ADMINISTRATION OF

MEDICAL CARE

SERVICES

New elements for the formulation of a continental policy

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

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NOTE

Because of their close relationship and the practical value of having them in a single volume, this publication includes the documents relating to the PAHO Study Group on the Coordination of Medical Care in Latin America (Washington, D.C., 12–16 July 1965), convoked jointly by the Pan American Health Organization and the Organization of American States, and those relating to the PAHO Advisory Committee on Planning of Hospitals and Other Health Services (Washington, D.C., 26–30 July 1965), attended by representatives of the Inter-American Development Bank. The addresses delivered by Dr. Abraham Horwitz at the inaugural sessions of both meetings are also included, as are the resolutions approved by the Directing Council of PAHO on the two topics.

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Coordination of Medical Care Services in Latin America

I. ADDRESS BY DR. ABRAHAM HORWITZ, DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU

Delivered at the inaugural session of the meeting of the PAHO Study Group on the Coordination of Medical Care in Latin America

I should like to thank you for being here today for the purpose of advising this Organization and the Organization of American States on a problem of great importance to the Americas. Joint action by these international agencies is warranted by the increasing complexity of medical care and by the repeatedly expressed desire of the Governments to improve the present systems of providing that care in order better to satisfy the pressing needs of their peoples.

This Group—insofar as PAHO is concerned—has been convened in compliance with Resolution XL [1] of the XV Meeting of the Directing Council of the Organization. A basic point in that resolution called for a Study Group's presenting to the Organization "a report containing its views regarding the promotion of better coordination among the public health services and the medical care programs provided by the social security agencies and other organizations," and for the Director's transmitting that report to the Governments in due course.

The Directing Council thus recognized the possibility of more effective coordination between the Government institutions that are responsible for meeting the demand for benefits on the part of both members of care programs and the indigent. The Council, moreover, considered it "necessary to improve the procedures designed to achieve active health planning, extend the coverage of health services, coordinate the financing schemes, and integrate preventive and curative activities."

In interpreting that resolution, we would clearly do well to ascertain the magnitude of the problem and to define its main characteristics. To that end, a survey has been suggested for the purpose of gathering objective data on, among other factors, coverage, availability and accessibility of services, comparative costs, and the return on the human, material, and institutional resources. Your views on the approach, scope, and procedure for conducting that survey, with regard to which a proposal [2] appears in the working document before you, will be both instructive and useful to us.

When it approved that resolution, the Council had in mind the moral obligation of the health administrator to provide timely services at the lowest possible cost and of the highest possible quality, without failing to consider the individual as a member of a family and of society, who is exposed to environmental risks and whose adaptation to those uncertain conditions takes the form of health or sickness. It is therefore in-

[1] See p. 32.

[2] See pp. 25-26.

cumbent upon public and private agencies—social security institutions included—to adapt their operations to the natural history of man's biological processes. Health, sickness, and disability, through which the continuity of the life cycle is expressed, are paralleled by the preventive, curative, and social activities of those agencies. The individual's ecological relationship to his environment should be reflected, in functional terms, in the institutions that society has established to serve him and of which he is constant beneficiary. Such institutions, including those in the economic sphere, should seek to promote well-being, offering each person the opportunity to achieve fulfillment, in keeping with his biological heritage and the characteristics of his culture. The increasing complexity of society, to which progress has led, has made the diversification of clearly defined functions a necessity. Our civilization, with its remarkable advances in science and technology, has compelled the Governments to institute organizational innovations in order to satisfy certain demands urgently expressed by the members of society. Yet, regardless of the scope of this undertaking, the essential point is not to lose sight of the ultimate goal. Our institutions are the means of achieving a noble, humanitarian, and moral purpose. Otherwise, our initial efforts might become a full-scale undertaking not necessarily leading to the common good. That is why we have maintained that coordination is an attitude; a way of living, thinking, and acting; a natural inclination to understand the causes and circumstances that govern each situation and to search for ways in which to benefit the largest possible number of people. However perfect our laws, standards, and regulations, they are no substitute for the state of mind that seeks effective coordination between institutions. Man does not live by truths alone, no matter how absolute they may seem!

One wonders whether the present lack of coordination between the medical care services of social security agencies and those of health ministries is due solely to conventional causes arising out of the fact that the two spheres of action are not clearly defined in juridical terms. Or does it have deeper roots in an economic and social process characteristic of developing countries? How can the State be helped in fulfilling its obligations of providing health care, if possible to the entire community, and in fully coordinating the resources at its disposal?

A study of these questions—all directly related to your own experience—should lead to a series of recommendations for achieving more effective results in terms of the number of people cared for by the State.

The working document contains background information on the various aspects of this complex problem, which was raised by the Directing Council and regarding which we should value the views of such qualified persons as the members of this Study Group. We hope that the document will be of use to you in your deliberations and that it will serve as the basis for organizing such recommendations as you may wish to make on ways in which a better understanding of the problem can be gained and a cooperative, rather than competitive, system established.

The joint sponsorship of this meeting by the Pan American Health Organization and the Organization of American States, to whose Secretary General, Dr. José A. Mora, we wish to express our sincere appreciation, is dramatic evidence of the importance of the problem throughout the Continent. It is one of the problems that most directly affect the future of Latin America's needy, whose hopes were rekindled by the revolution of rising expectations embodied in the Charter of Punta del Este. Everything in the Americas today should be in support of the stated goal of improving the living conditions and enlarging the horizons of the people, with social mobility being promoted so that there will be "more, knowing more." The accomplishments in economic integration, political

interdependence, and institutional reforms designed to increase income and bring about its more equitable distribution should serve that noble purpose. It is in this spirit that we would hope you might study the vital problem that brings you together on this welcome occasion. That you will do so, drawing upon your experience and high standards of service, I have no doubt; indeed, it is those very qualities that give rise to the optimism with which we view the future.

II. RELATIONSHIP BETWEEN SOCIAL SECURITY MEDICAL PROGRAMS AND THOSE OF MINISTRIES OF HEALTH OR OTHER OFFICIAL HEALTH AGENCIES

Working document prepared by Dr. Alfredo Leonardo Bravo for PAHO and the OAS, as the basis for discussion at the meeting of the Study Group on the Coordination of Medical Care in Latin America

A. INTRODUCTION

Throughout history, every country has been faced with the social need and the group commitment to provide medical care for the economically weak sectors of their population—the indigent and the destitute. The Latin American countries are no exception, and therefore in the early stages of their history they established primitive hospital facilities. Patterned after the institutions then prevalent in Spain, they were intended chiefly to give relief and comfort to the men wounded in the wars of conquest and to victims of the various diseases that decimated the armies. Thus began organizations called "beneficencias," which originated in private initiative and philanthropy and more recently have been coming under some degree of State control, as the rising cost of services has made Government subsidies necessary and also as a result of the introduction of more modern medical-social concepts, which have gradually transformed the purely charitable approach into a more advanced social welfare outlook.

Toward the end of the last century, the Industrial Revolution which changed the European countries' way of life and stirred up the working masses, led to the establishment of social insurance funds, under the inspiration of Chancellor Bismarck. As an instrument of the new social order, those funds were designed to compensate the worker and his family, in cash or kind, when for reasons of illness, accident, disability, old age, or death he lost his earning capacity temporarily or permanently. Since the risks covered could in large part be eliminated or reduced by means of medical care, health benefits were naturally considered the most effective means by which those who had become passive elements of this new industrial society, struggling to establish itself among the nations that had hitherto lived mainly by agriculture and mining, might be returned to active life, that is, their productive capacity and purchasing power restored.

The Latin American countries, bravely seeking their place in a world of dizzying change, were once again brought under the influence of the Old World. Skipping stages of development—and probably before they were fully prepared to take on the financial and administrative responsibilities involved—they established social security systems, with which were born the medical services of welfare agencies. Though very rapid in the

past 40 years, their growth has varied from one country to another, depending in large part on the existence and effectiveness of other governmental or charitable medical services capable of assuming the new responsibilities imposed by a sizable labor force that had gained a legal right to medical care. Organized labor demanded that right with the understandable vehemence of a new social class attempting to acquire a personality of its own. No one can deny the beneficial effect of the social security funds on the Latin American countries in promoting the construction of hospitals and polyclinics and the organization of new services to provide medical care to their members.

The natural course of progress and the development of new needs have enlarged the framework of social insurance activities into what is known, in modern terms, as "social security"—that area of a Government's economic and social policy that, together with a wage and full-employment policy, is designed to protect the workers and their families against need, by means of a system of benefits to restore the family's purchasing power by ensuring it a stable income and to provide services, especially medical services, to protect, promote, or restore the member's physical or mental health and thus his productive capacity.

For their part, the ministries of health, in fulfillment of their essential obligation to protect, promote, and restore the health of the members of the community—an obligation sometimes arising out of a constitutional mandate that makes the health of the population a major concern of the State—have adopted a policy of building hospitals, polyclinics, and health centers. These agencies have been gradually adopting the modern concepts of organizing local health facilities, which offer integrated (preventive, curative, and social) medicine to all members of the community. These services are provided through hospitals, peripheral clinics, and other medical care centers, which sometimes bring to the home and place of work all the benefits of a medicine that not merely relies on diagnosis and treatment but strives for a "health program," carried out by a "health team" composed of professionals and technicians in various fields. The services should range from sanitary and nutrition education, through immunization and preventive examinations of healthy persons, to the diagnosis and treatment of illness and the rehabilitation of the disabled.

The formulation and execution of health programs by the ministries and other public services are the result of an important change in outlook that originated largely in the humanistic political and social movement that dates back to the end of World War II and the Atlantic Charter. Over the years, this movement has become more clearly defined, thanks to the progressive and continuing efforts of the international organizations, whose technical and specialized agencies have given economic development and social advance a universal approach as the basis for a happier life, free from fear of poverty, ignorance, and sickness, and as the foundation for lasting peace among nations.

This, briefly, is the historical background of the medical care situation that exists, with some variations, in practically every Latin American country. First, there are services under the health ministry that are trying to practice integrated medicine, within the limitations imposed by the lack of human and material resources. Alongside, under a certain degree of control by ministry authorities, are the public or private "beneficencias," whose traditional role has been to furnish medical services to the indigent and destitute—services that, as efforts are made to reach a scientific level in keeping with the progress of medicine, are becoming so costly that they cannot continue without large Government subsidies. Finally, social security, following its own historical course and at the same time drawing upon internationally held concepts, has developed a net-

work of medical services paid for out of its income, services designed to benefit its members and therefore covering but one sector—sometimes quite a small one—of the population that is exposed to the risks of sickness or death.

B. PRINCIPLES AND INTERNATIONAL AGREEMENTS

1. ORIGIN OF THE PRESENT STUDY AND TERMS OF REFERENCE

International organizations could not remain aloof from the problem raised by the absence of coordination, the duplication, and at times the competition among the various Government agencies engaged in providing medical services to the population within the context of public medicine. The concern felt by those responsible at the ministerial level for the administration of this public medicine has been expressed many times within international organizations.

The problem was posed at a meeting of experts on social security convened by the Organization of American States in April 1959 to advise the Inter-American Economic and Social Council on the establishment of a long-range program in the field of social security. One of the group's recommendations was that the OAS examine the relations in its various Member Countries between the medical services provided by social security agencies and by other national medical services.

In accordance with this recommendation, the OAS decided to sponsor a study of the medical care provided by various agencies in different Latin American countries. The Pan American Sanitary Bureau, as the specialized organization in health problems of the Americas, contributed its technical experience to help set the terms of reference for the study and select the expert to conduct it. The study was carried out in five Latin American countries: Brazil, Chile, Costa Rica, Mexico, and Peru. The final report was published originally in English by the Pan American Union, General Secretariat of the OAS,[1] and some of its observations have been used in the present document. It was translated into Spanish by the PASB and published by the Pan American Union in 1964 under the title *La atención médica en América Latina.*

This study constitutes a first step in the effort to shed light on the difficult problem of coordinating medical care services among the ministries of health and the social security agencies. To continue the examination of the problem on the technical level the OAS and PAHO agreed to convene a jointly sponsored meeting of experts.

For their part, the participants in the Technical Discussions [2] of the XVI Pan American Sanitary Conference, held in Minneapolis in August-September 1962, while recognizing the progress represented by social security in coverage against physiological, pathological, professional, and social hazards, expressed reservations concerning the high cost of independent administration and operation, the discrimination between insured and noninsured persons, the methods used in recruiting professional staffs, and the obstacles its autonomy placed in the way of effective, uniform technical management of health problems.

As a sequel to this, the Executive Committee [3] of the Pan American Health Organization, examining the proposed program and budget for 1965 at its 50th Meeting, held in Washington in April-May 1964, discussed the relations between ministries or

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[1] Roemer, Milton I.: *Medical Care in Latin America.* OAS/PAHO Studies and Monographs III, 1963.

[2] See *Scientific Publication PAHO* **70,** 51–104 (published in Spanish only).

[3] *Official Document PAHO* **60,** 213.

secretariats of health and social security agencies and stated the need for undertaking a study of a problem that was assuming more and more importance. The discussions resulted in the inclusion of the topic on the agenda of the XV Meeting of the Directing Council under the title "Study of the Relationship between Social Security Medical Programs and those of Ministries of Health or Other Official Health Agencies."

During the XV Meeting of the Directing Council, held in Mexico City in August-September 1964, the representatives of the Governments fully expressed their opinions on the basis of the working document [4] submitted for their consideration. For reasons of space, the most pertinent are summarized:

The battle of the various public services for funds is not equitable at the highest level. There is a danger that the tangible results of social security benefits will work to the detriment of the intangible results of public health.

* * *

The only way to achieve balance is to establish a national health plan, which will make it possible to set priorities and goals with due consideration of national means and resources and of the fact that a high proportion of the population needs cost-free benefits.

* * *

To ensure over-all health planning, it is advantageous to have only one authority govern health policy throughout the country, and this function belongs constitutionally to the ministry of health.

* * *

The foregoing is not to ignore the importance of the social security services, which should be intensified; but relations between them and the ministries of health should be increasingly closer through coordination of all services, it being clearly understood that coordinating is not submitting, but living in freedom on the basis of mutual aid.

* * *

Emphasis was placed, moreover, on the freedom the countries should have to solve these problems in the manner best suited to their interests, their resources, their legal structure, and their characteristics. PAHO should be in a position to help all countries that request assistance in accelerating and facilitating coordination between social security and public health, with the object of preventing waste of human, economic, and other efforts, which in the long run hinders the necessary strengthening of both programs.

* * *

The Director of PASB, summarizing the discussions, pointed out that the matter involves political, financial, and institutional complexities and should therefore be handled cautiously. All the background material should be submitted to a purely technical Study Group, which would be composed of persons experienced in social security and health, not official representatives of their countries, and which would examine all aspects of the problem and formulate proposals on possible measures to promote the coordination desired by all. The report of this Group would then be transmitted to the Governments.

The Director of PASB noted that some countries are following a national health plan; others are thinking of incorporating all medical services into the ministry of health; others, on the contrary, prefer to coordinate the local activities while maintaining a degree of administrative detachment at the national level; and still others have decided against undertaking any new construction of hospitals or health centers except as provided for in a national building plan.

As a conclusion to the discussions, the Directing Council adopted Resolution XL (Annex 1),[5] which might be considered the frame of reference for the Study Group. The adoption of this resolution coincided

[4] *Ibid.*, pp. 328-335.

[5] See p. 32.

with the OAS decision mentioned above; thus two inter-American organizations have joined together in an effort to solve a problem that is of increasingly urgent concern to their Member States. Resolution XL considers it necessary to improve the procedures designed to achieve health planning, extend the coverage of health services, coordinate the financing schemes, and integrate preventive and curative activities, and states that the social security agencies are in a position to give assistance in the preventive and curative programs of governmental agencies responsible for serving the entire population, by expanding rates of coverage.

The operative part of that resolution calls for a continuation of advisory services to the Governments and for increased coordination with other international organizations. It recommends that the Director of the Pan American Sanitary Bureau convene a Study Group to consider the matter and present its views to the Organization in a report that would be transmitted to the Governments.

2. THE RIGHT TO HEALTH

The Constitution of the World Health Organization [6] states in its Declaration of Principles that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and also that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Further on it states that "Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

These principles are practically universal in their application, the WHO Constitution having been ratified by the 125 States that are Members. The main aspects of this Declaration deserve to be stressed, setting forth as they do, in precise and unequivocal terms, the concepts and standards applicable to health care: (a) health is a right of all citizens; (b) the concept of health is indivisible and broad; (c) the right to health should be guaranteed by the State; and (d) the measures taken by the State should be integrated and adequate to the danger.

Previously, the International Labour Conference at its XXVI Meeting, held in Philadelphia in April 1944, had approved a recommendation on medical care, stating the objectives and the methods that should govern the granting of medical benefits. Recommendation 69 being of great interest, the complete text is included in this document as Annex 2.[7] Attention should be called to some of its main points, since a global approach is apparent throughout and the right to health is established in terms that are still current and could be subscribed to by all who have concerned themselves with the problem.

In its preamble, the Recommendation refers to the Atlantic Charter and, after recapitulating International Labour Organisation activities in the fields of social security and medical care, recommends that the Members apply the principles set forth in the document as rapidly as national conditions allow.

Its operative part recognizes: "The medical care service should cover all members of the community, whether or not they are gainfully occupied" (paragraph 8); "A medical care service should meet the need of the individual for care . . . with a view to restoring the individual's health . . . (curative care); and with a view to protecting and improving his health (preventive care)" (paragraph 1); "The medical care service should be provided in close coordination with general health services, either by means of close collaboration of the social insurance institutions providing medical care and the authorities administering the general health services, or by

[6] *Official Document PAHO* **47**, 23.

[7] See p. 33.

combining medical care and general health services in one public service" (paragraph 43); "Where the whole of the population is to be covered by the service and it is desired to integrate medical care with general health services, a public service may be appropriate" (paragraph 10). In other words, Recommendation 69 of Philadelphia recognizes the right of the entire population to health and recommends the integration of preventive and curative medicine and the coordination or unification of social security medical care services with those of the ministry of health.

With respect to financing, it recommends that the cost of medical care services be met by payments from the insured and the employer and that "the cost of the medical care service not covered by contributions should be borne by taxpayers" (paragraph 79). It also recommends that when the medical care is provided by a public service, its cost be met by public funds, but when the administration of the medical care service is separate from that of the general health services, a special tax (health insurance) be "reserved for the purpose of financing the medical care service" (paragraph 87).

Finally, on the subject of administration, it says that "local administration of medical care and general health services should be unified or coordinated within areas" (paragraph 104) and adds that it would be advisable for all the services to be "administered properly by one area authority" (paragraph 105), the principle of regionalization and unification of activities at the local level thus being amply recognized.

For its part, the General Assembly of the United Nations adopted and proclaimed on 10 December 1948 the Universal Declaration of Human Rights, which states in Article 25, section 1: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." [8]

This Declaration states once again the basic concepts that have been mentioned—that is, the right to protection through the coordination of medical and social activities, for the purpose of raising living standards, which in the last analysis is the ultimate goal of all these programs, both in health and in social security.

The singleness of mind and of purpose so apparent in the Government officials, statesmen, and sociologists who helped formulate this social policy, of which medical care and health are an integral part, could not be passed over without comment.

In short, the Atlantic Charter (1941), Recommendation 69 of Philadelphia (1944), the Constitution of WHO (1946), and the Universal Declaration of Human Rights (1948), in one form or another, defined in clear and eloquent terms the principles on which the medico-social activities of the countries should be based, so that vigorous steps might be taken toward the achievement of the ideal shared by the health services and the social security services—the highest degree of health and social well-being for all persons, without discrimination.

In the Western Hemisphere, the same concern has been expressed in the Charter of the Organization of American States, in Operation Pan America, in the Act of Bogotá, and, finally and most fully, in the Alliance for Progress and in the Charter of Punta del Este. Because of the importance of this latter document, its Resolution A.2, which contains the Ten-Year Public Health Program of the Alliance for Progress, appears as Annex 3.[9] The provision dealing with medical care recommends that measures be taken "for giving increasingly better med-

[8] *Yearbook of the United Nations, 1948–49*. New York, 1950.

[9] See p. 43.

ical care to a larger number of patients, by improving the organization and administration of hospitals and other centers for the care and protection of health" (paragraph 2.b-5). To achieve this and other objectives, the Resolution recommends, among other measures: (1) the preparation of national health plans; (2) the education and training of health professionals; (3) the improvement of the organization and administration of health services by combining the functions of prevention and cure; and (4) the promotion of scientific research in the prevention and treatment of diseases.

The collection of agreements and recommendations cited shape a continental policy whose basic element is the over-all concept of health care as a right and the idea of regionalization of local health agencies, that is, hospitals and health centers. To this is added a methodology based on planning and supplemented by organization, the training of personnel, and scientific research, so that the best and most up-to-date knowledge available can be applied at the opportune moment.

Inspired by this continental policy, the Ministers of Health of the Americas, meeting in Washington in April 1963, under the joint auspices of the Organization of American States and the Pan American Health Organization, made the following statement on the subject under examination: "The ministries of health should take steps to secure the legal and institutional instruments required for the effective coordination of the planning and executive elements responsible for preventive and curative services of the State, as well as coordination between these and private, semiautonomous, and autonomous organizations providing health services of any type. The aim is to incorporate the medical care activities of those institutions, including hospitalization, into the basic health services of all levels—local, intermediate, or national—with the final objective of attaining a progressive integration of these activities. Preventive and curative services are but parts of an integrated whole. It is recommended that the regionalization of services be promoted on the basis of technical resources adequate for the protection, promotion, and restoration of health." [10]

The listing and quoting of the numerous agreements of important international deliberative bodies, composed of the countries' highest authorities in the field, are in themselves clear evidence of the prevailing thought and trends in the Americas during the past 20 years.

Finally, it is appropriate to cite the following passage from the message of President Gustavo Díaz Ordaz, of Mexico, to his country's Congress at the start of his term on 1 December 1964: "It is necessary to coordinate the activities of the various social security agencies and public health services in order to prevent duplication of effort and investment. Hospitals, clinics, sanatoria, and dispensaries should cover the country in a single interconnected network, which will make a practical reality of the Mexicans' right to combat illness with the aid of science. We shall take particular care in extending preventive medicine, the basis of which is environmental sanitation."

3. HEALTH OBJECTIVES AND ACTIVITIES

In the last analysis, the objective of any health service is to achieve for the people in its care the highest possible degree of health; in other words, to obtain for all citizens a complete state of physical, mental, and social well-being.

To achieve this broad objective, the health ministries or services must organize facilities for health protection, promotion, and restoration and administer them in a unified way, according to planning methods under which each activity should be given a priority based on (a) the importance of the activity in reducing the hazards of ill-

[10] *Task Force on Health at the Ministerial Level. Official Document PAHO* **51**, 37.

Activity	I	II	III	IV	V
Focus	Community	Healthy individuals	Healthy individuals	Sick individuals	Disabled and dependent individuals
Type	Environmental control	Health protection	Health promotion	Medical care	Social protection (social welfare)
Examples	Environmental sanitation, housing	Communicable disease control, immunizations, detection of asymptomatic illness	Maternal and child hygiene, mental hygiene, nutrition, health education	Physician's care, hospital care, special medical care programs for tuberculosis and mental illness	Vocational rehabilitation, social and economic protection of disabled or indigent

ness and death, (b) the resources available for carrying it out, and (c) the anticipated cost, measured in terms of the results expected from the activities planned. One of these activities is medical care, to which this document is chiefly devoted—not because it is the most important, but because these are the terms of reference of the Study Group; if the subject were broadened to include public health, it would become extremely complex, with perhaps a loss of perspective regarding the main topic.

The PAHO Advisory Group on Medical Care (Washington, 1962) accepted a scheme (see the above table) that defines the various health activities according to a scale ranging from environmental control in the left-hand column to social protection on the right and including health protection, promotion, and restoration.

Like all tables, the one given here has the defect of oversimplification. It has, however, the virtue of classifying activities and functions that are basic to coping with health problems as an indivisible whole closely linked to the physical, economic, and social environment. This unified approach to health calls for the performance of certain functions and activities, which are enumerated in the five columns of the table. The grouping of these functions and activities in one way or another in the various countries has depended on historical traditions, political beliefs, and administrative needs. Yet, if a modern and strictly technical concept of the health problem is accepted, it is necessary to accept also the idea that the ministry responsible for caring for the population's health should have the legal authority to direct, coordinate, and supervise all the agencies that are participating in one manner or another in this integrated (preventive, curative, and social) medicine. Obviously, however, the degree of coordination or integration of these health activities depends in large part on the size and importance of the executive agency. Whereas at the local level, in the rural hamlet, the mining camp, or the suburb, coordination is relatively easy and integration generally comes about in the person of the only professional available to carry on all these health functions, at higher levels, particularly at the central national level, the complexity of services and the need for specialization require an artificial separation of functions. Consequently, a coordinating authority at this central level is essential to the maintenance of unity.

