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MEANS FOR PROMOTING AND MAKING EFFECTIVE THE COORDINATION BETWEEN THE SERVICES AND PROGRAMS OF MINISTRIES OF HEALTH, SOCIAL SECURITY INSTITUTES, AND OTHER INSTITUTIONS THAT CONDUCT ACTIVITIES RELATED TO HEALTH

COORDINATION BETWEEN THE MEDICAL CARE SERVICES OF THE MINISTRIES OF HEALTH AND OF THE SOCIAL SECURITY INSTITUTIONS

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CHAPTER I

COORDINATION BETWEEN THE MEDICAL CARE SERVICES OF THE MINISTRIES OF HEALTH AND OF THE SOCIAL SECURITY INSTITUTIONS

In preparing the Technical Discussions on the above theme, two resolutions of the XVI Meeting of the Directing Council have been taken into account. In Resolution XIX, The Council invited Governments to progressively apply recommendations concerning machinery for coordination between ministries of health and social security institutions, "especially that which refers to the need for a survey to measure the real magnitude of the problem and to ascertain its characteristics". In Resolution XXIX, the Directing Council resolved to select the topic: "Means for Promoting and Making Effective the Coordination between the Services and Programs of Ministries of Health, Social Security Institutes, and other Institutions that Conduct Activities related to Health" for the Technical Discussions to be held during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas.

The Director decided that the best way to implement both resolutions would be through a preliminary survey for the collection of basic data, which would be made available to the participants in the Technical Discussions in order to provide them with realistic information on the present situation.

Continuing its policy of collaboration with other organs of the Inter-American System, PAHO requested the cooperation of OAS in order to carry out the survey recommended by the Directing Council. It is gratifying to note that OAS responded in a very effective manner to this request and agreed to sponsor the survey jointly with PAHO in those countries which volunteered to participate. It was made quite clear from the outset that this was a national survey with the assistance of international organizations, and that its aim was solely to make an objective,preliminary analysis of the present situation so as to obtain basic information in order to undertake at a later date,a thorough economic, demographic, and sociological study, the results of which would enable each country to evaluate its own problem and adopt its own solutions in accordance with its historic traditions, legal system, and financial ability to provide medical services.

Ten countries complied with the request of PAHO and OAS. They were: Brazil, Chile, Colombia, Costa Rica, El Salvador, Honduras, Panama, Peru, Mexico and Venezuela. Each country was asked to designate one investigator from the ministry of health and another from the social security agencies. These investigators received detailed instructions from officials of PAHO and OAS, as well as advisory services throughout the period data were collected.

The present study is intended primarily to measure the "quantity" of services that are being given at present and not their "quality". This fact

must be taken into account, particularly in analyzing costs, because it is obvious that the higher cost of certain services often results from their higher quality. In addition, an attempt has been made to investigate the way in which the services are utilized, their accessibility to the users, the population covered by the social security systems, and the cost of the services provided by the different institutions. In addition, an attempt has been made to analyze the human and material resources available for the operation of medical care services.

The general orientation of the study corresponds to the principles supported by PAHO, which have been ratified on many occasions by its Governing Bodies and its expert groups. In brief, these principles lay down that the preventive, curative and rehabilitative functions of medicine constitute an integral whole, medical care being recognized as one of the basic health services which should be provided to the community.

From the administrative point of view, the basic principle followed in considering this problem is that health services should have a regionalized structure, and that within each region there should be a network or system of establishments providing services, the sum total of which should be sufficient to ensure integral health care, avoiding duplication among related services.

When the problem is tackled in this manner it is possible to establish general technical principles from which measures applicable to any health service can be derived. In this way, discriminations or comparisons which could lead to further lack of coordination are avoided, and a basis is established in order that, by means of operational research at the local level, uniformity of health activities can be achieved, thus facilitating their progressive coordination.

The following comments stress the most outstanding characteristics of the problem and might serve as a guide for the Technical Discussions.

1. Availability of hospital beds.

It is extraordinarily difficult to obtain satisfactory indexes or rates for determining the ideal number of beds in relation to population. There are numerous variables which modify the need for beds, and many of these variables, unfortunately, cannot be measured easily. Another factor which complicates the calculation is that in the organization of medical services we are rarely working with a known universe. The population served by the beds of a given hospital can, in fact, vary within a rather wide range, depending on the means of communication and on whether or not there is a network of peripheral services to relieve the pressure on the regional hospital services.

The ministries of health, in replying to the questionnaire, had a tendency to give, as the population served by a hospital, the total

population of the city or region where the hospital was located, without making the corrections rendered necessary by the existence of other hospitals (maternity hospitals, children's hospitals, private clinics) which serve different sectors of the same population. This is unfavourable to the Ministry hospitals, because, when this exaggerated population figure is used as denominator, the rates per 1.000 inhabitants obtained are much lower than the true rates as well as much lower than the social security hospital rates.

A more accurate but also more complicated way of determining the beds required by a population is to study the demand for medical care. In its simplest form, this demand can be measured by the percentage of the population which requests admission to hospitals, and by the percentage of the same population which attends out-patient clinics. This however, only represents the part of the demand known as "effective demand", and to it should be added the "potential demand", based on that part of the population which, even though it needs medical care, does not ask for it, either because it does not have access to services or because it is not covered by the social security system.

In addition to this potential demand, which might be called demand of social origin, there is another kind of potential demand which originates in public health activities themselves. Thus, a preventive program for the control or eradication of communicable diseases, even though it may increase demand during its initial phase, tends in the long run to reduce demand by bringing about the reduction or possibly the disappearance of a certain group of diseases. On the other hand, a search for cases of chronic illness, particularly cardiovascular disease or cancer, will reveal a series of cases previously unknown, which generally require more or less lengthy hospitalization, and which in any case cause an increased demand for services.

On applying modern procedures of market research, it is possible to assess the total demand for medical care, making all the necessary corrections in order to add to the effective demand, the potential demand determined by the factors mentioned above, and deduct the additional or unnecessary demand caused by the persistence of diseases which can be eradicated or reduced in importance.

Once the total demand is known, it is still necessary to correct the figures on the basis of the real needs and also the aspirations of the community. There are a series of factors, such as a rising level of health education of the population, population growth or internal migration, and, finally, the advance of medical science, which create a constant growth in the demand for services. Unfortunately, often the resources necessary to provide the services do not grow equally rapidly and this gives rise to another factor which should be taken into account in planning health services, since this lack of sufficient resources to satisfy the demand is frequently a cause of conflict with the professional personnel responsible

for providing the services and also with the users of the service. These social or "trade-union" conflicts may provoke tensions which harm the prestige of the medical services and which,in any case, should be avoided.

Furthermore, when the availability of beds is not uniform for the different social groups, social discrimination arises and has repercussions on public health, inasmuch as the less favoured groups, which are usually those most exposed to the risk of sickness and death, will not have access to even minimal medical care. This is what occurs frequently in the countries covered by the present survey, which have a more or less satisfactory number of beds for a minority group, namely that part of the population covered by insurance, but have rates below the acceptable minimum for the majority consisting of the economically weaker groups of the population which are still without social security protection (Table 1).

In the survey, an analysis was made of the data concerning discharges per 1,000 inhabitants. These figures are very variable and reveal no definite tendency, but they are generally very low. This would seem to show that services are being provided only for a minority of the population supposed to be covered. Only the social security hospitals of El Salvador, Costa Rica, Honduras, Panama and Peru indicate averages of more than 100 discharges per 1,000 inhabitants, which may be regarded as a satisfactory figure. In the case of the rates for ministry hospitals, the source of error already mentioned must be considered, i.e. the use of an exaggerated theoretical population in making the calculations.

If we accept as adequate the rate of 100 discharges per 1,000 then, taking into account the fact that 10 days is a reasonable average stay, the conclusion is that there should be a rate of about 1,000 patient-days per year per 1,000 inhabitants. In the survey, only the Social Security Fund of Costa Rica and the Workers' Social Security Fund of Peru exceed this figure, while it is approached by the hospitals coming under the Ministries of Public Health of Costa Rica and of El Salvador, as well as by the social security hospitals of El Salvador, Panama and Peru (Seguro Social del Empleado).

2. Utilization of hospital resources.

The poor utilization of hospital resources creates an artificial shortage of beds which could easily be corrected by simple administrative measures designed to improve the medical care system. There are countries which complain of a lack of beds but whose statistics demonstrate that the average stay of patients in hospital is 25 days or more,and that because of this low turnover only 12 to 14 patients can be treated per bed per year. A better utilization of these beds, reducing the average stay to not more than 15 days (which is an acceptable figure and by no means exaggeratedly low) would permit 25 patients per year to be treated per bed. It is not easy, however, to improve the utilization of hospital beds as much as in the above example.

The utilization of the beds is affected by:

a) The hospitalization requirements of the population as compared with the number of beds available.

b) The duplication of parallel services.

c) The existence of sufficient professional personnel to provide for an adequate rate of bed turnover.

d) The existence of timely diagnostic and treatment services.

e) The need to satisfy the demand of the population for care to the maximum extent possible.

When the demand for care is very heavy and there is an attempt to increase the percentage of utilization beyond the limits permitted by the existing human and material resources, this increase is generally made by sacrificing the quality of the service and at the expense of the personnel. It should also be remembered that small hospitals habitually have a low utilization rate, so that, for this reason, it is better in countries which have limited resources to concentrate the latter in large medical centers where maximum use can be made of them.

As in so many other aspects of social phenomena, the rates of utilization of medical services are determined by many variables, some of them objective and measurable, and others subjective, depending on the cultural and emotional state of the population and not measurable or easy to overcome.

The objective factors that interfere with good utilization include, for example, low output per physician-hour or work, inadequate ratio of nurses to physicians,of auxiliaries to nurses, and of administrative to professional personnel, which may oblige the latter to devote a large proportion of their time to work that is not properly speaking the care of the sick, thus seriously decreasing their "output". Another factor which must be considered is the inadecuacy of certain installations such as X-ray, laboratory or electrotherapy services, which can create bottlenecks and interrupt the continuity of the process of diagnosis and treatment and is reflected in an undue length of hospitalization.

It follows, therefore, that in order to analyze the utilization of medical resources the causal factors must be known. Care should be taken to avoid any over-simple conclusions, indicting a given professional group or a given administrative system or a given institution for defects in the utilization of the resources which may be governed by factors completely external to the individuals or institutions providing the services.

To asses utilization, the following series of indexes has been established:

a) Index of hospital bed occupancy, which is considered adequate when it is between 80 and 85 per cent. Excessive occupancy indexes are the rule in all the specialized hospitals covered by the survey. Furthermore, certain general hospitals also show unduly high occupancy indexes, particularly in those countries where the shortage of beds is most serious.

b) Average length of stay of patients, which should not be more than 15 days in the case of acute illness. Evidently, this average will vary greatly depending on the particular specialty. For example, in maternity cases 3 or 4 days are considered adequate while in chronic disease services, such as psychiatry and tuberculosis services, stays of 90 to 100 days may be common.

c) Bed turnover, which depends on the foregoing and which, in the case of general hospitals for acute illnesses, should be 25 or more patients per year. In the hospitals studied in the survey, it can be seen that those with the longest average lengths of stay are at the same time those with the lowest bed turnover indexes (see in Table 2: the Rosales Hospital, San Salvador; Ministry of Health hospitals, Honduras; and the Hospital Obrero, de Lima, Peru).

d) The percentage of admissions relative to the population served by the hospital. This index is rather difficult to determine and was not investigated in the survey. As mentioned above, the population assigned to the hospital can vary greatly, depending on a series of factors quite apart from morbidity and related rather to the economical and social development of the region where the hospital is located. Furthermore, this index calls for individual statistics, which are rarely available in our hospitals.

In the countries participating in the inquiry these indexes show great variability but tend, in general, to be better in social security hospitals, very probably owing to the fact that administrative and financial control in these institutions is stricter than in establishments coming under ministries of public health. In the great majority of cases, however, the indexes of the hospitals considered show room for considerable improvement. As noted above, it would be necessary to study each individual case in order to determine and overcome the causes behind the unsatisfactory level of these indexes so as to improve utilization of the available resources. This is the preliminary step necessary to justify a request for new resources demanding a financial effort on the part of the governments and the communities concerned.

3. Out-patient care (ambulatory and domiciliary).

It is a well-known fact that 90 to 95% of the morbid conditions which lead to the demand for medical care can be treated in an ambulatory manner in out-patient departments. This is the policy which has been adopted by most of the social security institutions in Latin America (see Costa Rica, Peru and Honduras, Table 1). The data in Table 7 for the different countries taking part in the survey indicate that, in general, the out-patient clinics attached to social security institutions are better provided with laboratory and X-ray installations. It can be deduced indirectly from this fact that the quality of medical care may be higher in these out-patient clinics.

The modern concept of the structuration of medical care services is that they should form part of a network or system of services in which a general hospital, covering all the specialties, is the base of the operations for a network of small hospitals, peripheral out-patient departments, and health centers bringing medical care to every corner of a given geographical region and carrying on integrated -i.e. preventive, curative, and social- health activities. These peripheral services are, so to speak, the "antennae" of the health service which at the same time as taking health care to every part of the region, "pick up" health problems and diagnose cases which require more complicated treatment, before referring them to the specialized centers which should be located in the regional hospital. All these services should act as a whole, in a coordinated manner, and should plan their activities and evaluate the results obtained jointly. Even though the countries participating in the survey show an unmistakable tendency towards this type of organization, the truth is that there is still a long way to go before the system becomes generalized. It is still common for ministries and social security institutions to organize local health services which are completely independent of each other.

Only an analysis of the combined output of the different establishments which make up the network of medical services for a region can reveal errors in the functioning of the system, superfluous institutions, unnecessary duplication, lack of proportion between the services provided and real needs, and the importance of applying certain indexes and their effect on demand.

The output of an out-patient clinic can be measured by the number of contacts made per year between the medical team and the community it serves. This relationship, of a collective character, is often expressed in a simplified manner by the number of patient-doctor contacts, a ratio which is usually a good representation of the activity of the out-patient clinic, since medical work is the most complicated part of its action and the one most needed by the population, while at the same time it is the one that gives rise to other health welfare or social contacts between the family group and other members of the health team.

The ability of the out-patient clinic to satisfy the demand for its services is determined by various parameters, among which the following should be taken into account:

a) The number of hours of work per day assigned to the out-patient clinic and their distribution around the clock. This should take into account the free time of the industrial worker, family habits, and the hours when housewives and children are free to attend.

b) The number of working days per year. It is advisable for out-patient clinics to work at weekends and on holidays, when their clientele can more easily attend.

c) The average number of consultations per physician-hour in the different specialties, it being emphasized that this figure should be fixed by agreement between the health service authorities and the medical profession, and will be an average and not a maximum.

d) The location of the cut-patient clinic, which, as far as possible, should be in a frequented locality near places where its clientele live or work.

e) The existence of domiciliary services.

The effort made by health institutions to encourage the development of out-patient clinics and the repercussions of this effort as concerns satisfying the demand of the community for medical care can be measured by studying the number of out-patient consultations in a given period of time in relation to the population served by the hospital and by the out-patient clinic.

In out-patient clinics where the comparison has been made, it can be seen that the percentage of the population covered which uses the services is greater in social security out-patient clinics (see Table 8 for Honduras and Peru). The opposite is the case in Costa Rica. In the remainder of the countries, this study could not be made.

The health centers and social security out-patient clinics clearly attach greater importance to domiciliary medical care, as can be seen from the results of the survey in Costa Rica, Panama, Peru and Venezuela (Table 8).

In Chile, where, as a result of the integration of the medical services coming under the ministry with those of the social security system, the hospitals have been practically transformed into health centers, it can be seen that these establishments make a large number of domiciliary visits.

The same Table 8 gives, for the various countries, the immunization rate per 100 inhabitants served by out-patient clinics. It can be seen that immunization is frequently not carried out in the social security clinics and, even in those where it is, concerns a very low proportion of the population covered.

The time spent by the physician per consultation can also be used as an indirect index of the quality of the care given in out-patient clinics. All the countries show a similar tendency to use more doctor-hours in the health centers and the social security out-patient clinics,

at the expense of the out-patient clinics of general hospitals coming under the ministry of health, where the time per consultation is frequently very small.

The cost of ambulatory care is analyzed in Table 10, where it can be seen that the most expensive medical care is that given by mobile units (Honduras and Panama). Care given by health centers is generally more expensive than consultations in hospital out-patient clinics (Chile, Costa Rica, Panama, Peru and Venezuela). Apart from Venezuela, the social security out-patient clinics tend to be more expensive than the health ministry ones. The case of social security for employees in Chile and Peru calls for special attention, since their costs are several times higher than those of the ministries in the same countries.

4. Ability of the institutions to satisfy the demand

There are three basic elements which govern the ability of an institution to provide medical services. These are: the buildings, the equipment and installations, and the human resources.

As regards buildings, not only are their actual existence and size important, but their architectural design should also be suited to the functions for which they are intended. In the countries of Latin America, none of these conditions are satisfied: there are not enough buildings, those that do exist are old and their size is inadequate to satisfy the increasing demand of the peoples for medical care. To aggravate the problem still further, relatively new facilities have been built from an institutionalist viewpoint, without bearing in mind the need to integrate preventive and curative services and to take health care to the community which the hospital serves. Finally, either an erroneous policy or the shortage of financial means has resulted in the fact that, to all intents and purposes, there is no maintenance budget, so that relatively new buildings deteriorate too fast.

The effort which the countries are making through various sources of financing to build hospitals and other health establishments is extraordinary, and it may be estimated that large sums of money will be involved.* Unfortunately, there is rarely a preestablished plan aiming at the progressive satisfying of the health needs of the population. Owing to the financial difficulties of the governments, it is not uncommon to see the construction of a hospital prolonged for many years, and when it finally starts operations it is already inadequate for the needs of a growing population which is becoming ever more conscious of the importance of health. In contrast to this premature saturation of some hospitals, others do not use their full capacity because of lack of personnel or financial resources,

* Chile invested 29,000,000 escudos in the construction of 30 hospitals, as well as 5,000,000 on the enlarging and remodeling of 7 others and almost 2,000,000 in the construction of 8 health establishments without beds, during the period 1960-64.

and at times (which is worse) lack of clientele. The paradox arises, that while some hospitals are operating beyond their tolerable maximum capacity, others are half empty, and this occurs -at times simultaneously- in the same region and even inside the same city. All this results from lack of planning which brings to nought the financial efforts made by the countries and causes dissatisfaction among all interested parties, i.e. the users of the service, the medical and related professions, and the governmental executive and political authorities.

The problem of providing equipment is no less grave than that of buildings. A good part of the installations and equipment necessary for the diagnosis and modern treatment of disease is not manufactured in the Latin American countries and therefore has to be imported. This involves the additional problem of the availability of foreign exchange in hard currencies and of internal competition with other requirements for the import of industrial and agricultural machinery, etc., to which the governments often give preference.

As in the case of buildings, the financial efforts made by the government to obtain equipment are frustrated by lack of planning. As a result, purchases are made in a arbitrary manner, so that in the same city there may be one hospital lacking the most basic equipment for X-ray or laboratory tests, while another has an electron microscope and a cobalt bomb. In addition to this, there is a competition among the different medical services to acquire expensive installations (for example heart-lung machines for open heart surgery) which once installed can hardly be used because of the absence of the specialized personnel required.

The human resources situation is another of the factors which limits the capacity of institutions to provide medical service. Since the physician is the irreplaceable element in providing medical care, a brief analysis of the availability and utilization of medical work will give an idea of the medical care capacity of the countries. In Latin America, there are at present some 134,000 physicians in professional practice, which is a ratio of 5.5 physicians per 10,000 inhabitants for the estimated 244,000,000 population of Latin America. In other words, there is one doctor to every 1,800 inhabitants, including those doctors who are engaged in administrative or public health functions, and therefore, cannot be regarded as providing direct medical care. The ratio varies widely from 0.9 to 14.9 physicians per 10,000 inhabitants, which shows that there are countries with a more than sufficient physicians to meet their needs while others are in a real emergency situation, since the ratio is below the acceptable minimum for giving even minimal medical care to all the inhabitants.

The basic scarcity of physicians in most of the countries of Latin America is made more serious by their poor geographical distribution, since the great majority of them are concentrated in the large cities. As regards hospitals, the shortage is still more marked because of the traditional

habits of professional practice, which in many countries result in the physician working not more than two hours per day in the hospital. It is only fair to recognize, however, that the majority of the countries are making an effort to promote full-time work by hospital doctors, but they encounter serious financial difficulties in providing a satisfactory income compatible with the status of medical work.

Apart from the Honduras social security system, the percentage of full-time doctors in all the other countries is greater than that of those working part time (Table 3). On analyzing the medical work time (doctor-hours) in relation to the beds occupied in general hospitals, great variability is found ranging from 5' per bed in the "beneficencia" hospitals of Peru to 114' per bed in the Panama social security hospital. In the great majority of hospitals, the figure lies between 25' and 34'. Outside this group are numerous hospitals belonging to social security institutions, such as those of Rosales in El Salvador (79'); Honduras (54'); Panama (114'); the Employees' Social Security Institute of Peru (106') and the Venezuelan Social Security Institute (66').

The same position is found in regard to nursing time. The great majority of hospitals utilize between 15' and 35' daily of nursing time (nurse-hours) per occupied bed, while in the social security hospitals the figures are as follows: San Jose de Costa Rica, 50'; other Costa Rican social security hospitals, 68'; Employees' National Medical Service of Chile, 41'; Rosales Social Security Hospital, 59'; Honduras, 72'; Panama, 149'; Panama-Santo Tomás-Ministry of Health, 80'; other Ministry of Health hospitals, Panama, 67'; Peru - Workers' Social Security, 55'; Peru - Employees Social Security, 146'; Venezuelan Social Security Institute, 82'.

5. Coverage of the population

From the social and public-health points of view, the ideal would be to have total coverage --i.e. to ensure all the members of the community should enjoy the benefits of medical care from the instant of birth to the moment of death, applying the principle of continuity which recognizes that sickness, health, and invalidity are merely different phases of a single biological and social process.

The concept of coverage varies, depending on whether services operated by ministries or social security institutions are concerned. The latter employ a financial concept of coverage-- in other words, persons who contribute financially to the maintenance of the services, and certain members of their families recognized as beneficiaries by law, are those that have a right to the benefits. These services consequently work for a known population, which can be determined with a certain degree of precision. Services coming under the ministries of public health, on the other hand, theoretically apply the concept of the universality of medical care, recognizing the right to health of all members of society. In practice, this is not absolutely true, inasmuch as persons covered by social

security institutions, those who can pay for private medical care, those who belong to mutual cooperatives and other systems which provide medical care, members of the armed forces and the police, which generally have their own services, and those who, because they live in remote and isolated regions, have no access to the existing services, do not come to ministry of public health establishments. The majority of the latter establishments claimed in the survey a theoretical universe which was greater than the real one, leading to a factor of error -sometimes a large one- in the calculation of the rates and the indexes of output.

The low percentage coverage of the social security institutions greatly limits the effects of their action on the state of health of the community as a whole. It is known that for a health action to produce significant results and to reduce the risks of sickness and death, it must be applied to what in epidemiology is called a "useful level" of the population. This useful level varies with the activities planned and the risks covered, but must always be over 50% of the total population, as a minimum. As a result, health activities undertaken by the social security institutions for a lower percentage of the population cannot have any measurable effect on the health of the community until their coverage is increased to reach a higher level or the work is coordinated with that of other health services so as to attain such a level.

The trend apparent in all recent international meetings on the subject has been to extend the benefits of social security to new population groups before increasing the benefits of the groups already protected. If this orientation becomes translated into practice in the years to come, a significant increase in social security coverage in the field of medical care can be expected. It is possible to foresee, however, serious difficulties in the fulfillment of this program,since, as has already been noted, the right to services in the social security system, is acquired by the paying of contributions. It is evident that in the countries of Latin America there are still large numbers of the urban inhabitants who are unable to pay such contributions. Moreover, all the indigenous population groups and a good part of the rural inhabitants have money incomes so low that any attempt to demand a contribution from them to finance the medical services would be illusory. These indigent groups are the ones which have obliged the ministries gradually to develop medical care services, particularly in rural areas. The present and future needs of these population groups will continue to have a strong influence on government decisions, since the governments feel obliged to satisfy this demand for medical services in order to avoid social tension and unrest.

If we recognize that the conditions of our social and economic development oblige the two types of services to coexist, namely those of the ministries and those of the social security systems, then the need to reach a certain understanding so as to facilitate joint work appears obvious.

6. Quality of medical services

A precise evaluation of the quality of the medical care extended to a given individual can only be made by analyzing the case history by

means of medical audit studies, but this procedure cannot be used in an international survey such as the present one. Nevertheless, information has been sought on certain more or less simple elements which can provide an indirect measure of the quality of the services provided.

The need to engage in joint curative and preventive activities, for example, is today universally accepted. We have therefore made a simple study to determine whether the hospitals participating in the survey carry out immunizations against communicable disease in their out-patient departments, and have regarded this preventive action, which can be measured objectively and which may be recorded in the statistics, as an indication of the intention of the corresponding establishment to undertake work of a preventive nature. In the hospitals, in addition, we investigated the extent and development of the ambulatory and domiciliary medical services and determined whether there were X-ray and clinical laboratory services at the disposal of the out-patient department, since all these elements help to improve clinical work and to extend its influence to the home of the patient and consequently, to the community.

The place where all these combined activities are undertaken conjointly is the health center. The out-patient departments of the hospitals carry them on to a limited extent, while the social security out-patient clinics, even those with the most extensive and developed facilities for curative work, have, with rare exception, the drawback of not providing preventive care for their clientele. Domiciliary medical services hardly exist at all, whether under the ministries or under the social security system.

7. Cost of medical services

Table 6 shows that all the costs of medical care are higher in establishments run by social security institutions. It might sometimes be supposed that the shorter average stay in social security hospitals could partly make up for the greater cost per patient day. However, it can be seen from Table 6 that this is not the case, since the difference in the average stays is not sufficient to compensate for the difference in cost, often 2 to 6 times greater in social security establishments than in ministry ones.

It is very difficult, and would perhaps be injust, to make comparisons without a precise knowledge of the quality of the medical care given by the two institutions concerned. Nevertheless, the enormous differences encountered would not seem to be explainable satisfactorily solely on the basis of the quality of the care given.

We should like to call attention to a correlation which has been fairly constant in the hospitals where it could be studied. This is the correlation which exists between greater amount of medical time worked, shorter average stay, and higher cost of services (see Table 6). The

hypothesis might be put forward that the more time the physician spends per bed or per out-patient consultation, the more rapid the treatment of the case, but that this more intensive care makes the cost of each case higher. This is especially so in hospital work, where the average stay is long and the costs very low when the physician spends only a few minutes per day at each bed in his charge. On the other hand, short average stay and high costs coincide in those establishments which allow the physician to devote a more or less lengthy period to each bed in his charge.

This curious fact, which is evident from analysis of the statistical data collected, suggests that it is the high cost of the doctor-hour, and its repercussions on requests for X-ray and laboratory examinations and drug prescriptions, that make hospital care expensive. It would be necessary, however, to make a much deeper study in order to establish and verify what for the moment is merely a working hypothesis.

8. Attempts at coordination

In all countries there have been some limited attempts at coordination between the medical care services of the ministries of health and of the social security institutions. In at least one of the participating countries, legal provisions have been approved which establish a single administrative structure for the services. Even in that country, however, there still exist a number of small autonomous services which are unconnected with the national health service. In other countries, coordination has been sought at the local level. In still others, the services are using the same buildings, even though it is common practice in such cases, to hire the physical facilities while maintaining a totally separate administration. Finally, in some countries, the Ministry of Public Health has standard-setting and technical supervisory functions with regard to other medical services, which are rarely exercised because of lack of personnel or of economic resources for doing so.

In almost no country, however, is there coordination in the field where it is most important, i.e., in national health planning. The majority of the known health plans are only programs designed to improve the services of the ministries of health and completely ignore the services financed by social security institutions, which are often as great as and sometimes greater than those financed by ministries of public health. In other words, what is being planned is the public subsector of the health sector. It is not possible to have true health planning until this attitude is corrected, for the planners must determine all available resources and organize the best integral utilization of present and future resources, regardless of their origin.

9. Measures to improve coordination

The measures which are suggested below are simply intended to encourage the progressive coordination of services which are at present scattered. It would be an error to think that these measures can be introduced

rapidly or that they are going to give immediate results. The coordination of preventive and curative medicine can only be the result of a lengthy process of education of all the professional workers participating in the health team as well as the users of the present services. As a Scottish author has said, coordination cannot be imposed by decree but must rather be the product of an appropriate state of mind on the part of all the members of the health team.

a) Integral planning of development.- One of the fundamental conditions of planning as a scientific method is that it must incorporate all the elements of the sector being studied.

The health sector comprises programs directed towards the protection, the promotion and the restoration of health, and for this it is necessary to organize and develop resources in order to provide services covering environmental sanitation, preventive and curative medicine, and rehabilitation. These services are provided by local health agencies, which should have a regional and sectoral structure in order to concentrate highly specialized equipment and decentralize the basic services through an infrastructure making them available to the whole population.

The foregoing implies planning for the maximum utilization of the available resources, organizing health activities to avoid duplication, and assessing the present and future demand for service while progressively developing the ability to satisfy that demand.

In this complex process of planning, the participation of all the organizations and institutions that maintain health services and make investments for the development of health facilities is indispensable. Hygiene and preventive medicine are habitually and traditionally the responsibility of the ministries of health. As concerns curative medicine and rehabilitation, on the other hand, in addition to the ministries of health other central government agencies participate such as ministries of national defense, police and security services, as well as, social security agencies, and organizations of a private character, such as charitable agencies ("beneficencias"), foundations, the Red Cross, etc. In an integral health plan it is essential for the human,material, and financial resources of all these organizations and institutions interested in health to coordinate their action so as to achieve maximum utilization, and essential for them to follow a technically directed plan so as to ensure the enjoyment of the highest possible standard of health by all the members of the community.

In practice, what is required is that the authorized representatives of all these organizations which provide health services should form part of planning committees and that all their resources should be incorporated in the national health plans, the programs being governed by a single series of technical directives issued by a single competent authority.

b) Uniformity of the various social security systems.- Social security in Latin America has spread in a disorderly way and its coverage and field

of application, are governed by the varying degrees of pressure which the various groups of workers benefitting have been able to exercise in favour of a given system. One of the countries participating in the survey states that it has 7 separate systems of social security for different groups of the working population, with varying medical benefits for each group. Two or three different systems are common, and it is quite usual, for example, to have one social security system for wage earners and another for salaried employees, with completely different benefits.

The uniformity of all these systems of social security is one of the objectives which many governments have included in their immediate action plans,but only exceptionally has it been achieved, owing to the defense of their interests by the groups enjoying the most generous benefits.

Coordination would be much simpler if, as a first step uniformity of the social security systems could be brought about in the following respects:

1. A single system for collecting contributions, base on uniform percentages of wages depending on family responsibilities.

2. Equal medical and social benefits for all groups of workers.

3. A single scale of wages, salaries and social benefits for all employees of social security institutions.

These measures would avoid competition between different groups of the working population and the discrimination resulting therefrom, thus simplifying coordination of benefits, at the local level, for once these were similar they could be administered in a coordinated manner.

c) Extension of social security coverage.- There is, as already noted, a tendency to include new groups of the community in the social security system, establishing a minimum level of benefits which should be available to all members of the community.

Basically, this is an economic and financial problem: full coverage depends in the first place on the ability of the national product to absorb the financing of the social security benefits, and, in the second place, on the ability of each member of the community to pay the social security contributions. It is very probable that neither one nor the other will be able to finance universal coverage, which would be the ideal, but it is very likely, as is being done in many countries, that social security could extend its benefits to groups yet not covered. In this way, the field of action of the security institutions would be extended, and better financing of medical services would be brought about.

d) Coordination of local activities.- This is the simplest way to promote coordination, by creating in the infrastructures a suitable environment for the progressive coordination of health protection, promotion, and restoration activities at the local level.

It is necessary to take into account, however, that this coordination of local activities can only be successful if it meets with the support, the understanding, and the encouragement of the central authorities of the corresponding services. It cannot be expected that the officials working in a small rural village will coordinate their work if, at the central level, the higher executive authorities do not know one another, thus fostering lack of coordination at all levels.

There are several ways of putting such coordination at the local level into practice. One of them is the use of the same buildings for the services of different institutions. This is a system that is being utilize in many countries, but which frequently suffers from a serious defect, namely the maintenance of two administrations for the services although they work under the same roof. In practice, the result is that one part of the building is rented to an institution which, on occupying it, instals a complete administrative machinery, from the director down to the doorman, and operates in complete independence, even in ignorance, of the other administrative structure belonging to the institution owning the building. The truth is that such a system does not coordinate anything; on the contrary, it sometimes renders the defects and differences even more apparent, and this, in turn, leads to still less coordination.

The joint use of X-ray or clinical laboratory apparatus is another way in which coordination can be promoted.

Differences in administrative organization, as well as in the wages and the social benefits of the personnel of the different institutions, are generally a serious obstacle in the way of such coordination at the local level. When there is a group that is well paid, with stable career positions and good social benefits, working side by side with another group that receives insufficient wages, has no social protection, and at the mercy of political changes, the inevitable result is a feeling of resentment on the part of the underprivileged group.

Perhaps the most fruitful terrain for coordination is that of technical health activities in the field. When, by means of planning at the local level, the health needs and the demand for medical services of a community are determined, then the local authorities (of ministry of health services, social security institutions and other agencies concerned) can agree to carry out health protection, promotion and restoration program at the local level, using all available resources in the most rational possible manner in an attempt to satisfy the demand for medical services up to the maximum which these resources permit. A program of this kind calls for the appointment of a coordinator to whom, by agreement between the parties, is given sufficient authority to organize the resources with the sole aim of satisfying health needs. There are many programs of this kind under way in different countries of Latin America. Some, unfortunately, suffer from the limitation of not having access to

other programs of the"vertical type" for the eradication or control of specific communicable diseases or the sanitation of certain local areas. It is to be hoped, however, that this limitation will disappear when it is accepted that, once the attack phase of an eradication campaign terminates, it is essential for the integrated local health services to assume responsibility for continuing the maintenance phase.

e) Joint training of personnel.- As was stated at the outset, the process of coordination should be based, preferably, on a thorough understanding of its advantages by each and every member of the health team.

Training should begin in schools of medicine, nursing, midwifery, social work, dietetics, etc., in such a way that every member of these professions should, on starting work, be imbued with the concept of coordination acquired in student days in the respective university schools.

The post-graduate education of the specialist in public health, of the sanitary engineer, the hospital administrator, etc., should also lay appropriate stress on the concept of coordination. It is probable that this subject should be dealt with in the curriculum at even greater length than during undergraduate training. For these post-graduate courses will provide the high executives who will take charge of the health and medical care services at the national, intermediate and local levels, and because of this will be the key persons deciding the orientation of the integrated health programs. It is also desirable for the training of health service administrators to be undertaken in conjunction with that of hospital, and social and rehabilitation service administrators, since the administrative principles are always the same and only their practical application to different programs varies.

Finally, paramedical schools, for the training of auxiliary and supporting personnel should also incorporate the basic principles of coordination in their teaching programs, so that all the members of the health team, no matter how modest their position, may collaborate in an intelligent manner in achieving the objectives of integrated health programs.

As regards personnel already in service, they too should be trained in these disciplines by means of short courses and practical field experiments which will familiarize them with the general principles of coordinated administration.

CHAPTER II

THE COST AND SOURCES OF FINANCE OF MINISTRY AND SOCIAL SECURITY MEDICAL CARE

1. Relative importance of Ministry and Social Security expenditures for medical care

A simple, if rough, index of the relative importance of Ministries of Health and Social Security agencies in the provision of medical care is the relative amount of money each agency spends for the purpose. The percentage distribution of expenditure on medical care between the two types of agency is shown in Table 1. This money index is only approximate, since it is clear that the agency with the lower costs is serving a greater number of people per unit of money spent.

There appears to be no consistent pattern in the distribution of expenditure, except that the countries in which medical care under Social Security is a relatively recent development still of limited scope, such as El Salvador and Honduras, reflect this in relatively low medical care expenditure under Social Security, while this class of expenditure represents more than half the total in Peru, Mexico and Brazil.

It should be noted that the data for Chile are subject to the reservation that Social Security is represented only by the Employees' Medical Service, and that, as shown in Table 8 below, slightly more than 18 per cent of the expenditure of the National Health Service (Ministry) is derived from worker and employer contributions to social insurance.

Even in countries where the information is complete, the sum of Ministry of Health and Social Security expenditure for medical care by no means completes the picture for the public sector. Data prepared by the Sectoral Health Planning Office of Peru are shown in Table 2 to illustrate how complicated the public provision of health services can be. While the Ministry of Health and the two Social Security agencies did account for three-fourths of the recorded public expenditure on health in 1964 the health services of the armed forces, the other agencies of national government, and the Beneficencia system all represented considerable expenditure.

The mere fact that Social Security agencies account for a considerable part of medical care expenditure does not by any means imply that such agencies provide medical care solely by operating their own services. In some countries there are agreements whereby Ministry of Health hospitals and health centers provide medical care for persons covered by Social Security and are reimbursed by the Social Security funds, and in a few cases, the situation is reversed and Ministries of Health purchase services from Social Security facilities. In Chile the present National Health Service was built on the basis of the former Workers Social Security system, and the social

insurance agencies are decreasingly involved in the direct provision of medical care. In Peru, an important fraction of expenditure by the Employees Social Security represents reimbursement to covered persons for medical care expenditure in the private sector.

These variations are reflected in Table 3, which shows the percentage of Social Security expenditure on medical care devoted to the operation of their own facilities. The figure ranges from 100 per cent in Brazil and Mexico to 74 per cent in Peru and 60 per cent in Panama. While the health expenditures in Social Security agencies are almost completely devoted to the provision of medical care, this does not hold true for Ministries of Health which also have responsibility for a variety of preventive activities directed to individuals, such as vaccination, and for health measures directed to the community as a whole such as market inspection, health education, and the like. The percentage distribution of Ministry of Health expenditures among out-patient services, in-patient services, and community activities, is given in Table 4.

The extremely low figure for in-patient services in Costa Rica arises from the fact that the hospital care of the kind provided by Ministries of Health in most Latin American countries is largely financed in Costa Rica by local councils. If local financing were to be included with Ministry expenses, the per cent of total expenditure devoted to the community in Costa Rica would be correspondingly lower.

It will be observed, in addition to the wide variation in the relative importance of health services directed to the community as a whole, that the relative emphasis accorded to in-patient and out-patient care in Ministry expenditure also varies considerably. While a comparison for Ministries of Health and Social Security agencies for all ten countries is not available, 6 of the countries that provided Ministry data in Table 4 also provided information for Social Security medical care in Table 5. Even taking into account the many possibilities of error and non-comparability of data, a comparison for the countries appearing in both Tables 4 and Table 5 suggests that some sort of compensatory mechanism may be at work. With the exception of Honduras, Social Security agencies tended to give more emphasis to out-patient services in countries where the Ministry of Health gave relatively more to in-patient services, and vice-versa.

2. The problem of capital expenditure

Although it is important to distinguish between expenditures destined for the current operation of health services and investments in buildings, heavy equipment, and other items classified as "capital goods" in national accounts, the present study has emphasized current expenditure. One of the difficulties in making cost comparisons for Latin America is that national

accounting practices vary widely; it is seldom possible to ensure that no expenditure on capital items is included in data on current operations, while in some cases information on capital investment is not available.

The high cost and long life of hospitals and other major health facilities means -particularly in the case of the smaller countries- that a number of years may pass without significant capital expenditure while for years in which contracts for new construction are left the amounts will be extremely high. Data for the single year 1964, comparable with the information on operating expenditure, would therefore lack significance. Information was requested for the 1960-64 period instead, but even this proved extremely difficult to interpret for purposes of comparing Ministries of Health with Social Security agencies because other agencies of government were often importantly involved in the financing process. In Chile, for example, an autonomous public enterprise builds hospitals for the National Health Service and in Peru the National Health and Welfare Fund builds facilities which in other countries would fall in the Ministry of Health budget, while in Venezuela some Ministry of Health facilities are built with Ministry funds while others are financed by the Ministry of Public Works. Countries where the annual average capital expenditure in 1960-64 exceeded 10% of current operating expenditures for medical care were Mexico (37%), Venezuela (18%), and Honduras (12%) the figures relating to the Ministry of Health in all three. Although important construction programs were undertaken by Social Security Agencies, they generally fell outside the five-year period covered by the study except for Mexico where capital expenditure at an annual rate was 32% of operating expenditure on medical care by the IMSS.

In addition, in countries such as Brazil which have undergone severe price inflation, it is difficult to assess the current value of facilities built only a few years ago in the 1960-64 period.

Finally, as will be seen in the detailed country tables at the end of this document (in Appendixes 1-10) the investment required to put a bed into service is substantially different in the cases of new construction, remodeling of existing facilities, or acquisition by purchase.

The principal significance of capital data in the present instance is for the identification of items that should be excluded from current operating expenditure rather than for the separate analysis of capital accounts for a four-year or any other short period.

3. Direct comparisons of costs

One of the most difficult problems in the direct comparison of costs between Ministries of Health and Social Security agencies is the unit of measure. Obviously, since different populations are being served, the total expenditure does not necessarily correspond to the cost per unit of service delivered. Populations theoretically eligible for service do not provide an appropriate basis for comparison either, since theoretical eligibility and

actual access to service do not necessarily correspond. For purpose of a first approximation to direct comparison, therefore, Table 6 was based on the cost per patient-day in general hospitals operated by Ministries of Health and by Social Security agencies.

The first column on Table 6 shows ratios of costs per patient-day. While the cost was invariably higher in Social Security than in Ministry of Health institutions, the ratios varied from a low of 1.4 in Brazil to 5.8 in El Salvador and 6.1 in Honduras. The footnotes explaining limits to coverage are particularly important, since the relatively low ratio for Peru is based on data for the Workers' Social Security only, and it is known that costs per bed-day in the two large hospitals operated by the Employees' Social Security are considerably higher. Similarly; the substantially higher ratio for Chile reflects the costs of the Employees Medical Service while data for industrial accident insurance suggest that costs per patient-day in other social insurance funds may be far lower.

Columns 2 and 3 of Table 6 are designed to show costs per patient-day as related to an index of the level of prosperity of the different countries. The unit chosen (as being most commonly available) was gross domestic product at market prices, though it should be noted that gross national product at factor cost or any of the other general measures of national income would give roughly similar results. Gross product per capita was divided by 366 (1964 having been a leap year) to provide an estimate of product per person per day. Relating this measure to the cost per patient-day permits inter-country comparisons without the need for reference to exchange rates or money units.

Referring to the Ministry of Health data in column 2 of the table, the interpretation is as follows: Chile, El Salvador, and Venezuela have the lowest costs per patient-day in terms of national product. Regardless of whether the cost in escudos, colones, or bolívares is considered high or low, this means that relative to the country's ability to pay the cost was low. By contrast, the highest cost in terms of national product if found in Brazil and Peru, indicating that in these countries, where the cost is high relative to ability to pay, a greater sacrifice is involved in meeting the cost of a patient-day of medical care. The higher figures relating to the cost per patient-day in Social Security general hospitals in column 3 can be compared from country to country in the same way, though it should be noted that persons eligible for Social Security coverage usually have higher incomes than the national average and have contributed directly out of their incomes through the worker's share of Social Security financing as shown in table 9 below.

In analyzing the differences of cost, it is also important to identify the principal components of total cost. Table 7 shows the percentage distribution of costs in general hospitals among wages and salaries, medicines and medical supplies, and the remainder. Perhaps the most striking indication

of Table 7 is not the universal importance of wages and salaries in total cost, nor the range of variation recorded, but rather the indication that differences in relative share between countries are often more important than differences between Ministry of Health and Social Security hospitals within countries.

4. Sources of financing of medical care

Tables 8 and 9 show the percentage composition of total revenue for Ministries of Health and Social Security medical care. As might be expected, Ministries of Health obtain most of their resources from the national treasury while Social Security agencies rely most heavily on worker and employer contributions. A number of Ministries of Health, however, also receive substantial amounts from other sources. Further inquiry will be necessary before certain questions about the exact nature of "worker and employer contributions" and "transfer payments" can be resolved, but it is believed that in the main these items of Ministry revenue represent payments for services performed (e.g., medical care provided to persons covered by social security). Some countries have included contributions of international agencies such as PASB/WHO and UNICEF in the "other" category. Fees for service are negligible in half the countries covered, and range up to more than 7 per cent of total Ministry revenue in Peru. In most countries collecting fees, however, the revenues thus obtained are not at the disposal of the Ministry of Health but are required by law to be paid back to the national treasury.

In the case of Social Security agencies, legal dispositions vary, with some countries making explicit provision for contributions by national government while others rely almost exclusively on worker and employer payments. With the exceptions of Chile and Venezuela, fees for service are not a significant source of income. The large and variable "other" column reflects the autonomous financial management of social security agencies, which can obtain money from investments, from selling-off obsolete equipment, etc., and use the proceeds as operating income to supplement their revenue from workers, employers, and Government.

T A B L E I

Per cent distribution of medical care expenditure between Ministries of Health and Social Security Agencies, 1964.

	Ministries of Health	Social Security Agencies
Brazil	38(1)	62(2)
Chile	95	5(3)
Colombia	56	44
El Salvador	80	20
Costa Rica	56	44
Honduras	82	18
Mexico	13	87(4)
Panama	50	50
Peru	40	60(5)
Venezuela	63	37

(1) Includes some expenditure on items other than medical care.
(2) Six major retirement funds. (3) Employees Medical Service only.
(4) IMSS and ISSSTE. (5) SSE and SSO.

TABLE 2

Per cent distribution of total health expenditure
in the public sector, Peru, 1964

Agency	Per cent share of health expenditure
Ministry of Public Health and Social Assistance.....	34.3%
Other national ministries: Army	3.3
Navy	1.2
Air Force	0.4
Police	4.1
Education	0.4
National Health and Social Welfare Fund	6.5
Special Public Health Service	1.6
Employees' Social Security	22.6
Workers' Social Security	19.9
Charitable Institutions (Beneficencia)	5.6
Local Governments	0.2
Total	100.0

Source: Sectoral Health Planning Office, Ministry of Health

T A B L E 3

Per cent. of Social Security agencies' expenditure on medical care devoted to operation of their own facilities, 1964.

Brazil	100.0 (1)
Chile	80.0 (2)
Colombia	95.3
Costa Rica	91.8
El Salvador	89.4
Honduras	99.0
Mexico	100.0 (3)
Panama	60.3
Peru	74.4 (4)
Venezuela	79.5

(1) Six major retirement funds. (2) Employees' medical service only. (3) IMSS and ISSSTE. (4) SSE and SSO.

T A B L E 4

Per cent distribution of expenditures of Ministries of Health, 1964

Country	Out-patient services	In-patient services	Community health
Colombia		- 50 -	50
Costa Rica	67	1	32
El Salvador	27	65	8
Honduras	22	48	29
Panama	40	45	15
Peru	28	45	27
Venezuela	19	49	32

T A B L E 5

Per cent distribution of Social Security Medical care expenditure between in-patient and out-patient services, 1964

Country	Out-patient services	In-patient services
Brazil (1)	52	48
Chile (2)	40	60
Colombia	53	47
Costa Rica	68	32
Honduras	35	65
Mexico (3)	89	11
Panama	69	31
Peru (4)	52	48
Venezuela	70	30

(1) Six principal retirement funds. (2) Employees Medical Service. (3) Mexican Social Security Institute (IMSS). (4) Employees Social Security, Lima only.

TABLE 6

Relative costs per patient-day in Ministry of Health and Social Security General Hospitals, 1964, and comparisons of costs with gross domestic product per head per day.

Country	Ratio of cost per patient-day in Social Security general hospitals to costs in Ministry of Health general hospitals	Number of units of gross domestic product per-capita per day equal to cost of one general hospital patient-day	
		Ministry of Health facilities	Social Security facilities
Brazil.....	1.4 (1)	9.2	13.3 (1)
Chile.....	5.6 (2)	3.9	21.9 (2)
Colombia.....	2.2	4.8	10.5
Costa Rica.....	1.8	5.4	9.9
El Salvador.....	5.8	3.2	18.7
Honduras.....	6.1	5.2	31.7
Mexico.....	3.6 (3)	5.3 (3)	19.1 (3)
Panama.....	3.9	5.8	22.9
Peru.....	2.8 (4)	6.2	17.7 (4)
Venezuela.....	2.4	3.9	9.3

(1) Social Security data for Commercial Employees Retirement Fund only.

(2) Social Security data for Employees Medical Service only.

(3) Social Security data for Government Employees only. All data applies to D. F. only.

(4) Social Security data for Worker Social Security only.

Table 7

Distribution of current operating expenditure of general hospitals by class of expenditure, 1964.

Country and Institution	Wages and salaries	Medicines and medical supplies	Other
Brazil: Ministry of Health.....	82.8	- 13.8 -	
Social Security.....	...	...	...
Chile: National Health Service....	61.9	18.8	19.3
Employees Med. Service.....	...	...	...
Colombia: Ministry of Health.....	51.0	15.5	33.5
Social Security.....	42.0	43.7	14.4
Costa Rica: Ministry of Health....	60.1	15.9	24.0
Social Security (1)...	58.0	20.7	21.3
El Salvador: Ministry of Health (2)	51.4	34.0	14.6
Social Security.....	51.8	30.8	17.3
Honduras: Ministry of Health.....	57.3	42.4	0.3
Social Security.....	73.6	25.3	1.1
Mexico: Ministry of Health (3)....	75.6	14.0	10.4
IMSS.....	...	...	...
ISSSTE.....	...	...	...
Panama: Ministry of Health (2)....	61.1	16.9	22.0
Social Security.....	...	...	...
Peru: Ministry of Health.....	71.8	6.0	22.2
SSE.....	73.6	16.7	9.7
SSO.....	70.0	22.5	7.5
Venezuela: Ministry of Health.....	70.4	12.6	17.0
Social Security.....	65.1	7.4	27.5

(1) Out-patient services.

(2) Incl. health centers with beds.

(3) Health centers with beds.

Table 8

Per cent distribution of revenues of Ministries of Health, 1964, by source of funds.

Country	National Treasury	Contr. of workers + employers	Fees for service	Trans-fer payment	Other
Brazil.....	100.0	-	-	-	-
Chile (NHS).....	68.2	18.4	3.2	0.3	9.8
Colombia.....	92.8	-	-	-	7.2
Costa Rica.....	95.4	-	-	-	4.6
El Salvador.....	100.0	-	-	-	-
Honduras.....	73.8	-	1.5	21.4	3.1
Mexico.....	97.7	-	2.3	-	-
Panama.....	89.2	5.4	4.6	-	0.8
Peru.....	69.1	10.3	7.3	13.5	-
Venezuela.....	97.1	-	0.6	1.2	1.1

Table 9

Per cent distribution of revenues of Social Security agencies (sickness-maternity), 1964, by source of funds.

