Progress in the Development of Hospital Services In the Latin American Republics

The key position of the hospital in the scheme of medical care and public health in the Latin American countries here is traced historically and its main characteristics are described. "Hospital services," the evaluators felt, "must be reviewed critically with regard to the long-range possibilities of greater emphasis upon support of the preventable disease services."

HOSPITAL SERVICE is but one of the elements in the broad structure of health services, although in dollar expenditures for health it receives much greater emphasis than other elements in most of the Latin American countries. Hospital service must be reviewed critically with regard to the long-range possibilities of greater emphasis upon support of the preventable disease services. High morbidity and mortality rates in many of the Latin American countries for diseases such as tuberculosis, the dysenteries, and malaria have a profound influence on the demand for hospital beds and on the general social and economic welfare of the countries.

This is the twelfth in a series of excerpts from the report of the Public Health Service's evaluation of a decade of operation of the bilateral health programs undertaken by the Institute of Inter-American Affairs in cooperation with the governments of the Latin American Republics. Background information on the evaluation survey and on the origin and structure of these programs can be found in the September 1953 issue of Public Health Reports, beginning on page 829.

Historically, Latin America has had two main economic groups, the very rich and the very poor. A large proportion of the population can be considered medically indigent with regard to ability to meet medical care costs on an individual basis. This situation may have had an influence on the early adoption of social legislation, including provision for health insurance, in most of the Latin American countries. It has undoubtedly led to a greater degree of reliance on national funds for the support of hospital services than is customary in the United States. However, a growing middle class appears to be having a beneficial effect upon the development of hospital services.

Financial Support

The church played a dominant role in the provision of hospital service during the early history of the Latin American countries, utilizing funds derived largely from land grants and other property holdings. With the trend toward separation of church and state, the property holdings were turned over to quasi-independent boards of charity, the *Junta de Beneficencia*, made up of prominent, wealthy men and women. With funds from their prop-

erty holdings supplemented by government tax funds and, in some instances, returns from lotteries, these boards operate several hundred hospitals in Latin America. Increased government support to meet the public demand for hospital care has led to increased government supervision and control of the *Beneficencia* hospitals.

The rapid growth in recent years of hospital insurance programs, including both voluntary and compulsory arrangements, has brought about greater personal responsibility for meeting the costs of hospital care. It has also resulted in the construction and operation of hospitals by a new interest, the insurance fund. One of the most modern and well-operated hospitals seen in Latin America—at Lima, Peru—was constructed and operated by the workers' insurance fund (*Segura Obrera*). This fund also operates 12 other hospitals in Peru, and plans are under way for a hospital expansion program which will approximately double this number.

In 1950, the largest Chilean compulsory health insurance fund for workers hospitalized 100,000 of its beneficiaries in the *Beneficencia* hospitals for a total of 2,000,000 patient-days. In Uruguay, although hospital and medical insurance are not compulsory, almost 400,000 persons in Montevideo, approximately 50 percent of the city's population, have some form of coverage in voluntary health insurance societies. These societies either operate their own hospitals or pay for care in hospitals operated by the Ministry of Health or in private institutions.

The maldistribution and frequent shortage of hospital facilities and personnel often makes it impossible for insurance funds to provide the scope and quality of service promised under the social security programs. Social security progress in the field of hospital care is nevertheless considered highly significant, resulting not only in the introduction of numerous third-party arrangements, but also in a greater personal responsibility for hospital care than existed in previous decades.

Retarding Factors

Certain geographic factors have undoubtedly led to delays in providing adequate modern hospital services in Latin America. The large areas of sparse population in many countries have made difficult the provision of hospital services readily available to all the people. Tropical and subtropical climates have tended to slow down the tempo of life.

Certain geographic factors have tended also to further certain diseases, resulting in an excessive hospital patient load in most areas. Economic conditions hamper the proper use of known specific drugs and procedures which would shorten patient stay. The problem is further complicated by the tendency of the people to be more receptive to remedial care than to preventive measures.