The program of the ministries of health is, in principle, broad and comprehensive, encompassing all the activities listed in the five columns of the table, although in practice there is definitely more emphasis on columns I, II, and III—that is, on the functions of environmental control and of health protection and promotion.

The medical services of the social secur-

ity agencies, on the other hand, are concentrated almost exclusively on medical care (column IV), with a slight tendency toward column III in some cases, with respect to maternal and child hygiene, and column V, in the field of rehabilitation, especially of persons disabled in on-the-job accidents.

The application of health work having been stated in its broadest and most comprehensive terms, it seems best in this chapter to limit our comments to medical care programs, which form the frame of reference for the Study Group. These programs should be carried out through a stratified and coordinated system of hospitals of various types and of ambulatory and home-care services; insofar as possible, the system should be a self-sufficient whole that can cope with the problems arising from the population increase; from uneven population distribution, which sometimes causes insuperable difficulties in bringing modern, and even minimal, medical care resources to rural areas; from the ever-increasing costs of medical care; and from the necessary adjustment of medical and collaborating personnel to the new concepts of preventive, curative, and social medical care.

Under this arrangement, the hospital is directly in charge of medical care, giving technical and scientific support to all the peripheral facilities for ambulatory care. The hospital itself should have its own outpatient clinic, designed to provide general ambulatory and home care to those living in its area of action, and specialized advice to the peripheral services. According to the definitions formulated by the WHO Expert Committee on Organization of Medical Care in its First Report,[11] hospitals may be classified by size and by development of specialized services in the following manner:

a. *The regional hospital,* which is situated in the major city of a region and may work in cooperation with a medical school. This hospital provides excellent general medical, general surgical, pediatric, and obstetrical services in accordance with the needs of the inhabitants of its area; it also has highly specialized departments fully equipped to attend to patients in the region requiring such services.

b. The *intermediate hospital,* which is responsible for a smaller district. In addition to departments of general medicine, pediatrics, surgery, and obstetrics, it has a number of departments dealing with more common specialties (otorhinolaryngology, ophthalmology, and infectious diseases). An X-ray department under a well-qualified specialist is indispensable.

c. The *local hospital,* which provides general medicine, surgery, and obstetrics for the day-to-day needs of a small localized group.

With respect to ambulatory and home medical care, when these services are physically separate from the hospital, they are units serving a specific community. These facilities afford the best conditions for coordinating preventive and curative activities directed toward individuals. This type of facility should exist in all densely populated neighborhoods, in rural hamlets, in large factories, in schools—in short, wherever there is a heavy concentration of population—as a means of bringing care to the places where the beneficiaries live or work. What has come to be called "impact medicine"—that is, the diagnosis and ambulatory treatment of common ailments easily diagnosed and treated—might be practiced in these facilities. If this type of medicine is to maintain acceptable scientific standards, it is advisable for the clinics to have adequate diagnostic equipment such as a fluoroscope and a small laboratory, and to be staffed by a small medical team in which at least the basic specialties are represented. They should also have a telephone and an ambulance so that more complicated cases can be quickly transferred to a hospital for more complete care.

[11] *Wld Hlth Org. techn. Rep. Ser.* **122,** 17.

For certain very isolated rural sectors there might be medical posts run by auxiliaries, with periodic visits by professionals, so that the inhabitants will receive at least a minimum of medical care.

From the functional point of view, medical care needs to be broken down into regions and, within each region, into sectors. In each sector there would be a team of physicians and collaborating personnel to maintain regular contact with the population for the purpose of establishing essential human relations. This link should be encouraged by every possible means.

Finally, not to be overlooked is the need to set up a remunerative scale for medical and collaborating personnel in keeping with the exceptional efforts made by some individuals and the sacrifice involved in certain tasks, in order to create incentives that will promote good patient care, not impede it, as so often occurs now.

In accordance with the aforementioned principle of the right to health and the integration of health activities, all persons living in a given sector should be entitled to receive care at all these facilities, without discrimination between insured and noninsured. The benefits themselves should be integrated—preventive, curative, and social.

This system, obviously, is in effect in only a few places, but it indicates the trend and the ideal to which many ministries of health aspire in the field of medical care.

4. SOCIAL SECURITY OBJECTIVES AND ACTIVITIES

As has been said in the Introduction, social security is one element of a country's economic and social policy; its aim is to restore, through benefits in cash and in kind, the consumption capacity of insured workers and their families when, for reasons of illness, accident, disability, old age, or death, they have temporarily or permanently lost their earning capacity and their means of subsistence. Furthermore, it promotes the worker's return to active life in the shortest possible time, in order to put him back into production.

The basic principle of these social security activities, explained in its simplest form, is that to promote a country's economic and social development it is necessary to increase its production, and for this increase to be maintained at high and progressively rising levels it is essential to have, on the one hand, an adequate labor force and, on the other, the economic capacity to buy the goods produced. The former requires a healthy and strong active population; the latter, economic machinery whereby the consumption capacity of the entire population may be maintained and protected against emergencies that limit or destroy it. These measures are: (a) full employment, which ensures work for the entire active population; (b) a wage policy that guarantees the worker a remuneration adequate to his vital needs; (c) social security, which through cash benefits restores a minimum consumption capacity to the worker and his family.

To meet these financial obligations, social security consists of a fund that traditionally has been made up of tripartite contributions from the employer, the worker, and the State. In practice, however, the Government contribution comes from public funds collected through taxes; the worker, for his part, demands wage increases that will reimburse him for his insurance dues; and the employer, finally, charges against production costs both his own assessment and the worker's assessment, which, as noted above, has been automatically incorporated into his wages. In other words, all contributions to social security are ultimately paid for by the consuming public, through direct taxes or through price rises that in a sense really amount to indirect taxes; that is, the tripartite distribution of quotas is more or less arguable, since the cost of social security should actually be charged to the national product.

This interpretation of the financial aspect

of social security has led to a tendency to abandon the old system of capitalization of social security funds in favor of the allocation system, under which the annual cost is calculated actuarially and funds are apportioned as necessary to cover the anticipated benefits. Since these funds come from the national product, what happens is that social security joins in competition with other economic and social sectors to obtain, in the distribution of the national product, a share sufficient for carrying out its program but not so large as to limit the resources that should be used for capitalization, in order to maintain and increase industrial production. This is of the utmost importance, because proper and adequate capitalization increases the national product and hence adds to the wealth that can be redistributed along social lines in the future.

Thus, social security is closely and firmly linked to a country's economic and social development and to the planning of the economy. The decisions taken by the economic planners in order to achieve a proper distribution of the available resources are of prime importance. Unfortunately, in a realistic appraisal of the capitalization needs, it is not always possible to allocate sufficient resources to social security, in accordance with estimated expenditures. A common occurrence in countries that are barely developed economically, this must be accepted as a necessary temporary sacrifice, to be made up for later by larger assets when the national product has increased as a result of capitalization and leaves the necessary margin to satisfy the needs of social progress.

This strictly economic-financial argument, however, does not fulfill the broad objectives of social security, which are not merely economic but also biological. To social security, in fact, the protection of man as a biological and social being is of the greatest importance, since it is toward this man that the efforts and concerns of social progress are directed and by means of whose physical, mental, and social well-being the aims of social security will be achieved. As against purely economic reasoning, sociologists believe that the biological protection of the human being is the basic and essential goal and that through it economic development, for which the human heritage is a prerequisite, can next be achieved.

It is in this humanistic view that certain objectives and activities of social security coincide with those of public health. Social security is concerned with the normal growth and development of a child in order that he can become a healthy, vigorous adult who will be both productive and a good social security investment. It is further interested in seeing to it that the insured adult is protected, from the medical standpoint, against the hazards of illness and death, so as to avoid unnecessary disability. On the basis of these considerations, curative, and sometimes also preventive, medical care has become an essential activity of social security agencies, especially when a lack of other medical services or the inadequacy and poor quality of those that do exist have forced them to establish their own medical care units.

When the system includes the entire working population and their families, coverage is almost total and the results are appreciable, since at this level social well-being can be provided for the majority of the community. Unfortunately, quite frequently the social security systems of the Latin American countries protect only the worker himself (Annex 4)[12] and, sometimes, certain specific groups of workers. Lack of coverage of the family is a serious defect that vitiates the effects of the system, injures family unity (the basis of social organization), and works against basic principles of solidarity.

The consequence of selective coverage of certain groups of workers is that alongside the protected group receiving the benefits

[12] See p. 45.

of social security there is another, sometimes larger, group that has the same or greater needs but is not entitled to such benefits because it is not "insured." In very poor working classes this mere fact of not being insured may place the worker needing medical care in the category of "indigents." And under some systems even the insured worker, if he falls behind in his dues, loses his rights and may become "indigent."

These two differentiated groups of "insured" and "indigent" have led to the maintenance of separate medical care services on the ground that the former, but not the latter, have acquired a "right" to such care through their dues. But today, when the right to health is accepted as universal, as has already been noted, more and more countries are tending to make no distinctions and to care for both groups in the same institutions. In the economically underdeveloped countries, this responsibility is usually assumed by Government institutions, while in the countries with a sound economy and a high per-capita income the role of the private sector is predominant. In both cases the principles of economy and efficiency should be applied, so as to obtain the highest return with the lowest investment.

C. THE PLANNING OF DEVELOPMENT

1. THE PLACE OF HEALTH AND SOCIAL SECURITY IN PLANNING

The lack of economic development, with its concomitant malnutrition, poverty, ignorance, and inadequate housing, is in general a cause of disease; and disease, in turn, by diminishing working capacity, reduces productive capacity and thus leads to poverty and misery. This vicious circle of poverty and disease shows perhaps more objectively than anything else why economic development and an integrated health plan must be promoted simultaneously. Economists have come to understand this, having reached the conclusion that health, education, and economics—disciplines that are essential components of the process of socioeconomic development—are clearly interdependent. Only by approaching development as a harmonious, indivisible whole can we cope successfully with the problem posed for Western civilization by the obvious ecological imbalance in which most of the Latin American peoples live.

Within the intricate machinery that must be put into motion to promote development, health and social security services play a role of prime importance in that health services make it possible to break the vicious circle of poverty and disease by reducing the ravages of disease, while the social security services combat poverty. Planned, balanced and coordinated action in both systems is thus a cornerstone of socioeconomic development and of improved living conditions of the people.

It is therefore unquestionable that health and social security have an obligation to work closely together in the process of socioeconomic development, and to do so they must be fully incorporated into the planning activities. Piecemeal participation is unthinkable. The process of scientific planning requires each discipline to make a quantitative estimate of all its needs and all its resources so as to arrive at a realistic appraisal of the situation and, on that basis, decide on priorities for action. All this leads to the formulation of a policy and the enunciation of an integrated, coordinated plan.

2. BRIEF OUTLINE OF A HEALTH PLAN

A development plan may be national, provincial, statewide, regional, or local; the important point is that the geographical area covered should represent an economic and social unit and that within it the entire population should be included. Any distinction

that tends to exclude one group of the community necessarily affects the chances for success, since the economic and social problems of the excluded group may weigh so heavily on the whole that they become a threat to all and an obstacle to integrated development.

Another prerequisite of the planning process is that the studies include all the elements that make up the sector under examination. In the health sector, for example, it would be impossible to plan activities for prevention and promotion while ignoring those for medical care, or vice versa. It would be absurd, in a community where tuberculosis is a prevalent cause of sickness, disability, and death, to be concerned solely with the preventive needs of vaccination, chemoprophylaxis, case-finding, and isolation, without at the same time treating patients in order to remove the foci of contagion. Conversely, it would be a serious mistake to plan only for diagnosis and treatment while forgetting about all the epidemiological measures for preventing transmission of the disease to the persons surrounding the patient.

Strange as it may seem, such situations have occurred in the past, owing to the dichotomy between public health and medical care by virtue of which the latter is handled chiefly by the social security and welfare agencies. The ministries of health, which are responsible for planning in the health sector, often have no authority to include medical care in their health plans. It is essential that in the future the health plans be truly national and not confined to the activities of the ministries of health. Sectorial, not subsectorial, health planning is advocated.

Estimates of needs in the health sector are customarily made on the basis of available statistics on general morbidity and mortality and the specific rates by age and cause of death. In certain cases, there must be supplementary research into health problems for which the ordinary statistics are inadequate. Extrapolation of experience acquired in other regions may be utilized provided it is subjected to the necessary adjustments; otherwise, it might lead to serious errors.

The inventory of resources must be accompanied by a study of the social return on those resources, since very often resources that might otherwise seem insufficient can be made adequate by means of simple administrative measures that increase their output. A typical example is the number of hospital beds which may be altogether insufficient with an average stay of 20 days but which can be doubled in capacity and return if simple technical-administrative measures reduce the average stay to 10 days. Another resource that should be measured in terms of its benefit is outpatient clinics; this is sometimes quite a difficult problem, for only rarely are clinic costs recorded separately.

Once a complete, realistic, analytical, and comparative appraisal of needs and resources is available, a prediagnosis can be made of the true health situation in the region or country under study. Next it is necessary to decide on priorities, starting from the premise that resources are always smaller than needs. In the setting of priorities, a study of the vulnerability of the various health problems is important, for it is often preferable to begin by attacking the problems that are susceptible of solution by means of available resources, so as to clear away unnecessary problems that complicate the handling of the situation as a whole.

With all these criteria it is possible to shape a health policy and formulate a health plan setting short- and long-range goals and a methodology coordinated with other sectors, so that the manpower and material resources considered essential for carrying out the plan can be progressively developed.

This brief account of the various stages in the preparation of a national health plan has not been given with the intention of setting guidelines in this field; in any event, they have already been laid down by spe-

cialists. Its purpose is merely to emphasize that at every stage in the preparation of a national health plan two concepts dominate and direct the course of all activities: universal coverage and the integration of preventive, curative, and social action.

Today, when the planning of all activities aimed at achieving economic and social development is taken for granted and is being put into practice by the vast majority of the Latin American Governments as a *sine qua non* of Alliance for Progress programs, any system that discriminates among population groups or separates the components of the health sector must be regarded as anachronistic and detached from present-day realities. That is why health and social security have an extremely important part to play in the formulation of the plans, adhering to those basic general concepts and developing their respective medical and social programs—in terms of a worldwide and integrated approach—those programs following a parallel and in some cases convergent course to reach a common goal.

Another purpose of this chapter has been to indicate that the basic tools with which the health planner works bear a relationship to the risks of loss of health, and that the resources available for his work are hospitals, outpatient clinics, and health centers; in other words, health planning is largely made up of the basic elements of preventive and curative medical care.

D. REVIEW OF THE CURRENT SITUATION IN LATIN AMERICA

1. MEDICAL SERVICES OF THE SOCIAL SECURITY INSTITUTIONS

According to data furnished by the Organization of American States, 19 Latin American countries include maternity benefits and 16 included illness benefits among those provided to social security subscribers. Unfortunately, however, in most of these countries only a minority of the population is protected by social security; it may therefore be concluded that social security medical benefits are sometimes a privilege confined to certain selected groups of workers. The great mass of the economically weak in Latin America is excluded from these benefits, and this situation is a serious restriction on the medical services of social security. To this should be added a factor mentioned earlier—the warping of the family group, since the wife and children of the affiliated worker are not in all countries eligible, as he is, to use the social security medical service (Annex 4).[13] This circumstance undermines any possibility of medical-social or epidemiological activity, the importance of which in modern medicine cannot be overlooked.

A large proportion of the social security medical benefits are provided in the form of ambulatory services, centered in large clinics, which are usually located in social security hospitals, cover all the specialties, and have laboratory and X-ray equipment. For general hospitalization in cases of acute illness or maternity care, most social security agencies use their own hospitals. In countries where the "beneficencia" or health ministry hospitals have been able to assume responsibility for the hospitalization of insured patients, the social security agencies have signed agreements with them on the basis of pre-established methods of cost calculation and payment. These arrangements have always promoted greater coordination of benefits, since insured, noninsured, and indigent persons alike have in fact been receiving benefits under the same roof and from the same technical staff.

In other countries, where there was nothing usable in the way of hospitals at the time social security was started, or where the available institutions were old, inadequately equipped, and of limited capacity,

[13] See p. 45.

the social security agencies have had no alternative but to invest part of their funds in building and maintaining hospitals in order to carry out their legal responsibility to provide medical benefits to their subscribers.

In such cases, the hospitals built, equipped, and administered by the social security agencies have as a rule been of better physical quality than the old "beneficencia" or the new ministry hospitals; often they have been well staffed, owing to the higher salaries they have been able to pay.

It is a social fact that the white-collar group is increasing in almost all of Latin America. Thus there is a growing middle class that aspires to a different treatment from that accorded to workers but whose financial resources, in the face of the hazards of illness, make it comparable to the working class; that group has therefore been given social security services of its own. The need to provide medical benefits to a rapidly growing middle class is unquestionably one of the most critical problems in the organization of medical services throughout Latin America.

To summarize, social security in Latin America, by providing effective and timely, though not always economical, medical care, has created a health consciousness in working groups and has channeled large sums of money into medical services—all of which is undeniably advantageous to the general picture of organized medicine. However, the limitation of these benefits to a minority of the population and the creation of group privileges and distinctions are an obstacle to the organization of health services based on modern standards of total coverage and integrated health care.

2. MEDICAL SERVICES OF THE MINISTRIES OF HEALTH AND OTHER GOVERNMENT AGENCIES

The ministries of health comply with their medical care responsibility in very diverse fashions. In some countries the ministries themselves, with State funds, have built and operate free hospitals for indigent and noninsured persons, particularly in rural areas. It is also common for them to maintain rural and suburban outpatient centers that stress preventive activities and tend to be taken for health centers. In federally organized countries, the state or provincial government often runs medical services of various kinds, including hospitals, and it is also customary for some local governments or municipalities to undertake medical care through a network of various facilities, not always coordinated among themselves. All this is an indication of the need felt by governments at various levels to take responsibility for the provision of free services to large masses of population who are not protected by social security and are unable to pay for services themselves in case of illness.

In recent years, the ministries of health have built a number of large regional hospitals, generally in the provincial capitals, that are models of architecture and organization. These hospitals usually perform preventive and curative functions, have large outpatient clinics, and often serve the university faculty as teaching centers for physicians, dentists, nurses, midwives, and other medical care professionals.

Together with the progress of hospital construction, in various countries there has been a strong, clearly defined movement toward the appointment of regional health authorities, who direct the hospitals and other government facilities and are also in charge of coordinating medical facilities not run by the ministry. In practice, however, these efforts at coordination have produced few results because the officials lack legal authority and are not provided with sufficient resources.

Although the governmental hospitals have been established especially to care for the indigent and the noninsured, in practice they have been unable to prevent the increasing use of their facilities by members of the

middle and even the upper class, for whom special departments have been set up. The more personal care furnished in private rooms and with private physicians permits the hospitals to charge for their services as if they were private clinics, but generally at lower rates. These *pensionados,* departments that are very characteristic of Latin American hospitals, are a product of the gradual impoverishment of a middle class that cannot pay for its care in full yet is not protected by social security.

Sometimes the ministry hospitals have been purchased or merely transferred from the old "beneficencias," and their functions of medical care for the destitute classes are therefore often confused with those formerly exercised by the "beneficencia" hospitals. This is a misinterpretation that needs to be corrected. The historical fact is that the Governments took over the old "beneficencia" hospitals because it was no longer realistic, in view of the high and increasing cost of hospital maintenance, to try to finance them merely as a benevolent and charitable activity. Where this has been done, the means have varied in accordance with each country's historical tradition, legal provisions, and individual characteristics. In some, the hospitals have simply been transferred to the State by law; in others, also by law, the authority to direct and administer has been transferred, but the local "beneficencia" boards have been retained; in still others, a system of subsidies has been set up, the acceptance of which entitles the ministries to exert technical supervision and a certain amount of administrative and financial control; in some, finally, the ministry has been granted authority to draw up a hospital construction plan determining location, rules of operation, and construction features, and only hospitals that comply with these requisites are authorized to function.

By means of these various procedures the ministries have taken financial, technical, and administrative control of the old "beneficencia" hospitals. This control has been more or less effective, depending on the ministries' degree of authority. But what is more important is that it has led to a substantial change in orientation. The "beneficencia" hospitals were basically charitable and voluntary, devoted to elementary diagnosis and treatment by very simple means; the attending doctors were generally unpaid physicians, and all other activities—nursing, pharmacy, diet, and so on—were run by nuns. Under ministry control, the hospitals have, in general, become modern centers for integrated medical care, where services are granted as a right and where the most recent scientific advances are used for the benefit of individual and community health. Care is in the hands of full-time specialized professionals, and the facility operates 24 hours a day, providing emergency as well as regular service.

In other words, besides taking over the buildings of the "beneficencia" hospitals, the ministries have also changed their orientation.

The great operational limitation on ministry hospitals, in almost all the countries where they exist, has been a shortage of resources. Adequate financing of ministry facilities is consequently imperative if these hospitals, some of which are well staffed with qualified personnel and have excellent installations and equipment, are expected some day to carry out fully the function being assigned them by society.

3. RESOURCES IN PERSONNEL AND INSTALLATIONS

a. *Manpower*

Unquestionably the most serious obstacle to the development of medical care services in Latin America is the shortage of manpower and material resources. The problem is not only one of lack of adequate premises, which many countries have managed to overcome, but of lack of trained staff to run them, which forces the various

employing institutions to compete in a very tight labor market.

The shortage of resources limits the remuneration of the staff. This has had a strong impact on their efficiency, for it has been difficult to arouse a new spirit and a mental attitude more in accord with the new directions in the health sciences. This is especially noticeable in the lower-echelon staff members, who lack proper training and competence. Insufficient pay makes it impossible to attract more highly qualified personnel.

The medical staff, equally badly compensated, has had to resort to private practice to supplement its income; in this dual role, they are sometimes subjected to a tug of opposing forces, in which the hospital activity suffers.

According to PASB statistics,[14] the average number of physicians for all the Latin American countries was 5.8 per 10,000 population in 1962, which would not be too unfavorable if they were evenly distributed. It must be recalled, however, that the range between countries, and also between cities and rural areas in the same country, is wide. While the large capitals had from 7.3 to 28.8 physicians per 10,000 population in 1962, a rate comparable with that of any developed region in the world, there were areas in the interior where the figure was from 0.5 to 8.0 per 10,000, and there are even very remote areas where one physician is found for 50,000 to 60,000 population. This situation is understandable; it results from lack of development in the rural areas, where there are no adequate living conditions for a professional and where the people's capacity to consume medical services is minimal because of their economic backwardness. In an effort to attract physicians to these areas, the ministries of health have built rural hospitals, some of them very well equipped; offered financial incentives in the form of special cash bonuses; and even passed laws that require young physicians, as part of their training, to serve in rural areas for a certain period of time. In actual fact, none of these systems has been successful; despite everything, positions in rural areas remain vacant for years.

Only rarely have the social security agencies made a full-scale attack on the rural problem, chiefly because the rural population is not usually covered. When it has been necessary to set up facilities, they have been limited as a rule to medical posts, with professional services two or three times a week and a resident staff that is not university-trained, as a means of providing minimal medical care and thus complying with the legal requirement, if any.

The universities are contributing to the training of physicians in about a hundred medical schools, but the effort still seems insufficient; in general, the annual number of graduates barely covers the professional attrition, and the shortage is increasing as a result of the growth of the population and its greater health consciousness, which adds to the demand for services.

If the number of physicians is insufficient, the lack of nurses and midwives is almost dramatic. In Latin America as a whole there are only 2.1 nurses per 10,000 population. As a result of the lack of midwives, together with the scarcity of physicians, no less than 85 per cent of the births in some isolated rural areas take place with no professional attendance of any kind. The health authorities have tried to make up for the shortage of nurses with auxiliary personnel, trained intensively and in large numbers. The services of the auxiliaries are limited, however, because their training is rudimentary, consisting of 6- to 12-month courses after a minimum not exceeding three years of secondary schooling. They can only work under supervision and have not been legally authorized to attend births, so that the serious problem of obstetrical care remains unsolved.

[14] *Health Conditions in the Americas, 1961–1962. Scientific Publication PAHO* 104. Washington, D. C., 1964.

The supply of dentists and pharmacists is somewhat better. In addition, in several countries schools of medical technology have been set up to train university-level personnel qualified to do laboratory work under medical supervision.

b. *Material resources*

The situation with respect to hospital beds also varies greatly from country to country and from one region to another within the same country. Some countries have as many as 6.0 per 1,000 population, while others have barely 0.6.[15] These beds are concentrated in the large cities and particularly in the industrial areas. This situation of scarcity and poor distribution is another factor contributing to discrimination and to the provision of medical facilities only to selected population groups.

