# Elective Report: Universidad de Rosario (Hospital Universitario Mayor & Roosevelt Pediatric Institute), Bogota, Colombia

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## Describe the pattern of disease in Colombia and discuss in the context of global health?

Colombia's pattern of disease is similar to other middle income countries with a double burden of communicable and non-communicable disease. The health challenges within Colombia are complex. Eight of the ten leading causes of mortality are non-communicable diseases, with childhood obesity in parts of the country rivalling the United States. Three-quarters of the population of 45million live in cities, of which a large proportion end up in slums and are unable to access basic health services, to which they should be entitled by law. In these poorest people, rates of HIV, TB, Chagas, Dengue and other infectious diseases are high.

## Describe the pattern of healthcare provision in Colombia and contrast with the UK (and other countries).

Over twenty years ago, the Colombian government introduced changes to their health system to try to tackle inequalities and guarantee access to healthcare. Both employers and employees contribute to healthcare insurance and those who could not afford to are subsidised by the government. The health system was opened up to private companies to compete to provide services for profit. Since these healthcare reforms, the gap between rich and poor has increased. Prevention of infectious and chronic disease has been forgotten, leaving Colombia with a double burden of disease, in the face of a struggling economy. There are potential parallels and lessons for the future of the UK's National Health Service.

Colombia's 1993 health reforms were a neo-liberal experiment; a mixed model of contributory and subsidised health insurance. The introduction of market mechanisms and competition demonstrates interesting parallels with UK's evolving National Health Service. Colombia has since been praised by the WHO as having near-universal health coverage. However, health inequalities increased following the 1993 reforms. Rates of previously-controlled infectious diseases rose and the opportunity for strategic leadership was lost.

Health professionals had minimal participation in the development of healthcare reform. Therefore, basic principles such as cost-benefit, quality and implications for practice were forgotten. Colombia has fallen on the Human Development Index in recent years. Driven by market forces and private service providers, Colombia's health system faces financial collapse. The health system lacks basic auditting, monitoring and evaluation of services. In the face of economic crisis and widening health inequalities, the use of services is often wasteful and random. Without guidelines, health professionals trust what is advertised to them by pharmaceutical and other industries, rather than that which is known to be cost-effective.

## Health related objective

### To gain experience of a range of medical specialties (including emergency medicine, community medicine, pediatrics and psychiatry) in the context of a different health system and culture

The University of Rosario has been very patient in accomodating my wide range of interests! It has been a fascinating time. We have several specialities (including infectious diseases, neurology, rheumatology as part of our internal medicine week). We have seen a range of acute and chronic medical problems from tropical diseases (Chagas, Dengue, HIV), to pancreatitis, cancers, diabetes, arrthymias, myocardial infaractions, superior vena cava obstruction, renal failure and the list goes on. I feel this has given me a good overview of common problems I expect to see in the UK, but also rarer presentations that I would not have seen elsewhere. The structure of the health system has been interesting. I fear Colombia may only be a few years ahead of the UK in terms of their uncontrolled privatisation within a split system that does not offer universal coverage.

## Personal/professional development goals

### To develop my professional and clinical skills and confidence for future work as a doctor in the UK and abroad

I believe I have worked hard (7am to 5pm each day) and professionally throughout. I have made some good friends of other medical students and doctors during my elective. I have taken every opportunity I could to examine patients and I think my clinical skills are of a good quality having just sat my final medical exams. It has been interesting being able to take part in medical discussions here. In the SalEm they used many scales for grading severity of disease and also new inflammatory markers such as Procalcitonin, which I hadnt heard of before. I was impressed how doctors and students seemed so up to date with the literature and guidelines. They regularly consulted academic papers to guide their practice. I told myself I would try to do the same!

### To improve my medical spanish sufficiently to work independently (take history, examine, order investigations and manage).

My Spanish has certainly improved over the past few weeks. I still do not understand every word on busy ward rounds or conferences but I am able to follow what is being discussed, answer questions and make comments or suggestions. I have been able to take a medical history, examine patients, review results, present cases on the ward rounds and contribute to the discussions about ongoing management. I find the Bogota accent is very clear, although doctors from other parts of the country are harder to tune into! It has boosted my confidence to be able to operate in a foreign language and it is exciting to think that I might be able to work in a Spanish speaking country in the future.

**To reflect on my ability to cope in this foreign context.**

I have been pleased with how I have managed on this elective. I have enjoyed speaking Spanish, getting to know Bogota and a different health system. I have learned a lot from the experience. The cultural differences have been interesting, as on the surface there are many similarities. I found it strange and upsetting that some patients were tied down in SalEm, residents didn't seem trained to be 'trying out' procedures and communication with patients seemed poor. A senior doctor, nurse and a Professor of Public Health all agreed it was a problem and I am now working with them on a patient satisfaction survey about communication in the emergency department. I have been lucky enough to travel widely, seeing different health systems while working on research or partnerships. It has been interesting that my friend who I  have been travelling with has disagreed with me at times or at least questioned principles I had previously thought to be fundamental. I think it is important culture is not used to excuse poor practice or even violation of basic rights. Although the accepted 'norms' here are very different from those I am used to, so it is important to not jump to conclusions.