Provisional Agenda Item 26

PROGRESS ACHIEVED IN THE COORDINATION BETWEEN THE SERVICES AND PROGRAMS OF THE MINISTRIES OF HEALTH, SOCIAL SECURITY INSTITUTES, AND OTHER INSTITUTIONS THAT CONDUCT ACTIVITIES RELATED TO HEALTH. REPORT OF A STUDY GROUP

The Director of the Pan American Sanitary Bureau has the honor to bring to the attention of the Directing Council the report prepared by its Study Group on Coordination of Medical Care.

This Group was convened in cooperation with the Organization of American States and in pursuance of Resolution XX of the XVII Meeting of the Directing Council.
STUDY GROUP

on

COORDINATION OF MEDICAL CARE

Washington, D.C.

4 - 8 August, 1969

FINAL REPORT
On 4 August 1969, in Washington, D.C., a Study Group convened by the Organization of American States and the Pan American Health Organization met to discuss the coordination of medical services in the Region of the Americas.

The Meeting was inaugurated by the Director of the Pan American Sanitary Bureau, Dr. Abraham Horwitz, and the Director of the Department of Social Affairs of the Organization of American States, Mr. Theo Crevenna, who delivered addresses stressing the importance of the activities which these Organizations have been jointly conducting for the past seven years and which have taken the form of a Study Group that met in 1965, and of numerous projects within the countries aimed at coordinating their medical services in order to achieve, in the words of Dr. Horwitz, "full utilization of the installed capacity, efficient administrative practices, and the rationalization of manpower and material resources so as to accomplish the objectives of each program."

In another passage of his speech he added:

"It has become evident that, as the population has grown and its aspirations with it, together with the demand for health services, none of the participating institutions has proved capable of shoulder ing on its own the responsibilities for providing overall care to the entire population. By bringing them into association, with clearly defined objectives, common procedures, rational use of equipment, and well-trained professional staff aware of the essential objective aimed at, it will be possible to obtain from the available resources results which will always be superior to those at present achieved by the entities operating in isolation."

He concluded by requesting from the Members of the Study Group "a definition of principles and standards which can be adapted to the situation of each country and, more particularly, to the legislation in force and to the administrative structure."

For his part, Mr. Crevenna, speaking on behalf of the Secretary-General of the OAS, added that "a frank and open discussion between persons belonging to different disciplines and with different points of view is highly desirable, but still not very common."

"We have high hopes that this meeting will produce conclusions and recommendations truly useful to the countries of the Hemisphere."

The Group elected the following officers: Dr. Guillermo Arbona, Chairman; Dr. Gastón Novelo, Vice-Chairman; and Dr. Daniel Orellana, Rapporteur. It also approved the Draft Agenda (Annex II).
In the course of the meeting, each of the agenda items was discussed in detail and at the Closing Session held at 3.00 p.m. on Friday, 8 August the following Final Report was approved:

I. COORDINATION IN THE FORMULATION AND EXECUTION OF A HEALTH POLICY

The Group discussed the item on coordination in the execution of a health policy in all its aspects relating to the formulation of a policy, the participation of the various institutions which administer health services, and the financing of those services so as to provide as wide and as high-quality a coverage as resources permit.

The relationship between health policy and general economic and social development policy was analyzed, and it was recognized that a health policy cannot exist independently: on the contrary, it must be planned simultaneously and in harmony with the national industrial and agricultural development policy, as also with the educational, social and labor policy.

The countries have in general been developing their health services and endeavoring to satisfy the emergent needs as and when the demand for services made it necessary. This has been done through what might be termed as "implicit health policy", which in many cases has meant haphazard growth and has not always given priority to the most urgent problems.

As soon as the process of national health planning was initiated and procedures were established for determining priorities and fixing short-term and long-term goals, the need became apparent to formulate a policy based on demographic, statistical and epidemiological information; in other words, on the diagnosis of a health situation. This has resulted in the need to formulate an "explicit policy", which has been translated into health plans and, in some cases, into legislative changes aimed at adapting these structures so as to facilitate the changes necessary for adapting health care to the demand for health services. It was recognized that these changes, characteristic of the explicit policy, sometimes give rise to different interpretations and reactions among the institutions and persons connected with the provision of health services.

In general, the health policy should mark out the legal and administrative foundations of the medical care services, establish the program priorities and determine the degree of coverage of the population, all these being projected over a reasonable period of time.

The Group recommended very strongly that institutional coordination should begin at the stage of formulation of the health policy, so that social security institutions, medical schools, professional associations, and other bodies associated with health care, should feel from the start committed to the implementation of the approved policy, to the same degree as the Ministries of Health.
The Group endorsed the definition of coordination adopted at its 1965 Meeting:

"Coordination should be taken to mean an orderly arrangement in the use of all the available manpower and material resources in the various public and private health care institutions."*

It noted with satisfaction that there has been progress and that at least half the countries of Latin America have initiated the coordination process through various legislative, administrative and financial mechanisms. It was nevertheless recognized that these efforts are insufficient and that in some countries coordination has been approached somewhat timidly, perhaps because it has not been the reflection of a clearly defined policy. Coordination is easier to achieve in practice when there exist concrete tasks to be performed and when it has the moral and psychological support of the groups concerned.