Country	National treasury	Contr. of workers + employers	Fees for service	Transfer payments	Other
Brazil (1).....	29.7	59.2	0.1	-	10.9
Chile (2).....	-	89.3	4.6	6.0	-
Colombia.....	5.8	87.6	-	-	6.6 (3)
Costa Rica.....	16.0	79.7	1.3	-	2.9
El Salvador.....	17.7	80.1	-	-	2.2
Honduras.....	-	97.4	-	-	2.6
Mexico (4).....	24.8	74.5	0.1	-	0.6
Panama.....	6.6	74.6	-	-	18.7
Peru (SSE).....	-	97.8	(5)	-	2.2
(SSO).....	-	73.7	0.9	4.3	21.3
Venezuela.....	11.3	73.0	13.8	1.3	0.6

(1) Six major retirement funds. (2) Employees medical service. (3) Includes some fees for service. (4) Mexican Social Security Institute; the separate fund for government workers (ISSSTE) receives all of its income from contributions. (5) Less than 0.1 per cent.

A N N E X E S

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B R A Z I L

I. ORGANIZATION OF THE MEDICAL SERVICES

A. SOME ASPECTS OF MEDICAL CARE IN BRAZIL

A highly complex system for the protection and restoration of health has evolved in Brazil over the years, partly as a result of scientific and technical progress in medicine and related sciences, and partly from a combination of demographic, social and economic factors. Among the latter, the political organization of the country merits special attention.

Brazil is a union of 22 states, 3 territories and the Federal District that constitute the Federation and the Republic, under a representative form of government.

The Federal Government does not intervene in the states, except in cases of exceptional gravity, such as the preservation of the national integrity, repelling foreign invasion and putting an end to civil insurrection.

The Constitution of the Republic places specific responsibility on the Union for the following problems related to the public health

1. organizing continuing campaigns to combat rural endemic diseases;
2. legislating general standards for the defense and protection of health, and on qualifications required for the practice of the technical, scientific and liberal professions;
3. assuring that labor and welfare legislation includes the principles of occupational safety and hygiene health services including hospital and preventive medical care for the worker and the pregnant women, and compulsory workmen's compensation insurance by the employer.
4. assuring that the provision of maternity, infant and child care is provided on a compulsory basis throughout the national territory.

Pursuant to such provisions, the Union carries on, through a number of different agencies, many activities in the field of public health that may be grouped under the following headings:

a. formulation and execution of public health programs at the national level;
b. provision of technical and financial assistance to the states, municipalities and private bodies;
c. preparation and advanced training of specialized personnel;

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d. making studies and carrying on applied research;
e. standardization and manufacture of prophylactic products and control of their use;
f. regulating production, distribution and sale of therapeutic products;
g. establishing technical standards to be observed throughout the national territory;
h. maintaining diagnostic reference laboratories;
i. supervising collection of statistical data with regard to the health situation on a nation-wide basis, and making the appropriate analysis of such data;
j. enforcing compliance with health regulations established under international conventions.

In addition to the functions prescribed by the Constitution, the Union carries on publich health programs in the Federal Territories and promotes medical care programs in all of the ministries, independent agencies and mixed capital companies in which it participates, providing medical services for their employees or for specific groups.

Under their respective constitutions and such laws as they may enact pursuant to the principles laid down in the Federal Constitution, the States are responsible for the following activities in the field of health:

a. preparing and implementing public health programs at the State level;
b. providing technical and financial aid to the municipalities and private bodies;
c. training personnel for the health services, principally the auxiliary personnel;
d. providing medical and hospital care for patients suffering from mental diseases, tuberculosis and leprosy;
e. maintaining public health laboratories;
f. exercising supervision over the practice of the professions and trade in drugs and food stuffs, in accordance with the pertinent Federal legislation.

Finally, the municipalities, whose autonomy is guaranteed by the Federal Constitution, are responsible for the organization of the local public services, among which the most important are water supply and disposal of sewage and refuse.

There are no constitutional or legal provisions in Brazil requiring the Union, the States or the municipalities to provide medical care for the population in general.

However, this is now accepted in the country as in important public health activity, and, as such, it is included in the federal, state and

municipal health services and liberally financed, primarily by the Union, and the states, when it is carried on under the responsibility of private institutions.

The analysis of the distribution of hospital beds and the official public health services, by the type of agency maintaining the service, will give an idea of the participation of each sector in the provision of medical care (Tables 1 and 2).

B. ADMINISTRATIVE STRUCTURE OF THE CENTRAL AUTHORITY

The central authority responsible for preparing general directives on health problems in Brazil is the Ministry of Health, which is responsible for "study, research and guidance on medical and health problems, and the execution of measures within its competence designed to promote, protect and restore health".

However, there are other bodies at the federal level that have virtually autonomous health services, operating without any relation to the health policy carried out by the Ministry of Health. The most important of these entities are:

a. The Health Service of the Armed Forces, operating throughout the entire country.

b. The Ministry of Justice, which has under its jurisdiction the Child Welfare Service (SAM) and the Territorial Health Services.

c. The Ministry of Labor, which has the responsibility for legislation on occupational hygiene and safety. The Division of Occupational Hygiene and Safety, in the National Labor Department, has responsibility for establishing standards, the executive function being exercised by the Occupational Hygiene and Safety Service in the Regional Labor Offices.

   Also under the Ministry of Labor are the Retirement and Pension Institutes, the Home Medical Care and Emergency Service (SAMDU), and the Federal Employees' Social Security and Welfare Service (IPASE)..

d. In the Ministry of the Treasury, there is the Medical Service of the Federal Savings Banks; and, in the Ministry of Communications, the Medical Services of the Fereral Bureau of Public Roads, Loide Brasileiro and the Rio de Janeiro Port Authority.

Among the more important independent agencies directly under the Office of the President of the Republic, mention may be made of the Medical Services of Petrobras, and of the Brazilian Welfare Legion. The latter is specifically designed to provide mothers and children with services.

As may be seen, there is a plethora of governmental and paragovernmental agencies responsible for health services at the federal level; but, despite this fact, the Ministry of Health is responsible by law (Law No. 1920 of July 25, 1953) for "the resolution of all problems within the competence of the Federal Government with regard to human health."

The Ministry of Health consists of the following bodies directly responsible to the Minister (See Organization Chart):

- The Office of the Minister (GM)
- The National Health Council (CNS)
- The National Food Commission (CNA)
- The Documentation Service (SD)
- The National Security Section (SSN)
- The Health Statistics Service (SES)
- The Department of Administration (DA)
- The National Health Department (DNS)
- The National Children's Department (DNCr)
- The National Department of Rural Endemic Diseases (DNERu)
- The Oswaldo Cruz Institute (IOC)
- The National School of Public Health (ENSP)
- The Special Public Health Service Foundation (FSESP)

The Office of the Minister is responsible for receiving and transmitting orders of the Minister, and rendering the necessary cooperation and assistance in carrying out his duties and in his political and social representation.

The National Health Council is responsible for assisting the Minister in matters relating to the public health.

The National Food Commission coordinates activities related to food problems, carried on in various other governmental agencies.

The National Security Section is responsible for cooperating in the internal policy plans of the country with regard to health problems, in accordance with the guidelines established by the National Security Council.

The Documentation Service is designed to compile, organize and preserve documents, photographs and statistical data and to promote expositions and conferences on topics related to health.

The Health Statistics Service is responsible for preparing statistics with reference to the medical and health activities of the country, and for their dissemination. This Service functions as a part of the National Statistical Services, represented by the Brazilian Institute of Geography and Statistics.

The Department of Administration is responsible for promoting, or supervising the execution of activities related to personnel, materials, budget, works and transportation, etc, under the technical guidance of the Department of Public Service Administration (DASP).

The National Health Department is responsible for making surveys and carrying on research and studies relating to the health situation of the Brazilian population; supervising the administrative work of the federal services designed to foster, protect, and restore health, coordinating its services with those of the states and municipalities and with private organizations, guiding them and providing technical assistance, and further studying the criteria to be adopted for providing assistance and federal subsidies to carry on their health activities.

It has the following divisions:

- Division of Hospital Organization (DOH)
- Division of Sanitary Organization (DOS)
- Administrative Service (SA)
- Federal Medical Biometrics Service (SBM)
- National Mental Disease Service (SNDM)
- National Health Education Service (SNES)
- National Service for the Supervision of Medicine and Pharmacy (SNFM)
- National Tuberculosis Service (SNT)
- National Leprosy Service (SNL)
- National Port Health Service (SSP)
- National Cancer Service (SNC)
- National Service for the Supervision of Dentistry (SNFO)
- Branch Offices of the Federal Health Service (7)

The National Children's Department coordinates and gives technical aid to all of the public and private institutions dealing with maternity, infant, and adolescent care. It consists of the following bodies:

- Division of Organization and Cooperation (DOC)
- Division of Child Welfare (DPS)
- Fernandes Figueira Institute (IPP)
- Administrative Service (SA)
- Statistical Service (SE)
- Education and Information Service (SED)
- Federal Children's Department Branch Offices (DFCr)

The National Department of Rural Endemic Diseases is the agency responsible for combatting the major rural endemic diseases throughout the national territory, except in a large part of the State of São Paulo, where the state services are carrying on the campaigns for the eradication of malaria, and control of Chagas' disease, trachoma and schistosomiasis. Its organization comprises the following:

- Division of Prophylaxis (DP)
- Division of Cooperation and Information (DCP)
- National Institute of Rural Endemic Diseases (INERu)
- Prophylactic Products Service (SPP)
- Administrative Service (SA)
- District Offices (C)

The Oswaldo Cruz Institute has responsibility for studying problems of human biology and, specifically, the hygiene and nosology of the country, and for this purpose is authorized to make surveys, and carry on research projects and studies on the epidemiology of the diseases prevalent in the country, and the manufacture of biological products (sera and vaccines) for use in human medicine, the analysis of similar products whatever their origin, and performing the laboratory examinations required by the Federal health services.

The Oswaldo Cruz Institute has the following organization:

- Division of Research and Endemic Disease (DEE)
- Division of Physiology (DF)
- Division of Microbiology and Immunology (DMI)
- Division of Hygiene (DH)
- Division of Pathology (DP)
- Division of Chemistry and Pharmacology (DOF)
- Division of Virology (DV)
- Division of Veterinary Medicine (DZM)
- Administrative Section (SA)
- Auxiliary (Services) Section (SAu)
- Library (B)
- Museum (M).

The National School of Public Health is responsible for training technical personnel at all levels required by the Public Health Services of the country, and also engages, to the extent of its possibilities, in studies and research projects on matters of interest in the fields of medicine and health.

The Special Public Health Service Foundation is a para-governmental body, under the Ministry of Health, with jurisdiction throughout the entire national territory, and having its headquarters and seat in the Federal District.

Its principal purposes are to:

- organize and operate public health services in regions having economic development programs;
- study, design and construct water supply and sewerage systems;

- organize, administer and coordinate services for the development of a basic health structure, in states where the governments so request;
- coordinate, organize and administer independent water supply and sewerage systems, under contracts with the interested municipalities;
- carry out the necessary research projects, surveys and studies to develop its activities.

Its organization comprises the following:

- Division of Community Health
- Division of Education and Training
- Division of Planning and Evaluation
- Engineering Division
- Administrative Division
- Regional Health and Engineering Offices
- Technical Council

Despite the fact that the Ministry of Health ought to be essentially a regulatory body, it nevertheless comprises executive agencies as well as educational and research entities.

The National Department of Rural Endemic Diseases is both a regulatory and executive body, since it not only issues the directives to be followed in combatting endemic diseases, but also performs the work throughout the national territory.

There are three executive bodies in the National Health Department: the Service of Medical Biometrics, the Federal Biostatistics Service and the Port Health Services. Other services, such as the National Tuberculosis Service, and the National Leprosy Service, assume limited executive functions in some States of the Federation, but they are essentially of a regulatory nature.

The Special Public Health Service Foundation is both regulatory and executive, inasmuch as it maintains and operates a sizeable welfare network in virtually all areas of the country.

Finally, mention must be made of the establishment, under the forthcoming administrative reorganization of the Federal Government, of a planning body in each Ministry to be responsible for formulating plans and programs for the work in each sector, which plans will then be integrated into the General Development Plans prepared by the Ministry of Planning.

Summary Analysis of the Federal Health Agencies

a. In addition to its complexity, the Federal health structure suffers from the effects of institutional factors that still prevail in Brazil and that make difficult or even obstruct the operation of the country's technical and administrative machinery. The inadequate data, impeding research on the organization of services, and the lack of coordination between the Federal Government, the states, the para-governmental services and the private organizations prevent a satisfactory technical return from the existing services, that are frequently carrying on similar activities in the same locality or regions, involving vast technical and administrative losses.

The most glaring example of such lack of coordination is that of the social welfare system with the Ministry of Health. What happen is that the welfare agencies responsible for providing medical care to the working class do not even coordinate their own services, and much less do they coordinate them with those of the Ministry of Health. The latter, in turn, is financing a large number of beds in private institutions, and even supports and operates a large number through the SESP Foundation, the National Tuberculosis Service, the National Cancer Service, and the university hospital clinics.

b. Another negative aspect with regard to the welfare system is the lack of preventive services in its programs. The lack of coordination between the system and the Ministry of Health has made it impossible to integrate the system's health services in the general context of the country's public health program.

c. The lack of up-to-date legislation leads to deficiencies in regard to industrial and health inspection of products of animal origin, and the control of manufacture and trade in drugs, biological products, etc. There is an exaggerated centralization of such services in the Federal Government, and the latter, incapable of extending its services over the entire country, does not give the States authority to supervise and inspect products that can have an injurious effect on the public health.

d. Another important point to be considered concerns the branch offices of the Health and Children's Department, which should be reorganized in such a way that they could establish effective coordination between the Federal, state and private services in their respective fields of activity.

e. There is no uniformity in the compilation of data with regard to the cost and the volume of services rendered. In general, the organizations do not have any method of allocating costs that relates expenditures to the volume of services produced. At the same time, it should be

noted that the welfare institutions publish the most precise data on the sums expended for the restoration of health, although they are unable to report with any accuracy the volume of services rendered, or what proportion of their beneficiaries have access to such services.

State and Local Organization

With the recognition that better organization of the services is the first step in providing improved health services to the people, the States have made an attempt, some by creating Departments of Health and Welfare in lieu of the former Health Departments, and others by dividing the Department of Education and Health into two separate departments, to the end that all of the States at present have a separate Department of Health, with its own organization. However, for the most part they have certain common negative aspects that impede the effective operation of their services.

The following example of a State Health Service is given, with a critical analysis of its operation.

State Department of Health

1. Office of the Secretary
2. Bureau of Health Stations
3. Bureau of Medical Care
4. State Children's Bureau
5. Tuberculosis Bureau
6. Bureau of Sanitary Engineering
7. Leprosy Bureau
8. Bureau of Demography and Health Education
9. Bureau of Neuro-Psychiatric Services
10. Bureau of Professional Licensing
11. Administrative Bureau
12. School of Public Health (which includes the Hermantina Beraldo School of Nursing)
13. Ezequiel Dias Institute

The ten bureaus, the Institute and the two Schools carry on their activities through 47 services and 57 sections.

The executive agencies of the Department, that is, those that directly provide medical and health services to the population comprise:

- 41 Health Centers
- Pilot Health Center at Belo Horizonte
- 236 Hygiene Stations
- Cícero Ferreira Isolation Hospital

- Cancer Hospital
- Raúl Soares Institute
- Barbacena Mental Hospital
- Child Neuro-Psychiatric Hospital (Belo Horizonte)
- Child Neuro-Psychiatric Hospital (Oliveira)
- Psychopedagogic Institute (Belo Horizonte)
- Galba Veloso Hospital
- Ernani Agrícola Sanatorium (Sabará)
- Cristiano Machado Sanatorium (Roças Grandes)
- Santa Isabel Sanatorium (Mario Campos Station)
- Santa Fé Sanatorium (Três Corações)
- São Francisco de Assis Handicraft School (Bambuí)
- Padre Damião Sanatorium (Ubá)
- 10 Leprosy Dispensaries (1 in the capital and 9 in the interior of the State)
- Eduardo Menezes State Sanatorium (Belo Horizonte)
- João Penido State Sanatorium (Juiz de Fora)
- 8 Tuberculosis Dispensaries (2 in the capital and 6 in the interior of the State)
- Antônio Dias Regional Hospital (Patos de Minas)
- Samuel Libânio Regional Hospital (Pouso Alegre)
- Eduardo Menezes Welfare Sector (Juiz de Fora)

There are also 34 Health Units -6 Mixed Units and 28 Hygiene Units- in the State, directly administered by the Special Public Health Service Foundation, under an agreement signed with the State Government.

The public health services of this State Health Department reveal the following deficiencies:

a. The mere listing of the number of existing bureaus, with their respective services and sections, reveals excessive institutionalization, with an exaggerated number of division heads issuing regulations and frequently conflicting instructions to the welfare units. In other words, there is no organ for centralizing technical standards, so that each bureau acts in complete independence of the other, thus seriously prejudice the field work.

b. Biostatistical data are not systematically utilized in orienting the programs, and evaluating their effectiveness, and such poor utilization gives rise to an enormous lag in applying new techniques and resources.

c. Absence of a clear definition of responsibility, leading to disorganization and lack of coordination among the various agencies of the Department.

d. Lack of non-professional personnel, which is inadequately trained for the needs of the service. Auxiliary personnel is hired on the basis of political considerations and is consequently incapable of performing the most elementary tasks.

e. Lack of local supervision of the executive agencies. The principle of regionalization of the services is not followed. The welfare units report directly to the central bureaus, which, in a large State, leads to technical, administrative and even policy problems.

f. Resources are not utilized to the best advantage in view of the large number of agencies exercising directive functions.

Local Organization

The foregoing comments give an idea of the organization of health services at the local level, since all of the defects and lack of coordination at the higher echelons are duly reflected.

The local health units have multiple functions, with the basic activities of medical care, control of communicable diseases, maternal and child health care, environmental sanitation, biostatistics and health education. The staff varies according to the size of the unit, or in other words, in proportion to the number of persons to be served and the specialized services available to them. With regard to hospital facilities, there are specialized hospitals (Leprosy, Tuberculosis, etc.) and general hospitals provided with the basic services of clinical medicine, surgery, obstetrics and pediatrics.

In addition to those described in Chapter I, the following deficiencies can be pointed out in the local health organization:

a. Outpatient treatment and hospital care are provided in haphazard fashion, due to the lack of specialized personnel, medicines and adequate auxiliary services (laboratory, X-ray, etc.)

b. For these reasons, the Health Units are unable to provide emergency treatment, and do not have a few beds available for certain cases in which the patient may be hospitalized during the day, or is awaiting transfer to the nearest hospital.

c. There is no coordination between the Health Units and the hospital facilities that may possibly be available in their areas. This lack of coordination makes it impossible for the units to move patients in need of hospitalization.

d. Communicable disease control, both by medical and environmental sanitation,measures, is inadequate. The lack of adequate planning impedes improvement in environmental conditions through the installation of water supply systems (both large and small) or a satisfactory sewage disposal system. The immunization program is affected by the fact that bids must be opened for all types of supplies and services, in particular for obtaining a regular supply of high quality biological products for the State health services (and this is, as a matter of fact, a nation-wide problem).

C. NATIONAL HEALTH PLAN

Brazil does not yet have a national health plan.

Up to 1960, activities programmed at the national level were designed to control or eradicate certain diseases, such as malaria, yaws, plague, Chagas' disease; and economic development plans were limited to areas that constituted a political and social problem.

It may be stated that the era of national planning began after 1961, with the Three-Year Plan, and in 1964, the "Federal Government Economic Action Program - 1964/1966" began, although it did not constitute a global development plan.

Health was not included among the "Action Instruments", in that "Action Program", and appeared only in that part relating to social development, merely as an indication of priority areas for the use of Federal funds.

At the present time the Office of Applied Economic Research, in the Planning Ministry, is preparing a Ten-Year Economic and Social Development Plan for Brazil, scheduled for completion by the end of the current year, that will represent the first long-term plan devised for the country.

In view of the responsibilities assigned to the Union by the Constitution, a national health plan for Brazil would have to be developed by combining a Federal plan with the State plans in an harmonious way.

There will not be sufficient time to compile the necessary statistical data for a study of health activities carried on by the State and municipal governments and by the private organizations for inclusion in the Ten-Year Plan now in preparation.

Hence, with reference to health, the Ten-Year Plan will have the basic objective of assuring the best possible utilization of the Federal resources allocated to the principal institutions that constitute the Federal system for the protection and restoration of health.

According to the guideline adopted by the Health Sector of the Office of Applied Economic Research, in the Planning Ministry, these institutions are:

1. The Ministry of Health
2. The Special Public Health Services Foundation
3. The Ministry of Labor and Social Welfare
   a. Departments of Medical Care, in the six social security institutes
   b. Home Medical Care and Emergency Services
4. The Ministry of Communications
   a. National Bureau of Sanitary Works
5. Social Pioneers Foundation
6. Brazilian Welfare Legion

D. SOCIAL SECURITY INSTITUTIONS

Social insurance organization in Brazil is extremely complex. Coverage of wage-earners under the system is concentrated in the so-called IAP's (Retirement and Pension Institutes) under the general supervision of the Ministry of Labor and Welfare. The institutes provide uniform benefits that include medical and maternity care. Including insured workers and their dependents, some 20 million persons were covered in 1964. In that same year, the Rural Social Security Service was established, under the direction of the Industrial Workers' Retirement and Pension Institute, to give medical care to nearly 40 million beneficiaries. Accordingly, it is estimated that eventually the social security system will reach a total of 60 million persons. Benefits will become available to the new groups as soon as the task of registering population groups engaged in farming and stockraising activities is completed. Urgent measures are being taken to organize and coordinate all health and welfare resources to meet the forthcoming load.

In addition to the system described above, many other organizations are providing medical and welfare services and together, through various types of action programs, they constitute the Brazilian social security system. Among them may be listed: The Civil Service Social Insurance and Welfare Institute (IPASE), with nearly 500,000 beneficiaries covering Federal Government workers and their dependents; The Bank Employees' Social Insurance and Welfare Service, with nearly 24,000 beneficiaries; the welfare services of the Armed Forces and the various welfare agencies for State and municipal employees, covering the government employees in these political divisions of the country.

The bulk of the population (some 80 million persons) is covered in these systems, and their activities extend over considerable part of the nation's territory (8,500,000 square kilometers). Almost 9 million of the total population is concentrated in two major cities half of the population is dispersed over vast areas with a low population density. Similarly, medical care resources are either highly concentrated or diluted to the point of non-existence. The factors conditioning future welfare programs are indicated by these features.

Legislation to establish a social security system in Brazil had its origin in 1923, when the railroad workers were covered, on the basis of compulsory insurance, in a plan financed by monthly contributions from the wage-earner and the employer. Hundreds of retirement and pension funds, similar to that of the railroad workers, were rapidly set up covering many other groups of workers. Some included among their benefits cash payments to compensate for the loss of earning capacity by reason of sickness or childbirth. The more prosperous funds also provided medical care. The doctors employed on contract were given fees for the services rendered, or were employed on a straight monthly salary.

With the establishment of the Ministry of Labor in 1930, the then existing labor unions as well as the retirement and pension funds (that had by then grown to several hundred) were brought under its jurisdiction. Subsequently, these various funds were gradually absorbed and merged into the six existing retirement and pension institutes. Each of the latter had its own regulations and, prior to 1960, the types of benefits paid were many and varied. In that year, culminating a series of efforts on the part of the government dating back to 1945, an important objective was reached in the organization of the social security system. The Organic Social Security Law and its general regulations (LOPS and the LOPS Reg.) prescribed uniform standards for the then existing system. However, from the outset, implementation of that law revealed that submission to political pressures jeopardized the technical and administrative principles that should guide a social security program. Since no unification of the system had been accomplished, even though it was subject to uniform standards, its administrative and technical services were permitted to follow a variety of procedures, within the broad general precepts. The operating organs of the social security system, represented by the institutes, continued to function with six independent directorates, and under these six directorates, an equal number of medical bureaus continued to provide medical care to 20 million beneficiaries.

Social security in Brazil is based on a system of triple contributions, and the financial method of capitalization of resources, with employers and employees paying in equal amounts, based on the wage-scale of the insured, with the employee's contribution limited for these effects to multiples of the highest minimum-wage in effect in the country. The Federal Union is responsible for the contribution of an amount not exceeding the total contributions of the insured, to defray expenses of the general administration, including personnel, of the social security institutions, as well as covering their financial deficits and supplying the technical deficiencies in the services.

A fourth share, not necessarily equal to that paid in by the employees and employers, but specifically recovered from the capitalization method, completes the financial and economic structure of social security in Brazil. This latter portion is constituted indirectly from interest on capital investment of surplus revenues in each fiscal year.

With regard to maternity benefits, the pregnant insured worker, or the insured worker for his uninsured wife or person designated by him, is entitled to benefits after 12 monthly payments have been made into the fund, in an amount equal to the minimum-wage in effect in the area where the insured is employed.

If it is impossible to provide such medical care, the maternity benefit will be doubled.

Administrative Organization of Institutions Providing Medical Services

Each social security institution has a Department of Medical Care (DAM), headed by a director, under which there are various sections (personnel, equipment, hospitals, finances, technical consultants, etc.) to administer and supervise the services provided at the national level. The peripheral agencies operating under the direction of the DAM are the local medical bureaus, one in each State, with authority to administer and supervise provision of medical care within a given geographic area. Hospitals and outpatient services are under the State medical bureaus. This arrangement, in fact, fulfills the provisions of the law (Article 411, LOPS Reg.):

> "Social security institutions will organize their services on the principle of decentralization, in such a way that the benefits for which they are responsible will be promptly and effectively provided throughout the national territory".

The institutes maintain a home medical care and emergency service (SAMDU) that has a considerable degree of autonomy, with its own directorate. SAMDU has an organizational structure similar to that of the medical bureaus (DAM's) and its executive services are a part of the State medical bureaus that in turn operate a large number of health posts distributed in the interior of the States.

However, up to the present time, there has been no effective and properly oriented planning of this decentralized system. Various negative factors may be pointed out:

1. The multiplicity of local agencies providing services, resulting in a marked disparity in the quality and extent of such services.

2. Inevitable duplication of activities with a consequent increase in the cost of medical and para-medical services, and of material resources available locally, such as hospitals and equipment.

3. Increase in idle facilities in some areas, contrasted to their complete absence in others.

The National Department of Social Security (NDPS) under the Ministry of Labor and Welfare is responsible for planning, directing and coordinating administration of social security. Little positive progress has been made, despite many attempts, along the line of coordinating medical care.

For purposes of planning medical care, the DNPS has a Council on Social Security Medicine (CMPS), composed of the directors of the various medical bureaus and SAMDU and representatives of the medical profession. The law (Article 341, LOPS Reg.) provides the guidelines for the CMPS along two broad lines:

a. To assure the effective provision of medical care under a system of combined services.

b. To work with the competent authorities of the Ministry of Health and with other organizations providing services to effect the coordination or their activities with those of the social security system.

The system of combined services consists in providing the welfare services jointly, according to the local needs, the convenience of the beneficiaries, and the efficiency of execution. Those factors -local needs, the insured, and efficiency- constitute a trinomial equation that has not as yet been adequately solved. Only now, through the intermediary of the Planning Ministry, are national studies being made to develop the indicated solutions. Thus, only one attempt has actually been made, that of the Hospital in São Luis, the capital of the state of Maranhão, where the six institutes are sharing expenses. Under the system of combined services, one of the institutes (generally the one having the largest membership in the given area) is given overall responsibility for providing the services, with the others sharing expenses by means of contributions proportionate to the services utilized by their respective members. Another combined service, in this case pursuant to 1960 legislation, is that of SAMDU. This organization has its own administration, which has a certain degree of independence. That feature is also reflected in the expansion of its peripheral welfare services, not infrequently resulting in parallel activities. The benefits provided are, obviously, of considerable value. However, they are rendered on an uneconomic basis in view of the lack of coordination between the welfare services. It has been found that in the large cities both the medical services of the various institutes and SAMDU posts are operating, without there having been any provision regulating the required interdependence of the whole. Although of limited applicability, there is a provision in the law covering such situations (Article 121, VII, LOPS Reg.):

> "When the beneficiary of social security has established his eligibility, he may in cases of proven urgency receive treatment from an Institute other than the one of which he is a member, if the latter has no service of its own or a combined service in the place where the beneficiary is located".

Such a measure proved to be impractical since, paradoxically, as result of the lack of any type of cooperation between the peripheral services, it gave rise to a series of bureaucratic procedures that were naturally time-consuming and incompatible with the nature and requirements of an adequate medical service.

General Data on the Formation and Budgeting of Funds for Medical Care under the Social Security System

Brazilian social security legislation (LOPS, Article 45) guaranteed the insured workers and their dependents provision of clinical, surgical, pharmaceutical and dental care, in outpatient clinics, hospitals, sanatoria, or in the home, with the following directives:

a) Medical care would not be limited quantitatively or qualitatively as to the extent of services provided;

b) Medical care would be limited by the funds paid in;

c) Medical care would be limited by the local conditions.

The foregoing warrants some comments, especially since such comments can be based on the experience obtained on the first five-year period following the 1960 legislation.

The conflict between the first two directives is obvious. There can be no limit to expenditures on medical care when it is available without restriction. On the other hand, to limit it to a fixed annual budget, to be utilized for the benefit of millions of individuals, without adequate technical and administrative direction, leads to high costs, reduced efficiency, and hence a lower return on the amount invested.

Expenditures on medical care under the social security system are governed by the amount allocated each year in advance. The budget estimate establishes an amount to be allocated to each institute. During the succeeding fiscal year, each institute spends what it has been allocated. In other words, it provides the services it can pay for with the money received, without regard to the medical needs of the group receiving benefits. There is no plan, based on priority of services, and there is great disparity in the medical service offered. The "per capita" costs shown in the statistical tables for social security reveal this disparity.

The negative correlation between the two concepts -broad medical care and expenditures fixed in advance- is based to some extent on Article 121, VII, LOPS Reg. which states:

"Prior consideration will be given, in the provision of all medical care, to its extension to the largest possible number of beneficiaries, in the greatest number of localities, on minimum standards, rather than to the provision of high levels of service to a reduced number".

The principle advocated here can be conceived by the legislator, who may not always be properly advised. The medical profession in the country, as well as professional social security personnel, have been opposed to such a provision. Medical care based on minimum standards is not only an impractical compromise for the social security system but would weaken normal incentives to the practice of the medical profession. In fact, in standing on its traditional prerogatives, the medical profession is forced to include among them a normal and continuing receptivity to means of perfecting its training and techniques. Obtaining the highest caliber of medical care, without discriminating in favor of a limited number of beneficiaries, must be taken as the rule to be applied to all beneficiaries. Accordingly the opposite criterion to that recommended in the law must be established in planning such services. Along this line, a study was undertaken in 1962 to estimate the cost of the medical care provided. This study, made by a committee of doctors and actuaries, proposed that various categories be established for sharing the cost of the services utilized. Such payments would be graduated according to the income and the family responsibilities of the individual using the services. It was at this time that the concept emerged of a high and low risk, classified according to the relation between the expenses incurred and the financial capacity of the user. In principle, this approach to the question offers promising possibilities for controlling excessive expenditures on medical care. It has the support of the national medical corps, since it would permit a wider application of the so-called "free choice" system, under which the insured would be guaranteed freedom to select the doctor to treat him, provided he paid a part of the expenses. Unfortunately, representatives of the groups insured opposed continuance of the studies, on the ground that they would constitute an additional burden on wage-earning groups. In any case, problems related to the extension, the quantity, the quality and the cost of medical care remain unsolved and, on the basis of experience gained during the five-year period, must constitute the prime consideration in future planning.

Activities in the Field of Preventive Medicine

Activities in the field of preventive medicine were reduced to the point of not appearing in the budgets or in the accounts of the social security institutions. Tradition has linked this type of medical care to the governmental sphere (either Federal, State or municipal). The modern concept of integrated and combined services, whether in the field of disease prevention or in the restoration of health, was recommended by the law (Article 121, IX, LOPS Reg.):

"Medical care under the social security system will include preventive services to the extent possible, because of their social benefits as well as their effects on the incidence of risks covered by social security, including, for this purpose, not only regular systematic and continuing campaigns as may be indicated, but integrated and operated in cooperation with the general health services of the Federal, State and municipal governments".

Obviously, with limited budgets and with the burden of separating preventive and curative care, and primarily, in the total absence of plans formulated in conjunction with the public health services, the social security system failed to follow the recommendations of the law in this regard. This is one of its fundamental failings that must be corrected without delay.

Legal and Administrative Relationships between the Social Security Institutes and the Ministries of Health, with Special Reference to Overall Administration and Orientation of Such Institutions

Social security in Brazil is administered by the National Department of Social Security, an organ of the Ministry of Labor and Welfare. With regard to medical care, it is the responsibility of that Ministry to see that it is financed by compulsory social security contributions, under the system described above. The health services of the Ministry of Health are financed by the Federal Government and the funds obviously are supplied from the Federal revenue and tax system.

It is not the function of the Ministry of Health, as has been pointed out, to provide general medical care for the population, since the social security institutions are legally empowered to do so, to the extent permitted by their resources.

Legally, the social security institutions have no direct connection with the Ministry of Health. Indirectly, the latter Ministry of necessity can influence the institutes since it is responsible for proposing legislation on general standards for the protection and restoration of health, as provided in Article 5, XV-b, of the Federal Constitution. This connection also includes the Health Ministry's representation on the Council on Social Security Medicine (Article 341, Decree Law No. 48 959-A, in the General Social Security Regulations).

From the standpoint of administration, relationships between the social security institutions and the Ministry of Health have been established through the simple exchange of letters or in agreements. One of these, for example, requires the social security institutions to maintain a certain number of beds for tubercular patients in a hospital maintained by the Ministry of Health.

Consequently, coordination of medical care resources of the social security system and the Ministry of Health suffers from a lack of adequate legal and institutional instruments.

Various attempts in recent years have been made by the Federal Government to correct this situation. Among them may be mentioned the draft of an Organic Law on Medical Care and Hospitalization, prepared by the Committee created under Decree No. 37 773, of August 18, 1955, and the recommendations of a special committee appointed under Decree No. 51 647, of December 27, 1962, to consider measures required to coordinate the hospital and medical care resources of the country.

The Economic Action Program of the Government 1964-1966, now in effect in the country, provides (in Chapter XXIII) with regard to social security:

"Emergency measures dealing with one or another isolated sector of organization and operation, are not enough to correct the present social security situation. The vital necessity, after 41 years's experience with the National Social Security System, is to make a thorough-going revision of existing legislation, designed to correct the distortions in the social security field, and strengthen its bases..."

Among the general principles laid down for this revision, the Economic Action Program mentioned "transfer of all of the medical care functions, with the exception of the specialized services, to a single new Federal agency, to be given responsibility for providing medical services, in the broad sense, under the jurisdiction of the Ministry of Health".

Meanwhile, these efforts have not produced any practical measures to bring about the desired coordination of medical care services in the country.

In the matter of the social security system itself, there are also difficulties in coordinating medical services.

The historical factors that have led to the present organization of the social security institutes have made themselves felt whenever an effort has been made to unify the services or coordinate their activities. The institutes, established to consolidate retirement and pension funds by professional categories, on the one hand reflect this social stratification, and on the other, represent important sources of support for political voting blocs. Consequently, both their leaders and the members tenaciously defend their independence of action.

Without unification effected at the top echelon, it would be difficult to bring about any coordination of those institutions' medical resources.

The Outlook for Rural Social Security

On December 10, 1963, regulations were issued under the Rural Labor Statute, enacted into law in March of that year. The Industrial Workers' Retirement and Pension Institute (IAPI) was given responsibility for collection and administration of a fund to finance the benefits provided in the law. The importance of this vast expansion in the Brazilian social security system necessitates a discussion, even though a brief one, of the measures instituted in 1964. The facts and figures given here are taken from the IAPI General Report of 1964. That institution was initially given the task of organizing a social security system that would eventually include half of the Brazilian population, developing a method of collecting an entirely new tax, and registering millions of producers and bringing about registration of the entire rural population.

Difficulties of the Task

The Rural Labor Statute defined the groups subject to compulsory coverage under the new system as: rural workers, tenant farmers and sharecroppers, small farm owners, contractors and pieceworkers, and other physical persons engaged in the activities defined, having less than five employees. The list includes practically the entire rural working population. As of the end of 1964, this was estimated at around 17,644,000 individuals. Allowing on the average at least one beneficiary or dependent for each insured person, the number of persons covered by the new system is no less than 35,288,000, scattered throughout all of the rural areas of the country.

In the absence of any census of such workers that would indicate the number by municipalities, the concentration by regions, and the location by farm or stockraising establishment, the rural social security program was initiated in a population group of unknown dimensions, which would have to be gradually explored. IAPI was thus given a vast and difficult job since it had meagre resources and the industrial centers where its operating agencies were installed did not coincide with the preponderantly agricultural producing zones, or with the heavier concentrations of rural population. At the same time, collection of the taxes that would constitute the rural social security fund offered parallel problems of no less scope. The law adopted a system of taxing farm and livestock production. It was not considered feasible to collect an individual tax from each of the 17,000,000 persons subject to compulsory insurance. Similarly, the large number of producers, amounting to over 3,000,000 could not but present an enormous task of registration, assessment, supervision and collection. Another expedient was adopted to facilitate the task. Since farm and livestock production is for the most part handled by cooperatives or channeled through commercial and industrial enterprises, an attempt was made through contracts with such private organizations to have the rural social security taxes collected by them, and to have them handle the registration of producers connected with this sector.

Collection Agreements

In addition to the 480 agreements concluded in 1964 with cooperatives and enterprises connected with farm and livestock production, IAPI greatly increased the capacity of its collection network by authorizing banks and their branch offices to perform this work. By the end of that year, around 600 agencies of the Bank of Brazil, S. A., and 900 others constituted a total of approximately 1,600 locations where rural social security taxes could be collected, through a simple procedure devoid of the customary red tape.

Initial Results and Outlook for the Future

As the collection system is refined, the anticipated revenue will be collected on the total farm and livestock production of the country. Approximately 46 billion cruzeiros, representing 10 per cent on the 1964 output, will be added to the 75 billion estimated revenue for 1965. Agreements concluded with the state governments (Amazonas and Espíritu Santo) will make it possible to evaluate the experience of combining the collection of rural social security contributions with the collection of state taxes. It is too early to adopt any preliminary measures designed to attain full coordination of rural social security activities with those of the states, municipalities and private entities, but in the meantime the lessons learned and the experience obtained in the collection of contributions will probably be of enormous help in establishing the system for distributing benefits.

Benefit Plan

The problem of paying benefits is currently the major concern of the Rural Social Security Service, established by IAPI to serve as a nucleus for the entire future rural social security system. Benefits have not yet been granted because of the need to correct certain imperfections in the legal provisions that were approved. These provisions have not yet been implemented because of the need to scale benefit payments in consideration of the most urgent risks that affect the lives of the rural population. The law attempted to aid the rural worker, whose needs are essentially different from those of the urban worker, by applying identical measures. The general benefit plan provided is costly and would be designed to provide full protection against all risks when hitherto the rural worker has had none. It is obviously unworkable to provide the medical care proposed by the law. This is evidenced not only by the lack of local resources over vast areas of the country, but by the patent impossibility of developing adequate social and financial solutions within any reasonable period. Efforts to coordinate all of the medical care resources available in the country will consequently assume great importance in providing medical services for the rural population.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Brazil, 1964

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Retirement and Pension Institutes:									
IAPB (Bank employees)	732 928	680				0.9			
IAPC (Commercial employees)	3 100 000	690	a) 17 800	a) 226 000	...	0.2	5.7	72.9	...
IAPETEC (freight and transportation workers)	2 128 330	1 930				0.9			
IAPFESP (railroad and civil service employees)	1 809 232	395				0.2			
IAPI (industrial workers) 4 hospitals	7 200 000	b) 939				0.1			
IAPM (maritime workers) 3 hospitals	583 558	c) 648				1.1			
Federal Governments (FSESP) 24 hospitals	1 022 000	651	22 681	153 257	...	0.6	22.2	150.0	...

a) Estimated - 47,722 hospitalized of which 37.3 per cent were in hospitals of Instituto and remainder in contracted services of other hospitals
b) Maintains 12,307 beds in 235 hospitals
c) Contracts with 167 hospitals

TABLE II

Indices of Hospital Utilization, Brazil, 1964

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Commercial Workers' Retirement and Pension Institutes			
Institute hospitals	12.7	25.8	89.5
Contracted hospitals			
Surgery	9.7		
Mental diseases	69.6		
Tuberculosis	179.5		
Federal Government			
24 Hospitals	6.8	34.8	64.3

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Brazil, 1964

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Federal Government FSESP 24 hospitals	62	...	1,065	165	29	120	16	35	865	14.8	...	254.4	39.4	6.9	8.4	206.6

TABLE IV

Ratios on Distribution of Hospital Personnel, Brazil, 1964

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Federal Government FSESP 24 hospitals	0.5	...	2.7	...	4.1	...	23

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Brazil, 1964

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Federal Government FSESP			
24 hospitals	...	134	24

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Brazil, 1964

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultatio
Commercial Workers' Retirement and Pension Institutes							
Surgery - Maternity		.....		8 983			
Mental Diseases		69.6		2 819			
Pulmonary Diseases		179.5		3 783			
Federal Government FSESP							
24 Hospitals	153 257	6.8		6 237	42 412	2 282 700	

TABLE VII

Number and Type of Outpatient Establishments Reporting, Brazil, 1964

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Federal Government				
Health centers	34	...	26	5

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Brazil, 1964

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Federal Government																	
FSESP																	
34 health units	1 284 000	471 366	36.7	276 860	21 699	73 474	186 525	96 860	...	21.6	1.7	5.7	14.5	58.7	4.6	35.0	...
Commercial Workers' Retirement and Pension Institutes																	
39 Mobile units	3 100 000	518 750	16.7	1917 577	...	...	...	...	...	61.9	...	...	...	369.7	...	...	...
60 Clinics	3 100 000	28 076	0.9	126 004	...	...	...	...	...	4.1	...	...	...	448.8	...	...	...
Home Medical Care and Emergency Service - SAMDU (All Institutes)																	
200 medical posts	...	...	...	4500 000	...	500 000	...	...	...	...	...	...	...	...	...	...	...

TABLE IX

Personnel in Outpatient Establishments, Brazil, 1964

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Federal Government SESP													
34 health units	46	...	12	...	489	99	13	86	-	462	...	45	6

TABLE X

Average Cost per Outpatient Consultation, Brazil, 1964

Hospital	Mean cost	Median cost
Commercial Workers' Retirement and Pension Institutes (IAPC)	4 995	...
Home Medical Care and Emergency Service - SAMDU	4 000	...
Federal Government (FSESP) 31 health centers	2 968	...

C O L O M B I A

I. ORGANIZATION OF THE MEDICAL SERVICES

GENERAL BACKGROUND

1.1 Administrative Organization of the Central Authority

The Ministry of Public Health is an organ of the Executive Branch of the Federal Government, responsible for the direction of the Public Health Service throughout the national territory.

By Decree No. 3224 of 1963 (December 9), the Ministry of Public Health was reorganized as follows:

The service was set up on three functional levels - (a) national, (b) regional, and (c) local - covering the entire country.

The national level consists of the Ministry, which has the following functions:

a. Formulating the general plans for the public health service throughout the country;

b. Implementing its activities in detailed programs at the national level according to their order of priority;

c. Establishing general guidelines to attain its objectives;

d. Supervising, advising, coordinating and making the technical and administrative evaluation of its programs;

e. Studying the economic aspects of its plans and programs and coordinating them with the National Economic and Social Development Plan;

f. Programming, executing and supervising the education and training of personnel for the Public Health Service;

g. Approving the statutes, regulations, and other instruments of charitable agencies, as well as those of philanthropic institutions that require it under the law.

The Ministry is composed of various Offices, Divisions and Sections. Technical and administrative management of the Public Health Service is centered in the following Offices: Planning and Medical Economics; Evaluation and Organization of Methods; Personnel Education and Training; Legal; Drug and Biological Products Control. The Divisions are: Medical Care, Epidemiology, Environmental Sanitation, Auxiliary Technical Services and Administrative Services.

1.2 Organization of the Intermediate and Local Authorities

The regional level consists of one or more political and administrative divisions grouping zones or regions having similar social and anthropological or ecological features, in such a way as to facilitate more efficient utilization of manpower, and of the economic and social resources of the Public Health Service. At this level the following functions are performed: (1) National administrative functions are exercised at the regional level; (2) National health plans and programs are adjusted to regional and local conditions; (3) Health programs for the given region are given supervision, guidance, coordination and evaluation. The local level comprises the executive resources of the Public Health Service and is given responsibility for carrying out public health programs in a given geographic area in accordance with existing legislation and with the general guidelines established in agreements made by the Ministry of Health with the various political and administrative divisions of the country (Departments, Provinces, Districts). In the great majority of cases, the sectional organizations include Medical Care, Epidemiology, Environmental Sanitation, Technical and Auxiliary Services and Administrative Services.

1.3 Theoretically, there is a National Hospital Plan, under Law No. 12 of 1963, that authorized the executive branch to establish such a plan. However, this has not yet been done.

1.4 Steps are being taken to determine the legal feasibility of a national plan to coordinate and integrate all of the health services, but it is meeting with widespread resistance in the private sector. The National Government, through the Ministry of Health, supervises the practice of medicine and other health professions. As is the case in all of the Latin American countries, such supervision is not complete; and there are a large number of unlicensed practitioners operating in the field of medical care.

1.5 The National Health Plan

There is a Ten-Year Plan, 1962-1971, for the Ministry of Health, and a National Basic Sanitation and Rural Welfare Plan, both of which have been approved by the National Planning Office.

No mention is made of social security programs in either of the above-mentioned plans.

2. THE COLOMBIAN SOCIAL SECURITY INSTITUTE (ICSS)

2.1 Law No. 90 of 1946 provides that the ICSS should cover the entire working population of Colombia against all risks; sickness, accident, death, retirement and disability. At the present time, only very limited coverage is given to a small part of the Colombian working population, based on the categories established in the Labor Code with regard to the employer's obligation to the employee in the field of health. The ICSS covers only its members, and gives maternity services to wives or common-law wives, as well as medical care to infants under six months of age. Contributions are paid on a tripartite basis -by the Government, the employer, and the worker- in an amount proportionate to the latter's base salary.

2.2 Medical care services are organized by the employment of a specified number of doctors, dentists, nurses, medical technicians, etc., under contract, who work either in the dispensaries, where only outpatient treatment is provided, or in the hospitals where only institutional care is given. There is also a home-care service, available on a 24-hour basis. All of the medical, technical and auxiliary personnel in each health agency is under the control of a personnel section, a centralized body for each Fund, or each of the Geographic Sections in which the ICSS is divided throughout the country. The hospitals, in the majority owned by ICSS, have the standard organization consisting of a Medical Director and a non-professional Administrative Adviser. The former is responsible for the professional services, and the latter for the purely administrative activities of the hospital.

2.3 Budget.....Appointments are made by the Manager of each Fund or each Section of the ICSS, on the recommendation of the Section Medical Director. (There is considerable political influence in the appointment of personnel). With regard to salaries, an average of _____ has been established, based on the results of collective labor contracts concluded between the directors of ICSS and of ASMEDAS, the labor organization representing the Colombian medical and related professions, which has great influence in all spheres of national life.

2.4 There are no preventive programs, properly speaking, in the ICSS programs, unless an exception is made with regard to the pre-natal, post-natal and well-baby services, or perhaps with regard to such things as routine examinations: X-rays and serological.

2.5 The only relationship existing between the ICSS and the Ministry of Health is the latter's representation on the National Board of Directors of the ICSS.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Colombia

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Ministry of Public Health									
191 General hospitals		15 503	287 926	3 222 984	1 436 245				
12 Specialized hospitals		4 775	7 586	1 475 235	67 275				
19 Small hospitals		181	3 589	21 491	48 899				
Antioquia									
29 General hospitals		1 430	34 194	307 953	114 948				
2 Specialized hospitals		1 580	3 071	422 925	6 238				
4 Small hospitals		37	507	5 975	7 644				
Atlantico									
4 Small hospitals		41	1 804	5 858	30 780				
Bolivar									
5 General hospitals		618	16 700	155 504	81 335				
1 Specialized hospital		200	144	38 654	260				
3 Small hospitals		29	228	750	4 997				
Boyaca									
18 General hospitals		1 124	22 470	209 650	93 053				
2 Small hospitals		15	216	1 619	3 062				
Bogota									
3 General hospitals		1 010	16 943	228 065	236 930				
1 Specialized hospital		129	1 386	37 531	40 920				
Caldas									
21 General hospitals		1 974	35 643	429 263	131 981				
2 Specialized hospitals		473	465	155 755	-				
1 Small hospital		13	104	620	1 282				
Cauca									
1 General hospital		422	5 858	93 355	28 290				

TABLE I (Cont.)

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Colombia

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Cundinamarca									
21 General hospitals		1 662	25 730	344 589	113 967				
1 Specialized hospital		1 154	1 435	477 742	-				
1 Small hospital		12	111	4 225	-				
Choco									
2 General hospitals		109	2 337	18 525	12 778				
1 Small hospital		10	168	1 168	858				
Huila									
8 General hospitals		352	5 495	64 071	25 961				
1 Small hospital		8	70	211	-				
Magdalena									
General hospitals		149	2 258	20 107	9 337				
Meta									
4 General hospitals		213	5 792	49 255	18 073				
Nariño									
5 General hospitals		327	5 180	60 667	12 352				
1 Specialized hospital		650	349	231 323	-				
Norte de Santander									
2 General hospitals		200	1 430	18 267	11 716				
1 Specialized hospital		94	154	30 870	-				
Santander									
24 General hospitals		2 140	36 896	504 396	142 442				
Tolima									
23 General hospitals		1 473	22 689	259 110	93 092				

TABLE I (Cont.)