Ambulatory facilities are especially well developed and contribute effectively to the care of a large number of patients. Almost every hospital has a very active and very busy outpatient clinic. There are also clinics not connected with hospitals, often established by the social security agencies, that have very effectively strengthened medical care, particularly in industrial and suburban areas. The ministries of health, for their part, have set up health centers engaged chiefly in preventive work but necessarily directed into medical care because of client pressure.

The availability of these resources in the various Latin American countries is directly proportionate to each country's economic development and to the financial capacity of the sponsoring organization. In general, the greatest economic resources are found in the social security agencies; the facilities of the ministry of health are usually poorer; and those of the "beneficencias" are poorest of all. Hence the availability of services to the different population groups varies enormously, and the distinctions originally established by law are aggravated by nonaccessibility of sources, which emphasizes the differences in favor of certain groups.

[15] *Ibid.*

4. PERSONS RECEIVING BENEFITS

a. *Urban workers in business and industry*

These workers have been the chief concern of the social security agencies. They are equally privileged in medical care; generally they have at their disposal outpatient and domiciliary services provided directly by the social security agencies, and also hospitalization either in facilities of their own or, under contract, in those of the ministry or the "beneficencias." The same is true of dental care and drugs. Though these facilities are usually quite crowded, they sometimes exhibit a high degree of technical efficiency and enjoy prestige among insured clients.

b. *Workers in isolated industrial establishments (mines, oilfields, sugar mills)*

These workers often have available good-quality services in hospitals set up and maintained by the companies. These services generally result from labor agreements, with the social security agencies participating by delegating authority and sometimes turning dues back to the companies. Unlike medical facilities for urban workers, which as a rule are exclusively for the insured worker himself and not for his family, these company hospitals care for family members so long as they live on the grounds. This sometimes leads to difficult situations when married workers cannot find lodgings on the grounds and are obliged to live in satellite communities, whereupon their relatives are deprived of medical care.

c. *Agricultural workers*

These workers are seldom covered by social security and depend entirely on whatever free medical services are provided by the "beneficencia" or ministry of health hos-

pitals. It cannot be denied that in recent years there has been some progress in rural medical care as a result of the hospital construction plans of the ministries, which have placed special emphasis on rural facilities. In areas where one of these hospitals has been built, the care provided is integrated—preventive, curative, and social—and is available free of charge to the entire population. The rural areas of Latin America as a whole, however, are a long way from being covered by hospitals of this kind, and those that have been built suffer seriously from lack of manpower and material resources, as has been explained.

d. *Public and private white-collar workers*

These workers constitute the emerging class of most of the Latin American countries. Day by day they are becoming more aware of their rights, they demand to be treated in accordance with their social importance, and they seek the establishment of facilities of their own within their social security agencies, as has already been done in a few cases. These hospitals are usually extremely comfortable and give maternity care to members' wives—the obstetrical services being generally the busiest.

e. *The armed forces and the police*

These services commonly have medical facilities of their own for members and their families, financed from the national budget.

f. *Railroad personnel*

In some countries, for reasons of historical tradition not clearly defined, these persons enjoy medical services of their own.

g. *The indigent*

This group makes up a heterogeneous and very numerous one in the Latin American countries. Besides the unemployed, this category typically includes many self-employed workers, peddlers, and domestics, who are not affiliated with social security or are not entitled to benefits as dependents of an insured worker. They must all, therefore, resort to hospitals of the ministries of health, where they sometimes have to prove lack of means.

h. *Moderate-income people*

These people cannot, in general, meet the cost of complex and expensive diagnosis or treatment as required in prolonged illness or surgery. As science progresses, the costs of medical care are rising, as is the number of persons in this group, whose size is difficult to estimate. This group, poorly defined and known in some countries as the "medically indigent," is at the bottom of most of the conflict among the ministries of health, the social security agencies, and the medical profession. Basically, it consists of those who under a broad social security system should be entitled to medical benefits as insured persons.

Since most of the systems now in effect in Latin America do not cover them, the members of this group constitute the potential "clientele" of the private physician, but since they cannot pay for this care out of their own pockets, they are forced to seek free care in the hospitals. Thereupon, they enter into competition with the insured, who are the legal beneficiaries, and create a conflict with the medical profession, whose workload varies in proportion to the number of patients requesting care in the outpatient clinics of the hospitals.

i. *The well-to-do classes*

These groups are made up of landowners, industrialists, bankers, high officials in government and business, and all who have a large income that enables them to pay for the services they receive. They are customarily attended by distinguished physicians and are hospitalized in private clinics or in the *pensionados* of ministry of health hospitals. They constitute a small percentage of

the population and pose no medical-social problem.

* * *

To summarize, the number of persons receiving social security medical benefits in the Latin American countries is limited because the active population in these countries is relatively small. The interplay of various demographic and social elements is responsible for this situation. For one thing, these are young populations, with children and adolescents predominating; for another, there is a large number of invalids as a result of diseases and accidents; finally, job scarcity in many phases of the economy maintains a residue of regional and seasonal unemployment. In short, it may generally be said that no more than a third of the population works; and if to this is added the fact that the prevailing systems are selective, leaving large sectors uncovered by their benefits or without access to medical care, and that nonworking members of the family are not included in all countries, the outcome is that a very small proportion of the total population, varying by country, enjoys access to social security medical services. At the other extreme is the high-income group, which pays its own expenses and, as has been said above, is a minority.

Outside the affiliated group and the paying group is the great mass of the Latin American population, which is totally or partially incapable of coping with the financial problem of illness and falls into indigence as soon as it suffers prolonged illness or needs costly treatment. This enormous group, which may be estimated at about two thirds of the population and is poorly defined, is the one that creates the greatest difficulties and originates conflicts among the interested parties—that is, social security, ministries of health, and the medical profession.

Then too must be added several subgroups of the population that, though theoretically entitled to medical benefits, have no access to them because of an absence of services or a lack of personnel to provide them. This is the case, for example, in a good share of the rural communities, where there are workers who are affiliated with some social security system that theoretically guarantees them benefits but who cannot make use of them because of a complete lack of facilities. A similar instance is that of certain industrial or mining encampments that have facilities, sometimes including a small hospital, but because of their isolation cannot get physicians, nurses, or midwives at any price, so that the service does not operate or is handled badly by auxiliaries.

5. NEED FOR ADDITIONAL INFORMATION

What has been said above was extracted and summarized from various publications; [16] though it may at times suffer from oversimplification, it will serve as an introduction to the topic, to show its different facets and open discussion of possible solutions.

However, because there has not been in all the countries an objective analysis of the situation that would show the availability of resources, their accessibility, the cost of benefits, the ability to pay of various populations groups, and so on, the problem continues to be discussed on a theoretical basis and is strongly influenced by the interests of the various participating sectors. Hence the formulation of partial solutions that benefit certain groups who manage to exert enough pressure at a given moment but that do not follow a well-defined development plan and hinder an over-all solution.

For this reason, it is thought that the international institutions concerned with the

[16] Bravo, Alfredo Leonardo: "Development of Medical Care Services in Latin America." *Amer J Public Health* **48:** 434-447, 1958; Roemer, Milton I.: *Medical Care in Latin America.* OAS/PAHO Studies and Monographs III. Washington, D. C., Pan American Union, 1963; Pan American Health Organization and Organization of American States: *Planificación en salud y seguridad social en la República de El Salvador* (mimeographed), Washington, D. C., 1963.

matter might sponsor national surveys, with international assistance, to obtain the basic information indispensable to an objective and realistic analysis of the problem.

A scientific, sociological, and statistical study in depth should be made by means of a survey that will permit the gathering, at first hand, of reliable data. Aside from the technical obstacles caused by the lack of uniform statistics and precise definitions, it is necessary to arouse a disinterested, cooperative attitude on the part of institutions and individuals.

The study would be conducted in the countries that agreed to provide the necessary data. They would be offered advisory services, a team of OAS and PAHO experts being sent in such cases. In Annex 5 [17] are listed a series of points that might serve as the basis for the survey.

E. EFFORTS AT COORDINATION OR INTEGRATION

The need for coordinating the activities of the various medical care services is in the minds of most of those responsible for health administration in Latin America. A number of measures toward this end have in fact been put into effect in various countries. Some examples follow:

1. The granting of subsidies by the central Government to the local "beneficencia" boards and similar bodies. Along with the subsidy, the ministry has usually imposed technical and administrative standards and has assumed supervisory functions. The standards have indeed been minimal and the function of superintendence has not been practiced regularly for lack of inspectors, but in any case written agreements have been made that are progressively orienting activities toward common goals. When the subsidies have reached a sizable sum, transfer of the hospitals has occurred almost spontaneously and by agreement of the parties. This has been an inevitable consequence of the rise in hospital operating costs, whenever an attempt is made to maintain a high scientific level of medical care.

2. Coordination among the various social security agencies in a single country. Through a Chief Coordinating Council, a considerable amount of uniformity of activities and procedures has been achieved among the various agencies providing medical benefits to different labor sectors, and it has been arranged that hospitals built in the future will offer services without distinction to members of all the institutions.

3. The granting of social security benefits not only through the agencies' own facilities but also through the use of ministry or other hospitals, under contract. In certain countries, the extension of social security is subordinated to the construction of new hospitals by the Government; social security is thus ensured an adequate place in which to provide its medical benefits, and the ministry of health is insured an income for the maintenance of the hospital.

4. The application of ministry of health technical directives in such fields as statistics, immunization, and pharmaceuticals in all medical facilities in the country, including those run by social security.

5. The contracting of services in social security hospitals by the ministries of health to care for indigents in places where the ministries have no hospitals of their own.

6. The establishment by the ministries of health of a pyramidal administrative structure, with regional decentralization and the appointment, in each region, of a chief health officer to supervise all medical services in the area. In practice, many of these regional authorities have lacked the legal and financial backing necessary for effective action.

[17] See p. 47.

7. The passage of a law whereby certain formerly separate services for health protection, promotion, and restoration are integrated administratively, financially, and technically: the public health services of the ministry of health, the mother and child services, the "beneficencia" hospitals, the medical services of social security, and the industrial hygiene functions of the ministry of labor.

8. Transfer to the ministry of health, by law, of the medical services of the social security agencies, formerly operated independently.

It can easily be seen that definite, though isolated and sporadic, steps have been taken in the countries to promote some coordination or integration, depending on circumstances, of the respective health services of social security and the ministry of health. But it is apparent that there is no general trend in this direction as yet, and that time and effort will be needed to overcome pockets of resistance in institutions, trade unions, and the organized medical profession. It must be hoped that fuller information on the subject will create a shift in opinion toward putting the common good above parochial interests. For the sake of greater coordination of services, the present document, by attempting to gather together all the available evidence, seeks to facilitate the work of the Study Group and to lead to final recommendations that will be of practical help to the Member Governments.

F. THE CURRENT LACK OF COORDINATION AND MEANS OF REMEDYING IT

An awareness exists—it has been expressed again and again at many national meetings and by various persons—that the current lack of coordination is a source of discrimination from the social standpoint, of restrictions on epidemiological activity from the public health standpoint, and of waste from the financial standpoint. There is further a consensus, among the ministries of health of the Americas and among the members of the Governing Bodies of the Organization of American States and the Pan American Health Organization, that it is essential to take steps toward putting all public health and medical care activities under a single technical leadership that will promote the application of the latest advances in medicine through administrative coordination that permits uniformity of procedures and pay scales.

Who is hindering this coordination? What are the forces that have prevented reaching an understanding that is in the air? This is what we shall try to explain in this chapter; constructively, we shall propose certain measures that might mean progress toward coordination.

1. ELEMENTS INVOLVED IN THE LACK OF COORDINATION

a. *The medical profession*

In general, physicians distrust any system of social security and governmental medical services in which medical practice loses its independence and members of the profession become salaried employees of the insurance institution or, what is sometimes considered even worse, civil servants of the State. This advocacy of private practice, which is tending to diminish in the Latin American countries, excites varying degrees of fervor and is approached from very different angles.

On occasion, proposals to establish or extend a social security system have aroused the medical profession to trade-union activity ranging from protest to strikes. In other cases, the opposition has been expressed in more moderate fashion. For example, when physicians believed that certain legislation would result in reducing the private practice of medicine, they insisted that their financial interests be protected by means of free choice of physician and the payment of fees for service in accordance

with a schedule set up in advance by the Medical Society. The medical class has also asked to play the leading role in the administration of medical care services in which they participate.

In short, a common denominator in the various American countries is defense of the private practice of medicine. The question asked by the Director of the Pan American Sanitary Bureau, in his opening address to the meeting of the Advisory Group on Medical Care (Washington, 1962), is thus an important one: "What is the most suitable scheme for protecting, on the one hand, a worthy profession and, on the other, of ensuring that efficient and speedy service is rendered for the benefit of the community?" [18]

Probably the reply to this basic question will have to come by way of a compromise, in which the medical profession recognizes the course marked out for it by the progress of the social sciences and the organizations providing medical care accept the fact that physicians are the foundation of services (for care could not be provided without them) and are, therefore, entitled to proper consideration. The physician is, indeed, the professional in charge of providing medical care, and since this is a basic service in any health plan, there is clearly a close interrelationship between organized health services and the medical profession. It is the steadily increasing State intervention in the administration of medical services that brings the interest of the two into conflict. The problem becomes even more acute when social security enters into medical services, for its economic power and its autonomy often seem to the medical profession like evidence of strong competition.

The problem deserves the greatest attention, for without sincere and effective cooperation by the medical profession no active governmental medical organization can be expected.

[18] "Toward the Formulation of a Medical Care Policy." Document TFH/9 (mimeographed).

b. *The labor sectors*

Organized labor and unions generally mistrust public medical care and are more willing to accept the care dispensed by social security agencies, to the administration of which they have access and with which they are accustomed to deal. Certain class prejudices in the Latin American countries are also of interest: the private white-collar employee does not wish to mix with his opposite number in the Government, and both desire separation from the workingman. This attitude is fostered by the diversity of social security systems and by the inequality of benefits guaranteed by law to different labor groups.

But, apart from these social attitudes, there are unions that want the medical care given them to be more individualized, in outpatient clinics particularly and sometimes also in hospitals. They want to be free to choose their own physicians (here they agree with the medical profession) and also the hospital or clinic in which they will be treated. Finally, they want (in this case in opposition to the physicians) a significant voice in the administration of the service, so that they can be sure the funds of their group will not be used to finance care for other groups or to make up for fiscal budget deficits.

Obviously, meeting all these aspirations, together with those of the medical profession, makes the organization of governmental medical services difficult. On the other hand, most of these labor groups are unable to finance medical services by themselves, and to obtain them they need State subsidy.

c. *The social security agencies*

The social security agencies' militant support of keeping medical benefits within the framework of their own administration is understandable, since this service gives them the desired institutional prestige and an opportunity to show tangible results. They are also interested in granting personal and social

benefits, which bring them into direct contact with the affiliated members and enable them to gain their support and cooperation.

The prestige of the social security agencies is bolstered by their great economic resources, which generally enable them to build and maintain hospitals and outpatient clinics that are better equipped than those of the ministries of health. They also pay their physicians better, and this helps them attract outstanding professionals to their service.

Against them is the unarguable fact that they protect only a minority of the population and that even within this sector there are groups enjoying more in the way of benefits.

From the technical standpoint, they suffer from the serious defect of concentrating solely on curative aspects, generally neglecting preventive activity. Though the contrary is frequently upheld, in view of the fact that some agencies contribute to the cost of the preventive campaigns of the ministries of health, it is inevitable that preventive and epidemological work should be limited by lack of access of the entire population.

d. *The ministries of health and other Government agencies*

The traditional approach and the priority standards that led the Latin American ministries of health to concern themselves chiefly with problems of environmental hygiene, health education, control of communicable diseases, and, at most, mother and child protection have hampered their progress by allowing social security medical services to develop independently for years. Only recently has the incontrovertible evidence of experience in the field caused modern concepts of integrated medicine to penetrate the ministries of health. The fact is that pure preventive medicine cannot be practiced with destitute and sick populations, whose most pressing needs are for medical care and financial aid.

Since most of these populations are rural and a large proportion of them are not covered by the existing social security systems, the ministries of health have had to assume the entire responsibility, with a well-worked-out concept of social health in accordance with the WHO definition. Since, in addition, rural medicine is impossible in isolation, without the backing of urban services with all the medical specialties, the ministries have had to take the further step of setting up urban hospitals to absorb patients from the rural areas and also to serve the numerous groups of city inhabitants who do not have the means to pay for care in case of illness. Their limited resources have obliged them to develop architecturally modest facilities, which have often turned out to be too small to cope with the growing demand of a population that not only is increasing considerably but is becoming ever more aware of the value of health and therefore demands more services and goes more often to the doctor.

In favor of the public service is its policy of broad coverage and its integration of preventive, curative, and social medicine. Against it are its shortage of resources and its lack of legal authority to take other medical services under its control—this despite the fact that its legal status is usually defined in the Constitution, which declares health to be an obligation of the State and therefore gives the ministry dominion over all problems related to health.

More powerful reasons than the purely technical have so far impeded the centering of this constitutional authority in the technical organization created by the Governments themselves to deal with health problems.

2. PROPOSED MEASURES FOR PROMOTING COORDINATION

Now that the factors involved have been analyzed, it is the responsibility of the Study Group to propose to the OAS and PAHO

measures that will overcome the difficulties and result in greater coordination or, if possible, integration of the medical facilities of social security with those of the ministries of health or the national health services, as the case may be. They flow from the background presented in the previous pages:

a. *Integrated planning of economic and social development,* in which health and social security should occupy the prominent place befitting them as sectors of social progress—the former seeking the highest possible degree of health for all members of the community and the latter restoring the earning capacity and therefore the purchasing power of wage earners and their families when they are temporarily or permanently incapacitated for work, and contributing with their economic resources to the construction, equipping, and maintenance of hospitals and other local health facilities.

If planning is viewed as the harmonious arrangement of activities to obtain the highest possible return on the available resources for the purpose of achieving short-range and long-range goals, it is apparent that adopting it as a system must entail the combining of services and the formulation of a unified social policy.

The participation of social security agencies in health planning is essential to insure that planning at the national level will take into account the resources and facilities of every organization providing medical care. Any effort to promote better utilization of the limited manpower, material, and financial resources that a country can devote to the health sector must necessarily have at its disposal a complete inventory of medical and paramedical personnel, hospitals, outpatient clinics, health centers, and medical posts and of the funds available to finance medical services. Only with this information can health activities be planned to deal with the needs of the entire population. It may be, however, that many countries are not yet prepared to apply the planning method so broadly and fully. Other, simpler measures are therefore suggested, which may be regarded as preliminary, temporary stages.

b. *Standardization, on the national level, of the various social security systems,* to eliminate inequality of programs, which is a disturbing factor when individual and broader benefits are demanded. This standardization should affect dues (an equal percentage of wages, up to a ceiling), benefits, and payment of officials, who should receive equal pay for equal work (this would include physicians and paramedical personnel), with incentive allowances to attract enough people for heavy work or work that involves sacrifices (rural areas, night work, and so on).

c. *Extension of coverage of social security programs* to protect all wage- and salary-earning groups and their families, including small businessmen, small manufacturers, small farmers, and so on. A close look might well be given to such regulatory mechanisms as control of morbidity, regular examinations, health education, cost sharing for repeat consultations, and justified hospitalization, and also to the possibility of charging for certain services (hospitalization in a *pensionado,* false teeth, gold inlays, free choice of professional man, and so on).

Such a system would provide universal basic coverage, a satisfactory minimum of care to cover the risks of illness and accidents, and additional benefits for those who wanted them or could afford to pay for them.

d. *Establishment of health insurance* along British lines, with the entire population enrolled and with payments made by the head of the household at any Treasurer's office or even at the post office, the amount depending on family size and income. This requires a level of education and economic development that perhaps few Latin American countries have attained. Probably, under

present conditions, most of the rural population and certainly all the Indian population could not pay even the minimum. The rate would have to be based on the cost of the integrated health service and should represent a percentage of it, the rest to be paid by the Treasury through the national budget, financed by the general taxes. A by-product of this system, which would not burden the employer directly, would be that, with the costs of production lowered, a reduction in prices could be demanded; the cost of services would no longer be allowed to be charged to prices.

With good planning, the health service income plus the Government contribution would result in financing adequate to cover the costs of an integrated health service, without the financial limitations now felt by the ministries of health.

e. *Strengthened financing and legal authority for the ministries of health,* to give them the resources for improvement of services and the legal power to carry out the function of coordination. This authority and these financial resources are unquestionably implicit in the legislation passed when the final stage of integrated planning is reached. But until this time comes the ministry of health might be given greater authority—for example, to study and decree a construction plan for hospitals and other health facilities and to require that all construction, public, semipublic, or private, adhere to it, so that no hospital, health center, or polyclinic could be built without authorization by the ministry of health and without meeting its specifications.

f. *Coordination of local health activities,* the easiest and most elementary way to start coordination. In small towns in rural or mining areas, coordination occurs *de facto* in the person of the only available physician. With a systematic plan and the good will of the parties, however, coordination could be carried a little further—as, for example, in small cities or districts of large ones where the institution with the best building provides space for another, so that the staffs of the two become accustomed to working under the same roof while still preserving their institutional individuality. This promotes consultation and prompt referral, with obvious benefit to the patient. Also, in small cities, agreement may be reached for joint use of the only X-ray machine or laboratory. Examples of such arrangements are found in many countries, and more could be encouraged.

g. *Organization of union seminars,* to acquaint workers with the objectives and advantages of integrated medical care service, with its relationship to social security, and with the way in which the most advantageous use can be made of facilities without unduly burdening them. Through informative courses or seminars, the intelligent cooperation of the unions could be obtained and their opposition lessened.

There is no doubt, however, that beyond all these methods, which will take more or less time to put into effect through the channels of law and regulations, what matters most is mutual good will and an intelligent understanding by both the ministries of health and the social security agencies that social progress, the essential complement of economic development, can be achieved only when each fulfills its respective assignment. Both are important instruments of social well-being and of a rise in the standard of living, and they should not engage in futile competition but should cooperate to reach their common goals.

As was aptly said by the Director of the Pan American Sanitary Bureau at the XV General Assembly of the International Social Security Association (Washington, 1964), "the health sciences are evolving progressively and parallel with the social sciences. One need only examine the definition proposed in the Basic Charter of the World Health Organization to appreciate its universality as an affirmation, as a postulate at

the service of man and as an ethic of hopeful aspiration. The somatic, spiritual, and social aspects are intermingled in a harmonious conception that makes health an attribute of a life fully lived and realized. It may thus be said that the development of the social sciences and of health are parallel and consubstantial, which explains their common aims, many still unfulfilled but all aspired to."

ANNEX 1

Resolution XL [1] of the XV Meeting of the PAHO Directing Council (Mexico, D. F., Mexico, 1964)

Study of the Relationship between Social Security Medical Programs and those of Ministries of Health or Other Official Health Agencies

THE DIRECTING COUNCIL,

Having examined the report of the Director on the relationship between social security medical programs and those of ministries of health or other official health agencies (Document CD15/15); [2]

Considering that it is necessary to improve the procedures designed to achieve active health planning, extend the coverage of health services, coordinate the financing schemes, and integrate preventive and curative activities; and

Considering that the social security agencies are in a position to give assistance in the preventive programs of governmental agencies responsible for serving the entire population,

RESOLVES:

1. To take note of and thank the Director for his report on the relationship between social security medical programs and those of ministries of health or other official health agencies (Document CD15/15).

2. To instruct the Director to continue to provide advisory services to the countries at their request and to promote the coordination of international organizations interested in this subject.

3. To recommend to the Director that he convene a Study Group to present to the Organization a report containing its views regarding the promotion of better coordination among the public health services and the medical care programs provided by the social security agencies and other organizations, and that he transmit that report to the Governments in due course.

4. To authorize the Director to take into account, when implementing the program and budget for 1965, such new needs as may arise from this resolution.

[1] Approved at the fifteenth plenary session, 9 September 1964.
[2] See *Official Document PAHO* **60**, 328-335.