Progress in many areas has undoubtedly been retarded by the lack of organized and adequately staffed public health units and by the centralization of responsibility for hospital services, as well as many other health services, at the national level. There is a lack, as well as maldistribution, of such personnel as hospital administrators, physicians (particularly specialists), and nurses. Moreover, adequate arrangements have not been provided in most countries for employing hospital staff on a full-time basis.

In general, there is a shortage of funds for required new construction or replacement of hospital facilities or for the use of up-to-date procedures in hospital operation.

Elements of the Problem

The problem of providing modern hospital services in Latin America involves:

Provision for economic support of required services.

Positive measures in the field of public health, particularly in the control of intestinal diseases and tuberculosis, to decrease the demand for hospital service.

Training of medical, nursing, administrative, and auxiliary personnel.

Development of a broad health program which will bring about a unification of the many health and medical services under a comprehensive planning and administrative unit operating at local as well as national levels of government.

The organizational philosophies and struc-

tures of health services in the United States may not necessarily be adaptable to the problems in Latin America. Any cooperative effort should recognize these local factors and allow for the establishment of new and carefully studied experiments.

Progress and Deficiencies

The growth of hospital service in Latin America, as in other parts of the world, has usually followed the pace of economic and social progress. The most modern hospitals rendering the highest quality service are usually in the more highly developed countries and in the capitals and other large urban centers. In Uruguay, for example, there is a ratio of 5.92 hospital beds of all types per 1,000 population in rural areas and a ratio of 12.67 beds of all types per 1,000 population in Montevideo. In Brazil, available figures show a ratio of only 1.8 hospital beds of all types per 1,000 population. The Federal District of Rio de Janeiro has approximately 5.7 beds per 1,000 population, and the rural State of Goyaz has only 0.6 beds per 1,000 population.

Government support for hospital services is greater in the underdeveloped and economically depressed countries and in the backward areas of the more progressive and economically secure countries than in the more highly developed countries or areas. For example, while the large majority of hospitals in Ecuador, Paraguay, and El Salvador are maintained by the government, the largest proportion of private support is in the capital cities of these countries. In general, hospitals receiving financial support from philanthropy and contributions from patients, through insurance or otherwise, are better than those supported primarily by the national government.

National hospital organizations like the American Hospital Association are scarce in Latin America. This lack has been a major handicap in attempts to establish an effective inter-American hospital association.

Physical Facilities

From the standpoint of the number of hospital beds, the physical facilities for hospital care in most Latin American countries are far short of modern accepted standards. The need for additional hospital facilities is particularly acute in rural areas, especially beds for patients with tuberculosis, chronic illness, and mental illness.

Throughout Latin America, some excellent, well-designed, modern hospitals were seen. The majority of the hospital plants, however, are old and obsolete. They lack adequate central services required for modern diagnosis and therapy, and, in many instances, they are so large that administration is difficult and the potentialities of a smaller hospital for personalized individual patient attention are lost.

Poor design in some of the hospitals built during recent years and delays in completion were noted in several countries. Because of the policy determining appropriations, 14 hospitals in Chile, for example, were in various stages of construction for periods far in excess of that usually required for the construction and equipment of an institution.

Importance of Planning

Hospital planning is important at the national, regional, and community levels. It is important in relation to social, cultural, and economic factors and in relation to the other health programs of the country. It is essential in relation to the location, design, staffing, administration, and financial support of the individual hospital. Adequate hospital planning implies arrangements both for effective distribution of medical skills and for training programs and personnel practices essential to efficient and effective hospital service.

Several countries, notably Chile, have developed national hospital planning programs, and other countries have recognized the need for such programs and appear interested. In Chile, planning has included an inventory of available hospital facilities and needs for the construction of new hospitals and the replacement, modernization, or expansion of old ones. Legislation has been proposed for the fusion of preventive and curative services. It includes provision for the coordination of all agencies concerned with hospital service at the national level and, through the development of a regional

approach, a coordination of hospital administration activities and financial support embracing the numerous interests, governmental and voluntary, at national, regional, and local levels.