The majority of the members of the Group agreed that coordination is a mechanism which is always necessary and which makes possible steady and orderly progress towards the ideal goal of integration of services. Some participants, however, advocated immediate integration without passing through the transitional stage of coordination.

The Group discussed various levels and mechanisms of coordination and in this connection some examples were mentioned of experiments being carried out in certain countries of the Continent.

The pressure of increasing demand for services is obliging the countries to introduce changes into their systems for provision of health services and to make more effective use of the available resources. The Group recognized that coordination in the planning of health services is a tool for meeting this need for change. It is essential, furthermore, that the health sector obtain its rightful share in the distribution of the national resources and this is more easily achieved when the various institutions of the health sector act in a coordinated way instead of engaging in mutual competition.

Coordination should extend to all levels of the administration of services, thus constituting a two-way flow. This facilitates the process, insofar as it brings into it as participants the responsible authorities at the different levels of the administration. It was recognized, too, that the countries have applied different patterns of coordination, which are linked to their own economic, social, and political characteristics and are, therefore, not transferable from one country to another.

There are different techniques for implementing coordination and each country must choose the one which can most effectively influence the provision of health services. Taking into account the political, legal, social and financial situation of the country concerned, the pace can be faster or slower, further steps being taken towards greater coordination or, eventually, towards more or less integration. In any case, the Ministry of Health should be the promoter of coordination among all the institutions operating in the health sector, including the private area.

To put this coordination process into operation, the Group recommended that health councils or commissions be established at the highest administrative and political level and with sufficient legal authority to advise the Ministry of Health on the framing of a health policy, and on administrative coordination at the operational level. The effectiveness of such central coordination councils or commissions is enormously reinforced by the establishment of inter-institutional committees for the study of specific health problems such as preventive medicine, epidemiology, statistics, development of manpower resources, standards of medical care, basic tables and other similar areas. Wherever necessary or desirable, local agreements should be established between the participating institutions.

The Group emphatically recognized the dominant role to be played by faculties of medicine in coordination, and in this connection stressed the importance of education and training committees, through which it is possible to promote a health policy as well as stimulate the development of the necessary manpower resources to put it into practice.

The Group recognized the need for wide coverage of the population, but also pointed out the limitations which inevitably have to be accepted to this principle. Only by supplementing the resources of the institutions and by their rational utilization will it be possible to approach the ideal of universal coverage. For the rural population, in particular, the initial coverage should provide promotional services of a communal nature, such as basic sanitation measures. The medical attention offered in such cases can only consist of a certain number of minimum measures which could be achieved by delegating medical care activities to non-professional personnel, should that be necessary.

It was also pointed out that it is unwise to extend coverage on extrapolate models to unprotected areas without first carrying out experimental surveys to provide the basic demographic, administrative, and statistical information essential for making a soundly-based decision.

The Group recognized the need for simulated trials, which should be carefully evaluated, the decision to apply them on a large scale being taken only once their value was proved.

**Systems of Organizing Medical Care**

With regard to provision of medical care and doctor-patient relationships, there exists a wide variety of systems ranging from the traditional private medical practice to medical services organized by the government and
furnished free of charge through public institutions. Between these two extremes there is a whole gamut of medical services organized by the social security institutions, by mutual organizations, and by public and private social welfare institutions, which offer services to various selected groups of the population.

The history of social security shows that it has been an economic policy mechanism for channeling towards social programs, including medical services, resources which otherwise would have been allotted to other purposes. The result has been that workers enjoy greater benefits and services than the rest of the population. The services provided by social security institutions are, moreover, of better standard and the remuneration received by their staff is generally higher. All this combination of circumstances leads to competition for manpower between the social security system and the other health institutions: the result should be a stimulus towards raising the levels of quality and utilization of the less favored services, thus facilitating coordination.

The worker, as a factor of production and key element in industrialization, has been given priority attention in all plans for coordination of services. This priority must have as its corollary, measures for redistribution of resources so as to render uniform the benefits and services allotted to other population groups. The aim of coordination must be to attain better utilization of the available resources now and in the future, endeavoring to avoid the establishment of a large number of systems of medical care organizations that engage in mutual competition. The larger financial resources available to social security institutions frequently cause irritation in ministries of health. Nevertheless, comparative studies between different countries show that the availability of greater resources in the social security system does not necessarily imply any reduction in the amount of money available in ministries of health. On the contrary, it has been found that when social security is economically strong, the ministry also enjoys the larger financial resources.

The construction of hospitals by social security institutions has increased and improved the installed capacity indispensable for providing health care and has contributed to the development of manpower resources. In short, the establishment of social security systems has resulted in a strengthening of health resources. This does not mean, however, that the present situation, with separate administration of health care services and consequent disparities in standards of quality, can be accepted indefinitely. The time has come for ministries and social security institutes to cooperate among themselves so that the provision of services may become evermore efficient.

To sum up, the Group recognized that if the whole range of preventive, curative and social services is to be offered, and considering the high level attained by the cost of health care, it cannot be expected for the time being that a single institution or body will be in a position to finance them in
their entirety, and it will therefore be necessary to have recourse to multilateral financing and to coordinated administration under a national health system.

II. COORDINATION IN THE PROVISION OF HEALTH CARE

1. Use and Productivity of Resources

The Group considered the concepts and techniques traditionally proposed for increasing the productivity and efficiency of hospital services. Among others it considered the following:

1. Improvement of hospital administration, through the application of administrative practices of recognized effectiveness.