ANNEX 2

Recommendation 69 of the XXVI Session of the International Labour Conference (Philadelphia, Pennsylvania, 1944)[1]

Recommendation Concerning Medical Care

The General Conference of the International Labour Organisation,

Having been convened at Philadelphia by the Governing Body of the International Labour Office, and having met in its Twenty-sixth Session on 20 April 1944, and

Having decided upon the adoption of certain proposals with regard to the question of medical care services, which is included in the fourth item on the agenda of the Session, and

Having determined that these proposals shall take the form of a Recommendation, adopts this twelfth day of May of the year one thousand nine hundred and forty-four the following Recommendation, which may be cited as the Medical Care Recommendation, 1944:

Whereas the Atlantic Charter contemplates "the fullest collaboration between all nations in the economic field with the object of securing for all improved labour standards, economic advancement and social security"; and

Whereas the Conference of the International Labour Organisation, by a Resolution adopted on 5 November 1941, endorsed this principle of the Atlantic Charter and pledged the full co-operation of the International Labour Organisation in its implementation; and

Whereas the availability of adequate medical care is an essential element in social security; and

Whereas the International Labour Organisation has promoted the development of medical care services—

by the inclusion of requirements relating to medical care in the Workmen's Compensation (Accidents) Convention, 1925, and the Sickness Insurance (Industry, etc.) and (Agriculture) Conventions, 1927.

by the communication to the Members of the Organisation by the Governing Body of the conclusions of meetings of experts relating to public health and health insurance in periods of economic depression, the economical administration of medical and pharmaceutical benefits under sickness insurance schemes, and guiding principles for curative and preventive action by invalidity, old-age and widows' and orphans' insurance.

by the adoption by the First and Second Labour Conferences of American States of the Resolutions constituting the Inter-American Social Insurance Code, by the participation of a delegation of the Governing Body in the First Inter-American Conference on Social Security which adopted the Declaration of Santiago de Chile, and by the approval by the Governing Body of the Statute of the Inter-American Conference on Social Security, established as a permanent agency of co-operation between social security administrations and institutions acting in concert with the International Labour Office, and

by the participation of the International Labour Office in an advisory capacity in the framing of social insurance schemes in a number of countries and by other measures; and

[1] International Labour Office: *International Labour Conference—Agreements and Recommendations.* Geneva, Switzerland, 1952.

Whereas some Members have not taken such steps as are within their competence to improve the health of the people by the extension of medical facilities, the development of public health programmes, the spread of health education, and the improvement of nutrition and housing, although their need in that respect is greatest, and it is highly desirable that such Members take all steps as soon as possible to reach the international minimum standards and to develop these standards; and

Whereas it is now desirable to take further steps for the improvement and unification of medical care services, the extension of such services to all workers and their families, including rural populations and the self-employed, and the elimination of inequitable anomalies, without prejudice to the right of any beneficiary of the medical care service who so desires to arrange privately at his own expense for medical care; and

Whereas the formulation of certain general principles which should be followed by Members of the Organisation in developing their medical care services along these lines will contribute to this end;

The Conference recommends the Members of the Organisation to apply the following principles, as rapidly as national conditions allow, in developing their medical care services with a view to the implementation of the fifth principle of the Atlantic Charter, and to report to the International Labour Office, as requested by the Governing Body, concerning the measures taken to give effect to these principles:

I. GENERAL

Essential Features of a Medical Care Service

1. A medical care service should meet the need of the individual for care by members of the medical and allied professions and for such other facilities as are provided at medical institutions—

(*a*) with a view to restoring the individual's health, preventing the further development of disease and alleviating suffering, when he is afflicted by ill health (curative care); and

(*b*) with a view to protecting and improving his health (preventive care).

2. The nature and extent of the care provided by the service should be defined by law.

3. The authorities or bodies responsible for the administration of the service should provide medical care for its beneficiaries by securing the services of members of the medical and allied professions and by arranging for hospital and other institutional services.

4. The cost of the service should be met collectively by regular periodical payments which may take the form of social insurance contributions or of taxes, or of both.

Forms of Medical Care Service

5. Medical care should be provided either through a social insurance medical care service with supplementary provision by way of social assistance to meet the requirements of needy persons not yet covered by social insurance, or through a public medical care service.

6. Where medical care is provided through a social insurance medical care service—

(*a*) every insured contributor, the dependent wife or husband and dependent children of every such contributor, such other dependants as may be prescribed by national laws or regulations, and every other person insured by virtue of contributions paid on his behalf, should be entitled to all care provided by the service;

(*b*) Care for persons not yet insured should be provided by way of social assistance if they are unable to obtain it at their own expense; and

(*c*) the service should be financed by contributions from insured persons, from their employers, and by subsidies from public funds.

7. Where medical care is provided through a public medical care service—

(*a*) every member of the community should be entitled to all care provided by the service;

(*b*) the service should be financed out of funds raised either by a progressive tax specifically imposed for the purpose of financing the medical care service or of financing all health services, or from general revenue.

II. PERSONS COVERED

Complete Coverage

8. The medical care service should cover all members of the community, whether or not they are gainfully occupied.

9. Where the service is limited to a section of the population or to a specified area, or where the contributory mechanism already exists for other branches of social insurance and it is possible ultimately to bring under the insurance scheme the whole or the majority of the population, social insurance may be appropriate.

10. Where the whole of the population is to be covered by the service and it is desired to integrate medical care with general health services, a public service may be appropriate.

Coverage Through a Social Insurance Medical Care Service

11. Where medical care is provided through a social insurance medical care service, all members of the community should have the right to care as insured persons or, pending their inclusion in the scope of insurance, should have the right to receive care at the expense of the competent authority when unable to provide it for themselves.

12. All adult members of the community (that is to say, all persons other than children as defined in paragraph 15) should be required to pay insurance contributions if their income is not below the subsistence level. The dependent wife or husband of a contributor should be insured in virtue of the contribution of her or his breadwinner, without any addition on that account.

13. Other adults who prove that their income is below the subsistence level, including indigents, should be entitled to care as insured persons, the contribution being paid on their behalf by the competent authority. Rules defining the subsistence level in each country should be laid down by the competent authority.

14. If and so long as adults unable to pay a contribution are not insured as provided for in paragraph 13, they should receive care at the expense of the competent authority.

15. All children (that is to say, all persons who are under the age of sixteen years, or such higher age as may be prescribed, or who are dependent on others for regular support while continuing their general or vocational education) should be insured in virtue of the contributions paid by or on behalf of adult insured persons in general, and no additional contribution should be payable on their behalf by their parents or guardians.

16. If and so long as children are not insured as provided for in paragraph 15, because the service does not yet extend to the whole population, they should be insured in virtue of the contribution paid by or on behalf of their father or mother without any additional contribution being payable on their behalf. Children for whom medical care is not so provided should, in case of need, receive it at the expense of the competent authority.

17. Where any person is insured under a scheme of social insurance for cash benefits or is receiving benefit under such a scheme, he and his qualified dependants, as defined in paragraph 6, should also be insured under the medical care service.

Coverage Through a Public Medical Care Service

18. Where medical care is provided through a public medical care service, the provision of care should not depend on any qualifying conditions, such as payment of taxes or compliance with a means test, and all beneficiaries should have an equal right to the care provided.

III. THE PROVISION OF MEDICAL CARE AND ITS COORDINATION WITH GENERAL HEALTH SERVICES

Range of Service

19. Complete preventive and curative care should be constantly available, rationally organized and, so far as possible, coordinated with general health services.

Constant Availability of Complete Care

20. Complete preventive and curative care should be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an administrative, financial or political nature, or otherwise unrelated to their health.

21. The care afforded should comprise both general-practitioner and specialist out- and in-patient care, including domiciliary visiting; dental care; nursing care at home or in hospital or other medical institutions; the care given by qualified midwives and other maternity services at home or in hospital; maintenance in hospitals, convalescent homes, sanatoria or other medical institutions; so far as possible, the requisite dental, pharmaceutical and other medical or surgical supplied, including artificial limbs; and the care furnished by such other professions as may at any time be legally recognised as belonging to the allied professions.

22. All care and supplies should be available at any time and without time limit, when and as long as they are needed, subject only to the doctor's judgement to such reasonable limitations as may be imposed by the technical organisation of the service.

23. Beneficiaries should be able to obtain care at the centres or offices provided, wherever they happen to be when the need arises, whether at their place of residence or elsewhere within the total area in which the service is available, irrespective of their membership in any particular insurance institution, arrears in contributions or of other factors unrelated to health.

24. The administration of the medical care service should be unified for appropriate health areas sufficiently large for a self-contained and well-balanced service and should be centrally supervised.

25. Where the medical care service covers only a section of the population or is at present administered by different types of insurance institutions and authorities, the institutions and authorities concerned should provide care for their beneficiaries by securing collectively the services of members of the medical and allied professions and by the joint establishment or maintenance of health centres and other medical institutions, pending the regional and national unification of the services.

26. Arrangements should be made by the administration of the service for securing adequate hospital and other residential accommodation and care, either by contracts with existing public and approved private institutions, or by the establishment and maintenance of appropriate institutions.

Rational Organisation of Medical Care Service

27. The optimum of medical care should be made readily available through an organisation that ensures the greatest possible economy and efficiency by the pooling of knowledge, staff, equipment and other resources and by close contact and collaboration among all participating members of the medical and allied professions and agencies.

28. The wholehearted participation of the greatest possible number of members of the medical and allied professions is essential for the success of any national medical care service. The numbers of general practitioners, specialists, dentists, nurses and members of other professions within the service should be adapted to the distribution and the needs of the beneficiaries.

29. Complete diagnostic and treatment facilities, including laboratory and X-ray services, should be available to the general practitioner, and all specialist advice and

care, as well as nursing, maternity, pharmaceutical and other auxiliary services, and residential accommodation, should be at the disposal of the general practitioner for the use of his patients.

30. Complete and up-to-date technical equipment for all branches of specialist treatment, including dental care, should be available, and specialists should have at their disposal all necessary hospital and research facilities, and auxiliary out-patient services such as nursing, through the agency of the general practitioner.

31. To achieve these aims, care should preferably be furnished by group practice at centres of various kinds working in effective relation with hospitals.

32. Pending the establishment of, and experiments with, group practice at medical or health centres, it would be appropriate to obtain care for beneficiaries from members of the medical and allied professions practising at their own offices.

33. Where the medical care service covers the majority of the population, medical or health centres may appropriately be built, equipped and operated by the authority administering the service in the health area, in one of the forms indicated in paragraphs 34, 35 and 36.

34. Where no adequate facilities exist or where a system of hospitals with out-patient departments for general-practitioner and specialist treatment already obtains in the health area at the time when the medical care service is introduced, hospitals may appropriately be established as, or developed into, centres providing all kinds of in- and out-patient care and complemented by local outposts for general-practitioner care and for auxiliary services.

35. Where general practice is well developed outside the hospital system while specialists are mainly consultants and working at hospitals, it may be appropriate to establish medical or health centres for non-residential general-practitioner care and auxiliary services, and to centralize specialist in-patient and out-patient care at hospitals.

36. Where general and specialist practice are well developed outside the hospital system, it may be appropriate to establish medical or health centres for all non-residential treatment, general-practitioner and specialist and all auxiliary services, while cases needing residential care are directed from the centres to the hospitals.

37. Where the medical care service does not cover the majority of the population but has a substantial number of beneficiaries, and existing hospital and other medical facilities are inadequate, the insurance institution, or insurance institutions jointly, should establish a system of medical or health centres which affords all care, including hospital accommodation at the main centres, and, so far as possible, transport arrangements; such centres may be required more particularly in sparsely settled areas with a scattered insured population.

38. Where the medical care service covers too small a section for complete health centres to be an economical means of serving its beneficiaries, and existing facilities for specialist treatment in the area are inadequate, it may be appropriate for the insurance institution, or the institutions jointly, to maintain posts at which specialists attend beneficiaries as required.

39. Where the medical care service covers a relatively small section of the population concentrated in an area with extensive private practice, it may be appropriate for the members of the medical and allied professions participating in the service to collaborate at centres rented, equipped and administered by the members, at which both beneficiaries of the service and private patients receive care.

40. Where the medical care service covers only a small number of beneficiaries who are scattered over a populated area with adequate existing facilities, and voluntary group practice as provided for in paragraph 39 is not feasible, beneficiaries may appropriately receive care from members of the medical and allied professions practising at their own offices, and at public and approved private hospitals and other medical institutions.

41. Traveling clinics in motor vans or aircraft, equipped for first-aid, dental treatment, general examination and possible other health services such as maternal and infant health services, should be provided for serving areas with a scattered population

and remote from towns or cities, and arrangements should be made for the free conveyance of patients to centres and hospitals.

Collaboration with General Health Services

42. There should be available to the beneficiaries of the medical care service all general health services, being services providing means for the whole community and/or groups of individuals to promote and protect their health while it is not yet threatened or known to be threatened, whether such services be given by members of the medical and allied professions or otherwise.

43. The medical care service should be provided in close coordination with general health services, either by means of close collaboration of the social insurance institutions providing medical care and the authorities administering the general health services, or by combining medical care and general health services in one public service.

44. Local coordination of medical care and general health services should be aimed at either by establishing medical care centres in proximity to the headquarters for general health services, or by establishing common centres as headquarters for all or most health services.

45. The members of the medical and allied professions participating in the medical care service and working at health centres may appropriately undertake such general health care as can with advantage be given by the same staff, including immunization, examination of school children and other groups, advice to expectant mothers and mothers with infants, and other care of a like nature.

IV. THE QUALITY OF SERVICE

Optimum Standard

46. The medical care service should aim at providing the highest possible standard of care, due regard being paid to the importance of the doctor-patient relationship and the professional and personal responsibility of the doctor, while safeguarding both the interests of the beneficiaries and those of the professions participating.

Choice of Doctor and Continuity of Care

47. The beneficiary should have the right to make an initial choice, among the general practitioners at the disposal of the service within a reasonable distance from his home, of the doctor by whom he wishes to be attended in a permanent capacity (family doctor); he should have the same right of choice for his children. These principles should also apply to the choice of a dentist as family dentist.

48. Where care is provided at or from health centres, the beneficiary should have the right to choose his centre within a reasonable distance from his home and to select for himself or his children a doctor and a dentist among the general practitioners and dentists working at this centre.

49. Where there is no centre, the beneficiary should have the right to select his family doctor and dentist among the participating general practitioners and dentists whose office is within a reasonable distance from his home.

50. The beneficiary should have the right subsequently to change his family doctor or dentist, subject to giving notice within a prescribed time, for good reasons, such as lack of personal contact and confidence.

51. The general practitioner or the dentist participating in the service should have the right to accept or refuse a client, but may not accept a number in excess of a prescribed maximum nor refuse such clients as have not made their own choice and are assigned to him by the service through impartial methods.

52. The care given by specialists and members of allied professions, such as nurses, midwives, masseurs and others, should be available on the recommendation, and through the agency, of the beneficiary's family doctor who should take reasonable account of the patient's wishes if several members of the specialty or other profession

are available at the centre or within a reasonable distance of the patient's home. Special provision should be made for the availability of the specialist when requested by the patient though not recommended by the family doctor.

53. Residential care should be made available on the recommendation of the beneficiary's family doctor, or on the advice of the specialist, if any, who has been consulted.

54. If residential care is provided at the centre to which the family doctor or specialist is attached, the patient should preferably be attended in the hospital by his own family doctor or the specialist to whom he was referred.

55. Arrangements for the general practitioners or dentists at a centre to be consulted by appointment should be made whenever practicable.

Working Conditions and Status of Doctors and Members of Allied Professions

56. The working conditions of doctors and members of allied professions participating in the service should be designed to relieve the doctor or member from financial anxiety by providing adequate income during work, leave and illness and in retirement, and pensions to his survivors, without restricting his professional discretion otherwise than by professional supervision, and should not be such as to distract his attention from the maintenance and improvement of the health of the beneficiaries.

57. General practitioners, specialists and dentists, working for a medical care service covering the whole or a large majority of the population, may appropriately be employed whole time for a salary, with adequate provision for leave, sickness, old age and death, if the medical profession is adequately represented on the body employing them.

58. Where general practitioners or dentist, engaged in private practice, undertake part-time work for a medical care service with a sufficient number of beneficiaries, it may be appropriate to pay them a fixed basic amount per year, including provision for leave, sickness, old age and death, and increased if desired by a capitation fee for each person or family in the doctor's or dentist's charge.

59. Specialists engaged in private practice who work part time for a medical care service with a considerable number of beneficiaries may appropriately be paid an amount proportionate to the time devoted to such service (part-time salary).

60. Doctors and dentists engaged in private practice who work part time for a medical care service with few beneficiaries only may appropriately be paid fees for services rendered.

61. Among the members of allied professions participating in the service, those rendering personal care may appropriately be employed whole time for salary with adequate provision for leave, sickness, old age and death, while members furnishing supplies should be paid in accordance with adequate tariffs.

62. Working conditions for members of the medical and allied professions participating in the service should be uniform throughout the country or for all sections covered by the service, and agreed on with the representative bodies of the profession, subject only to such variations as may be necessitated by differences in the exigencies of the service.

63. Provision should be made for the submission of complaints by beneficiaries concerning the care received, and by members of the medical or allied professions concerning their relations with the administration of the service, to appropriate arbitration bodies under conditions affording adequate guarantees to all parties concerned.

64. The professional supervision of the members of the medical and allied professions working for the service should be entrusted to bodies predominantly composed of representatives of the professions participating, with adequate provision for disciplinary measures.

65. Where, in the proceedings referred to in paragraph 63, a member of the medical or allied professions working for the service is deemed to have neglected his professional duties, the arbitration body should refer the matter to the supervisory body referred to in paragraph 64.

Standard of Professional Skill and Knowledge

66. The highest possible standard of skill and knowledge should be achieved and maintained for the professions participating both by requiring high standards of education, training and licensing and by keeping up to date and developing the skill and knowledge of those engaged in the service.

67. Doctors participating in the service should be required to have an adequate training in social medicine.

68. Students of the medical and dental professions should, before being admitted as fully qualified doctors or dentists to the service, be required to work as assistant at health centres or offices, especially in rural areas, under the supervision and direction of more experienced practitioners.

69. A minimum period as hospital assistant should be prescribed among the qualifications for every doctor entering the service.

70. Doctors wishing to furnish specialist service should be required to have certificates of competence for their specialty.

71. Doctors and dentists participating should be required periodically to attend post-graduate courses organized or approved for this purpose.

72. Adequate periods of apprenticeship at hospitals or health centres should be prescribed for members of allied professions, and post-graduate courses should be organized and attendance periodically required for those participating in the service.

73. Adequate facilities for teaching and research should be made available at the hospitals administered by or working with the medical care service.

74. Professional education and research should be promoted with the financial and legal support of the State.

V. FINANCING OF MEDICAL CARE SERVICE

Raising of Funds under Social Insurance Service

75. The maximum contribution that may be charged to an insured person should not exceed such proportion of his income as, applied to the income of all insured persons, would yield an income equal to the probable total cost of the medical care service, including the cost of care given to qualified dependants as defined in paragraph 6.

76. The contribution paid by an insured person should be such part of the maximum contribution as can be borne without hardship.

77. Employers should be required to pay part of the maximum contribution on behalf of persons employed by them.

78. Persons whose income does not exceed the subsistence level should not be required to pay an insurance contribution. Equitable contributions should be paid by the public authority on their behalf: Provided that in the case of employed persons, such contributions may be paid wholly or partly by their employers.

79. The cost of the medical care service not covered by contributions should be borne by taxpayers.

80. Contributions in respect of employed persons may appropriately be collected by their employers.

81. Where membership of an occupational association or the possession of a license is compulsory for any class of self-employed persons, the association or the licensing authority may be made responsible for collecting contributions from the persons concerned.

82. The national or local authority may be made responsible for collecting contributions from self-employed persons registered for the purpose of taxation.

83. Where a scheme of social insurance for cash benefits is in operation, contributions both under such scheme and under the medical care service may appropriately be collected together.

Raising of Funds under Public Medical Care Service

84. The cost of the medical care service should be met out of public funds.

85. Where the whole population is covered by the medical care service and all health services are under unified central and area administration, the medical care service may appropriately be financed out of general revenue.

86. Where the administration of the medical care service is separate from that of general health services, it may be appropriate to finance the medical care service by a special tax.

87. The special tax should be paid into a separate fund reserved for the purpose of financing the medical care service.

88. The special tax should be progressively graded and should be designed to yield a return sufficient for financing the medical care service.

89. Persons whose income does not exceed the subsistence level should not be required to pay the tax.

90. The special tax may appropriately be collected by the national income tax authorities or, where there is no national income tax, by authorities responsible for collecting local taxes.

Raising of Capital Funds

91. In addition to providing the normal resources for financing the medical care service, measures should be taken to utilize the assets of social insurance institutions, or funds raised by other means, for financing the extraordinary expenditure necessitated by the extension and improvement of the service, more particularly by the building or equipment of hospitals and medical centres.

VI. SUPERVISION AND ADMINISTRATION OF MEDICAL CARE SERVICE

Unity of Health Services and Democratic Control

92. All medical care and general health services should be centrally supervised and should be administered by health areas as defined in paragraph 24, and the beneficiaries of the medical care service, as well as the medical and allied professions concerned, should have a voice in the administration of the service.

Unification of Central Administration

93. A central authority, representative of the community, should be responsible for formulating the health policy or policies and for supervising all medical care and general health services, subject to consultation of, and collaboration with, the medical and allied professions on all professional matters, and to consultation of the beneficiaries on matters of policy and administration affecting the medical care service.

94. Where the medical care service covers the whole or the majority of the population and a central government agency supervises or administers all medical care and general health services, beneficiaries may appropriately be deemed to be represented by the head of the agency.

95. The central government agency should keep in touch with the beneficiaries through advisory bodies comprising representatives of organizations of the different sections of the population, such as trade union, employers' associations, chambers of commerce, farmers' associations, women's associations and child protection societies.

96. Where the medical care service covers only a section of the population, and a central government agency supervises all medical care and general health services, representatives of the insured persons should participate in the supervision, preferably through advisory committees, as regards all matters of policy affecting the medical care service.

97. The central government agency should consult the representatives of the medical and allied professions, preferably through advisory committees, on all questions relating

to the working conditions of the members of the professions participating, and on all other matters primarily of a professional nature, more particularly on the preparation of laws and regulations concerning the nature, extent and provision of the care furnished under the service.

98. Where the medical care service covers the whole or the majority of the population and a representative body supervises or administers all medical care and general health services, beneficiaries should be represented on such body, either directly or indirectly.

99. In this event, the medical and allied professions should be represented on the representative body, preferably in numbers equal to those of the beneficiaries or the government as the case may be; the professional members should be elected by the profession concerned, or nominated by their representatives and appointed by the central government.

100. Where the medical care service covers the whole or the majority of the population and a corporate body of experts established by legislation or by charter supervises or administers all medical care and general health services, such body may appropriately consist of an equal number of members of the medical and allied professions and of qualified laymen.

101. The professional members of the expert body should be appointed by the central government from among candidates nominated by the representatives of the medical and allied professions.

102. The representative executive body of the expert body supervising or administering medical care and general health services should be responsible to the government for its general policy.

103. In the case of a federal State, the central authority referred to in the preceding paragraphs may be either a federal or a State authority.

Local Administration

104. Local administration of medical care and general health services should be unified or coordinated within areas formed for the purpose as provided for in paragraph 24, and the medical care service in the area should be administered by or with the advice of bodies representative of the beneficiaries and partly composed of, or assisted by, representatives of the medical and allied professions, so as to safeguard the interests of the beneficiaries and the professions, and secure the technical efficiency of the service and the professional freedom of the participating doctors.

105. Where the medical care service covers the whole or the majority of the population in the health area, all medical care and general health services may appropriately be administered by one area authority.

106. Where, in this event, the area government administers the health services on behalf of the beneficiaries, the medical and allied professions should participate in the administration of the medical care service, preferably through technical committees elected by the professions or appointed by the area or central government from among nominees of the professions concerned.

107. Where a medical care service covering the whole or the majority of the population in the health area is administered by a representative body, the area government, on behalf of the beneficiaries, and the medical and allied professions in the area, should be represented on such body, preferably in equal numbers.

108. Where the medical service is administered by area offices or officers of the central authority, the medical and allied professions in the area should participate in the administration, preferably through executive technical committees, elected or appointed in the manner provided for in paragraph 106.

109. Whatever the form of the area administration, the authority administering the medical care service should keep in constant touch with the beneficiaries in the area through advisory bodies, elected by representative organizations of the different sections of the population, in the manner provided for in paragraph 95.

110. Where the social insurance medical care service covers only a section of the population, administration of that service may appropriately be entrusted to a representative executive body responsible to the government, and comprising representatives of the beneficiaries, of the medical and allied professions participating in the service and of the employers.

Administration of Health Units

111. Health units owned and operated by the medical care service, such as medical or health centres or hospitals, should be administered under democratic control with adequate provisions for the participation of the medical profession, or wholly or predominantly by doctors elected by, or appointed after consultation of, the members of the medical and allied professions participating in the medical care service, in cooperation with all the doctors working at the unit.

Right of Appeal

112. Beneficiaries or members of the medical or allied professions who have submitted complaints to the arbitration body referred to in paragraph 63 should have a right of appeal from the decisions of such body to an independent tribunal.