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Colombia

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Valle									
21 General hospitals		2 300	48 311	460 207	309 990				
4 Specialized hospitals		495	582	80 435	19 857				
2 Small hospitals		16	381	1 065	276				
Colombian Social Security Institute									
13 Hospitals	438 451	2 404	113 050	592 620	557 472	5.5	257.8	1 351.6	1 271.4

TABLE II

Indices of Hospital Utilization, Colombia

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Ministry of Public Health			
General hospitals	11.2	18.6	56.8
Specialized hospitals	194.5	1.6	84.4
Small hospitals	6.0	19.8	32.4
Colombian Social Security Institute			
13 Hospitals	5.2	47.0	67.4

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Colombia

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Ministry of Public Health																
118 General hospitals	...		8 264	3 157	246	2 911	-	292	4 815	...	...	86.8	33.2	2.6	3.1	50.6
11 Specialized hospitals	...		1 374	553	37	516	-	32	789	...	...	49.7	20.0	1.3	1.2	28.6
17 Small hospitals	...		96	41	1	40	-	1	54	...	...	121.8	52.0	1.3	1.3	68.5
Antioquia																
General hospitals	...	...	695	271	20	251	-	12	412							
Specialized hospitals	50	...	511	286	13	273	-	8	217							
Small hospitals	...	...	20	4	-	4	-	-	16							
Atlantico																
General hospitals	2	...	16	6	1	5	-	-	10							
Specialized hospitals	2	...	8	4	-	4	-	1	3							
Small hospitals	8	...	26	13	-	13	-	1	12							
Bolivar																
General	113	...	435	183	38	145	-	27	225							
Specialized hospitals	9	...	74	4	-	4	-	1	69							
Small hospitals	6	...	13	8	-	8	-	-	5							
Boyaca																
General hospitals	95	...	541	171	14	157	-	25	345							
Small hospitals	1		8	2	-	2	-	-	6							
Bogota																
General hospitals	248	...	883	424	71	353	-	59	400							
Specialized hospitals	59	...	223	83	12	71	-	12	128							
Caldas																
General hospitals	163	...	984	336	3	333	-	16	632							
Specialized hospitals	11	...	93	20	-	20	-	1	72							
Small hospitals	1	...	4	1	-	1	-	-	3							

TABLE III (Cont.)

Hospital Personnel with Ratios per 100 Occupied Beds, Colombia

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Cauca																
General hospitals	64		238	111	3	108	-	6	121							
Cundinamarca																
General hospitals	82	...	753	223	8	215	-	32	498							
Specialized hospitals	15		117	20	-	20	-	3	94							
Small hospitals	-		6	3	-	3	-	-	3							
Choco																
General hospitals	8	...	86	42	1	41	-	3	41							
Small hospitals	1	...	3	2	-	2	-	-	1							
Huila																
General hospitals	13	...	148	66	1	65	-	-	82							
Small hospitals	-		2	1	1	-	-	-	1							
Magdalena																
General hospitals	10	...	61	13	1	12	-	2	46							
Small hospitals	2		4	3	-	3	-	-	1							
Meta																
General hospitals	19	...	115	42	1	41	-	5	68							
Nariño																
General hospitals	16	...	111	33	-	33	-	2	76							
Specialized hospitals	4		33	13	-	13	-	-	20							
Norte de Santander																
General hospitals	4	...	44	18	-	18	-	2	24							
Specialized hospitals	2		23	4	-	4	-	-	19							
Santander																
General hospitals	103		803	291	13	278	-	27	485							

TABLE III (Cont.)

Hospital Personnel with Ratios per 100 Occupied Beds, Colombia

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Tolima																
General hospitals	55		455	192	9	183	-	9	254							
Valle																
General hospitals	443		1 896	735	62	673	-	65	1 096							
Specialized hospitals	20		292	119	12	107	-	6	167							
Small hospitals	2		10	4	-	4	-	-	6							
Colombian Social Security Institute																
13 hospitals	621	362	2 327	1 365	128	1 230	7	242	720	32.3	18.8	121.0	71.0	6.7	12.6	37.4

TABLE IV

Ratios on Distribution of Hospital Personnel, Colombia

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care *
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Ministry of Public Health							
General hospitals	...	...	...	...	11.8	40	41
Specialized hospitals	...	...	...	...	13.9	20	43
Small hospitals	...	...	...	...	40.0	62	44
Colombian Social Security Institute	0.2	0.4	2.2	3.8	9.6		76

*Excluding physicians.

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Colombia

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Ministry of Public Health			
General hospitals	...	114	9
Specialized hospitals	...	68	4
Small hospitals	...	177	4
Colombian Social Security Institute	48	242	23

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Colombia

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Ministry of Public Health							
191 General hospitals	3 222 984	11.2	1 436 245	39.33	440.50	14 395	7.87
12 Specialized hospitals	1 475 235	194.5	67 275	16.67	3 242.32	6 101	3.33
19 Small hospitals	21 491	6.0	48 899	22.69	136.14	8 305	4.54
Colombian Social Security Institute							
9 Hospitals	403 912	5.2	416 975	86.21	448.29	31 553	17.24

TABLE VII

Number and Type of Outpatient Establishments Reporting, Colombia

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry of Public Health				
191 Outpatient clinics in general hospitals	191	...	81	77
12 Outpatient clinics in specialized hospitals	12	...	6	6
19 Outpatient clinics in small hospitals or health centers	19	...	-	-
509 Outpatient establishments	509	...	49	32
Colombian Social Security Institute				
(11 units in Antioquia and Valle)	11	1	11	11
Total	40	1	40	40

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Colombia

Establishment	Population		Per cent attending	Number					Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Ministry of Public Health																	
191 Outpatient clinics in general hospitals	...	...	...	1436 245	137 706	...	81 895	848 311	113 177	...	...	...	...	...	...	59.1	7.9
12 Clinics in specialized hospitals	...	...	...	68 275	15 453	...	-	67 870	30 433	...	...	...	...	...	...	99.4	44.6
19 Clinics in small hospitals	...	...	...	48 899	3 407	...	1 315	-	-	...	...	...	...	...	...	...	...
509 Outpatient establishments	...	...	...	2804 012	2 645 113	290 537	756 739	587 101	136 319	...	...	...	...	...	...	20.9	4.9
Colombian Social Security Institute																	
Antioquia and Valle 11 Clinics	a)222 756	205 792	92.4	1241 128	593 935	38 062	89 473	506 333	59 852	557.2	266.6	17.1	40.2	603.1	288.6	40.8	4.8
Bogota																	
Central clinic	186 484			333 449	...	...	-	218 471	12 157	178.8	...	...	-	...	...	65.5	3.6
9 Other clinics	...	...		129 104	...	...	-	36 281	...	...	...	...	...	...	...	28.1	...
Caldas																	
5 Clinics	43 306	...		124 498	366 027	11 873	-	68 151	5 498	287.5	845.2	27.4	-			54.7	4.4
Magdalena																	
3 Clinics	14 218	7 163	50.4	30 260	28 980	117	-	16 259	1 149	212.8	203.8	0.8	-	422.4	404.4	53.7	3.8

a) May be slight duplication of population and persons attending small clinics.

TABLE IX

Personnel in Outpatient Establishments, Colombia

Hospital	Physicians		Dentists		All other					Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other		
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives		Total	Nurses
Ministry of Public Health												
119 General hospital-outpatient clinics*										...	23	2
12 Specialized hospitals*										...	14	1
19 Small hospitals*										...	35	1
509 Outpatient establishments	1 722	...	561	...	6 652	2 570	155	2 415	-	4 082	...	59	4
Colombian Social Security Institute												
Bogota												
10 Clinics	267	1 061	70	280	168	83	6	77	-	85	45	22	2
Antioquia												
1 Clinic	254	889	109	350	458	254	-	254	-	204	24	39	-
Caldas												
5 Clinics	60	...	15	...	45	27		27	-	18	...	7	-
Magdalena												
3 Clinics	16	37	2	5	12	8	-	8	-	4	22	17	-
Valle												
10 Clinics	175	459	39	155	324	140	10	130	-	184	22	17	1

* For data on personnel see table on hospitals.

TABLE X

Average Cost per Outpatient Consultation, Colombia

Hospital	Mean cost	Median cost
Ministry of Public Health		
191 General hospitals	7.87	
12 Specialized hospitals	3.33	
19 Small hospitals	4.54	
509 Outpatient establishments	...	
Colombian Social Security Institute		
Bogota		
11 Clinics	107.00	
Antioquia		
1 Clinic	35.00	
Caldas		
5 Clinics	...	
Magdalena		
2 Clinics	13.10	
Valle		
10 Clinics	18.60	

C O S T A R I C A

I. CERTAIN ASPECTS OF FUNCTIONAL RELATIONS BETWEEN MINISTRY OF PUBLIC HEALTH PROGRAMS AND THOSE OF OTHER HEALTH AGENCIES

In Costa Rica at the present time the following institutions administer the health sector:

1.- The Ministry of Public Health, which has both a Directorate General of Public Health, primarily responsible por preventive services, and a Directorate General of Social and Medical Care responsible for the National Hospital System.

2.- The Costa Rican Social Security Fund which provides the insured population (22% of the total) primarily with curative care and health restoration services.

3.- The National Social Insurance Institute, a State monopoly which purchases medical care services.

4.- The Banana Company, a private organization which provides its workers with medical care and covers the cost of certain aspects of environmental sanitation. Furthermore the municipalities also allocate a part of their health budgets to environmental sanitation.

The National Water Supply and Sewerage Service is responsible for water supply and sewage disposal and there are other private health agencies also operate primarily in the field of medical care services.

The Ministry of Public Health, is the supreme governmental health authority, it establishes national policy and standards, and presents the annual health budgets. The Office of the Minister of Health has two general directorates, Public Health, and Social and Medical Care, responsible for preventive and curative medicine and Administrative Management primarily responsible for administrative activities.

The Directorate General of Public Health establishes policy for disease prevention and health promotion, and prescribes the measures to be applied in the local services. Certain central departments have executive functions when carrying out their programs as health campaigns.

The Directorate General of Medical Care is the technical, directing, and administrative agency of what is known as the National Hospital System. The policy governing health care services is established by a Technical Council, composed of representatives of the various institutions that make up the system.

The nomenclature used in the hospital sector suggests a certains degree of regionalization in medical care, but it is only a geographical and not an operational classification. A patient is free to use whichever service is advisable for handling his case.

The fact that there are numerous institutions with ill-defined spheres of influence has in the past prevented effective coordination of their health activities.

In almost all areas of the health sector the growth of these agencies has been from the center to the periphery, and this in general has given rise to a strong central structure and vertical chain of command in field units, whether these be hospitals, health units or dispensaries, with no coordination at the local level, duplication of efforts, and inefficient use of available facilities.

A health regionalization plan initially covering Area 1 in the northwestern part of the country was begun in 1965. In addition, an extensive plan is under way to coordinate the curative and preventive activities of the Costa Rican Social Security Fund and the Ministry of Public Health, so as to eliminate duplication of services and improve performance.

It is estimated that health services provided by health units and dispensaries of the Ministry of Public Health and those of the Costa Rican Social Security Fund cover 60 per cent of the total population.

As part of penetration plans, mobile units were established to care for the rural localities in which there are no fixed health establishments. These units provide a population of 280,000 with basic services for its prevention and cure of diseases and the promotion of health.

In 1951 the total investment of all governmental, autonomous, and private institutions in the various health services amounted to 42,194,142 colons a figure which rose to 115,096,864 colons in 1963. In other words, the amount invested in health has tripled in the course of thirteen years. In relation to the general budget for public administration, the amount allocated to preventive medicine has decreased from 4.1 per cent in 1951 to 2.0 per cent in 1963.

The amount invested by the Ministry of Public Health in operating medical care establishments rose from 22,568,930 colons in 1951 to 49,782,950 colons in 1963.

The investment of the Costa Rican Social Security Fund increased from 9,366,735 colons in 1951 to 49,607,647 colons in 1963. The insured population which was 82,157 in 1951 had risen to 294,847 by 1963.

Development conditions in general show that it was difficult for the national economy to maintain its growth rate between the years 1950 and 1962, rather the rate of growth has shown a downward trend in 1965, when coffee prices began to decline.

If the high rate of population growth of 3.7 per cent per annum remains constant, the population of 1,356,000 (according to the 1954 census) will double in a period of 19 years. Costa Rica is a country with a "young population", a high birth rate, and declining death rate and child mortality rates. This "young population" is costly to the nation in terms of social development.

An outstanding characteristic in the structure of the Costa Rican economy is the high population density and social and economic activity in the Central Meseta.

An industrial census taken in 1958 showed that 83.6 per cent of the industrial wealth of the country was located in the Central Meseta.

The increasing social problems in this geographic area, in such fields as housing, schools and health, are strong reasons for a change in policy.

These problems were exacerbated in 1963 and 1964 with the volcanic activity that affected primarily the Central Meseta, the most densely populated and economically active area of the country. The damage had two unfavorable results: volcanic ashes affected livestock and equipment, and changed the course of certain rivers, causing floods at some times and droughts at others, and in addition, destroyed important fixed assets.

With regard to housing, the 1963 census indicated that 34.5 per cent of the houses were in a fair state of repair, and 33.8 per cent were in poor repair, the situation being worse in rural areas. Some 10 per cent of these houses lack home connections for water, and over 60 per cent are served by water from insanitary wells and water lines. 25.3 per cent of the houses has no sanitary facilities, and 50 per cent do not have minimum acceptable installations.

As to education, the census of 1963 showed a 14.6 per cent illiteracy rate in total population aged ten years or more.

Mortality, which was 12.2 per 1,000 population, fell to 8.5 in 1962. The infant mortality was 90.2 per 1,000 live births in 1950 and 65.8 in 1962. The greatest decline in mortality during that period occurred in the 1-4 age group, which dropped from 16.3 per 1,000 in 1950 to 7.5 per 1,000 in 1962.

In the last ten years, mortality in the 0-4 age group as a percentage of general mortality remained at between 50.6 per cent and 52.3 per cent, although the population in that age group increased from 16.5 per cent of the total population to 20.7 per cent in 1963.

The ten main causes of death have remained constant over the past ten years; there has been no change in the order of the first four: gastroenteritis and colitis; diseases of the circulatory system; tumors and pneumonia; and bronchopneumonia which accounted for 42.1 per cent of all deaths in 1962.

NATIONAL HEALTH PLANS

In the years 1963-1964 a national diagnosis was made of the health sector; it comprised the following: 1) basic preliminary data; 2) data on the health situation in the country; 3) evaluation of the problems and objectives of the plan; and 4) plan of action. As a result of this diagnosis appropriate priorities were established, the criteria used being the magnitude of the health risks and their impact on the most important population groups.

To prepare the diagnosis a Planning Unit was established at the central level, since there were no field data, no trained personnel and no registration of areas.

The Planning Office of the Ministry of Public Health assumed responsibility for the health sector, and working primarily with the education, housing, transportation, water supply and sewerage sectors, with coordination at the level of OFIPLAN (National Planning Office).

At the OFIPLAN level, the health plan was integrated along broad lines into the social and economic development plan. It should be noted that the investment plan for the health sector was incorporated into the public sector investment plan.

The change-over from orthodox planning to methodological planning, has been in process since 1965 and the system is now being applied in part.

National programs were formulated, annual targets being established in the light of both the available and required resources. In addition, performance standards were established in order to measure the progress of programs by the number of activities carried on.

In order to coordinate the planning activities of the health sub-sectors, meetings are being held to decide on the establishment of planning units, their functions, personnel training, and the method for reviewing the health diagnosis and formulating plans to be applied in the field of activity of each sub-sector.

Other development sectors have participated in some health programs begun in 1965, as for instance the campaign against intestinal parasites in which the education sector collaborated, and the municipalities participated financially.

In general, after the health diagnosis was made, an investment plan for the health sector was also drawn up, as were annual plans for priority health programs. Moreover, the penetration plan designed to bring basic health services to rural communities was improved. Annual targets were also established in the training plan.

One of the purposes of the national health plan is to provide a broader sector of the population with better health services. One method employed for that purpose is to utilize the existing services while improving their technical efficiency, and adopting new work methods so as to expand coverage. The second method is to develop an investment plan, either expanding or remodelling existing premises or building new ones, whether in outpatient care units or inpatient establishments of the Public Health Ministry. The policy for the four-year period 1965-1968 is to improve utilization of the existing resources of the Costa Rican Social Security Fund, with the gradual expansion of the Fund's program it has now become imperative to build new hospital establishments and dispensaries so as to increase in the 4-year period, the number of bed by 1,500 distributed in four establishments, and to build and equip 16 new dispensaries.

GENERAL LAW OF MEDICAL AND SOCIAL CARE

Article 1.- The Directorate General of Medical and Social Care is hereby established as an agency of the Ministry of Public Health.

Article 3.- The Directorate General of Medical and Social Care shall have the following functions, in accordance with the directives established by the Medic - social Council referred to in Article 5 of this Law:

a) Coordinate the services of the existing medical care institutions and those that may subsequently be established, as well as the services of the social welfare agencies under its direction;

b) Exercise technical direction and financial supervision of the institutions referred to in the preceding paragraph, when they are supported or subsidized by the State or by the municipalities;

c) Exercise technical supervision over similar institutions that are supported by private funds;

d) Audit the accounts of the institutions referred to in paragraph a) of this Article; verify the general balance sheets;

e) Approve budgets and propose any necessary changes therein;

f) Approve, reject, or amend contracts for amounts exceeding 2,000 colons proposed by the institutions covered by this Law. No commercial contract or transaction shall be valid when concluded with the directors, board members, and superintendents of institutions, or with their relatives to the third degree of consanguinity or to the second degree by marriage, either directly or through third parties;

g) Propose to the Ministry of Public Health, laws, regulations, and general provisions aimed at improving medical and social care; and

h) Ensure compliance, by the institutions included under this Law, with the laws and regulations governing them.

Article 5.- To comply with this law, the Directorate General of Medical Care shall have jurisdiction over hospitals, maternity hospitals, dispensaries, sanatoriums, preventoriums, day nurseries, milk dispensing stations, Red Cross, anti-tuberculosis organizations, and any other similar institutions in conformity with the terms of this Law.

Article 23.- It is the responsibility of the State to guarantee medical care for all inhabitants of the Republic, but at the same time it is the obligation of the State to prevent any abuses or "featherbedding" in the institutions defined by this Law.

Article 24.- The institutions listed shall provide care, free of charge, to all indigent persons in need of it, as well as to persons suffering from leprosy, tuberculosis, and venereal disease; the remainder of the population shall pay for such services in accordance with its financial capacity. Nevertheless, in the event of public calamity, catastrophe, or an officially declared epidemic, hospitals shall admit all affected persons without cost and without delay.

Article 25.- A Payment Section shall be established in the Directorate General, for the specific purpose of investigating the income of persons receiving medical and hospital care, and for collecting the amounts such persons may owe in each case. The Section shall be headed by a director and shall be staffed with such additional personnel as may be necessary.

GENERAL RULES FOR NATIONAL HOSPITALS

Article 15.- In order to receive care in any of the institutions of the National Hospital System, a patient must show his identity card on admission, at which time it shall be recorded on his admission card. In the case of minors, the parent or accompanying person shall show his identity card.

Emergency cases are exempt from this provision, and in such cases, the requirement can be met during the first few hours after admission.

Article 16.- Patients cared for in institutions of the National Hospital System shall be classified as follows:

a) free treatment cases (charity cases)
b) pay patients
c) pensioners
d) to be paid for by the Costa Rican Social Security Fund beneficiaries
e) to be paid for by the National Social Insurance beneficiaries and
f) to be paid for by other institutions

Free treatment cases (charity cases): patients whose resources or income is below that established in Article 17 of these Rules.

Pay patients: patients whose income exceeds that established in the aforementioned Article. Such persons shall pay for their hospital expenses in accordance with Scale of Charges established in the same Article.

Pensioners: patients who occupy special beds or rooms. On admission they shall deposit the amount established in the Regulations of the institution, and shall pay the entire cost of hospitalization according to the scale of charges of that institution, depending on the classification of the pensioner, except for professional medical services.

Costa Rican Social Security Fund beneficiaries: insured patients who shall be cared for in hospital institutions that have concluded or are concluding contracts with the Costa Rican Social Security Fund, in accordance with its regulations, or in their absence, in accordance with scale of charges of the institution.

National Social Insurance Institute beneficiaries: patients whose occupational risks are covered by that agency, and who shall be cared for in those hospital establishments that have concluded or are concluding contracts with the Institute, in accordance with the terms of such contracts, or, in their absence, in accordance with the scale of charges of the respective establishment.

Beneficiaries of other organizations: patients who are either associated with, or employed by, commercial firms, professional associations, cooperatives, or other agencies; who shall receive care in those hospitals that have concluded, or are concluding contracts with such firm, association or cooperative.

Article 17.- To comply with Articles 23, 24, and 27 of the General Law of Medical and Social Care and with Articles 12 and 16 of the present Rules, Class "A", "B", and "C" hospital institutions shall have a section of Hospitalization Accounts, which having studied the case will determine the cost of hospital services that the patient, or the responsible person must pay, in accordance with the following table:

a) persons with assets under 15,000 colons, or a fixed annual income under 5,000 colons are not required to make any payment; and

b) persons with assets in excess of that amount will pay the balance remaining after a deduction of 50 colons for each dependant, whether a minor, an aged person, or an invalid.

In the event of any claim by an interested party, the account shall be brought to the attention of the Director General of Medical Care, who will determine the charges. If the claim is upheld, legal power exists for collection in accordance with Article 26 of the General Law of Medical and Social Care.

I. COSTA RICAN SOCIAL SECURITY FUND

1.- Purposes and Field of action of the Costa Rican Social Security Fund:

The Costa Rican Social Security Fund is an autonomous institution, or in other words, an agency of the State, that functions in absolute independence of the Executive Branch, in accordance with the provisions of the Political Constitution of Costa Rica and the Law establishing the Fund.

This institution was established by Law No. 17 of 22 October 1943, Article 1 of this law reads:

> "The Institution established for the purpose of applying compulsory social insurance and encouraging voluntary insurance, shall be called the Costa Rican Social Security Fund, and for the effects of this Law and its regulations, shall be referred to as the 'Fund'"

The Fund, as an autonomous agency, is charged with a special mission: to enforce the application of compulsory social insurance and to encourage expansion of the voluntary system. Compulsory social insurance includes protection of workers and their families against the risks of sickness, maternity, disability, old-age and death.

To carry out this task, the Costa Rican Social Security Fund has been duly organized to provide the services required by its insured participants under the health, maternity and family assistance program, and to administer the funds and provide services to workers who are insured against the risks of disability, old-age and death. The insured worker under these two programs receives protection from the moment of birth to the moment of death, and to this end, the Fund has been organized as a service center at the disposition of the worker and his dependents.

Under the health, maternity and family benefit program, the Fund covers the insured worker and the members of his family who are financially dependent on him. The services provided are intended primarily to restore his health at the earliest possible moment in order that he may be returned to his job and to society in good physical condition. In addition, he is given financial benefits so that he and his family may have an adequate income during the period of sickness and loss of earning power.

When the Constitution was amended in May of 1961, a transitional provision was included to the effect that: "The Costa Rican Social Security Fund should apply its various programs universally, so as to include coverage of the family unit under the Sickness and

Maternity Benefits Program within a period not to exceed ten years" from the date on which the constitutional amendment was promulgated. This mandate has stimulated the Fund's activities, looking toward the expansion of the social security program it administers within the ten-year period, and establishing the necessary medical care facilities to meet the demands for services from its insured.

A brief review of Law No. 17 of October 22, 1943, governing the consitution of this social security system, is essential to a better understanding of the purpose of the Costa Rican Social Security Fund and its field of action. That law clearly indicates the Fund's field of application in Articles 2, 3, 4 and 5, as follows:

"Article 2. Compulsory social security includes the risks of sickness, maternity, disability, old age, and involuntary unemployment; in addition, it implies participation in the cost of maternity, survivors and burial benefits, according to the scale established by the Fund, provided death is not a consequence of occupational risk.

Article 3. Every wage-earner or salaried worker shall be subject to compulsory insurance, and the amount of his contribution under this Law shall be estimated on his total remuneration.

Nevertheless, in the case of sickness and maternity risks, compulsory insurance will be applicable only to those workers who earn 1,000 colons or less per month.

The Fund will issue Regulations determining the elegibility requirements for each protection plan, as well as the benefits, and conditions under which they may be granted.

No person over 65 years of age may enroll in the Sickness and Maternity benefit plan and should he do so, the Fund shall exclude him.

The Board of Directors shall establish the date on which the social security plans will become applicable to self-employed workers, as well as the conditions of such coverage.

Transitional provision. Workers who are insured against sickness and maternity risks at the time this Law is promulgated may continue to be protected, even though their salaries exceed 1,000 colons per month. (As amended by Law No. 2273 of 28 October 1958).

Article 4. The following will not be subject to compulsory insurance:
a. members of the employer's family who live with him, are employed by him, but receive no salary in cash;

b. workers who are receiving a pension from the State, its agencies, or the municipalities. Nevertheless, those who meet the requirements stipulated in the pertinent rules or regulations may continue to participate in the compulsory sickness and maternity insurance plan;

c. workers who, in the opinion of the Board of Directors, should not be covered under the compulsory insurance plan. Cases included in the preceeding paragraphs will be excluded at the initiative of the Fund or at the request of an interested party. (Amendment by Law No. 2353 of 21 May 1959.)

Article 5. Social security shall be optional only for workers who for any reason are no longer subject to compulsory insurance and who voluntarily wish to continue to derive the benefits of the present Law. In such case, he shall pay the contribution for optional insurance established by the Board of Directors, which will also determine the benefits to which the interested person will be entitled, subject to the provisions of Article 3".

To meet the obligations and purposes as established by the law, the Costa Rican Social Security Fund proceeded to establish the necessary administrative and technical organization to provide the insured with the benefits and services defined in the constituent Law.

2.- Administrative and Technical Organization of the Costa Rican Social Security Fund:

The Costa Rican Social Security Fund has been duly organized from the administrative and technical viewpoint to handle the services, responsibilities, programs, and goals established for this institution.

In its 21 years of operation to date, it has achieved an outstanding position in the organization of social security institutions, to the degree that its advice and suggestions are solicited throughout Central America. Moreover, its administrative and technical organization has produced the desired results, to the benefit of the country and the insured. Hence, it is a well established institution, aware of its responsibilities and effective within the sphere of its functions.

Administration of the Fund at the top echelon has been entrusted to a "Board of Directors", composed of seven members, one of whom is the Minister of Labor and Social Welfare. The other members, representing employers, the insured, and one from the medical profession, are appointed by the President.

The members themselves elect a Vice-Chairman each year, for a one-year term.

The Board of Directors is responsible for the establishment of policy and provides guidance in the management of the Fund. It approves the program and budget; rules on appeals against decisions of the management; appoints the director, assistant director, and the controller; issues regulations; supervises the results of administrative activities, and performs all functions required for special activites that fall outside the routine operations of the Fund.

The Secretariat of the Board of Director, which is administratively under the management, provides services in connection with its meetings, minutes, recording its deliberations and resolutions, communicating decisions, and other customary secretarial duties.

The Board of Directors appoints the Controller who maintains continuing supervision and inspection in all departments of the Fund. Accordingly, he is responsible for close control over the use of funds, inspects the accounting procedure, carries out the audits, and reviews all financial and economic operations and balance sheets and accounts. To perform these functions, the auditor has a corps of inspectors and auxiliary staff as needed, and a Control Section, that handles specific cases requiring investigation and performs such supervisory activities as are specifically assigned to it by the Controller.

The Board of Directors also appoints the Manager and Assistant Manager, who constitute the managerial staff and are responsible for the executive administration of the Fund and its technical services, on the basis of directives issued by the Board of Directors, and the provisions of the pertinent laws and regulations and also appoints and dismisses the personnel of the Fund.

The management has the following sections or departments to carry out its functional responsibilities: Finance Department, with its various sections; The Actuarial Department; The Medical Services, with its agencies; Legal Department; Planning Department for Expansion, and Social and Economic Studies; General Secretariat, with its sections and offices; Personnel Section; IBM Machine Section; Planning and Building Section, with its Maintenance Office; Branch Offices Section; a Supply Section, and the Fund's Farm Management Section.

Finance Department: This department directs the Revenue Section, which is in charge of all services relating to the receipt of funds, such as the payroll, tax payments, payment of invoices, loans, fines, etc., maintaining the necessary records, and the controls for that purpose; Treasury Section, which acts as custodian of the Fund's securities, and handles its receipts and expenditures. Warehouse and Supply Section, which has custody of materials, equipment, supplies, etc.,

needed by the agencies of the Fund; the Cash Benefits Section, which handles all services and benefits, payable in cash to the insured, according to the legal provisions and regulations of the Fund; the Accounting Section which keeps the books, records and accounting, and the Loan Office which handles the investments of funds accruing under the Disability, Old Age, and Death Benefit Plan. In addition to its work of direction, coordination and supervision, the Finance Department also prepares the annual budget estimate for the Fund and administers the budget, keeps the Fund's books, and processes loan transactions.

Actuarial Department: Carries out all of the technical studies to determine the financial stability of the sickness and maternity benefit plan and the disability, old age, and death plan. This specialized technical department provides the basis for institutional policy, and guidance to the management. It has a statistical Section, which is responsible for statistical analysis and control of all movements of funds, especially as regards services for the insured, the results of which provide useful criteria to the administration.

Legal Department: This department advises the Board of Directors and the management on legal and juridical matters. It also represents the Fund in all court actions; resolves any questions presented to it by other sections; executes such contracts as are required to carry on the Fund's activities; handles collections that require legal action; prepares the legal justification documentation for decisions of the management, and performs all other functions that require the services of professional lawyers.

General Secretariat: This department helps the management in the handling of claims, requests, decisions and the administration of the Fund, and has immediate responsibility for the direction and supervision of the following agencies, or sub-divisions: Office of Miscellaneous Services, which performs the services of binding, reproduction, repairs to office machines and equipment, and other services to aid the work of the secretariat; the Transportation Office, which is in charge of the Fund's vehicles, their maintenance and repair, and supplying the required transportation services; the Office of Central Files, which maintains the file of all employer-payroll forms and makes the necessary search of the records in response to various requests for evidence on the wages paid to insured workers, and to establish their eligibility for benefits; and the Office of Public Relations, which is in charge of public information programs.

Department of Planning for Expansion, and Social and Economic Studies: This department carries on all research and prepares reports and studies required for social security purposes. It also has responsibility for the following sections: Inspection, which performs the supervisory functions necessary to enforce compliance with Social Security laws and

regulation; Affiliation Section, which applies and supervises the employment record of the insured, and verifies their rights; and the Social Service Section, which provides the social services to suplement the systems administered by the Fund, and assists insured persons to understand the purposes of the Institution and to solve any problems they may have.

There are, in addition, six departments reporting directly to the Manager, as follows:

Supplies Section: Handles all purchase and sales procedures initiated by the Fund whether through direct transactions or through the process of public or private bid.

Personnel Section: Responsible for personnel administration, in accordance with the pertinent legal instruments, principally staff Rules and Standing Orders; it also has responsibility for establishing training courses and making organization and methods studies.

Administration of "La Caja" Farm: Handles all matters pertaining to the farm and its production programs, with special attention to crops and farms; decides on the land management practices and administers all other aspects required by the operation of the farm.

IBM Machine Section: In charge of all automated processing operations for the Fund and performs the services needed by the various departments and sections of the Fund that require the use of the machines under its care.

Planning and Building Section: In charge of planning construction to be carried out by the Fund in its expansion programs, and prepares the plans and budgets for the same. In some cases, the Section has direct responsibility for the work, and in other cases it supervises the projects under contract with an outside firm. In planning hospitals and dispensaries, the Section is in close relation with the office of the assistant manager who provides the criteria and technical guidance on characteristics and conditions required in planning each health care unit. The Section has a Maintenance Office, which is directly in charge of minor construction works, and performs maintenance and repair work for the various installations of the Fund.

Branch Offices Section: In charge of directing, administering, coordinating, and supervising the work of the Social Security branches established in various areas in the country. In addition, it cooperates with the management in studies relating to the expansion of systems administered by the Fund to new areas.

3.- Medical Organization

We have left the description of the medical organization of the Fund for the last, because it represents one of the most important aspects for purposes of this report. This organization deals solely with direct medical services, since the Fund has centralized services for control, financial organization, administrative facilities, actuarial studies and statistics, general accounting and costs, and are provided for all of its departments.

The medical organization of the Fund is under the immediate direction of the Assistant Manager, who has an Assistant to supervise the work of the dispensaries and regional hospitals. In this way, the policy established by the Board of Directors and the General Manager in the matter of medical care services is carried out, and the work of the Central Hospital, the Jurrialba Hospital, the dispensaries located in various parts of the country, the Pharmaceutical Products Laboratories and other specialized technical agencies is directed and supervised.

HEALTH AND MATERNITY INSURANCE REGULATIONS

Article 15.- Health insurance provides the following benefits:

a) general medical, special, and surgical care;
b) hospital care;
c) pharmaceutical services;
d) dental services (with the limitations indicated herein below)
e) medical and pharmaceutical care with right to hospitalization for children of the insured during the first two years of life, provided the mother is entitled to maternity benefits at the time of delivery and continues to be actively insured when the care referred to in this paragraph is required, in accordance with the provisions of Articles 32 and 34;
f) cash subsidies
g) funeral grant, and
h) social welfare assistance

Article 16.- The insured will be provided with general medical, special, and surgical care, as the case may be, in the Fund's out-patient clinics, dispensaries, and hospitals and hospital clinics, at home, or at any other place that may be indicated by the Fund in special circumstances.

The manner and conditions of providing such services will be established in special regulations.

The Fund will not be responsible for medical services not provided by its medical officers, under its direct control and in accordance with the provisions established in these regulations.

Nevertheless, under very exceptional circumstances, when justified by severity of the disease and when it can be shown that it was physically impossible for the insured to request medical services from the Fund without severely endangering his health by the delay, the management may, at its discretion, authorize the amount of payment owed to a physician for the first visit, and the cost of medication prescribed by a physician who is not a member of the Fund, in accordance with the Fund rates and with the provision of the last paragraph of Article 18 of these Regulations. (As amended by Article 9, Session No. 3037 of 3 September 1963).

Article 17. Free selection of a physician will be approved only in cases of surgery and delivery.

Medical fees and the cost of medicaments and medical supplies are payable, in accordance with the Fund's established rates.

Authorization for the free selection of a physician is the responsibility of Medical Care Department, which must conform to the provisions of the pertinent regulations.

Article 18. Pharmaceutical services include the provision of those medicines included in the basic table of medicaments prescribed by physicians of the Fund.

No payment will be made for the cost of medicine acquired by the insured outside the medical services of the Institution.

Article 19. Dental Services include the following benefits:

a) Oral hygiene;
b) Extraction;
c) Filling;
d) Prostheses (plates), and
e) Oral surgery.

Article 45. Insured persons entitled to maternity benefits, who on the occasion or as a consequence of the delivery are found to suffer from some disease, whether related to the delivery or not, will be entitled to receive medical care for the disease in the manner established in these regulations, even though at the time of delivery they had ceased to the active members of the Fund and entitled to receive medical benefits.

Article 46. The insured person must obey directions of the Fund physician designed to ensure a successful delivery and the health of the infant.

Article 48. Every insured person, regardless of civil status, is entitled to medical care under the maternity insurance plan.

Article 53. Abortion and its consequences will also be covered under the sickness insurance plan. Induced abortion will in no case entitle the insured to cash benefits.

Article 55. Family benefits extend to the relatives of the insured as enumerated in Articles 57 and 58 for the following care:

a) General, special and surgical medical care;
b) Hospital care;
c) Pharmacy services;
d) Obstetrical care for the wife, or common law wife of the insured;
e) Transportation and hospitalization in cases of emergency, subject to prior approval of the Chief Medical Officer of the dispensary in question.

Article 56. Benefits pursuant to the preceding article will be granted only to members of the family of the insured who are not gainfully employed and are financially dependent on him.

Article 57. For purposes of receiving care, the following will be considered as the family of the insured:

a) His wife;
b) Minor children of either parent or of both under 18 years of age;
c) The mother of the insured;
d) A father who is over 65 years of age, or under that age, if incapacitated for work, provided that in either case he is financially dependent on the insured. Incapacity to work will be determined by the medical services of the Fund. In the case of persons over 65 years of age, no medical examination will be required;
e) Minors in the legal custody of the insured, or who have been placed in his custody by the National Child Bureau until they reach 18 years of age. In the latter case, benefits will be granted subject to an examination of the case to be ordered by the management to determine whether or not the social and economic conditions of the family and the nature of the relationship between the insured and that minor justify granting that benefit;
f) Children in common of unmarried parents, until they reach age 18, provided they live with the parents, and subject to verification on the part of the Costa Rican Social Security Fund (Resolution approved in Article 6, Session 3130 of 11 March 1964).

Article 58. The common law wife of the insured will be entitled to the family benefit, provided the following conditions are met:

1) In the absence of a legitimate spouse, or when that spouse is not entitled to the benefits in accordance with the preceeding Article;

2) When, she meets each and every one of the conditions indicated in the first paragraph of Article 56; and

3) When she has lived with the insured in the relationship of man and wife for one year or more.

Article 62. Family protection does not include the following benefits:

a) Free election of the physician;
b) Dentistry, except for extractions, which are so authorized;
c) Funeral grant;
d) Cash grants as indicated in Articles 21, 22, 35 and 38 of these Regulations.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Costa Rica, 1964

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Ministry of Health									
San Juan de Dios	481 956	1 170	34 600	409 869	195 453	2.4	71.8	850.4	405.5
Social Security									
Central Hospital	128 343	428	13 265	136 470	440 796	3.3	103.4	1 063.3	3 434.5
Ministry of Health									
16 General hospitals	a) 1 267 158	3 360	110 818	870 578	447 953	2.7	87.5	687.0	353.5
Social Security									
3 General hospitals	331 363	544	19 143	166 144	499 439	1.6	57.8	501.4	1 507.2
Ministry of Health									
16 Rural centers	a) 236 307	202	4 666	14 331	9 628	0.9	19.7	60.6	40.7
4 Specialized hospitals	1 387 000	1 793	2 299	401 851	13 442	1.3	1.7	289.7	9.7
Total Ministry	1 387 000	5 355	117 783	1 287 760	471 023	3.9	84.9	927.7	339.6

a) The population covered may be served by additional hospitals.

TABLE II

Indices of Hospital Utilization, Costa Rica, 1964

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Ministry of Health			
San Juan de Dios	11.8	29.6	96.7
Social Security			
Central Hospital	10.3	31.0	87.1
Ministry of Health			
16 General hospitals	7.9	33.0	72.5
Social Security			
3 General hospitals	8.7	35.2	83.4
Ministry of Health			
16 Rural centers	3.1	23.1	21.2
4 Specialized hospitals	174.8	1.3	91.9

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Costa Rica, 1964

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Ministry of Health																
San Juan de Dios	185	a)142	1 051	475	60	415	-	31	545	14.9	11.5	84.9	38.4	4.8	2.5	44.0
Social Security																
Central Hospital	66	...	500	254	90	164	-	12	234	17.7	...	134.0	68.1	24.1	2.1	63.8
Ministry of Health																
16 General hospitals	393	302	2 949	1 185	b)186	999	-	122	1 642	14.7	11.3	110.0	44.2	6.9	4.6	61.2
Social Security																
3 General hospitals	79	...	637	296	97	199	-	20	321	16.3	...	131.1	60.9	20.0	4.1	66.0
Ministry of Health																
16 Rural centers	17	11	108	44	b) 16	28	-	3	61	35.4	22.9	225.0	91.7	33.3	6.2	127.1
4 Specialized hospitals	55	...	746	146	31	115	-	33	567	3.3	...	45.1	8.8	1.9	2.0	34.3

a) Assuming average of 4.6 hours per physician derived from data on remaining hospitals of Ministry. b) Assuming midwives in Costa Rica are nurse-midwives.

TABLE IV

Ratios on Distribution of Hospital Personnel, Costa Rica, 1964

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Ministry of Health							
San Juan de Dios	0.3	0.4	2.6	3.3	6.9	56	56
Social Security							
Central Hospital	1.4	...	3.8	...	1.8	...	59
Ministry of Health							
16 General hospitals	0.5	0.6	3.0	3.9	5.4	52	51
Social Security							
3 General hospitals	1.2	...	3.7	...	2.1	...	55
Ministry of Health							
16 Rural centers	0.9	1.5	2.6	4.0	1.8	14	51
4 Specialized hospitals	0.6	...	2.7	...	3.7	62	29

1) Total number of physicians. 2) Number of full time physicians based on total hours contracted and a six hour day.

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Costa Rica, 1964

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Ministry of Health			
San Juan de Dios	29	131	16
Social Security			
Central Hospital	...	141	50
Ministry of Health			
16 General hospitals	29	151	23
Social Security			
3 General hospitals	...	207	68
Ministry of Health			
16 Rural centers	58	312	114
4 Specialized hospitals	...	30	6

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Costa Rica, 1964

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Ministry of Health							
San Juan de Dios	*414 055	11.8	195 453	a) 33.27	392.59	12 177	a) 6.65
Social Security							
Central Hospital	136 470	10.3	440 796	b) 75.72	779.92	27.714	b) 22.73
Ministry of Health							
16 General hospitals	*891 818	7.9	447 953	a) 39.20	309.68	14 347	a) 7.84
Social Security							
3 General hospitals	166 144	8.7	499 439	b) 72.12	627.44	26 395	b) 21.55
Ministry of Health							
16 Rural centers	*15 703	3.1	9 628	a) 55.85	173.14	20 441	a) 11.17
4 Specialized hospitals	*603 098	174.8	13 442	16.97	2 966.36	6 211	3.39

a) Excluding costs of amortization and remodeling, and assuming cost of five outpatient consultations is equivalent to one day of hospitalization. b) Includes capital costs which are approximately 5 per cent of expenditures for 1964.
* Census days.

TABLE VII

Number and Type of Outpatient Establishments Reporting, Costa Rica, 1964

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry of Health	37	3	22	16
Hospitals	16	3	15	16
Health centers	21	2	7	-
Social Security	3	23	3	3

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Costa Rica, 1964

Establishment	Population		Per cent attending	Number						Rate per 100 population				Laboratory exams per 100 medical consultations	X-rays per 100 medical consultations	Consultations per 100 attending	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations			Medical	Other
				Medical	Other					Medical	Other						
Ministry																	
Total hospitals	1 267 158	...	...	447 953	147 718	-	-	155 678	56 362	35.4	11.7	-	-	34.8	12.6	...	...
13 Health centers	209 230	93 041	44.5	69 495	148 548	9 004	23 166	55 556	-	33.2	71.0	4.3	11.1	79.9	-	74.7	159.7
8 Health centers	...	44 156	...	35 716	56 233	5 313	15 565	14 332	-	...	...	...	...	40.1	-	80.9	127.4
Total Health centers	...	137 197	...	105 211	204 781	14 317	38 731	69 888	-	...	...	...	...	66.4	-	76.7	149.3
Social Security	331 363	72 596	21.9	522 918	14 884	9 281	...	456 900	91 298	157.8	4.5	2.8	...	87.4	17.5	720.3	20.5

TABLE IX

Personnel in Outpatient Establishments, Costa Rica, 1964

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Ministry													
16 Hospital outpatient departments	...	...	...	...	...	...	...	...	...	...	6	30	5
21 Health centers	24	117	-	-	67	65	20	45	-	2	17	26	8
Social Security													
Central Policlinic	80	...	15	...	230	22	7	15		208	...	6	2

TABLE X

Average Cost per Outpatient Consultation, Costa Rica, 1964

Hospital	Mean cost	Median cost
Ministry		
Hospital outpatient departments	a) 7.84	...
Health centers	29.30	...
Social Security	21.70	20.63

a) Based on assumption that cost of 5 outpatient consultations is equivalent to one patient day of hospitalization.

C H I L E

I. ORGANIZATION OF THE MEDICAL SERVICES

A) NATIONAL HEALTH SERVICE

Law No. 10,383 of 8 December 1952 established the National Health Service and made it responsible for the functions, duties, and obligations that had previously been performed by the following bodies: National Hygiene Service; Central Board of Social Security and Welfare; Department for the Protection of Children and Adolescents; General Director of Labor; Bacteriological Institute; Medical and Health Services of the Municipalities.

Since that time, the National Health Service has been, by law, the sole legal instrument "responsible for the protection of health by action in the areas of health, social welfare, and preventive and curative medical care."

1. FUNCTIONS AND OBLIGATIONS

The functions and obligations of the National Health Service are the following:

1.- Protect and promote the health of the entire population of the country;

2.- Provide medical care:

a) comprehensive and free in character, for all manual workers and their families, for its own personnel and their spouses and children, for the economically underprivileged, and for the poor;

b) for all members of the population of the country who are not protected by law, who apply personally for paid medical care to any of its establishments, subject only to the by-laws of the service requiring that preference should be given to beneficiaries;

c) for persons injured in the course of occupational accidents without prejudice to the subsequent recovery of the cost from the insurer or employer under the current schedules of payment;

3.- Provide financial assistance for its subscribers in the event of temporary disability caused by illness, through the payment of the corresponding allowance;

4.- Provide financial compensation for insured women during the periods of pre-natal and post-natal convalescence, through the payment of maternity benefit and grant a nursing allowance to women breast-feeding their children, provided that they are not receiving a supplementary diet.

5.- Award preventive convalescence allowances.

2. NATIONAL HEALTH SERVICE PRINCIPLES AND POLICY

The theoretical objective of the activities of the National Health Service is solve the country's health problems and reflects the process of development and the changes that have occurred in the social, economic, and cultural environment of the country. It is a new approach that attempts to meet the new and growing health needs of society in a larger context. It is motivated by a firm desire to find more rational solutions to existing medical and social problems. This approach is, therefore, based on sociological, economic, medical, administrative, and legal considerations in nature of which it maintains that:

1.- Health is not an attribute of man in isolation. Society is influenced to a greater or lesser extent, by the state of health of its members. The physical and intellectual energies of the individuals of which society is composed contribute to the welfare of all. Any reduction or increase in such energies has a direct bearing on social and economic vitality.

2.- In the physical, cultural, and economic environment in which the majority of the members of our society live there are conditions that hinder its effective growth. The by-products of these exercise a manifest influence on the processes of health and disease. The functions and responsibilities of the National Health Service are limited to assisting organized society to solve its health problems, whereas it is the duty of the State and of society to take all the steps necessary to modify other environmental factors outside the specific sphere of action of the Service such as wages, food, housing, education, recreation, communications, etc.

3.- As it is a duty of the National Health Service to contribute to the well-being of the family and of society, it must be emphasized that its objective is to reduce the risk of illness and limit its short and long-term consequences, reduce general and specific mortality rates, and increase the life expectancy through the promotion of physical, mental, and social health: this objective should be realized through the integration of activities to promote, protect, and restore health and to encourage health education.

4.- With a view to integrating these activities, the National Health Service has defined medical care as the whole series of measures seeking to make available to the individual, the family, and the community all the means at the disposal of medicine and its related sciences, not only with a view to restoring the patient's health by therapeutic methods or by rehabilitation, but also for the purpose of promoting and protecting the health of healthy persons.

5.- The continuity of medical care, both in its duration and in its location, is the second of the tenets on which the National Health Service is based. The first is the explicit recognition of the natural right to

health of all persons, in the course of their progress through life, covering the contingencies of disease, accident, disability, etc. The second is the ready availability of an easy transition between outpatient, home and hospital treatment, and with this in view,the service encourages the development of medical care on a regional basis.

In accordance with the foregoing principles, the operational policies of the National Health Service provide that:

1.- Medical care shall be systematic, economical, and human, which implies a scientific and planned basis for its activities: maximum efficiency and productivity of all the resources used and respect for human dignity.

2.- Plans, programs, and projects, whose scientific, technical, and economic characteristics have been duly evaluated, constitute the basic instrument of its operational policy and it has few years been successfully operating a system of financial and budgetary control, through functional budgets, with which it is possible to determine the unit cost of each activity.

3.- In view of the wide differences that exist in geographical, climatic, economic, cultural, and other factors, and of the manifestly heterogeneous character of the health problems that arise in our communities, it is essential to deal with these within a framework of local planning by "program areas". The concept of the "hospital area" has therefore been introduced, the limits of which are defined not only in terms of the preceding factors, but also in the light of the availability of data, an evaluation of resources, the number and composition of the population, accessibility and of any other characteristics that would justified the existence of such an area as a self-sufficient unit.

4.- Recognizing that health is a local process, it has been decided to attach the highest importance to the decentralization of executive responsibilities and the concentration of policy-making authority.

5.- The high level of our morbidity rate, the nature of the diseases that are prevalent and the volume of investment make it essential that, at the present stage, first priority should be given to the restoration of health, without, however, underestimating the needs of other fields or overlooking the importance of a harmonious correlation of all efforts.

6.- For similar reasons special emphasis is being laid on the outpatient clinics, as these are regarded as a basic and fundamental unit in medical care.

7.- The preparation, training and distribution of personnel, in accordance with the health requirements of communities, is fundamental.

8.- The constant improvement of the system of medical care is an integral part of the operational policy of the National Health Service.

3. ORGANIZATION AND STRUCTURE

The National Health Service is at present organized as follows:

- DIRECTING ORGANS: the Director and the National Council.
- TWO DEPARTMENTS: Technical and Administrative.
- A GENERAL SECRETARIAT and the ZONAL DIRECTORATES.

The higher management of the National Health Service is the responsibility of the Director General, without prejudice to the powers vested in the Council under the law. They have joint executive responsibility for the exercise of the powers granted under the law.

1) The Department of the Director General exercises its authority through its two departments: each has nation-wide jurisdiction and the units of which the National Health Service is composed are responsible to them.

The Technical Department has regulatory functions, advisory functions, undertakes technical inspection and supervision, and is responsible for planning and evaluation. It is made up of the following divisions: Protection, Promotion and Restoration of Health, Architecture, a Planning Unit, and the Bacteriological Institute; it contains the following sections: Medical Inspectorate, Vital Statistics, Financial Surveillance of Medical Activities, Health Evaluation, Training and Fellowships, Biological Control and Medical Professions.

The composition of the divisions and sections is shown in the attached organizational diagram.

The Administrative Department includes the following divisions: Legal, Financial Control and Budget, Properties, and also the Control Store, and the sections responsible for Agricultural Management and the Workshops Center.

The General Secretariat is responsible for coordinating internal services at headquarters and itself has neither directing nor executive responsibilities.

2) The Zonal Directorates represent the second administrative level. Their principal functions are: coordination, advice, inspection, and control in respect of all the services within their jurisdiction. They provide the local machinery for implementing the policy of decentralization of work adopted by the Director General's Department and carry out their work through the hospitals.

3) The hospitals are the executive and functional units of the service, responsible for carrying out the work of health protection, health promotion, and health restoration on an integrated basis, under the direction of a single authority and for relating the general policy of the service to local conditions.

4. THE SYSTEM OF MEDICAL CARE

Medical care facilities are provided on a functional basis, and various bodies participate in making them available.

For the purposes of administrative and technical organization the country is divided into health zones and these are subdivided into hospital areas.

HEALTH ZONES

Thirteen Health Zones are at present in existence.

In making the division into zones, due allowance was made for geographical, physical, economic, cultural, and demographic factors, as well as for the major health problems of each region and its communications and means of access.

This division does not correspond to the political divisions of the country but is, nevertheless, regarded as the most logical and reasonable way of dealing with the many aspects of health care affecting populations distributed throughout the national territory. It is temporary in character, and subject to modification as the country develops.

The zones are the regional and decentralized units of the service and the zonal directorates are responsible for the coordination and execution of programs in the areas falling under their jurisdiction.