2. Facilities for communication among the various hospital institutions and adoption of systems to promote comparability of clinical reports, hospital statistics, and of economic reports and educational programs.

3. Raising the quality of services to the highest feasible level, at which hospital establishments will achieve equivalent efficiency and the care, by whomever it is provided, will be equally well accepted by the consumer.

It was proposed that a system of hospital accreditation be adopted as the driving force in the systematic fulfillment of requirements programmed for each country, in accordance with its capabilities, and making possible the attainment of the prescribed quality standards in the provision of services and in the discharge of the teaching function.

The Group discussed at length the choices that arise between implementing programs of high scientific quality and those other programs in which minimum medical care is offered with wide coverage of the population. The consensus was that, from the medico-social point of view, it is desirable to achieve the widest possible coverage that is of a standard and quality compatible with the present state of advancement of the medical sciences and with the available resources. Reference was made to the case of intensive care units, whose cost is high, but which at the same time offer a chance of saving many lives. Moreover, if the intensive care units are supplemented by intermediate care and ambulatory or domiciliary treatment, the costs can be reduced, since extensive ambulatory treatment is promoted, avoiding hospitalization and making better use of the hospital bed facilities. In this connection, attention was drawn to the need for establishing basic criteria to make possible satisfactory distribution of the patients at each phase of progressive care.
It was pointed out that hospitals have grown up in accordance with cultural patterns peculiar to each region or country and that their development and their present features must, therefore, necessarily be different. It was also pointed out that the very wide disparities in the quality of the services provided by hospitals constitute an obstacle to their coordination. It would, therefore, be desirable to endeavor to attain uniformity at least in certain areas and procedures in the provision of services, which would help to facilitate coordination. In this connection, it was agreed that the system of evaluation of the quality of hospitals constitutes a valuable tool both for medical care services and for teaching programs. Hospital accreditation should not be limited to a mere system of registration, but should constitute a continuous process of evaluation and of cooperation among hospitals for the progressive improvement of their services. The areas of least efficiency in hospitals should be identified and stimulus given to improve them.

The Group agreed that, while progressive improvement in hospital techniques in accordance with contemporary knowledge is highly desirable, it must not be made an indispensable prerequisite for coordination. The difficulty in this regard is the large number of hospital institutions with a limited number of beds whose technical and administrative improvement is not easy, since the necessary specialized manpower resources for undertaking it do not exist. Hence it will be necessary to organize and coordinate, with a realistic approach, what already exists at each level, striving towards its harmonious and progressive improvement.

The Group also considered that it would be necessary to keep under constant review the training programs for hospital administration personnel, and there was general agreement on the need to set up a directing and administrative team headed by a physician, with assistance from other professional and technical staff for dealing with the different areas of administration. The type and number of administrators must depend on the medical, legal, and administrative situation of each country.

2. Regionalization

Regionalization is a system for coordination of the health resources, whether manpower or material, of an economic and social development area, in order to make them more accessible to, and more widely utilized by, the entire population. It, therefore, has as its objective better distribution of the health services.

From the technical point of view, regionalization is the administrative instrument which makes possible, at the intermediate level, the consolidation of national health programs in order to facilitate their implementation at the local level.

The Group recognized that, implicitly, the various levels of the health services spontaneously coordinate their activities at the regional level, but in order to strengthen coordination this regionalization must become explicit and have legal backing. It was recognized, too, that the
establishment of a regionalized system entails great difficulties, inasmuch as each of the participating institutions has to surrender part of its sovereignty in the interest of joint objectives and programs. Despite such difficulties, regionalization must be encouraged, since it constitutes the most effective tool for coordination within a country. In order to facilitate the coordination process, it is desirable that factors of mutual advantage be introduced into its application, so that the institutions concerned, while giving up certain prerogatives, gain an obvious advantage from participating in the coordinated system. Regional health commissions, with inter-institutional membership and powers delegated by the national commission, can greatly facilitate regional and local agreements for this purpose.

The regional services must be organized at their respective levels into a system of health establishments, in such a way as to constitute a mechanism for redistribution of resources while at the same time facilitating their accessibility. The regional hospital will be at the apex of this pyramid of services.

If regionalization is to prove an effective tool for coordination, it is essential that all the health establishments of the region, irrespective of the institution to which they belong, participate in the planning, administration and implementation of local health programs.

At the regional, as at the central level, it is desirable that the organized medical profession, as well as teaching institutions, participate in the planning of health services. It is of the greatest importance that clinical physicians, each within his own specialization, have a part in the planning and implementation of the respective regional programs.

3. **Local Coordination**

Integrated health programs offer preventive and curative care to the individual, together with communal services such as drinking water, food inspection, preservation of the environment, drug control, etc.

Not all the services have to be provided by the same establishment. The commonest pattern is for a group of specialized institutions to participate, though in very small localities all the responsibilities fall on a single institution. What matters is that institutions and individuals should coordinate and pool their efforts for the common benefit, avoiding duplications which lead to waste of resources and an increase in the cost of services.