113. Members of the medical and allied professions against whom disciplinary measures have been taken by the supervisory body referred to in paragraph 64 should have a right of appeal from the decisions of such body to an independent tribunal.

114. Where the supervisory body referred to in paragraph 64 takes no disciplinary action on a matter referred to it by the arbitration body, in accordance with paragraph 65, the interested parties should have a right of appeal to an independent tribunal.

ANNEX 3

Resolution A.2 Annexed to the Charter of Punta del Este (Uruguay, 1961)[1]

Ten-Year Public Health Program of the Alliance for Progress

WHEREAS:

A mutual relationship exists between health, economic development, living standards, and well-being;

There is an agreement between the governments of the American states for the simultaneous planning of economic growth and social progress during the decade that began in 1960;

It is essential, for this purpose, that arrangements be concluded in advance for the preparation of national plans that contemplate the problems of primary importance to the societies;

Programs in process of execution should not be interrupted while these plans are being prepared, but should, on the contrary, be extended to other communities, and other plans having economic and social significance should be undertaken giving priority to emergency plans in some of the countries;

It is essential to coordinate the various activities that contribute to individual and collective well-being, not only in national plans but also in projects that are already being carried out and in those to be undertaken in the future;

[1] *OAS Official Records* OEA/Ser.H/XII.1 (Eng.), 30-32.

The Group of Experts of the Organization of American States on Planning for Economic and Social Development in Latin America determined "that improvements [in health conditions] are desirable in themselves, that they are an essential prerequisite for economic growth, and that therefore, they must be an integral element in any meaningful development program for the region"; and

The Council of the Organization of American States recommended that governments, in planning and negotiating the financing of their economic development, should include public health programs essential and complementary to their economic programs, and also recommended the technical advisory services of the Pan American Sanitary Bureau for the formulation of such programs (Resolution VII, Second Meeting of the Special Committee to Study the Formulation of New Measures for Economic Cooperation),

The Special Meeting of the Inter-American Economic and Social Council at the Ministerial Level

RESOLVES:

1. To recommend to the governments the following long-term measures for the prevention of diseases and the protection and recovery of health:

a. To prepare national plans for the next 10 years.

b. To create planning and evaluation units in the Ministries of Health, with appropriate representation at the national agencies for the over-all planning of economic development and social progress, to ensure due coordination.

c. To improve the collection and study of vital and health statistics as a basis for the formulation and evaluation of national health programs.

d. To give particular importance to the education and training of professional and auxiliary personnel to engage in activities related to the prevention and cure of diseases. To this end it will be necessary:

(1) To determine the number of experts required in the various categories for each activity or profession;

(2) To provide in-service training to present staff members, and progressively train a minimum number of additional personnel; and

(3) To expand or create the necessary educational centers.

e. To improve the organization and administration of national and local health services by combining the functions of prevention and cure; to obtain a better return from medical care services; to create the necessary services gradually; and to ensure financial accessibility to therapeutic agents and means for the prevention of disease.

f. To adopt legal and institutional measures to ensure compliance with the principles and standards of individual and collective medicine for the execution of projects of industrialization, urbanization, housing, rural development, education, tourism, and others.

g. To make the best possible use of knowledge obtained through scientific research for the prevention and treatment of diseases.

2. To recommend that the governments carry out the following measures to take immediate effect:

a. To complete projects that are now being executed, particularly those related to the control or eradication of communicable diseases, sanitation, nutrition, medical care, maternal and child care, health education, and other projects for the protection of health, giving due priority to the emergency programs of certain countries.

b. To formulate projects for gradual development for the following purposes:

(1) To supply potable water and sewage disposal for at least 70 per cent of the urban population and 50 per cent of the rural population during the present decade, as a minimum;

(2) To reduce the present mortality rate in children under five years of age by one-half;

(3) To eradicate malaria and smallpox from the Hemisphere and intensify the control of other common infectious diseases, such as enteric ailments and tuberculosis;

(4) To make substantial improvements in the feeding and nutrition of the most vulnerable sectors of the community by increasing the consumption of animal or vegetable protein; and

(5) To take measures for giving increasingly better medical care to a larger number of patients, by improving the organization and administration of hospitals and other centers for the care and protection of health.

3. To establish as a broad goal for health programs during the present decade an increase of five years in the life expectancy at birth of every person.

4. To recommend that governments, whenever they consider it advisable, utilize the technical advisory services of the Pan American Sanitary Bureau, Regional Office of the World Health Organization, in the preparation and execution of the aforementioned plans; and likewise to support the projects of that organization for establishing systems of health planning in the countries of Latin America.

5. To recommend, at the same time, the use of other means of technical assistance, whether multilateral or bilateral, available to the countries of this Hemisphere.

ANNEX 4

Sickness and Maternity Benefits in Social Security Systems *

Country and institution	Sickness benefits				Maternity benefits			
	Cash		Services		Cash		Services	
	Insured person	Dependents	Insured person	Dependents	Insured person	Dependents	Insured person	Dependents
Argentina								
Caja de Maternidad	–	–	–	–	x	–	–	–
Bolivia								
Caja Nacional de Seguridad Social	x	–	x	x	x	–	x	x
Caja de Seguro Social de Trabajadores Petroleros	x	–	x	x	x	–	x	x
Brazil								
Instituto de Aposentadoría e Pensões dos Industriários	x	–	x	x	x	x	x	x
Instituto de Aposentadoría e Pensões dos Comerciários	x	–	x	x	x	x	x	x
Instituto de Aposentadoría e Pensões dos Empregados em Transportes e Cargas	x	–	x	x	x	x	x	x
Instituto de Aposentadoría e Pensões dos Ferroviários e Empregados em Serviços Públicos	x	–	x	x	x	x	x	x
Instituto de Aposentadoría e Pensões dos Bancários	x	–	x	x	x	x	x	x
Instituto de Aposentadoría e Pensões dos Marítimos	x	–	x	x	x	x	x	x
Chile								
Servicio de Seguro Social (Servicio Nacional de Salud)	x	–	x	x	x	–	x	x
Caja de Previsión de los Empleados Particulares (Servicio Médico Nacional del Empleado)	x [a]	–	x [a]	–	–	–	–	–

* Prepared by the Program of Social Security, Department of Social Affairs, Pan American Union, April 1965.

Country and institution	Sickness benefits				Maternity benefits			
	Cash		Services		Cash		Services	
	Insured person	Dependents	Insured person	Dependents	Insured person	Dependents	Insured person	Dependents
Colombia								
Caja Nacional de Previsión	x	–	–	–	x	–	x	–
Instituto Colombiano de Seguros Sociales	x	–	x	–	x	–	x	x
Costa Rica								
Caja Costarricense de Seguro Social	x	–	x	x	x	–	x	x
Dominican Republic								
Instituto Dominicano de Seguros Sociales	x	–	x	x [b]	x	–	x	x
Ecuador								
Instituto Nacional de Previsión (Caja Nacional del Seguro Social)	x	–	x	x	x	–	x	–
El Salvador								
Instituto Salvadoreño del Seguro Social	x	–	x	–	x	–	x	x
Guatemala								
Instituto Guatemalteco de Seguridad Social	x [c]	–	x [c]	–	x [d]	x [d e]	x [d]	x [d]
Haiti								
Institut d'Assurances Sociales d'Haiti	–	–	–	–	–	–	–	–
Honduras								
Instituto Hondureño de Seguridad Social	x	–	x	x [e]	x	–	x	x
Mexico								
Instituto Mexicano del Seguro Social	x	–	x	x	x	–	x	x
Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado	x	–	x	x	x	–	x	x
Nicaragua								
Instituto Nacional de Seguridad Social	x	–	x	x [f]	x	–	x	x
Panama								
Caja de Seguro Social	–	–	x	x [g]	x	–	x	–
Paraguay								
Instituto de Previsión Social	x	–	x	x	x	–	x	x
Peru								
Caja Nacional del Seguro Social Obrero	x	–	x	–	x	–	x	–
Seguro Social del Empleado	x	–	x	–	x	–	x	x
Uruguay								
Consejo Central de Asignaciones Familiares	–	–	–	–	x	–	x	–
Venezuela								
Instituto Venezolano de los Seguros Sociales	x	–	x	x	x	–	x	x

[a] Cancer, tuberculosis, cardiovascular diseases, and syphilis.
[b] Children under eight months.
[c] Occupational diseases and common accidents only.
[d] In Guatemala Department only.
[e] In case of member's death only.
[f] Children under two years.
[g] Children under six years.

ANNEX 5

Formulation of an International Survey [1]

Bases for the questionnaire

1. *Administrative organization*

a. *Of ministries of health:* Legal capacity to set an over-all integrated health policy; types of services carried out; authority over other services providing medical care.

b. *Of social security agencies:* Ministry to which attached; relationship with ministry of health; top administration and executive body; size of staff in relation to number of insured; method of selecting and compensating physicians.

c. *Attempts at coordination:* Legal and administrative relations between ministries of health and social security agencies; preventive activities in behalf of the family as a unit of labor; coordination of services at the local level, particularly in rural areas; joint policy on staff training, recruitment, and pay.

2. *Studies of coverage*

a. *By ministries of health:* Population theoretically entitled to care by law; population actually having access to services; availability of beds in relation to theoretical population; average length of stay and index of occupancy of hospital beds; number of outpatient consultations in relation to theoretical population; specialized services; domiciliary care.

b. *By social security agencies:* Risks covered, number of persons affiliated; number of family-member beneficiaries; benefits granted; availability of beds in relation to total beneficiaries; average length of stay and index of occupancy of hospital beds; number of outpatient consultations in relation to total beneficiaries; specialized services; domiciliary care.

3. *Studies of costs and financing* [2]

a. *In ministries of health and social security agencies:* Economic-financial factors and their impact on costs of social security; comparative financial contribution of different labor groups; financial ability of different labor and ethnic groups to pay for medical services or to finance social security systems providing medical benefits.

b. *In hospitals of either organization:* Capital costs in comparison with regular operating expenses; components of capital costs per bed equipped and per outpatient clinic; analysis of operating expenses by budget item (salaries, feeding, pharmacy, and so on); analysis of operating expenses by department (medicine, surgery, laboratory, kitchen, and so on); cost per day per bed; cost of outpatient consultation per working hour and per patient seen; cost per beneficiary; cost per inhabitant per year.

c. *Income of physicians,* comparing salaries of ministries with those of social security agencies and with estimates of average income, according to fees as regulated by medical associations.

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[1] See working document, section D-5, page 25.

[2] All studies of costs would employ the definitions of Dr. Brian Abel-Smith in *Paying for Health Services.* Geneva: World Health Organization. Public Health Papers 17, 1963.

III. FINAL REPORT OF THE STUDY GROUP ON THE COORDINATION OF MEDICAL CARE IN LATIN AMERICA

With special emphasis on the Relationships between Social Security Programs and those of Ministries of Health or Other Government Health Agencies

INTRODUCTION

The Study Group jointly convened by the Pan American Health Organization and the Organization of American States to discuss the coordination of social security medical care and that provided by ministries or other Government health agencies met on 12 July 1965, at 9:00 a.m., in the Conference Room of the Pan American Sanitary Bureau.

The meeting was opened by Dr. Abraham Horwitz, Director of the Pan American Sanitary Bureau. In welcoming the participants, he said that when it approved the convocation of the Study Group, "the Council had in mind the moral obligation of the health administrator to provide timely services at the lowest possible cost and of the highest possible quality, without failing to consider the individual as a member of a family and of society, who is exposed to environmental risks and whose adaptation to those uncertain conditions takes the form of health or sickness." The Director went on to say that it is "incumbent upon public and private agencies—social security institutions included—to adapt their operations to the natural history of man's biological processes. Health, sickness, and disability, through which the continuity of the life cycle is expressed, are paralleled by the preventive, curative, and social activities" that should be conducted by the institutions responsible for health care. Finally, Dr. Horwitz posed several questions for the Study Group to examine. "One wonders," he said, "whether the present lack of coordination between the medical care services of social security agencies and those of health ministries is due solely to conventional causes arising out of the fact that the two spheres of action are not clearly defined in juridical terms. Or does it have deeper roots in an economic and social process characteristic of developing countries? How can the State be helped in fulfilling its obligation of providing health care, if possible to the entire community, and in fully coordinating the resources at its disposal?" In concluding, Dr. Horwitz thanked Dr. José A. Mora, Secretary General of the Organization of American States, for the understanding shown by that Organization in jointly sponsoring the current meeting.

The next speaker was Mr. Beryl Frank, representing the OAS Secretary General. After relating the various steps taken by the OAS and PAHO in this cooperative task of improving coordination of medical care, "particularly between the two major suppliers of such services, the ministries of

health and the social security agencies," he concluded by saying, "we are all aware that this is a historic moment, which I hope will initiate a new phase in the relations between the ministries of health and the social security institutions."

Dr. Carlos Andrade Marín was elected Chairman of the Study Group, and Dr. Nelson de Araujo Moraes, Rapporteur.

Dr. René García-Valenzuela, Secretary of the Study Group, outlined the procedure drawn up for the meetings of the Group and announced its frame of reference, which is as follows:

(a) To examine the current relations between the medical care or other services of the ministries of health and those of the social security agencies.

(b) To recommend procedures for obtaining a better knowledge of the problem that will enable the countries to strengthen and improve their local and national health services and will make it possible for the PAHO and the OAS to establish the agencies and methods capable of providing effective assistance in this field, at the countries' request.

(c) To propose measures for promoting better coordination of the medical care services of the ministries of health with those of social security or other agencies, and of all these with the basic health services, through effective, integrated planning of the health sector.

Dr. Alfredo Leonardo Bravo, Special Adviser, announced the agenda and the program of work, succinctly explaining the approach to the problem taken in the working document[1] previously distributed to the members of the Group. This document, after reviewing theoretical aspects and international agreements on health care, examines the current situation in various Latin American countries. It mentions various attempts at coordination or integration of services, and also the place of health and social security in the planning of development, now being carried out more and more by the countries of the Hemisphere. After analyzing the apparent obstacles to coordination between the social security medical services and those of the ministries of health, Dr. Bravo closed by suggesting several methods of promoting greater coordination in a gradual plan adapted to the varying stages of development of the health care services.

The Study Group, after carefully examining the working document, concluded that its basic conception of the problem is correct and that it emphasizes the major aspects; furthermore, the document accurately describes the current situation in Latin America and proposes valid methods for remedying the lack of coordination among the institutions that provide medical care. The Group therefore adopted the recommendations and suggestions and decided to have the entire document annexed to the present report.

The Group also agreed to call to the attention of the sponsoring organizations the following additional points, which were discussed at the meeting and are analyzed in subsequent pages of this report.

A. Historical review of the obstacles that have impeded proper coordination.

B. The concept of coordination.

C. The planning of development.

D. Coverage of social security medical benefits and standardization of systems.

E. Manpower.

F. Costs and financing.

G. Design of the survey.

H. Other recommendations.

[1] See p. 6.

A. HISTORICAL REVIEW OF THE OBSTACLES THAT HAVE IMPEDED PROPER COORDINATION

The members of the Group kept in mind that, although coordination among the various public and private facilities providing medical benefits as part of the health care of different community groups is, and has been, a constant concern of the Governments, it became of prime importance after the approval of Resolution A.2 annexed to the Charter of Punta del Este, which mentioned medical care as one of the basic elements in Latin American economic and social development. Unfortunately, no representatives of social security were present at Punta del Este.

The result was that the statements contained in Resolution A.2 were very general in nature and did not take into account the influence of social security on socioeconomic development. Further, the agreement calls for greater attention to and the improvement of services, but contains no provision on what is regarded as fundamental—the need for close cooperation among the organizations responsible for community health care.

The group drew attention to the common situation in many countries in which there is lack of coordination not only between ministries of health and social security agencies but also between different departments within the ministries or agencies in their dealings with one another. The result of this lack of collaboration and understanding among various Government organizations is disintegration of the health sector, which is being planned in a piecemeal manner in terms of subsectors, each unaware of, or opposed to, the others.

In addition, the Group stated that it would be most advantageous to promote coordination not only among the various organizations responsible for medical care at the national level but also in the technical assistance provided by international organizations, which do not always uphold the same principles or apply the same methods.

It was recognized that a major reason for the current lack of coordination can be traced to weaknesses in the countries' past. In most of the Latin American countries, social security antedates the establishment of the ministries of health, and both were preceded by the "beneficencias," which had traditionally given medical services to the Indian population and to the destitute since colonial times. Social security was initiated, under the inspiration of European countries, with a strictly curative orientation, that is, toward the diagnosis and treatment of illness. The ministries of health, on the other hand, influenced chiefly by U. S. concepts of public health, devoted themselves for a long time to the preventive aspects and to environmental sanitation, and only later became aware of their obligation with respect to curative activities. In so doing, they have established a relationship with or have absorbed, as the case may be, the facilities of the "beneficencias," thus taking on a whole tradition of medical care approached from the charitable standpoint. This has led to institutional prejudices, the basis for the current lack of understanding and coordination.

For their part, the medical services of the social security agencies developed in widely varying fashion in the different American countries. While in some they preceded economic benefits, in others they were put off until the institutions acquired enough capital to consider them. In countries where the social security agencies emphasized medical care, building hospitals of their own and organizing high-quality services, such care quickly became modernized and its material, economic, and professional resources have reached levels of effectiveness with which the ministries can hardly compete. In such cases, coordination is rather difficult. In other countries, where medical care fur-

nished by social security agencies developed more slowly, without the organization of separate facilities, coordination has come about almost spontaneously, since social security, having no hospitals, had to buy services in suitable places—that is, in ministry or "beneficencia" hospitals. The case was also mentioned of a country in which ministry hospitals were transferred to a social security agency, which introduced changes that resulted in extraordinary progress.

Some members of the Group expressed the opinion that rather than start by promoting integration through legal compulsion, which is usually resisted, it might be better to work for practical coordination in the field, especially in the places or environments best suited for this step, such as small cities or certain communities in the rural sector.

Also mentioned was the need to bear in mind the different situation in countries with a federal system, where the central Government has only normative powers and the executive authority rests with the states.

Finally, it was suggested that coordination can be achieved through the extension of social security coverage.

The Group agreed that one of the greatest obstacles to proper coordination is the fear, felt by both affiliated unions and social security authorities, that the funds collected in dues might, in a coordinated system, be used for other purposes or to make up the deficit in ministry of health facilities. It was therefore thought that the solution lies in effective integrated planning of development, through which all services would be adequately financed. This would eliminate the fears and would create a better attitude toward the coordination of services, in view of the fact that the single, common objective is the well-being of the individual as a member of a community.

B. THE CONCEPT OF COORDINATION

The meaning of *coordination* and of *integration,* and the distinction between them, were discussed at length. The consensus was that most of the Latin American countries are not yet ready for the integration of services—by which is meant total administrative and financial unification—which can be regarded only as a long-range ideal.

The Group took cognizance of the fact that PAHO prefers to speak of technical integration of preventive and curative activities and of administrative coordination as an element of intra- and interinstitutional cooperation.

The Group concluded by deciding that, for purposes of the topic under discussion, *coordination* should be taken to mean an orderly arrangement in the use of all the available manpower and material resources in the various public and private health care institutions.

With the concept thus defined, the Group agreed that the objectives should be as follows:

(a) To bring about the rational use of the available resources by the various institutions in the health sector;
(b) To indicate ways of getting the best possible return on the available resources; and
(c) To bring future investments and contributions into proportion with needs, in order to insure their full utilization.

The advantages of coordination seem obvious in the light of the aforementioned objectives, and it is apparent that the principles of efficiency and economy would be put into effect if the scanty resources at the disposal of the institutions and the countries were used to the full and made available to the largest possible number of persons.

The simplest way of achieving coordina-

tion is the orderly arrangement of resources and action at the local level, particularly in small rural communities. The Group recognized, however, that this local coordination can hardly be successful unless at the same time there is coordination of aims at the national level, through which the various participating institutions decide to unite their efforts while maintaining their administrative individuality and financial independence.

Coordination can also be achieved through the measures adopted for a specific campaign to control a particular disease or for dealing with an emergency or a large-scale disaster. In such cases, a program with well-defined objectives and precise operating procedures could easily be financed jointly by the institutions and placed under a single command named by common agreement. It is also possible to coordinate the use of physical resources (hospitals, health centers, and so on) and of such equipment as laboratories, X rays, laundries, dietary services, and so on.

One of the greatest obstacles to coordination of activities in the field is the shortage, and at times the lack, of trained personnel. The Group recognized that it would be advisable for the various institutions and ministries to coordinate their efforts in organizing in-service training courses to overcome this deficiency.

A coordination plan might be implemented through the establishment of central and local coordinating committees, on which the sectors concerned would be represented. It is important to guarantee that each agency will retain its independence and its individual personality and to assure each that it will not be hampered in fulfilling its legal obligations and its own purposes.

C. THE PLANNING OF DEVELOPMENT

It was the unanimous view of the Group that health is a singular problem and constitutes a whole that should be planned integrally on a national scale.

In this connection, it was noted that in several Latin American countries the health sector is not represented on the planning boards at the presidential level, and that in others it is split into subsectors that make their proposals independently and compete for authority and funds within the same field. The Group recognized unreservedly that the incorporation of the health sector into the national planning of economic and social development should be considered a way to solve the problem and a means of access to the highest level, and at the same time the best source of intra- and intersectorial coordination. A national development plan amounts to a permanent law under which each element is given a specific weight and value; as long as the plan has the Government's decisive financial and political support, as it must in order to prosper, it serves as a guide to technicians in the various sectors. Every effort should be made to enable the health administrator to participate in planning at the highest level, for there is no question that the maintenance of health depends on a number of nonmedical factors and that medical programs, in turn have an impact on the success of other development factors. Illustrations of this point are agricultural extension programs, which must meet nutritional needs by producing protective foods in accordance with the dietary demands of the community; housing programs, which must be supplemented by sanitation measures, such as drinking-water supply and garbage and excreta disposal, of unquestionable help in eliminating disease and reducing mortality; the establishment of new industries, which must be accompanied by hygienic measures for lighting, ventilation, control of atmospheric pollution, and so on, to prevent accidents and occupational

diseases; and road building, which permits the transport of sick persons and the concentration of medical resources in large regional hospitals, well equipped and capable of providing high-quality medical care.

The Group was fully aware that all these plans, which are not part of the health sector as such and are not the responsibility of the medical profession, nevertheless have an undeniable impact on the preservation or loss of health. They are therefore of great significance to the administrator of health services, who cannot evade his responsibility to pose the problems and contribute with his knowledge to the preparation of the plans. The Group also believed that regular contact among all the subsectors of health, and between these and other sectors of economic and social development, will be very helpful in establishing better working relations between the ministries of health and the social security agencies, and that this joint work will gradually promote coordination and some day even, it is to be hoped, integration.

The Group, noting the existence of resources and fellowships for training health technicians in planning methods, recommended that these resources, which until now have been reserved for ministry officials, be made available to social security administrators, since working together is a learning process and obtaining similar knowledge can also contribute to coordination.

In conclusion, it was stated that the planning of the health sector will reach its full development and usefulness only when it is carried out in close correlation with, and as an integral part of, a national plan for economic and social development. Efforts at health planning in countries that do not have a national development plan have had but relative and questionable success.

D. COVERAGE OF SOCIAL SECURITY MEDICAL BENEFITS AND STANDARDIZATION OF SYSTEMS

In accordance with the information available, the Study Group observed that the percentage of those covered by social security medical care in the Latin American countries is very low in terms of the total and the active populations, and that the ideal of extending coverage to the entire population must be carried into effect in stages related to the successive steps in the planning process.

Universal coverage is an ideal that cannot be attained quickly, since there are rural masses and large Indian groups that are outside the countries' political and social structure and beyond the reach of the public services. At the moment it is difficult to get medical care services to them. Furthermore, these are destitute populations unable to pay for medical services. The Group agreed, however, that despite the great difficulties foreseen in the incorporation of these sectors into social security systems, it is essential for reasons of solidarity to guarantee them health, so as to make them a factor of production and social progress. To do this, financing systems have been devised—for example, a per-capita assessment paid by landowners on the people living on their estates, or a land tax that will pay the social security charges of the farm workers who cultivate the land.

The Group considered it essential to take steps toward incorporating the rural population into social security. This can be done only through agrarian reform, as part of economic development, with the medical care institution receiving from the agrarian-reform administration sufficient funds to meet the medical care needs of farm workers gradually, as they change from factors of consumption to factors of production.

For the reasons given above, the Study Group believed that the Latin American countries are not at present, and probably

will not be in the near future, ready for national health insurance along the lines of Great Britain or other highly developed countries.

It was recognized, however, that steps should be taken toward standardizing the assessments and benefits of the various social security systems and, whenever possible, toward unifying them into a single institution for all wage-earning groups.