HOSPITAL AREAS

The Health Zones are divided into Hospital Areas, i.e. geagraphical units with in the zones, in which a series of institutions with coordinated activities (or a single institution) take the necessary measures with respect to the inhabitants and their environmental situation. The Hospital Areas seek to provide full medical care, contribute to social welfare, and promote and inspect environmental hygiene, in the interests of the community within each area. The functional coordination of the work of the institutions in each area facilitates a better use of its resources of personnel, equipment and medical supplies.

The number of Hospital Areas is at present fifty-three.

The most fully equipped hospital in the area is regarded as the base hospital i.e the principal agency in the system of medical care, provided with all the resources needed sufficient personnel, laboratories, equipment, organizational structure, funds, etc.,to support activities for the promotion and protection of health and health education in the community, and beds available to patients so that diagnoses can be completed and treatments that require hospitalization can be provided.

The base hospital is, therefore, the foundation on which the entire system of medical care in Chile rests and the executive and functional unit of the service that is best equipped to further its work and carry out its activities, providing coverage for the entire urban, suburban, and rural population of the geographical area assigned to it.

In practice, the total resources of medical care in a given area are governed by the density, location, and social and economic characteristics of its population, and only limited by the existing capacity of its institutions. It will therefore be evident that the further the population groups move from the hospital centers, the less these are able, by themselves, to provide all the services needed and the move they must, therefore, develop their activities through the out patient clinics.

The services provided in each of these units must satisfactorily meet local needs so that there is a true graduation ranging from the simplest forms of medical care given by rural medical posts and stations to the most complex and specialized hospital facilities; but the sum of the services available in an area must, in any case, meet the programmed requirements laid down in the general policy of the National Health Service.

The National Health Service, making use of the facilities that were available to the former Social Welfare and Public Assistance Services, the former Compulsory Insurance Fund, the former Service for the Protection of Children and Adolescents, and the former National Hygiene Service, and itself setting up other facilities, has continued to develop the activities for which the hospitals were responsible through the agency of the so-called out patient clinics, specialized clinics, general clinics, maternal and child health clinics or "peripheral" clinics, emergency services, class D hospitals, rural medical posts and stations, and medical visiting.

To introduce this system it has been necessary to adapt the hospitals, clinics and other establishments to the new methods of work and to build and renovate other hospitals, a process that has involved investment on a considerable scale in the course of the three-year period from 1959 to 1961.

5. IMPORTANCE OF THE ROLE OF CLINICS IN MEDICAL CARE

The National Health Service regards the clinics as the principal arm of the system of medical care, as they are best able to provide the medical services needed in the light of local morbidity trends, the amount and nature of the resources available and the very consider predominance of minor illnesses.

The clinics also perform an important role in the programs of health restoration. In these the Service makes its first contact with the patient in order to make a provisional and then a final diagnosis, give treatment, or indicate the nature of the hospitalization necessary. They are used to keep under surveillance discharged patients referred to them by the hospitals, or to continue their treatment as outpatients until they can be finally discharge.

Improvements in the work of the clinics and its effective coordination with the hospitalization services, reduce the duration of periods of hospitalization and increase the number of benefits.

The clinic is the unit that best illustrates the close relationship between measures for health restoration, health protection, health promotion, and health education, as it is the focal point for immunization, the supply of milk, ante- and post-natal examinations, general educational measures, etc., and is a true expression of integrated medicine, that is of the integration of preventive and curative medical care.

Finally, the clinic being the service closest to the people themselves is the one that best reveals the strong or weak points of our organization.

B) NATIONAL MEDICAL SERVICE FOR EMPLOYED PERSONS

The Employees National Medical Service came into existence in 1943, principally as the outcome of a merger of the Medical and Dental Services of the Private Employees Social Welfare Funds, the National Fund for Public Employees and Journalists, and the Social Welfare Fund of the Chilean Merchant Navy.

It is at present governed by Legislative Decree No. 286 of 6 April 1960, which defined its Statutes: its by-laws are contained in Decree No. 1,155 of 17 November 1954.

It is a para-statal Social Welfare Agency with legal personality whose relations with the Government are conducted through the Ministry of Public Health, without prejudice to the rights of inspection of the Superintendency of Social Security and the Office of the Comptroller General of the Republic.

The Institution is directed and administered by an Executive Vice-President, who must be a Chilean physician and appointed by the President of the Republic.

The Executive Vice-President is advised in his duties by a Board composed of:

a) The Minister of Public Health who shall act as its Chairman;
b) The Executive Vice-President who shall assume the chair in the absence of the Minister;
c) Two representatives appointed by the Council of the National Fund for Public Employees and Journalists;
d) Three representatives appointed by the Council of the Private Employees Social Welfare Fund;
e) A representative appointed by the Council of the Social Welfare Fund of the Merchant Navy;
f) Three representatives of affiliated employed persons appointed by the President of the Republic;
g) A representative of the Medical Association appointed by the President of the Republic;
h) The Superintendent of Social Security under the terms of Act No. 13.211;

The provision in the preceding subparagraph is without prejudice to the terms of Act No. 8,707.

FUNCTIONS PERFORMED BY THE NATIONAL MEDICAL SERVICE FOR EMPLOYED PERSONS

Article 4 of its Statutes provides that "the Employees National Medical Service shall discharge the functions entrusted to it under the law", in particular:

1) Grant preventive medical allowances in conformity with Act No. 6,174 and other legislation supplementing it;

2) Pay the convalescent benefits and other cash allowances that the Social Welfare Funds and Agencies referred to in the present legislative decree are required to pay under the provisions of Act No. 6,174;

3) Grant such supplementary benefits, arising out of the provisions of Act No. 6,174 as may be determined by the Service in accordance with the regulations;

4) Grant to subscribers to the National Fund for Public Employees and Journalists the scheduled curative medical benefits based on legislative Decree No. 1,340 bis of 6 August 1930 and any others that are provided for in supplementary legislation or may be laid down in the regulations;

5) Provide subscribers to the Social Welfare Fund of the Chilean Merchant Navy with the curative medical care to which they are legally entitled, charging the cost to the two per cent contribution made by that Fund;

6) Grant scheduled curative medical care to dependent members of the families of active or inactive member of the National Fund for Public Employees and Journalists persons;

7) Grant curative medical care under existing legislation and current regulations to members of the families of active or inactive members of the Social Welfare Fund of the Chilean Merchant Navy and of the Sub-Section for Printing and Publications of the Department of Journalists of the National Fund for Public Employees and Journalists;

8) Grant scheduled curative medical care to subscribers and the members of their families that constitute recognized dependents in the case of Social Welfare Funds and Agencies that do not have their own facilities for this, provided that they make the necessary funds available to the Service either by agreements under special legislation;

9) Provide scheduled dental care for subscribers and members of their families affiliated to the Service, on the conditions laid down in the regulations;

10) Carry out the provisions of Act No. 6,935;

11) Grant medical and dental loans to active and inactive member in accordance with the regulations;

12) Grant to persons in private employment who are active members of the Social Welfare Fund for Persons in Private Employment, financial assistance as defined in Article 4 of Legislative Decree No. 2,096 of 31 December 1927, in urgent cases recognized by the Executive Vice-President or the Advisory Board in accordance with the regulations;

13) Grant active member to the Social Welfare Fund for the Chilean Merchant Navy and of the Sub-Section for Printing and Publications of the Department of Journalists of the National Fund for Public Employees and Journalists sickness benefits in accordance with the law and the regulations;

14) Grant the medical and financial benefits defined in Law No.11,462 of 29 December 1953 and its regulations, in so far as the National Medical Service for Employed Persons is affected;

15) Grant such medical benefits as are referred to in the Statute relating to persons employed in the State Civil Service, so far as the National Medical Service is affected;

16) Established cases of disability of persons in private employment, who are affiliated to the National Medical Service, under the terms of Act No. 10,475;

17) Build, purchase or rent suitable establishments for the clinical and hospital care of the beneficiaries of the Service, both with respect to its preventive and curative functions, in accordance with the regulations, and

18) Discharge such other functions as may be entrusted to it under the law.

BENEFITS PROVIDED BY THE SERVICE

In the first place it should be pointed out that the National Medical Service for Employed Persons has 437,000 members, of which 180,000 are public employees, 220,000 private employees, 25,000 members of Auxiliary Social Welfare Agencies and 12,000 members of the Fund for the Chilean Merchant Navy.

Persons in the private employment receive preventive medical care and dental care only, whereas public officials, members of the Merchant Navy and members of Auxiliary Agencies are entitled to both preventive and curative medical care, a benefit that is extended to their dependents -amounting to 434,000- so far as curative medicine is concerned.

1. Facilities provided by the National Medical Service for Employed Persons

The Service, through its various Regional Departments, Teams, and Medical Sub-Offices, provides the following forms of care:

a) Preventive Medical Care;
b) Curative Medical Care;
c) Laboratory and X-Ray facilities;
d) Hospitalization in Sanatoria;
e) Examinations of pregnant mothers and infants;
f) Dental Care;
g) Medical Examinations for Superannuation, and
h) Medical Examinations on Admissions.

2. Cash benefits

a) Maternal benefits;
b) Eyeglasses and orthopedic apparatus;
c) Convalescent benefits under Acts Nos. 6,174 and 11,462;
d) Grants for the removal of sick persons;
e) Allowances for Private Employees under Decree No. 2,096;
f) Cancer allowances;
g) Disability Pensions and Superannuation, and
h) Medical benefits.

FINANCING OF THE SERVICE

The National Medical Service for Employed Persons is financed with the following funds:

a) With the employer's contribution of one per cent of salaries commissions and wages provided for in Article 8 of Act No. 6,174;

b) With the contribution of 2.5 per cent of the gross revenues of Social Welfare Agencies provided for in Article 8 of Legislative Decree No. 286 of 1960;

c) With such fifty per cent increases in the contributions provided for in the preceding subparagraphs as are or may be decreed by the President of the Republic by virtue of the power vested in him in Article 9 of Act No. 6,174;

d) With the two per cent of the gross revenues of the National Fund for Public Employees and Journalists as provided for in Article 45 of Legislative Decree No. 1,340 bis;

e) With four per cent of the revenues of the Sub-Section for Printing and Publications of the Department of Journalists of the National Fund for Public Employees and Journalists in conformity with the provisions of Article 68 of Act No. 10,621;

f) With the contribution of five per cent of the revenues indicated in Article 67 of Act No. 10,621 as being set aside for the provision of special forms of curative medical care for journalists who are subscribers to the National Fund for Public Employees and Journalists, on such conditions as may be laid down by the President of the Republic;

g) With the two per cent of salaries, allowances and other emoluments in respect of which contributions are payable to the Social Welfare Fund of the Chilean Merchant Navy in accordance with the provision of Acts Nos. 6,037 and 7,759;

h) With the one per cent of the interest produced by the accumulated capital funds referred to in Article 4 of Legislative Decree No. 2,096 of 31 December 1927;

i) With such funds, percentages or contributions as may be certified in their respective budgets for the medical and dental care or social welfare of their subscribers by Social and Welfare Agencies that are affiliated to the Service;

j) With its own revenues obtained from the scheduled forms of care provided by the Service;

k) With such donations, inheritances, legacies, special contributions and voluntary payments as it may receive;

l) With such interest, charges, earnings, dividends, rates or funds as it may receive or as may be produced by the Services investment funds;

m) With the accumulated funds in the Social Welfare Funds defined in Decree No. 286 of 1960 as a consequence of the application of Act No.6,174, without prejudice to the provisions of Article 16 of that Act;

n) With the contribution referred to in Article 45 of Act No. 10,223, for which purpose provision shall be made for the necessary funds in the National Budget Act;

o) With the penalties imposed under the terms of Article 13 of Act No. 6,174, it being understood that Article 1 (c) of Act No. 11,855 refers to the National Medical Service for Employed Persons, in the case of the Social Welfare Agencies that are affiliated to the latter, in conformity with the present Legislative Decree, and

p) Such other earnings as it may be resolved by law to assign to it.

The Budget for the 1965 financial year amounted to E° 38,805,000.

C) WORKMEN'S COMPENSATION FUND

The organization of the WORKMEN'S COMPENSATION FUND is based on Legislative Decrees Nos. 309 and 150 of 1960.

It is a para-statal Agency with its own legal identity and assets, whose relations with the Central Government are conducted through the Ministry of Labor and Social Welfare. It is subject to inspection and supervision by the Superintendency of Social Security.

Under the provisions of Legislative Decree No. 278 of 1960 the higher management of the Fund is the responsibility of its Board and Executive Vice-President.

The composition of its Board of Directors is as follows:

a) The Minister of Labor and Social Welfare, who acts as Chairman;

b) The Executive Vice-President, who acts as Chairman in the absence of the Minister;

c) Three Members of the Board freely elected by the President of the Republic, one of whom shall be a physician;

d) A representative of the Society of Industrial Development;

e) A representative of the National Mining Company;

f) A representative of the National Agricultural Company;

g) Two workers' representatives, and

h) The Superintendent of Social Security under the terms laid down in Act No. 13,211.

FUNCTIONS OF THE FUND

These are to:

a) Undertake workman's compensation insurance and provide the necessary medical and welfare services and cash grants for injured work people whose employees are covered by policies taken out with the Fund;

b) Inspect and approve the guaranties to be furnished by employers who have no association, in conformity with Section 3 of Article 261 of the Labor Code;

c) Inspect and approve the guaranties that must be provided by uninsured employers in cases of accidents at work to their employees resulting in the death or permanent disability of the victim, in accordance with paragraph 1 of Article 22 of Act No. 4,055 concerning accidents at work (now Act No. 10,383);

d) Provide a pensions service in accordance with paragraph 2 of Article No. 22 of Act No. 4,055 (now Act No. 10,383);

e) Administer the Guaranty Fund established under Act No. 4,055 in accordance with the principles lay down in that Act and the corresponding regulations;

f) Propose to the Minister of Labor and Social Welfare, at least every two years, the scales of premiums to be charged for workman's compensation insurance;

g) Organize and maintain up-to-date central records of disabled persons and beneficiaries in the case of accidents at works, which shall list all injured persons unable to work and those persons entitled to pensions as the result of the death of an injured person;

h) Provide, so far its resources will allow, an occupational rehabilitation service, which shall make assistance available to injured persons who have applied to the Fund as a result of insurance directly taken out with it.

The Fund may provide these services for private persons on such terms as it may itself determine;

i) Sign agreements with Government, semi-Government and autonomous institutions, Social Welfare Funds and private persons for the provision of specialized medical care for injured persons;

j) Undertake reinsurance in respect of work accidents.

BENEFITS PROVIDED BY THE FUND

It should be pointed out that the Workman's Compensation Fund meets the needs of a total population of approximately 350,000 employed persons and operatives.

The benefits available to this varied group of workers are:

1) Cash benefits

a) Allowances;
b) Compensation for permanent partial disability;
c) Compensation for permanent total disability;

d) Compensation for the death of injured persons;
e) Family allowances;
f) Pensions adjustment, and
g) Funeral grants.

2) Benefits in services

a) Medical care;
b) Hospital care;
c) Pharmaceutical services, and
d) Technical advice to employers on accident prevention.

3) Benefits in kind

a) Drugs
b) Orthopedic and prosthetic apparatus.

ASSETS OF THE FUND

The Fund's financial assets consists of the following:

1. Premiums paid for insurance undertaken by the Fund;

2. Sums it collects for provision of pension services;

3. Grants under the terms of Article 28 of Act No. 9,689 of 20 September of 1950 and Article 45 of Act No. 10,223 of 6 December 1951;

4. The revenues, interest, and proceeds of its assets;

5. The inheritances, legacies and donations it receives;

6. Money paid into the Fund's Guaranty Account, without prejudice to the limitations prescribed by law, and

7. Such other income it may be assigned under the Law.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Chile, 1964 or 1965

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations(a)	Beds	Discharges	Patient days	Outpatient consultations
National Health Service									
164 General Hospitals	8 391 000	21 233	633 193	6 173 658	5 534 857	2.5	75.5	735.7	659.6
16 Specialized hospitals	8 391 000	8 386	27 779	2 339 144	160 480	1.0	3.3	278.8	19.1
12 Delegated Health Services	...	918	24 874	214 147	333 722	...	...	...	...
Workmen's Compensation Fund									
12 Hospitals (b)	...	817	3 879	165 987	31 307	...	...	...	...
National Medical Service for Employed Persons (b)									
1 General hospital	651 000	72	2 818	21 370	59 992	0.1	4.3	32.8	92.2
3 Specialized hospital	651 000	323	530	117 237	-	0.5	0.8	180.1	-

(a) Medical consultation including emergency. (b) Year 1965.

TABLE II

Indices of Hospital Utilization, Chile 1964 or 1965

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
National Health Service			
164 General hospitals	9.8	29.8	80.1
16 Specialized hospitals	84.2	3.3	92.1
12 Delegated Health Services	8.6	27.1	62.2
Workmen's Compensation Fund			
12 Hospitals	42.8	4.7	52.8
National Medical Service for Employed Persons			
1 General hospital	7.6	39.1	81.5
3 Specialized hospitals	221.2	1.6	92.5

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Chile, 1964 or 1965

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
National Health Service																
147 General hospitals	3 156	2 312	30 206	17 527	810	16 088	629	1 332	11 347	16.6	12.1	158.4	91.9	4.2	7.0	59.5
10 Specialized hospitals	257	219	3 123	992	88	880	24	176	1 955	4.2	3.6	50.6	16.1	1.4	2.9	31.7
5 Delegated health services	43	43	532	308	48	237	23	18	206	8.5	8.5	105.3	61.0	9.5	3.6	40.8
Workmen's Compensation Fund																
12 Hospitals	a) 33	23	407	104	5	99	-	18	285	7.4	5.1	90.8	23.2	1.1	4.0	63.6
National Health Service for Employed Persons																
1 General hospital	9	5	151	63	7	47	9	1	87	15.3	8.5	257.2	107.3	11.9	1.7	148.2
3 Specialized hospitals	4	4	265	24	5	19	-	3	238	1.3	1.3	88.6	8.0	1.7	1.0	79.6

(a) Excludes "honorarium."

TABLE IV

Ratios on Distribution of Hospital Personnel, Chile, 1964 or 1965

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
National Health Service							
147 General hospitals	0.3	0.4	5.6	7.6	19.9	...	66
10 Specialized hospitals	0.3	0.4	3.9	4.5	10.0	...	42
5 Delegated health services	1.1	1.1	7.2	7.2	4.9	...	64
Workmen's Compensation Fund							
12 Hospitals	0.2	0.2	3.2	4.5	19.8	59	35
National Health Service for Employed Persons							
1 General hospital	0.8	1.4	7.0	12.6	6.7	96	46
3 Specialized hospital	1.2	1.2	6.0	6.0	3.8	74	12

(1) Based on total physicians. (2) Based on total physician hours divided by six.

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Chile, 1964 or 1965

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
National Health Service			
147 General hospitals	31	313	14
10 Specialized hospitals	9	55	5
5 Delegated Health Services	28	208	32
Workmen's Compensation Fund			
12 Hospitals	13	79	4
National Medical Service for Employed Persons			
1 General hospital	22	366	41
3 Specialized hospitals	3	27	6

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Chile, 1964 or 1965

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
National Health Service							
147 General hospitals	5 922 467	9.8	5 274 334	19.13	187.47	7 002	3.83
10 Specialized hospitals	2 236 486	84.2	105 875	7.39	622.24	2 705	1.48
12 Delegated Health Services	208 957	8.6	333 772	...	...	...	...
Workmen's Compensation Fund							
12 Hospitals	157 865	42.8	31 307	26.88	1 150.46	9 838	5.38
National Medical Service for Employed Persons							
1 General hospital	21 478	7.6	59 992	107.36	815.94	39 294	21.47
3 Specialized hospitals	109 337	221.2	-	23.01	5 089.81	8 422	-

TABLE VII

Number and Type of Outpatient Establishments Reporting, Chile 1964 or 1965

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry of Health				
Hospital outpatient departments	168	...	94	98
Other outpatient departments	23	...	4	4
Delegated Health Services				
Hospital outpatient department	1	...	1	1
Other outpatient department	1	...	-	-
Workmen's Compensation Fund				
Hospital outpatient departments	12	...	1	12
National Medical Service for Employed Persons				
Outpatient clinics	28	...	25	28

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Chile, 1964 or 1965

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Ministry of Health																	
168 Hospital outpatient departments	8 391 000	...	...	5 698 149	2375 933	559 276	463 1405	3 260 945	478 571	67.9	28.3	6.7	55.2	...	...	57.2	8.4
23 Other outpatient clinics	8 391 000	...	...	1 907 177	90 489	21 581	-	209 819	130 350	22.7	1.1	0.3	-	...	...	11.0	6.8
Delegated Health Services																	
1 Hospital outpatient department	...	...	...	14 485	2 134	-	-	13948	3 547	...	...	...	...	...	....	96.3	24.5
1 Other outpatient clinic	...	...	...	9 247	-	1 514	-	-	-	...	...	...	...	...	...	...	...
Workmen's Compensation Fund																	
Hospital outpatient department	...	...	...	31 307	...	...	-	-	28 776	...	...	...	-	...	...	-	91.9
National Medical Service for Employed Persons																	
28 Clinics	651 000	...	...	387 958	125 198	177 364	60 794	229 771	219 995	59.6	19.2	27.2	9.3	...	...	59.2	56.7

TABLE IX

Personnel in Outpatient Establishments, Chile 1964 or 1965

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
National Health Service													
Hospital out-patient	...	...	...	...	...	...	...	...	...	...	6	63	3
19 Other out-patient clinics	265	899	79	273	970	507	46	433	28	463	10	33	3
Delegated Health Services													
1 Hospital out-patient (a)	...	...	...	...	...	...	...	...	...	...	4	42	6
1 other out-patient clinic	1	6	-	-	5	4	-	4	-	1	10	54	-
Workmen's Compensation Fund (a)													
12 Hospital out-patient clinics	...	...	...	...	...	...	...	...	...	...	3	16	1
National Medical Service for Employed Persons													
27 Clinics	218	731	169	553	1 476	422	107	290	25	1 054	61	120	30

(a) Same personnel as for hospitals with time for 5 consultations considered equivalent to one patient day.

(b) Average for all hospitals in the group.

TABLE X

Average Cost per Outpatient Consultation, Chile, 1964 or 1965

Hospital	Mean cost	Median cost
National Health Service		
147 Hospital outpatient	3.83	...
11 Other outpatient clinics	12.67	10.96
Delegated Health Services		
Hospital outpatient	...	...
Other outpatient clinics	...	...
Workmen's Compensation Fund		
12 Hospital outpatient clinics	5.38	...
National Medical Service for Employed Persons		
13 Clinics	40.77	26.22

E L S A L V A D O R

I. ORGANIZATION OF MEDICAL SERVICES

1.- Ministries or Departments of Public Health

1. Pursuant to Articles 205 and 206 of the Constitution, health is considered a national resource and the State and its citizens have the responsibility for its maintenance and restoration. The State is responsible for the maintenance and restoration of health for the indigent. In El Salvador, the Ministry of Public Health and Welfare is the governmental agency having primary responsibility for providing preventive measures and medical care for the community in general; but another agency, the Salvadoran Social Insurance Institute, is also providing medical services for an important sector of the population.

2. The annexed organizational chart shows the Ministry as well as its regional and local agencies. The Office of the Director General of Health carries out its functions through a central regulatory body composed of the directors of its various divisions (Epidemiology, Nutrition, Maternity and Child-Care, Tuberculosis, Dentistry, Environmental Sanitation, etc.) and an executive staff at the regional level. Its relations with the large hospitals consist of advisory services, technical direction and coordination, inasmuch as the hospitals enjoy a certain degree of autonomy with regard to their budgets and equipment.

3. Since 1954, the health service has been regionalized and the country is divided into Regions I, II, III and IV, comprising respectively the Western, Central, Para-Central and Eastern Regions; and more recently the metropolitan area (comprising the Capital City and its suburbs) has been given a separate organization, in view of its importance and the multiplicity of its problems.

   Each of these regions is in the charge of a Regional Director who has direct responsibility for preventive medicine activities along with the outpatient clinics of the Health Units, the Health Stations and the Mobile Rural Units, for local hospitals and for coordination with the regional hospitals.

   Patients are hospitalized through a process of referral from the Health units to the local hospitals; if the latter are unable to provide adequate treatment, the patients are sent on to the regional hospital, or, if necessary, to the central hospitals in the Capital of the Republic, which also serve as the regional hospitals for the Central Region (II).

4. The Office of the Director General of Health, through its regulatory bodies, is the agency responsible for formulating working standards, establishing guidelines, coordinating the various activities and

supervising the technical personnel at the different levels. However, the Ministry also has a "Planning and Evaluation Unit" established under Executive Order Nº 997, which advises the authorities of the branch.

5. There is a national health plan known as the "First Ten-Year Health Plan, 1964-1973". Programs and activities in the field of preventive medicine and medical care, and outpatient and hospital services have been brought under the plan. This does not include the Salvadoran Social Insurance Institute, which is an autonomous agency of another branch of the Government.

The Ministry of Public Health and Welfare is not represented on the National Economic Planning Council, but the latter is represented on the Planning Council of the Ministry of Public Health and Welfare, and there are coordinating and working relationships between the two bodies at the level of their respective secretariats.

6. Health budgets are prepared in the various divisions of the Ministry, by programs, and pursuant to the directive: "Group the various activities to be carried on by agencies under the headings of Programs, sub-Programs, Activities, etc., and proceed to budget each one of them in such a way that the total requirements for funds, materials and personnel are clearly related to the goals of physical accomplishment, and the volume of work of each program and activity, with the administrative unit responsible for its execution similarly described in detail".

The Office of the Director General of Health assembles the budget estimates from the various agencies operating in the health field, analyzes the programs by activity, by region, and by individual hospitals, and in turn prepares programs to be carried out at the central staff level, such as training, research, malaria campaign, rural programs, etc., and sends them to the Ministry for review. The latter in turn discusses them with the President of the Republic; and, when approved, they are transmitted to the National Legislative Assembly for study, debate, and approval.

The budget for Public Health and Welfare amounts to 10 per cent of the National Budget.

Recommendations for the appointment of personnel in the health branch are made by the Office of the Director General of Public Health to the Ministry of Public Health and Welfare, which issues the appointment order.

There is a Civil Service Law, enacted by Legislative Decree Nº 507, establishing standards for the appointment and selection of personnel, rights and responsibilities of officials and employees, disciplinary measures, etc., and there is a Civil Service Board that hears appeals.

Cabinet ministers and assistant secretaries of State, members of the Supreme Court, representatives to the National Legislative Assembly, the Attorney General of the Republic, directors of bureaus and services, doctors, nurses and technical personnel are not subject to the Civil Service law.

There is also a law establishing holidays, vacation, and leave of absence for governmental employees. The Personnel Officer of the Bureau of Public Health is responsible for personnel control, with regard to establishment of registers, appointments, leave and files.

2. The Salvadoran Social Insurance Institute

Administrative Organization

Planning, direction and administration of the social security system is the responsibility of the Salvadoran Social Insurance Institute, an autonomous agency organized under public law and linked to the government through the Ministry of Labor and Social Security, with legal personality and its own funds, and having its principal domicile in the City of San Salvador.

The highest directive organs of the Institute are the Executive Council and the Office of the Director General (see attached organization chart). The former constitutes the highest echelon in the administrative, financial and technical organization, and is composed of 12 members selected in the following manner:

a) The Minister of Labor and Social Security or the Assistant Secretary of State for that branch;

b) Four representatives of the government, one for each of the following ministries: Treasury, Labor and Social Security, Economy, and Public Health and Welfare;

c) Two members representing labor, elected by the labor unions;

d) Two members representing the employers, elected by the most important of the employers' associations;

e) One member representing the Salvadoran Medical Association;

f) One member representing the Salvadoran Dental Society;

g) The Director General of the Institute or, in his absence, the Assistant Director General.

The Minister of Labor and Social Security, or, where appropriate, the Assistant Secretary, serves as chairman ex officio of the Council.

The Director General or, in his absence, the Assistant Director General of the Institute serves as Secretary.

The Office of the Controller of Accounts is directly responsible to the Executive Council (see attached organization chart).

The Director General and the Assistant Director General of the Institute are appointed by the President of the Republic.

The Office of the Director General is assisted by the Legal Adviser, the Medical Audit and the Office of Organization and Methods. There are five departments having administrative functions, and the Bureau of Medical and Hospital Services, reporting directly to the Director General of the Institute.

The Director of Medical Units (hospitals and outpatient clinics) of the Metropolitan zone and the Sonsonate Branch Office report to the Medical and Hospital Services Bureau, but the administrative staff of the Sonsonate Branch reports directly to the Director General without going through the Medical Services Bureau.

II. RESOURCES AND FUNDS

The Institute finances its social security program with the proceeds of compulsory contributions of employers and employees, and contributions from the Government.

The total contribution amounts to 10 per cent of the insured worker's wages, with the insured worker paying 25 per cent; the employer, 50 per cent, and the Government, 25 per cent.

Assets acquired by gift, inheritance or legacy, as well as any income from such assets, and fines collected in accordance with the Social Security law and its regulations are also considered resources of the Institute.

The Institute carries out its plans and programs on the basis of a budget in which revenues and ordinary expenditures are balanced, or the simple allotment method.

As required by its Regulations, a fixed amount is set aside as a reserve fund to cover the contingencies as specified in such Regulations.

These reserves are deposited in a current account in the Central Reserve Bank or in the Salvadoran Mortgage Bank.

Reserves in excess of the amount specified in the Regulations for maintenance in the current account are invested in securities guaranteed

by the Government, and the proceeds of such investments are considered as ordinary revenue of the Institute.

The Institute is prohibited from engaging in activities for profit. Accordingly to existing legislation, whenever there is a real surplus at the conclusion of any fiscal year, the amount may be utilized solely for purposes of expanding or improving the regular services of the Institute, or to establish new continuing services. Periodically, at intervals not exceeding five years and at such times as the Executive Council considers desirable, actuarial studies are made for the Institute's financial projections.

Finally, the Government's share of the contributions is paid from general revenues of the Government and is appropriated in the National Budget Act and made available to the Institute through the Ministry of the Treasury at the beginning of each quarter.

III. GENERAL DATA ON PREPARATION OF THE INSTITUTE'S BUDGET

As stipulated in the pertinent law, the following principles are applied in preparing the budget:

1. The Income Section shall contain an estimate of the resources for the fiscal year, showing the breakdown of items of income that are to be regarded as ordinary or special revenues, in accordance with their definition in the ISSS Law.

2. All estimated income and expenditures that by their nature so require shall be itemized in detail.

3. In the Expenditures Section, the budget shall fix the items or ordinary expenditures in amounts that shall not exceed the corresponding income items in the same category.

4. In the Expenditures Section, the budget shall establish the appropriate breakdown between the items authorizing expenses for:

   1) Administration;

   2) Operation and maintenance of the various services established for the benefit of the insured;

   3) Payment of cash benefits to insured or their beneficiaries;

   4) Studies and planning;

   5) Acquisition of capital goods;

   6) Formation of Reserves as specified in the regulations, and

   7) Other activities.

With reference to the procedure for appointment and remuneration of personnel, permanent employees shall be appointed in accordance with the provisions of the special salary law that is prepared by the Institute and submitted to the National Legislative Assembly through the Ministry of the Treasury, as an annex to the National Budget.

IV. FIELD OF APPLICATION

A. Geographic Area

The social security system is applicable to all gainfully employed workers in establishments located in the municipalities of San Salvador, Soyapango, Cuscatancingo, Mejicanos, Villa Delgado, Ayutuxtepeque, San Marcos, Nueva San Salvador (Santa Tecla), Antiguo Cuscatlán, Ilopango, and Apopa (geographic areas regarded as constituting the Metropolitan Zone); and in the municipalities of Sonsonate and Puerto de Acajutla (the area constituting the Sonsonate Branch). At a meeting of the Council of Ministers on May 5 of this year, it was decreed that social security coverage would be extended to the following municipalities in the Department of San Salvador: Aguilares, El Paisnal, Guazapa, Nejapa, Panchimalco. Rosario de Mora, San Martín, Santiago Texacuangos, Santo Tomás and Tonacatepeque, and to the municipality of Quezaltepeque, in the Department of La Libertad.

With regard to the Port of Acajutla, the system is not applicable to longshoremen and stevedores, cargo handlers and other dock workers that are classified by the Bureau as casual workers.

According to the Regulations on Applicability, the following workers are not yet covered:

a) Employees of the National Government and municipal Governments, and of the autonomous governmental agencies. An exception is made in the case of the Salvadoran Social Insurance Institute employees, employees of the Executive Committee for the Port of Acajutla and the Central Reserve Bank of El Salvador;

b) Domestic workers;

c) Workers who work only occasionally for one employer;

d) Workers who earn more than 500 colons a month in regular wages from one employer, and

e) Agricultural workers.

As of January 1965, workers employed in the geographic areas covered in that year, by an employer having fewer than five employees, were brought into the system.

The following table, taken from the "Annual Report of the Director General of the Salvadoran Social Insurance Institute" for the year 1965, shows the expansion of social security coverage since 1955, the first year in which the Institute was operating:

PARTICIPATING WORKERS, EMPLOYERS AND BENEFICIARIES

FOR THE YEARS 1955-1966

YEAR	Participating		Beneficiaries
	Workers	Employers	
1955	24,443	965	9,084
1956	27,474	976	10,926
1957	31,161	1,025	12,228
1958	32,069	1,048	12,327
1959	32,053	1,082	12,097
1960	35,644	1,155	13,162
1961	38,638	1,193	14,331
1962	40,528	1,256	14,801
1963	44,361	1,466	15,977
1964	50,409	1,564	17,738
1965	62,097	3,233	21,115

The average monthly total of participating workers in the first four months of 1966 was 65,200; with the normal increase and the inclusion of new insured groups in the municipalities listed above, it is estimated that the average monthly total of insured participants may reach 70,000 for this year.

B. Coverage

In its present stage of development, the social security system provides protection against the following risks:

a) General sickness and accident;

b) Work accidents and occupational disease;

c) Maternity.

In cases of sickness, maternity and occupational risks, the insured worker is provided with medical, surgical, pharmaceutical, dental, hospital and laboratory services. In cases of work accidents or occupational disease, prosthetic and orthopedic devices recommended by the doctors and dentists for the rehabilitation of the patient are provided when required.

The Institute also grants life pensions for permanent disability, either total or partial, arising from occupational diseases or work accidents. Survivor's benefits are paid to the beneficiaries of the insured when death results from such causes.

Maternity benefits are granted to the spouse or common-law wife.

In addition to providing medical care, the Institute grants cash payments for temporary disability resulting from sickness or childbirth and occupational risks.

Other benefits include funeral grants, layette; and milk allowance for the new born who, in the opinion of the attending physician, cannot be nursed by their mother.

It should be added that studies are currently in progress to include disability, old-age and death benefits, and that the Social Security law also envisages coverage for lay-offs.

At the present time, the only activity in the field of preventive medicine is that of prenatal care, which is available to insured female workers and to beneficiaries of insured male workers.

V. COORDINATION OR SERVICES AT THE LOCAL LEVEL BETWEEN THE SOCIAL INSURANCE INSTITUTE AND THE MINISTRY OF PUBLIC HEALTH AND WELFARE

When the program to provide medical care and hospitalization was initiated, the Institute concluded agreements with the Ministry of Public Health and Welfare whereby hospital beds were made available to the latter while it was in process of building its own establishments. Accordingly, it has been occupying space for its insured patients in the Rosales Hospital of San Salvador (National Medical Center), the Maternity Hospital of San Salvador, the San Rafael Hospital in Nueva San Salvador, the San Juan de Dios Hospital in Sonsonate, and the National Sanatorium at Los Planes de Renderos. In these institutions, the Social Insurance Institute pays the Public Health Ministry a stipulated amount for beds, which includes rental of the space, food and administrative expenses. But it is the Social Insurance Institute that finances the cost of the medical and auxiliary medical personnel, and the administrative and service staff. In the Psychiatric Hospital, payment is made for each patient receiving treatment, and the Social Insurance Institute pays its psychiatrist according to the salary scale established in its Salary law.

At Clinic Nº 6 in Apopa, the Social Insurance Institute uses the premises and the administrative and nursing staff of the Ministry of Public Health and Welfare and pays them extra fees. The medical and dental staff belong to the Institute. This same procedure will be followed when the system is extended to the remaining municipalities of San Salvador and Quezaltepeque(Department of La Libertad), and an agreement has been reached between the two agencies for this purpose.

VI. ACCESSIBILITY OF MEDICAL SERVICES

All of the insured workers and their beneficiaries covered under the system have ready access to existing medical services.

VII. CONSTRUCTION OF THE ISSS HOSPITAL FACILITIES

At the present time, construction is proceeding on the buildings for the Institute's hospital and clinics, which will help to solve one of its most pressing problems -that of providing the required services in some of the branch centers where limited space is available in the present location.

The principal features of this construction work are as follows:

Covered area		19,560.00 square meters
Outpatient clinic	5,665.00 square meters	
Hospital	12,770.00 square meters	
Machine room	1,225.00 square meters	
Exterior works		7,640.00 square meters
Plaza	2,100.00 square meters	
Access roads and parking area	3,470.00 square meters	
Gardens	2,070.00 square meters	
TOTAL AREA		27,200.00 square meters.

Hospital Services

Number of beds		400
Maternity and gynecology	135	
Pediatrics	45	
General Medicine	110	
Surgery	110	
Delivery rooms	4	
X-ray rooms	5	
Operating rooms	8	

Outpatient clinic

Number of offices	43	
TOTAL COST		8,000,000.00 colones

(Source: "Annual Report of the Director General, etc." for the year 1965).

On the summary sheet of Form 1-b, the amount shown as investment in the construction and renovation in the five-year period 1960-1964 is quite low, since the bulk of the investment was made in previous years, prior to the opening of each new clinic or hospital, as may be seen from the inauguration dates shown on the form for each health establishment.

VIII. EXTENSION OF SOCIAL SECURITY COVERAGE

In 1965, there were 62,097 covered workers, representing 7 per cent of the gainfully employed population of country, under the social security system, with coverage limited to sickness, maternity and occupational risks. However, the directors of the Institute, aware of the necessity of extending the system geographically and broadening the coverage provided in accordance with the accepted concept of social security, have already prepared projects to extend the system to the cities of Santa Ana (the second ranking city after San Salvador) to Chalcuapa, Ahuachapán and Metapán, which would complete coverage of the entire Western Zone, and have made preliminary studies for the City of San Miguel (located in the Eastern Zone, and the third-ranking city in the country).

Studies to include protection against disability, old-age and death have already been completed as noted above, and it is proposed to add medical care for children under two years of age, so as to initiate a program of protection for the entire family unit.

In summary: modern hospital buildings, adoption of new techniques to improve existing services, geographic extension of the system so as to cover the three most important regions of the country (the Western, Eastern and Central Zones), providing coverage for risks not hitherto included and adding general sickness benefits for children, spouses and common-law wives of insured workers are all measures of progress that we shall soon see in operation, and that reveal the concern of the present authorities to foster the development of the social security system in El Salvador.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, El Salvador, 1964

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Ministry of Health									
Rosales Hospital	767,900	727	11,296	284,073	166,247	0.9	14.7	369.9	216.5
Social Security									
Rosales Hospital	45,925	136	3,994	44,746	17,164	3.0	87.0	974.3	373.7
Ministry of Health									
8 hospitals reporting	1,017,700	3,132	88,722	945,305	381,333	3.1	87.2	928.9	374.7
Social Security									
6 hospitals (excluding tuberculosis)	68,147	206	10,388	65,174	21,238	3.0	152.4	956.4	311.6
Ministry of Health									
2 health centers reporting	97,100	83	3,573	15,058	13,925	0.9	36.8	155.1	143.4

TABLE II

Indices of Hospital Utilization, El Salvador, 1964

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Ministry of Health			
Rosales Hospital	25.1	15.5	106.8
Social Security			
Rosales Hospital	11.2	29.4	90.5
Ministry of Health			
10 hospitals reporting	10.3	29.1	82.3
Social Security			
6 hospitals reporting	6.3	50.4	86.8
Ministry of Health			
2 health centers reporting	4.2	43.0	49.6

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, El Salvador, 1964

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time (a)		Total	Nurses	Auxiliaries	Midwives			Total	Full Time (a)		Total	Nurses		
Ministry of Health Rosales Hospital	133	85	990	409	89	320	-	12	569	15.3	9.8	114.2	47.2	10.3	1.4	65.6
Social Security Rosales Hospital	41	41	265	94	23	71	-	10	161	30.8	30.8	199.2	70.7	17.3	7.5	121.1
Ministry of Health 10 hospitals reporting	289	214	2 790	1 164	282	882	-	86	1540	10.0	7.4	96.9	40.4	9.8	3.0	53.5
Social Security 6 hospitals reporting	48	48	364	147	30	117	-	11	206	25.3	25.3	191.6	77.4	15.8	5.8	108.4
Ministry of Health 2 health centers reporting	6	6	57	26	9	17	-	2	29	12.2	12.2	116.3	53.1	18.4	4.1	59.2

(a) Total physician hours contracted per day divided by six hours, assuming full time physician would work 6 hours.

TABLE IV

Ratios on Distribution of Hospital Personnel, El Salvador, 1964

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care (a)
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Ministry of Health							
Rosales Hospital	0.7	1.0	3.1	4.8	3.6	...	49.3
Social Security							
Rosales Hospital	0.6	0.6	2.3	2.3	3.1	...	47.4
Ministry of Health							
10 hospitals reporting	1.0	1.3	4.0	5.4	3.1	...	50.0
Social Security							
6 hospitals reporting	0.6	0.6	3.1	3.1	3.9	...	50.0
Ministry of Health							
2 health centers reporting	1.5	1.5	4.3	4.3	1.9	...	54.0

(1) Total number of physicians. (2) Number of full time physicians based on total hours contracted and a six hour day. (a) Including total number of physicians.

TABLE V

Physicians and Nursing Time* (Minutes) per Day per Occupied Bed, El Salvador, 1964

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Ministry of Health			
Rosales Hospital	25	161	35
Social Security			
Rosales Hospital	79	241	59
Ministry of Health			
10 hospitals reporting	19	138	33
Social Security			
6 hospitals reporting	65	264	54
Ministry of Health			
2 health centers reporting	31	181	62

*Assuming physicians work 6 hours per day and nurses 8 hours per day.

TABLE VI

Costs of Hospitalization and Outpatient Consultations, El Salvador, 1964

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Ministry of Health							
Rosales Hospital	284 073	25.1	166 247	7.67	192.52	2 807	a) 9.81
Social Security							
Rosales Hospital	*45 069	11.2	17 164	b)36.36	407.23	13 308	b) 7.27
Ministry of Health							
10 hospitals reporting	972 361	10.3	408 795	5.90	60.77	2 159	a) 8.92
Social Security							
6 hospitals reporting	*65 465	6.3	21 238	b)33.96	213.95	12 429	b) 6.79
Ministry of Health							
2 health centers reporting	15 058	4.2	13 925	3.40	14.28	1 244	a) 6.81

a) Costs of outpatient service were calculated by subtracting costs for patient days from total current expenditures of hospital. b) Total cost per patient day including costs of outpatient services was given as 39.42. Assuming 5 outpatient consultations as equivalent to one patient day, outpatient costs were removed. *Census.

TABLE VII

Number and Type of Outpatient Establishments Reporting, El Salvador, 1964

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry	11	1	11	2
Social Security	6	3	6	6

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, El Salvador, 1964

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Ministry	252 300			75 291	129 479	16 301	114 552	...	15 553	29.8	15.3	6.5	45.4			...	20.7
Social Security	68 147			350 764	258 421	-	-	98 924	23 595	514.7	379.2	-	-			28.2	6.7

TABLE IX

Personnel in Outpatient Establishments, El Salvador, 1964

Hospital	Physicians		Dentists		All other						Medical (a) time per consultation (in minutes)	Nursing time (b) per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Ministry	24	75	5	10	111	58	29	29	-	53	18	35	18
Social Security	107	219	27	55	203	70	12	58	-	133	12	14	2

a) Based on hours of physicians and dentists. b) Based on total consultations.

TABLE X

Average Cost per Outpatient Consultation, El Salvador, 1964

Hospital	Mean cost	Median cost
Ministry	4.88	3.69
Social Security	5.54	5.86

H O N D U R A S

SURVEY OF THE COORDINATION OF MEDICAL CARE

I. ORGANIZATION OF MEDICAL SERVICES

1) Ministry of Public Health and Social Welfare

GENERAL INFORMATION

The Secretariat of Public Health and Social Welfare of Honduras is part of the Executive Branch of the Government and is under the direct authority of the President of the Republic, in accordance with the Constitution of the Republic in force in 1964 as well that in force in 1966.

The Ministry of Public Health and Social Assistance is responsible for the promotion, protection, and restoration of health throughout the entire country.

These activities are carried out through three departments: the medico-social care department, the public health department, the national malaria eradication service.

The Secretariat of Public Health and Social Welfare is also known as the Ministry of Public Health and Social Welfare.

The Secretariat of Public Health and Social Welfare receives technical assistance from PAHO/WHO, FAO, INCAP, CLACE, UNICEF, AID, CARE, all of which are international agencies, and some of which give technical assistance in the form of equipment, supplies, etc.; PANI also cooperates with the Secretariat of Public Health and Social Welfare since it is a decentralized agency of that Secretariat.

The Secretariat of Public Health and Social Welfare is under the direction of the Secretary of Minister of Public Health and Social Welfare, who exercises the principal directing function, and acts through the departments which are under the direct authority of the Secretariat.

The Secretary for Public Health and Social Assistance is assisted in his directing functions by the Assistant Secretary of Public Health and Social Welfare, who, in the absence of the former, assume responsibility for the Secretariat.

The principal officer of the Secretariat of Public Health and Social Welfare acts as the liaison officer between the Secretariat and the Departments. This official handles the decisions of the Secretary

and the Assistant Secretary, and communicates them to the various subordinate agencies. He is also responsible for the international correspondence of the Secretariat.

The following departments are under the direct authority of the Secretariat of Public Health and Social Welfare:

The National Malaria Eradication Service, a decentralized agency which is responsible for malaria control throughout the country. This agency is independent as far as activities are concerned, and acts through its health education, evaluation, spraying, and administrative sections.

The Administrative Service Section, which is under the direct authority of the Secretariat of Public Health and Social Welfare since it controls the income and expenditure of the Secretariat and its agencies consists of accounting, purchases, personnel, and transport unit. It also exercises administrative supervision over the Administrative Section of the Department of Public Health.

Audit is another agency of the Secretariat, which, as its name indicates, has specific functions.

The Secretariat also has a legal office, as does PANI.

In accordance with special provisions the Division of Vital Statistics is under the direct authority, since 1964, of the Secretariat, but also serves all the agencies.

The Public Health Department is provided with the advisory services of a technical adviser; for administrative management it has an administrative department which is responsible for the administration of all the agencies of the Public Health Department. Its functions include: preparation of payrolls, purchase of supplies and equipment at the local level, distribution of supplies and equipment to the various agencies, administration of travel allowances, control of transportation, maintenance of physical plant.

In 1964 the Public Health Department contained two divisions: the division of local public health services with seven health districts, each of which had under it technical and administrative authority the local public health units, that is, district health centers, health centers, health sub-centers, maternal and child health clinics, and health posts.

The Public Health Department is under the direction of the Director of Public Health. He exercises his directing function through the division of local services, and the Regulatory division. The first has executive functions for the application of the standards and techniques prepared by the Regulatory Department through its own agencies.

Directly under the division of local public health services are the district chiefs who are normally public health doctors. The district chief has executive and technical functions in his own district. He is responsible for the administration of all its dependent units, applies the standards and adapts them to local conditions, receives statistical reports, prepares general reports for the local services division, supervises and evaluates the units in his district.

All the district units are responsible for preventive medicine services and health restoration services on an out-patient basis.

The Regulatory Division, like the local services division, is under the direction of a public health officer who exercises the functions of the Director of Public Health as laid down by the law, in the absence of that officer.

The Regulatory Division consists of the following units: division for the regulation and execution of environmental sanitation activities, which acts through the water supply and sewage disposal section, the well-drilling section, rural water supply section, general sanitation and the latrine construction section. Their functions are quite obvious.

The Epidemiology Department with its cancer, leprosy, veterinary public health sections, is responsible for specific activities in connection with epidemics, infectious and contagious diseases. It also establishes standards, directs immunization campaigns, and is responsible for supervision and evaluation in its field.

The Tuberculosis Division is responsible for the prevention of tuberculosis and the treatment of out-patients. It operates in rural areas through mobile units. It issues work standards and procedures and is responsible for supervision and evaluation.

The Health Promotion Division is assisted by four departments: maternal and child health, nutrition, and dental public health. Its functions are regulatory, supervisory, and it is also responsible for evaluation. The Public Health Dentistry Department also has executive and administrative functions with respect to the dental services in the health centers.

The Laboratory Division with its various sections exercises regulatory, administrative, and policy application functions.

The General Services Division consists of two departments: health education and public health nursing. It has regulatory and supervisory functions. The nursing department also has executive functions.

The Medical Health and Social Care Department comes under the Secretariat of Public Health and Social Welfare, and is responsible for establishing work standards, and administering, supervising and evaluating

the various state hospitals, as well as the hospital unit of the Hondurian Social Security Institute. It is also responsible for the supervision of private hospitals in the country.

There is a national public health plan but it only covers the institutions under the authority of the public health department; it forms part of the general economic and social development plan.

The programs of work are prepared by each of the divisions in the light of local resources, and they have specific targets.

The general budget of the Secretariat is prepared by the departments through their administrative sections, in the context of the development of programs and their targets.

The budget of the Secretariat amounted to L.7,544,427. Other monies come from PANI, the municipalities, governerships, etc. The State pays quotas to various international agencies. There are no specific rules for the appointment and management of personnel.

2) Hondurian Institute of Social Security

GENERAL INFORMATION

The social insurance system in Honduras was established by the Social Insurance Law of 19 May 1959, embodied in Decree No. 140 of the National Congress. Executive Decision No. 51 of 23 February 1962 approved the regulations for compulsory social insurance adopted by the Governing Board of the Hondurian Social Security Institute in accordance with Article 102 of the above-mentioned law.

The Social Insurance Fund in Honduras is the youngest in Latin America, since, despite the fact that it was decreed by law in 1959, it was not until 1 March 1962, exactly four years later, that medical services were inaugurated.

The HSSI is an autonomous agency with legal personality and its own assets. It is responsible for the orientation, direction, and administration of social insurance.

The system will be gradually and progressively extended, as far as risks to be covered, geographical areas, and type of protected workers are concerned.

At the present time social insurance is limited to the towns of Tegucigalpa and Comayagüela, and covers workers in the Central District.

Between the public authorities and the Institute the channel is the Ministry of Labor and Social Welfare.

The Institute may enter into contracts with agencies, undertakings and other bodies which have established their own medical and hospital services for salaried workers, whereby these organizations take on the responsibilities for all or part of the sickness, maternity, and work injury benefits. In return, the Institute reduces the employer's contribution proportionate to the nature and amount of services provided by the organizations, undertakings, or agencies.