Integrated health programs should enjoy the backing of a system of health administration in which the unified technical supervision comes
from the highest levels down to the smallest local units. It must be borne in mind that there are activities which it is a simple matter to integrate at the local level, whereas others cannot be integrated, or only with great difficulty. The integration of preventive and curative medicine at the local level is easier, the smaller the unit of service. When the aim is to serve the rural areas or the less affluent groups of the urban population, medical care will have to be provided mainly by the national health authorities, through local units.

The basic infrastructure of the local health organization (district, area, etc.) is the health center, which constitutes the minimum basic care unit for providing overall health services to the individual, the family and the community through a team of health workers consisting of at least one physician assisted by nurses, auxiliaries and other technical staff.

The work of these health centers is supplemented by sub-centers, which are run by a general practitioner and which cover the health protection, promotion and restoration requirements of the population under their care.

Since in many places private medical practice constitutes an important sector in the field of medical care, it is highly desirable that it be coordinated with the public sector.

4. Participation of Teaching Hospitals in Integrated Health Programs.

The community desires more rapid application of new knowledge for the diagnosis and treatment of diseases and is aware of the need to have a larger number of physicians and auxiliary personnel.

Nowadays it is accepted that medical care has close links with medical education. There is an increasing number of internships and residencies in public and private hospitals and this has helped to bring medical education programs and scientific progress in medicine into better relationship with the community.

The traditional concept of the university hospital as a center for teaching and high-level scientific research has been rendered obsolete by the demands of an accelerated teaching process and by the need to bring its services to bear on social problems whose manifestations belong to the fields of cultural anthropology, the behavioral sciences and community organization. Academic medical science, represented by the university, has the additional responsibility to develop optimum systems for the provision of services, including planning, organization and operation, as also for the effective implementation of the program as reflected in the prevention of disease and in effective diagnosis and treatment.
If the teaching hospital is to be expected to design models for medical care, it must necessarily be given responsibility for the provision of services, since otherwise the theoretical model is liable to prove inapplicable in practice. Hence, the teaching hospital must adapt itself, together with the medical study curricula, to the actual epidemiological, social, economic and cultural situation of the community.

The teaching hospital should form part of a coordinated system of health services such that the future physician can be given as complete a picture as possible of the realities he will encounter in his professional life. It is important to incorporate into the teaching process other hospitals and health establishments belonging to the Ministries and to the social welfare and social security systems, and for this purpose a coordination arrangement must be made linking the establishments among themselves through a regionalization mechanism.

The university medical center, even though it must have and fulfill objectives and responsibilities of its own, would be able to serve the national community more effectively by placing at the disposal of the coordinated system its irreplaceable experience of teaching and research. At the same time, medical education will benefit from using the clinical fields of the hospitals of other institutions and the social fields of the community as practice areas for students.

The Group considered four important areas for research:

1. Analysis of the causes of the continued rise in the cost of medical care, particularly in the case of hospital in-patients, and development of new ideas for controlling this cost rise.

2. Study of methods whereby the largest possible percentage of patients could be cared for through ambulatory and semi-ambulatory treatment.

3. Emphasis to be placed on the analysis of methods for the widest possible application of modern technology to medical care.

4. Promotion of the development of plans aimed towards the adoption of physical structures and installations that offer flexibility and permit modernization and expansion in line with changing program requirements.

III. COORDINATION IN MANPOWER DEVELOPMENT

Coordination in manpower development must take into account both the technical and financial aspects and those relating to the formulation of a basic policy in this field for the health sector.
Manpower development cannot and must not be the responsibility of a single organization and in fact constitutes part of the broader process of health planning. The health sector (ministries of health and social security institutions) and the educational sector (ministries of education and universities) must coordinate their efforts for this planning.

Manpower planning must go hand in hand with general health planning, and form an integral part of it. This has been recognized in the various health planning methods developed for this purpose and now in use. This concept, however, which is self-explanatory has been very difficult to put into practice. On the one hand, it has proved very difficult to assess the magnitude of available manpower, since a clear definition of this resources has not yet been formulated. For example, the care furnished by so-called "empirical" personnel seems to constitute a very important part of general health care in some countries. If there are difficulties in assessing quantity, many more arise in measuring quality. Little or nothing is known of the real turnover of many of the activities carried out by health personnel.

Planning must be quantitative, with adequate projection in time, and qualitative, taking into account the type of professional and technical staff required and course content. It must be a continuous process and must be adjusted to the dynamics of social and scientific change. The grades and levels must be defined within each profession and there must also be research on the individual factors which steer persons towards the various professions.

The training process tends to create and change attitudes by imparting knowledge and developing ability and skills. In this sense, the purposes of education must be divided into formative and informative. The teaching of preventive and social medicine and of the behavioral sciences, throughout the course, is fundamental, since it fulfills both purposes.

The Group recognized that, among the means for coordination, intersectoral committees on professional education constitute a very effective device, as also do national advisory committees for manpower development.

A program of such a nature must necessarily be reflected in educative aspects which have as their purpose the training of the necessary professional staff for its operation and, as a result, will produce repercussions on the various elements that constitute the undergraduate and postgraduate curricula of the medical schools.

The content of the study programs, the arrangements of the subjects within a general scheme, their scope and depth, reflected in each case in the corresponding curriculum, are the factors which have to be considered. Nevertheless, the content of an educational plan takes on shape and meaning only in virtue of the objectives to be attained and through a methodology which takes into account both material resources and manpower, the latter comprising both educators and students.
The medical schools should aim at imparting to personnel a clear understanding of the benefits their own countries stand to gain from the establishment of an integrated program of medical services. This, in turn, presupposes a familiarity with each and every one of the medical services available in the country which have been coordinated to achieve integration.