The development of hospital insurance programs has accentuated the importance on national hospital planning. Such planning is essential to secure the beneficial effects of joint private and governmental interest and support.

Administration and Operation

Two fundamentals entered into the evaluation of the administration and operation: Good administration of the individual hospital is essential for even the best hospital plant to provide good or economical service. Sound administrative policy and direction of the national hospital system is necessary for this system to make its maximum contribution.

Although the national administration of hospital services is usually a responsibility of the ministry of health, supervision is seldom provided by the director of a country's health service. Hospital administration at the national level frequently presents the characteristics of bureaucratic governmental organization. The financial support of the hospital system often appears to be subject to factors inherent in the national economy, and budgets for personnel, food supplies, drugs, equipment, plant maintenance, and plant expansion, to be limited. Budgets for individual hospitals have sometimes been approved without respect to scope, quality, or volume of service, and with little or no supervision over the actual hospital expenditures. The uncertainty of annual income from the *Beneficencia* properties frequently has led to limitation of service, for example, the withholding of expensive drugs or the actual closing down of a service.

Throughout Latin America, particularly in the larger cities, there were evidences of the value of assigning hospital administration to competent individuals. The administration of such hospitals as the Segura Obrera Hospital and the Tuberculosis Sanatorium at Lima, Peru, and the St. Vincent de Paul University Teaching Hospital at Santiago, Chile, would compare favorably with that of any North American institution.

Modern hospital administration, however, is far from the rule. Administration is often in the hands of a practicing physician who spends a few hours or less at the hospital each day. It usually follows no orderly pattern and employs few of the recognized and accepted procedures. With improved hospital administration and management, more and better patient care could be given for the money now being spent.

Staffing and Services

The maldistribution of physicians between urban and rural areas which exists in North America and other sections of the world was also noted in Latin America. In practically all countries, the large cities are in a very favorable position, whereas the smaller urban and rural areas are badly in need of additional physicians. The development of specialties is still primarily confined to the large cities.

There are examples of excellent medical staff organization. At the San Salvador Hospital in Santiago, for instance, undergraduate, intern, and residency training programs are well supervised, and clinical research is receiving considerable attention. However, in most hospitals, particularly those in the more remote areas, the staff is not well organized. Frequently, each service has its own operating suite and outpatient department. Generally, physicians are employed in large numbers, almost always on a part-time basis. This situation is aggravated by inadequate hospital budgets which prevent the use of many needed diagnostic and treatment procedures.

Many physicians hold several part-time salaried jobs, usually with the government. It is estimated that in Chile, 95 percent of the physicians in private practice also hold one or more government part-time positions. Many countries, particularly Chile, are recognizing the desirability of full-time salaried positions at income levels commensurate with a professional livelihood.

Professional nursing is just beginning to be recognized to any great degree in Latin America. Many large hospitals are operated without a single graduate nurse. Bedside and other nursing duties are often carried out by individuals with little or no formal training.

Outpatient Services

Although good outpatient clinic services were observed in several of the Latin American countries, primarily in the large cities, ambulatory outpatient services are not usually well organized. Clinics are usually crowded and lacking in sufficient medical and nursing staff. There is a tendency to look upon them as emergency, charitable services, with little appreciation of or connection with the home or other health and social agencies in the community. However, many of the health insurance programs and medical teaching hospitals include good dispensary service for medical care beneficiaries and in some areas provide medical care in the home. Ambulatory outpatient services normally expected of a community hospital are often provided at the health centers in Latin America.

Laboratory Services

Although a number of hospitals, particularly medical teaching institutions, such as the San Salvador Hospital in Santiago, the Segura Obrera Hospital at Lima, and several other large hospitals, provide laboratory examinations for all patients entering the hospital and a wide range of indicated clinical laboratory and pathology services, many hospitals were observed where such services are limited both in scope and volume. Laboratory work is often performed by persons with little basic education or formal training and often lack adequate medical supervision.