The process of unification is not easy, for it is resisted by the most influential and longest-established welfare agencies, which are usually the best financed. Some labor groups have enough political power to maintain or obtain their independence and to enjoy social security systems providing larger benefits than those of other groups. It was pointed out that in order to facilitate the unification process some agreement should be sought whereby all social security agencies would use the existing facilities, no matter who owns them. It was recognized that standardization of benefits and assessments is really the best path toward unification of the social security systems and their coordination with the ministry of health. Improvement in the quality of benefits was also said to be a good incentive to the acceptance of a unified service by all the beneficiaries. Finally, it was noted that uniform and adequate staff salaries also contribute significantly to unification of the various systems.

The Study Group thought it appropriate to call upon the countries to prevent, at all costs, the continuance of unnecessary diversification and subdivision of the present social security agencies.

The Study Group noted that some labor sectors in various Latin American countries oppose any attempt at coordination or unification. They view apprehensively what they call the plunder of property they consider their own and the infringement of their vested interests, which might be curtailed if incorporated into broader systems in which their own services would lose their individuality and independence.

The following means of solution were suggested:

(a) Standardization of benefits and assessments in the various agencies.

(b) Coordinated action in sectors not now covered, such as rural communities.

(c) Inclusion of families in medical benefits.

(d) Better utilization of the available installed capacity.

(e) Cooperative construction of future health facilities in areas not now covered.

E. MANPOWER

The Study Group examined the shortage of physicians and other trained professionals and technicians for the medical care services and the poor distribution of this personnel, which is concentrated mainly in the large urban centers. Although the personnel shortage cannot in itself be regarded as an obstacle to coordination, the fact is that a staff that is overworked and underpaid becomes dissatisfied, always seeking to transfer to the best-paying institution.

The organized medical profession is unquestionably involved in this matter. The Group noted an imbalance in professional practice, caused by the historical evolution of medicine from the personal to the collective, from an art to a science, from a general approach to specialization, and from the individual to the family and, more recently, to the community. In this situation, the physician whose university education has been primarily individualistic and who has not been prepared to serve as a community leader feels that he has lost his old place in society and turns his dissatisfaction toward problems of remuneration. The Group agreed that the cooperation of the medical profession is necessary to the health

care function, whichever public or private organization or system performs it.

The experience of the medical profession in many European countries and some in America would seem to indicate that the conflict affecting physicians tends inevitably to be resolved contrary to their interests. For this and other reasons, the newer generations find themselves faced with a ready-made situation they can do nothing about.

Some members of the Group commented that in the struggle for a better remuneration system the physician is basically defending himself against the single-employer situation that arises in an integrated medical service and against the administrative burden that is also often involved. It was said that, sooner or later, the physician will have to realize that he must adjust his aspirations to the historical realities of the society and the era in which he is to practice.

The Group recognized, however, that the chief motivation of the physician and other professionals working in health services lies in the professional satisfaction derived from attractive working conditions, in terms of buildings, installations, and equipment and the opportunity to teach, study, and conduct scientific and social research. Whenever the organization concerned is in a position to offer these favorable working conditions, there is a decline in demands for higher pay.

It was also stated that physicians have little inclination toward administrative tasks and will not accept bureaucratic control. This attitude, it was said, can be altered only by training the younger generations in medical schools that teach the practice of medicine in a changing social environment, in which the doctor-patient relationship has been replaced by the medical team-community relationship.

The Group was unanimous in believing that it is essential to promote a positive attitude on the part of the medical profession toward the sociological aims of medical care services, and there was agreement that a mutual interdependence exists between coordination of the various services to permit better utilization of the energies of the medical profession and a satisfied medical body contributing to the general progress of coordination.

To promote this positive attitude, the following measures were proposed:

(a) Active and informed participation by physicians in the formulation of health programs.
(b) Continuing professional development and participation in teaching and in scientific research.
(c) Team medicine, with compulsory exchange of knowledge and experience among team members.
(d) Adequate training in administrative problems.
(e) Rotating and voluntary medical audit.
(f) Guarantee of full-time work.
(g) Uniform scales of remuneration and rank in the State services and those of social security.
(h) Social benefits (vacations, terminal benefits, pensions, and so on).
(i) Adequate buildings, equipment, and installations.

It was emphasized that the comments regarding physicians are applicable to the rest of the staff and that a policy of coordination of services between ministries of health and social security agencies will similarly contribute to better utilization of the available manpower.

F. COSTS AND FINANCING

Stress was laid on the need to make it clear that health is not the only factor to be taken into account in the distribution of national resources. However important health problems are, only a limited part of the gross national product or the fiscal budget can be assigned to it. What is important is that the economic planners under-

stand the scope of health plans and consequently give them due weight in the harmonious planning of the investment of public resources.

The Group agreed that the trend toward constantly rising costs of services could be braked by applying the concept of installed capacity; that is, through proper utilization of resources it is possible to prevent unused capacity, which artificially raises the unit cost of benefits. The consensus was that administrative coordination could bring about better utilization of and return on present resources, which would indirectly reduce the cost per unit. Coordination of personnel and equipment could also help lower costs.

The Group also recognized that the information available is insufficient, and that the data are not comparable because there are no definitions to show precisely what the cost components are and what quality of service is offered.

In this field, the Group agreed to make the following recommendations:

(a) The first step is to obtain the maximum return on the available resources through technical-administrative measures that enable manpower to be used to its maximum productivity and in its proper function; to use hospital beds rationally, reducing average lengths of stay and raising the index of occupancy to optimum levels; and, finally, to organize patient reception, appointments, and circulation in outpatient clinics in such a way as to prevent waiting lists, crowds, and wasted time.

(b) To promote the application of technical measures for the protection and promotion of community health, in order to reduce morbidity and mortality and hence the demand for medical care.

(c) Only after the foregoing two measures have been adopted will it be possible to learn the real magnitude of the problem of imbalance between needs and resources and to calculate objectively how much supplementary financing is needed to make up for the deficiencies in current resources. This financing can be obtained through an extension of social security coverage or through the national budget when the people's financial capacity prevents their incorporation into social security institutes.

G. DESIGN OF THE SURVEY

The Group was fully apprised of the difficulties in the way of a survey such as the working document proposes. It was noted in the first place that, since this is a national survey with international assistance, the participating Governments should formally agree that complete data will be promptly supplied by all the pertinent institutions and ministries.

Mention was also made of the need to establish precise definitions so that the data collected from all the participating countries will be comparable, particularly with respect to costs of services.

During the discussions of the Study Group, it became apparent that there is far too little information to permit an objective analysis of the problem on a statistical and scientific basis. The data to be gathered in the survey would be more or less as follows:

(a) Resources available at present.
(b) Comparative costs of services of the ministry of health and the social security agencies and, for each, capital investments and operating expenses.
(c) Utilization of services, through an analysis of returns on hospital beds and outpatient clinics.
(d) Population covered by social security agencies and by the ministry and/or other public services.
(e) Proportion of the population with access to the existing services.

(f) Acceptance of the services provided, by the beneficiaries and by the medical profession.

The Group was unanimous in believing that, despite all the difficulties involved, every effort should be made to carry out this survey.

This Study Group or a similar one might advise the international organizations, at future meetings or by correspondence, on the drafting of the questionnaire for the survey. The following comments and recommendations were made:

(a) *Formulation of the survey:* At this preliminary stage it would be useful to have members of the Group examine the draft and give their opinion.

(b) *Definitions:* These should be very precise, especially with respect to medical care in general and to costs in particular. In relation to medical care, the need for a definition for survey purposes is stressed, and the PAHO working hypothesis with respect to it as *one* of the basic services of a national or local health program is suggested.

(c) *Simplicity:* The countries are rather tired of surveys. It is desirable that this one should not be too laborious, in order to expedite it as much as possible. In some countries, answers might be given only to certain points included in the survey.

(d) *International cooperation:* The OAS and PAHO must actively provide this, to make up for the shortage of national personnel. An understanding between them will expedite replies by the subsectors and overcome initial reservations. The consultants should be carefully chosen for their technical qualifications and ability to synthesize the data and for their adaptability to a given country. It should be noted that the survey contains a number of points involving subjective analysis. There should be continuing contact between the organizations and the members of the Group and between the latter among themselves. The preliminary results of the survey should be discussed first with the respective countries.

(e) *National personnel:* The shortage of such personnel and the absolute necessity of prior training were recognized.

(f) *Countries that might be selected:* The members of the Group might be influential in their countries in insuring the success of the survey, since it involves a serious commitment. Panama and Ecuador made initial offers.

(g) *Precision of terms:* The designations for the services and their main functions must be standardized, and for this and other purposes a glossary would be in order.

(h) *Available prior information:* There is a considerable amount of such information in its original sources. There are special references on international social security institutions.

H. OTHER RECOMMENDATIONS

Besides the recommendations mentioned in each of the previous chapters, the Group suggested the following:

(a) That a continuing effort be made at the international level, with the cooperation of specialized health and social security organizations, to promote interest in these subjects and to take successive steps toward the coordination of medical care in Latin America.

(b) That seminars be organized, with the participation of employers' associations, labor federations, and medical societies, to inform these groups of the advantages of coordination of medical care services.

(c) That community organization at the local level be promoted, in order to disseminate modern concepts of health care as widely as possible and to seek informed cooperation in the plans of Governments or international organizations.

* * *

The Study Group held its closing session at 2:30 p.m. on 16 July 1965. The present report was read and unanimously approved. All members of the Group expressed their pleasure at having been able to participate in such a constructive meeting and thanked the Director of the Pan American Sanitary Bureau and the Secretary General of the Organization of American States for having invited them; they also thanked the Secretariat personnel and advisers for their help in the accomplishment of their task.

Dr. Walter Sedwitz, Assistant Secretary for Economic and Social Affairs (OAS) and Executive Secretary of the Inter-American Committee on the Alliance for Progress (CIAP), upon special invitation, attended the latter part of the closing session. On behalf of both organizations, he expressed his satisfaction that the meeting, attended by outstanding personalities in the field of social security and high-ranking officials of the ministries of health of various American countries, had been held for the purpose of exchanging views and recommending measures to bring about a better coordination of medical care in Latin America. "This is a task to which we are all committed," he said, "the task of economic and social development in the Hemisphere."

Dr. Sedwitz noted that "economic planning has always pointed to the need for greater investments, on the ground that increased investments brings about greater production, and hence greater consumption; in other words, a higher level of living for the people. The possibility of reversing the procedure is now being tested. First, consumption targets for each country are to be established—targets which, though necessarily rather modest, will be both quantitative and qualitative. The next step is an effort to match investments and production to consumption in its broadest sense, that is, education, health, housing, food, and clothing, to provide the people with hope for the future."

The speaker noted that "a conceptual motivation of this kind within the process of economic and social development inevitably leads to the integration of social planning and economic planning, with the understanding that by planning we mean effective management. Economic and social development being a concern of the Governments, the active and responsible participation of the people should be given sufficient importance so that the leaders of each society might be drawn into the development of the country and into the political plans of its Government."

"This," he concluded, "is the clear and firm position of the Chairman and members of CIAP. We have come to realize that it will not be possible to advance rapidly in the attainment of our objectives without the active participation of the peoples of Latin America and without the substantial cooperation of the ministries of health, education, housing, social security, and others. The members of CIAP stand ready to cooperate with those present in any research that might be required." Dr. Sedwitz thanked the Director of the Bureau and his staff for the excellent organization of the meeting.

Dr. John C. Cutler, Deputy Director, PASB, thanked Dr. Sedwitz for having come to the closing session and for his stimulating words. On behalf of the Bureau, he also thanked the members of the Study Group for having so freely given of their experience and knowledge. As Dr. Sedwitz had said, the meeting of the Group constituted the first step on the road toward coordination between public health and social security services, and the source of hope for all who are interested in the economic and social development of the Americas.

On a note of optimism, Dr. Carlos Andrade Marín, the Chairman, closed the meeting at 5:00 p.m. on Friday, 16 July 1965.

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IV RESOLUTIONS OF THE XVI MEETING OF THE PAHO DIRECTING COUNCIL

Resolution XIX [1]

Relationship between Social Security Medical Programs and Those of Ministries of Health or Other Governmental Health Agencies

THE DIRECTING COUNCIL,

Having considered the Final Report of the Study Group on Coordination of Medical Care in Latin America, with special reference to the relationship between social security medical programs and those of ministries of health or other official health agencies (Document CD16/25); [2]

Bearing in mind that the opportunity to enjoy the highest attainable standard of health is a right of all human beings without distinction, a right which should be ensured by the State through the organization or promotion of a system of services for the protection, promotion, and restoration of health;

Recognizing that government health services and social security medical services complement each other; and

Recognizing that the planning of economic development and social progress requires that the countries make rational use of existing installations and program the development of their human and material resources in a methodical and coordinated manner,

RESOLVES:

1. To take note of the Final Report of the Study Group.

2. To thank the Director of the Bureau and the members of the Study Group for their profound analysis of the problem, and the Organization of American States for its efficient cooperation.

3. To reiterate its previous resolution to the effect that the above-mentioned Report be transmitted to the Governments together with an invitation to progressively apply the recommendations in it concerning machinery for coordination between ministries of health and social security institutions, especially that which

[1] Approved at the thirteenth plenary session, 6 October 1965.

[2] See p. 48.

refers to the need for a survey to measure the real magnitude of the problem and to ascertain its characteristics.

4. To recommend to the Governments that social security institutions and all public or private agencies that engage in health activities participate in the national planning of the health sector.

5. To recommend to the Director of the Bureau that:

a) He make studies, diffuse knowledge, and offer advisory services to the Governments on how to achieve the maximum degree of coordination between ministries of health and the autonomous, semiautonomous, and private institutions that engage in health activities.

b) He sponsor and promote, in collaboration with national and international agencies concerned, educational programs designed to lead to the development of a common doctrine on the administration of medical care.

c) Through the Governments concerned, to help spread modern concepts of health care among trade unions and the local communities, in order to secure the adoption of a favorable attitude toward coordination.

d) To promote joint meetings of medical authorities and other high officials of the ministries of health and of the social security institutions of the Member Countries in order to encourage the above-mentioned coordination.

Resolution XXIX [3]

Selection of Topics for the Technical Discussions during the XVII Pan American Sanitary Conference, XVIII Meeting of the Regional Committee of WHO for the Americas

THE DIRECTING COUNCIL,

Bearing in mind the provisions of Articles 1, 2, and 7 of the Rules for Technical Discussions,

RESOLVES:

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.

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[3] Approved at the fifteenth plenary session, 7 October 1965.

Planning of Hospitals and Other Health Services

I. ADDRESS BY DR. ABRAHAM HORWITZ, DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU

Delivered at the inaugural session of the meeting of the PAHO Advisory Committee on Planning of Hospitals and Other Health Services

The Pan American Health Organization has succeeded in formulating a coherent policy with regard to medical care. Care of the sick is part of a process that combines prevention and cure. This policy takes into account the most important events in man's life cycle, during which health alternates with sickness as a result of changes in the mechanisms of adaptation that are put into motion by the environment.

Viewed in that light, health problems arise out of a combination of biological, economic, historical, and cultural factors that lead to diseases and their social dynamics. The various activities and systems for solving such problems should therefore be much the same, that is, they should compose a social medical care service adapted to the communities of which it is an integral part.

Within the policy of the Pan American Health Organization, medical care is not a phenomenon separate from the prevention of disease. Both part of a process that conceptually and administratively is indivisible, they are divided into stages of health promotion, protection, and restoration, depending on the nature of the problems. We believe health, in turn, to be a component of development, an expression of the economic growth and structural changes designed to improve the well-being of the people.

A distinguishing feature of present-day Latin America is the imbalance that exists between needs and resources, between income and the demands of the people. The distribution of national resources is not equitable, as is evident from the marked disparity in per-capita real income and from the restrictions on the accessibility of services. Nevertheless, what needs to be done to change this situation, both on a national and a continental scale, is clear. The Governments have come to recognize the advisability of planning economic and social development, by defining the problems and assigning them priorities and by setting goals to be achieved within certain periods. Such a program involves structural and administrative reforms for speeding up the application of resources where the needs and returns are greatest, in terms of the common good. It covers buildings and installations and, most important, education and training. Ideas of economic integration and political interdependence prevail at the regional level, together with a desire to do away with an outmoded nationalism, which leads to a narrow statism on which opportunities for mutual benefit founder, in the absence of concerted action by the countries.

These concepts pervade a whole social movement in the Americas, with health, as envisaged by our Organization, a part of it.

This explains the interest of the PAHO Governing Bodies, in recent years, regarding medical care as visualized from the viewpoint of essential resources for promoting and carrying such care into effect, according to a modern concept. Evidence of this approach is Resolution XXV [1] of the XV Meeting of the Directing Council, which deals with the planning of hospitals and other health facilities. That resolution requested the Bureau, through an Advisory Committee, to study the planning aspects of hospitals within the national health planning process, and recommend how the Bureau can best participate in the planning for the construction, staffing, and operation of integrated hospitals and related health facilities designed to serve the community needs in the various countries. The Committee referred to is the one you have been good enough to constitute; the valuable experience of its distinguished members will insure the high quality of the recommendations that will enable the Bureau to discharge the responsibilities assigned to it by the Directing Council. We are grateful for your presence and aware of the sacrifice it entails; yet, we believe the sacrifice to be justified by the purpose and importance of this meeting.

In approving that resolution, the Council had in mind the obvious need for additional hospitals and other health facilities and for the reorganization of existing ones. It took into account also the enormous sums currently being invested in construction, installation, and operation, leaving aside the waste resulting from overlapping of medical care services and their deficient administration.

To facilitate the task of the Advisory Committee, we have prepared a working document [2] containing background information that is related directly or indirectly to medical care and community health.

We should value your opinions and your recommendations on each of the areas analyzed in the document. The problem is expressed quantitatively in terms of the indices normally used to measure it. This justifies the Organization's interest, as expressed by the Directing Council, in seeking solutions that are in keeping with the current economic, technical, political, and social situation.

International cooperation is by nature supplementary, not substitutive, coming as it does from an organization that the Governments have created to serve their needs. Its success is measured by the capacity of each country to provide itself with techniques and resources, and by the possibility of defining other areas in which advisory services are required.

The planning of hospitals and similar establishments, including the building, equipping, and proper operation, so as to meet the real needs of the population, is a continent-wide problem. What are the responsibilities that might be assigned to PAHO as adviser to the Governments? Should they be limited to making technical recommendations on certain services, at the request of the Governments? Or should the Organization broaden its sphere of action in order to assist the Governments in a building program that is in accord with national health plans and with the expansion of the economic infrastructure? If such a course of action is feasible, what steps should be taken to implement it?

The formulation of a long-range program of hospital construction and installation involves a plan for its financing. As indicated in the working document, current local investments are enormous. Yet, despite the effort being made at the national level, the bed capacity is below present demands, as well as those that can be expected as a result

[1] *Official Document PAHO* **58**, 78-79.
[2] See pp. 68-123.

of the simple natural growth of the population, even if the organization and administration of the services were to be rationalized. In view of the social nature of the investment, foreign capital in the form of long-term, low-interest loans is obviously needed. We should like to have the Advisory Committee's opinion on the feasibility of creating a system of regional cooperation whereby the domestic resources would be supplemented by outside assistance and the sum total invested in a program carefully formulated by the Governments with the collaboration of the Organization. Carrying out such a plan might require a special agreement, in the form of an instrument—indeed, a convention—that would establish the conditions under which the Governments and the investors would participate in a cooperative venture of such magnitude.

We are gratified at the confidence shown in the Organization by the Directing Council's resolution on the problem under study. Because of its importance, we believe it to be an expression of the times the Americas are living through, when problems are posed in the light of their causes and consequences —whatever the implications—and when solutions are sought and advanced with courage and imagination—whatever the sacrifice. Those who see clearly the future of the Continent, so late in coming into its own, are imbued with a desire to do everything that will broaden the opportunities, speed up the social mobility, and increase the well-being of the people.

We have accepted the mandate of the Directing Council, confident that the knowledge and experience of the members of this Advisory Committee will lead to valuable recommendations so essential to the enormous task that lies ahead.

Those recommendations must take into account the disinterested support we have received from the Inter-American Development Bank. To Mr. Felipe Herrera, the President, we wish on this occasion to express our appreciation for his having sent a distinguished group of his collaborators to this meeting, further evidence of the close ties the two agencies are establishing in the field of international cooperation in order better to serve the countries of the Continent.

II. PLANNING OF HOSPITALS AND OTHER HEALTH SERVICES

Working document prepared by Dr. Humberto Flisfisch for the meeting of the Advisory Committee convoked by PAHO pursuant to Resolution XXV of the XV Meeting of the Directing Council of the Organization

We are convinced that there has been no planning in the field of medical care. If there has been any, there has been very little of it. In most countries, there has been neither national planning nor long-term planning. In most, there is no orderly arrangement of needs, priorities, and resources, no statement of definite objectives nor the funding necessary to achieve them.

(From the opening address by the Director of PASB at the meeting of the first Advisory Group on Medical Care in March 1962.)[1]

PART I

PERTINENT BACKGROUND TO GUIDE THE DISCUSSIONS OF THE ADVISORY COMMITTEE

It has been thought appropriate, for the guidance of the Advisory Committee, to sum up in a few paragraphs certain background material on previous international and Organization activities. This relates to the major aspects of the health sector as a component of development. Medical care is incorporated into it as one of the basic services in any national or local health plan, within a cohesive, integrated system that will make it succeed. This first part concludes with a more detailed account of the terms of reference of the Advisory Committee.

A. DEFINITION AND A RESULTING POLICY

By the term medical care, the Pan American Health Organization means "the totality of direct and specific measures aimed at placing within reach of as many people as possible facilities for early diagnosis, prompt, thorough, and restorative treatment, and follow-up. . . . The facilities and specific measures can be provided through institutional and private medicine. As one of the basic services of an integrated health program, medical care also contributes to training and research; in addition it con-

[1] Mimeographed document TFH/9, p. 25.

tributes indirectly and through the individual to the promotion and protection of community health, as part of a systematic, coordinated, and coherent program."[2]

In this definition, which is quite broad and eclectic, specific and nonspecific responsibilities are distinguished, in order not to trespass upon other disciplines; the individual and his family are considered to be the social unit; the coexistence of Government and private medicine is recognized; impartial collaboration in health protection and promotion is offered; care of the sick is incorporated into national and local health programs; the need for establishing a "system" of facilities is mentioned; and the coordination of all health activities is implicitly advocated.

The proposed definition is included as helping to delimit more clearly the conceptual outlines of the topic "Planning of Hospitals and Health Facilities," for the debates of the Advisory Committee, which are expected to be constructive and illuminating. The sense of the definition is that hospitals, which are basic institutions of medical care, cannot and should not be considered apart from the other facilities that go to make up a cohesive "system." This was the consensus of the last meeting of the Executive Committee when it analyzed this concept.[3]

[2] *Ibid.*, p. 2.

[3] *Official Document PAHO* **64**, 101-110.

B. TOWARD THE FORMULATION OF A CONTINENTAL POLICY

As is well known, a number of events in recent years have occurred to substantiate the principle that health is a component of economic development and social progress, since there is a close and reciprocal relationship between people's health and their economic situation.

This principle, stated at Buenos Aires (1959) and Bogotá (1960), was consolidated at Punta del Este, Uruguay (1961). On medical care, there is an explicit recommendation "to take measures for giving increasingly better medical care to a larger number of patients, by improving the organization and administration of hospitals and other centers for the care and protection of health."[4]

Resolution A.4 annexed to the Charter of Punta del Este recommended that the Secretary General of the Organization of American States establish task forces in various phases of economic and social development to study the most significant problems and recommend solutions "that may serve as a basis for the member states in preparing their national development programs."[5] With respect to health, the resolution indicated that the task force should be organized through the Pan American Sanitary Bureau, which was specifically called upon to "appraise prevalent problems and suggest general lines of action of immediate effect relating to: the control or eradication of communicable diseases; sanitation, particularly water supply and sewage disposal; reduction of infant mortality, especially among the new-born; and improvement of nutrition; and that it also recommend actions for education and training of personnel and improvement of health services."[6]

To carry out this mandate, the Organization in March 1962 assembled in Washington the Advisory Group on Medical Care, among others. Its final report[7] established the bases for the formulation of a continental policy on medical care.

In August 1962 the Technical Discussions at the XVI Pan American Sanitary

[4] *OAS Official Records* OEA/Ser. H/XII.1 (Eng.), p. 32.

[5] *Ibid.*, p. 34.

[6] *Ibid.*, p. 35.

[7] Mimeographed document TFH/9, pp. 79-119.

