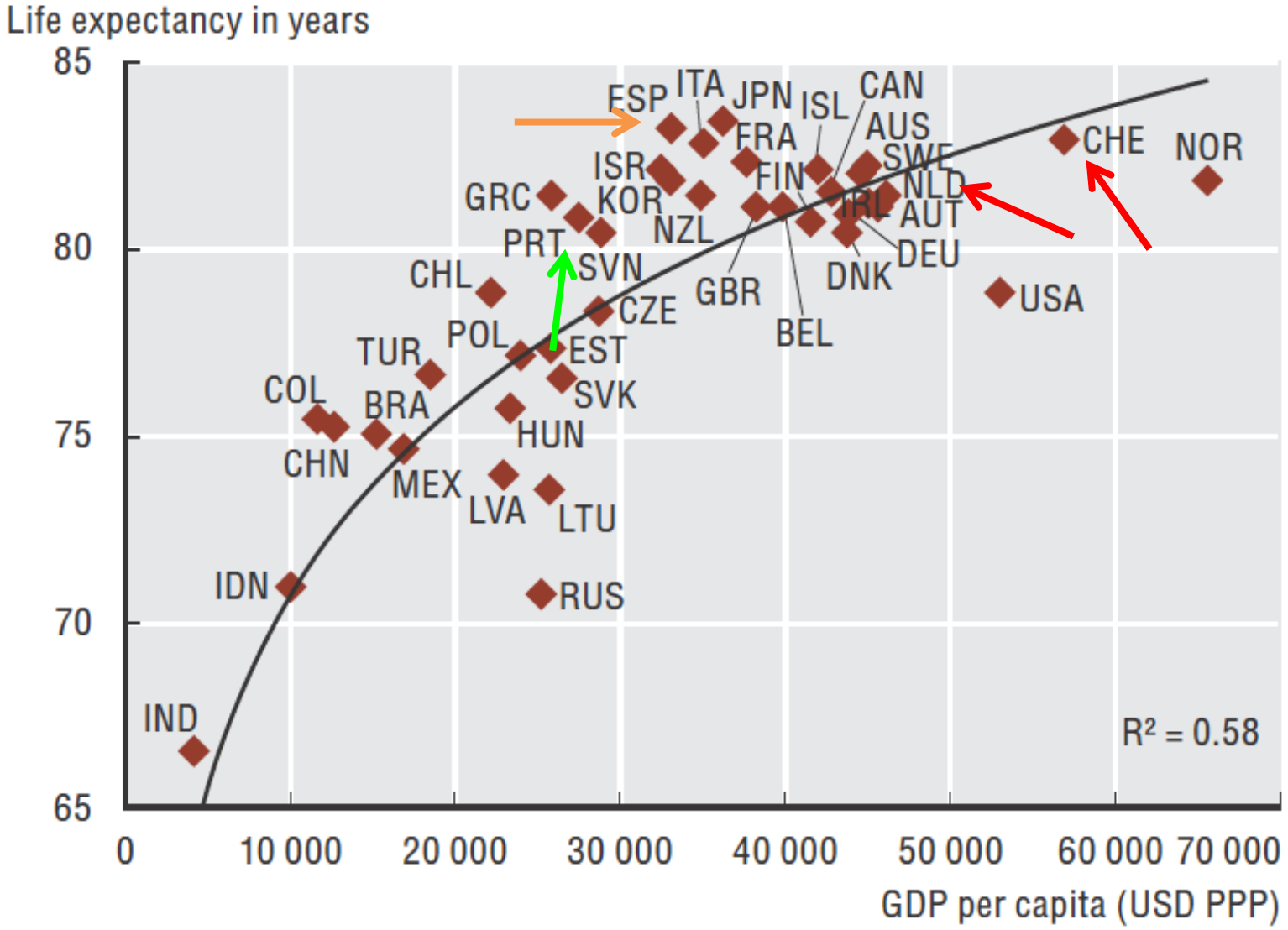
Note: Countries are ranked in descending order of life expectancy at 65 for women.

1. Three-year average (2012-14).

Source: Eurostat Database.

EUROPE

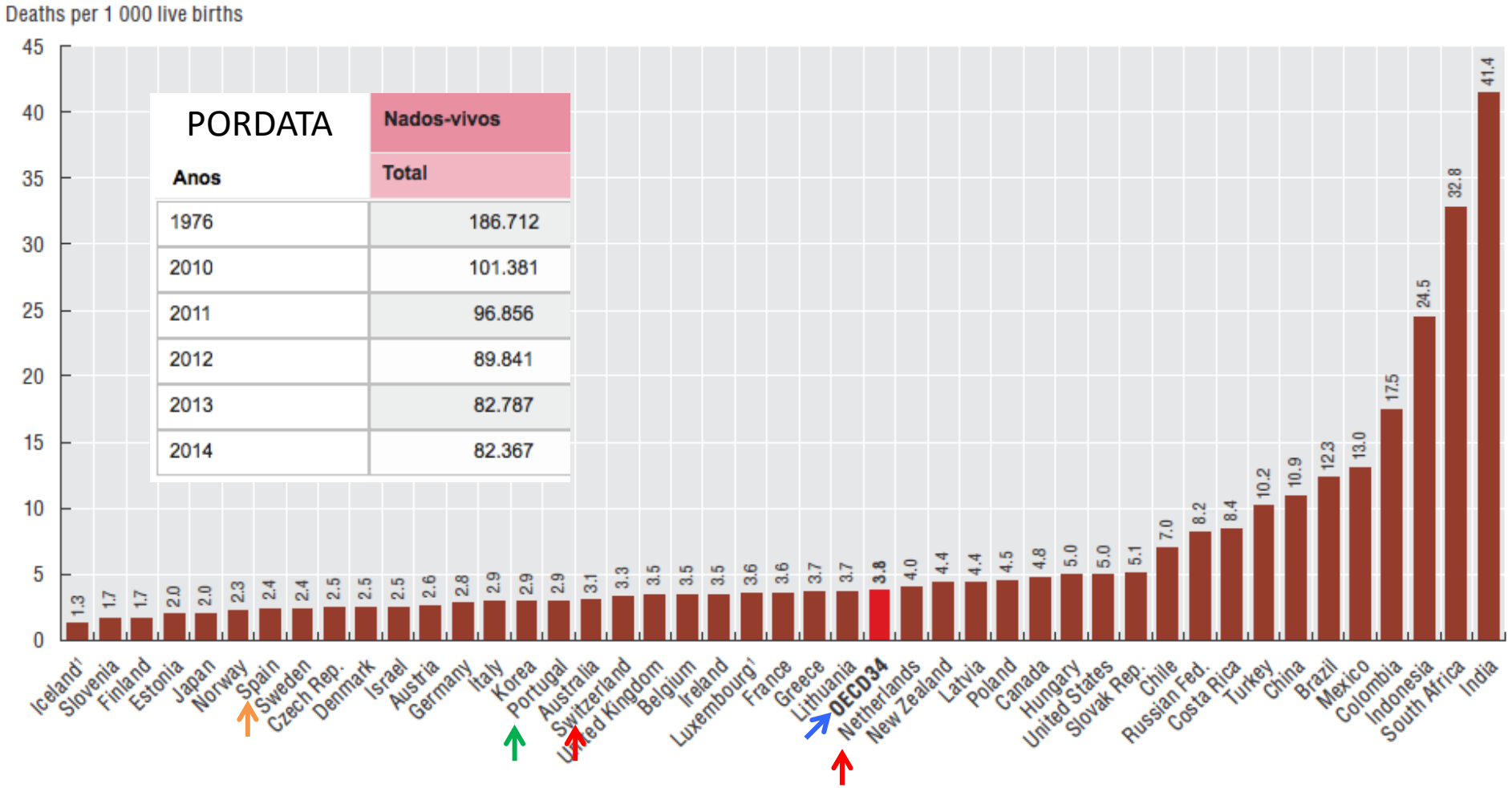
3.2. Life expectancy at birth and GDP per capita, 2013 (or latest year)



Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933280727

3.14. Infant mortality, 2013 (or nearest year)



PORDATA

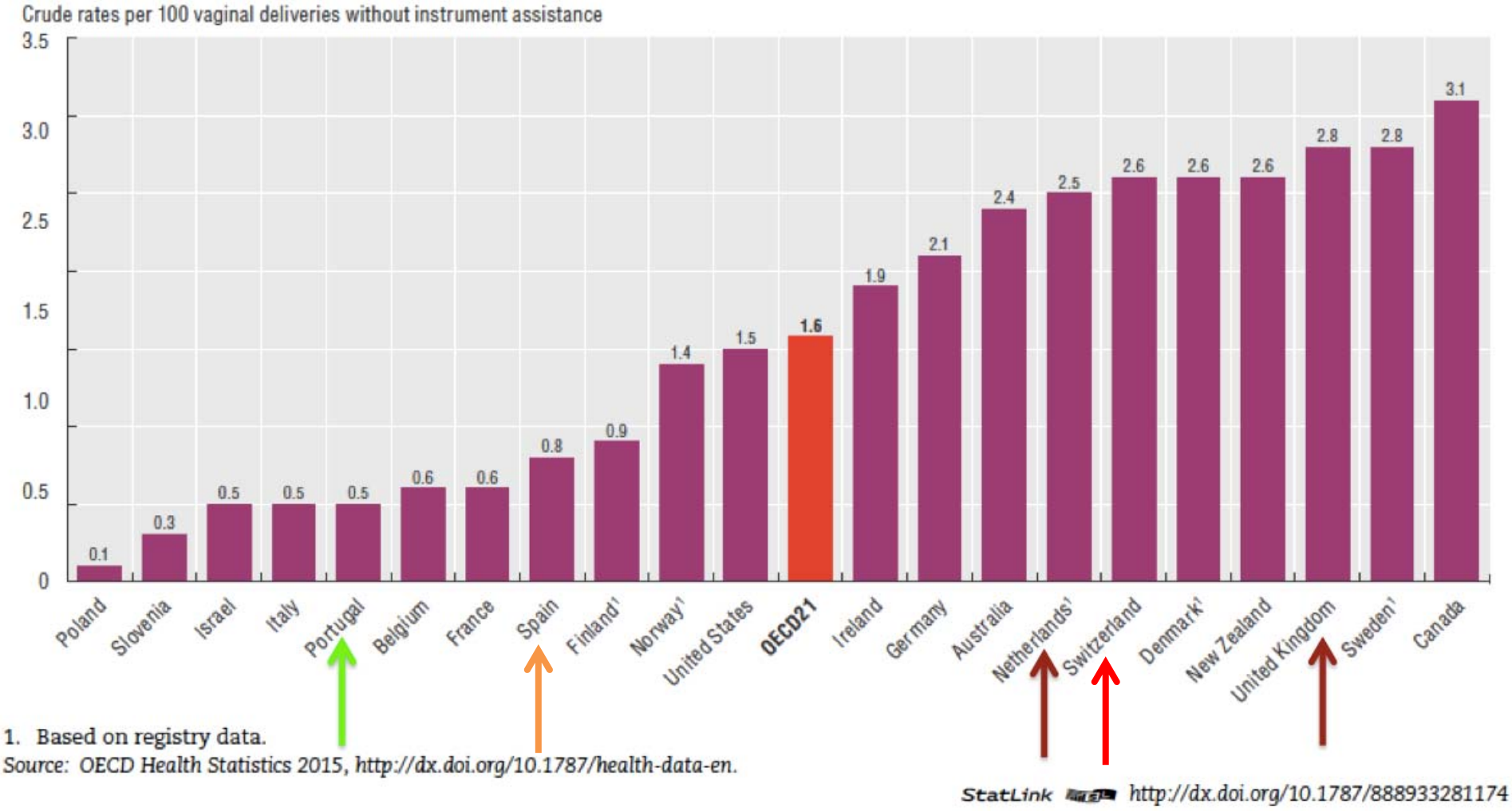
Anos	Nados-vivos Total
1976	186.712
2010	101.381
2011	96.856
2012	89.841
2013	82.787
2014	82.367

Note: The data for most countries are based on a minimum threshold of 22 weeks of gestation period (or 500 grams birthweight) to remove the impact of different registration practices of extremely premature babies across countries.

1. Three-year average (2011-13).

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

8.20. Obstetric trauma, vaginal delivery without instrument, 2013 (or nearest year)



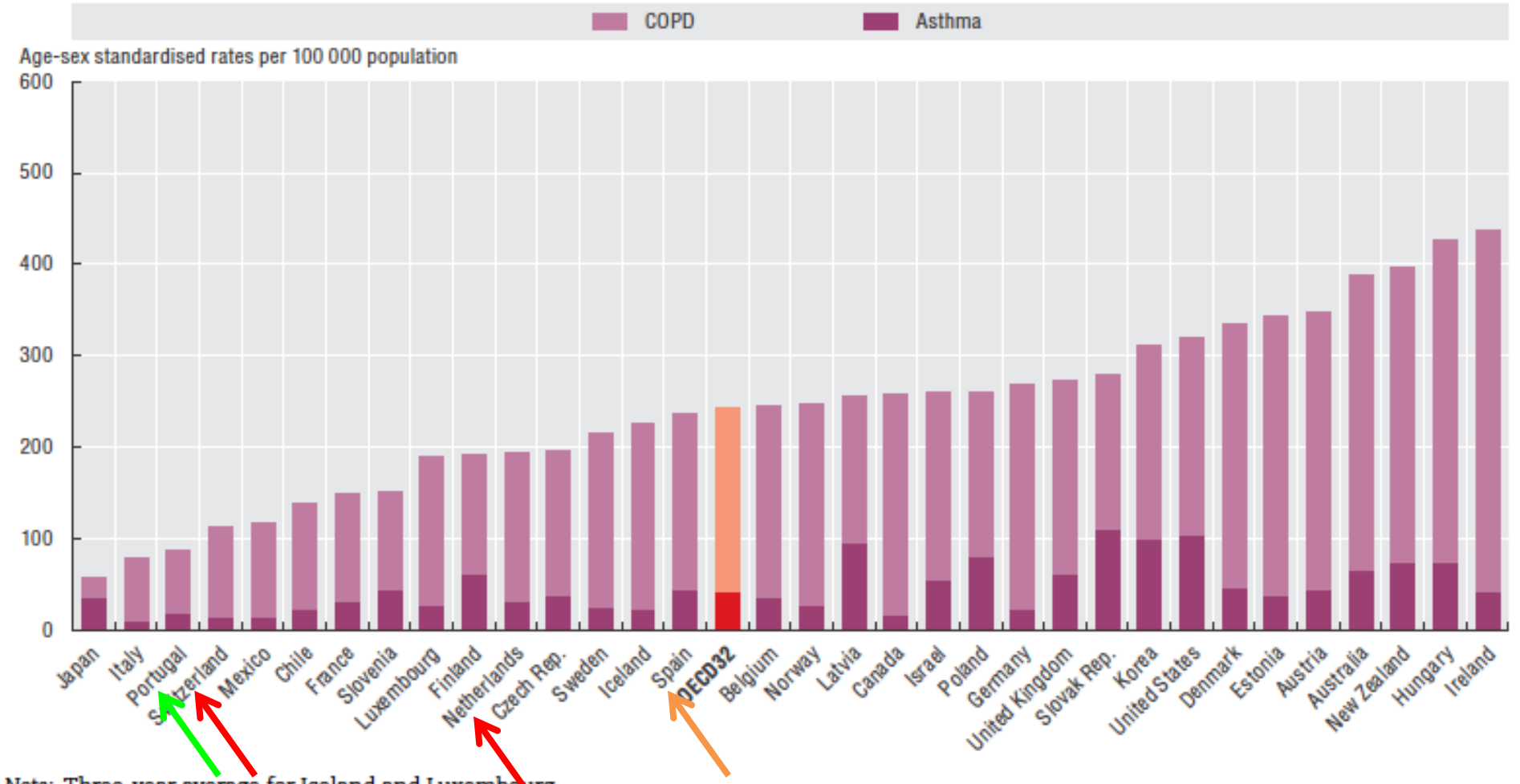
1. Based on registry data.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933281174