Patient Care

To understand hospital care of the patient in Latin America, some of the local philosophies and beliefs, as well as the development of the whole society, must be appreciated.

In the more underdeveloped countries, the majority of the patients on the wards of the hospitals are free-care patients. Patients in the higher income brackets tend to go to the United States for treatment for serious illness, or to be cared for in private hospitals, usually operated by physicians, occasionally by other groups of Latin Americans.

In the more progressive countries with greater monetary resources and an increasing middle-class population, different situations were encountered in the capitals and other large cities. For example, in Lima, Peru, in addition to the workers who budget for their hospital care under the health insurance fund, approximately 10 percent of the patients of the *Beneficencia* hospitals pay for their care. There is also a large number of private institutions for pay patients. In the 1,100-bed university teaching hospital at Santiago, about one-third of the patients pay for their care through various insurance funds; one-third pay individually, in part or in full; and the remaining one-third are free-care patients. Under competent administration, the percentage of patients paying in part or in full greatly increased during a 2-year period following the institution of a social service interview. In contrast to this situation, the 500-bed regional general hospital at Talca, Chile, reported that only 17 percent of the hospital income is secured from the workers' insurance fund, 3 percent from private patients, and 10 percent from part-pay patients. The remaining 70 percent is in the form of charity or tax-supported revenue of the *Beneficencia* or the government.

Patient Costs

It was not possible, because of time limitations and the unavailability of statistics, to make a comparison of hospital costs per patient-day by country. However, had this been done, the range probably would have been great because of variations in the number of personnel employed, the amount of nursing service provided, the quality of food, drugs, and supplies, and the existing inflationary situations in several of the countries. Moreover, a high per diem cost which reflects an excellent quality of care is in itself not undesirable.

The cost per patient-day at the university teaching hospital in Santiago was approximately $3.50. In Brazil, the hospital division of the Ministry of Health was inclined to grade the efficiency of the hospital by the cost per patient-day. In general, the hospitals operated by the social security program were considered of good quality. The cost per patient-day was about $9 in these hospitals, whereas some general hospitals had patient-day costs of about $3. It appears that when a patient, either through

insurance or otherwise, is providing a contribution toward his hospital care, the care tends to be of better quality.

Grouping

In most Latin American countries, there is a tendency to develop specialty hospitals for infectious diseases, tuberculosis, and mental illness, and for the care of children. In outlying rural and small urban hospitals, however, patients in all categories are sometimes in the same hospital. In one locality, patients with tuberculosis, typhoid fever, hypertension, and alcoholic psychoses were seen on the same ward, without segregation. Wards sometimes contain as many as 50 or 60 beds.

Except in the larger, newer hospitals, nurseries for the newborn are not the rule. Babies are usually cared for in the mothers' beds or in bassinets at the bedside. At one hospital visited, half of the obstetrical beds had 2 mothers and 2 babies in each. Outside the major cities, little attention is paid to special dietary measures or techniques.

Drugs

In general, the newer drugs were available in the hospitals visited, both in urban and rural areas. However, although there was no evidence of withholding necessary drugs in the hospitals in the larger cities, in some hospitals visited the patients were not getting needed drugs unless they were able to pay for them. The superintendent of one of the latter hospitals recognized the shortsightedness of this policy by citing this experience. In cases of typhoid and typhus, the average hospital stay when chloromycetin was used was 4 to 5 days with no mortality; without chloromycetin the average stay was 4 weeks with a 7-percent mortality.

The change from the old to the new was observed on visits to the pharmacies of individual hospitals. Although the empirical drugs were still on the shelves in their fancy jars, the more specific and effective drugs commonly in use today were in stock.