As has already been stated, the utilization of health establishments for professional training regardless to whom they belong, is certainly an objective that medical schools must pursue and develop in all its educational and social potentialities. For this, it will be necessary to strengthen the means of communications between health institutions and universities. Joint programs should receive ample stimulus and encouragement. The pooling of effort must extend to operational programs and to joint, multidisciplinary discussion activities. To the extent possible, cooperation between health institutions must be not only technical, but also financial.

For coordination to work, there must always be a concrete aim and immediate objectives which can progressively change from year to year and which constitute the vehicle in which coordination continues its progress.

The objectives of medical education are of two kinds: essential and contingent. The former are universal, the latter changeable and subject to constant revision. It is necessary to establish which are its fundamental objectives and clearly determine the importance both of specialization and of general medical practice.

The Group recognized that the main problem in the provision of health services to the population is the growing demand and the inadequacy of resources, to which must be added the lack of coordination between the institutions responsible for providing the services. Taking these factors into account, coordination between different institutions must be aimed towards the fulfillment of certain basic objectives, among which the following may be taken into consideration:

1. To meet the quantitative social demand for medical services, ensuring that they are provided as and when required;

2. To raise qualitative standards of medical care;

3. To balance the budget for the operation of these services.

In order to adjust educational plans to the developing changes and to the objectives of coordination, the following are proposed:
1. Promotion of closer contact between the authorities of medical schools, ministries or departments of health, and social security institutions, probably through the organization of joint commissions whose members include representatives of all these bodies together with student representatives;

2. Development of studies on manpower resources in each country, a particularly objective analysis being made of the qualitative demand with a view to arriving at a precise definition of the functions which the professional will be performing;

3. Adequate definition of the teaching objectives, on the basis of the above-mentioned studies, determining the content of the curricula and the methodology to be followed;

4. Analysis of the systems adopted by governmental and social security institutions and establishment of minimum requirements for their participation in the teaching program; and

5. Accreditation of hospital services and health centers for the training of students under teaching supervision.

1. Undergraduate Education

The unanimous consensus is that the fundamental need in Latin America is to train general practitioners. The training of the general practitioner will continue to constitute the main function of the medical schools and the characteristics of this kind of physician must be carefully defined.

The general practitioner that Latin America needs must possess the following essential traits:

1. A precise knowledge of the country's health problems and of the resources available for solving them;

2. The orientation and skill necessary to exercise his profession in the field of public health and preventive medicine;

3. Adequate preparation for tackling the health problems of a developing population;

4. A willingness to enter the practice of institutionalized medicine and the ability to work as part of a team with other non-medical professionals; and
5. Qualities of leadership so as to be able to organize the members of the community in the cause of positive health.

To the above should be added the need to encourage the physician to know his local environment and to fit himself into it without detriment to his overall vision of the trends and development of medicine in the country, in such a way as to allow him sufficient flexibility to select, within his possibilities and vocation, the place of work which is most suitable for him and in which he can be most productive.

For this he must have a sound scientific grounding, a positive attitude towards service and an ingrained habit of study.

A sound program of medical education presupposes the existence of an integrated program of medical care. It also presupposes that, on the basis of the distribution of functions, students are taught the knowledge, abilities and skills which constitute the objectives and make evaluation possible. The content, which is usually known as the curriculum, is the means used to obtain this end.

Physicians practice their profession in different manners as a result of differences in institutional organization. The curriculum should lay emphasis on the profession as a whole and not on each of its individual parts.

It is desirable that all the institutions participating in the process of coordination of medical care should have an opportunity to express their views on the preparation of the curriculum. In so doing, each one must understand the requirements and make concessions in their interest so as to make possible the change in the orientation of the teaching.

The curricula must be integrated, and for this their components have to be elastic.

There exists a need to introduce into the curricula an earlier opportunity for directly treating patients, as also for tackling the social and ecological aspects of the population to which the faculty is providing care.

The existence of an integrated health program will substantially assist in preparing adequate medical education plans. Simultaneous development in both fields is therefore indispensable. This is perhaps one of the most important areas of coordination at the present time.

The associations of medical schools, integrated with the health institutions, the organized medical profession and ministries of education, can constitute the securest backing for these coordination objectives.
The raising of the professional standard of the general practitioner can be facilitated through greater recognition of general practice as a speciality with its own specific features which characterize it, according to the country concerned, as family medicine or community medicine.

The teaching of administration is necessary inasmuch as the physician in the hospital, while exercising his primary clinical function, at the same time performs a subsidiary but permanent function of administrative management by having at his disposal and utilizing the manpower and material resources of the institution in the implementation of his decisions. Moreover, the clinical physician in the rural areas has to tackle not only the medical problems of the populations concerned, but also the problems of organization and administrative management of rural hospitals and health institutions.

Administration, epidemiology, ecology, and preventive and social medicine must be major components of the medical curriculum. The teaching of administration comprises the procedure, behavioral factors and quantitative aspects which characterize the various components of the national health system.