Tears that extend to the perineal muscles and bowel wall require surgery

8.1. Asthma and COPD hospital admission in adults, 2013 (or nearest year)

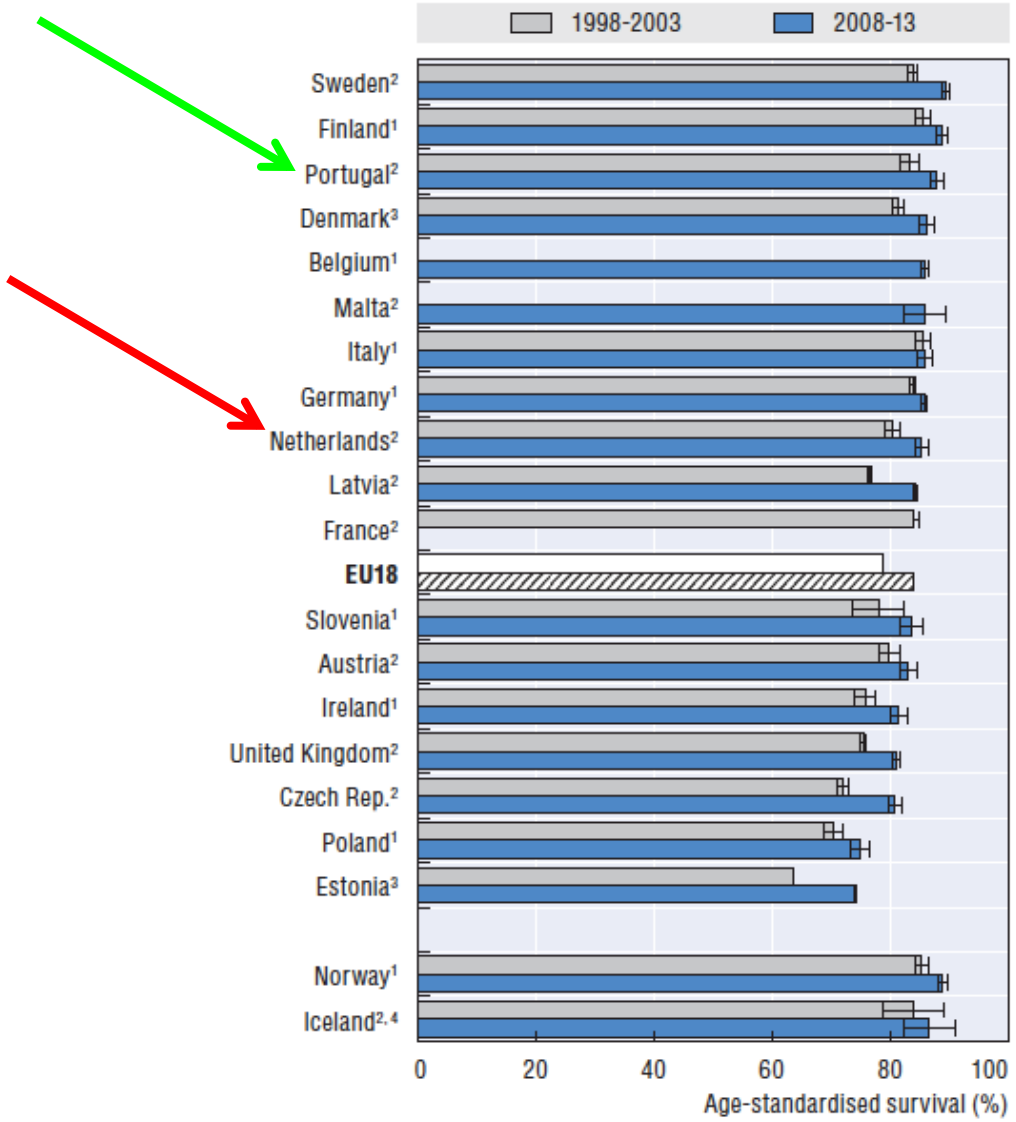


Note: Three-year average for Iceland and Luxembourg.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933281105