Governing Bodies

The supreme authority of the Institute is the Board of Directors, which is the deliberative and decision-making organ, and the Director-General, who is the executive organ.

The Board of Directors is composed of:

a) The Director-General who is a titular member and Chairman of the Board;

b) The Ministry of Labor and Social Welfare;

c) A representative of insured workers;

d) An employer's representative;

e) A representative of recognized medical associations.

Control organs

Inspection and auditing of accounts and financial operations of the Institute are the responsibility of an internal auditor appointed by the Board of Directors on the recommendation of the Comptroller General of the Republic.

Inspection and external supervision are the responsibility of the Comptroller General of the Republic who is responsible for ascertaining that the operations of the Institute have been carried out in a legal manner, and for informing the Board of Governors of any irregularity or infraction he may note.

FINANCES

Reserve Funds

The Institute must establish a fund to meet possible emergencies, the amount of which is established by the regulations. Any sums in excess of that amount shall be invested in bonds issued and guaranteed by the State.

Financial operations

The Institute is authorized to take on long-term loans for their investment solely in works of a permanent nature which cannot be financed by the ordinary budget.

Resources

The resources of the Institute are constituted by:

a) The contributions of employers and workers; and the contributions and State grants;

b) Interest from investments;

c) The product of fines and penalties;

d) Donations, bequests, and legacies to the Institute; and

e) Any other securities, goods, or monies which are assigned to the Institute by other laws.

The quotas and contributions of workers and the employers must be fixed in the regulations in the following proportions: insured workers 25%; employers 50%; the State 25%. Autonomous, semi-autonomous, and decentralized State agencies must contribute 75% with the exception of municipalities which contribute the same amount as employers.

FIELD OF APPLICATION

The following are subject to compulsory social insurance:

a) Private employees who render services to a natural or juridical person, regardless of the type of labor relationship which binds them, or the form of remuneration and who work within the jurisdiction of the Central District;

b) Public employees, employees of autonomous, semi-autonomous and decentralized agencies of the State.

Exclusion:

The following are temporarily exempt from compulsory social insurance:

a) Home workers;

b) Domestics;

c) Temporary workers;

d) Occasional workers doing work unrelated to the nature of the undertaking;

e) Agricultural workers except those who work in agricultural undertakings proper, or in industrial or commercial undertakings related to agriculture and employing a minimum number of workers to be fixed in the regulations.

The spouse, parents, and children under 16 years of age of the employer who work for him are not subject to compulsory social insurance, nor are the members of the Armed Forces.

BENEFITS

Initially, social insurance will cover sickness, accident, maternity, work injury, and industrial disease risk.

Non-professional sickness

In the case of non-professional sickness, the insured person is entitled, within the limitations and conditions fixed by the pertinent regulations, to the following benefits:

a) Medical, health and surgical, general and specialized care; hospital care, pharmaceutical assistance as may be necessary, and dental benefits except prosthetic work.

b) In the case of recognized incapacity, a pension in money equivalent to 60% of the base daily wage, from the fourth day of incapacity onward, and provided that the insured person had seventy-five days of contribution in the previous six months.

Funeral benefits are paid on the death of an insured person. A non-professional accident will be treated in the same way as a non-professional illness.

In principle the Institute will provide, in establishments and through appropriate medical and auxiliary personnel, the benefits in kind to which the insured are entitled. In special cases the Institute may make contracts or agreements with public and private health centers, and also with private physicians to provide all or some of these benefits within the limitations to be fixed by regulations.

The children of insured persons under two years of age are also entitled to the benefits in kind fixed by the law.

Maternity

In the event of maternity the insured persons are entitled, within the limitations and conditions fixed by the regulations, to the following benefits:

a) Prenatal, natal, and post-natal medical care, as required;

b) A cash benefit, provided that the insured person does not do any paid work during the time in which she receives the benefit which will be equivalent to 66% of the base daily wage;

c) The Institute shall also be entitled to give assistance during lactation, either in kind or money, as well as a layette.

The wife or common-law wife of an insured worker shall be entitled to the benefits in kind in accordance with the conditions laid down by the pertinent regulations; a female employee, or wife, or common-law wife who is laid off, provided that the laying off is due to the fact that the person concerned is pregnant, the same as in the case of the death of the insured person.

Industrial accidents or industrial diseases:

The benefits granted are as follows:

a) Medical-surgical, hospital or dental care as required, as well as necessary medicines, prosthetic apparatus, and such other therapeutic aids as the state of health of the insured person may call for;

b) A daily benefit when the industrial accident or illness causes temporary loss of working capacity;

c) A permanent disability benefit, which may be up to a 100% of full pension or a lump-sum where appropriate;

d) A grant and assistance with funeral expenses in the event of the the death of the insured person, which will be paid to his survivors in accordance with the regulations.

A disabled worker is required to submit to medical examinations, as well as the treatments which are prescribed for him by the medical officers of the Insurance Fund. The Institute may suspend the payment of a benefit in the event of failure to comply with this provision, as well as the payment of the permanent disability pension if the person concerned refuses to undergo the examinations ordered.

The insured person is entitled to the benefits without any minimum contribution time, and the benefit is payable, after a three-day waiting period, for such time as the disability lasts or until the injury is healed, but in no case will it exceed 52 weeks. When that time limit is passed, the degree of disability is established by the physicians of the Institute through an opinion based on the nature of the injury, functional disorder, general condition, age, occupation, physical and mental capacity, professional qualifications before and after the accident, and a decision is reached as to whether the disability is total or partial permanent for the purposes of paying a pension.

The Institute carries on a systematic propaganda campaign about accident prevention both through the Department of Public Relations, and through the Inspectors of Hygiene and Security. The Institute may give bonuses to undertakings which have contributed to the reduction of professional hazards through the adoption of preventive measures.

GENERAL REPORT ON THE BUDGET

The budget of income and expenditure of the HSSI is prepared, taking into account that received or incurred at a given date in order to refine the estimates for the year for which the budget is being made, as well as the provisions established in the Financial Regulations, and the legal precepts which serve as a basis for the actuarial calculations.

The contributions for covering sickness, maternity, industrial accident, and industrial disease risks are calculated on the basis of the assurable salaries in the following proportion:

Workers 2-1/2%, Employers 5%, State 2-1/2%. When an employer, the State contributes 7-1/2%, as do the autonomous and semi-autonomous institutions, but the municipalities contribute only 5%. Once the amount of probable income is determined, it is distributed in accordance with Regulation 2 of the Financial Regulations as follows:

Percentage	For covering the following needs:
4.17 *	Benefits in service and in kind
1.67 *	Benefits for temporary incapacity
0.87	Grants, pensions and funeral benefits
1.50	Administrative costs
1.79	Basic fund
10.00	Total salary contributions

Interests, fines, etc. increase the basic fund.

* These percentages include expenditures for Sickness and Maternity risks.

The 1966 budget has been prepared as a program budget as follows:

Direction, and higher administration	603,900.00
Supervision	44,075.00
Out-patient services	718,780.80
Hospital services	1,334,250.32
Investments	990,500.00
Transfers	1,254,293.88
TOTAL	4,945,800.00

The probable income was calculated as follows:

Contributions	4,820,800.00
Fines and Penalties	15,000.00
Miscellaneous and contingencies	110,000.00
TOTAL	4,945,800.00

MEDICAL SERVICES

Medical benefits are at present granted in two units: out-patient services, and hospital services, each of which is under the direction of a director, and is under the authority of the Department of Medical Services, which is in turn under the general directorate, the executive organ responsible for the conduct of the Institution. Both the out-patient department and the hospital form a single block and are the property of the Institute.

The out-patient services physically consist of 22 cubicles for general and specialized medicine, dentistry, home service, and administrative offices, admission, nursing, etc.

The present distribution is as follows:

General medicine	9 physicians	30 hours a day
Pediatrics	9 physicians	22 hours a day
Well-baby clinic	1 physician	3 hours a day
Pre-natal	4 physicians	9 hours a day
Extemporaneous consultations	1 physician	6 hours a day
Dentistry	5 physicians	15 hours a day
Specialities	12 physicians	20 hours a day
Home service	1 physician	6 hours a day
TOTAL	42 physicians	111 hours a day

Shifts: 8 a.m. to 12 p.m., and 2 to 6 p.m.

The physicians work part time, usually 2 to 4 hours a day, although some work 6 hours distributed in two periods, 8 a.m. to 12 p.m. and 2 to 6 p.m. We do not have any full-time physicians except the heads of unit who work 8 hours. There is a shortage of personnel, especially of medical specialists.

The Institute runs a home service for cases in which the insured person is unable to come to the hospital or the out-patient department, or for patients who have recently been discharged from hospital and need some supervision.

Hospital

This is at present housed in a building especially appointed for that purpose. It has 130 beds, and 47 cots for new-born babies. It is divided into the following sections: medicine, men and women; surgery, men and women; pediatrics; maternity; nursery; rehabilitation and physical medicine service; emergency service with a sector for observation for adults and children. In addition, care is provided for other specialities such as chest surgery, neurology, neuro-surgery, traumatology and orthopedics, cardiology, gastro-enterology, neurology, psychiatry, dermitology, plastic surgery, etc.

The Institute has its own laboratory and blood bank, X-ray department, and encephalography, etc. The physicians normally work in the morning and leave the hospital in the hands of interns, and such other physicians who are on call for urgent cases. There is a shortage of professional nurses in the country. The Institute has a training center for nursing auxiliaries.

A third storey will soon be built, and will improve the installations and make the service more functional and efficient.

Preventive activities have been reduced to the personal work of the physicians, to lectures by specialized nurses and some physicians in service, compulsory DPT vaccination, BCG vaccination in the newborn, smallpox and typhoid vaccination. The two last-mentioned immunizations are given in agencies of the Public Health Department.

This month a preventive medicine service will be established under the direction of a specialized physician who will be responsible for directing, coordinating, and supervising activities for the promotion and protection of health in HSSI establishments; he will also be responsible for the epidemiological and health education sections. His directing functions will mainly concern:

1) Prevention of infectious and contagious diseases;

2) Tuberculosis control;

3) Control of syphillis and other venereal diseases;

4) Health education;

5) Education;

6) Research.

The Hondurian Social Security Institute has no legal relationship to the Ministry of Public Health. At present, relations are limited to contracts for services for the treatment of hospitalized patients in the National Sanitorium for Tuberculosis Patients, and the General Hospital for radio-therapy, radium and cobalt therapy, as well as for children suffering from poliomyelitis.

It has not been possible to coordinate the services of HSSI and the Public Health Department in the field of preventive medicine. What we have done on several occasions is to supply doses of vaccine for insured persons, for example, during the recent polio epidemic.

The Director-General of HSSI and the Medical Services are aware that all preventive medicine work should be carried out in coordination and cooperation with the Ministry of Public Health in order to prevent duplication of services, to reduce cost, and to give better service to the community. As far as the right to the benefits conferred by the regulations, the beneficiaries are completely cared for by the medical services.

Tegucigalpa, Central District, March, 1966.

H O N D U R A S

TABLES

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Honduras, 1964

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Ministry									
San Felipe	...	1 396	14 189	372 474	221 806	...	...	...	...
Social Security									
Hospital	41 649	120	4 366	25 567	17 983	2.9	104.8	613.9	431.8
Ministry									
8 General hospitals	2 092 000	2 281	40 217	619 379	317 764	1.1	19.2	296.1	151.9
3 Specialized hospitals	1 245 931	830	1 780	362 052	5 431	0.7	1.4	290.6	4.4

TABLE II

Indices of Hospital Utilization, Honduras, 1964

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Ministry			
San Felipe	26.3	10.2	72.9
Social Security			
Hospital	5.9	36.4	58.3
Ministry			
8 General hospitals	15.4	17.6	74.2
3 Specialized hospitals	203.4	2.1	...

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Honduras, 1964

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Ministry																
San Felipe	80	...	658	340	43	297	-	35	283	7.0	...	57.8	29.9	3.8	3.1	24.8
Social Security																
Hospital	36	17	200	94	17	77	-	17	89	45.0	21.2	250.0	117.5	21.2	21.2	111.2
Ministry																
8 General hospitals	153	...	1 358	587	55	532	-	76	695	8.2	...	72.8	31.5	2.9	4.1	37.2
3 Specialized hospitals	33	...	358	143	25	118	-	15	200	...	...	...	...	...	...	...

TABLE IV

Ratios on Distribution of Hospital Personnel, Honduras, 1964

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Ministry							
San Felipe	0.5	...	4.2	...	6.9	...	62
Social Security							
Hospital	0.5	1.0	2.6	5.5	4.5	...	62
Ministry							
8 General hospitals	0.4	...	3.8	...	9.7	...	54
3 Specialized hospitals	0.8	...	4.3	...	4.7	...	49

(1) Ratio to total number of physicians.
(2) Ratio to full-time physicians (physician hours divided by six).

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Honduras, 1964

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Ministry			
San Felipe	...	102	13
Social Security Hospital	54	564	72
Ministry			
8 General hospitals	...	107	10
3 Specialized hospitals	...	...	...

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Honduras, 1964

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Ministry							
San Felipe	372 474	26.3	221 806	6.22	163.59	2 277	...
Social Security							
Hospital	25 567	5.9	17 983	a)36.74	216.77	13 447	...
Ministry							
8 General hospitals	619 379	15.4	317 764	5.45	83.93	1 995	...
1 Psychiatric hospital	...	253.6	4 563	3.25	824.20	1 190	...
2 Tuberculosis hospitals	...	174.2	868	6.06	1 055.65	2 218	...

a) Differs from data on form on expenditures.

TABLE VII

Number and Type of Outpatient Establishments Reporting, Honduras, 1964

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry of Health				
General hospitals	8	...	8	8
Specialized hospitals	2	...	2	2
Health centers	10	3	9	5
Health subcenters	20	1	12	1
Health posts	14	1	-	-
Mobile units	8	...	-	-
Maternal and child health clinics	23	1	6	-
Social Security	1	21	1	1

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Honduras, 1964

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Ministry of Health																	
General hospitals	2 092 000	...	...	317 764	...	-	-	325 672	43 367	15.2	...	-	-	102.5	13.6		
Health centers	513 564	152 282	29.7	214 225	-	20 680	91 540	159 183	56 865	41.7	-	4.0	17.8	74.3	26.5	140.7	-
Health subcenters	330 084	72 879	22.1	126 688	-	6 130	32 787	45 613	-	38.4	-	1.9	9.9	36.0	-	173.8	-
Health posts	112 620	18 680	16.6	37 393	-	2 014	1 337	-	-	33.2	-	1.8	1.2	-	-	200.2	-
Mobile units (a)	124 286	...	...	79 775	67 376	12 092	12 127	-	-	64.2	54.2	9.7	9.8	-	-	...	
Maternal and child health clinics	342 816	42 379	12.4	94 994	-	8 700	9 242	24 484	-	27.7	-	2.5	2.7	25.8	-	224.2	-
Social Security	41 649	27 479	66.0	122 780	...	3 621	389	...	5 254	294.8	...	8.7	0.9	...	4.3	446.8	...

(a) Data on 6 units only.

TABLE IX

Personnel in Outpatient Establishments, Honduras, 1964

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Ministry of Health													
General hospitals (a)	...	...	...	...	...	...	...	...	...	...	...	21	2
Health centers	33	164	8	18	243	66	15	51	-	177	12	38	9
Health subcenters	25	102	8	23	135	41	6	35	-	94	13	40	6
Health posts	5	20	-	-	16	11	-	11	-	5	8	37	-
Mobile units	8	64	-	-	27	27	-	27	-	-	13	42	-
Maternal and child health clinics	29	104	4	11	74	31	3	28	-	43	17	41	4
Social Security	35	88	5	13	55	25	2	23	-	30	11	25	2

(a) Not possible to distinguish inpatient and outpatient personnel on forms.

TABLE X

Average Cost per Outpatient Consultation, Honduras, 1964

Hospital	Mean cost	Median cost
Ministry of Health		
General hospitals	...	...
Health centers	...	...
Health subcenters	...	...
Health posts	...	...
Mobile units	15.00	15.00
Maternal and child health centers	...	...
Social Security	5.30	5.30

M E X I C O

I. ORGANIZATION OF THE MEDICAL SERVICES

1. MEDICAL CARE IN MEXICO*

Medical care in Mexico has undergone important changes in philosophy, procedures and volume in recent decades; in fact, until a relatively short time ago, it was characterized by the fact that it was the almost exclusive prerogative of the population groups with the financial means to pay for the services, and sufficient education to make use of them. These services were provided by physicians trained to engage in individual medicine, who worked independently or with very little professional contact, on the system of referring their patients to specialist but always engaging in medical practice in an atmosphere of intellectual and professional isolation.

The medical profession comprised a highly qualified elite, generally receiving post-graduate specialized training in foreign countries, principally Europe.

This group of doctors carried on its hospital practice in private, profit-making institutions, many of which were poorly equipped and frequently totally outside the mainstream of scientific progress.

Other medical institutions that had for a long time been operated by private charitable organizations, were later taken over by the governments, which operated them to provide services for low-income population groups.

However, the rural population and the masses of urban workers received medical care only under special circumstances, and in general were treated by practitioners of traditional indigenous medicine.

Mexico of today is a country with a population of 42 million, spread over an area of approximately 2 million square kilometers, with an average population density of 21.5 inhabitants per square kilometer. The annual population rate of growth over the last decade has averaged 3.2 per cent, which means a gross increase of 1,200,000 per year, which is apparently tending to accelerate at a rapid rate. It is estimated that by 1969 there will be a population increase of 1,500,000 each year.

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* Presented at the Twenty-fourth Meeting of the Mexican-United States Border Health Association, at Saltillo, Coahuila, Mexico, June 6-10, 1966, by Dr. Francisco Fonseca, Assistant Medical Director of the ISSSTE; Dr. Luis Méndez, Assistant Medical Director of IMSS; Dr. Pedro Daniel Martínez, Assistant Secretary of Health.
Traditional medicine was favorable to the physician working in isolation; Social Security must shun the patient being cared for in isolation.

As is true for all of Latin America, Mexico has a young population, in which 44.21 per cent falls in the under-14 age group. It also continues to have a high proportion (49 per cent) of rural population, although this is decreasing rapidly in relation to the urban population.

General mortality has shown an impressive decline, dropping from 23.8 per 1,000 in 1934 to 10.3 per 1,000 in 1964. Infant mortality has also declined substantially, from 146.8 per 1,000 live births in 1931 to 64.5 per 1,000 live births in 1964.

In the same period, life expectancy at birth estimated at 38.7 years in 1934 has increased to 64.6 in 1964.

Despite the progress in the public health situation indicated by these statistics, the principal causes of death in the country continue to be infectious diseases and accidents, although the incidence of certain degenerative diseases has been gradually increasing.

At the present time, there are 24,174 practicing physicians in the Mexican Republic: 11,419 (47.2 per cent) of them live in the Federal District, where 6,468,137 persons, representing 13.9 per cent of the country's population, are concentrated.

This marked concentration in the Capital is repeated, although to somewhat lesser degree, when we compare the distribution of doctors in the state capitals to that of the rural areas.

On the other hand, the rate of increase in the number of doctors is lagging behind the rate of population increase, so that the physician/population ratio is becoming constantly more unfavorable.

In Mexico of today, doctors are being drawn predominantly from the middle classes, with a significant percentage coming from the working class and rural population. There is an increasing decline in the number of doctors coming from wealthy families, which is perhaps due to the fact that although the average income of doctors is still comparable, in general terms, to that of businessmen and industrialists at the middle level, it has been gradually declining. Possibly the fact that the country's growing industrial development offers more, and more attractive, opportunities in other professional activities, both from the financial aspect and perhaps even that of social prestige, has also had an influence on the reduced growth of the Mexican medical profession, and the change in the class that is being attracted to it.

The percentage of doctors benefiting from formal post-graduate training is exceedingly small, and there is still a sizeable proportion whose practice is limited to small communities.

The number of hospitals in the country and the ratio of hospital beds to total population is one of the lowest in the Americas. This means that the Mexican doctor has only the most restricted opportunities for training and practice in hospitals. On the other hand, the majority of the hospitals prefer to handle surgical emergency cases and occasional medical emergencies. This is the consequence, on the one hand, of the scarcity of hospital resources and, on the other, to the type of medical attention demanded by the population. The latter, in turn, is determined by the cultural background of the Mexican people.

Until only a few years ago, obstetrical care was given almost exclusively at home; however, in the last two decades the percentage of childbirths in hospitals has increased considerably, although in many cases such care is of poor technical quality.

As late as 1934, there was no children's hospital in the Capital of the Republic, and there were only 40 beds reserved for pediatrics in the General Hospital. At the present time there are several children's hospitals, with a total of approximately 2,000 beds.

Many of the hospitals outside the Capital have limited technical facilities and a large number lack the essential auxiliary diagnostic services. Their budgets are often quite limited, and few of them have facilities for training interns.

In 1936, on the basis of experience acquired in the two preceding years in the operation of cooperative rural medical-care services, the Federal Government established medical-care services on the ejidos (in the La Laguna area); and thus social security was initiated in Mexico.

These ejidal services, later called Cooperative Rural Medical Services, were subsequently extended to many parts of the country. They provided medical treatment, preventive medicine and public health services for rural workers who made contributions at differing rates under a number of different systems (individual insurance, by companies, by percentage of production, by cultivated areas, etc.). The contribution of rural workers is supplemented by government subsidies that increase the current operating budget to 38 million pesos. The services comprehend some 237 entities providing medical care of which 56 are hospitals; 180, rural health centers; and one, a home providing pre-natal care. There is a total of 1,380 hospital beds available. These services cover 569,261 insured and provide supervision over the health of 1,356,608 persons.

The law creating the Mexican Social Security Institute was enacted in 1943. In planning this system, it was recognized on the basis of actuarial data that it would be desirable to postpone coverage of non-occupational sickness and maternity benefits for the families of the insured for a few years, in order to use the period to build up reserves for their later

introduction. However, factors of both a social and a public health nature, as well as the demands of the groups involved, determined that coverage would be extended immediately to dependents of the workers, thus protecting the basic family unit whose health and welfare are directly reflected in general living standards and productivity of this population sector.

IMSS extended coverage to the following worker groups:

Persons exployed by others under a work contract
Persons employed under apprentice contracts
Members of production cooperatives
Members of the ejidal communities
Rural wage-earners
Seasonal farm labor
Sugar-cane producers
Permanent wage-earning employees of the sugar-cane producers
Members of ejidos and small farm owners, not members of the local ejidal credit or agricultural enterprises, in the municipalities of Mexicali, Tecate, Tijuana and Ensenada, in the State of Lower California, and in San Luis Río Colorado, in the State of Sonora.
Occasional and seasonal urban workers
Members of the ejidos and small farm owners having not more than 10 hectares of irrigated land, or its equivalent in other types of land
Migratory agricultural workers
Voluntary contributors
It also extended coverage to the families of the insured and to those on retirement pensions.

It provides protection against the following risks:

General sickness
Maternity
Occupational diseases and accidents
Disability
Old Age
Unemployment

The covered population increased to 6,746,123 persons in 1966.

The system provides medical care services in outpatient clinics, home visits and hospitalization through the following medical units:

MEDICAL UNITS IN SERVICE
(as of December 31, 1965)

Direct Service

General hospitals		16
Specialized hospitals		10
T-1 hospital clinics		43
T-2 hospital clinics		36
Auxiliary hospital clinics		205
General clinics		45
Auxiliary clinics		168
Nursing stations		75
Factory stations		243
	Sub-Total	841

Services under contract

General hospitals		31
Specialized hospitals		43
	Sub-Total	74
	TOTAL	915

The total number of hospital beds in service increased to 13,878, with 7,885 doctors working under the Institute.

In 1965, in round numbers, there were 27 million medical consultations and half a million cases of hospitalization.

For various reasons of a political and social nature, it was necessary to extend social security coverage to other groups of workers, and to set up the appropriate agencies independent of the IMSS. Hence, in 1959, the Civil Service Social Security and Welfare Institute (ISSSTE) was established, and in 1962 the Armed Services Social Security Law was enacted.

Both institutes, as well as other decentralized bodies such as Petróleos Mexicanos (PEMEX) and the National Railroads, have medical services that operate within the broad framework of the social security system.

ISSSTE provides coverage for 1,217,599 beneficiaries, of which 271,022 are insured Federal Government employees, and the remainder their co-beneficiaries or dependents.

Of that total, 665,788 receive treatment in the Federal District and 551,811 are handled by the Regional Medical Services*.

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* Regional = outside the Federal District.

The ISSSTE has the following units to provide its medical services:

1. Hospital units:

In the Federal District:

General Hospital	1	
Specialized Hospitals	3	
with:	1,162	beds
Under contract	360	beds
Total beds:	1,522	beds

In the regions:

Regional hospitals	8	
Local hospitals	16	
with:	694	beds
Under contract	551	beds
Total beds:	1,245	beds

Total beds for the entire country: 2,767

2. Consultation:

38 clinics in the Federal District
95 clinics outside the Federal District (regional)
28 State medical bureaus
285 Peripheral posts

In that same year, there were 7,549,113 consultations, 2,340,178 by the Regional Services and 5,208,935 by the Federal District Services.

Private medical care is still given in the traditional manner earlier described, in those small communities where social security is not yet operating or, in the large cities, for the more affluent groups that prefer to go to private doctors and do not use the services provided by the Government.

Medical care available under the various social security systems is not yet accessible to 100 per cent of the population entitled to them; however, the proportion of the covered population has been gradually increasing, and is gradually approaching the ideal of total coverage.

The Department of Health and Welfare, a part of the Federal Executive Branch, has the responsibility for providing medical care essential to the uninsured population through 1,764 Health Centers of various types. It treats approximately 22 million persons, 10 million of whom are in the rural areas.

The medical care provided by the Department is primarily designed for pregnant women, pre-school age children and persons with communicable diseases. Nevertheless, the demand for services requires the Health Center to devote a good proportion of their work to providing medical consultation of all types, to the detriment of their activities in the preventive field.

A substantial proportion of the medical care received by this population group outside of the social security system is provided by local hospitals of highly varied size and technical quality, supported by the state governments. These hospitals provide care primarily for those persons without means who voluntarily request it and, in general, their resources are devoted preferably to the emergency cases.

The state governments also maintain other types of institutions devoted to different aspects of medical care, such as outpatient clinics, specialized dispensaries for the treatment of specific diseases, medical welfare services for specified groups of employees, forensic medicine services, etc.

In general, the Department of Health aids the state governments, in one way or another, and in varying amounts, to maintain these services.

As we have seen, medical care in Mexico is provided by a number of different agencies, with independent administrative organizations, which fact contributes to duplication of services and the resultant waste of resources. In order to correct this situation, a Joint Coordinating Committee on Public Health, Welfare and Social Security Activities at the cabinet level has been established by presidential order. This Committee is constituted by representatives of the Department of Health and Welfare, the Mexican Social Security Institute, and the Mexican Civil Service Social Security and Welfare Institute, and holds regular meetings at which programs are studied and appropriate measures adopted to obviate conflicts or duplication of activities by the three agencies.

We have already pointed out that the increase in the number of doctors -a factor of basic importance in the development of medical care in the country- has been taking place at a much slower rate than that of the population growth. We have also mentioned that the relative lag in the formation of doctors is caused in part by the greater attraction of other professions, by the limitation on the income of the medical class, and by the financial inability of the bulk of medical school graduates to finance, even to a limited extent, the high cost of an adequate education. Mexican universities are financed for this purpose almost exclusively by the Federal Government and as a result do not have sufficient financial independence to set up an adequate organization.

The new groups entering the medical profession are increasingly attracted by the advantages offered in the social security system, including an adequate income and security, and the possibility of advancing their professional training by working as a part of a medical team and practicing in an adequately equipped hospital institution.

The growth of social security has given rise to an accelerated and notable improvement in the technical quality of medical care. All of the specialized branches of medicine that require a high degree of technical training are practiced with much greater efficiency within the groups that constitute the social security system. On the other hand, there has been no improvement -or possibly even some deterioration- in the type of medical care requiring the integral treatment of the individual, and a satisfactory handling of inter-relationships of the social group.

Consequently, social security requires the doctor to reorient his essential personality, and not only his technical capacity, in adapting himself to the demands and possibilities of organized medicine. Materialism and the measurement of social achievement by personal wealth are disappearing, or tending to disappear, and in contrast the practice of medicine within the framework of the organized social security system puts a premium on prestige built on personal efficiency and professional capability.

The system offers the possibility of increasing such efficiency by setting up continuing advanced training programs for the staff it employs. At the same time this continuing education can be reenforced through systems of supervision (auditoría médica).

Social security encourages the doctor's self-improvement along other lines: intellectual contacts, exchange of professional experiences and their adequate recording, and the establishment of formal standards, with a scientific base, for improved utilization of medical resources.

It also facilitates organization of educational programs in medicine and hygiene for the insured, and by this means fosters the gradual cultural change that will eventually bring about the acceptance and utilization of modern occidental-type medical services, in preference to the traditional native practitioners or witchdoctors.

In recent decades, Mexico has seen how medical care has been penetrating with relative rapidity into areas that formerly were totally lacking such resources. This penetration has been stimulated by the expansion of health centers, especially those in rural areas. Although the original purpose of these centers was somewhat different, they have served to create a new collective attitude to health and disease, and have played the dual role of stimulating both demand for, and acceptance of, such services.

The basic health problems in Mexico are still communicable diseases, malnutrition and accidents: all three demand preventive activities above all. Such activities have been developed with some success but this development has been handicapped by the lack of funds to introduce extensive programs of sanitation and nutrition, and by the difficulty -also economic- of extending preventive and restorative activities to larger percentages of the population.

In Mexico, as in all countries of similar cultural and economic structure, more medical care for each individual is required than is the case in the developed countries. At the same time, there is much less economic and cultural capacity to attain such a level of service in the underdeveloped countries. In other words, more medical care is available to meet a lower level of need in the developed countries, while the inverse is the case in the underdeveloped countries.

Medical services in countries such as Mexico must also be of high quality, which implies both service to the individual and to the group. In other words, it is not enough to provide a few individuals with first-class medical attention, but all members of a given group must receive services of the highest available quality. Moreover, in a country with such enormous divergencies in pathology and in cultural and educational levels as Mexico, it is essential that the medical care programs have the special features suited to each group, keeping in mind the provision of the best possible service for 100 per cent of the group as one of the goals. For example, we mean that medical care for university groups must reach all of the university groups and must have the special features demanded by the epidemiological and cultural needs of the group. On the other hand, a medical care program for indigenous groups would be very different, since it would be adapted to their peculiar cultural and epidemiological needs, while it too must be directed to the entire group.

Finally, we must point out that Mexico has never developed the European standard of the bedside physician, except for a very limited group in the highest social and economic strata. Consequently, for this as well as for other reasons, the Mexican people in the majority have a minimal discernment in the selection of a personal physicians. Such selection is customarily based on the advertising or the social prestige of the doctor.

Mexican social security has not created this criterion for the selection of a doctor and, nevertheless, it has improved the quality of medical care. It has shown in contrast a tendency (that we believe should be encourage) to place the care of family in the hands of general physicians who are consulted on a continuing basis. Development of this type of medical care by the same doctor, combined with a humanistic home medical service, in the family environment, can lead to the creation of medical care that seeks not only technical and scientific progress but the development of new attitudes on the part of the doctor that will equip him to understand and treat the problems of the individual in their inter-relationship with the family and the social group.

2. MEXICAN SOCIAL SECURITY INSTITUTE

a) Legal Provisions on Social Security Coverage

Article 6 of the Mexican Social Security Law provides: The Federal Executive, on the basis of study and recommendations by the Institute, shall determine the date and the bases for the extension of social security benefits to workers in family and home industries and to part-time and temporary domestic workers.

Decrees issued by the Federal Executive implementing the authority accorded herein shall specify the worker categories to which the provisions refer, the periods, and the procedures to be established for their registration and for the collection of employer-employee contributions, define the wage-groups in which they are included and the pertinent procedures for benefit payments and utilization of the services to which they are entitled. Likewise, such decrees shall prescribe procedures for changes in worker classification and the consequences of such changes.

The worker categories to which this article refers shall be determined in accordance with the provisions of the respective laws, or, in the absence thereof, by the provisions of the decree instituting the Social Security System.

The Federal Executive shall also determine, on the recommendation of the Institute, the dates on which the various branches of social security will be instituted, and the territorial divisions in which they will be applicable, taking into account the industrial and agricultural development, the geographical conditions, the population density of the insurable population in such territorial divisions and the possibilities of establishing the appropriate services.

The Federal Executive shall also fix the dates and establish procedures for effecting the first general registration of employers, as soon as the foregoing determinations are made.

It shall likewise fix the dates and establish procedures for instituting compulsory social security for rural wage-earners in the territorial divisions where such insurance has already been instituted for urban wage-earners, but not for the rural group.

With the approval of the Federal Executive, the Institute may extend social security coverage to branches of industry, in territorial divisions where it has not yet been introduced, provided that the conditions set forth in Article 65 of the Law are met. A special regulation shall establish the bases for extension of this coverage.

Amount of contributions for Sickness and Maternity Coverage.

Article 63 of the Mexican Social Security Law: Employers and workers shall pay the contributions indicated in the following table for Non-Occupational Sickness and Maternity coverage:

	DAILY WAGE			WEEKLY CONTRIBUTION	
GROUP	OVER..	AVERAGE	NOT MORE THAN	EMPLOYER	EMPLOYEE
			(In Mexican pesos)		
E	---	7.00	8.00	2.20	1.10
F	8.00	9.00	10.00	2.84	1.42
G	10.00	11.00	12.00	3.46	1.73
H	12.00	13.50	15.00	4.26	2.13
I	15.00	16.50	18.00	5.20	2.60
J	18.00	20.00	22.00	6.30	3.15
K	22.00	26.40	30.00	8.32	4.16
L	30.00	35.00	40.00	11.02	5.51
M	40.00	45.00	50.00	14.18	7.09
N	50.00	60.00	70.00	18.90	9.45
O	70.00	75.00	80.00	23.62	11.81
P	80.00	---	---	28.36	14.18

Contributions required to cover benefits to which the insured and their beneficiaries are entitled shall be established on the basis of the foregoing table, in such a way that in lieu of a daily wage the monthly wage shall be calculated by the day by dividing the total by thirty. Contributions to be paid by the insured shall be withheld from his monthly wage. The Institute shall collect the employer's contribution for Disability, Old-Age, Dismissal and Death benefits, and, where appropriate, for Workmen's Compensation insurance...

Article 62 of the Mexican Social Security Law: The funds necessary to cover benefit payments and administrative expenses for the Non-Occupational Sickness and Maternity coverage, and to constitute a reserve fund, will be obtained through compulsory contributions by the employer and the worker, and the contribution of the Government.

In 1964, the total payments into the IMSS for Non-Occupational Sickness and Maternity coverage amounted to $1,957,765,339.67.

With regard to the type of benefit payments, there is annexed hereto a study that will give a breakdown of benefits under the Mexican Social Security Law, by worker category and type of coverage, and will show the amounts corresponding to the Non-Occupational Sickness and Maternity branch.

b) Administrative Organization of the Medical Services

The highest authority of the Mexican Social Security Institute is its General Assembly, consisting of 30 members: 10 representing the Federal Executive, 10 representing employers' associations and 10 representing labor organizations. Members serve for a term of six years and may be reelected.

Next in order of authority are the Technical Council, the Inspection Committee (Comisión de Vigilancia) and the Director General.

At the beginning of 1965, there were the following bureaus under the Office of the Director General:

ADMINISTRATIVE,
PURCHASE AND SUPPLY,
EQUIPMENT AND CONSTRUCTION,
LEGAL,
TECHNICAL,
MEDICAL.

There were, in addition, a number of other entities, such as International Affairs, the Office of the Controller, the Treasurer, Press and Information, Public Relations, General Services, the General Secretariat and Evaluation.

The Medical Bureau consists of six Departments:

1. DEPARTMENT OF MEDICAL SERVICES IN THE FEDERAL DISTRICT,
2. DEPARTMENT OF REGIONAL MEDICAL SERVICES,
3. DEPARTMENT OF PREVENTIVE MEDICINE,
4. DEPARTMENT OF TECHNICAL PLANNING OF MEDICAL SERVICES,
5. DEPARTMENT OF WORKMEN'S COMPENSATION AND DISABILITY,
6. DEPARTMENT OF COMPLAINTS AND SUGGESTIONS.

Medical institutions or units, both hospitals and outpatient clinics, report directly to the heads of the Departments of Medical Services in the Federal District, and the Regional Medical Services. Authority for operation of these medical units is delegated to their respective Directors.

c) Preparation and Amount of the Budget

In preparing the budget and determining the estimated amount, two types of procedure are followed: one is that utilized by the Department of Budget Control, and the other is that employed by the Institute's Actuarial Department.

The first-mentioned is based on amounts expended in previous years, and has the help of the budget requests presented by the branch offices of the Institute in each State of the Republic (state or regional branches). The same procedure is applied to both estimated income and estimated expenditures.

In preparing its estimate of income, the Actuarial Department uses figures supplied by the Department of Accounts, rather than income for previous years. It also examines the trends and the various factors that may influence such revenue. Similar estimates are made by each district.

In preparing its estimated expenditures, the Actuarial Department similarly analyzes all of the factors and trends that might cause variations. It also takes into consideration other factors that might influence expenditures such as:

a. the inclusion of new areas or groups of workers under the program,
b. salaries of personnel (normal increase or anticipated extraordinary increase),
c. new insured groups,
d. careful control over the rate of collections under the Workmen's Compensation branch, since these have varied from year to year,
e. changes in the minimum wages for the country and for each state,
f. changes in collective labor contracts,
g. average expenditures per insured, per year,
h. others...

Salaries of the permanent and executive staff are based on the Institute's classification plan and the wage-scale established under collective contracts. The length of the work-day and whether or not it is a continuous or split shift are taken into consideration.

Certain requirements are established with regard to the appointment of medical staff. The candidate must present a curriculum vitae, identification photographs, a completed application form, letters of recommendation, meet the established age requirements, present appropriate documentation attesting to his medical qualifications (degree and license to practice issued by the Department of Professional Licensing) and professional background and experience. All of these requirements are mentioned, among others...

d) Preventive Medicine Activities

Preventive services for workers are carried on at two levels: those related to the job, and disease prevention. The latter are also provided for his dependents, and for the population in general, in cooperation with other health agencies.

Among the preventive activities may be cited: those designed to ensure safety and hygiene of the worker on the job, campaigns against infectious and communicable diseases, cancer, tuberculosis and rheumatic fever detection, for both the child and the adult population, immunization against diphtheria, whooping-cough, tetanus, measles, poliomyelitis, typhoid fever, etc.

e) Legal Relationships with other Medical Institutions

There are no legal or administrative relationships with special reference to overall institutional administration and the source of directives.

f) Attempts at Coordination

At the present time there is a presidential order requesting that a study be made of all elements in the services and in their financing that might be considered essential and useful in effecting coordination of the medical welfare services, all at the national level.

However, in the rural areas there are a number of existing agreements or established regulations for coordination of the medical services. Examples are: the service contracts (hospital beds, X-ray and laboratory services, outpatient clinics, etc.) concluded by the Mexican Social Security Institute with the medical units of other health agencies.

g) Accessibility of services

This topic may be considered from three different angles:

1. Not all of the population covered by the Institute has access to its medical services, inasmuch as there are certain private enterprises that have agreements whereby the employer's contribution is returned in exchange for providing benefits; i.e., companies that maintain their own medical departments. Another type is that of the banking institutions that also manage their own medical program.

2. There is also a small group of insured or their beneficiaries for which the Institute is unable to provide the medical services requested by the insured, because of lack of hospital space; this is the only case in which hospital units do not provide care. Nevertheless, the cost of such care is covered by the Institute, on presentation of proper substantiation, and on the basis of the average daily cost established by the authorities.

3. All of the covered population has access to medical services even when they are in other parts of the country. The Department of Eligibility Protection in each case issues a card authorizing provision of medical services in its units and for the period that the worker or his family are away from their regular place of registration.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Mexico, D.F.

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Department of Health									
8 General hospitals	* 5 873 000	3 364	65 003	1 172 542	486 774	0.6	11.1	199.6	82.9
5 Specialized hospitals	5 873 000	1 160	3 500	287 549	57 675	0.2	0.6	49.0	9.8
Mexican Social Insurance Institute									
6 General hospitals	1 979 972	2 470	103 146	697 874	406 240	1.2	52.1	352.5	205.2
2 Specialized hospitals	1 979 972	628	6 244	163 389	120 605	0.3	31.5	82.5	60.9
4 General clinics	...	95	11 512	21 821	816 533	0.0	5.8	11.0	412.4
Civil Service Social Security and Welfare Institute									
1 General hospital	668 076	610	20 240	158 607	75 333	0.9	30.3	237.4	112.8
1 Specialized hospital	668 076	60	488	18 084	-	0.1	0.7	27.1	-
S.S.A.									
General hospital of City of Mexico	5 873 000	1 874	24 738	768 965	200 308	0.3	4.2	130.9	34.1
I.M.S.S.									
Central hospital	1 979 972	802	17 908	239 925	150 115	0.4	9.0	121.2	75.8
I.S.S.T.E.									
Hospital "20 de Noviembre"	668 076	610	20 240	158 607	75 333	0.9	30.3	237.4	112.8

* Estimated figures not given.

TABLE II

Indices of Hospital Utilization, Mexico, D.F.

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Department of Health			
8 General hospitals	18.0	19.3	93.0
5 Specialized hospitals	82.1	3.0	74.6
Mexican Social Insurance Institute			
6 General hospitals	6.8	41.8	77.2
2 Specialized hospitals	26.2	9.9	71.1
4 General clinics	1.9	121.2	62.8
Civil Service Social Security and Welfare Institute			
1 General hospital	7.8	33.2	71.0
1 Specialized hospital	37.1	8.1	* 82.3
S.S.A.			
General hospital of Mexico City	31.1	13.2	108.6
I.M.S.S.			
Central hospital	13.4	22.3	81.7
I.S.S.T.E.			
Hospital "20 de Noviembre"	7.8	33.2	71.0

* Based on discharge day.

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Mexico, D.F.

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Department of Health																
8 General hospitals	950	612	5 057	1 983	428	1 513	42	561	2 513	28.0	18.0	148.9	58.4	12.6	16.5	74.0
5 Specialized hospitals	252	104	1 294	395	149	246	-	123	776	28.1	11.6	144.4	44.1	16.6	13.7	86.6
Mexican Social Insurance Institute																
6 General hospitals	960	...	5 810	2 980	1 324	1 656	70	672	2 158	45.1	...	272.9	140.0	62.2	31.6	101.4
2 Specialized hospitals	121	...	1 248	497	197	300	-	148	603	23.6	...	243.6	97.0	38.5	28.9	117.7
4 General clinics	184	...	705	193	53	140	-	125	387	36.4	...	139.4	38.2	10.5	24.7	76.5
Civil Service Social Security and Welfare Institute																
1 General hospital	241	241	1 947	1 035	493	536	6	418	494	50.8	50.8	410.3	218.1	103.9	88.1	104.1
1 Specialized hospital	10	10	89	31	2	29	-	4	54	20.2	20.2	180.2	62.8	4.0	8.1	109.3
S.S.A.																
General Hospital of Mexico City	456	156	2 738	994	160	826	8	235	1 491	21.3	7.3	127.7	46.4	7.5	11.0	69.5
I.M.S.S.																
Central Hospital	252	...	1 518	...	...	...	...	1 149	369	34.2	...	205.8		155.8		50.0
I.S.S.T.E.																
Hospital "20 de Noviembre"	241	241	1 947	1 035	493	536	6	418	494	50.8	50.8	410.3	218.1	103.9	88.1	104.1

TABLE IV

Ratios on Distribution of Hospital Personnel, Mexico, D.F.

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Department of Health							
8 General hospitals	0.5	0.7	2.1	3.2	3.5	70	58
5 Specialized hospitals	0.6	1.4	1.6	3.8	1.7	83	50
Mexican Social Insurance Institute							
6 General hospitals	1.4	...	3.1	...	1.3	100	68
2 Specialized hospitals	1.6	...	4.1	...	1.5	34	56
4 General clinics	0.3	...	1.0	...	2.6	100	56
Civil Service Social Security and Welfare Institute							
1 General hospital	2.0	2.0	4.3	4.3	1.1	100	77
1 Specialized hospital	0.2	0.2	3.1	3.1	14.5	...	45
S.S.A.							
General hospital of Mexico City	0.4	1.0	2.2	6.4	5.2	70	53
I.M.S.S.							
Central Hospital	...	...	...	...	...	100	79
I.S.S.T.E.							
Hospital "20 de Noviembre"	2.0	2.0	4.3	4.3	1.1	100	77

1) Total physicians
2) Full time physicians

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Mexico, D.F.

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Department of Health			
8 General hospitals	46	199	43
5 Specialized hospitals	30	150	57
Mexican Social Insurance Institute			
6 General hospitals	...	477	146
2 Specialized hospitals	...	331	131
4 General clinics	...	130	36
Civil Service Social Security and Welfare Institute			
1 General hospital	130	743	354
1 Specialized hospital	52	214	7
S.S.A.			
General Hospital of Mexico City	19	158	26
I.M.S.S.			
Central Hospital	...	...	
I.S.S.T.E.			
Hospital "20 de Noviembre"	130	743	354

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Mexico, D.F.

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Department of Health							
6 General hospitals	1 172 542	18.0	486 774	82.96	1 493.28	30 363	...
4 Specialized hospitals	287 459	82.1	57 675	71.87	5 900.53	26 304	...
Mexican Social Insurance Institute							
6 General hospitals	697 874	6.8	406 240	...	...	...	...
2 Specialized hospitals	163 389	26.2	120 605	...	...	...	...
4 General clinics	21 821	1.9	816 533	...	...	...	...
Civil Service Social Security and Welfare Institute							
1 General hospital	158 607	7.8	75 333	300.00	2 340.00	109 800	...
1 Specialized hospital	18 084	37.1	-	80.00	2 968.00	29 280	...
S.S.A.							
General Hospital of Mexico City	744 611	31.1	200 308	67.40	2 096.14	24 668	...
I.S.S.T.E.	158 607	7.8	75 333	300.00	2 340.00	109 800	...

TABLE VII

Number and Type of Outpatient Establishments Reporting, Mexico, D.F.

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Department of Health				
1 Hospital Outpatient Department	3	6	2	3
22 Health centers A	a) 22	10	19	18
19 Health centers B	a) 19	6	8	5
4 Specialized clinics	5	6	2	-
4 Clinics	4	18.5	4	4
Mexican Social Insurance Institute				
General Hospital outpatient	b) 10	28	10	10
Specialized hospital out-patients	4	20	4	3
General clinics	19	33	19	14
Civil Service Social Security and Welfare Institute				
Hospital outpatient	1	...	1	1
General clinics	29	6	1	1
Specialized clinics	4	28	4	4

a) Group A in general includes large health centers than Group B but services are fairly similar and two groups could be combined.
b) Includes clinics with beds with information on hospitalized patients.

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Mexico, D.F.

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Department of Health																	
3 Hospital Outpatient Departments	...	97 424	...	140 998	48 158	2 705	29 338	60 374	16 968	...	...	...	...	144.7	49.4	42.8	12.0
20 Health centers	3 978 454	609 620	15.3	627 107	376 163	317 760	1168 304	152 160	39 295	15.8	9.5	8.0	29.4	102.9	61.7	24.3	6.3
17 Health centers	1 282 637	308 610	24.1	229 095	156 239	94 910	339 543	38 978	6 537	17.9	12.2	7.4	26.5	74.2	50.6	17.0	2.9
4 Specialized clinics	...	40 876	...	51 673	4 454	8 988	14 632	1 542	252	...	...	...	...	126.4	10.9	3.0	0.4
4 Clinics	...	148 442	...	150 289	24 184	-	8 451	14 334	2 177	...	...	...	...	101.2	16.3	9.5	1.4
Mexican Social Insurance Institute																	
Hospital Outpatient																	
9 General	1 979 972	...	...	1 415 637	-	51 213	156 116	1184 894	91 631	71.5	-	2.6	7.9	...	...	83.7	6.5
3 Specialized	1 979 972	...	...	162 913	-	-	-	298 901	81 732	8.2	-	-	-	...	...	183.5	50.2
19 Outpatient clinics	1 979 972	...	...	4 407 021	-	301 731	512 743	1516 017	107 992	222.6	-	15.2	25.9	...	...	34.4	2.5
Civil Service Social Security and Welfare Institute																	
1 Hospital Outpatient Department	668 076	...	...	75 333	-	61 007	6 205	414 038	32 104	11.3	-	9.1	0.9	...	...	549.6	42.6
29 General outpatient clinics	668 076	249 821	37.4	782 014	168 298	118 813	124 569	95 050	7 309	117.1	25.2	17.8	18.6	313.0	67.4	12.2	0.9
4 Specialized outpatient clinics	668 076	202 219	30.3	335 513	5 527	-	-	635 422	34 640	50.2	0.8	-	-	165.9	2.7	189.4	10.3

TABLE IX

Personnel in Outpatient Establishments, Mexico, D.F.

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Department of Health													
1 Hospital Outpatient Department	20	160	3	20	27	14	2	12	-	13	20	14	2
22 Health centers	331	1 067	51	141	1 303	587	132	439	16	716	28	64	15
19 Health centers	125	381	15	47	504	220	53	157	10	284	27	67	16
4 Specialized clinics	34	121	2	6	207	22	4	17	1	185	38	49	9
4 Clinics	102	215	8	16	236	61	31	30	-	175	24	44	22
Mexican Social Insurance Institute													
Hospital Outpatient Department													
General	...	...	...	...	...	...	...	...	...	...	...	...	...
Specialized	...	...	...	...	...	...	...	...	...	...	...	...	...
19 Outpatient clinics	913	6 429	91	...	2 626	668	172	496	-	1 958	23	20	5
Civil Service Social Security and Welfare Institute													
19 Outpatient clinics	...	...	...	...	...	...	...	...	...	...	26	150	70
29 General outpatient clinics	426	1 572	47	152	1 079	375	51	324	-	704	34	49	7
4 Specialized outpatient clinics	150	538	64	195	527	149	17	132	-	378	34	55	6

TABLE X

Average Cost per Outpatient Consultation, Mexico, D.F.

Hospital	Mean cost	Median cost
Department of Health		
Hospital Outpatient Department	...	...
13 Health centers	9.17	9.00
10 Health centers	14.36	17.38
4 Specialized clinics	2.92	3.00
3 Clinics	12.76	18.53
Mexican Social Insurance Institute		
Hospital Outpatient Department	...	...
General		
Specialized		
Outpatient clinics	...	...
Civil Service Social Security and Welfare Institute		
Hospital outpatient department	...	...
General outpatient clinics	...	...
Specialized outpatient clinics	...	...

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, San Luis, Potosí, Mexico

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Dis-charges	Patient days (a)	Outpatient consul-tations	Beds	Dis-charges	Patient days	Outpatient consul-tations
Department of Health									
1 Hospital	100,820	54	1,836	11,014	13,390	0.5	18.2	109.2	132.8
5 Health Centers with beds	194,833	71	1,869	4,442	13,840	0.4	9.6	22.8	71.0
Mexican Social Insurance Institute									
3 Clinic Hospitals	78,270	181	7,701	44,854	288,201	2.3	98.4	573.1	3,682.1

(a) Census days.