2. Continued Education

Continued education activities provide an opportunity for reinforcing the knowledge acquired at the undergraduate stage. For many physicians, these are perhaps the only or simplest opportunities for professional betterment within their reach. With few exceptions, however, in most of the countries no organized plans have been established for their development and utilization.

3. Joint In-service Personnel Training

Joint in-service personnel training to accomplish the foregoing objectives may be summarized under two headings: standards and procedures applicable to any country or region, and characteristics peculiar to a given country.

The responsibility of faculties of health sciences extends not only to the training of physicians, but also to that of other members of the health team, health being conceived as a unified whole and man as an integral biopsychosocial entity.

The cooperation of the health institutions will be particularly necessary here, since hitherto the training of this latter type of personnel has been largely the responsibility of such institutions.
The training of health personnel must include profound motivation towards teamwork. Each individual must be aware of the common objectives and the characteristics of the other members of the team. This creates the feeling of respect, appreciation and tolerance which facilitates the consolidation of the group and the coordination of the work.

Joint programs between health care institutions and teaching institutions, of which there are excellent examples in several countries, must be evaluated through the application of scientific method to operational problems. It is desirable that this be promoted and sponsored by the international agencies.

Joint in-service training of personnel offers excellent practical opportunities for coordination. Ministries of health, social security institutions and faculties of medicine must develop educational programs for the staff of health services, to whatever authority they are attached.

Positive experience such as that of the Inter-American Permanent Committee on Social Security should be put to use on a larger scale by ministries of health and social security institutions in order to train their executive staff at various levels of the administration.

Finally, the Group recommended the organization and strengthening of joint training of medical staff members of the different health institutions. It was recognized, furthermore, that frequently such joint training can be the responsibility of the schools of public health.

IV. COORDINATION IN FINANCING

1. Field of operations

The Group took note of the working documents prepared for this item and recognized that there exists an inevitable trend toward a rise in the costs of medical care as a result of the advances in the medical sciences and of a demand that becomes evermore exacting in respect of quantity and quality. The fundamental problem in this regard is the fact that high quality services also have a high price and are very difficult to place at the disposal of an entire community inasmuch as the lack of any coordinated system makes it impossible, with present sources of financing, to expand those services to what would be the necessary extent.

The Group recognized, nevertheless, that levelling of standards is an indispensable factor for coordination of services. This has been seen very clearly in the case of those participants in social security schemes who do not accept the services in hospitals belonging to ministries or to social welfare institutions when the quality of those services leaves much to be desired. On the other hand, in those countries where, prior
to the creation of the social security system, there existed hospital networks of some degree of efficiency, the social security system has not needed to establish its own services and has found it more advantageous to provide its medical benefits indirectly through contractual services.

Despite the practical difficulties entailed in the joint use of hospital establishments, it is recognized that this is the field where, for the time being, the most immediate opportunities for coordination exits. Mention was made of three different mechanisms whereby the joint use of services is possible:

1. The utilization of beds, paying the required patient-day cost;
2. Leasing of a floor or complete sector of a hospital; and
3. Contractual service arrangements.

The Group decided in favor of contractual services, since this is the mechanism which comes nearest to fulfilling the conditions of close technical and administrative coordination. The least desirable is renting of a complete sector, which often results in that sector becoming physically isolated and being managed in complete independence of the general administration of the hospital.

There was general agreement among the members of the Group that the first step toward coordination is to establish sound administrative practices by means of standard rules and administrative methods which allow the best use to be made of the available resources. The provision of services of the highest quality, and of uniform quality in all areas of the hospital establishment, facilitates their joint utilization. The Group also agreed on the need to ensure that priority is given to the organization of ambulatory medical care services, since they are less costly in terms of capital outlay as well as of operational expenditure.

It was noted that the installed hospital capacity must be considered as common property which belongs to the country and which must benefit all its inhabitants without discrimination, irrespective of the institution that owns the establishment. The various public services are under an obligation to coordinate and mutually complement their efforts in order to achieve the supreme objectives of the State, which are nothing else than the development of the nation and the welfare of all its population.

The activities of central inter-institutional committees in ensuring uniformity in basic tables, in provision of drugs and in acquisition of equipment will be extremely useful for promoting the sharing of services and their more effective utilization at lower cost.
A full discussion then ensued on the problem of production of pharmaceutical chemicals, which is often costly and does not meet the minimum requirements of pharmaceutical technology and professional ethics. In this connection, the Group considered the advantages and disadvantages of certain procedures which contribute to lowering costs and to making available to doctors and patients pharmaceutical products that carry full scientific guarantees and are distributed in the light of social considerations.

The Group also discussed the impact produced on the cost of medical care by staff remuneration and particularly by medical salaries and fees. Note was taken of the various systems for remuneration of physicians and it was recognized that the manner in which payment is made for the work of doctors and other professional health workers is generally dependent on the system under which medical care is provided. Mention was made of the fee-for-service, capitation and fixed salary payment systems and some members expressed a preference for the last named of these. It was unanimously agreed that it is combined systems which are the least desirable, since they do not encourage identification of the physician with the institution that employs him and result in waste of resources.

The joint use of facilities implies the existence of common standards of operation. Such standards must be worked out by bilateral or multilateral procedures. The specific administrative requirements of the medical benefits provided by the social security system must be taken into account so that they can be fulfilled in the integrated services.