6.19. Breast cancer five-year relative survival, 1998-2003 and 2008-13 (or nearest periods)

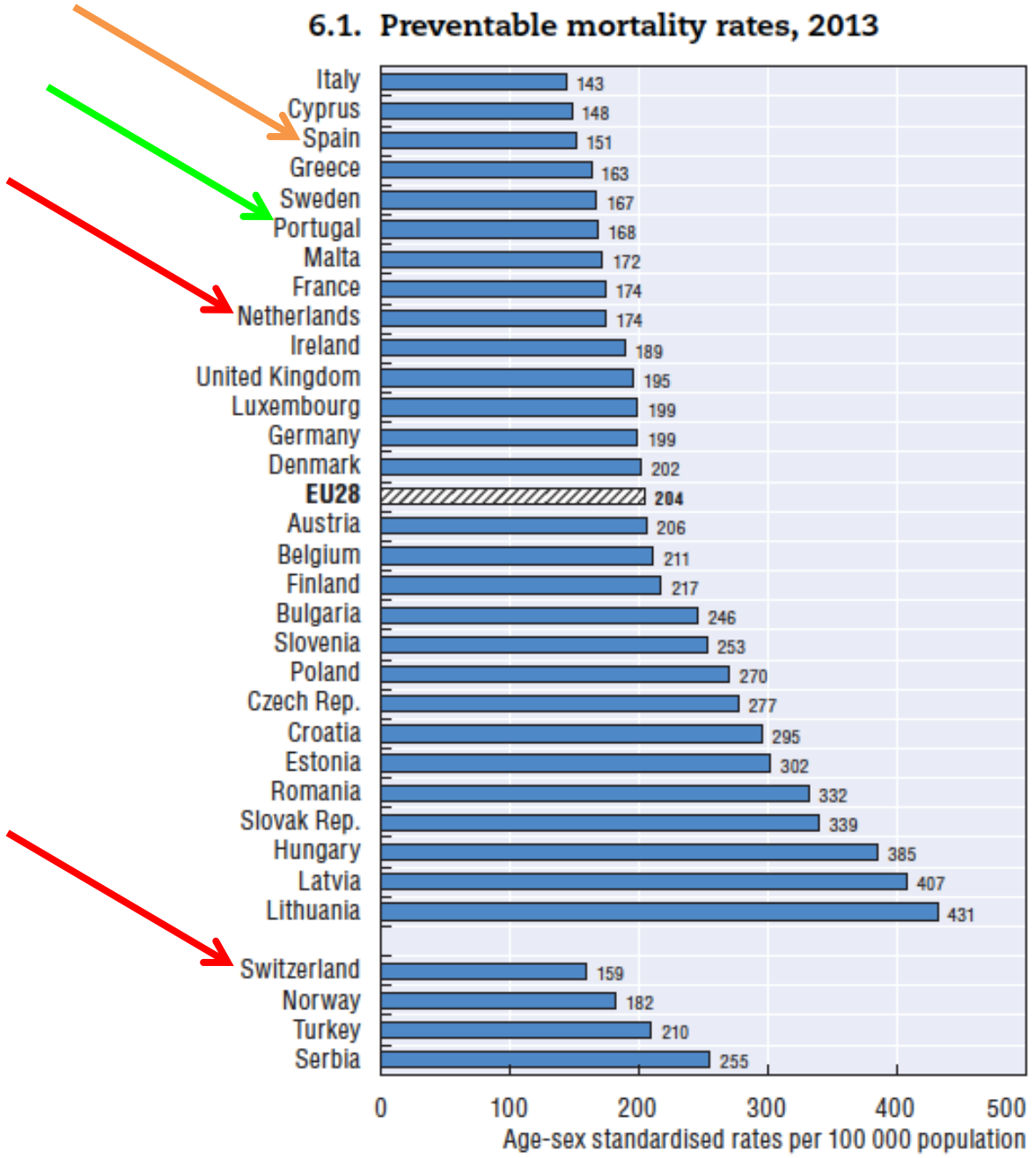


Note: 95% confidence intervals represented by H. EU average unweighted.

1. Period analysis. 2. Cohort analysis.
3. Different analysis methods used for different years.
4. Three-period average.

Source: OECD Health Statistics 2016.

StatLink http://dx.doi.org/10.1787/888933429543

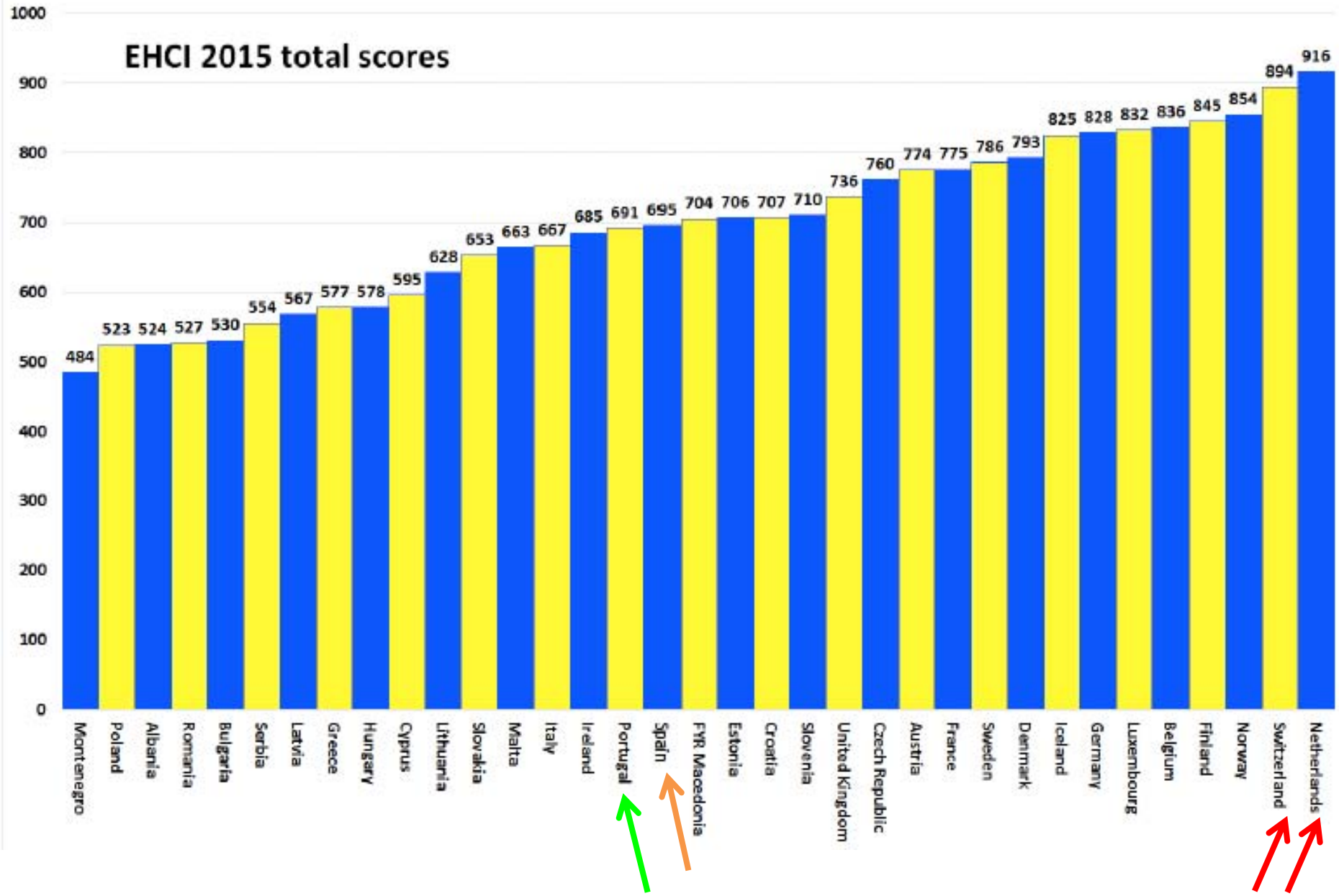


Source: Eurostat Database.

StatLink http://dx.doi.org/10.1787/888933429364

EUROPE

Health Consumer Powerhouse
Näsbydalsvägen 16, SE-183 37 Täby, Sweden, Phone +46 8 642 7140



ortugal has one of the best ublic ealth ervices in the world!

- niversal
- heap
- xtraordinary health indicators

BURNOUT

Falta de condições de trabalho e de recursos leva 66% dos médicos à exaustão

Os resultados do primeiro estudo de âmbito nacional sobre *burnout* na classe médica realizado em Portugal são reveladores: dois terços dos médicos sentem-se em exaustão emocional, um dos sinais mais relevantes da síndrome de *burnout*. Os profissionais das especialidades de neurocirurgia e medicina legal são dos mais afetados, bem como os médicos mais jovens.