TABLE II

Indices of Hospital Utilization, San Luis Potosí, Mexico

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Department of Health			
1 Hospital	6.0	34.0	55.7
5 Health centers with beds	2.4	26.3	17.1
Mexican Social Insurance Institute			
3 Clinic hospitals	5.8	42.5	67.7

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, San Luis Potosí, Mexico

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Department of Health																
1 Hospital	15	8	54	24	4	15	5	5	25	40.2	21.4	144.4	64.2	10.7	13.4	66.8
5 Health centers with beds	10	4	44	29	7	19	3	-	15	50.8	20.3	223.4	147.2	35.5	-	76.1
Mexican Social Insurance Institute																
3 Clinic hospitals	56	47	285	119	48	67	4	41	125	20.0	16.8	101.8	42.5	17.1	14.6	44.6

TABLE IV

Ratios on Distribution of Hospital Personnel, San Luis Potosí, Mexico

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Department of Health							
1 Hospital	0.3	0.5	1.6	3.0	3.8	100	64
5 Health centers with beds	0.7	1.8	2.9	7.2	2.7	20	72
Mexican Social Insurance Institute							
3 Clinic hospitals	0.9	1.0	2.1	2.5	1.4	100	63

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, San Luis Potosi, Mex.

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Department of Health			
1 Hospital	58	219	36
5 Health Centers with beds	56	502	121
Mexican Social Insurance Institute			
3 Clinic Hospitals	43	145	58

TABLE VI

Costs of Hospitalization and Outpatient Consultations, San Luis Potosí, Mexico

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Department of Health							
1 Hospital	11,014	6.0	13,390	68.86	413.16	25,203	13.77
5 Health centers with beds	4,442	2.4	13,840	47.37	113.69	17,337	9.47
Mexican Social Insurance Institute							
3 Clinic hospitals	44,854	5.8	288,201	...	...	...	...

TABLE VII

Number and Type of Outpatient Establishments Reporting, San Luis Potosí, Mexico

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Department of Health				
Hospitals	2	12	2	2
Centers with beds	5	2	-	1
Health centers	21	1	1	1
Mexican Social Insurance Institute				
Clinic hospitals	3	6	2	2
Clinic	1	18	-	-
Auxiliary centers	6	1	2	1

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, San Luis Potosí, Mexico

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Department of Health																	
2 Hospitals	a) 200000	22511	11.3	32955	11497	362	877	20138	3073	16.5	5.7	0.2	0.4	146.4	51.1	61.1	9.3
5 Health centers with beds	194833	50114	25.7	10153	6746	2880	82987	2428	-	5.2	3.5	1.5	42.6	20.3	13.5	23.9	-
21 Health centers																	
11 with population covered	346472	73295	21.2	61126	40632	22553	391272	22446	4892	17.6	11.7	6.5	112.9	83.4	55.4	36.7	8.0
10 without population covered	...	6492	...	1162	27326	2085	29950	89	-	...	...	...	...	17.9	420.9	7.7	-
Mexican Social Insurance Institute																	
3 Clinic hospitals	78270	...		288221	-	12821	10707	62785	10150	368.2	-	16.4	13.7	...	...	21.8	3.5
1 Clinic	56103	...		141245	-	10409	4118	-	-	251.8	-	18.6	7.3	...	...	-	-
6 Auxiliary clinics	68525	...		94161	-	7240	636	3098	592	137.4	-	10.6	0.9	...	...	3.3	0.6

(a) Used as both in San Luis Potosi.

TABLE IX

Personnel in Outpatient Establishments, San Luis Potosí, Mexico

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Department of Health													
1 General hospt.	10	20	1	2	22	12	6	6	-	10	18	77	38
1 Children's hospital (a)	...	...	...	...	...	...	...	...	...	...	12	44	7
5 Health centers with beds (a)	...	...	...	...	...	...	...	...	...	...	11	100	24
21 Health centers	24	70	2	6	92	81	19	60	2	11	19	78	18
Mexican Social Insurance Institute													
3 Clinic hospitals (a)	...	...	...	...	...	...	...	...	...	...	16	29	12
1 Clinic	14	114	2	...	58	13	2	11	-	45	13	11	2
6 Auxiliary clinics	11	71	1	...	33	10	-	10	-	23	12	13	-

(a) Same personnel as in table for hospital personnel.

TABLE X

Average Cost per Outpatient Consultation, San Luis Potosí, Mexico

Hospital	Mean cost	Median cost
Department of Health		
1 Hospital	14.00	14.00
5 Health centers with beds	9.47	...
19 Health Centers	17.86	...

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Guerrero, and Hidalgo, Mexico

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
GUERRERO									
Department of Health									
1 General hospital	150,000	50	3,048	18,052	680	0.3	20.3	120.3	4.5
19 Health centers with hospital	184,650	238	4,783	29,088	45,390	1.3	25.9	157.5	245.8
Mexican Social Insurance Institute									
4 Clinic hospitals	53,294	a) 149	4,114	b) 22,898	306,738	2.8	7.7	43.0	575.6
HIDALGO									
Department of Health									
1 General hospital	209,800	150	2,389	26,602	2,058	0.7	11.4	126.8	9.8
26 Health centers with beds	870,444	408	7,897	46,942	59,264	0.5	9.1	53.9	68.1
1 Specialized hospt.	120,102	18	36	4,869	-	0.1	0.3	40.5	-
Mexican Social Insurance Institute									
6 General hospitals	43,973	93	3,409	b) 13,183	234,566	2.1	77.5	299.8	5,334.3

a) 40 beds opened on November 25, 1964
b) Census days.

TABLE II

Indices of Hospital Utilization, Guerrero, and Hidalgo, Mexico

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
GUERRERO			
Department of Health			
1 General hospital	5.9	61.0	98.6
19 Health centers with beds	6.1	20.1	33.4
Mexican Social Insurance Institute			
4 Clinic hospitals	5.6	a) 36.4	a) 55.4
HIDALGO			
Coordinated Public Health Services			
1 General hospital	11.1	15.9	48.5
26 Health centers with beds	5.9	19.4	31.4
1 Specialized hospital	135.3	2.0	73.9
Mexican Social Insurance Institute			
6 General hospitals	3.9	b) 43.2	b) 45.6

a) Adjusted for 40 beds in service only 1-1/4 months.
b) Adjusted for 16 beds in service only 1-1/2 months.

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Guerrero, and Hidalgo, Mexico

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
GUERRERO																
Department of Health																
1 General hospital	6	6	44	21	-	20	1	4	19	12.0	12.0	88.0	42.0	-	8.0	38.0
19 Health centers with hospital	36	27	162	76	6	68	2	4	82	34.6	26.0	155.8	73.1	5.8	3.8	78.8
Mexican Social Insurance Institute																
4 Clinic hospts.	52	52	295	105	8	97	-	38	152	22.6	22.6	128.3	45.7	3.5	16.5	66.1
HIDALGO																
Coordinated Public Health Services																
1 General hospital	17	6	58	27	2	25	-	2	29	23.0	8.1	78.6	36.6	2.7	2.7	39.3
26 Health centers with beds	32	a) 32	249	114	10	102	2	3	132	19.9	19.9	155.0	71.0	6.2	1.9	82.2
1 Specialized hospital	4	4	11	3	3	-	-	-	8	30.1	30.1	82.7	22.6	22.6	-	60.2
Mexican Social Insurance Institute																
6 General Hospts.	51	51	175	58	8	46	4	28	89	31.1	31.1	106.6	35.3	4.9	17.1	54.2

a) All reported 6 hrs. except one hospital.

TABLE IV

Ratios on Distribution of Hospital Personnel, Guerrero, and Hidalgo, Mexico

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
GUERRERO							
Department of Health							
1 General hospital	-	-	3.5	3.5		100	62
19 Health centers with hospital	0.2	0.2	2.1	2.8	11.3	74	59
Mexican Social Insurance Institute							
4 Clinic hospitals	0.2	0.2	2.0	2.0	12.1	100	56
HIDALGO							
Coordinated Public Health Services							
1 General hospital	0.1	0.3	1.6	4.5	12.5	...	61
26 Health centers with beds	0.3	0.3	3.6	3.6	10.2	...	53
1 Specialized hospital	0.8	0.8	0.8	0.8	-	-	47
Mexican Social Insurance Institute							
6 General hospitals	0.2	0.2	1.1	1.1	5.8	100	61

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Guerrero and Hidalgo

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
GUERRERO			
Department of Health			
1 General hospital	41	143	-
19 Health centers with hospital	66	249	20
Mexican Social Insurance Institute			
4 Clinic hospitals	58	155	12
HIDALGO			
Coordinated Public Health Services			
1 General hospital	21	125	9
26 Health centers with beds	51	242	21
1 Specialized hospital	77	77	77
Mexican Social Insurance Institute			
6 General hospitals	79	120	17

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Guerrero, and Hidalgo, Mexico

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
GUERRERO							
Department of Health							
1 General hospital	18,052	5.9	680	24.36	143.72	8,916	a) 2.75
17 Health centers with beds	23,219	6.1	64,236	49.58	302.44	18,146	b) 9.92
Mexican Social Insurance Institute							
4 Clinic hospitals	22,898	5.6	306,738	...	...	...	...
HIDALGO							
Coordinated Public Health Services							
1 General hospital	26,602	11.1	2,058	25.82	286.60	9,450	5.16
26 Health centers with beds	46,942	5.9	59,264	57.90	341.61	21,191	11.58
1 Specialized hospital	4,869	135.3	-	12.32	1666.90	4,509	-
Mexican Social Insurance Institute							
6 General hospitals	13,183	3.9	234,566	...	...	...	...

a) As given
b) The cost of five consultas is assumed to be equivalent to that for one patient day.

TABLE VII

Number and Type of Outpatient Establishments Reporting, Guerrero, and Hidalgo, Mexico

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
GUERRERO				
Department of Health				
Hospital outpatient	1	5	1	1
Health centers with beds	24	...	10	4
Health center	1	7	1	1
Rural health centers	41	...	-	-
Mexican Social Insurance Institute				
4 Clinics with hospital	4	6	2	3
1 Auxiliary	1	1	-	-
HIDALGO				
Coordinated Public Health Services				
1 General hospital	1	3	1	1
26 Health centers with beds	26	1	4	4
Mexican Social Insurance Institute				
6 General hospitals	6	4.5	2	2

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Guerrero, and Hidalgo, Mexico

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
GUERRERO																	
Department of Health																	
1 Hospital outpatient	150000	2743	1.8	680	21948	-	371	394	300	0.5	14.6	-	0.2	24.8	800.1	57.9	44.1
24 Health centers with beds	323347	129951	40.2	131516	120571	40902	199709	33868	6699	40.7	37.3	12.6	61.8	101.2	92.8	25.8	5.1
1 Health center	57761	24529	42.5	22021	2656	9860	41938	25064	13474	38.1	4.6	17.1	72.6	89.8	10.8	113.8	61.2
41 Rural health centers	95597	41843	43.8	46942	36312	41760	102735	-	-	49.1	38.0	43.7	107.5	112.2	86.8	-	-
Mexican Social Insurance Institute																	
4 Clinics with hospt.	53294	...	...	306738	-	1606	41306	63990	8745	575.6	-	3.0	77.5	...	...	20.9	2.9
1 Auxiliary	813	...	...	1736	-	19	228	-	-	213.5	-	2.3	28.0	...	...	-	-
HIDALGO																	
Coordinated Public Health Services																	
1 General hospt.(a)	...	5576	...	2058	3460	-	-	1112	220	...	...	...	...	...	...	...	...
26 Health centers with beds	870444	53394	6.1	59264	71874	43654	144013	12983	1868	6.8	8.3	5.0	16.5	111.0	134.6	21.9	3.2
Mexican Social Insurance Institute																	
6 General hospitals	43973	...	...	234566	-	8431	6601	32455	5697	533.4	-	19.2	15.0	...	...	13.8	2.4

a) Children's Hospital - activities not related to general population.

TABLE IX

Personnel in Outpatient Establishments, Guerrero, and Hidalgo, Mexico

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
GUERRERO													
Department of Health													
1 Hospital out-patient (a)											8	29	-
Health centers with beds (a)											13	50	3
1 Health center	7	26	3	9	30	22	4	15	3	8	25	111	20
41 Rural Health centers	37	...	-	-	52	46	-	45	1	6	...	69	-
Mexican Social Insurance Institute (a)													
4 Clinics with hospitals											12	31	2
1 Auxiliary	1	...	-	-	4	2	-	2	-	2	...	144	-
HIDALGO (a)													
Coordinated Public Health Services													
1 General hospt.											4	b) 25	2
26 Health centers with beds											10	b) 48	4
Mexican Social Insurance Institute													
6 General hospts.											16	b) 24	3

a) Same personnel as for hospitals. b) Based on medical consultas only; obtained from assuming that 5 medical consultas are equivalente to one patient day in cost and time.

TABLE X

Average Cost per Outpatient Consultation, Guerrero, and Hidalgo, Mexico

Hospital	Mean cost	Median cost
GUERRERO		
Department of Health		
1 Hospital outpatient	2.75	2.75
17 Health centers with beds	9.92	...
1 Health center	48.78	48.78
41 Rural health centers	...	...
Mexican Social Insurance Institute		
4 Clinics with hospitals	...	...
1 Auxiliary	...	...
HIDALGO		
Coordinated Public Health Services		
1 General hospital (a)	5.16	...
26 Health centers with beds (a)	11.58	...
Mexican Social Insurance Institute		
6 General hospitals	...	

a) Obtained by assuming five outpatient medical consultations as equivalent to one patient day.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Sonora and Yucatan, Mexico

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Dis-charges	Patient days	Outpatient consul-tations	Beds	Dis-charges	Patient days	Outpatient consul-tations
SONORA									
Department of Health									
2 General hospitals	110000	394	8719	28625	64096	3.6	79.3	260.2	582.7
1 Specialized hospital	500000	38	110	12065	1153	0.1	0.2	24.1	2.3
6 Health centers	82175	57	1916	5262	26364	0.7	23.3	64.0	320.8
Mexican Social Insurance Institute									
10 General hospitals	169930	469	15504	105702	755862	2.8	91.2	622.0	4448.1
YUCATAN									
Department of Health									
5 General hospitals	200000	761	13432	138847	368195	3.8	67.2	694.2	1841.0
4 Specialized hospitals	...	256	1329	82128	7823	...	...	...	...
14 Health centers with beds	300007	170	1707	8058	178566	0.6	5.7	26.9	595.2
Mexican Social Insurance Institute									
2 General hospitals	65650	132	4916	28612	362188	2.0	74.9	435.8	5517.0

TABLE II

Indices of Hospital Utilization, Sonora and Yucatan, Mexico

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
SONORA			
Department of Health			
2 General Hospitals	3.3	22.1	19.9
1 Specialized hospital	109.7	2.9	86.7
6 Health centers	2.7	33.6	25.2
Mexican Social Insurance Institute			
10 General hospitals	6.8	a) 33.9	a) 63.1
YUCATAN			
Department of Health			
5 General hospitals	10.3	17.7	49.9
4 Specialized hospitals	61.8	5.2	87.7
14 Health centers with beds	4.7	10.0	13.0
Mexican Social Insurance Institute			
2 General hospitals	5.8	b) 41.1	b) 65.4

a) Four hospitals open for 10.3 months
b) One hospital open for 1.5 months

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Sonora and Yucatan, Mexico

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
SONORA																
Department of Health																
2 General hospitals	47	16	213	125	40	83	2	28	60	41.6	14.2	188.5	110.6	35.4	24.8	53.1
1 Specialized hospital	4	1	15	9	1	8	-	2	4	11.9	3.0	44.6	26.8	3.0	6.0	11.9
6 Health centers	14	3	88	38	1	37	-	4	46	48.6	10.4	30.6	131.9	3.5	13.9	159.7
Mexican Social Insurance Institute																
10 General hospitals	171	171	780	329	16	311	2	84	367	24.4	24.4	111.1	46.9	2.3	12.0	52.3
YUCATAN																
Department of Health																
5 General hospitals	110	59	676	259	21	218	20	43	374	18.9	10.2	116.4	44.6	3.6	7.4	64.4
4 Specialized hospitals	24	18	101	34	5	29	-	18	49	10.5	7.9	44.1	14.8	2.2	7.9	21.4
14 Health centers with beds	29	17	118	54	1	53	-	12	52	24.2	14.2	98.3	45.0	0.8	10.0	43.3
Mexican Social Insurance Institute																
2 General hospitals	84	84	330	116	14	98	4	45	169	24.4	24.4	119.6	42.0	5.1	16.3	61.2

TABLE IV

Ratios on Distribution of Hospital Personnel, Sonora and Yucatan, Mexico

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
SONORA							
Department of Health							
2 General hospitals	0.9	2.5	1.8	5.2	2.1	...	76.9
1 Specialized hospital	0.2	1.0	2.2	9.0	8.0	25.0	78.9
6 Health Centers	0.1	0.3	2.7	12.7	37.0	21.6	54.9
Mexican Social Insurance Institute							
10 General hospitals	0.1	0.1	1.9	1.9	19.4	100.0	61.4
YUCATAN							
Department of Health							
5 General hospitals	0.2	0.4	2.4	4.4	10.4	26.6	52.4
4 Specialized hospital	0.2	0.3	1.4	1.9	5.8	6.9	60.8
14 Health centers with beds	0.0	0.1	1.9	3.2	53.0	35.9	64.6
Mexican Social Insurance Institute	0.2	0.2	1.4	1.7	7.0	100.0	59.2

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Sonora and Yucatan, Mexico

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
SONORA			
Department of Health			
2 General hospitals	36	377	120
1 Specialized hospital	8	92	10
6 Health Centers	26	449	13
Mexican Social Insurance Institute			
10 General hospitals	...	160	8
YUCATAN			
Department of Health			
5 General hospitals	31	152	12
4 Specialized hospitals	20	50	8
14 Health centers with beds	36	153	3
Mexican Social Insurance Institute			
2 General Hospitals	61	143	17

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Sonora and Yucatán, Mexico

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
SONORA							
Department of Health							
2 General hospitals	28625	3.3	64096	133.98	442.13	49037	26.80
1 Specialized hospital	12065	109.7	1153	53.02	5816.29	19405	10.60
6 Health Centers	5262	2.7	26364	183.64	495.83	67212	36.73
Mexican Social Insurance Institute							
10 General hospitals	105702	6.8	755862	...	...	...	...
YUCATAN							
Department of Health							
5 General hospitals	138847	10.3	368195	43.26	445.58	15833	...
4 Specialized hospitals	82128	61.8	7823	a)39.20	2422.56	143472	...
14 Health centers with beds	8058	4.7	178566	39.54	185.84	14471	14.48
Mexican Social Insurance Institute							
2 General hospitals	28612	5.8	362188	...	...	...	...

a) For two hospitals only.

TABLE VII

Number and Type of Outpatient Establishments Reporting, Sonora and Yucatan, Mexico

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
SONORA				
Department of Health				
3 General hospitals	3	5	3	3
1 Specialized hospital	1	4	1	1
6 Health centers with beds	6	2	1	2
22 Health centers	22	1	-	-
3 Type A	3	...	3	3
Mexican Social Insurance Institute				
24 Clinic auxiliaries	24	1	5	3
YUCATAN				
Department of Health				
6 General hospitals	6	3	5	4
3 Specialized hospitals	3	3	1	2
1 Health Center A	1	10	1	1
15 Health Centers B	15	2	3	2
23 Rural	23	1	-	-
Mexican Social Insurance Institute				
1 General hospital	1	27	1	1
6 Clinics auxiliaries	6	1	-	-

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Sonora and Yucatan, Mexico

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
SONORA																	
Department of Health																	
3 General hospitals	274145	...	...	77191	-	-	2827	55531	7098	28.2	-	-	1.0	...	...	71.9	9.2
1 Specialized hospt.	500000	1104	2.2	1153	-	-	-	1343	1149	2.3	-	-	-	104.4	-	116.5	99.7
6 Health centers with beds	82175	17834	21.7	26364	28973	18877	42709	5716	4580	32.1	35.3	23.0	52.0	147.8	162.5	21.7	17.4
3 Type A	254927	52043	20.4	65492	-	22139	157058	23486	18101	25.7	-	8.7	61.6	125.8	-	35.9	27.6
22 Health centers	90284	...		7453	21835	9502	38351	-	-	8.3	24.2	10.5	42.5	...	...	-	-
Mexican Social Insurance Institue																	
8 General hospitals	159810	...	...	696677	-	8645	35811	151082	25400	435.9	-	5.4	22.4	...	...	21.7	15.9
24 Auxiliary clinics	...	...	...	217072	-	5413	505	1474	-	...	...	...	...	...	...	0.7	-
YUCATAN																	
Department of Health																	
6 General hospitals	200000	...		368675	...	...	...	78139	10167	184.3	...	...	...	...	...	21.2	2.8
3 Specialized hospts.	...	...		7174	735	-	-	...	...	...	...	...	...	...	...	...	...
1 Health Center A	200000	53547	26.7	61244	-	15748	72480	46304	12728	30.6	--	7.9	36.2	114.4	-	75.6	20.8
15 Health centers with beds	308895	58609	19.0	265234	100628	16152	41451	765	27	85.9	32.6	5.2	13.4	452.5	171.6	1.3	0.0
23 Health centers	73424	25441	34.6	67548	40825	12361	14936	168	-	92.0	55.6	16.8	20.3	265.5	160.4	0.2	-
Mexican Social Insurance Institute																	
1 General hospital	62804	-		361942	-	14211	23075	102935	10422	576.3	-	22.6	36.7	...	...	28.4	2.9
6 Auxiliary clinics	...	-		13502	-	69	179	-	-	...	...	...	...	...	...	-	-

TABLE IX

Personnel in Outpatient Establishments, Sonora and Yucatan, Mexico

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
SONORA													
Department of Health													
2 General hospitals (a)	...	...	...	...	...	...	...	...	...	...	7	75	24
1 Specialized hospital (a)	...	...	...	...	...	...	...	...	...	...	2	18	2
6 Health centers with beds (a)	...	...	...	...	...	...	...	...	...	...	5	84	3
3 Health centers with beds	32	63	6	10-1/2	83	54	1	53	-	29	18	103	2
22 Others	13	15	-	-	44	44	-	44	-	-	31	187	-
Mexican Social Insurance Institute													
8 General hospitals	160	926	...	...	...	...	...	...	...	...	21	32	2
24 Clinics auxiliaries	28	232	1	-	34	27	-	27	-	7	17	16	-
YUCATAN													
Department of Health													
5 General hospitals (a)	...	...	...	...	...	...	...	...	...	...	6	30	2
4 Specialized hospitals (a)	...	...	...	...	...	...	...	...	...	...	4	10	2
1 Health center A	13	40	4	10	69	36	10	26	-	33	13	73	20
14 Health centers B(a)	...	...	...	...	...	...	...	...	...	...	7	31	1
23 Rural	20	28.4	-	-	41	26	-	26	-	15	7	30	-

a) Same personnel as for hospitals.

TABLE IX (Cont.)

Personnel in Outpatient Establishments, Sonora and Yucatan, Mexico

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
YUCATAN (Cont.)													
Mexican Social Insurance Institute													
1 General hospital	...	...	....	...	...	...	...	...	...	...	17	28	3
6 Clinics auxiliaries	7	20.5	-	-	20	9	-	9	-	11	25	83	-

TABLE X

Average Cost per Outpatient Consultation, Sonora and Yucatan, Mexico

Hospital	Mean cost	Median cost
SONORA		
Department of Health		
3 General hospitals	23.40	...
1 Specialized hospital	10.60	...
6 Health Centers with beds	36.73	...
22 Health Centers	11.06	7.80
3 Type A	10.07	5.98
Mexican Social Insurance Institute		
8 General hospitals	...	...
YUCATAN		
Department of Health		
6 General hospitals	...	...
4 Specialized hospitals	...	
1 Health center A	7.55	7.55
14 Health centers B	14.48	...
23 Rural	8.46	30.22
1 General hospital	...	...
Mexican Social Insurance Institute		
6 Clinics auxiliaries	...	...

P A N A M A

I. ORGANIZATION OF MEDICAL SERVICES

1. MINISTRY OF LABOR, SOCIAL WELFARE AND PUBLIC HEALTH

This Ministry was established by Legislative Decree 1 of June 15, 1945, as recorded in Official Gazette 9760 of July 27 of the same year, following a coup d'état that altered the entire Government structure. Prior to that date, Government health activities were supervised by a Ministry of Health and Public Works set up in 1931. Following its convocation, the Constituent Assembly issued Legislative Decree 1 and subsequently Decree 6 of July 6 (appearing in Official Gazette 9763 of July 31, 1945) establishing the ministerial divisions, which included organization of the Ministry of Labor, Social Welfare and Public Health. The pertinent regulations were set forth in National Executive Decree 31 of August 14, 1945, according to Official Gazette 9788 of August 30, 1945. These were later amended and expanded by Law 65 of December 19, 1965, and Law 13 of January 25, 1961 (Official Gazette, issues 13192 of March 11, 1957, and 14338 of February 27, 1961, respectively).

The same Constituent Assembly stipulated in Chapter V, Article 92 of the Constitution that health was the duty of the State and the citizen. This section reads as follows:

Chapter V. PUBLIC HEALTH AND SOCIAL WELFARE

Article 92. The care of public health is an essential function of the State. The individual has a right to protection, preservation and restoration of his health and an obligation to conserve it.

Consequently, the State shall carry out the following main activities:

a) Combat, by means of individual treatment and environmental sanitation, all communicable diseases;

b) Provide maternity protection and reduce child mortality by means of medical care and proper nutrition;

c) Supplement the diet of needy pupils and provide medical supervision for school children;

d) Establish, according to the requirements of each region, hospitals, dental clinics and clinics in which services and medicines are furnished free to the indigent;

e) Publicize systematically the principles of scientific diet, personal hygiene and home sanitation.

The National Assembly shall issue the Health Code. (50)

The duties of the Ministry of Labor, Social Welfare and Public Health are:

I. Organization, direction and supervision of social welfare and assistance programs (which the Department of Social Welfare establishes).

II. Conciliation of the labor relations governed by the National Constitution and the Labor Code (which the Department of General Board of Labor defines, with the labor courts enjoying legal autonomy).

III. Programming, coordination, and control of all matters relating to public health throughout the country (which is the basis for the operation and expansion of the National Department of Public Health, the largest of the three departments composing the Ministry, which accounts for approximately 83 per cent of the employees and 92.6 per cent of the expenditures of the Ministry in 1964).

The Ministry of Labor, Social Welfare and Public Health is composed of three departments and the Administrative Section. There are two assistant ministers, the Assistant Minister for Public Health and the recently created post of Assistant Minister for Labor and Welfare. This new post is considered to represent a step towards the division of the present Ministry into two new ones, as follows:

a) Ministry of Health
b) Ministry of Labor and Social Welfare

Such a division, along the lines proposed, which is expected to be legally enacted during the 1966 legislative period and to enter into force in 1967, is justified by the enormous expansion of the Department of Public Health.

The following autonomous entities also form part of the ministerial structure:

a) National Welfare Lottery
b) Merchant Marine Commission
c) National Red Cross
d) Superior Labor Court
e) National Minimum Wage Commission
f) National Health Planning Commission

1.1 The National Department of Public Health was set up as an official agency in 1925 by Law 12 of January 17 of that year. At that time, it was divided into two institutions:

a) Department of Hygiene and Public Health
b) Department of Child Care and School Hygiene

Earlier, in the absence of any such organization, the State maintained a health budget for the operation of various health institutions and organizations. For example, as early as 1907, items were allocated to finance medical offieers, pharmacies and hospitals; in 1908, the School of Obstetrics (Decree 58 of December 6) was established, Santo Tomás Hospital (Decree 61 of December 14) was organized and the School of Nursing was opened. In 1917, the National Red Cross was assigned responsibility for child welfare, to which the care of tuberculosis patients was added in 1918. In 1914, the Rockefeller Foundation conducted studies and demonstration projects on the prevention and treatment of hookworm and malaria and suggested the establishment of the first Health Unit in Bejuco.

The first Director of Public Health, Dr. Guillermo García de Paredes, was appointed in 1926 (Decree 30 of May 31). Beginning in the following year, a series of agencies was set up under that department, which formed part of the Ministry of Health and Public Works.

This can be considered to represent the first great stage of Panamanian health activities, in which we might include the entire prerepublican period. Law 50 (Official Gazette 8516 of May 20, 1941) establishing the Department of Public Health was enacted on May 14, 1941. From that date until 1944, a series of supplementary laws gradually provided a solid framework for the Department of Public Health and constituted the second stage in the history of the Panamanian health sector.

The legislation establishing the Ministry of Labor, Social Welfare and Public Health transfers the agencies of the Department of Public Health to that Ministry. A series of decrees and laws have been passed to organize the National Department of Public Health, as follows:

Decree or Law	Official Gazette
Decree 8 (July 13, 1945)	9789 (August 31, 1945)
Decree 810 (June 9, 1945)	9722 (June 9, 1945)
Decree 31 (August 14, 1945)	9788 (August 31, 1945)
Decree 95 (April 27, 1946)	9988 (May 6, 1946)
Law 20 (August 21, 1946)	10093 (September 9, 1946)
Law 66 (November 10, 1947)	10467 (December 6, 1947)
HEALTH CODE (*)	

(*) The organic law of Panamanian health, approved by the Constitutent Assembly jointly with the Labor Code, which also envisages certain aspects of workers' health. The Labor Code is Law 67 of November 11, 1947.

Decree or Law	Official Gazette
Decree Law 1 (June 27, 1949)	10939 (July 6, 1949)
Decree 1136 (November 7, 1951)	11699 (February 4, 1952)
Law 3 (January 16, 1956)	12935 (April 19, 1956)
Decree 104 (January 30, 1956)	13638 (September 11, 1958)
Law 26 (January 29, 1962)	14574 (February 16, 1962)
Decree Law 6 (April 18, 1963)	14868 (May 2, 1963)

These laws and decrees, as well as the successive budget laws, have contributed to the current organization of the National Department of Public Health.

During this period, two regional plans emerged, one covering the western zone (which failed to follow a clearly defined method and lacked any means of implementation) and one for the central region containing a complete scientific method of research and establishing in Panama the first criteria for health indices and levels, based on surveys in the field and an examination of existing health policy. The latter plan was the first to call for administrative decentralization and the integration of preventive and curative services at the local level.

The plan for the central region was followed by the National Public Health Plan as part of the National Economic and Social Development Plan. Some of its proposals, concepts, philosophy and health policy are included in the country's development program.

The National Plan establishes a number of important objectives, including the following:

a) Integration of and development of an integrationist approach by the preventive and curative health services.

b) Effective establishment of the three regional divisions (eastern, central and western).

c) Emphasis on the medico-sanitary areas as the operating framework for national health policy at the local level. Sixteen medico-sanitary or health areas are set up with all the features of an administrative corporation as applied to the field of health. This concentration on the medico-sanitary area is part of the policy of administrative decentralization. (*)

d) Coordination with other health institutes such as IDAAN, the Social Security Fund, private organizations, etc.

(*) The Plan employs the old term "decentralization".

Implementation of the plan was initiated between 1961 and 1962 with the establishment and development of the sixteen medico-sanitary areas and the conversion of Area 5, Penonomé, into a model or pilot area.

The enormous effort under way appears to represent the culmination of this third stage in Panamanian health activities. The fourth stage of progress in this field will be marked by the establishment of the Ministry of Health in 1967 and the affirmation of the policy of coordination established between social security and public health and between the latter and various autonomous agencies and civic organizations engaged in health promotion at the National Conference of the Department of Health and First Congress of the Panamanian Public Health Association.

1.2 The Department of Public Health operates at various national levels to provide advisory services, set standards and health policies and supervise and execute. These national activities are carried out through sections, services and campaigns. In addition, chiefs of these services with the power of decision and experts who have studied planning compose a working group on planning. The sections at the national level are:

Vertical or Special Programs

National Tuberculosis Campaign, which includes the Nicolás A. Solano Hospital

National Malaria Eradication Service

Mental Health Service, which includes the National Psychiatric Hospital

Sanitary Engineering, which covers the subservice of Industrial Health

National Public Health Laboratory

Public Health Veterinary Science

Pharmacy, Drugs and Food

General Programs:

Epidemiology
Nutrition
Maternal, Child and School Health
Nursing
Medical Social Service
Dental Health
Health Education

Programs of Basic Services

Training
Health Reports and Studies (Statistics)
Administration of Medical Care
Designs, Plans and Projects

Programs of Local Services

Eastern Region (with 4 health areas)
Central Region (with 7 health areas)
Western Region (with 5 health areas)

1.3 The regional system is described below:

There is a Regional Medical Director who is assisted by an administrative and supervisory staff. He coordinates the various health areas of his region. The Regional Director meets with the Area Medical Directors to form the Regional Council.

Each health area contains a general hospital composed of a health center (building or services) that forms the operating basis for the area framework and contains its headquarters. This institution is known as the integrated medical center (urban or rural). It is responsible for medical institutions located in the surrounding districts, which are generally health centers that may or may not include a maternity annex (with a limited number of maternity beds) and pediatric station (with a limited number of beds for seriously or "critically" ill children).

A health center may include both a maternity annex and a pediatric station or only one of these services.

Some of these health centers also contain a number of beds for emergency care and serious cases, as for example, Cañazas, San Félix, etc.

There is a transfer system for patients from these health centers with a lower service potential to the integrated medical centers.

The personnel are assigned to the area rather than to any specific institution so that they can be moved from one locality to another. This offers an advantage with respect to the medical personnel, since the physician at a peripheral health center can operate at the integrated medical center on certain days while a replacement from the medical center takes over his duties during his absence (the Penonomé model area employs a systematic procedure for such cases).

The health center or integrated medical center is responsible for the health subcenters, which are attended on specific days a stated number of times each month or week by personnel from their parent center. In this instance, the subcenters may or may not employ a nurse or nursing aide with special training on a permanent basis. There are more than 100 such subcenters operating in the country. The best organization of this type is found in the Penonomé Model Area, where there are twenty-three such institutions which are also staffed by midwives trained at the integrated medical center. This organization is outlined on a separate page.

1.4 This point has been discussed under 1.2. It need only be added, that standards have evolved gradually as required, as noted in the preceding points and in the chronological history of Panamanian public health presented separately in the interests of a clearer understanding of the subject. This chronological history, beginning with the prerepublican or colonial period and ending in 1965, provides a sound orientation in this respect. Decisions are generally reached at the monthly meetings (held on the last Tuesday in each month) of sectional and regional chiefs and transmitted to the field for implementation (adoption and adaptation) in each medico-sanitary area. The decisions discussed at the monthly meetings have been studied, analyzed and resolved in advance by the Planning Group that meets every Tuesday morning during the first weeks of the month and on Tuesday afternoon in the last week jointly with the Regional Medical Directors for final adjustment of the decisions.

The foregoing indicates that, in addition to the Health Code and the other special laws in effect on various subjects, a series of technico-executive decisions are gradually introduced and become part of the health structures without the need for special legislation. These are, generally speaking, administrative and technical in nature and are designed to utilize scant available resources as productively as possible to achieve greater efficiency in the supply of services.

This explains why, despite the shortage of resources, performance appears to maintain a high level in most of the institutions closest to the headquarters of the health areas, and how it has been possible to emphasize outpatient care (that is, for the ambulatory or "vertical" patient) as a means of gradually generating more service per unit of monetary value in the future.

The 1964 survey will undoubtedly reveal little of this aspect, for only in that year did it begin to make progress. Most of the Health Committees that are in full operation in 1966 were formed during the last four months of 1964.

This integration of preventive and curative services entails not only coordination between health centers and hospitals, but also the following changes in institutional policies:

a) The hospitals (now integrated medical centers) are not confined solely to in-hospital service; their staffs continue the practice of the health centers by visiting communities that lack medical services.

b) The medical centers now undertake health protection and promotion activities not envisaged previously, such as immunization, environmental sanitation, dental protection, water supply, maternal and child care, school services, etc.

c) In addition to their traditional protective functions, the health centers furnish all types of treatment and rehabilitation services.

d) Emphasis is placed on the vertical or ambulatory patient in order to assist in providing timely health protection, recovery, rehabilitation and promotion as a substantial contribution to the national economic and social development program. This focus on the ambulatory patient is implemented both within the hospital and through a service network or rural subcenters and mobile brigades (PUMAR and traditional services) designed to treat the individual in his own community (whether or not it is easily accessible).

1.5 Aside from the National Health Plan, the planning methods of CENDES are being gradually introduced with a view to revision, amplification, evaluation and the establishment of future national health plans. The Social Security Fund has been taken into account in their preparation and is, as a result, participating in certain programs of institutional reorganization (Amador Guerrero de Colon Integrated Medical Center, Health Area 2; Outpatient Clinic of Santo Tomas Hospital, Health Area 3, etc.) and agreements in force assign to the institutions part of the receipts for care of insured persons, of which 50 per cent is earmarked for a reserve fund to finance remodeling, equipment, etc., and the remainder is forwarded to the medical institutions for the payment of medical fees and medical and nursing personnel, with the balance deposited by these institutions in the Cash Unit of the Internal Revenue Service and of the Office of the Comptroller General of the Republic.

Two further interesting aspects of this service agreement between the Department of Public Health and the Social Security Fund should be pointed out: a) In localities lacking hospitalization facilities and services for insured workers, the health centers furnish these services free of cost to the Social Security Fund, as will be indicated by the

3e survey questionnaires and as revealed by the 3d forms for Santo Tomas Hospital, where the overwhelming majority of patients are social welfare cases, and b) there is a solid mutual understanding between the Director of Public Health and the Medical Director of the Social Security Fund, who meet periodically; this human factor is of particular value in the development of coordination between the two institutions.

The 1962-1970 National Public Health Plan is, as noted, an integral part of the National Economic and Social Development Plan.

Owing to this change in the country's health policy, in filling out the survey questionnaires, forms 2a and 2b have been completed for all integrated medical centers (institutions equipped with beds, as designated by the survey), since form 2a does not contain items 8a, 8c, 8d, 8e, 9a, 9b, 9c, or 6. For the same reason, it was necessary to include the receipts and expenditures (for form 3a) for the Health Committees and PUMAR; this revenue is derived from the community and utilized for various types of service improvements. PUMAR, for its part, received a contribution of 57,228.06 balboas in 1964 in medicines, per diems and salaries; since no breakdown is available for this amount, it was not itemized under each beneficiary institution.

It is also apparent that outpatient services and expenditures greatly exceed what can be ascertained by the SIES unitary system of data recording and processing. This explains why these items fail to coincide with total expenditures in form 3c. Form 3c has utilized the information available from the IBM equipment of the Health Reports and Studies Service. In the case of the Amador Guerrero IMC, it was decided to furnish outpatient data as well, since very scant information was supplied on expenditures owing to internal situations created by the reorganization of that institution.

For this reason, forms 3d and 3e of the survey asked whether the subject had social security coverage or not, and, to assist the tabulating personnel in Washington, an attempt was made to ascertain, insofar as possible, the distance in kilometers from the home to the institution.

1.6 As indicated in the preceding points, the programs and budget are formulated by a process that is initiated in each institution; they are then reviewed by the Planning Group and transmitted to the General Health Bureau. The proposed budget is also submitted on the ministerial level, where it is reviewed and adjusted to the amount proposed by the Budget Office of the General Bureau of Planning and Administration under the Office of the President of the Republic, which makes the final alterations and adjustments prior to its presentation to the National Assembly. The budget is then amended in a caucus of the Assembly Budget Committee during a preliminary discussion and again modified at a plenary session of the Assembly; finally, it emerges from a third debate as an organic law of the Republic, subject to the approval or veto of the President.

The budgets for public health alone between 1960 and 1966 were as follows:

Year	Balboas
1966	9 492 693
1965	11 055 613
1964	11 134 363
1963	8 982 578
1962	8 190 718
1961	10 449 896
1960	10 241 315

However, actual expenditures from this budget for 1963 and 1964 were:

Year	Expended
1964	11 665 906.95
1963	12 407 839.21

The above data reveal an important fact, for, despite indications, many sections failed to absorb more than 90 percent of the budget and some accounted for barely 40 percent in those years, which means that the increase over and above the budgeted level was used to pay off arrears of earlier debts.

There are no rules for personnel appointments, except for the offices covered by the administrative career system, which employ a selection procedure based on academic requirements and previous experience, submitting a list of three candidates from which one is chosen by the Minister and the President of the Republic.

The technical and professional staff not governed by the administrative career system is selected pursuant to an informal agreement between the Ministry and the General Bureau of Public Health, which makes the recommendation.

Personnel administration is the responsibility of the General Bureau of Public Health, which delegates this function to each agency. In certain instances, transfers and other movements of personnel can be arranged by the decision or at the request of the ministerial level, which also maintains the personnel office.

The removal of career personnel is subject to a procedure or process that requires a legal review and a ruling by the Personnel Bureau of the Office of the President of the Republic prior to dismissal. Any removal that fails to follow this judicial process is illegal and the staff member is allowed time to report the illegality and to pursue the process of reconsideration. An employee whose illegal dismissal is proved is restored to his post and is entitled to receive payment of his full salary for the period covered by his illegal removal.

There is no restriction on the dismissal of the rest of the personnel.

Although the Health Code stipulates the salary scale for health personnel, together with certain staff standards, this section is not in force.

About 40 percent of all health personnel is covered by the administrative career system. Furthermore, since 1961, a tacit moral agreement has existed with respect to the tenure of health professionals, which has made recent significant progress possible without necessarily entailing protective legislation. Professional respect and dignity have been greatly reinforced since 1961.

2. SOCIAL SECURITY FUND OF PANAMA

a. Legal Provisions

The Social Security Fund of Panama was established by Law 23 of March 21, 1941, exactly twenty-five years ago. This law was far from perfect and contained serious technical defects, but it did at least have the special merit of being the legal instrument that created the executive body of the Panamanian social security system.

Two years later, based on the experience acquired, Law 134 of April 27, 1943, which made substantial changes in the system, was enacted. Law 23 of 1941 was applicable to only a limited geographic area, for although it provided compulsory coverage for all public employees of the State, the provinces, the municipalities and the autonomous and semi-autonomous public agencies, coverage for employees of the private sector was confined to the districts of Panama and Colon and did not extend to the rest of the national territory.

Law 134 of 1943 extended illness, maternity, disability, old age and death benefits, as stipulated by Law 23 of 1941, to include the entire national territory, through a system of progressive incorporation of districts. The financing system was reorganized on a more technical basis and benefits were defined more specifically.

Law 134 of 1943 remained in effect for a period of ten years. In 1954, the enactment of Decree Law 14 of August 27 gave a new direction to the Panamanian system of social security. Compulsory enrollment of resident workers was extended to new districts, the system of voluntary insurance was refined, the possibility of subscribing to additional, optional insurance was introduced, minimum pensions were set up and a different method of calculating them adopted, alterations were made in the administrative mechanism, etc.

Subsequently, Law 19 of January 29, 1958, introduced another series of amendments, particularly in connection with the administrative activities of the Insurance Fund, as well as in the financial system.

However, the most substantial and revolutionary reforms undertaken in the system are contained in Decree Law 9 of August 1, 1962, and Law 81 of November 29, 1963.

These changes extended medical care and pharmaceutical services to the wife and children of the beneficiaries; set up a cash subsidy in cases of illness; reduced the contribution period required for old age pension eligibility; increased the amount of minimum and maximum old age and disability pensions; provided broader and more generous death benefits by establishing, in addition to the funeral grants already stipulated, widows' and orphans' pensions for the wives and children of beneficiaries, etc.

The system currently offers illness, maternity, disability, old age, widows', orphans' and funeral benefits, pursuant to the provisions of Article 93 of the National Constitution, which serves as its legal basis.

Lay off and family subsidy benefits are provided for in the legislation, but are subject to actuarial studies that have not yet been carried out. Job risks (work accidents and occupational diseases) are not included in the social security system, since they are covered by private insurance companies.

At present, public employees, private workers in the incorporated districts and domestic workers are subject to the compulsory system of social security. The following districts are included: Panama, Colon, David, Boquete, Chitre, Santiago, Aguadulce, Nata, La Chorrera, Las Tablas, Bugaba, Penonome, Boqueron and Alanje. Studies are being conducted with a view to the incorporation of new districts.

The system does not provide coverage for casual or seasonal workers, non-permanent farming operations or foreigners contracted for a period of up to two months, who would otherwise be obligated to join.

Protection is extended to the wife and to children under ten years of age, in addition to the beneficiary himself.

The social security quotas are assigned to each sector as follows: for the beneficiary, 5 percent of his wages; for the employer, 7 percent of the wages paid.

The sickness benefits provided by the Fund include medical care, surgery, pharmaceutical services, dentistry and hospitalization, in addition to a subsidy for temporary disability when the illness incapacitates the beneficiary for work.

Maternity coverage includes prenatal and obstetrical care and a maternity leave grant when a certain number of contributions have been paid during fourteen (14) weeks. An old age and disability pension is also extended and death benefits further include, in addition to the funeral grant, pensions for survivors of the beneficiaries, as already noted.

b. Administrative Organization of Services

The Social Security Fund furnishes medical care to its subscribers at its own installations and at State hospitals or certain private institutions whose services it has contracted.

The installations owned by the system are the General Hospital located in Panama City and outpatient polyclinics in the capital and in each of the agencies in the interior of the Republic.

The medical services are administered by a Medical Director who is appointed by the Director General of Social Security.

The Medical Bureau is divided into three departments which cover outpatient service in the capital, the General Hospital and medical services of the agencies. Each of these departments is headed by a Chief Physician.

The outpatient service in the capital is composed of two polyclinics for adults and one for children, where the beneficiaries and their families come for treatment and consultation.

The General Hospital, with a capacity of 261 beds, is used solely by beneficiaries requiring hospital care, since their families are not eligible for this benefit.

The medical services of the agencies consist of the polyclinics maintained by the social security system in each of its agencies in the provinces, which provide only outpatient care, since patients requiring hospitalization are accommodated in the State hospitals.

c. Budget Preparation and Total

The budget for sickness and maternity benefits is calculated on a basis equivalent to 5.5 percent of aggregate annual wages of the workers paying premiums.

This budget, which includes the items to cover payment of sickness and maternity benefits, has been estimated at ten million, seven hundred and fifty thousand balboas (B/10,750,000) for 1966.

The social security system pays physicians, dentists, nurses and other auxiliary medical personnel salaries comparable to those paid by the Ministry of Labor, Social Welfare and Public Health, since the remuneration received by these professionals is governed by law.

Medical interns and residents are employed full time, while staff physicians are appointed by hours of service and are prohibited from working more than seven (7) or less than two (2) hours a day for the Fund.

In general, vacancies are filled on a competitive basis and appointments are made by the Director General.

Physicians and dentists are granted tenure in their posts upon completing two years of work with the system, as are the nurses, nursing aides and laboratory technicians, who are protected by special laws.

d. Preventive Medicine

The preventive activities of the Social Security Fund are currently confined to vaccinations against diphtheria, tetanus, whooping cough and polyomielitis in the children of beneficiaries under ten years of age and to investigation of the contacts of tuberculosis patients undergoing treatment in this institution.

e. Legal Relations with Other Medical Institutions

The highest administrative organs of the Social Security Fund are the Board of Directors, the organ of deliberation and decision, and the Director General, the organ of administration and execution.

The Board of Directors is composed of the Minister of Labor, Social Welfare and Public Health, who presides; the Manager of the National Bank; the Comptroller General of the Republic; three representatives of management; three representatives of labor, and a physician not employed by the social security system who represents the national medical profession.

The representatives of management, labor, and the medical profession are appointed by the President of the Republic, who selects them from lists of three candidates submitted to him by the respective trade unions or associations.

These appointments, and that of the Director General, require prior confirmation by the National Assembly.

f. Coordination Efforts

Under the terms of an existing agreement between the Social Security Fund and the Ministry of Labor, Social Welfare and Public Health, the Ministry makes available to the beneficiaries the facilities of the State hospitals when they require hospital care. For this service, the Fund pays the Ministry a daily rate for each insured person hospitalized. In almost all of these hospitals, the social security system pays the salaries of certain interns, nurses and any other auxiliary medical personnel required to give insured persons proper medical care.

This agreement also set up a common fund contributed to equally by both institutions which is used to improve the installations of the State hospitals used by the insured workers. The fund is administered by the social security system and all purchases of equipment or repair of buildings must be approved by both parties.

g. Availability of Services

Not all insured workers have access to the medical services furnished by the Social Security Fund, since many of them live in areas where no Fund installations are available.

In regions where State hospitals are located, insured workers utilize those facilities when hospital care becomes necessary. The social security system pays the State a daily quota for the use of these installations and the salary of the attending physicians.

In areas where social security outpatient clinics are lacking, the State physician employed by the Health Units of the Ministry is paid an additional stipend for attending to the insured patients residing in those localities.

REGIONAL LEVEL

This comprises three great regions: Eastern, Central and Western.

The Eastern Region is composed of the Provinces of Panama, Darien and Colon and is divided into four health areas: DARIEN HEALTH AREA, comprising the Urban Integrated Medical Center of San Jose, La Palma, the Rural Integrated Medical Center of El Real and the Darien Mobile Brigade; COLON HEALTH AREA, composed of the Integrated Medico-Sanitary Center of Colon, the Nargana Mobile Brigade, the Acquatic Mobile Brigade (North Coast) and the Department of Sanitation and Waste Collection and Disposal; PANAMA HEALTH AREA, including Santo Tomas Hospital, the Emiliano Ponce Integrated Medico-Sanitary Center and the Health Centers of Juan Diaz, el Chorrillo, Pueblo Nuevo, Rio Abajo and Chepo; LA CHORRERA HEALTH AREA, comprising the La Chorrera Health and Training Center, the Chame and San Carlos Health Centers and Maternity Annexes and the Health Centers of Arraijan and Capira.

The Central Region is composed of the Provinces of Cocle, Herrera, Los Santos and Veraguas and is divided into 7 health areas: PENONOME HEALTH AREA, including the Aquilino Tejeira Urban Integrated Medical Center, the Health Center and Pediatric Station of El Valle, the Health Center and Pediatric and Maternity Units of Anton, and the La Pintada Health Center; AGUADULCE HEALTH AREA, composed of the Marcos Robles Urban Integrated Medical Center, the Nata Health Center and Pediatric Station and the Aristides Vallester Health Center and Pediatric Station; CHITRE HEALTH AREA, covering the Cecilio Castillero Urban Integrated Medical Center, the Health Center and Pediatric Station of Santa Maria, the Herrera Mobile Brigade and the Antituberculosis Clinic of Chitre; LOS SANTOS HEALTH AREA, constituted by the San Juan de Dios Urban Medical Center and the Macaracas Rural Integrated Medical Center; SANTIAGO HEALTH AREA, comprising the Santiago Urban Integrated Medical Center, the Cañazas Rural Integrated Medical Center, the Santa Fe Health Center, the Antituberculosis Clinic of Santiago, and the Health Center and Pediatric and Maternity Units of La Mesa; LAS TABLAS HEALTH AREA, including the Gerardino de Leon Urban Integrated Medical Center and the Health Centers of Tonosi, Pedasi, Guarare and Paritilla; SONA HEALTH AREA, composed of the Ezequiel Abadia Urban Integrated Medical Center.

