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Perspective

All in a Day's Work — Equity vs. Equality at a Public ICU in Brazil

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"Of all forms of inequality, injustice in health care is the most shocking and most inhumane."
— Martin Luther King, Jr.

We begin another day at 7:00 a.m., and once again we need to decide who will get an intensive care unit (ICU) bed after an elective surgical procedure. A 55-year-old grandmother with colon cancer? An elderly man with liver metastases? A young woman suffering from pain who needs an arthrodesis to keep working so she can continue to feed her family? Should we choose or deny patients because they have cancer? Should we choose on the basis of age? On patients' previous quality of life? Or on social impact, if, for instance, one patient has four children to raise? Should we give the bed to a patient whom we've already had to refuse once? Or should we perhaps just stop playing God and give it to whoever asked first?

Every day, all around the world, intensivists face such cruel choices. And deciding which patients will have elective surgery is not even our most hideous task; emergency admissions are far worse. Death is probably not imminent for a patient who is denied the chance to have a tumor removed, but some patients will die without immediate intensive care to sustain their lives.

Poverty is shocking, but social inequality may be even worse. Social inequality is the hallmark of middle-income countries, which usually have two distinct health care systems, one public and one private. How can we advocate for equality in health care, treating all patients the same, if not everyone is starting from the same place? Recently, the Brazilian Federal Council of Medicine reported that people covered only by the public system have access to 9.9 ICU beds per 100,000 population, while those with private health insurance can count on 41.4 beds per 100,000 population.[1] The access disparity is even more striking in Brazil's poorest states.

Nor are the problems facing intensivists limited to the number of ICU beds. The Brazilian health care system is one step away from the abyss because of our political and economic crises. In 2012, Brazil had the world's sixth-largest gross domestic product (GDP); not only is it now ranked ninth, but the per capita GDP ranked 80th in the world in 2014.[2] Moreover, Brazil ranks 75th on the Human Development Index (HDI, a measure encompassing such variables as duration of healthy life and standard of living) — and rates even lower after adjustment for the level of inequality within the country.[3] The economic crisis has led to increased unemployment that has affected the private health care system. More than 1.8 million people have lost their health coverage in the past 18 months,[4] increasing the burden on a public health care system that was already on the verge of crashing.

The crises have meant severe budget reductions for public hospitals, including tertiary and quaternary care units, which are usually based in university hospitals. Beyond the usual shortage of ICU beds and staffing, we now face shortages of medications, laboratory tests, equipment, and disposables. Such shortages are no longer a problem only in our poorest settings. One of the primary principles of our Unified Health System (SUS), equity, is heavily compromised by resource constraints. Even in one of the largest university hospitals in the richest city in South America, we face these realities every day.

On one recent day, I was asked to approve an extracorporeal membrane oxygenation (ECMO) procedure, which is not a typical procedure for our unit. The patient was a 32-year-old woman with refractory respiratory failure from community-acquired pneumonia; should we place her on ECMO?

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She fulfilled the clinical criteria; the literature offers evidence of the procedure's benefits. Should she not receive treatment that could save her life and that she would certainly receive at any of the best private hospitals in Brazil? Why should her social status influence her right to receive adequate treatment? Shouldn't public referral hospitals in Brazil be able to provide ECMO?

But putting a patient on ECMO costs at least $6,000, which would buy 1250 doses of meropenem. Essentially, we must weigh one patient's right to life against the right of many others to receive the basic care they need. The ethical dilemma is clear: Should we prioritize individual needs over group needs?

If equality is the principle that guides us, this woman has the same right to care as everyone else. But resources are always limited, even in rich countries. Why should we give her ECMO? Is it because in our minds, her death will immediately and clearly result from our denying her treatment, whereas the relationship between not administering proper antibiotics and death is more indirect or less obvious? Our National Commission for Technological Incorporation (CONITEC), which is responsible for incorporating new technologies into the public health system, denied inclusion of ECMO in 2015 — a decision undoubtedly driven by cost concerns. CONITEC is probably right: ECMO is an expensive therapy that would save a few patients' lives, and its use should be restricted to referral institutions.

If CONITEC approved ECMO, its use would no longer be restricted because we have an additional concern: health care litigation. If a new technology or drug is incorporated into the public system, will its use always be based on decisions made by highly qualified physicians at referral institutions, or will they be left to judges who receive demands from patients and families? Throughout Brazil, people are turning to the courts to obtain better health care, usually to gain access to an ICU bed or expensive treatments.[5]

Health care litigation may impose a severe and unsustainable burden on city and state budgets. What seems fair in terms of health may clash with the SUS's principle of equity. Judges usually base their decisions only on the law. According to the Brazilian constitution, the right to health is granted to all citizens and is a duty of the state. Judicialization could help ensure the delivery of universal, high-quality health care, but it has been misused as a tool to expand inequities. In terms of the law, if the family of a 90-year-old patient with Alzheimer's disease wins a lawsuit, it doesn't matter if a young father is waiting for an ICU bed. Because of the rise of health care litigation, clinical priorities are no longer paramount. In some Brazilian states, the lack of ICU beds is leading to daily lawsuits as people try to ensure their own or their relatives' admission to an ICU. Intensivists are being threatened with imprisonment for noncompliance with judges' decisions even if no ICU beds are available. Such litigation has resulted in an inversion of duties: it should be the government's responsibility, not that of physicians, to ensure that each person who needs an ICU bed gets one.

We clearly face a moral dilemma: Do we strive for equality, treating all patients the same, or for equity, aiming to provide each patient with what he or she needs? If we cannot provide basic critical care to everyone, should we still provide ECMO to some? The best solution is to increase the available resources so that we can meet everyone's needs. That solution, however, cannot be achieved quickly. We need to increase global awareness of the issue of equity in critical care and to facilitate dialogue among providers, administrators, and justice representatives to find a better balance in which all stakeholders can have their demands adequately addressed.

Did I make the correct decision about ECMO? The patient was placed on ECMO as requested . . . and then died less than 24 hours later. It was an emotionally based decision, not a rational one, and it was the wrong decision. As physicians, we have been taught to protect life. As administrators, we need to consider the best way to protect as many lives as we can.

Disclosure forms provided by the author are available at NEJM.org.

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