Portugal, 2016

Diário de Notícias

14-11-2015

Hospitais sem capacidade para formar todos os novos médicos

Especialidade. Centros hospitalares de Santa Maria e São José não têm vagas para formar novos cirurgiões. No total, faltam 180 lugares

DIANA MENDES

Os hospitais públicos e os centros de saúde não têm capacidade para formar todos os novos médicos. Em 2016, as unidades vão perder vagas em várias especialidades, tal como os cuidados primários, que têm quase menos 50 do que no ano anterior. Como o número de candidatos é cada vez maior, e as unidades já têm dificuldades em acompanhar todos os seus internos, a Ordem dos Médicos (OM) admite que não foi possível abrir

No ano passado havia mais de 1600 vagas, mas havia menos candidatos. Neste ano, muitas das principais especialidades tiveram reduções. Desde logo a cirurgia geral, que perde duas vagas no país, mas cinco em dois dos maiores centros hospitalares – Lisboa Norte (Santa Maria e Pulido Valente) e Lisboa Central (que engloba São José ou Curry Cabral) –, e que perdeu três, de acordo com os mapas de vagas do ano passado e o atual.

Carlos Cortes, presidente da Secção Regional do Centro da Ordem dos Médicos, refere as inúmeras

PAULO SPRANGER/GLOBAL IMAGENS

Consultas com oito estudantes a observar doentes

ESTUDO As conclusões de um estudo promovido pela Associação Nacional de Estudantes de Medicina (ANEM), e avançado pelo DN na semana passada, revelam que os doentes que recorrem a hospitais afiliados de sete escolas médicas existentes no território continental (Lisboa, Porto, Coimbra, Braga e Covilhã) "podem encontrar, juntamente com o seu médico, em média, cerca de oito estudantes". A investigação alerta para o número de estudantes nos hospitais e a falta de tutores, que põem em risco a formação.

Pode a austeridade diminuir os custos com a saúde?

Norwegian School of Economics

Opinião
Armando José Garcia Pires

Público
23-08-2015

A saúde é um dos sectores que sofrem o que William Baumol (New York University) apelida de "doença dos custos", ver *The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't* (2012). Segundo Baumol, alguns sectores estão condenados a ficarem mais caros com o passar dos anos.

Baumol defende também que entregar a saúde aos privados pode ter efeitos opostos aos pretendidos. Como o exemplo dos EUA demonstra, os custos com a saúde em vez de diminuírem podem aumentar quando esta é dominada por privados. Quando a saúde está nas mãos dos privados, isto pode conduzir a um racionamento deixando os mais pobres com menos acesso aos serviços, ao mesmo tempo que pode fazer explodir os custos para aqueles com recursos. De facto, quem pode pagar estará sempre disposto a gastar o que for preciso com a sua saúde. O racionamento em períodos de guerra conduziu muitas vezes a estes dois efeitos díspares: os pobres nem para o pão tinham, os ricos gastavam fortunas para obter bens como o vinho. Deseja-se o mesmo no sector da saúde: intermináveis filas de espera para os mais necessitados, enquanto os privilegiados gastam fortunas em operações plásticas?

UM FUTURO PARA A SAÚDE
todos temos um papel a desempenhar

RELATÓRIO FINAL

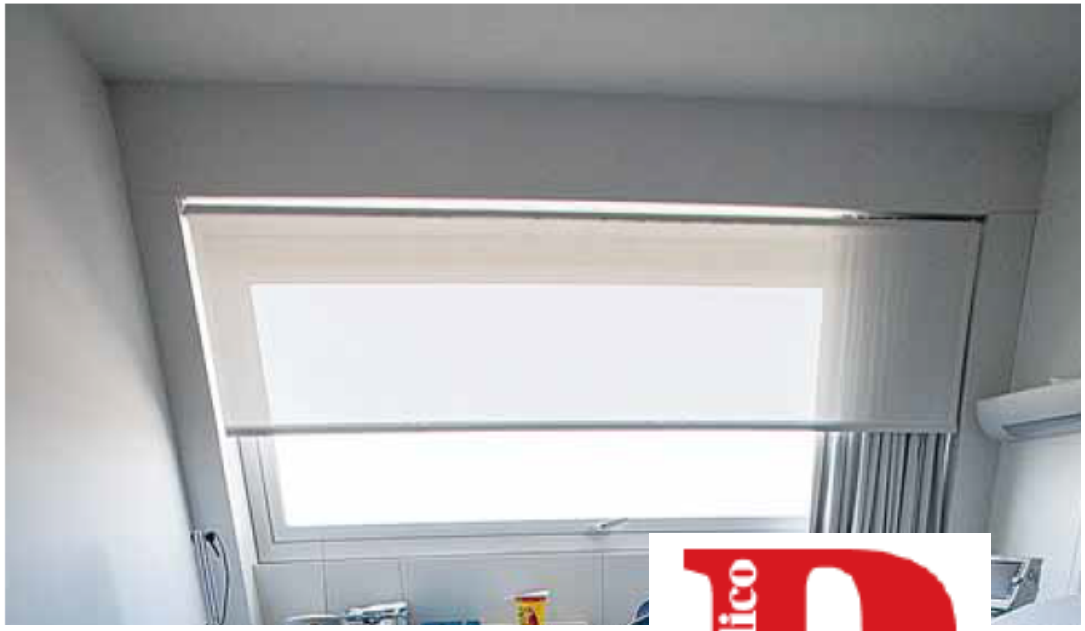
FUNDAÇÃO
CALOUSTE GULBENKIAN
INOVAR EM SAÚDE

OS CUSTOS DA QUALIDADE DEFICIENTE

A deficiente qualidade dos cuidados de saúde não é apenas má para os doentes, já que é também muito cara.

Facturação dos hospitais privados mais do que duplicou numa década

Estados europeus baixam gastos com saúde. Alerta vem de Itália: nível de qualidade não será garantido se despesa pública cair abaixo de 7% do PIB



Saúde

Alexandra Campos

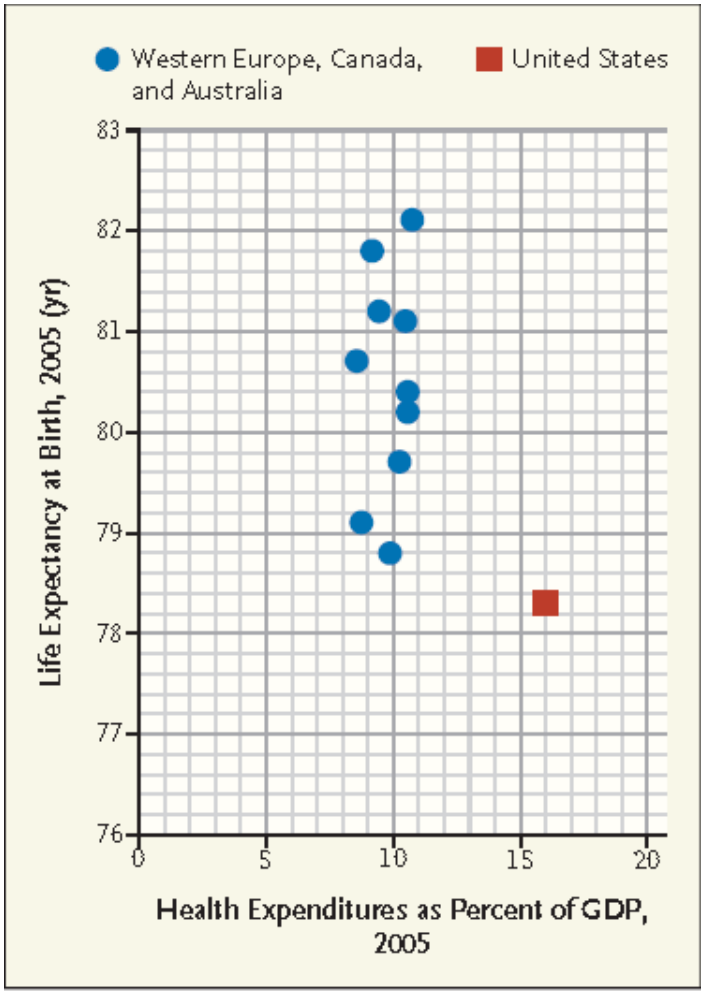
O volume de negócios do sector privado da saúde em Portugal cresceu mais do dobro em dez anos: em 2005 era de 750 milhões de euros, no ano passado chegou a 1750 milhões de euros, segundo dados da Associação Portuguesa de Hospitalização Privada.