The Western Region consists of the Provinces of Chiriqui and Bocas del Toro and is divided into five health areas: DAVID HEALTH AREA, containing the Jose D. de Obaldia Hospital, the David Health Center and Mobile Brigade, the David Antituberculosis Clinic and the Boquete Health Center; SAN FELIX HEALTH AREA, which includes the San Felix Health Center and Pediatric and Maternity Units, the Remedios Health Center and the Tole Health Center; BARU HEALTH AREA, consisting of the Health Center of Puerto Armuelles; BUGABA HEALTH AREA, which includes the La Concepcion and Aserrio Health Centers; BOCAS DEL TORO HEALTH AREA, constituted by the Bocas del Toro Integrated Medical Center.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Panama, 1964

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days (a)	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
Ministry - Total	1 185 000	1 683	82 831	516 794	586 096	1.4	69.9	436.1	494.6
13 General hospitals	1 185 000	1 645	81 999	515 130	536 742	1.4	69.2	434.7	452.9
6 Health centers	91 870	38	832	1 664	49 354	0.4	9.1	18.1	537.2
Social Security									
1 General hospital	70 272	261	7 218	66 418	18 672	3.7	102.7	945.2	265.7
Ministry									
Santo Tomas	...	778	35 568	247 687	300 633	...	...	...	...

a) Census days

TABLE II

Indices of Hospital Utilization, Panama, 1964

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate
Ministry - Total	6.2	49.2	83.9
13 General hospitals	6.3	49.8	85.6
6 Health Centers	2.0	21.9	12.0
Social Security			
1 General hospital	9.2	27.7	69.5
Ministry			
Santo Tomas	7.0	45.7	87.0

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Panama, 1964

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Ministry - Total	255	205	1 807	990	350	584	56	164	663	14.7	11.8	104.9	57.2	20.2	9.5	38.3
13 General hospitals	248	198	1 701	937	336	549	52	147	a)617	14.6	11.6	100.0	55.1	19.8	8.6	36.3
6 Health centers	7	7	116	53	14	35	4	17	46	22.6	22.6	374.2	171.0	45.2	54.8	148.4
Social Security																
1 General hospital	114	86	526	225	84	126	15	35	266	59.4	44.8	274.0	117.2	43.7	18.2	138.5
Ministry																
Santo Tomas	145	106	869	538	197	300	41	39	a)292	17.2	12.6	103.3	64.0	23.4	4.6	34.7

(a) "Other" personnel at St. Tomas estimated from ratio of "other" personnel to beds in remaining hospitals of Ministry.

TABLE IV

Ratios on Distribution of Hospital Personnel, Panama, 1964

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Ministry - Total	1.4	1.7	3.9	4.8	1.7	a) 48	68
13 General hospitals	1.4	1.7	3.8	4.7	1.6	b) 44	68
6 Health centers	2.0	2.0	7.6	7.6	2.5	69	63
Social Security							
1 General hospital	0.7	1.0	2.0	2.6	1.5	100	58
Ministry of Health							
Santo Tomas	1.4	1.9	3.7	5.1	1.5	...	71

(a) Based on 6 hospitals and 6 health centers. (b) Based on 6 hospitals. (1) Based on total physicians. (2) Based on total physician hours divided by six.

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Panama, 1964

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Ministry - Total	31	195	69
13 General hospitals	30	188	67
6 Health centers	76	583	154
Social Security			
1 General hospital	114	399	149
Ministry			
Santo Tomas	32	218	80

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Panama, 1964

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Ministry - Total	516 794	6.2	586 096	7.86	48.73	2 877	1.77
13 General hospitals	515 130	6.3	536 742	7.83	49.33	2 866	1.65
6 Health centers	1 664	2.0	49 354	15.17	30.34	5 552	3.19
Social Security							
1 General hospital	66 418	9.2	18 672	30.74	282.81	11 251	6.15
Ministry							
Santo Tomas	247 687	7.0	300 633	9.99	69.93	3 656	1.99

TABLE VII

Number and Type of Outpatient Establishments Reporting, Panama, 1964

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry of Health				
General hospitals	13	4	11	7
Health centers with beds	7	2	6	-
Health centers	24	1	14	-
School clinic	2	1	-	-
Mobile units	2	-	-	-
Social Security				
General hospital	1	...	1	1
Outpatient clinics	13	3	10	4

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Panama, 1964

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations				
				Medical	Other					Medical	Other			Medical	Other	Laboratory exams	X-ray
Ministry of Health																	
13 General hospitals	1 185 000	195 594	16.5	541 826	88 483	3 268	80 281	388 619	19 250	45.7	7.5	0.3	6.8	277.0	45.2	71.7	3.6
7 Health centers with beds	97 260	26 948	27.7	52 422	9 334	2 501	31 225	52 295	-	53.9	9.6	3.6	32.1	194.5	34.6	99.8	-
20 Health centers	350 682	71 699	20.4	117 177	49 131	18 633	96 431	33 342	1 907	33.4	14.0	5.3	27.5	163.4	68.5	28.5	1.6
1 School Clinic	36 982	2 294	6.2	5 140	839	12	3 384	-	-	13.9	2.3	0.0	9.2	224.1	36.6	-	-
1 Mobile unit	20 760	1 191	5.7	1 853	...	...	1 886	450	-	8.9	...	...	9.1	155.6	...	24.3	-
Social Security																	
General hospital	70 272	...	...	18 672	...	...	...	...	...	26.6	...	...	...	...	...	...	...
Outpatient clinics	132 675	...	...	625 048	165 601	-	-	442 347	38 029	471.1	124.8	-	-	...	...	70.8	6.1

TABLE IX

Personnel in Outpatient Establishments, Panama, 1964

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Ministry of Health													
13 General hospitals(a)	...	...	...	...	...	...	...	...	...	...	6	38	13
6 Health centers with beds (a)	...	...	...	...	...	...	...	...	...	...	15	116	31
23 Health centers	30	171	10	17	379	118	44	71	3	261	19	69	26
2 School clinics	-	-	2	4	5	4	2	2	-	1	24	14	7
1 Mobile unit	1	8	-	-	13	11	-	11	-	2	67	742	-
Social Security													
1 General hospital(a)	...	...	...	...	...	...	...	...	...	...	23	80	30
13 Outpatient clinics	176	727	27	95	583	171	44	127	-	412	21	27	7

(a) Personnel included in hospital data.

TABLE X

Average Cost per Outpatient Consultation, Panama, 1964

Hospital	Mean cost	Median cost
Ministry of Health		
13 General hospitals	1.65	1.46
7 Health centers with beds	3.29	3.76
21 Health centers	2.23	2.93
2 School clinics	0.92	0.96
1 Mobile unit	5.56	5.56
Social Security		
1 General hospital	6.15	6.15
13 Outpatient clinics	3.26	2.69

P E R U

I. ORGANIZATION OF THE MEDICAL SERVICES

1. Administrative Structure of the Ministry of Public Health and Welfare at the central, regional and local levels

The Ministry of Public Health and Welfare is the executive body representing the State which is responsible for the protection of the public and private health of the Peruvian people. In this capacity it exercises regulatory and executive functions in protecting, promoting and restoring health. The organizational structure of the Ministry of Public Health and Welfare envisages two basic levels of operation: the central and the peripheral.

The central organization has directive, regulatory, advisory and coordinating functions. It also operates at two levels:

1. The Office of the Minister, as the directing organ, implements the national health policy of the Government, regulating and coordinating health activities carried on by all of the public and private bodies in the health sector.

2. The Office of the Director General of Health, as the highest body responsible for maintaining unified technical and administrative operations, and for programs, organizes, directs, coordinates, advises, supervises and controls the activities of the Ministry of Public Health and Social Welfare. It has the following organizational divisions as advisory and/or auxiliary bodies:

2.1 The Bureau of Standards and Supervision
2.2 The Bureau of Personnel
2.3 The Bureau of Finance
2.4 The Bureau of Feeding Programs
2.5 The Bureau of Pharmacy
2.6 The Sectoral Office for Health Planning (as the programming office of the Ministry of Public Health and Welfare)
2.7 The Office of the Legal Adviser
2.8 The Office of Health and International Relations
2.9 The Institute of Occupational Health

The peripheral executive bodies consist of the Health Areas, as the agencies responsible for carrying on integrated activities to promote, protect and restore health in a given region of the country. These activities, including that of rehabilitation, are carried on, under a decentralized system, in accordance with the respective programs, and under the executive direction of the Health Units at the local level,

with coordination, advisory services and supervision on a regional basis by the offices of the heads of the Health Areas. There are also two levels under this system:

1. The regional level, consisting of the offices of the heads of the Health Areas, as the bodies providing direction, coordination, supervision, advisory services and control of the executive services. The technical and administrative staff for providing such advice, supervision and control of operations are at this level.

2. The local level, consisting of the Health Units into which the various Health Areas are divided, and which group the executive agencies of a given geographic area directly under a single technical and administrative staff. The Health Unit comprises the following entities:

2.1 Health Center Hospitals
2.2 General and Specialized Hospitals
2.3 Health Centers
2.4 Medical Stations
2.5 Health Posts
2.6 Other health and welfare services.

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Constitutional or legal responsibility for the formulation of standards and regulations, coordination and supervision of the operation of the services and supervision of technical personnel at the different levels

1. The State is responsible under the Constitution for protecting the health of the Peruvian people. As an agency of the executive branch, the Ministry of Public Health is responsible for carrying out these functions and, as such, it is empowered to formulate regulations and standards for both public and private services. To assure better coordination of these activities, the National Health Council, composed of heads of the principal agencies responsible for health services and representatives of private medical practice and of the medical schools and associations, functions at the sectoral level.

In formulating the appropriate standards and regulations the following procedure is employed: An advisory group in the Bureau of Standards and Supervision prepares all of the necessary studies and proposed their adoption through the Office of the Director General of Health; at the regional

level of the Health Areas, the technical staff in the specific fields adapts the regulations and standards developed at the national level to the special conditions existing in the respective area.

2. Coordination is effected at various levels:

2.1 On a sectoral basis activities are coordinated at the level of the Office of the Minister.

2.2 On a sectoral basis, but with regard to technical matters, coordination is effected by the Sectoral Office for Health Planning.

2.3 On the institutional basis, within the Ministry of Public Health and Welfare, coordination is effected by the Office of the Director General of Health.

2.4 At the regional level both internal and external coordination with other institutions, related in one way or another with health activities, is effected by the Office of the Chief of the Health Area.

2.5 At the local level, the Office of the Chief of the Health Unit is responsible for coordination.

3. The Office of the Director General of Health supervises the services at the national level through the technical staff of the Bureau of Standards and Supervision with regard to the technical aspects of the specific fields, and through the staff of the other Bureaus with regard to the specialized functions, such as administration, with coordination at the national level in each case.

Technical specialists at the level of the Area Office carry on the more specific supervision of the local health services through the functional staff of that Office.

At the local level the immediate chief of the local institution supervises all activities and personnel.

Health Plans

The National Health Plan, 1966-1970, now in effect, was completed in 1965 in advance of the National Economic and Social Development Plan, the methodology used being that developed by CENDES-WHO.

At the present time, the diagnostic phase has been completed within the context of the latter, and a National Health Plan as an integral part of the National Economic and Social Development is now being prepared. This plan will enter into effect in 1967, and will take into consideration the entire health sector including the social security agencies.

General data on methods employed in the preparation of the plan and budget

The methodology developed by CENDES-WHO were utilized in preparing the National Health Plan, with the participation of the staff at all organizational levels of the Ministry of Public Health and Welfare. The public sector programming method is being used in preparing the sectoral plan for the health sector as a part of the Development Plan, with the participation of the programming offices of the sector, coordinated at the sectoral level by the Sectoral Office for Health Planning, and at the national level by the National Planning Institute. The technique of the functional budget, or program budget, related to the targets established in the Plan, is being used in preparing the budget.

With regard to personnel administration, decentralization of the executive activities has begun, with the regulatory and general coordination functions remaining centralized. A complete personnel administration system is now in process of being installed.

2. The National Social Insurance Fund

On August 12, 1936, Major General Oscar R. Benavides, then President of Peru, promulgated Law 8433 which gave effect to a group of legislative provisions establishing the right of the worker to certain protection against specified risks. In other words, this law marked the inauguration of the era of compulsory social insurance in Peru that is identified with the Worker' Social Insurance Plan and its governing body, the National Social Insurance Fund.

Laws 8505 and 11321 were subsequently promulgated, the appropriate regulations issued thereunder, and through a process of improving, expanding and up-dating, the original law was supplemented by various legal instruments that gave the social security system, in general, and the Workers' Social Insurance Plan, in particular, their present scope and content.

On February 10, 1941, four and a half years after the enactment of the law creating the Workers' Social Insurance Plan, and when the basic phase of organization, construction and equipping of the first Medical Care Centers under the Workers' Social Insurance Plan had been completed, direct benefits became available to the insured workers with the simultaneous

inauguration of Workers' Hospitals in Lima and Ica. This was followed in rapid and regular succession by the opening of other hospitals and workers' clinics, as shown in the following table:

		Date of Opening	Number of beds
1	Lima	February 10, 1941	894
2.	Ica	February 10, 1941	159
3.	Callao (Polyclinic)	October 7, 1941	26
4.	Huacho	November 30, 1941	251
5.	Chiclayo	January 2, 1943	224
6	Chocope	November 27, 1943	137
7.	Pisco (Polyclinic)	June 5, 1944	-
8.	Arequipa	November 11, 1944	144
9	Chincha	October 13, 1946	106
10	Cañete	July 19, 1948	102
11.	Trujillo	January 20, 1951	98
12	Piura	August 3, 1951	140
13	La Oroya	June 8, 1953	157
14.	Cerro de Pasco	March 8, 1958	33
15	Huariaca	March 9, 1958	157
16	Polyclinic No 1, Lima	- -	-
17.	Chimbote	August 12, 1963	140
		Total	2,767

Given the existing conditions with regard to hospital services in the country at the time the Workers' Social Insurance Plan began to operate, it was absolutely essential that the institution have its own medical centers. Establishment of these centers without any doubt marked the beginning of the era of scientific hospital care in our country. For the first time the country had hospitals that were not merely reduced to the institutionalization of the sick, but real medical care centers that had as their mission the bringing together of a staff capable of providing complete medical services of the highest quality.

The example provided by the National Social Insurance Fund, the advances in the field of medicine, and the accelerated development of social consciousness have been reflected in an evident improvement in the quality of hospital care in our country. As a result, the NSIF policy of building its own Medical Centers -an essential requirement thirty years ago- has now been superseded that of utilizing health resources of all types available in the country in a systematic and coordinated manner. This explains why the National Workers' Social Insurance Fund has directed its medical policy along the lines of contracting for health services with medical centers of the Central Government, of other agencies in the sub-sector of autonomous governmental bodies, and of the private sector, whenever the full utilization of existing capacity does not justify the construction of new buildings.

Risks Covered

Workers' Social Insurance, since its institution, has covered the risks of sickness, maternity, disability, old-age and death, providing benefits in cash and services for sickness and maternity, pensions for disability and old-age, funeral expenses and cash death benefits to beneficiaries for all of the risks enumerated above. Under the provisions of Law 13640, establishing the Workers' Retirement Fund, all gainfully employed workers are entitled to retirement benefits on reaching age 60. The National Social Insurance Fund also has a program of institutional benefits for its own employees.

Administrative and Financial Organization

The National Social Insurance Fund is one of the agencies comprising the sub-sector of autonomous governmental agencies. Its highest directive body is the Executive Council (Consejo Superior), composed of representives of the government, employers, workers and the School of Medicine. Its principal officers are the General Manager, the Manager and the Director of Health Services (the present title of the General Superintendent of Hospitals).

Its source of funds, as provided by law, is a tripartite system of contributions by the Government, the employers and the workers. In Peru the total contribution amounts to 11 percent of the total payroll, 2 percent being contributed by the Government, 6 percent by the employer, and 3 percent by the worker. This same 11 percent is distributed as follows in the payment of benefits:

Sickness and maternity benefits	6.3 percent
Disability pensions	2.2 percent
Old-age pensions	2.0 percent
Death benefits	0.5 percent

Funds for the Workers' Retirement Plan are provided by a 4 percent tax on workers' payrolls, with the contributions divided equally between the employer and the worker.

Insured Population

At the present time there are 447,427 workers enrolled in the plan as active insured participants, with coverage of sickness and maternity risks. Of this number, the Medical-Care Centers of that institution are providing direct service for 424,395 and contracted services for 23,032. This means that 45.5 percent of the workers in the country are protected by the Workers' Social Insurance Plan against the risks of sickness and maternity. From the standpoint of geographical coverage, this system is in effect in 30.7 percent of the national territory, or 395,54.73 square kilometers out of a total of 1,285,215.6.

The Workers' Retirement Plan covers 562,440 members.

The Workers' Social Insurance Plan has its own services in the provinces of Piura, Paita, Chiclayo, Lambayeque, Ferreñafe, Trujillo, Santa, Chancay, Lima, Cañete, Callao, Chincha, Pisco, Ica, Palpa, Arequipa, Yauli and Cerro de Pasco. It has services under contract in the provinces of Tumbes, Sullano, Cajamarca, Maynas, Huaraz, Leoncio Prado, Huánuco, Ambo, La Merced, Huancayo, Tarma, Tacna, Cuzco, Moquegua (Toquepala), Puno, San Román, Lampa, Carabaya, Azángaro, Sandia and Huancavelica.

Bureau of Health Benefits

This is the body responsible for sub-Section II - Sickness, Maternity and Disability, under the National Social Insurance Fund Budget; it comprises the following three programs:

Program 1.	The Bureau of Health Benefits
Program 2.	Sickness and Maternity Risks
Program 3.	Disability Risks

Through Program No.1 the function of directing the whole sub-section of the Budget is performed: the correct execution of the three programs is guided and channeled; the Functional Budget for Sickness, Maternity, and Disability Risks is adapted and kept up to date; and personnel training is carried on. Through Program No.2 benefits in cash and kind are given to 447,427 active members of the Insurance Fund who are protected against sickness and maternity risks; and through Program No.3 disability pensions are provided for insured persons who have lost two-thirds of their working capacity.

In the Budget by Objectives for 1965, the Health Benefits Bureau will provide the following volume and types of medical care:

Hospitalization	735,530
Visits to clinics	1,119,234
Home visits	35,134
Rural visits	360,470
Pediatric consultations	407,340
Emergency Services	135,012
Dental treatment	538,746

The listed end-results imply, in addition, the provision of the following related and intermediate services, among others:

Physical Medicine services	134,504
Surgical treatment	18,630
Deliveries	5,264
X.ray	142,078
Laboratory analyses	701,772
Prescriptions for medicaments	3,964,148
Meals	2,706,916

In addition to the foregoing services, 144,000,000 soles will be paid in cash sickness benefits, in accordance with the provisions of the Workers' Social Insurance Plan to the effect that benefits will be paid in cash if sickness results in loss of wages on the job. These payments are designed to ameliorate both the physical and economic impact of sickness on the worker and his family.

The operation of Program II involves an average expenditure of 1,670.20 soles for each covered worker. The social importance of this figure can be better appreciated if it is recognized that in a country such as Peru, where the annual per capita income barely amounts to 4,000 soles, it would be virtually impossible for the average agricultural or industrial wage-earner to spend nearly 50 percent of his income to meet the contingencies of sickness. Accordingly, through the application of such eminently objective criteria as these statistics, it can be seen that the Workers' Social Insurance Plan is not only fully justified but is, in fact, carrying out its purposes in the letter and spirit of the law governing social security in Peru. It will further contribute to an understanding of this proposition to remember that in Canada, for example, where the general level of health is one of the highest in the world, 60 percent of the population experiences one or more periods of sickness, averaging 12 days per person, per annum, with an average of five to six medical consultations and two days of hospitalization. In the United States, the annual average of days lost on sick leave for each insured worker is 15 days for severe diseases of the respiratory system. In West Germany, the average expenditure for workers covered by health insurance is 300 RM.

These figures showing what occurs in some of the more advanced countries give an idea of what can, and does, happen in the underdeveloped countries where the conditions of education, food, housing and general living standards give rise to a low level of health, and consequently imply more medical visits, days of hospitalization and loss of work. To fill in this picture, it must be pointed out that in Peru - as is the case with all of Latin America, a region with one of the highest rates of population growth in the world - the currents of internal migration are developing on an erratic pattern, giving rise to a disorderly urban growth, a chaotic depopulation of rural areas and the growth of slums, variously known as "poverty belts", "barriadas", "favelas", "tugurios", "calampas", etc., that spark our health problems.

Short-term accomplishments

As one step to facilitate implementation of its programs, and that reflects an adaptation of the organizational structure to the function to be performed, the Bureau of Health Services has, in 1966, completed the task of institutional reorganization that can be described in a few words but that represents an exceedingly difficult accomplishment:

1 Financial order has been attained, and credit has been restored with the liquidation of all obligations of the various agencies and of the Health Centers that had accumulated over previous fiscal years and that were outstanding as of December 31, 1965.

2. Modernization of the Centers according to a system of priorities has entered the stage of effective accomplishment. Replacement of the vehicle fleet is in the final stages and by means of an effective system of budget control it has been possible to acquire new equipment for the Health Centers. This project will be gradually stepped up in 1966 until this phase of the program has been completed. It is pertinent to note that completion of the task is assured, since in restoring credit it was not necessary to resort to new sources of financing.

3. A program for improved utilization and distribution of funds is now in progress. This will be reflected in opening peripheral health services, especially in metropolitan Lima where new facilities are ready to be inaugurated in the industrial zone of Avenue Argentina. During 1966 other facilities will be installed in the zones of the Capital that have a heavy concentration of workers, thereby alleviating overcrowding at the Lima Workers' Hospital and providing greater flexibility and efficiency in the services.

4. Improvements are being made in the method of supplying the different health centers that will make it possible for them to have the drugs equipment and supplies when needed.

5 The Bureau of Health Services has given special emphasis to the quality of work to be performed by the staff at all levels, which, in final analysis, is reflected in the improved institutional care of the patient. Accordingly, along with new projects for the education and training of the respective staff and the establishment of standards for the work, a program for coordinating and supervising the work, and for its evaluation, is being instituted. As part of the latter activity, a Medical Audit has been set up and will begin to function in 1966. This is the first such activity, not only in our Health Centers, but in the entire country. The establishment of the regional hospital system by the Social Insurance Fund - which is designed to provide adequate institutional care for its patients on a geographical and functional basis - has been instituted with the opening of the Regional Hospitals at Chiclayo, in the Northern Area, Oroya, in the Central Area, and Ica in the Southern Area. Gradual implementation of this program will mean that eventually each of these large geographical areas will have self-sufficient institutions available to meet the needs of the insured population for general and specialized health services.

Future Plans

The Bureau of Health Services is planning a gradual expansion in coverage for the working population, on both a territorial and a demographic basis, by means of a systematic and coordinated utilization of the country's health resources. At the same time, it is taking the appropriate preliminary steps that will facilitate planning, developing and carrying on a program that will make maximum use of the advances in medical care and restorative medicine, integrating them with the needs of preventive and social medicine.

In order to carry out a program of this nature, all sectors of the population must have a full and clear understanding of the fact that any talk of good and cheap medicine is illusory, that resources devoted to health activities are productive resources and that money invested in such health resources will yield returns equal to or greater than that invested in those activities that are customarily considered as the most productive. Programs to promote and improve health constitute one of the most vital elements of infrastructure. Their importance is reflected, and can be measured, not only in the strictly economic field but in the broader field of socio-economic activity. A sick country is a country without a high-quality labor force. No one can expect that the great effort implied in the "take-off" operation that is to lift Peru from its present position of a country in process of development to that of an advanced country -the goal and the hope of all Peruvians- can be accomplished with inadequate tools, such as a population that does not enjoy a state of general good health.

TABLE I

Number of Hospitals and Hospital Beds with Rates per 1,000 Population, Peru, 1964

Hospitals or group of hospitals	Population covered	Number				Rate per 1,000 population			
		Beds	Discharges	Patient days	Outpatient consultations	Beds	Discharges	Patient days	Outpatient consultations
.nistry									
5 General hospitals	913,951	1,320	19,738	438,486	182,167	1.4	21.6	479.8	199.3
24 Hospital-Health Centers	2,297,654	3,197	39,795	530,962	372,983	1.4	17.3	231.1	162.3
16 Medical Posts with beds	279,177	123	929	4,324	36,321	0.4	3.3	15.5	130.1
10 Specialized hospitals	...	2,560	5,630	838,118	192,346	...	...	...	...
aritable Institutions									
6 General hospitals	745,357	634	21,402	268,573	12,602	0.9	28.7	360.3	16.9
1 Specialized hospital	2,078,574	1,150	314	431,922	8,940	0.6	0.2	207.8	4.3
tional Social Insurance und									
14 General hospitals	418,747	2,610	48,626	725,286	1,723,911	6.2	116.1	1,732.0	4,116.8
laried Employees' Social nsurance									
2 General hospitals	340,790	1,007	25,605	311,794	647,566	3.0	75.1	914.9	1,900.2

TABLE II

Indices of Hospital Utilization, Peru, 1964

Hospitals or group of hospitals	Average length of stay	Turnover rate	Occupancy rate (a)
Ministry			
11 General hospitals	12.7	27.2	94.2
29 Hospital-Health Centers	12.9	13.4	47.1
19 Medical Posts with beds	4.8	8.6	11.4
10 Specialized hospitals	148.9	2.2	89.5
Charitable Institutions			
6 General hospitals	12.5	33.8	115.7
1 Specialized hospital	1,375.5	0.3	102.6
National Social Insurance Fund			
15 General hospitals	15.2	18.1	75.1
Salaried Employees' Social Insurance			
2 General hospitals	12.2	25.4	84.6

(a) Based on discharge days.

TABLE III

Hospital Personnel with Ratios per 100 Occupied Beds, Peru, 1964

Hospitals or group of hospitals	Number									Ratio per 100 occupied beds						
	Physicians		Total excluding physicians	Nursing personnel				Other medical care personnel	Other	Physicians		Total excluding physicians	Nursing personnel		Other medical care	Other
	Total	Full time		Total	Nurses	Auxiliaries	Midwives			Total	Full Time		Total	Nurses		
Ministry																
11 General hospitals	394	267	3,217	1,743	369	1,197	177	154	1,320	12.2	8.3	99.9	54.1	11.5	4.8	41.0
28 Hospitals - Health centers	366	280	3,808	1,317	267	997	53	207	2,284	21.2	16.2	220.1	76.1	15.4	12.0	132.0
19 Medical Posts with beds	18	17	102	53	4	42	7	2	47	40.0	37.8	226.7	117.8	8.9	4.4	104.4
10 Specialized hospitals	154	154	1,607	639	257	376	6	100	868	6.4	6.4	67.1	26.1	10.7	4.2	36.2
Charitable institutions																
5 General hospitals	17	9	188	69	20	48	1	6	113	2.8	1.5	30.9	11.3	3.3	1.0	18.6
1 Specialized hospital	43	25	680	408	73	335	-	17	255	3.6	2.1	57.4	34.4	6.2	1.4	21.6
National Social Insurance Fund																
15 General hospitals	606	...	4,307	1,718	486	1,181	52	a) 171	2,418	20.0	...	142.4	56.8	16.0	5.7	80.0
Salaried Employees' Social Insurance																
2 General hospitals	354	354	3,419	1,315	516	674	125	289	1,815	29.4	29.4	283.5	109.0	42.8	24.0	150.5

(a) Excludes 41 dentists for whom hours were not given.

TABLE IV

Ratios on Distribution of Hospital Personnel, Peru, 1964

Hospitals or group of hospitals	Ratios					Percent of nursing auxiliaries trained	Percent of personnel in medical care
	Nurses to physicians		Nursing personnel to physicians		Auxiliaries to nurses		
	(1)	(2)	(1)	(2)			
Ministry							
11 General hospitals	0.9	1.4	4.4	6.5	3.2	...	63
28 Hospital-Health centers	0.7	1.0	3.6	4.7	3.7	...	45
20 Medical Posts with beds	0.2	0.2	2.9	3.1	10.5	...	61
10 Specialized hospitals	1.7	1.7	4.1	4.1	1.5	...	51
Charitable institutions							
5 General hospitals	1.2	2.2	4.1	7.7	2.4	...	45
1 Specialized hospital	1.7	2.9	9.5	16.3	4.6	...	65
National Social Insurance Fund							
15 General hospitals	0.8	...	2.8	...	2.4	40.4	51
Salaried Employees' Social Insurance							
2 General hospitals	1.5	1.5	3.7	3.7	1.3	100.0	52

(1) Based on total physicians. (2) Based on total physician hours per day divided by six.

TABLE V

Physician and Nursing Time* (Minutes) per Day per Occupied Bed, Peru, 1964

Hospitals or group of hospitals	Physicians	Nursing Personnel	
		Total	Nurses
Ministry			
General hospitals	30	184	39
Hospital-Health centers	58	259	53
Medical Posts with beds	136	401	30
Specialized hospitals	23	91	37
Charitable Institutions			
General hospitals	5	39	11
Specialized hospitals	8	117	21
National Social Insurance Fund			
General hospital	...	194	55
Salaried Employees' Social Insurance			
General hospitals	106	372	142

TABLE VI

Costs of Hospitalization and Outpatient Consultations, Peru, 1964

Hospitals or group of hospitals	Patient days	Average length of stay	Outpatient consultations	Cost (national currency)			
				Per patient day	Per hospital stay	Per occupied bed year	Per outpatient consultation
Ministry							
11 General hospitals	1,057,102	12.7	607,545	106.67	1,354.71	39,041	85.59
25 Hospital-Health Centers	522,277	12.9	403,520	76.21	983.11	27,893	191.6
18 Medical Posts with beds	6,192	4.8	51,216	32.05	153.84	11,730.30	53.75
10 Specialized hospitals	838,118	148.9	192,346	108.44	16,146.72	39,689	...
Charitable Institutions							
4 General hospitals	206,776	13.7	12,602	29.85	408.95	10.925	...
1 Specialized hospital	431,922	1,375.5	8,940	61.30	84,318.15	22,436	...
National Social Insurance Fund							
15 General hospitals	760,880	15.2	1,729,468	a)303.84	4,618.37	111,205	60.77
Salaried Employees' Social Insurance							
1 General hospital	282,870	12.3	547,092	456.50	5,614.95	167,079	160.20

(a) Assuming cost of 5 outpatient consultations is equivalent to one patient day.

TABLE VII

Number and Type of Outpatient Establishments Reporting, Peru, 1964

Hospital	Total	Median number of examining rooms	Number with laboratory facilities	Number with X-ray facilities
Ministry of Health				
General Hospitals	11	...	a) 7	6
Hospital-Health Center	26	...	b) 22	21
Medical Posts with beds	20	...	c) -	-
Specialized hospitals	7	...	d) 2	2
Medical Posts without beds	12	...	e) -	-
Health Centers	21	...	f) 5	4
"Consolidados"	70	...	g) -	-
Charitable Institutions				
General hospitals	3	...	h) 1	1
Specialized hospitals	1	...	1	1
National Social Insurance Fund				
General Hospitals - Worker	15	...	15	15
Outpatient clinic - Worker	1	...	1	1
Salaried Employees' Social Insurance				
General hospitals	2	...	2	2

(a) Of 8 establishments providing this information. (b) Of 23 establishments providing this information. (c) Of 8 establishments providing this information. (d) Of 2 establishments providing this information. (e) Of 9 establishments providing this information. (f) Of 8 establishments providing this information. (g) Of 37 establishments providing this information. (h) Of 2 establishments providing this information.

TABLE VIII

Utilization of Outpatient Establishments and Services Rendered, Peru, 1964

Establishment	Population		Per cent attending	Number						Rate per 100 population				Consultations per 100 attending		Ratio per 100 medical consultations	
	Covered	Attending		Consultations		Home visits	Immunizations	Laboratory exams	X-rays	Consultations		Home visits	Immunizations	Medical	Other	Laboratory exams	X-ray
				Medical	Other					Medical	Other						
Ministry																	
5 General hospitals	913,951	...	...	182,167	...	-	...	...	...	19.9	...	...	...	...	...	...	...
24 Hospital-Health Centers	2,297,654	...	...	372,983	...	-	...	...	...	16.2	...	...	...	...	...	...	...
16 Medical posts with beds	279,177	34,209	12.3	36,321	11,115	...	73,659	...	...	13.0	4.0	...	26.4	106.2	32.5	...	...
10 Specialized hospitals	...	...	...	192,346	...	...	...	...	...	...	...	...	...	...	...	...	...
19 Health centers	727,284	...	...	213,923	15,654	8,858	460,398	2,985	116	29.4	2.2	1.2	63.3	...	...	1.4	0.1
11 Medical posts without beds	163,919	23,961	14.6	30,202	1,691	...	47,612	-	-	18.4	1.0	...	29.0	126.0	7.1	...	...
56 "Consolidados"	675,105	124,910	18.5	141,833	7,488	3,364	310,379	-	-	21.0	1.1	0.5	75.6	113.5	6.0	...	...
Charitable institutions																	
6 General hospitals	745,357	...	...	12,602	...	...	...	...	...	1.7	...	...	...	...	...	...	...
1 Specialized hospital	2,078,574	...	...	8,940	...	...	...	...	...	0.4	...	...	...	...	...	...	...
National Social Insurance Fund																	
14 General hospitals	418,747	...	...	1,723,911	-	36,026	-	670,925	156,102	411.7	-	8.6	-	...	...	38.9	9.1
1 Outpatient clinic	5,648	...	...	31,311	-	169	-	4,477	2,612	554.4	-	3.0	-	...	...	14.3	8.3
Salaried Employees' Social Insurance																	
1 General hospital	310,929	125,454	40.3	547,092	291,209	5,783	29,574	230,211	26,060	176.0	93.7	1.9	9.5	436.1	232.1	42.1	4.8

TABLE IX

Personnel in Outpatient Establishments, Peru, 1964

Hospital	Physicians		Dentists		All other						Medical time per consultation (in minutes)	Nursing time per consultation	
					Total	Nursing				Other			
	Persons	Hours	Persons	Hours		Total	Nurses	Auxiliaries	Midwives			Total	Nurses
Ministry													
General hospitals	-	-	-	-	-	-	-	-	-	-	6		
Hospital-Health Centers	-	-	-	-	-	-	-	-	-	-	12		
Medical Posts with beds	-	-	-	-	-	-	-	-	-	-	27		
Specialized hospitals	-	-	-	-	-	-	-	-	-	-	5		
12 Medical posts without beds	15	59	4	14	55	45	6	34	5	10	37		
20 Health centers	65	249	23	75	315	160	13	137	10	155	18		
70 "Consolidados"	58	217	9	27	171	117	2	103	12	54	27		
National Social Insurance Fund													
General hospitals (a)	-	-	-	-	-	-	-	-	-	-	...		
Outpatient clinics	7	...	1	...	11	9	1	8	-	2	...		
Seguro Social del Empleado	...	761	...	112	-	-	-	-	-	-	21		

(a) Included in hospital

TABLE X

Average Cost per Outpatient Consultation, Peru, 1964

Hospital	Mean cost	Median cost
Ministry		
11 General hospitals	85.59	...
25 Hospital-Health Centers	191.6	...
18 Medical Posts with beds	53.75	...
12 Medical Posts without beds	47.15	43.38
19 Health Centers	84.89	68.32
67 "Consolidados"	44.86	51.61
National Social Insurance Fund		
15 General hospitals	60.77	...
Outpatient clinics	...	...
Salaried Employees' Social Insurance		
1 General hospital	160.20	160.20

V E N E Z U E L A

I. ORGANIZACION DE LOS SERVICIOS MEDICOS

INFORMACION GENERAL

1. Ministerio de Sanidad y Asistencia Social

1.1 Estructura Administrativa de la Autoridad Central. Breve descripción acompañando organograma.

La organización actual del Ministerio de Sanidad y Asistencia Social, responde a una estructuración en trance, que trata de lograr una mayor coordinación de todos sus programas, con fines de alcanzar la integración tanto técnica como administrativa de todas sus dependencias.

Esta organización como puede verse gráficamente, en sus lineamientos generales en los organogramas anexos consta fundamentalmente de cinco (5) Direcciones: Dirección General, Dirección de Salud Pública, Dirección de Malariología y Saneamiento Ambiental, Dirección de Asuntos Sociales y Dirección de Administración.

Dirección General. La Dirección General es un Organismo fundamentalmente ejecutivo. Coordina las funciones de las otras Direcciones y a través de la Oficina de Servicios Regionales de Salud, comanda las acciones técnico-administrativas para la ejecución de los programas a nivel de los Servicios Locales de Salud Pública.

Como toda Dirección tiene funciones de asesoramiento, supervisión y evaluación.

La Dirección General está constituída por las siguientes oficinas:

a) Servicios Regionales de Salud

b) Unidad de Planificación Sectorial

c) Auditoría

d) Salud Pública Internacional

e) Publicaciones, Biblioteca y Archivo

f) Personal

Dirección de Salud Pública. Las funciones de esta Dirección son eminentemente de carácter normativo y se pueden resumir en Coordinación, Asesoramiento, Supervisión y Evaluación de los Programas de Atención Médica que se realizan a nivel de los Servicios Locales de Salud Pública. Desde el punto de vista ejecutivo, realiza programas de investigación, de docencia (Escuelas de Enfermeras) y algunos de tipo vertical, tales como, el de Fiebre Amarilla y Peste, Epidemiología, etc. La Dirección de Salud Pública está constituída por Departamentos y estos a su vez por Divisiones.

Los Departamentos son los siguientes:

a) Departamento de Demografía y Epidemiología, comprende las Divisiones de Epidemiología, Población, Estadística Vital y Fiebre Amarilla y Peste.

b) Departamento Instituto Nacional de Higiene, comprende, el Instituto Nacional de Higiene, División de Laboratorios y el Servicio Nacional de Anatomía Patológica.

c) Departamento de Enfermedades Crónicas e Higiene del Adulto, lo integran las Divisiones de: Tuberculosis y Enfermedades Pulmonares, Enfermedades Cardio-Vasculares, Oncología, Dermatología Sanitaria y Venereología.

d) Departamento de Higiene Materno Infantil, comprende el Instituto Nacional de Puericultura y las Divisiones de Higiene Escolar y Odontología Sanitaria.

e) Departamento de Servicios Médicos Asistenciales, con las Divisiones de Veterinaria de Salud Pública y Enfermería.

f) Departamento de Higiene Mental.

Las Divisiones de Educación Sanitaria y Farmacia y la Sección de Registro de Alimentos, están adscritas directamente a la Dirección de Salud Pública.

Dirección de Malariología y Saneamiento Ambiental. Las funciones de esta Dirección son de tipo normativo y ejecutivo. Planifica, Ejecuta, Coordina, Supervisa y Evalúa los Programas de Erradicación de la Malaria y de Saneamiento Ambiental. Igualmente tiene programas de docencia e investigación.

Está compuesta por las siguientes Divisiones:

a) División de Ingeniería Sanitaria

b) División de Endemias Rurales (Erradicación de Malaria, control de la enfermedad de Chagas y control de otros vectores).

c) División de Anquilostomiasis y otras Helmintiasis

d) División de Acueductos Rurales

e) División de Vivienda Rural

Además de estas Divisiones existen los Servicios Auxiliares Administrativos y la Escuela de Malariología y Saneamiento Ambiental.

Dirección de Asuntos Sociales. Corresponde a esta Dirección las funciones de tipo normativo y ejecutivo en los programas de Acción Social, que se realizan como complemento de los Programas de Prevención, Fomento y Restitución de la Salud. Igualmente existen Programas de Docencia (Escuela Nacional de Servicio Social).

Esta Dirección la integran los siguientes Departamentos y Divisiones:

a) Departamento de Bienestar Familiar, comprende las Divisiones de Trabajo Social y Socio-Económica.

b) Departamento de Desarrollo de la Comunidad, lo integran una División Urbana y otra Rural.

c) División de Socorro y Defensa Civil

d) División de Docencia

Las dos últimas Divisiones están adscritas directamente a la Dirección.

Dirección de Administración. Es una Dirección con funciones de tipo ejecutivo y normativo. Se encarga de velar por la ejecución y control del Presupuesto financiero y actúa como organismo auxiliar de las demás Direcciones en aspectos Administrativo-financieros, como serían adquisición de materiales y equipos, su depósito y suministro a los servicios y realiza algunas acciones de mantenimiento de Edificio y equipos de los Servicios Locales de Salud, así como también la construcción de pequeñas ampliaciones en las edificaciones existentes.

Está constituída por las siguientes Divisiones:

a) Habilitaduría

b) Contabilidad

c) Compras

d) Proveeduría y Transporte

Además tiene un Departamento denominado: Departamento de Servicios Generales que comprende las Divisiones de Arquitectura y Construcciones. (Se anexan Organogramas).

1.2 Estructura de las autoridades intermedias y locales.

Como autoridades intermedias consideramos los Servicios Cooperativos de Salud Pública o Regiones Sanitarias, que representan la autoridad delegada del Ministerio de Sanidad y Asistencia Social y los Ejecutivos Estatales para la administración de la Salud Pública a nivel de los Estados. Dichas Instituciones mantienen una organización compuesta por: Dirección, Secretaría, Consejo Asesor de Salud Pública, Administración Sanitaria, Epidemiología y Estadística Vital, Atención Médica, Sancamiento Ambiental, Asuntos Sociales, Programas Especiales y Servicios Administrativos (Organograma).

Como autoridades locales se tiene: Hospitales, Unidades Sanitarias, Centros de Salud y Medicaturas Rurales. Hospitales, integrados por Dirección, Secretaría, Comisión Técnica, Departamentos Médicos (Medicina, Cirugía, Pediatría, Obstetricia), Servicios Auxiliares de Diagnóstico y Tratamiento, Servicios Técnicos Auxiliares y Servicios Administrativos Operación y Mantenimiento. Las Unidades Sanitarias en general se componen de: Dirección, Secretaría, Epidemiología y Estadística Vital, Higiene Materno Infantil, Venereología, T.B.C. y otras Enfermedades Pulmonares, Odontología Sanitaria, Higiene del Adulto, Dermatología Sanitaria, Veterinaria de Salud Pública, Educación Sanitaria, Penetración Rural, Organización y Desarrollo de la Comunidad, Cardiología, Despistaje Precóz del Cáncer Uterino, Laboratorio etc. Centros de Salud está organizado por: Dirección, Secretaría, Comisión Técnica, Servicios Administrativos, Departamentos Médicos de Restitución de la Salud y Departamentos Médicos de Fomento y Protección de la Salud, Laboratorio etc. Las Medicaturas Rurales son las Unidades más simples de la Organización Sanitaria al frente de las cuales generalmente se halla un sólo médico, en la cual se cumplen programas de medicina preventiva y curativa de tipo ambulatorio.

1.3 El objetivo del Sistema Regional tiene como base doctrinaria, la descentralización e integración administrativa a nivel regional, y el establecimiento de un comando único para planificar, coordinar, ejecutar, supervisar y evaluar las actividades integrales de los Servicios Locales de Salud Pública, de Malariología y Saneamiento Ambiental y cuyo conjunto de acción social constituye la organización regional, y orientar dichas actividades según las normas del Despacho.

Descripción del Sistema Regional si es que existe. De las 22 Entidades Federales del País, 7 cuentan con el sistema regionalizado, y se tiene programado incorpcrar al sistema nuevos Estados en forma inmediata. Mientras esto ocurre se hacen labores de promoción y difusión de la doctrina de descentralización, llevándose adelante las actividades de organización funcionales partiendo desde las células más elementales de los establecimientos.

1.4 Atribuciones constitucionales o legales sobre formulación de normas y estándares, coordinación y fiscalización del funcionamiento de los servicios y supervisión del personal técnico a distintos niveles.

Consagrado por la Constitución Nacional el derecho a la salud del pueblo Venezolano, el ejercicio de todas aquellas actividades públicas y privadas que conlleven acciones de salud quedan sometidas a la vigilancia, coordinación y responsabilidad del Ejecutivo Federal, quien las ejerce por intermedio del Ministerio de Sanidad y Asistencia Social según Ley de Sanidad Nacional promulgada el 15 de julio de 1938. Las funciones de fomento, protección y restitución de la salud las ejerce el Ministerio de Sanidad en representación o por autoridad delegada del Ejecutivo Federal y las aplica en base a mandatos de la Constitución Nacional, de la Ley de Sanidad Nacional, de la Ley de Ministerios y de un conjunto de Leyes específicas en la materia, Decretos, Resoluciones y Reglamentos Vigentes en el país. Las funciones del Ministerio de Sanidad y Asistencia Social se resumen así:

a) Fomento, Conservación y Restitución de la Salud

b) Los programas, proyectos, organización, dirección técnica y administración de todos los servicios directamente destinados al fomento y conservación de la Salud, así como de los servicios nacionales destinados a la asistencia y protección moral y material de las personas necesitadas

c) Los programas, proyectos, organización, dirección técnica, administración e inspección de los servicios públicos destinados a la restitución de la salud en la medida que lo establezcan las Leyes y Reglamentos.

d) La aprobación e inspección de todos los servicios destinados a la restitución de la salud

e) La coordinación de las actividades Nacionales, Estadales, Municipales y Privadas en materia de Salud Pública y Servicio Social

f) La ejecución de las obras directamente destinadas a la lucha contra las enfermedades de origen hídrico o telúrico, que no esté atribuida especialmente a otro Ministerio

g) Las estadísticas sanitarias

h) La vigilancia del ejercicio de las profesiones de médico, farmacéutico y odontólogo, y la aprobación de los Reglamentos internos de los respectivos colegios profesionales de acuerdo con la Ley

i) La vigilancia de las actividades profesionales en materia de enfermería asistencia no médica de partos, trabajo social, laboratorio y otros similares

j) La preparación técnica del personal necesario para el cabal cumplimiento de sus funciones

k) La organización y dirección de los servicios de veterinaria que se relacionen con la Salud Pública

l) Las relaciones y la supervisión del funcionamiento de los Institutos Autónomos adscritos al Despacho.

1.5 Indicar si existe un plan nacional de salud, si en su formulación se han considerado los recursos de las Instituciones de Seguridad Social y si este plan forma parte de un plan nacional de desarrollo económico y social.

A pesar de que en el Plan de la Nación 1963-66 se exponen, a grandes rasgos, los diversos programas que las instituciones de gobierno llevan a cabo en el Campo de la Salud, es bien cierto que ello no responde a un proceso de programación sectorial con criterio de prioridades establecido según una base epidemiológica y en estrecha vinculación con los planes del desarrollo. Por otra parte, y a pesar de que el Decreto-Ley No. 492 de la Junta de Gobierno autoriza la creación de Oficinas sectoriales a nivel de Ministerios e Institutos Autónomos, no es sino con fecha 19 de Junio de 1964 que se dicta la Resolución No. 15 del Ministerio de Sanidad y Asistencia Social creando la Unidad de Planificación Sectorial a nivel del mismo organismo y señalándole las siguientes atribuciones:

a) "Hacer estudios acerca del desarrollo de la Salud Pública en escala nacional, para lo cual podrá dividir este trabajo con las Oficinas correspondientes de los Institutos Autónomos adscritos al Ministerio".

b) "Reunir y consolidar las propuestas de Presupuesto-Programa que presentan las respectivas Direcciones y remitirlas a la Oficina Central de Coordinación y Planificación en el tiempo y forma que está prescrita".

c) "Al hacer remisión de los proyectos a la Oficina Central, señalar el orden de prelación que el Despacho considere conveniente".

d) "Auxiliar al Ministerio en todo lo referente a programación, coordinación y vigilancia de la ejecución y preparación de programas y servir de enlace y ayudar a la Oficina Central de Coordinación y Planificación".

e) "Elaboración de programas de adiestramiento de personal requerido por los organismos de Planificación de la Salud".

La aplicación de la Resolución No. 15, tiene su cumplimiento en la Ley de Presupuesto de 1965, apareciendo esta Oficina con los cargos que se le asignan dentro de la Dirección General del Ministerio de Sanidad y con cuatro (4) oficinas para la división del trabajo de planificación. Es a mediados de 1965 cuando se inicia la organización de la Unidad con programas de dotación de ambientes, mobiliario, asignación del personal previsto, de discusión del reglamento interno, de preparación de su personal, de trabajos de recolección de información y preparación de informes para las demás Oficinas del Ministerio de Sanidad, Coordiplan, Ministerio de Hacienda etc. En 1966 se está recogiendo la información necesaria para la formulación del Presupuesto-Programa del Ejercicio Fiscal enero-diciembre de 1967, aplicando la primera etapa del proceso de la Metodología de la Planificación (Método CENDES-OSP) este procedimiento va ser aplicado estrictamente al radio de acción del Ministerio de Sanidad, quedando fuera las Instituciones de Seguridad Social y otros Organismos dispensadores de Salud. Lo importante de esta iniciativa radica en que constituye el paso inicial para la formulación futura del plan de Salud.

1.6 Datos generales sobre los sistemas usados por la formulación del Programa y Presupuesto, el monto de este último y las normas que existen para nombramientos y manejo del personal de todos los niveles.

El Presupuesto-Programa ha venido presentándose como un documento anexo al Presupuesto Financiero, determinado ello, por la ausencia de planes específicos.

El Presupuesto Financiero se elabora de acuerdo con los lineamientos generales que el Ministerio de Hacienda dispone anualmente para ser utilizados por todos los Organismos que conforman el poder público nacional.

Es así como, tomando como base los formularios que el Organismo anteriormente citado prepara, el Ministerio de Sanidad y Asistencia Social procede a recabar la información, a nivel nacional y de todos sus servicios de todos los rubros que constituyen la estructura de gastos del Despacho. Esa información se procesa a fin de preparar el documento único que posteriormente, previa la aprobación del Soberano Congreso Nacional, constituirá la Ley de Presupuesto para el Ejercicio Fiscal venidero.

Posteriormente el Presupuesto Sectorial se descompone en Presupuesto por Programas, Sub-Programas y Actividades, y en los rubros de gastos se detalla por Partidas, Sub-Partida Genéricas y Sub-Partidas Específicas, a fin de establecer una íntima relación entre estos y los primeros. (Se anexan cuadros de Presupuesto comparativos).

En 1964, se reorganizó la oficina de Personal como una dependencia de la Dirección General otorgándose la jerarquía de Dirección, con el propósito de poner en práctica un sistema ordenado de registro de todos los funcionarios, empleados y obreros del Despacho. También el de los aspirantes a cargos, previo el estudio y análisis de sus aptitudes, conocimientos y experiencias para mantener activo un dispositivo de reclutamiento y enganche de personal. Se tomaron las disposiciones oportunas y pertinentes para la clasificación de los cargos, de acuerdo a las directrices generales establecidas para todo el sector público nacional por la Comisión de Administración Pública, y, a ese efecto, la mencionada Oficina procuró solucionar del mejor modo y con la colaboración de las Direcciones Técnicas los problemas que naturalmente suscita la implantación de un nuevo sistema.