Duration of Stay

Comparison of the duration of patient stay in Latin American hospitals with North American standards was frequently difficult because of the inclusion of tuberculosis patients in the general hospitals. Even in the large medical centers in Latin America, the average stay is considerably longer than the average in the United States. However, the introduction of trained hospital administrators seems to have had a beneficial effect on patient turnover. The patient stay at the university teaching hospital in Santiago was lowered from 26 days in 1946 to 16 days in 1951, for example.

There was considerable evidence in most of the hospitals visited that more effective use of hospital beds could be made with improvement in administrative, medical, nursing, and therapeutic techniques.

Hospital Records

Hospital records are necessary for a proper evaluation of the individual patient's care and progress. They are necessary as basic information for good hospital administration and, from the standpoint of national supervision, they are indispensable for an equitable distribution of insurance or tax funds.

Good hospital records were seen at many of the larger institutions, but, in general, considerable improvement is needed. The need for accurate patient records and uniform hospital statistics assumes greater importance as third-party interests, in the form of health insurance funds or other sources of revenue, enter the field of hospital care. In one country where practically all of the hospitals are supported by the ministry of health, a hospital division was being organized in the ministry to handle distribution of national tax funds among the individual hospitals, as well as to perform other administrative functions.

Special Disease Problems

Tuberculosis, one of the major causes of death in most of the countries, presents an acute problem with regard to control measures, including hospital care. With the exception of Uruguay, all of the countries visited have an extreme shortage of tuberculosis hospital beds. The gravity of this situation is indicated by reported tuberculosis mortality rates. For ex-

ample, in Chile a rate of 450 deaths per 100,000 population a year has been reported, although at the time of the survey the general agreement amoung public health authorities was that the rate was about 250 per 100,000 population.

Leprosy also presents special hospital facility and administrative problems in many Latin American countries, particularly in the more tropical regions.

Although the tendency in most Latin American countries has been to establish isolation or infectious disease hospitals, particularly in the larger cities, there was found an intermingling of these patients on the wards of the general hospitals, particularly in the rural and small urban areas. The high incidence of infectious diseases in many of the countries points to the need for strengthening local public health and sanitation programs in both rural and urban areas. The new, excellently operated and staffed infectious disease hospital in Santiago, Chile, has had a very large number of typhoid patients. The high caseload of venereal diseases at the San Juan de Dios Hospital at Quito, Ecuador, indicates that possible savings in hospital costs might be realized if adequate antibiotic therapy and other control measures were practiced by the venereal disease clinic in that city. A visit to the clinic revealed that only about 10 percent of the venereal disease cases treated received penicillin therapy.

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The national and local budgets for hospital service in all of the Latin American countries represent the major portion of the total health budget. Frenquently, expenditures for hospital service are many times the amount expended for organized public health preventive services. The demand for hospital and medical care is large, loud, and continuous. Unless this demand is met with a judicious appraisal of the interrelationships of the two services, the progress of badly needed preventive public health work may be impeded and the ultimate health and economy of the people adversely affected.

"To fight against . . . misunderstanding"

Before the National Council of Negro Women on November 12, 1953, Undersecretary of Health, Education, and Welfare Nelson A. Rockefeller spoke of the importance of giving visitors from abroad an opportunity to "see how we live in America." He said:

May I close by reading you the words of one visitor to our country? Although his English is not perfect, his message is a moving tribute to the power of face-to-face contact to foster good will and understanding.

"And now two years have passed. The wonderful trip through USA has been finished. I cannot say I built up an institution or there arose a great action of mine. But much flowers make spring, many small pieces of mosaic a picture, much drops of water rain.

"So I work day by day for a new 'profile' of work. I have more security in many fields of social work, more knowledge how to do, and these new ideas overflow in all directions. About all this I speak with the young social workers, with the juvenile court, with the teachers, parents, and so on. There were some meetings with Government persons, doctors, and other official persons of responsibility in working out these new ideas.

"And I enjoy very much to fight against all kinds of misunderstanding between our peoples."