saúde [nos últimos anos] são os ministros das Finanças", corroborou Hans Marter, representante do Centro Político Europeu, um grupo de reflexão independente, que acredita também que o desinvestimento na modernização representa um grande risco. Pelas suas contas, bastaria um crescimento da ordem dos 0,5% ao ano neste indicador para conter o peso do impacto demográfico (envelhecimen-

Público

28-09-2015

The $640 Billion Question — Why Does Cost-Effective Care Diffuse So Slowly?



Health Care Expenditures and Life Expectancy in the United States and Ten Other Developed Countries, 2005.

To avoid financial crises in federal and state governments and turmoil for health care stakeholders, U.S. health care must become more cost-effective

- **physicians are the most influential element in health care.**
- **The public's trust in them makes physicians the only plausible catalyst of policies to accelerate diffusion of cost-effective care.**

Physicians who practice most cost-effectively typically standardize their approaches to care, rely on group decision making, and emphasize outcome measurement and peer review.

Victor R. Fuchs, Arnold Milstein. NEJM, May 18, 2011

OPEN ACCESS Freely available online PLoS MEDICINE

Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review

Sanjay Basu[1,2,3]*, Jason Andrews[4], Sandeep Kishore[5], Rajesh Panjabi[6], David Stuckler[3,7]

1 Department of Medicine, University of California, San Francisco, California, United States of America, **2** Division of General Internal Medicine, San Francisco General Hospital, San Francisco, California, United States of America, **3** Department of Public Health and Policy, London School of Hygiene & Tropical Medicine, London, United Kingdom, **4** Division of Infectious Diseases, Massachusetts General Hospital, Boston, Massachusetts, United States of America, **5** Tri-Institutional MD-PhD Program, Weill Cornell Medical College/Rockefeller University/Sloan-Kettering Institute, New York, New York, United States of America, **6** Division of Global Health Equity, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts, United States of America, **7** Department of Sociology, Cambridge University, Cambridge, United Kingdom

Conclusions: Studies evaluated in this systematic review do not support the claim that the private sector is usually more efficient, accountable, or medically effective than the public sector; however, the public sector appears frequently to lack timeliness and hospitality towards patients.

BMJ

NEWS

Private healthcare market may be anti-competitive with poor returns for patients

Nigel Hawkes

London

The Office of Fair Trading (OFT) has referred the private healthcare market to the Competition Commission, saying that it is not working properly for consumers. It warned last December that it intended to make the referral and the results of a public consultation since then have not changed its mind.

The OFT is critical of a lack of the information needed by consumers to make informed decisions and says that local monopolies and the ability of existing providers to make it difficult for new entrants to the market distort competition. As a result patients might pay higher prices than they need to or get poorer quality care.

The decision was also welcomed by the health insurers BUPA. Natalie-Jane Macdonald, managing director of BUPA health and wellbeing, said: "The cost of private healthcare has been rising to unsustainable levels in large part because of a lack of competition and efficiency in the private hospital market and among consultants in private practice. We are pleased that the Competition Commission will now be investigating this and we will be engaging with them on behalf of our members."

The OFT study says that costs and quality of care are hard for patients and insurers to assess, and that patients cannot easily calculate any shortfall they will have to pay when an insurer's

ERS

MAIO DE 2016

ESTUDO DE AVALIAÇÃO DAS PARCERIAS PÚBLICO-PRIVADAS NA SAÚDE

Por seu turno, não se encontrou evidência de que a gestão hospitalar em regime de PPP poderá levar a uma maior ou menor eficiência relativa na comparação com outros hospitais, na medida em que não foi possível identificar diferenças estatisticamente significativas entre os resultados dos dois tipos de hospitais.

thebmj

BMJ 2015;350:h2184 doi: 10.1136/bmj.h2184 (Published 24 April 2015)

RESEARCH NEWS

Alternative providers of GP services perform worse than traditional practices

Zosia Kmietowicz

The BMJ

Researchers have warned that the quality of care in the NHS in England may suffer from the influx of private and voluntary sector providers, after finding that the performance of alternative providers of GP services was worse than that of traditional practices on a range of indicators.

alternative provider practices may have had a history of poor performance and that the number of practices switching to alternative provider status may have been too small for the effect of change to be detected. They concluded that their findings "provide little support for the hypothesis that increasing plurality

Proliferation of private online healthcare companies

Should the NHS try to keep up?

Jessica Watson *academic clinical fellow*[1], Chris Salisbury *professor in primary health care*[1], Helen Atherton *assistant professor*[2], John Campbell *professor of general practice and primary care*[3], Brian McKinstry *professor of primary care e-health*[4], Sue Ziebland *professor of medical sociology*[5]

With an app for just about everything, why not one for contacting your doctor? In the United Kingdom, private companies offering primary healthcare are proliferating, with Dr Morton, a website offering email or telephone consultations, and Dr Now, a smartphone app offering video consultations. Companies in the United States are offering an Uber-type experience, where instead of a car, a doctor appears at your door.[1]

While NHS GPs try to reduce antibiotic prescribing, websites such as Dr Morton's offer travel packs containing clarithromycin for self diagnosed chest infection, trimethoprim for urinary tract infection, and ciprofloxacin for travellers' diarrhoea, with further "add on" antibiotics for additional fees

BMJ 2016;352:i1076 doi: 10.1136/bmj.i1076 (Published 23 February 2016)

Managed Competition for Medicare? Sobering Lessons from the Netherlands

Kieke G.H. Okma, Ph.D., Theodore R. Marmor, Ph.D., and Jonathan Oberlander, Ph.D.

Discussions about U.S. health care reform are often parochial, with scant attention paid to other countries' experiences. It is thus surprising that in the ongoing debate over Medicare, some U.S. commentators have turned to the Netherlands as a model of regulated competition among private insurance companies.[1] The Dutch experience is particularly relevant given the proposal by Congr Ryan (R-WI) to el tional Medicare and vide beneficiaries v to purchase priva (The Republican m

Four key points emerge from the Dutch experience. First, competition has not sharply slowed the rate of growth in health care spending. Health care expenditures continue to outpace general inflation, having increased at an average annual rate of 5% since 2006.

Second, some Dutch people remain uninsured, and there has been a substantial increase in the number of insured persons failing to pay their insurance premiums.

N ENGL J MED 365;4 NEJM.ORG JULY 28, 2011

The New England Journal of Medicine

Third, the expansion of consumer choice has not worked as envisioned.

Fourth, notwithstanding the rhetoric of competition, the Netherlands still relies heavily on regulation. Indeed, the Dutch case shows that competitive systems that seek to escape supposedly centralized, bureaucratic control of medical care paradoxically require sophisticated regulation and government intervention in order to work.