Conference, held in Minneapolis, Minnesota, were devoted to a single subject: "The Present Status of Medical Care in the Americas in Relation to Its Incorporation as a Basic Service in Integrated Health Programs." Three working documents, covering available information, economic aspects, and effective utilization of existing resources, were submitted for consideration. These were summarized in the Report of the Rapporteur, which was approved with slight modifications. All the documentation thus assembled was compiled by the Organization as Scientific Publication No. 70.[8]

This general orientation was then considered in April 1963 by the Task Force on Health at the Ministerial Level, which discussed medical care as part of the topic "Improvement of Health Services." The final report set forth the following basic premise as a continent-wide criterion and a future line of action:

> "It is necessary, when planning for the expansion of health services, especially in the case of medical care, to take into account not only the cost of construction and equipment, but also the quantitative and qualitative personnel requirements and the budget for operation. Such expansion should be prudently phased; at the same time, existing resources should be fully utilized. Construction plans should form an element of national health plans." [9]

This, in brief, is the historical background up to the XV Meeting of the Directing Council, at which Resolution XXV[10] was adopted. That resolution led to the calling of the Advisory Committee on the topic dealt with in the present working document.

[8] *Op. cit.*

[9] *Official Document PAHO* **51**, 37.

[10] *Official Document PAHO* **58**, 78-79.

C. THE DIRECTING COUNCIL ENDORSES A STRENGTHENING OF INTERNATIONAL ADVISORY SERVICES

During the XV Meeting of the Directing Council, held in Mexico City in September 1964, the Director of the Pan American Sanitary Bureau, at the second plenary session, summarized the problem in the following terms:

> "Medical care was perhaps the field in which the problem of putting available resources to use was most apparent. The difficulty was particularly noticeable in hospital administration because of the magnitude of this function and the investments required. . . . Hospital building and installation was primarily a technical problem, but one with broad financial implications. Owing to the heavy investments being made by the Latin American countries, international cooperation might play a more active role through some sort of regional mechanism to which detailed consideration should be given." [11]

The present working document ventures to draw attention to this last point because it constitutes one of the most important terms of reference of the group convened to express its judgment in the matter.

The idea was taken up by the Directing Council. Indeed, Resolution XXV, adopted at its twelfth plenary session, held on 8 September 1964, reflects the Council's determination to put it into practice.

In the preamble, this resolution indicates that the health planning process includes defining the relative roles of hospitals and other facilities in orderly national health development; recognizes the need for additional hospitals and other health facilities and for the re-orientation of existing ones, as demonstrated by the first health plans; takes note of the enormous sums of money required for hospital construction and operation; expresses concern over the costly overlapping of medical care facilities in some countries; and notes that the IA-ECOSOC[12] has made recommendations on

[11] *Official Document PAHO* **60**, 26.

[12] *OAS Official Records,* OEA/Ser.H/XII.6 (Eng.) 1964, pp. 69-70.

outpatient care. In view of all this, the Directing Council resolved:

1. To request that the Director of the Bureau, through an advisory committee, study the planning aspects of hospitals and health facilities within the national health planning process, and that he report to the 52nd Meeting of the Executive Committee and to the XVI Meeting of the Directing Council on how the Bureau can best participate in the planning for the construction, staffing, and operation of integrated hospitals and related health facilities designed to serve the community needs in the various countries.

2. To urge that the recommendations on this subject made by the Second Annual Meeting of the Inter-American Economic and Social Council at the Ministerial Level be taken into account.

The breadth of scope of this resolution is revealed by its implications:

(a) Orderly incorporation of medical care into the national and local plans for social and economic development; improvement of health services, hospitals, and outpatient clinics as a result of the technical integration of preventive and curative activities.

(b) Construction of new health facilities and remodeling of existing ones so as to increase population coverage on a continental, national, and local level; improving their organization and administration through adequate coordination of the institutions involved, so that better use can be made of available resources.

(c) Planning of health services with a better understanding of the present and the future, determining the initial investment required for buildings and installations, operating budgets, and personnel needs.

(d) A meeting of an advisory committee for a comprehensive study of the problem, with a view to finding how best to strengthen the technical assistance the Pan American Sanitary Bureau can give in this field and how to put it on a permanent basis.

With regard to this last point, it is worth while to emphasize once again, for the Advisory Committee's information, the idea of establishing machinery for regional action and setting up a system in the Pan American Sanitary Bureau whereby Governments requesting it could receive advice on the general programming of integrated health services, with particular stress on medical care. They could thus be helped to determine the number, nature, and geographical distribution of facilities needed. They would also be able to count on advice about type and quality of equipment and installations and about personnel requirements and training. All this is to be financed through the national budgets or foreign capital contributions, with due attention to the fact that the idea of planning involves prior study of the economic infrastructure (communications, transportation, power, and so on).

D. FIRST STEPS TOWARD COMPLYING WITH RESOLUTION XXV

These are the main characteristics and implications of Resolution XXV, which the Pan American Sanitary Bureau was called upon by the XV Meeting of the Directing Council to put into practice. The quotations and comments above show the scope of the problem and the difficulties to be overcome during the next stages.

The Bureau's immediate task was clearly indicated: to convene the Advisory Committee and provide it with all the background material that could be assembled, so that it could examine the matter with full knowledge of the facts and draw up recommendations for consideration, in due time, by the Organization and its Governing Bodies.

In order to carry out Resolution XXV

and derive the fullest benefit from the creative activity of the Advisory Committee, the Organization had first to determine what information could be furnished to enable the Committee to make useful recommendations to the Organization and its Governing Bodies for current and future purposes.

The brevity of Resolution XXV by no means indicates that its contents, or its short- and long-range implications, may be overlooked. With this in mind, the Organization proposed the following general pattern:

(a) *Current status of the health sector.* Health services. Classification and geographical distribution of the services. Population coverage rate. Specific responsibilities of the institutions involved. Degree of coordination among them. Duplication and overlapping.

(b) *Health care.* Preventive establishments that in one way or another assist the basic medical care services. Institutional medical care. Medical care at home. Outpatient medical care.

(c) *Hospitals.* General classification. Number. Size. Number of beds. Allocation of beds. Condition of installations. Organization and administration. Patient-days. Average stay. Bed occupancy. Outpatient services and number of new and repeat visits. Number of consultations per patient per year. General and special costs.

(d) *Personnel.* Professional, technical (laboratory), and auxiliary groups. Absolute figures and indexes. Distribution. Training needs. Current shortages.

(e) *Planning.* General program of new construction and remodeling to establish a graded "system" of health services technically integrated, administratively coordinated, and regionally distributed according to local requirements and demand. Technical capacity to cope with this job (Government services or private enterprise, personnel, materials, construction capacity). Study of recent construction and costs. Special expenses for national or international advisory services on plans, drawings, construction, and installations. Equipment and installations available within the country or importable. Approximate cost per bed. Amount budgeted for maintenance, repairs, and renovation. General estimate of equipment considered useless, unsuitable, or superfluous. Requirements for the normal operation of the program, once all construction and remodeling have been finished, in terms of operating program budgets, personnel needs, and training expenses.

(f) *International advisory services.* Methods, procedures, and organizations through which the Bureau might intensify its technical advice to the Member Governments in planning, construction, fitting out, remodeling, organization and administration, personnel training, and applied research in health services and medical care.

E. THE EXECUTIVE COMMITTEE APPROVES A PRELIMINARY REPORT

Most of the foregoing considerations were included in the Preliminary Report [13] submitted, in accordance with Resolution XXV, to the 52nd Meeting of the Executive Committee of the Organization, held in Washington in April 1965. This body's reaction was favorable to the central idea of establishing in the Pan American Sanitary Bureau a regional mechanism for strengthening international assistance in the planning of hospitals and health facilities.

Opinion was unanimous that the Organization should be supported in its effort to deal with the problem of medical care within the general planning of health services as a component of economic and social development; that coverage should be increased, particularly in rural areas; that the planning

[13] Document CE52/4 (mimeographed).

of hospitals should not be considered separately from other health facilities; that coordination is essential among the plans of all agencies engaged in health work of one kind or another.

Thus many of the participants made special reference to social security institutes and to the need for strengthening coordination machinery. The point had to be made that this important subject had been omitted from the report under discussion because it was to be taken up specifically by another study group [14] in the middle of July 1965.

Commenting on the opinions expressed by the members of the Executive Committee, the Director of PASB indicated some practical aspects. He recognized that the subject was a complicated one and should receive special attention. For some time Government representatives and Bureau experts had been noticing in Latin America the curious fact that there was a shortage of facilities of all types and qualities and that those that did exist were less productive than might be expected. He recognized that large sums were being invested, but not always in accordance with the needs indicated by technical people. The fact was that the Governments either did not have the resources or, if they did, failed to employ rational programming in the use of this combination of national and foreign capital. The Bureau hoped that the group of experts soon to meet would recommend a regional mechanism that would make possible the active utilization of all existing and potential resources in the provision of care to the sick and in the promotion of health among the population. No concrete idea had yet been formulated, and it was important that the group should express its point of view since this was the mandate of the Directing Council. He emphasized, however, that the Bureau wished to go further than a mere recommendation—the authority for which it had already received from the Governing Bodies. An undertaking of greater scope was envisaged, in view of the settled conviction that the Hemisphere as a whole had excellent technicians whose services could, by means of the Bureau mechanism, be taken advantage of wherever needed. In construction, in the quantitative and qualitative programming of resources, in equipment, in the education and training of technicians, the Hemisphere had unsuspected resources. In short, anticipating the Bureau's presentation to the Advisory Committee, he said that what was wanted was not just a consultation or a recommendation—which the Bureau was authorized to make—but a thorough examination of the problem with a view to solving it from a continental standpoint through the establishment of whatever structure was best for the purpose and capable of attracting the help of foreign capital.[15]

The consensus of the Executive Committee's discussions is summed up in Resolution XVI: [16]

1. To take note of the report of the Director on the planning of hospitals and health facilities (Document CE52/4), and of the progress made toward complying with Resolution XXV of the XV Meeting of the Directing Council.

2. To commend the Director and the staff of the Bureau on the preparation of a sound, comprehensive plan of operations for the studies and advisory services requested in Resolution XXV, and to emphasize the need for this plan of operations to be supplemented by the work of an Advisory Committee that will be appointed to make a thorough study of the medical care problem in the Continent which will cover all the subsectors that provide medical care services.

3. To emphasize the importance of having senior officials responsible for the medical care benefits of social security services take part in the discussion of this problem at the XVI Meeting of the Directing Council, and to request that the Director, when convening the meeting of the Council, suggest to the Governments that they include such officials in their delegations.

4. To recommend to the Directing Council that it support the proposed plans and induce the Governments to do so, and to request the

[14] See first part of this publication.

[15] *Official Document PAHO* **64**, 109.

[16] *Official Document PAHO* **62**, 38-39.

Director to submit a report to the 54th Meeting of the Executive Committee and to the XVII Pan American Sanitary Conference on the progress made in the planning of medical care services incorporated into the general health services or coordinated with them.

F. FRAMEWORK FOR COMMITTEE ACTION IN THE LIGHT OF PREVIOUS AGREEMENTS

The foregoing account may appropriately be followed by fairly detailed reference to the framework for the Advisory Committee's activities, before the supplementary background on which its work will be based is set forth, in Part II.

Primary objective of the meeting: Preparatory statement on the necessity, suitability, and feasibility of establishing a regional technical assistance organization in the Pan American Sanitary Bureau. Minimum permanent structure through which adequate technical assistance in Member Governments' various needs and requirements may be obtained—by contract in whatever country and from whatever organization or professional is best able to provide it—for those that so request and that agree to the procedures. Practical ideas for structures, methods, and procedures for the review, fulfillment, and resolution of requests and contractual principles for bilateral or multilateral agreements.

Types of assistance: To establish practices where the need is most urgent and pressing, particularly in connection with preliminary studies in: (a) General planning of "systems" of national or local health facilities, with medical care included or coordinated. (b) Planning of new facilities, with respect to geographical distribution; construction; equipment; study of staff needs and systems for selection, training, and orientation; organization and administration of services; costs, investment and operating budgets; national and international financing. (c) Improvement and, where necessary, remodeling of existing facilities according to the criteria listed under point b.

Minimum requirements: To recommend priority standards for the approval of requests for technical assistance in relation to: (a) Existence of national or local plans for economic and social development, projected or under way, in which the various sectors are aligned and balanced. (b) The requesting Government's desire and ability to set up the necessary structures, organization, and administration for achieving its goals, through the resulting reforms. (c) Current status of preinvestment studies. (d) Desire to contribute demonstration and application areas. (e) Size and importance of these areas. (f) Technical integration of preventive and curative activities and administrative coordination of the various health institutions.

A careful examination of this part will show that it covers virtually all the ideas contained in the discussions and resolutions of the meetings of the Organization's Governing Bodies and the mandates emanating from them.

PART II

CURRENT BASIC INFORMATION FOR USE BY THE ADVISORY COMMITTEE

A. GENERAL CONSIDERATIONS

Resolution XXV adopted at the XV Meeting of the Directing Council requested that "the Director of the Bureau, through an advisory committee, study the planning aspects of hospitals and health facilities within the national health planning process, and that he

report . . . on how the Bureau can best participate in the planning for the construction, staffing, and operation of integrated hospitals and related health facilities designed to serve the community needs in the various countries." It thus implicitly recognized that the planning of hospitals and health facilities is an inseparable component of medical care, of integrated health activities, of programs in this sector, and—in logical consequence—of national development plans.

The preparation of a working document for the Advisory Committee required not only study and analysis of the figures on hospitals built, their cost, their staffing, programs for the future, and so on, but also a panoramic view of the health situation in all the Latin American countries.

The task was not easy, because of the short time available and because of the lack of complete and reliable information on various points. Despite these difficulties, however, the facilities provided by the Ministers and Secretaries of Health in the countries visited and by the Directors of Health and their medical and nonmedical colleagues made it possible to learn a good deal about the organization of health facilities. Mention should also be made of the help afforded by officials of the Pan American Health Organization who cooperated in the drawing up of programs for interviews, visits, and trips to the interior of the countries and particularly in the improvement by their own knowledge of the survey agreed upon.

It is worthwhile to note that on occasion the personal contact was more valuable than the obtaining of bald figures, the interpretation of which was often dubious or difficult.

The Consultant's program of visits to eight countries considered representative of the present status of health and medical care in Latin America was determined by the need for providing the Advisory Committee with as much new or updated background information as possible on the aspects mentioned in Part I of this working document. As the planned stages were completed, it became clear, as was to be expected, that in each country the situation is different, though there are numerous points in common that induce an over-all assessment. But when the situation of the health sector in these countries is compared, it can be seen that some are in the midst of stages through which others have already passed, the latter being able to contribute useful experience that can be adapted to each country's individual characteristics.

Historical, ethnic, cultural, socioeconomic, as well as structural and organizational factors, together with a sizable population growth unaccompanied by adequate economic and technological development, have brought about diverse systems and facilities in the health sector of the Latin American countries. These are not easy to reconcile and are susceptible of improvement through more rational patterns ensuring better use of existing resources. Leading roles in the achievement of these changes are played by the national policy of the incumbent Government; by the institutional policy of the public and private sectors; and by the habits and attitudes of organized medicine, the nonmedical professionals, and the community. On more than one occasion it was possible to observe the reluctance of some of these groups—components of economic and social development—toward accepting plans, programs, systems, or procedures that would make it easier to achieve certain goals.

An analysis both of previously existing information and of the new data obtained in the countries visited shows the effort being made in each of them to achieve a higher level of health in the population—an effort expressed through the establishment of coordinating and planning agencies; programs for the building of hospitals, clinics, and other health facilities with domestic resources and/or foreign aid; an increase in the education and training of personnel on various levels; agreements toward the coordination and sometimes the administrative

integration of the different health facilities; the technical integration of preventive and curative activities; the development of programs in medical care, rural medical care, maternal and child health, nutrition, sanitation, food control, epidemiology, and special fields.

In some Hemisphere countries a start has been made on drawing up health plans in the form of program-budgets, through the planning departments, either subsectorial or at the ministerial level. By means of a newly adopted and rational methodology, an attempt is being made to put existing health resources to the most advantageous use through a determination of costs and priorities in expenditures and investments. The results cannot be anticipated; the evaluation made in one of the countries visited a few months after the method went into effect is not and cannot be indicative of its success or failure.

With respect to the national development programs, it is apparent that interministerial coordination is defective or nonexistent in some countries; in others, plans for the health sector have been formulated by themselves, without the support of the other sectors, which limits and impedes the correct and proper application of the plan. Besides this, the organization of health ministries, secretariats, and bureaus is so structured in some countries that it does not facilitate good preparation and execution of programs.

Another significant fact noticeable in many Latin American countries is the advance of social security in the sphere of medical care. Although this important matter is being considered by another Study Group, it was deemed necessary to examine its relationships with other health facilities and all the aspects that may provide the Advisory Committee with more and better information.

Significant progress has been made in the education and training of health personnel. The various countries are anxious to increase the available human resources. Two basic problems have arisen in this field: shortage and/or poor distribution of personnel. In some countries personnel-distribution ratios have been applied, and in others performance quotas have been assigned in accordance with the program-budgets (health plans).

In certain countries emphasis has been placed on the training of physicians through the establishment of new medical schools—the number in some has tripled during the past five years. The lack of specialized medical administrators is obvious in many countries, and to train these specialists it is therefore becoming necessary to set up short courses—besides the regular long courses—in the public health and hospital administration schools.

Another important item is the shortage of nurses, which is general in Latin America. As in the preceding case, various procedures have been tried to increase the number and to keep them from migrating to other countries where better financial prospects are offered. The same thing is happening with other nonmedical professional groups. In addition, there has recently been an increase in the training of nursing auxiliaries, with selected candidates, in courses ranging from three months to a year.

In the past five to ten years, the planning, construction, and remodeling of hospitals, health facilities, outpatient clinics, and other medical care institutions in Latin America have run the gamut of systems, criteria, and procedures. It is perhaps in this aspect of medical care and, consequently, of community health care, and also in the organization and administration of health services, that international organizations can most effectively give help to countries when they need it, since, as has been said previously, programs related to the construction of hospitals, clinics, and so on cannot be detached from sectorial health plans and from the very organization of their services without the risk of duplication, often at very high cost.

Finally, in this general review, it should be noted that more and more frequently international programs that are designed to eradicate communicable diseases and to solve nutritional, basic sanitation, and other problems are being drawn up and put into effect. Furthermore, an ever-increasing interchange of professionals, technicians, and specialists is creating in Latin America an awareness that better goals (satisfied demand and a decrease in deaths) must be achieved by making rational use of resources through the adoption of working methods and organizational systems that are attuned to the real situation and to the individual characteristics of each country.

The general considerations that have just been reviewed make it advisable to stress once again the importance of Resolution XXV with respect to improving, on new bases, the Pan American Sanitary Bureau's full and permanent assistance on medical care incorporated into health facilities—the main topic submitted for Advisory Committee discussions leading to recommendations on the best means of putting it into practice.

B. DEVELOPMENT OF THE SURVEY

The survey conducted for the gathering of information, background, and theory comprised four groups of questions:

1. Present status of the health sector—health facilities.
2. Health care.
3. Health resources (institutions, staff, financial means).
4. Planning.

Initially, various aspects for investigation were included in these groups; some came to be discarded because it was impossible to obtain adequate replies or because they proved to be of little use when the data recently obtained in each country were analyzed as a whole and compared with those already existing. They might be a subject for future research that would fill in our knowledge of the status of medical care in Latin America.

Furthermore, it was not easy to quantify the material collected in cases where figures supplied by two or three different sources disagreed or could not be reconciled.

1. PRESENT STATUS OF THE HEALTH SECTOR HEALTH FACILITIES

a. *The health sector as a component of economic and social development—Health plans*

In recent years, at various international meetings held in Latin America, emphasis has been placed on the need for promoting the populations' welfare in order to improve living conditions. On this premise, the Governments, through plans and programs for economic and social development, have sought a growth in their economies, in production, and in productivity, and also an improvement in health, education, housing and nutrition, and labor and recreation, among the most outstanding fields.

At the Meeting of the Task Force on Health, held in Washington 15–20 April 1963, it was stated in the Final Report:

> A healthy and active population is essential for economic growth and social progress. Health is therefore a basic component of development and of the standard of living. Resources devoted to health care are an investment, a source of productivity, not an expenditure. The return on that investment can be measured in terms of the improved capacity of the members of a community to create, produce, invest, and consume. It may likewise be measured by the greater yield obtained from natural resources as a result of health work.
>
> Seen from another viewpoint, improvement of health implies a raising of living standards that basically benefits the low-income groups of our communities. Consequently, it contributes notably to the attainment of one of the most important goals of the development

process, that is, to bring about a better distribution of an increasing real income.[17]

With health considered as a component of development, its close relationship to the other sectors becomes plain; thus the health sector cannot be omitted from national planning. It must be said that so far the health planners have been tightly bound to the respective ministries and that the whole of a given country's or region's resources have not always been considered in the plans. These omissions in national health planning are due in almost all the Latin American countries to ignorance of the sum total of material and human resources available in this sector. Only in a few have censuses or statistical surveys of resources been made by specialized personnel traversing the entire country, since the survey procedure is subject to error and personal interpretation. There is a remarkable, but not unique, case of a national capital in which up to a year ago the list of health establishments included a 100-bed hospital that was supposed to have been in operation for 20 years. When the census was taken, it was found that the hospital had never existed. Investigations revealed that it had reached only the initial step of an application for its establishment.

In addition, it is extraordinarily difficult to obtain usable and reliable background on the private subsector of health, for which complete information—the basis for a plan or program—does not exist or is very defective.

Since it is essential that health plans be not merely ministerial or subsectorial but truly national, in totaling the resources of all the organizations concerned it is necessary first to set up standards and procedures that will make possible exact knowledge of the true situation of the health sector.

According to up-to-date information at the time of preparing this document, there are planning units in the ministries of health of 17 Latin American countries and health plans have been completed in 10 of them. It must be stressed that in the majority these are merely subsectorial health plans. Also, according to the same sources, in 5 of the countries plans are being formulated.

b. *The ministries of health and their responsibilities*

In attempting to examine the present status of the health sector in Latin America, it must be borne in mind that since health is an eminently medical, economic, and social problem, the formulation and fulfillment of a health policy should be the responsibility of a single Government agency—the ministry of health, covering the entire population. Through the existing health services, by delegation of activities, the ministry of health develops this policy in plans and programs that comprise integrated health activities (preventive and curative).

With the background available, it is safe to say that in no Hemisphere country has this responsibility been given to the ministry of health. On the contrary, participating in community health care are such other ministries as labor and welfare, to which the social security funds belong; education, which carries on programs of school medical care; defense, which has its own curative services; development and public works, with medical care services for certain labor groups; and others. In two countries, the ministry of health also includes welfare and labor.

This state of affairs has come about because the ministries of health are unequipped —financially, in resources, and otherwise— to satisfy the obvious demand for medical care, both out-patient and hospitalized, and to carry out the programs of health protection and promotion that are within its sphere. Furthermore, the lack of sufficient legal and administrative support has helped perpetuate this situation.

It should be noted in this respect that the Pan American Health Organization has been

[17] *Task Force on Health at the Ministerial Level. Official Document PAHO* **51**, 4.

advocating a legal and administrative strengthening of the ministries of health. As for the former, it ascribes particular importance to written law because of the weight this carries in the Latin American countries. As for the latter, it believes that the power to establish standards and control the administration of health services belongs by right to the ministries of health, without prejudice to their power of delegating activities to other health institutes.[18]

In accordance with this doctrine, some countries have passed laws giving greater authority to the ministries of health and have modified and simplified their structures. Because these changes are recent, however, the results cannot be evaluated.

c. *Health services*

An outline that will permit an orderly grouping of the various health services existing in Latin America is not easy to present because of the diversity of national, regional, and local systems performing health activities. The background offered above explains the reason for this situation.

The goal of a single health service with total coverage of the population, with technical integration of preventive and curative activities, centralized with respect to standards, decentralized in the carrying out of programs, financed by health insurance or other direct financing, is far from being reached. To facilitate their placement, these services are grouped below in a simple general outline.

(i) Public subsector

a) Services of, or responsible to, the central Government, wholly financed by the Governments

• Branches of the ministry of health, which establishes their structures, sets standards for organization and administration, and supervises them. In all the Latin American countries the programs dealing with basic sanitation, food control, immunization, eradication of communicable diseases, and so on, are the responsibility of the ministries of health. In recent years their scope has come more and more to include hospitals and clinics of the "beneficencias" or those built by the ministry itself, and some have extended medical care to rural areas through a system of small units scattered throughout the country. In four of the countries visited, the number of units built and functioning in the period 1960–1964 was considerable, and they have been assigned a most important role in solving the health problems of thinly populated communities.