Class consciousness in the insured population, and its absence among the group benefiting from the social welfare services, constitutes a serious obstacle to ensuring joint use of the services. This situation is contrary to the spirit of solidarity which inspired the establishment of the social security system. For coordination to exist, there must be equality in the standard of benefits provided, and this can be achieved only by creating the necessary machinery for bringing the organization of services up to standards of excellence. It was also observed that interest could be aroused among persons who are not yet participating in a social security scheme by offering them as an incentive the high quality of the services provided by the scheme.

Since there exist various methods already in use for the joint utilization of services, it would be desirable to carry out evaluation studies of those mechanisms in order to perfect those which are capable of improvement and trying out other new ones.
It was emphasized that coordination should be the result of a process of maturation in which the various institutions, despite their individual differences, agree on certain objectives, sacrifices and obligations for the sake of a common goal whose attainment would not be possible to each one of them separately.

The Group noted the existence of the following sources of financing for health services:

1. Government, which may be national or local, federal or state;

2. Social security institutions, which can generate substantial financial resources and, in addition, accumulate reserves of money which can be invested in hospitals;

3. Private firms - industrial, mining, agricultural, etc.;

4. Charitable and philanthropic bodies;

5. Fees charged to patients.

2. Investment Area

Plans for the construction, expansion, remodelation and maintenance of health establishments must be the result of coordinated joint work by the institutions providing health services. Any excess must be avoided in the acquisition of costly equipment, and there must be an efficient maintenance service to ensure long life for equipment and installations. When a hospital possesses certain expensive appliances or instruments, arrangements should be made for their use to be shared with other nearby establishments so as to prevent duplication and promote coordination among them.

Coordination in the financing of a program for construction of hospitals and other health establishments must be exercised at the highest possible administrative and political level and must contribute to justifying various areas of coordination in financing. The institutions which can most often coordinate their activities are the central government and the social security institutions, but in other cases it is possible, through local agreements with universities or with social welfare or other institutions, for social security to make an effective contribution to channelling its resources towards the implementation of a hospital construction program that will benefit the entire community.

In the course of the discussion, the Group was informed of a number of national experiments aimed at channelling internal financial resources towards a program for construction of hospitals and other health services.
The Group agreed to recommend the establishment at the national level of a joint fund towards which would be channelled the resources of all national institutions interested in the medical care programs existing in the country. The fullest possible legal backing must be obtained for this type of mechanism and efforts made to obtain the participation in it not only of public and social security institutions, but also of private firms whose interest it is to protect the health of their workers. The fund thus constituted should be managed by a technical commission closely linked with the health policy of the government and possessing legal authority to implement the plan, establish priorities and exercise financial responsibility with a view to putting into effect the program of hospital construction.

The Group took note of the existence of international sources of credit, public and private, which could be mobilized on behalf of construction programs in the health field. It is clear, however, that in allotting these funds priority is given to economic projects of an industrial or agricultural nature and that they are only exceptionally earmarked for programs in the social sector.

The Group was informed of the special recommendation of the Meeting of Ministers of Health in Buenos Aires on the establishment of an Inter-American Health Fund, administered by PAHO, which would grant loan for construction of hospitals and other health centers.

The Group was informed that the next technical discussions of the Directing Council would be on the subject of "Financing the Health Sector" and that the basic document which would serve as an outline for the discussions was being prepared by an economist from the Inter-American Permanent Committee for Social Security, who had been placed at the disposal of the PAHO for some weeks for that purpose. A general indication was given of what would be the tenor and content of this document.

Finally, the Study Group gave its approval to the following recommendations:

RECOMMENDATIONS

1. That institutional coordination should begin at the stage of formulation of the health policy, so that social security institutions, medical schools, professional associations, and other bodies associated with health care should feel from the start committed to the implementation of the approved policy to the same degree as the ministries of health.

2. That health councils or commissions be established at the highest administrative and political level and with sufficient legal authority to advise the ministry of health on the framing of a health policy and on administrative coordination at the operational level.
3. That inter-institutional committees for the study of specific health problems and, more particularly, a professional training committee, with the participation of the medical schools, be established.

4. That if the whole range of preventive, curative, and social services necessary for maintaining health is to be made available, and considering the high level attained by the cost of health care, it cannot be expected for the time being that any single institution or body will be in a position to finance them in their entirety, and it will, therefore, be necessary in the meantime to have recourse to multilateral financing and to coordinated administration under a national health system.

5. That an effort be made to raise the quality of care and achieve uniformity in certain service areas, since extreme disparities constitute an obstacle to coordination. For that purpose, a hospital accreditation scheme covering both care and teaching activities might be useful.

6. That the teaching hospitals should form part of a coordinated system of health services and actively participate in the provision of care to the community, while at the same time their specialized services should be made available for conducting operational and community research.

7. That it is important to bring into the teaching process hospitals and other health establishments belonging to the ministries, to social security institutions and to public and private social welfare agencies, since this would have the advantage of enabling students to make contact, at an early stage, with the medico-social and epidemiological problems of the home and the community.