Perennial Health Care Reform — The Long Dutch Quest for Cost Control and Quality Improvement

Ewout van Ginneken, Ph.D.

N ENGL J MED 373;10 NEJM.ORG SEPTEMBER 3, 2015

Almost 10 years in, the reforms have not led to the desired cost containment or a leap in quality.

Consumer organizations have welcomed increased choice, but individuals increasingly worry about cost-related access problems.[2]

The system remains costly as compared with those of other countries in the Organization for Economic Cooperation and Development (OECD)

The New England Journal of Medicine

Perspective

JANUARY 7, 2016

INTERNATIONAL HEALTH CARE SYSTEMS

Innovation and Change in the Chilean Health System

Thomas J. Bossert, Ph.D., and Thomas Leisewitz, M.D., M.P.H.

Chile has often been a regional health system innovator. One of the first Latin American countries to adopt a Bismarckian social security system that provides white-collar workers with health insurance

e vouchers to cover private care. The

workers to opt out of the social security system and use the legally mandated 7% of wages to purchase private health insurance, creating a two-tiered system in which private insurance, at its peak, covered 26% of the population. Private insurance companies

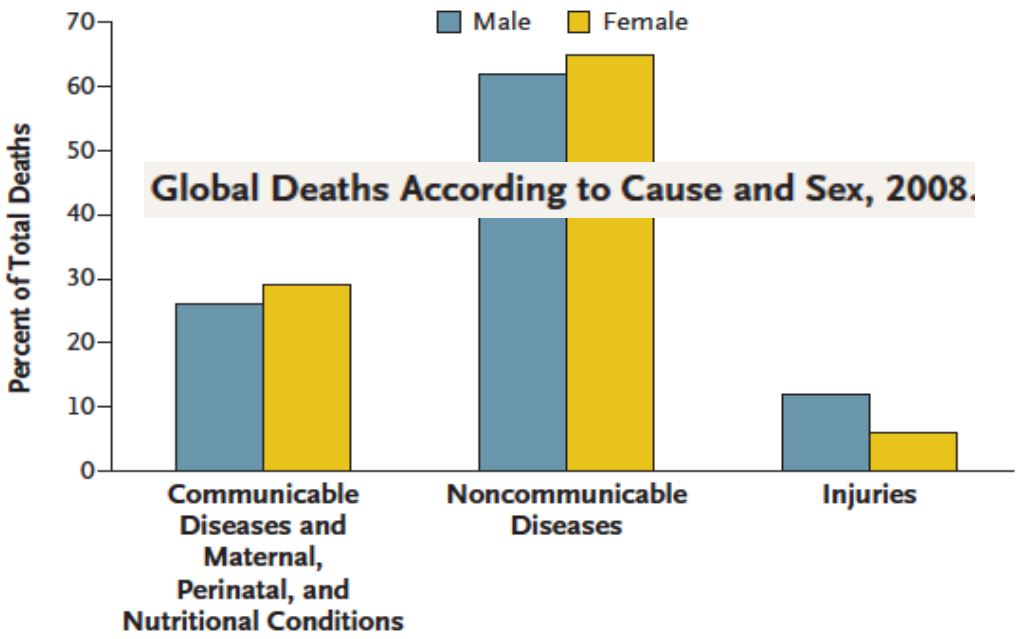
In addition to facing common epidemiologic changes, Chile is contending with substantial inequality between high-income participants in the private system and the large majority covered by social insurance and tax-funded public health services.

With courts and both public and private sectors acknowledging the need for reform, presidential advisory commissions have been convened to develop a consensus plan.

The most recent commission recommended returning to a single-payer public insurance system

PREVENÇÃO

Noncommunicable Diseases



Program for the prevention and control of noncommunicable diseases must integrate:

1- policies designed to foster a societal environment in which people are encouraged to make and maintain healthy living choices,

2- promote health literacy so that people can protect and improve their health,

3- provide health services focused on early detection and cost-effective management of noncommunicable diseases and their risk factors

Population-based interventions should include:

1- increase taxation of tobacco and alcohol,

2- reduce salt and saturated fat,

3- eliminate trans fats in processed foods,

4- create smoke-free spaces

5- promote exercise

6- reduce consumption of sugared beverages.

Hunter D, Reddy K. N Engl J Med 2013;369:1336-43

"Legislation that would regulate advertising to children, prohibit snack food and soft drink sales in schools, and tax fast foods and other unhealthy items."
Editorial. Lancet, 2002; 359: 1955

"Even modest steps such as limiting advertising of unhealthy food during children's television programming or placing small taxes on unhealthy foods are met with seemingly insurmountable resistance from the food industry and others."
JAMA, 2006; 295: 94-5

A alimentação, o álcool, o tabaco, o automóvel, as farmacêuticas e a indústria das armas são agora as principais fontes de danos para a saúde pública. BMJ 2014; 349: g7516

IMPOSTO DA SAÚDE sobre o REFRIGERANTES: 20%!

V ENCONTRO DE TELEMEDICINA

CONIMBRIGA, 30 SETEMBRO 2016

TELE-SAÚDE: VETOR ESTRATÉGICO DO SNS

ACESSIBILIDADE, QUALIDADE DOS CUIDADOS E SUSTENTABILIDADE

PROGRAMA

09h00 **Abertura do Secretariado**

09h30 **Início Trabalhos**
Eduardo Castela - Presidente da APT
Nuno Moita – Presidente da Câmara Municipal de Condeixa
Virgílio Correia - Director do Museu de Conímbriga

09h45 **Sessão de Abertura**
Fernando Araujo – Secretário de Estado Adjunto e da Saúde
Gabriel Silva – Reitor da Universidade de Coimbra
Martins Nunes – Presidente do Conselho de Administração do CHUC

10h15 **Deontologia e qualidade da prestação de cuidados em Tele-Saúde**
José Manuel Silva, Bastonário Ordem dos Médicos

BMJ 2015;351:h4333 doi: 10.1136/bmj.h4333 (Published 10 August 2015)

Tackling social factors is key in reducing cardiovascular disease, say US heart doctors

NEWS

Michael McCarthy

Dealing with the social determinants of health offers the greatest opportunities for reducing death and disability from cardiovascular disease (CVD) in the United States, says a policy statement by the American Heart Association released on 3 August.[1]

After three decades of decline the prevalence of CVD in the US is expected to rise by 10% from 2010 to 2030, partly driven by an ageing population but also by rising rates of obesity, hypertension, and physical inactivity, the statement said.

It concluded that, in addition to modifiable and non-modifiable physiological, lifestyle, and genetic risk factors, efforts to prevent CVD must incorporate a "third arm of risk"—the social determinants of health. "Failure to demonstrate awareness of this third dynamic will result in a growing burden of CVD, especially in those with the least means to engage in the healthcare system," the statement warned.