3) RECURSOS ASIGNADOS AL MINISTERIO

a) Por Programas

No.	Programa	Presupuesto y modificaciones 1964		Presupuesto y modificaciones 1965		Presupuesto 1966	
		Bs.	%	Bs.	%	Bs.	%
1	Servicios Centrales	7.019.028	1,27	14.698.065	2,40	16.125.127	2,24
2	Administración General	37.123.024	6,67	24.936.227	3,60	21.718.212	3,20
3	Servicios normativos de Fomento y Restitución de la Salud	34.562.624	6,20	38.256.085	6,00	40.993.872	6,00
4	Servicios normativos de Malariología y Saneamiento Ambiental	65.832.437	11,82	85.090.645	13,50	102.066.879	14,80
5	Servicios normativos de Bienestar Social y Desarrollo de la Comunidad	17.107.848	3,07	18.333.624	3,00	19.541.371	2,70
6	Servicios Regionales de Protección de la Salud	38.226.515	6,87	41.227.419	6,30	37.683.575	5,50
7	Servicios Regionales de Restitución de la Salud	177.183.368	81,80	212.401.219	33.20	235.695.318	34,50
8	Servicios Regionales de Fomento de la Salud	67.958.247	12,20	74.751.107	11,50	67.525.426	9,80
9	Financiamiento a Organismos adscritos	112.010.000	20,10	130.800.000	20,50	144.100.000	21,26
	Instituto Nacional de Nutrición	9.600.000		10.200.000		9.600.000	
	Patronato Nacional de Comedores Escolares	22.000.000		22.000.000		22.000.000	
	Instituto Venezolano de Investigaciones Científicas	11.210.000		16.900.000		17.500.000	
	Hospital Universitario de Caracas	24.500.000		27.500.000		30.500.000	
	Patronato Nacional de Ancianos	2.300.000		3.300.000		3.600.000	
	Consejo Venezolano del Niño	42.400.000		50.900.000		60.900.000	
	TOTALES:	557.023.091	100	640.494.391	100	685.449.780	100

2. Las acciones de Salud son realizadas a nivel de:

27.	Hospitales Generales	8.106 camas
28.	Centros de Salud	1.271 "
14.	Sanatorios Antituberculosos	2.861 "
488.	Medicaturas Rurales	

b) Por objeto del Gasto:

Partida	Concepto	Presupuesto y modificaciones 1964		Presupuesto y modificaciones 1965		Presupuesto 1966	
		Bs.	%	Bs.	%	Bs.	%
10	Sueldos Básicos y Compensaciones a los mismos	128.512.920	23,07	149.510.927	23,34	171.976.916	25,09
12	Sueldos Variables, Dietas y Salarios	7.105.532	1,28	4.291.713	0,67	2.980.202	0.43
13	Otros Gast. de Pers.	13.195.990	2,37	18.316.581	2.86	20.506.298	2,99
20	Mater. y Suministros	20.061.066	3,60	22.175.583	3,46	21.169.990	3,09
30	Servicios	10.209.723	1,83	10.806.003	1,69	11.870.650	1,73
40	Conserv. y construcciones temporales	701.649	0,13	808.226	0,13	3.997.100	0,58
50	Adquisición de Maquinaria y Equipo	16.040.340	2,88	12.791.359	2,00	6.364.711	0,93
70	Obras	7.600.000	1,36	6.600.000	1,03	2.000.000	0,29
80	Transferencias	136.819.168	24,56	158.823.564	24,79	172.248.646	25,13
90	Desemb. Financ.	750.000	0,13	750.000	0,12	1.560.536	0,23
	Asignaciones Globales						
	Sosten. Esc. Enferm.	4.093.636	0,73	4.435.820	0,69	4.452.820	0,65
	Campañas Sanitarias Especiales	2.200.936	0,39	2.800.000	0,44	3.558.357	0,52
	Programas Especiales de Higiene Mental			1.500.000	0,23	2.000.000	0,29
	Acueductos Rurales	7.285.604	1,31	6.426.160	1,00	6.426.160	0,94
	Acueductos Rurales. Aporte para acued. rurales a ser financiados con recursos de operación de crédito público	8.000.000	1,44	22.500.000	3,51	22.500.000	3,28
	Vivienda Rural	16.469.816	2,96	17.147.156	2,68	17.100.000	2,50
	Gastos de sostenim. de Serv. Hospit.	73.234.560	13,15	64.672.931	10,10	64.501.005	9,41
	Ampliaciones y nuevos servicios Médico Asistenciales			16.780.912	2,62	10.000.000	1,46

b) Por objeto del Gasto: (Continuación)

Partida	Concepto	Presupuesto y modificaciones 1964 Bs.	%	Presupuesto y modificaciones 1965 Bs.	%	Presupuesto 1966 Bs.	%
	Gastos de sostenimiento de servicios no hospitalarios	4.553.554	0,82	3.323.656	0,52	4.876.444	0,71
	Sostenimiento de internados y Gastos de funcionamiento de Escuelas	875.316	0,16	1.525.316	0,24	1.525.816	0,22
	Programas especiales contra Chagas					15.000.000	2,19
	Contratos colectivos	99.313.281	17,83	114.508.484	17,88	118.884.629	17,34
	TOTALES:	557.023.091	100	640.494.391	100	685.449.780	100

2. Las acciones de Salud son realizadas a nivel de:

27.	Hospitales Generales	8.106 camas
28.	Centros de Salud	1.271 "
14.	Sanatorios Antituberculosos	2.861 "
488.	Medicaturas Rurales	

INFORMACION ADICIONAL

1. Para la realización del presente trabajo, se han tomado en cuenta los siguientes servicios:

1.1	Hospital Central de Valencia. Edo. Carabobo	560	camas
1.2	Hospital Rodríguez Rivero. San Felipe. Edo. Yaracuy	119	"
1.3	Hospital Central. San Cristóbal. Edo. Táchira	421	"
1.4	Centro de Salud Padre Oliveros. Nirgua. Edo. Yaracuy	50	"
1.5	Hospital Psiquiátrico de Barquisimeto. Edo. Lara	140	"
1.6	Sanatorio Antituberculoso "R.G. Plaza" Valencia. Carabobo	165	"
1.7	Medicatura Rural de Campo Elías. Estado Yaracuy	---	
1.8	Medicatura Rural de Guama. Estado Yaracuy	---	
1.9	Medicatura Rural de Turmero. Estado Aragua	6	"
1.10	Medicatura Rural de Guarico. Estado Lara	9	"
1.11	Medicatura Rural de San Mateo. Estado Aragua	5	"
1.12	Medicatura Rural de San Diego. Estado Carabobo	3	"
1.13	Medicatura Rural de Sarare. Estado Lara	---	
1.14	Unidad Sanitaria de Valencia. Estado Carabobo	---	

2. Las acciones de Salud son realizadas a nivel de:

27.	Hospitales Generales	8.106	camas
28.	Centros de Salud	1.271	"
14.	Sanatorios Antituberculosos	2.861	"
488.	Medicaturas Rurales		

2	Sanatorios Antileprosos	900	camas
8	Hospitales Psiquiátricos	3.878	"
1	Hospital Oncológico	86	"
51	Unidades Sanitarias	---	
	Total	17.102	camas

3. La consideración de primera consulta o sucesiva está basada en función al daño y no a la persona.

4. En la encuesta a pacientes egresados y consultantes, se han considerado como foráneos, únicamente las personas procedentes de regiones que están fuera del territorio del Estado en que el Hospital tiene su sede. Asimismo los formularios que de pacientes egresados, no tienen fecha de egreso, es porque en el período de realización de la encuesta, estos permanecían hospitalizados. Igualmente existen encuestas con los datos de tipo económico en blanco, debido a que no se pudo lograr la información.

2. Instituto Venezolano del Seguro Social

I N T R O D U C C I O N

Cumplida esta fase de la encuesta recomendada por la Organización Panamericana de la Salud, labor desarrollada dentro de las normas y definiciones pre-establecidas por dicha organización, el Instituto Venezolano de los Seguros Sociales aspira poder aportar en ella valederos elementos de estudio que contribuyan al análisis del complejo problema de la prestación de asistencia médica al individuo en Latinoamerica.

La constitución tripartita del Seguro Social Venezolano (Estado, Trabajadores y Patronos) define claramente su status de organización distinta a la de un instrumento de filantropía en manos del estado y por el contrario la tipifica como organización de los sectores fundamentales de la sociedad, con metas claras y perfectamente definidas hacia la protección y conservación de la salud en el elemento humano.

El cumplimiento cabal de estos postulados, obliga a realizar una efectiva labor asistencial de todo orden, que va desde la asistencia médica hasta la conservación de la capacidad económica del trabajador y su grupo familiar en los estados de necesidad.

La prestación de servicios de asistencia médica a cargo del Instituto Venezolano de los Seguros Sociales, se cumple parcialmente en instalaciones propias y, conscientes de la necesidad de evitar duplicaciones mezquinas y onerosas, orientamos una política de utilización racional de las disponibilidades asistenciales del Estado, llegando inclusive hasta la coordinación experimental de servicios como el que describimos bajo el No. 2-6 en la narrativa del presente informe. Todo ésto sin desvirtuar en ningún momento el derecho del trabajador a una asistencia de primera calidad; derecho que es una consecuencia del sistema social moderno, no pudiendo en ningún momento interpretársele como discriminatorio, ya que es de elemental lógica que el pago directo de un servicio, cause en forma directa la prestación y disfrute consiguiente del mismo.

Consideramos pues, que nuestras realizaciones no fomentan la creación de grupos privilegiados, toda vez que si sería injusto pretender obligar a los grandes sectores laborales a renunciar al derecho que le otorga un sistema de vigencia universal, autofinanciado y generador de ventajas indiscutibles no sólo para sus propios aportantes sino para toda la población.

Información general

De acuerdo a los requerimientos e instrucciones suministradas, desarrollamos de seguida la narración descriptiva sobre la información general del Instituto Venezolano de los Seguros Sociales.

2.1 Disposiciones legales con especial referencia sobre la extensión geográfica y ocupacional de la cobertura (indicando además si las familias o dependientes recibe prestaciones médicas), el monto de las cotizaciones y el carácter de las prestaciones.

Situación Actual

El Seguro Social en Venezuela está regido por el Estatuto Orgánico del Seguro Social Obligatorio, promulgado el 5 de octubre de 1951 que modifica la ley de Seguro Social Obligatorio de 24 de julio de 1940. Aplica los riesgos de enfermedad-maternidad, accidentes y enfermedades profesionales; prevé que mediante leyes especiales se extenderá el Seguro Social Obligatorio a los riesgos de vejez, invalidez, muerte y paro forzoso.

Se dispone que el régimen se aplicará progresivamente a todo el País y a los trabajadores de la industria y del comercio, con excepción de los empleados públicos, los agrícolas y pecuarios, los trabajadores a domicilio cuyas condiciones de trabajo no pueden asimilarse a las de los trabajadores ordinarios, los trabajadores domésticos, los trabajadores temporeros y los que prestan servicio a varios patronos.

Los miembros de la familia del asegurado que tienen derecho a las prestaciones previstas en la ley son:

a. La mujer del asegurado, sea o no su cónyuge; la no cónyuge deberá tener al menos un año de vida en común como el asegurado o tener hijos de esa unión.

b. Los hijos legítimos, naturales o adoptivos y los hermanos huérfanos de padre o madre o asimilados, hasta los 15 años de edad o mientras cursen estudios regulares, siempre que vivan en el hogar del asegurado o a sus expensas.

c. La madre del asegurado que viva con él y a sus expensas.

d. El padre totalmente inválido que viva a cargo del asegurado y en su hogar.

e. El cónyuge totalmente inválido que viva a cargo del asegurado y bajo el mismo techo.

El financiamiento se opera mediante la contribución de patronos y trabajadores en un 50 por ciento para el seguro de enfermedad-maternidad y por la contribución de los patronos para el seguro de accidentes y enfermedades profesionales. El estado sufraga los gastos de administración, los de primer establecimiento y los que causen las extensiones a nuevas zonas del país.

Las cotizaciones se recaudan mediante el sistema de nóminas elaboradas por el Instituto, de acuerdo a la información de los empresarios y mediante la liquidación de períodos mensuales vencidos. Durante el año de 1964 las cotizaciones por concepto del seguro de enfermedad-maternidad, alcanzaron a la suma de 157 millones de bolívares.

En cuanto a prestaciones, el seguro de enfermedad-maternidad proteje a los trabajadores cuyos salarios no excedan de Bs. 24.000 anuales. Los beneficios de esta cobertura pueden ser en especie o en dinero, los primeros proveen al asegurado y a todo su grupo familiar, sin ningún tipo de diferencias, asistencia médico, quirúrgica, hospitalaria, farmacéutica y odontológica. Los segundos se otorgan sólo al asegurado cotizante según la categoría del sueldo o salario que devengue, a cuyo efecto existe una escala de ocho niveles y con respecto a ellos se determina el pago de indemnización, fundamentando el mismo en una correspondencia a las 2/3 partes del salario de base.

El asegurado incapacitado para el trabajo por enfermedad tendrá derecho, a contar del cuarto día de incapacidad y hasta por 26 semanas, a una indemnización, la cual se pagará de conformidad con la tarifa siguiente:

Categorías de Salario	Indemnización en Bolívares	
	Diaria	Semanal
1	1,80	10,80
2	4,00	24,00
3	6,60	39,60
4	9,30	55,80
5	12,00	72,00
6	16,00	96,00
7	21,33	128,00
8	28,00	168,00

Estructura de la Organización

Organograma del Instituto (Anexo)

Descripción del Tipo de Organización

El I.V.S.S. es una organización de tipo lineal, en que la autoridad pasa departamentalmente desde el más alto nivel ejecutivo a todos los niveles de la organización.

Es un Instituto Autónomo con fines de asistencia médica y social no lucrativos, que tiene cierta descentralización administrativa para desarrollar sus funciones en las zonas de aplicación del territorio nacional.

Funciones básicas de las unidades principales

El Consejo Directivo como órgano superior imparte las directrices generales para la organización, funcionamiento y administración del Instituto Venezolano de los Seguros Sociales.

El Director General tendrá la representación jurídica del Instituto y será su órgano ejecutivo.

La División de Control; inspecciona y controla los fondos manejados por funcionarios del I.V.S.S. colabora con las demás Divisiones dentro de sus atribuciones.

La División de Personal, dicta las normas generales relativas a la administración de personal.

Corresponde a la División de Administración cuidar de la ejecución de los programas en materia administrativa; organizar y llevar la Contabilidad del Instituto; mantener al día los inventarios de bienes; preparar los balances; inspeccionar directamente la Tesorería; organizar y supervisar los servicios generales.

La División de Servicios Médicos, coordina, supervisa y controla las actividades médicas en las zonas de aplicación del régimen de los Seguros Sociales, cuya meta final es primordialmente la conservación y restitución de la salud del trabajador asegurado y sus familiares calificados.

2.2 Organización administrativa de aquellas instituciones que prestan servicios médicos indicando la estructura y dependencia de los hospitales y servicios de atención ambulatoria.

La prestación de servicios médicos en el Seguro Social venezolano, está incorporada a la estructura misma de la organización a través de su unidad "División de Servicios Médicos"; por tal motivo nos permitimos presentar una información general sobre la estructura administrativa del Instituto.

I.V.S.S. Funciones y Objetivos Básicos

Las causas fundamentales de su creación lo constituye el propósito firme y evidente de aliviar y eliminar los males sociales por medio de una acción coordinada, sistemática y consciente de acuerdo a la doctrina de la seguridad social, ampliando la asistencia médica en las zonas de aplicación del Seguro Social.

Su campo de acción: el resguardo y restablecimiento de la buena salud en el campo del conglomerado laboral venezolano, cubriendo los riesgos de enfermedad, maternidad, accidentes del trabajo y enfermedades profesionales.

La nueva Ley del Seguro Social Obligatorio, actualmente en discusión por el Congreso Nacional, cubrirá los riesgos de Asistencia Médica; Prestaciones en dinero a corto plazo; pensiones de vejez, invalidez, muerte y paro forzoso.

Los programas de administración encierran el propósito de actualizar la gestión administrativa del Instituto, para alcanzar su principal objetivo como es el de la coordinación y desarrollo de las actividades inherentes a las oficinas normativas con las dependencias asistenciales para el logro de su función específica en el campo de la Seguridad Social.

La nueva estructura administrativa a regir desde 1966, permitirá al Instituto atender con mayor eficiencia las nuevas zonas geográficas a cubrir los riesgos incorporados de acuerdo a la nueva Ley de Seguro Social Obligatorio.

La extensión geográfica del Seguro así como la inclusión de los nuevos riesgos, conjuntamente con la ampliación del limite de cotización incorporan al Seguro Social nuevos núcleos de trabajadores lo cual involucra un mayor radio de acción de la función administrativa del Organismo.

AÑO 1964 - SEGURO DE ENFERMEDAD-MATERNIDAD

ZONAS DE APLICACION - CIUDADES	ASEGURADOS	FAMILIARES	TOTAL BENEFICIARIOS	COTIZACIONES Bs.
Caracas y su zona Metropolitana	172.158	346.229	518.387	89.179.323
Edo. Miranda				
Los Teques Guarenas	5.901	11.447	17.348	2.255.289
Distrito Federal				
La Guaira	15.108	35.735	50.843	6.445.278
Edo. Aragua				
Maracay La Victoria	24.631	50.328	74.959	9.090.568
Edo. Carabobo				
Valencia Puerto Cabello	41.149	87.177	128.326	16.161.133
Edo. Lara				
Barquisimeto	47.551	8.974	56.525	5.058.185
Edo. Falcón				
Coro Punto Fijo	11.463	40.770	52.233	4.682.441
Edo. Zulia				
Maracaibo	29.945	66.589	96.534	15.924.252
Edo. Táchira				
San Cristóbal	9.118	23.592	32.710	2.502.979
Edo. Bolívar				
Ciudad Bolívar Puerto Ordaz	7.952	19.206	27.158	5.997.707
T O T A L E S:	334.324	720.699	1.055.023	157.297.154

División de Cajas Regionales, a través del programa de la División de Cajas Regionales se coordinan, ejecutan y centralizan todas las actividades inherentes a Cajas Regionales, Sucursales y Agencias.

Dentro de estas actividades pueden destacarse:

a) Velar por la aplicación de las disposiciones legales reglamentarias y estatutarias correspondientes.

b) Cumplir y hacer cumplir todo lo relacionado con el régimen de cotizaciones y prestaciones

c) Realizar todos los actos y operaciones que sean necesarias para cumplir los fines que están atribuidos.

La División Legal, representa al I.V.S.S. en todas las actuaciones judiciales o extra judiciales, evacua las consultas jurídicas del Instituto e informa sobre las apelaciones que intenten ante la Dirección General.

División de Medicina del Trabajo, Higiene y Seguridad Industrial; el objetivo fundamental de la División en la protección integral del hombre en el trabajo, continuamente expuesto a los riesgos profesionales. Su función preventiva la conduce a evitar que hayan lesionados, incapacitados o muertos que le restan al país elementos valiosos en todos los campos de su actividad técnica, científica y cultural, además de producir las consiguientes repercusiones económicas y sociales en perjuicio de la Institución del Seguro Social.

2.3 Datos generales sobre formulación y monto del Presupuesto y sistemas de nombramiento y remuneración de personal.

La formulación del Presupuesto del Instituto corresponde a la División General quien lo remite al Consejo Directivo a los fines de su aprobación.

Los recursos necesarios para su total cobertura, se logran en dos grandes fuentes:

a) Cotizaciones de trabajadores y patronos, estos ingresos se destinan a cubrir los costos de las prestaciones en especie, efectúan los pagos que originan las prestaciones reales y a la formación de los fondos que ordene la Ley.

b) Aportes del Fisco Nacional: destinados a cubrir los gastos de administración, adquisición de equipo sanitario y los de primer establecimiento del servicio.

Actualmente se calcula este aporte en una taza del 9% sobre el monto global de las cotizaciones.

En el ejercicio del año 1964, el monto total del presupuesto alcanzó a la suma de Bs. 218.736.000.00; destinándose Bs. 166.248.000.00, al Presupuesto de Enfermedad-Maternidad.

Lo relativo a la función de personal, se cumple de la siguiente manera: en su Artículo 18 del Reglamento General del Estatuto Orgánico del Seguro Social Obligatorio, establece que el personal del Instituto será organizado, distribuido y nombrado o contratado por el Director General. Esta labor se cumple a través de la División de Personal mediante la ejecución de las siguientes políticas.

1) La función de personal se desarrollará en los términos señalados en el Decreto 394, y atendiendo a las recomendaciones de la Oficina Central de Personal de la Comisión de Administración Pública.

2) El Director General autorizará y firmará los reglamentos, políticas, procedimientos e instrucciones generales de administración de personal para el Instituto; y también autorizará el nombramiento, la cesantía y el despido de los empleados. Las actividades específicas y de rutina de personal serán atendidas directamente por la Oficina de Personal.

3) Se evitarán toda clase de trámites, pasos, papeles y gastos innecesarios en el manejo de asuntos de personal, mediante la centralización de los procesos y sistemas de personal a través de la División de Personal en Caracas.

4) Las acciones y decisiones de personal deberán ser imparciales; y los sistemas y procedimientos que se establezcan serán tan uniformes como lo permitan las circunstancias.

5) Los trabajadores deberán ser tratados con justicia y obtener la remuneración, servicios, seguridad y prestaciones sociales de acuerdo con las mejores técnicas de personal y los recursos del Instituto.

6) Deberá mantenerse un equilibrio racional entre el trabajo a desarrollarse y el número de empleados y obreros.

7) El nombramiento, contratación y los ascensos de los empleados se harán sobre la base de méritos, tomando en consideración la capacidad, habilidad, experiencia, integridad y antecedentes de los candidatos.

Asimismo cabe señalar la existencia de Contratos y Convenios de Trabajo entre el Instituto y diversas entidades profesionales y sindicales que operan en el país, como son entre otras: la Federación Médica Venezolana, la Federación Nacional de Trabajadores de la Salud, el Colegio de Odontólogos de Venezuela, el Colegio de Bioanalistas, etc. Estos acuerdos aportan toda una serie de beneficios al personal traduciendo una verdadera política de estímulos e incentivos sociales y económicos.

Durante el ejercicio del año 1964 el Instituto Venezolano de los Seguros Sociales pagó a su personal la suma de Bs. 72.795.816,00, por concepto de salario y Bs. 14.614.800.00, por concepto de beneficios derivados de los contratos y convenios de trabajo, lo que totaliza una centidad de Bs. 174.821.232,00 destinados a la remuneración de sus trabajadores.

2.4 Actividades preventivas en favor de los asegurados y de su grupo familiar.

En Venezuela existen expresas disposiciones legales que establecen el alcance, la cobertura de las acciones de salud, fundamentalmente las que tienen carácter preventivo. El Ministerio de Sanidad y Asistencia Social es la unidad ejecutora de tales planes y en consecuencia su jurisdicción exclusiva; ello determina la referencia permanente de pacientes protegidos por el Seguro Social a los Centros de prestación de servicios del citado Ministerio.

Paralelamente a la situación antes establecida, el Instituto Venezolano de los Seguros Sociales, desarrolla a nivel de sus Centros Ambulatorios y Hospitalarios una labor típicamente preventiva de la salud de sus beneficiarios y considerando los factores ecológicos que inciden en la vida de los grupos familiares asegurados, logra desarrollar un efectivo plan de prevención que clasificamos así:

a) Prevención de enfermedades comunes; orientando a la totalidad del grupo familiar y cumplido a diario dentro del volumen de consultas ordinarias.

b) Prevención de la maternidad; va sólo a un sector de sus beneficiarios pero con un alto grado de desarrollo, puesto de relieve por la existencia, con carácter de riesgo específico de seguridad social en nuestra legislación vigente.

c) Prevención de riesgos profesionales; dirigidos a los trabajadores cotizantes, hemos logrado un relevante grado de desarrollo en lo que a Medicina del Trabajo, Higiene y Seguridad Industriales se refiere, pudiendo asegurarse que sin incurrir en exageraciones la División correspondiente del seguro venezolano es factor fundamental de tal actividad en el ámbito nacional.

Resultado de las acciones preventivas

Las ventajas derivadas de esta actividad son notables, por sus repercusiones positivas a nivel segurista, social, médico, económico y fundamentalmente nacional, ya que según esta política, el Instituto Venezolano de los Seguros Sociales no sólo colabora en el mantenimiento y

protección de la salud del pueblo venezolano sinò evita egresos indirectos al Ministerio de Sanidad y Asistencia Social al complementar coordinadamente con acciones de alto tenor científico las labores preventivas sanitarias que el Ejecutivo Nacional desarrolla.

2.5 Relaciones jurídicas y administrativas entre las instituciones de Seguridad Social y los Ministerios de Salud con especial referencia a la administración superior de éstas instituciones y al origen de sus directivas.

Las relaciones jurídico-administrativas entre el Instituto Venezolano de los Seguros Sociales y el Ministerio de Sanidad y Asistencia Social, está perfectamente normadas por el Estatuto Orgánico del Seguro Social Obligatorio y su Reglamento General, las cuales nos permitimos clasificar así:

Aspecto Asistencial: El Estatuto en su Art. 31 y el Reglamento General en sus artículos 6-10; 52-2 inal; 53-3; 146 y 147 confiere al Ministerio de Sanidad las siguientes atribuciones:

a) El Ministerio es el órgano del Ejecutivo Federal para dirigir y vigilar la marcha de los servicios sanitarios del Seguro Social; con juridicción hasta para emitir opinión sobre las necesidades de edificaciones y equipos asistenciales que alegue o solicite el Instituto.

b) El Ministerio está expresamente facultado para ccntrolar los servicios médicos del Seguro, indicar, modificar e inclusive sancionar el incumplimiento a tales recomendaciones.

c) Los servicios médicos del Seguro están obligados a coordinar sus actividades con los servicios sanitarios nacionales.

Aspecto Administrativo: El Reglamento General del Estatuto Orgánico, establece en su Art. 6 aparte 9 y 10 una fluida y permanente comunicación entre el Ministerio de Sanidad y el Seguro Social en los siguientes términos:

a) El Instituto enviará anualmente al Ministerio, una copia de la MEMORIA de Actividades que presente al Ejecutivo Nacional.

b) El Ministerio queda facultado para solicitar del Seguro, cualquier información que requiera, cada vez que lo juzgue necesario.

Aspecto Legal: Contenido en el Art. 6 aparte 5 del Reglamento, el Ministerio de Sanidad queda facultado conjuntamente con el Ministerio del Trabajo, para aprobar con carácter de requisito de vigencia, los Estatutos del Seguro Social.

Administración Superior del Instituto

La administración del Instituto Venezolano de los Seguros Sociales, está a cargo de un Consejo Directivo que ejerce funciones de órgano superior administrativo y de un Director General que es el órgano Ejecutivo. El Consejo esta compuesto de seis miembros principales con sus respectivos suplentes, distribuídos así:

Dos Representantes del Ejecutivo Federal
Dos Representantes de los Asegurados
Dos Representantes de los Patronos

Su calificación y nombramiento corresponde al Presidente de la República por órgano del Ministerio del Trabajo con las siguientes particularidades: los representantes del Ejecutivo, son de libre elección y remoción del Presidente de la República; los Representantes de patronos y asegurados, son escogidos entre las postulaciones que hace cada sector y duran dos años en sus funciones. La presidencia del Consejo Directivo la ejerce cualquiera de sus miembros, designado por el Presidente de la República a través del Ministerio del Trabajo.

2.6 Descripción de cualquier ensayo de coordinación de servicios de nivel local entre Seguro Social y Servicios Públicos Gubernamentales, especialmente en las áreas rurales.

Desde el año 1961 el Instituto Venezolano de los Seguros Sociales tiene con el Hospital Central de las Fuerzas Armadas un plan de coordinación para 320 camas, en la zona de San Martín. Este sistema ha venido funcionando sin complicaciones de ninguna naturaleza y ha traducido en la práctica que si se puede llevar a efecto; lo que representa grandes ventajas por cuanto permite a dos Instituciones ayudarse en forma mutua y beneficiarse en la reducción de gastos que la coordinación deriva.

El Sistema se basa en que el Hospital de las Fuerzas Armadas pone a disposición del Instituto las camas, más los servicios comunes de mantenimiento general, de luz y fuerza eléctrica, de teléfonos, de alimentación, de lavandería, de estacionamiento, de esterilización, etc. El Instituto por su parte, a un precio establecido según los costos, paga el valor de las camas, pero el personal tanto médico, paramédico, como administrativo corre por cuenta del Instituto, quien a su vez es responsable de los compromisos contractuales con los organismos profesionales y sindicales. Conviene definir que el personal que rige por los reglamentos del Seguro, de acuerdo a predicciones del convenio suscrito con la Federación Médica Venezolana, el cual establece como obligación del Instituto al contratar servicios, que el personal médico y paramédico sea por su cuenta y bajo su dirección, aunque ciertas normas del Hospital una vez que son estudiadas por ambos organismos, pueden aplicarse.

Hasta ahora, el servicio que se presta ha sido satisfactorio, no ha ofrecido ningun inconveniente y los contratos son prorrogados a su vencimiento; aplicando esta experiencia en el interior del país se han firmado contratos de servicios, en coordinación con el Ministerio de Sanidad en las ciudades de Barcelona y Valera, esperándose la firma de un documento similar para el Hospital de San Cristóbal en el Estado Táchira.

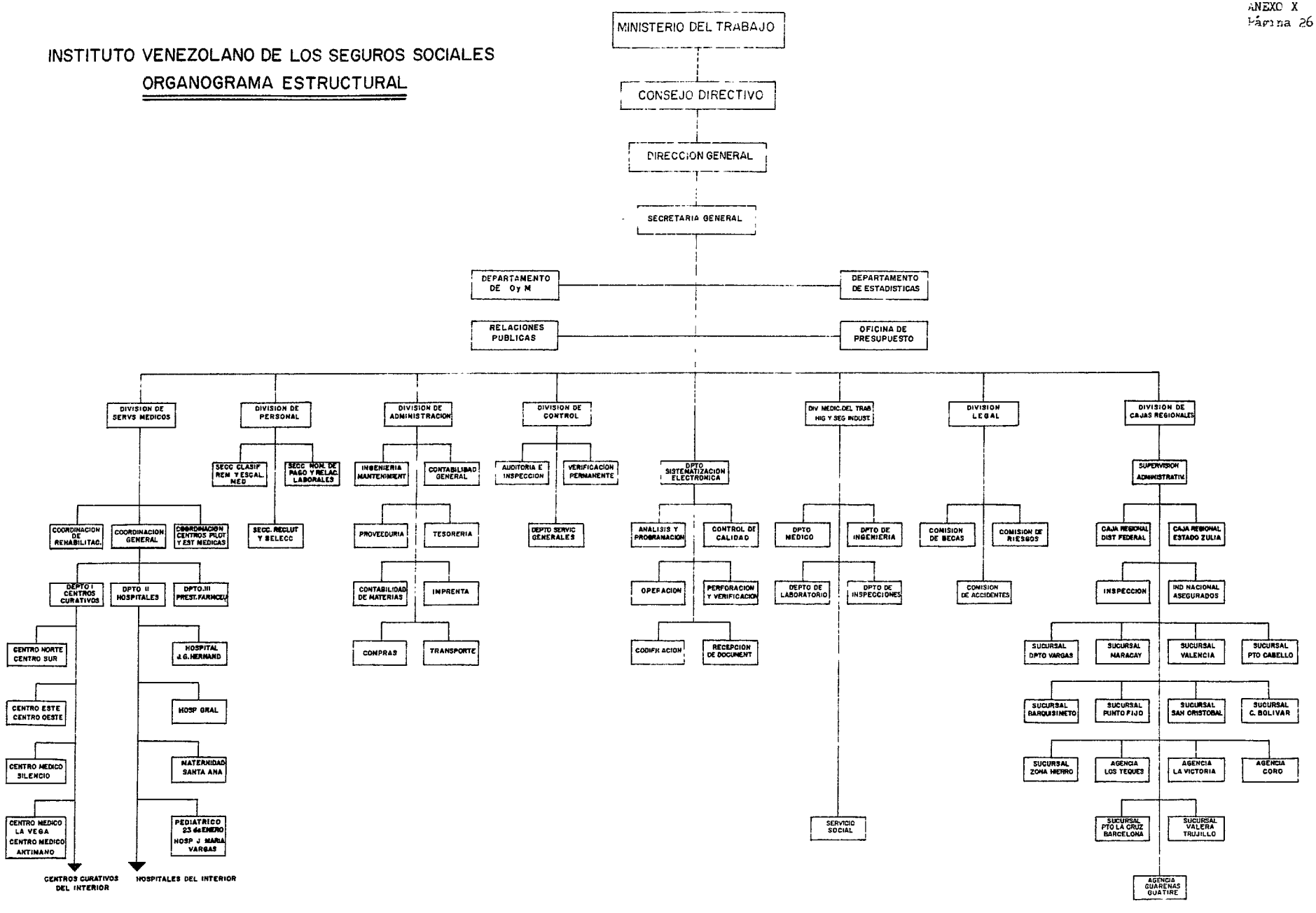
2.7 Indicar si los beneficiarios del Seguro tienen en su totalidad acceso a los servicios médicos existentes en la seguridad social y, en caso negativo qué medios se utilizan para ofrecerles prestaciones médicas a aquellos asegurados que tienen derecho a atención, pero no tienen acceso a los servicios existentes.

En Venezuela todos los grupos familiares tienen acceso a los servicios médicos del I.V.S.S., ya que la población amparada por el régimen de seguridad social, se encuentra ubicada fundamentalmente en centros urbanos dotados con suficiencia de medios de comunicación.

Cuando las características de un tratamiento especial, motivan el traslado del paciente de una ciudad a otra, el Seguro Social provee los recursos necesarios a tal fin.

INSTITUTO VENEZOLANO DE LOS SEGUROS SOCIALES

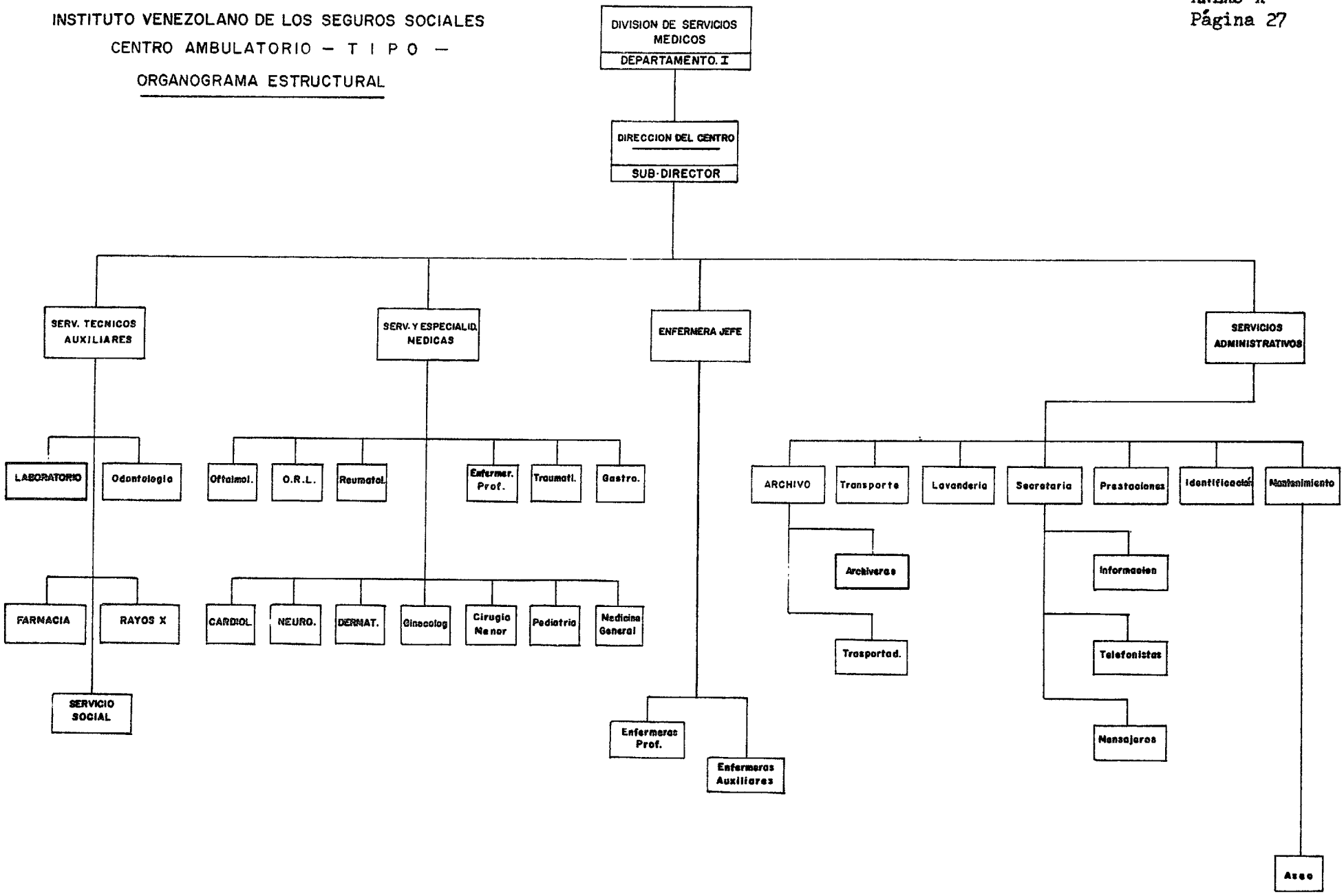
ORGANOGRAMA ESTRUCTURAL



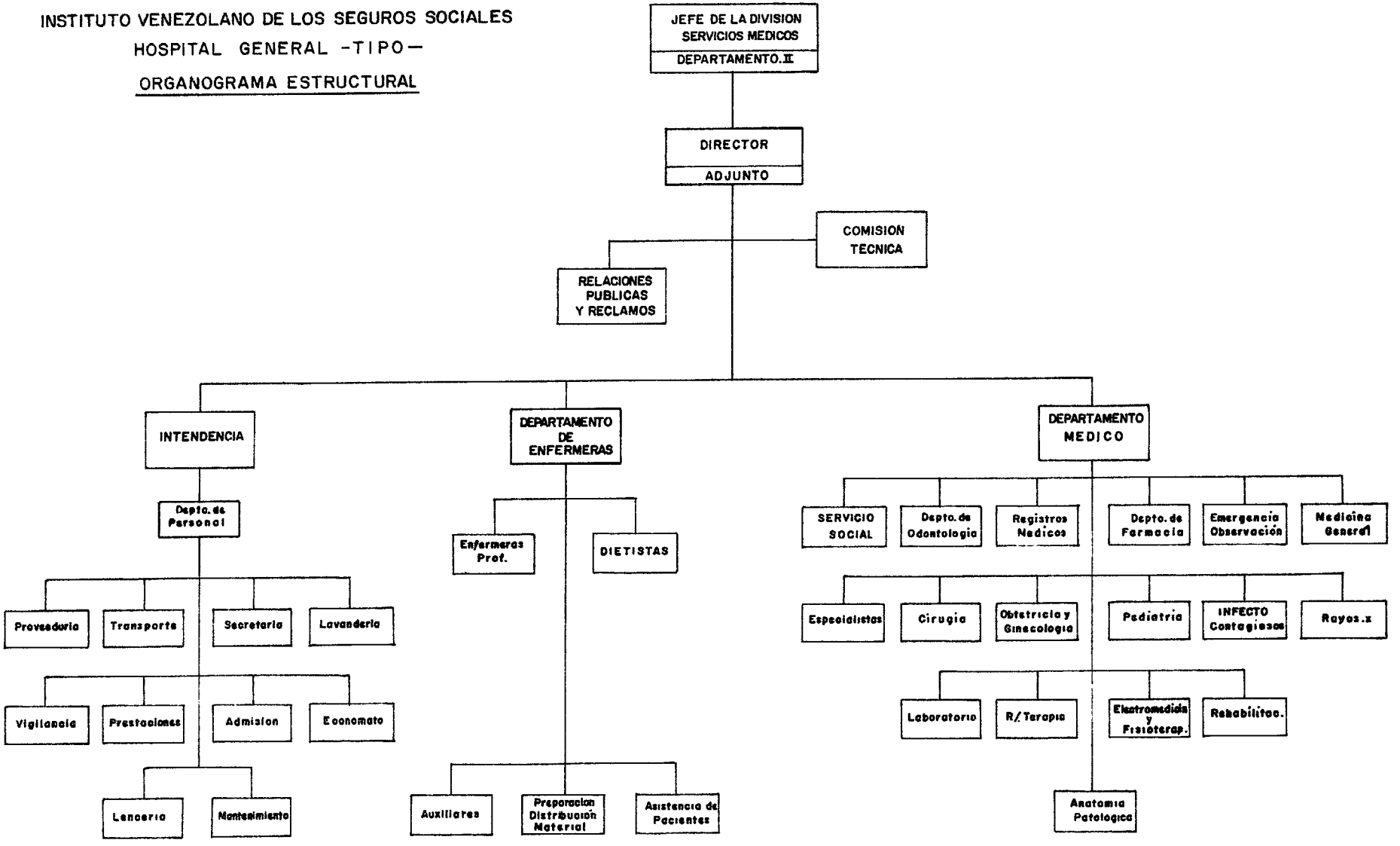
INSTITUTO VENEZOLANO DE LOS SEGUROS SOCIALES

CENTRO AMBULATORIO – T I P O –

ORGANOGRAMA ESTRUCTURAL



INSTITUTO VENEZOLANO DE LOS SEGUROS SOCIALES
HOSPITAL GENERAL -TIPO-
ORGANOGRAMA ESTRUCTURAL



CUADRO I

Número de hospitales y camas hospitalarias. Tasas por 1.000 habitantes, Venezuela, 1964

Hospital o grupo de hospitales	Población abarcada	Número				Tasa por 1.000 habitantes			
		Camas	Altas	Días-paciente	Consultas pacientes externos	Camas	Altas	Días-paciente	Consultas pacientes externos
Ministerio de Sanidad y Asistencia Social									
4 hospitales generales	463 936	1 150	31 279	341 469	338 459	2.5	67.4	736.0	729.5
2 hospitales especializados	766 940	305	810	72 694	8 084	0.4	1.1	94.8	10.5
4 medicaturas rurales	46 096	23	749	2 449	35 484	0.5	16.2	53.1	769.8
Seguro Social									
15 hospitales generales	2 097 230	1 671	52 687	482 141 (a)	1 426 883	0.8	25.1	229.9	680.4

(a) Días del censo.

CUADRO II

Indices de utilización de hospitales, Venezuela, 1964

Hospitales o grupo de hospitales	Permanencia media	Tasa de movimiento de pacientes	Indice de ocupación
Ministerio de Sanidad y Asistencia Social			
4 hospitales generales	10.9	27.2	84.0
2 hospitales especializados	89.7	2.7	92.2
4 medicaturas rurales	3.3	32.6	28.8
Seguro Social			
15 hospitales generales	*9.2	31.5	78.8

*A base de los días del censo.

CUADRO III

Personal de hospitales y proporciones por 100 camas ocupadas, Venezuela, 1964

Hospital o grupo de hospitales	Número									Proporción por 100 camas ocupadas						
	Médicos		Total excl. médicos	Personal de enfermería				Otro pers. asist. méd.	Otro pers.	Médicos		Total excl. médicos	Personal enfermería		Otros cuidados médicos	Otros servicios
	Total	Tiempo compl		Total	Enferm	Auxil.	Parteras			Total	Tiempo compl		Total	Enf.		
Ministerio de Sanidad y Asistencia Social																
4 hospitales generales	234	126	887	499	113	386	-	43	345	24.2	13.0	77.1	43.4	9.8	3.7	30.0
2 hospitales especializados	16	8	144	80	40	40	-	7	57	5.7	2.8	51.2	28.5	14.2	2.4	19.7
4 medicaturas rurales	6	25	29	22	1	21	-	1	6	90.9	37.9	111.6	84.6	3.8	3.8	23.1
Seguro Social																
16 hospitales generales	496	339	2 471	1 180	322	858	-	132	1159	37.3	25.5	185.6	88.7	24.2	9.9	87.1

CUADRO IV

Proporciones en la distribución de personal hospitalario, Venezuela, 1964

Hospital o grupo de hospitales	Proporciones					Porcent. de aux. de enf. adiestr.	Porcentaje de personal en la asistencia médica
	Enfermeras por médicos		Pers. enferm. por médicos		Aux. de enferm.		
	(1)	(2)	(1)	(2)			
Ministerio de Sanidad y Asistencia Social							
4 hospitales generales	0.5	0.9	2.1	4.0	3.4	45.9	69
2 hospitales especializados	2.5	5.0	5.0	10.0	1.0	100.0	64
4 medicaturas rurales	0.2	0.4	3.7	8.8	21.0	19.0	83
Seguro Social							
16 hospitales generales	0.6	0.9	2.4	3.5	2.7	100.0	61

CUADRO V

Tiempo* (en minutos) de servicios médicos y de enfermería por día y por cama ocupada, Venezuela, 1964

Hospital o grupo de hospitales	Médicos	Personal de enfermería	
		Total	Enfermeras
Ministerio de Sanidad y Asistencia Social			
4 hospitales generales	33	148	33
2 hospitales especializados	7	97	48
4 medicaturas rurales	97	288	13
Seguro Social			
16 hospitales generales	66	302	82

CUADRO VI

Costos de hospitalización y consultas de pacientes externos, Venezuela, 1964

Hospital o grupo de hospitales	Días-paciente	Estancia media	Consultas pacientes externos	Costo (en moneda nacional)			
				Por paciente al día	Por estancia en el hospital	Por cama ocupada al año	Por consulta de paciente externo
Ministerio de Sanidad y Asistencia Social							
4 hospitales generales	353 441	10.9	338 459	44.41	484.07	16 254	15.22
2 hospitales especializados	102 932	89.7	8 084	26.98	2 420.11	9 875	a) 17.65
4 medicaturas rurales	2 422	3.3	35 484	40.12	132.40	14 723	10.35
Seguro Social							
16 hospitales generales	487 227	9.2	1 477 139	b)105.13	967.20	38 478	c) 13.41

(a) Sólo un hospital. (b) Difiere de los datos contenidos en el cuadro sobre gastos
(c) A base de 8 consultorios.

CUADRO VII

Número y clase de instituciones de consulta externa que informaron, Venezuela, 1964

Hospital	Total	Número medio de salas de examen	Número de instituc. con serv. de lab.	Número de instituc. con serv. de rayos X
Ministerio de Sanidad y Asistencia Social				
Hospitales generales	4	18	4	4
Hospitales especializados	2	6	1	1
Centros de salud	1	13	1	1
Medicaturas rurales	7	2	-	2
Seguro Social				
Hospitales generales	12	9	11	9
Consultorios	23	7	20	14
Consultorios auxiliares	7	2	-	-
Consultorios especializados	7	2	2	4

CUADRO VIII

Utilización de instituciones de consulta externa y servicios prestados, Venezuela, 1964

Institución	Población		Porcentaje de solicitantes	Número						Tasa por 100 habitantes				Consultas por 100 solicitantes		Proporción por 100 consultas méd.	
	Abarcada	Solicitante		Consultas		Visitas a domicilio	Inmunizaciones	Exámenes de lab.	Rayos X	Consultas		Visitas a domicilio	Inmunizaciones	Médicas	Otras	Exámenes de lab.	Rayos X
				Médicas	Otras					Médicas	Otras						
Ministerio de Sanidad y Asistencia Social																	
4 hospitales generales	463 936	212 926	45.9	338 459	124 401	2 131	14 568	361 864	34 368	73.0	26.6	0.5	3.1	159.0	58.4	106.9	10.2
2 hospitales especializados	766 940	6 129	0.8	8 084	...	52	-	14 358	2 283	1.1	...	0.0	-	131.9	...	177.6	28.2
1 centro de salud	226 985	10 578	4.7	44 905	159 740	16 750	165 271	53 432	31 231	19.8	70.4	7.4	72.8	424.5	1 510.1	119.0	69.5
7 medicaturas rurales	66 783	45 789	68.6	66 527	57 922	5 514	24 514	1 892	4 054	99.6	86.7	8.3	36.7	145.3	126.5	2.8	6.1
Seguro Social																	
12 hospitales generales	349 653	...	...	1 442 289	518 580	83 422	6 752	1 560 176	49 206	412.5	148.3	23.9	1.9	...	...	108.2	34.1
23 consultorios	1 052 866	...	...	3 068 025	992 782	349 129	35 618	1 106 237	52 190	291.4	94.3	33.2	3.4	...	...	36.1	1.1
6 consultorios auxiliares	25 200	...	...	28 400	43 308	389	-	-	-	112.7	171.9	1.5	-	...	...	-	-
7 consultorios especializados	...	...	...	182 587	149 891	-	193	7 157	-	...	...	...	...	...	...	3.9	-

CUADRO IX

Personal de instituciones de consulta externa, Venezuela, 1964

Hospital	Médicos		Dentistas		Otro personal					Tiempo del médico por consulta (en minutos)	Tiempo de enfermería por consulta	
	Personas	Horas	Personas	Horas	Total	Enfermería Total	Enfer.	Auxil.	Parteras	Otro pers.		Total	Enferm.
Ministerio de Sanidad y Asistencia Social													
3 hospitales generales	212	494	5	7	a)463	118	20	98	-	a)348	27	35	6
2 hospitales especializados	6	12	2	...	22	5	2	3	-	17	23	77	31
1 centro de salud	17	96	3	9	106	84	11	37	36	22	36	51	7
7 medicaturas rurales	10	58	5	5	68	59	1	32	26	9	15	59	1
Seguro Social													
12 hospitales generales	294	706	37	158	836	189	32	157	-	647	12	16	3
23 consultorios	895	2 400	131	550	1 741	613	130	483	-	1 128	15	19	4
7 consultorios auxiliares	15	52	1	4	47	24	2	22	-	23	23	36	3
7 consultorios especializados	90	208	6	32	175	42	8	34	-	133	21	16	3

a) Se observa cierta duplicación con el personal hospitalario.

CUADRO X

Promedio del costo por consulta de pacientes externos, Venezuela, 1964

Hospital	Costo medio	Costo mediano
Ministerio de Sanidad y Asistencia Social		
4 hospitales generales	15.22	14.55
1 hospital especializado	17.65	17.65
1 centro de salud	15.74	15.74
7 medicaturas rurales	9.39	10.03
Seguro Social		
9 hospitales generales	13.31	12.01
23 consultorios	11.78	11.89
7 consultorios auxiliares	10.90	11.32
7 consultorios especializados	22.15	14.74