8. That the primary function of schools of medicine should be to train a general practitioner whose personal traits should be the following:

1. A precise knowledge of the country's health problems and of the resources available for solving them;

2. The orientation and skill necessary to exercise his profession in the field of public health and preventive medicine;

3. Adequate preparation for tackling the health problems of a developing population;

4. A willingness to enter the practice of institutionalized medicine and the ability to work as part of a team with other non-medical professionals; and

5. Ability to lead the members of the health team so as to be able to organize the members of the community in the cause of positive health.
9. That undergraduate training should include basic notions of health administration and social security and be supplemented by continued education of graduates.

10. That joint in-service training of personnel with a strong comprehensive health care component should be organized and strengthened, as far as possible under the responsibility of the schools of public health and of the teaching departments of health services and social security institutions.

11. That performance of hospital services under contract between institutions should be encouraged, since this is the mechanism which comes nearest to fulfilling the conditions of close coordination, provided that the technical and administrative unity of the establishment is maintained.

12. That sound administrative practices be established by means of standard rules and administrative methods which allow the best use to be made of the available resources as a first step towards coordination and as a means to achieving higher productivity of services.

13. That encouragement should be given to the development of ambulatory and domiciliary services, which entail smaller capital outlay and whose operation is less costly.

14. That the financing of the operational costs of health services should be multilateral and that the participating institutions, despite their differences, must agree on certain objectives, sacrifices and obligations for the sake of a common goal, which is to provide total health care, of adequate quality, to as broad a sector of the population as possible, and in such a way that its financing is compatible with the available resources.

15. That there be established, at the national level, a joint investment fund towards which should be channelled the available resources of all the institutions interested in medical care programs. The fund thus constituted should be managed by a technical commission closely linked with the health policy of the government and possessing authority to put into operation the program of hospital construction, within the framework of the national health plan where such a plan exists.
At the closing session Dr. Alfredo Leonardo Bravo gave thanks, on behalf of the Director of PAHO, for the assistance provided by the OAS in the organization of this meeting. He also thanked each and every one of the members of the Study Group for the consistently high and distinguished level of their contributions, which had made it possible to reach conclusions that would certainly be extremely useful for those countries of the continent which desired to establish a system for coordination of health services.

Mr. Beryl Frank then expressed appreciation of the hospitality provided by PAHO to this group and stressed the already long history of cooperation between OAS and PAHO in the field of medical care.

On behalf of the members of the Group, the Chairman, Dr. Guillermo Arbona, thanked the sponsoring organizations for the opportunity given to members of the Group to meet and discuss problems which were at present particularly acute in national health administrations.

Dr. Cuccodoro said that ILO was very gratified at the results of the meeting, since its conclusions amply endorsed the new policy adopted by ILO in the field of medical care.

Dr. Lechuga, speaking on behalf of the ISSA and ICSS, wished to be associated with the unanimous congratulations offered to the institutions that had organized the meeting. He stressed that, in itself, the presence of observers from several non-governmental organizations interested in the subject was proof of a new attitude of inter-institutional cooperation which portended a more promising era in the provision of health services.

The meeting closed at 5:50 p.m. on 8 August 1969.

Annexes
Annex I

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*In addition, Mr. G. Aldo Olivero, Secretario Coordinador del Plan Nacional de Salud del Brasil, was invited but was able to be present at only some of the sessions.
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AGENDA

1. Coordination in the Execution of a Health Policy
   1.1 Institutional coordination at the national level
   1.2 Participation of Ministries of Health, social security institutions, social welfare institutions and schools of medicine.
   1.3 Coordination committees and committees for the study of specific problems
   1.4 National health systems
      1.4.1 Population coverage
      1.4.2 Health insurance
      1.4.3 Systems of organizing medical care
      1.4.4 The problem of medical care in rural areas

2. Coordination in the Provision of Health Care
   2.1 Use and productivity of resources
      2.1.1 Improvement of hospital organization and administrative methods in hospitals
      2.1.2 Medical records, clinical histories and hospital statistics
      2.1.3 Improving the quality of medical care
      2.1.4 Accreditation of hospitals
   2.2 Regionalization of services
      2.2.1 Delegation of authority from the national to the regional level
      2.2.2 Relations between hospitals and peripheral services (flow of personnel, equipment and patients)
      2.2.3 Participation of clinicians in problems of preventive and social medicine in the community and in the administration of local health programs
2.3 Integrated health programs

2.3.1 Description of integrated activities

2.3.2 Participation of teaching hospitals in integrated health programs

2.3.3 Incorporation of private institutions in integrated health programs

2.3.4 Integration of preventive and curative activities at the local level

3. Coordination in Manpower Development

3.1 Planning of manpower development by Ministries of Health, social security institutions and institutions responsible for the training of health personnel

3.2 Adaptation of the undergraduate and postgraduate curricula of medical schools so as to produce personnel of the appropriate type for providing health services in an integrated program

3.3 Cooperation of Ministries of Health and of social security institutions in the expansion of teaching resources in order to satisfy the demand for professional personnel

3.4 Participation of medical care personnel in undergraduate and postgraduate teaching.

3.5 Joint in-service personnel training

4. Coordination in Financing

4.1 Operational area

4.1.1 Medical costs and hospital costs (salaries, drugs, general expenses, etc.)

4.1.2 Multilateral financing (fiscal public sector, decentralized public sector, private sector)

4.2 Investment area

4.2.1 Program for the construction, renovation and maintenance of hospitals and peripheral medical services
4.2.2 Remodelling and adaptation of health establishments

4.2.3 Mobilization of national and international resources.