Manter actual equilíbrio entre:

- Características constitucionais do SNS
- Pequeno sector privado independente
- Grande sector privado

Preservando:

- Elevados padrões de Qualidade
- Cuidados de proximidade
- Baixo custo per capita
- Competitividade
- Solidariedade Social
- Humanização

Continuar a caminhar no sentido do:

- Emagrecimento violento do SNS
- Liquidação do pequeno sector privado
- Grandes oligopólios privados

Implicando:

- Perda global de Qualidade
- Saúde a duas velocidades
- Aumento dos custos em Saúde
- Proletarização dos profissionais de saúde
- Cartelização
- Indicadores quantitativos

EDITORIALS

The political determinants of health—10 years on

Public health professionals need to become more politically astute to achieve their goals

Ilona Kickbusch *director*

Global Health Programme, Graduate Institute for International and Development Studies, Geneva, Switzerland

Health is a political choice, and politics is a continuous struggle for power among competing interests. Looking at health through the lens of political determinants means analysing how different power constellations, institutions, processes, interests, and ideological positions affect health within different political systems and cultures and at different levels of governance. Bambra et al provide three arguments why health is political[1]: health is unevenly distributed, many health determinants are dependent on political action, and health is a critical dimension of human rights and citizenship.

Complex relations

"Lack of political will" is often cited as the main reason for failing to deal with factors affecting health. Sometimes it is difficult to discern any difference between advocacy and analysis; indeed, many a public health researcher has turned advocate when confronted by evidence of unacceptable health inequalities. Yet Mackenbach has rightly warned of "romantic illusions" in the face of messy problems.[7] Instead he highlights that public health professionals need a much better understanding of how politics work and what politics can

Debate Sector público e privado

José Manuel Silva

O melhor Serviço Nacional de Saúde do mundo

ENRIC VIVES-RUBIO

Considerando a relação Qualidade (excelentes indicadores)/Acessibilidade (universal)/Custo per Capita (baixo)

Surpreendem alguns artigos sobre saúde, como o que Rui de Albuquerque publicou neste jornal, com números completamente falsos – no caso, que Portugal gasta 10 por cento do PIB para financiar o Serviço Nacional de Saúde (SNS).

Consultando o rico e elucidativo documento *Health at a Glance 2015. OECD Indicators*, verificamos que Portugal, somando a despesa pública [illegible] 9,1 por cento do [illegible] 8,9 por cento no[illegible] apenas cerca de [illegible] respeito a despes[illegible] o SNS, contra 6,5[illegible] OCDE.

Nesse artigo é t[illegible] comparação com [illegible] sistema privado, [illegible] segundo mais caro do mundo!

O mesmo autor diz que a despesa da Saúde em Portugal é elevadíssima, criticando os 10 (!) por cento de despesa. Porém, contraditoriamente, já elogia o sistema suíço, apesar de este gastar 11,1 por cento do PIB em Saúde, constituindo a despesa pública quase 8 por cento.

Na verdade, se compararmos a despesa total *per capita* pública e privada, a diferença é gritante: a Suíça gasta 6325 dólares por pessoa, por ano; e Portugal somente 2514 dólares (a média da OCDE é de 3453). Há várias razões para esta diferença, nomeadamente os vencimentos; mas este dado, quando comparado com a média da OCDE, demonstra como Portugal tem um sistema de Saúde muito barato e, sobretudo, barato para o Estado, o qual em Portugal apenas assume 67 por cento das despesas totais com a saúde – abaixo dos 73 por cento da média da OCDE.

Por outro lado, a Suíça gasta 22 por cento do Orçamento do Estado em Saúde, enquanto Portugal gasta 12 por cento. Seria, aliás, impossível para Portugal sustentar um sistema tão despesista como o suíço!

[illegible] de regulação não funcionam.

Analisando a razão custo/benefício de ambos os sistemas, na análise da relação entre a esperança de vida à nascença e o PIB *per capita*, Portugal está francamente acima da curva, enquanto a Suíça está abaixo da curva. Ou seja, em termos relativos, Portugal consegue uma melhor eficiência do seu sistema de Saúde.

> **Não há nenhuma evidência científica de que, em Saúde, a gestão privada seja melhor do que a pública**

Também na mortalidade infantil, um dos principais indicadores de saúde, Portugal está melhor, com uma mortalidade de 2,9/1000/ano, enquanto a Suíça tem 3,3/1000 (média da OCDE 3,8). Na [illegible] e o tentam destruir fazem-no não pela falta de sustentabilidade do mesmo, mas sim pela ambição de aumentar a fatia da privatização de serviços e a margem de lucro à custa do aumento da despesa em saúde para os cidadãos com mais poder de compra. E, com isso, agravam as desigualdades de acesso e pioram os cuidados para os mais pobres, com uma perda global de qualidade.

Pela minha parte, enquanto médico, defendo um sistema de Saúde composto por quatro componentes: público; social; grande privado; e pequeno privado. Ora, foi o equilíbrio deste sistema que foi ativa e deliberadamente destruído pelo anterior Governo. O pequeno sector privado, independente e de proximidade, quase desapareceu e não é possível continuar a reduzir artificial e violentamente o SNS mais do que aquilo que já foi feito, pelas consequências negativas que teria para o país e para os cidadãos.

Sublinhe-se que, conforme está publicado, não há nenhuma evidência científica de que, em Saúde, a gestão privada seja melhor do que a pública. Basta recordar o descalabro da banca privada portuguesa para se perceber esta verdade! Bem pelo contrário,

Público

24-11-2015

The McDonaldization of Medicine

E. Ray Dorsey, MD, MBA [1]; George Ritzer, PhD, MBA [2]

JAMA Neurol. Published online November 16, 2015. doi:10.1001/jamaneurol.2015.3449.

[+]A

As
soc
pre
val

ectors of American
ficiency, calculability,
herished and defining

Mc
irra
lon
phy
ine

od thing," [1]
pularity often leads to
to reduce the time
tive, the visit may be

Table. Dimensions of McDonaldization of Medicine

Dimension	Description	Example	
		Fast Food	Medicine
Efficiency	Choosing the optimal means to achieve a given end	Drive-through window, limited menu, self-ordering register, finger foods, customers clear their table	Minute clinics, broader use of medical assistants, robotic surgery, brief visits with physicians, patients complete questionnaires
Calculability	Calculating, counting, and quantifying means and ends, with quantity serving as a surrogate for quality	Big Mac, supersize options, No. of hamburgers sold, precise measurement of hamburger size (9.843 cm)	"Big Med," medical school rankings, RVUs to measure productivity, *ICD-10*, length of stay, 30-d readmission rates
Predictability	Services and products being very similar from one time and place to another time and place	Extensive use of logos, standardized appearance of stores, use of frozen products, assembly-line food production, scripted interaction with customers	Extensive use of logos, standardized order sets, checklists and templates, clinical pathways, scripted histories and physicals
Control	Increased control of humans through use of nonhuman technology	Factory farms of chicken and cattle, hormone-treated animals, precut and preprepared food, automated soft-drink dispenser, uncomfortable chairs	Billing codes, electronic medical record, debt burden, formularies, utilization review

The struggle against the McDonaldization of medicine will be both increasingly necessary and ennobling

BMJ 2014;349:g7516 doi: 10.1136/bmj.g7516 (Published 15 December 2014)

EDITORIALS

CHRISTMAS 2014: EDITORIALS

How 21st century capitalism is failing us

It requires a thoroughgoing democratic transformation

Richard Wilkinson *emeritus professor of social epidemiology*[1], Kate Pickett *professor of epidemiology*[2]

[1]University of Nottingham, Nottingham, UK; [2]University of York, York, UK

If we wanted evidence that the antisocial behaviour of big corporations is a large political problem, their record on tax evasion provides it.

Perhaps then our salvation lies in a thoroughgoing democratic transformation of capitalism.