• Branches of other ministries, such as the military, naval, aeronautical, police, and school health services with programs of their own; also, the medical services of other ministries. Basically, these all provide curative medical care in hospitals and clinics.

b) Independent or autonomous services with bi- or tripartite financing to which the central Government is one of the contributors

In this group are included:

• The medical services of the social security agencies that provide curative medical care to members and sometimes to their families. Maternity care for insured women and wives of insured men. Compensation for illness, maternity and nursing, disability, and in some countries on-the-job accidents. The other risks covered by the social security funds are not considered because they are not specifically related to health care.

• Public "beneficencia" societies, which constitute the oldest existing health services in Latin America, providing curative care to the indigent or needy in hospitals and clinics. The high and rising cost of medical care has forced the Governments to increase gradually the contribution they make for the maintenance of these facilities. Whereas in one Hemisphere country the charity or

[18] *PAHO Policy on Medical Care in the Communities.* IV Meeting of the Country Representatives of Zone IV, July 1964 (mimeographed document).

"beneficencia" hospitals were simply transferred by law to the State, in another there are 21 charities or "beneficencias" to which 98 per cent of the hospitals belong, independently operated despite certain legal provisions requiring supervision by the ministry of health. In general, there is a move, by means of various procedures, toward financial, technical, and administrative control by the ministries of the old charity hospitals, so as to incorporate them into an integrated health system.

- Societies building hospitals and health establishments; local corporations for development and the construction of hospitals and health facilities; sanitation corporations.

- Medical services and institutes of the medical schools of the Government universities.

c) *Federal and local services*

- In countries with a federal political-administrative organization, health services subordinate to the states or provinces and departments have been established. In some there are state or provincial ministers or secretaries of health, who may or may not be under the national minister of health. In several countries definite progress has been made in coordinating these secretariats with the central Government through agreements; in others, for financial and economic reasons, the states have turned the administration of their hospitals over to the ministry of health.

- The municipalities, as an expression of the local governments of the autonomous commune, have established their own health services in the form of outpatient care at clinics and certain health activities. In financially capable communes, these services have attained a certain prominence.

(ii) Private subsector

In this subsector have been grouped those facilities in which the central Government does not intervene and to the support of which it gives no financial aid. In some of the countries visited, the construction of hospitals or health facilities has been regulated, so that private clinics must submit their programs for review by the ministry of health. In several countries, the control of these establishments and of the private practice of medicine has been made a responsibility of the ministry. Facilities in this subsector have been grouped as follows:

Private, industrial, and religious hospitals, clinics, and health centers, profit-making and nonprofit.

Private charitable societies.

Mutual-aid societies.

Private voluntary health organizations.

Medical, paramedical, or health-related schools and institutes within private universities.

Private, medical, paramedical, or related clinics.

d. *Geographical distribution of health services—Urban and rural areas*

In the consideration to be given later to the health resources available in Latin America, the emphasis will be on their geographical distribution, which does not correspond to the principle of distributive equity used by economists.

A knowledge of the geographical distribution of the population is essential for the distribution of services and resources. During the past decade the rates of growth in urban areas have been very high, owing in part to migration, and stress has often been laid on the problems this has brought about in the large cities. Urban and rural distribution varies considerably in the American countries. In a few, a high proportion of the population lives in the big cities and the smaller urban areas; in others, the situation is reversed.

There is no common definition of the term *rural area* in Hemisphere countries; numerical data are therefore subject to error, sometimes of significant dimensions. In some countries it is the Census Bureau that has established the characteristics of rural communities, solely on the basis of number of

inhabitants, which ranges from 2,500 (2,499) to 5,000. This definition puts into the rural sector towns that in every way are part of large, densely populated urban centers and have all the resources in health, education, housing, transportation, communications, and so on, that are lacking in real rural areas. Hence it seems more useful to seek a definition that, taking into account the lack or shortage of such resources, might be common to all America.

It has been estimated that more than 50 per cent of the population of the Hemisphere is engaged in farming, grouped in rural areas. To this should be added those working in mining regions, who also live in rural areas, and amount to about 10 per cent. The total rural population in Latin America comes to nearly 60 per cent. The figure varies among the countries from 78 per cent of the population living in rural areas in Honduras to 34 per cent in Argentina.

Another point that deserves emphasis is the concentration of the urban population in cities of more than 100,000 inhabitants, which amounts to a significant percentage in Argentina and Colombia.

As a result of this situation, some countries in recent years have undertaken programs of rural medical care that have had the help of international organizations and in which a genuine system of rural medical facilities has been set up, consisting of small establishments with or without beds—depending on the size of the locality—and with or without doctors and other staff, carrying on integrated health activities. In some ministries and secretariats of health, departments of rural medical care have been established to set standards and supervise these programs. What has been observed on the spot encourages the expectation that, when the system has been improved and sufficient good human resources—the major obstacle at this time—are available, considerable progress will be achieved in solving the health problems of this large sector of the American population.

A heavier present concentration of health facilities in urban areas, and in those with the greatest population density, is general in all the countries of the Hemisphere. This is explained by the tendency of medical and other professional groups to work in centers that have larger resources and a population better able financially to provide an income from private professional practice; by the need for professionals engaged in teaching, research, and administration at central and intermediate levels; and by the ever-increasing pressure of these populations, who because of their higher culture and education demand more services of this kind.

e. *Population coverage*

Numerous and important gaps in information lie in the way of determining how much of the population is covered by the curative medical care services. Even in countries that have prepared sectorial health plans, the figures are approximate and must be refined as the results obtained are evaluated. It is further believed that, theoretically, the average population protected by the private subsector is no higher than 10 per cent. The potential rate of coverage of the health services of the Government or autonomous subsector, including social security, is from 80 to 90 per cent of the population.

The variations found in the different countries depend on a number of factors; among the most important are the financial capacity of the population, the quality of medical care given, the geographical location of facilities, and the transportation and communication facilities, besides the historical, cultural, and other considerations.

f. *Organization of health facilities*

The organization of health facilities in Latin America, a general description of which has been given, has been influenced by various factors—above all the Governments' concept of health problems and their

solution through a policy executed by the ministry of health and other ministries.

Generally, all the systems and services have a pyramidal organization, with centralization of standards and objectives and decentralization of operations through the delegation of functions and powers.

In the Latin American health services there are generally three levels with respect to structure: central, intermediate, and local. (Facilities in the private subsector are omitted from consideration.) The authority of the central level, the ministry or secretariat of health and/or health bureaus, with their departments or divisions and sections, is subject to extratechnical contingencies that account for the way in which well-worked-out programs may be interrupted, altered, or replaced before their results can be evaluated. Similarly, periodic changes in the professionals or technicians at the head affect the development of programs.

While in some countries the central authority is represented by the minister or secretary of health, in others it is vested in the director of health. Either way, the tendency is for the administrative aspect to be separate from the technical, but always under a single authority. In the technical field, the setting of standards and the supervision of activities are in the hands of departments of health restoration, promotion, and protection or subsecretariats or divisions of medical care and health. In the first case, these departments are coordinated by the minister or director of health; in the second, coordination is theoretically at the ministerial level. No details are given on the other departments and sections that go to make up those basically described; they are much the same in the various countries. In the past decade, departments of national health planning, with or without interministerial coordination, have been coming into being at this level.

The tendency toward technical and administrative decentralization, with a view to preventing hypertrophy of the health ministries or bureaus, has in some Hemisphere countries created an intermediate level grouping a certain number of health regions or zones, which is responsible for coordinating its subordinate services and facilities and for applying the technical standards issued by the central authority. For proper coordination with other sectors of economic and social development, this intermediate level should coincide with the political-administrative division of the country. It has been observed that, despite the good results, in some countries this zonal or regional level does not exist and, instead, hospitals are regionalized, with or without a well-defined structure.

Finally, the third level of this organization is represented by local health centers and units, with or without administrative and/or technical coordination of activities. In general, the organizational scheme at this level is more or less similar in all Hemisphere countries. Posts, primary centers, rural medicatures, health centers, sanitation units, outpatient clinics with or without beds, hospitals of various sizes, and so on, recur throughout America. In some countries emphasis has been placed on rural medical care with specific programs; in others, medical care on this level is combined in a single program.

g. *Social security*

Social security, which originated in Europe in the second half of the nineteenth century as a consequence of the Industrial Revolution, constitutes "one element of a country's economic and social policy; its aim is to restore, through benefits in cash and in kind, the consumption capacity of insured workers and their families when, for reasons of illness, accident, disability, old age, or death, they have temporarily or permanently lost their earning capacity and their means of subsistence. Furthermore, it promotes the worker's return to active life

in the shortest possible time, in order to put him back into production." [19]

This definition contains a basic economic principle of production and consumption applicable to all members of a community but with its greatest bearing on the active population. To uphold this principle there must be, on the one hand, a healthy population and, on the other, the economic capacity to consume, through a conjunction of such factors as full employment, a wage policy that guarantees every inhabitant an adequate living, and social security in the form described.

Social security is financed by contributions that are generally tripartite—proportions of the wage or salary varying in the different laws, paid by the employer, the employee, and the State. In some countries, certain social security benefits have bipartite financing—employer and employee.

To handle health benefits, most of the social security agencies established their own medical facilities to give curative medical care and maternal and child care to subscribers and their families, under various systems and with various limitations. Outpatient centers and hospitals were built and agreements were reached with ministries of health, public "beneficencias," and private institutions for the contracting of services (specialized outpatient consultations and hospitalization) not offered, whether generally or in certain areas, by the social security agencies themselves. This policy has become more marked in recent years in many countries, where the trend is toward their building more hospitals of their own or, as was observed in two countries, toward assigning certain beds in a ministry hospital to social security, which organized and operated them in its own manner, independently of the rest of the hospital, and had different salary scales and work schedules for its staff.

The hospitals and clinics built and equipped by the social security agencies have as a rule been of better physical quality than the old "beneficencia" or new ministry hospitals. Often they have had better staffs, both professional and auxiliary, owing to a higher salary scale.

According to data supplied by the Organization of American States, 19 Latin American countries include maternity and 16 include illness among the social security benefits offered to subscribers. As has been said, however, population coverage is very uneven. It could be determined only by special research.

By providing generally effective and timely medical care, social security in Latin America has created a health consciousness among working groups and has channeled large sums of money into medical services, all of which is unquestionably beneficial to the general picture of organized medicine. But the current structure of social security inspires three reservations from the standpoint of modern views on total coverage and integrated medical care:

High cost of medical care, out of all proportion—as will be shown later in figures—to what is being spent to protect the uninsured population.

Benefits reaching a very small percentage of the population of America.

Creation of group privileges and distinctions in Hemisphere countries with respect to medical care.

h. *Coordination and integration*

Much emphasis has been placed on administrative integration of the various health facilities, a different matter from technical integration of health activities. It has been warmly defended by some, assailed by others; the possibilities of achieving it have met stumbling blocks in the political, economic, and personal sectors and in institutional autonomy, shortage of resources, and other difficulties.

These limitations, which are also valid

[19] As set forth in the working document of the meeting of the Study Group on the Coordination of Medical Care in Latin America; see p. 15.

with respect to achieving good coordination of health facilities, should be more precisely outlined, since the success of the program depends on the multiple alternatives they present.

Among them must be recalled the medical profession's defense of private practice and its opposition to bureaucratic medicine as injuring its financial prospects; the professional training given by the medical schools; the distrust of the labor sectors toward Government medical care, which they consider poor or deficient; and the interests that have promoted laws granting different benefits. To these must be added the separation that has so far existed, and survives in some countries, between preventive and curative activities, which are subject to the policies of institutions that grew separately. Despite these difficulties, a change of attitude is occurring in the Hemisphere that sooner or later will result in new patterns for raising the health level of the populations.

In this respect, it should be recalled that technical and administrative integration has been achieved at the national level in only one American country; in another, this has come about partially, since coverage is not total in regard to institutions and population. In the face of this situation, coordination of the health services was indicated as a temporary or final stage; in some Hemisphere countries, this has been started in some regions and localities (pilot projects).

The efforts toward effective coordination within the health sector have taken the following forms in the various countries:

(i) The granting of subsidies to local "beneficencias" and similar bodies, with the ministry of health reserving the right to set standards of organization and administration and assuming supervisory functions. In some countries where this procedure, reinforced by written agreements, has been put into effect, it has not had the expected results in changing situations so deep-rooted and traditional. Nevertheless, efforts should be continued and the control and supervision procedures should be improved.

(ii) Transfer or purchase of hospitals and health facilities between institutions, where the original proprietor is financially unable to pay the operating expenses or where the Government contribution is very large. In one country the ministry of health sold some hospitals to a social security institute for $36,000,000; contrariwise, another institute turned over a hospital to the ministry of health for remodeling and administration. Such examples are showing that moves of this kind can promote more active interinstitutional coordination.

(iii) Coordination among the various social security agencies within a country, by means of a higher coordinating council. With this a great number of activities have been shared by the various agencies and it has been settled that, in the future, new hospitals will provide services without distinction to affiliates of all the institutions.

(iv) Contracts between the ministries, the social security agencies, and other health services for utilization of beds without discrimination among beneficiaries.

(v) Technical directives, issued by the ministries of health and nationally applicable, on statistics, pharmaceutical products, immunization, conditions on premises for food processing and sale, and so on.

(vi) In some countries changes have been made in the administrative structures of the ministries of health, with regional decentralization and a technical chief—a health specialist—for each area, in charge of directing and supervising medical services there. Experience has shown that this procedure is adequate and suitable; however, owing to lack of legal and financial support, the work of these authorities has sometimes not been as effective as it

should be. In most countries, the scarcity of health specialists has been another factor impeding the execution of this procedure.

(vii) In one country, a law was passed under which formerly separate services were integrated administratively and technically. This service was put in charge of all preventive activity in the country and of curative coverage exceeding 70 per cent of the population.

In any case, the question arises how to achieve this coordination. Integrated planning of economic and social development; standardization on the national level of the different social security systems; establishment of health insurance covering the entire population; financial, legal, and administrative strengthening of the ministries of health; coordination of local health activities; education of the trade-union sector—these are some of the measures recommended for achieving coordination of health services.

The first Latin American Regional Assembly of the World Medical Association, held in Santiago, Chile, 3–10 April 1965, summarized its ideas on the problem as follows, in the conclusions of the topic "The Various Medical Care Services and Their Application in Latin America:"

Any medical care system in a country should be adapted to its history; its economic and social situation; its ecological, educational, and sanitary conditions; and its possible planned evolution.

Considering:

1. That there are differences between the Latin American countries with respect to demographic situation, health problems, and cultural and organizational characteristics;

2. That health is a right and that therefore medicine should be universal, prompt, adequate, continuous throughout life in health and in sickness, integrated, and including health promotion, protection, and recovery in its broad community sense;

3. That resources at present seem insufficient for the provision of medical care with these characteristics.

The following goals are recommended:

(1) The formulation of national health plans and the establishment of a directing organization in harmony with other agencies for national planning.

(2) Coordination of the various institutions for medical care.

(3) Centralization of work standards and decentralization in the performance of activities.

(4) Regionalization and organization into systems in which the basic units are peripheral outpatient clinics and local organization for health promotion and protection, in a functional relationship with the general hospital.

2. HEALTH CARE

The chief characteristics of health care in America are the dynamism and flexibility with which the trends and knowledge of various periods are applied and the constant creation and change of systems in response to the needs of the environment. Advancing more or less rapidly, the countries have been assimilating the experience of others and adapting it, in successive stages, to their own ecological conditions.

Four basic concepts emerge from an examination of health care systems:

a) The right to health and social security of a country's inhabitants.

b) Acceptance of the interrelationship between health, sickness, and economic development.

c) The value of diagnosis and prompt treatment of morbidity and preventive control of diseases.

d) Agreement that curative medicine, despite its highly advanced techniques, could not alone reduce significantly the high morbidity-mortality indexes, which are affected by environmental factors.

As an inevitable consequence of scientific and technical progress, costs rose, especially in health restoration. This led to the idea of combining resources, coordinating the activities of various facilities, and formulating national programs through planning offices or departments.

The ministries of health cover all aspects

of health protection through programs in basic sanitation, food control, industrial hygiene, zoonoses, control of infectious and parasitic diseases, and so on. These activities, set out in Sanitary Codes and other regulations, are carried on by specialists and technicians through a network of hospital facilities, health centers, sanitary units, rural medical units, or other services differently named but basically similar. But in more than one country these programs are difficult to carry out, especially when other sectors are involved in them by law. A good example is water supply and excreta disposal, especially in rural areas. In one of the countries visited, 73 per cent of the urban population and only 5 per cent of the rural population have potable water. With respect to excreta disposal, 51.6 per cent of the urban population has sewer systems and only 40 per cent of the rural population; the remaining 60 per cent has none at all and uses the fields. Under the law, the ministry of public works is in sole charge of water supply and excreta disposal in communities of over 1,000 inhabitants. Smaller clusters and isolated communities are not included in the programs of the bureau of sanitation works of the ministry of public works. Consequently, the national health service had to take charge of this serious problem—no proper solution to it—thus creating an overlap in the use of resources, especially manpower.

The same situation occurs in another country, where community water supply is handled by the national institute of sanitation works (ministry of public works), for towns of more than 5,000 population, and the rural aqueducts division (ministry of health and social welfare), for the smaller communities. Natural population growth and the trend toward concentration in urban sectors with more than 5,000 inhabitants (39 such centers in 1941; 127 in 1965) have created serious problems for both of these organizations in project financing and maintenance. Here there is also duplication that should be corrected for the most profitable use of resources.

To avoid repetition, all the material concerning hospital, outpatient, ambulatory, and home medical care will be considered in the next chapter, which deals with the material, human, and financial resources available to health facilities in the Americas.

3. HEALTH RESOURCES

Given the need to use existing resources to the best possible advantage, avoiding duplication and excessive costs and programming activities in accordance with priorities based on a community's health hazards and needs, it is essential to find out first what resources are available—that is, to make a partial diagnosis of the situation.

For the purposes of this report, the examination of resources in America has been divided as follows:

a. *Material resources:* number of establishments; size; number of beds, distribution by specialty and geographically, status of installations and distribution in the country; authority to which responsible; organization and administration; patient-days; average length of stay; rate of occupancy; outpatient consultations, new and repeat visits; consultations per patient per year.

b) *Manpower:* professional, technical, and auxiliary groups; absolute number, indexes; distribution; training needs; present shortages.

c) *Economic resources:* expenditures on health, on medical care, on personnel, and on certain important branches, among them such programs as nutrition, medicines, and maintenance.

It should be noted that figures of the Pan American Sanitary Bureau and those obtained in the countries visited have been use for quantifying. The lack of adequate information in some countries prevents the data from being complete and entirely reliable.

a. *Material resources*

(i) Number of health facilities

The term health facilities has been employed because it comprises hospitals and centers, health units, rural medicatures, and so on, assigned to health care in America.

In the case of hospitals, this numerical information is of limited value, since it may or may not be related to the number of beds. A given country may have few hospitals and enough beds, or the reverse.

Table 1 shows for each country the local health facilities and the estimated population, together with the rate of growth.

Table 1. Number of Facilities in the Americas, with Population and its Rate of Growth.

Country	*Population*	*Year*	*Local health facilities*	*Annual growth rate*
Argentina	22,024,000	1960	714	1.7
Bolivia	3,668,000	1960	193	1.4
Brazil	78,809,000	1962	3,588	3.1
Canada	19,272,000	—	—	2.7
Chile	8,769,000	1964	461	2.8
Colombia	16,040,000	1964	1,051	3.2
Costa Rica	1,391,000	1963	134	4.0
Cuba	7,336,000	1964	256	2.1
Dominican Republic	3,452,000	1964	291	3.5
Ecuador	4,877,000	1961	148	3.1
El Salvador	2,824,000	1964	74	3.0
Guatemala	4,396,000	1964	212	3.1
Haiti	4,550,000	1962	188	3.0
Honduras	2,092,000	1964	82	3.0
Jamaica	1,730,000	1963	166	1.3
Mexico	39,643,000	1964	2,895	3.1
Nicaragua	1,584,000	1963	163	3.3
Panama	1,243,000	1964	186	2.9
Paraguay	1,949,000	1960	258	2.6
Peru	11,357,000	1964	658	2.5
Trinidad and Tobago	948,000	1963	97	2.9
United States of America	191,334,000	1962	2,069	1.6
Uruguay	2,996,000	1964	—	1.6
Venezuela	8,427,000	1964	520	4.0

The number of health facilities has been related to the population and its rate of growth because this is one of the basic factors in estimating a country's bed needs.

According to the available 1962 information, brought up to date to include recent hospital construction in some countries, there were 17,883 hospitals in America, of which 8,404 were in North America, 2,740 in Central America, and 6,739 in South America. If it is recalled that about half the population of the Americas is grouped in Central and South America and the hospitals for these regions are totaled, the figure is 9,479—higher than the 8,404 for North America. This might suggest, falsely, that Central and South America have enough hospitals, granted that those in North America are sufficient in number to cover the needs of the population; but not if the geographical distribution, number of beds, and distribution by specialty are examined as a whole and, more particularly, for each country.

(ii) Number of beds

A knowledge of the number of hospital beds in a country is one of the basic elements in planning.

In the statistics furnished by some countries, the term *hospital beds* does not include those in clinics, especially rural clinics, where patients remain for 24 to 48 hours, receiving emergency care, and are then moved to local or regional hospitals for

proper examination and treatment.

To ensure uniformity in the collection of data, the term *hospital bed* should be precisely defined and a common nomenclature used for all the countries of the Hemisphere.

It is estimated that at present there are 2,601,908 hospital beds in the Hemisphere —a figure that will change when a reliable census of available resources has been taken. In many countries such an inventory is now being made, with a view to the formulation of a national health plan. Of this total, North America has 898,230 beds; Central America, 128,097; and South America, 335,588 in general hospitals. In specialty hospitals there are 988,928, 64,833, and 178,864 beds, respectively. The remaining 117,471 are divided between the aged and chronic invalids. It is noteworthy that while North America has 851,401 beds for mental patients, in Central America there are only 32,573 and in South America 76,398.

For tuberculosis, however, the proportion changes, since adding the number of beds for this specialty in Central and South America produces more or less the same figure as for North America.

In the goals set in health plans, the ratio of beds to 1,000 population is used as one indication of the number needed. It has been estimated that for acute cases there should be 4.5 per 1,000. An examination of the current figures shows a deficit for South and Central America, both in total beds and in those for acute cases. In Central America the figures are 2.7 for acute and 1.8 for general hospitals; in South America, 3.5 and 2.3; and in North America, 9.2 and 4.4. In addition, the figures vary considerably from country to country.

It should be borne in mind that the ratio of 4.5 beds per 1,000 population is far from being reached in most of the Latin American countries, and that what is considered an adequate ratio could probably be lowered if better use were made of resources, with longer hours in the outpatient clinics (morning and afternoon; not, as in many countries, mornings alone), shorter average lengths of stay, and higher rates of occupancy.

It has been impossible to learn the distribution of beds by such specialties as surgery, medicine, pediatrics, and obstetrics in the bed total for general hospitals. Though information has been obtained in some countries, it is not sufficient to show the real situation in the Americas; however, the figures below may be useful in indicating trends in the countries mentioned.

Table 2. Percentage Distribution by Beds of Specialties in Some Hospitals in Chile, Colombia, El Salvador, Peru, and Uruguay (1962–1964).

Country	*Year*	*Total beds*	*Medicine %*	*Surgery %*	*Obstetrics %*	*Pediatrics %*	*Tuberculosis %*	*Mental %*
Chile	1963	22,360	18.1	14.8	11.8	19.6	19.8	17.0
Colombia	1962	31,778	18.4	10.22	12.52	16.81	9.57	15.58
El Salvador	1964	6,503	44.0		10.8	10.7	24.3	8.9
Peru	1963	18,530	28.4	26.2	9.8	7.4	10.8	2.1
Uruguay	1964	7,243	—	—	4.3	11.0	—	—

In Table 2 only beds for certain services are considered; others have been omitted for lack of data. A striking item is the high percentage of beds assigned to pediatrics in Chile as compared with the others, which is explained by the country's high infant mortality—the highest in the Americas, together with that of El Salvador. Similarly, Uruguay designates only 4.3 per cent of its beds for obstetrics, which is justified by a slow population growth rate of 1.6 (aging population). It is obvious how important the age distribution of the population is in the apportionment of beds by specialties.

Much stress has been laid, in preparing program-budgets for national or sectorial

health plans, on the notion of fair distribution of resources, which is closely related to the number of beds available in urban and rural areas and their concentration in large population centers.

The publication *Health Conditions in the Americas 1961–1962* contains the following statement:

> Knowledge of the distribution of hospital beds within a country is important for planning for services for the entire population. . . . Since information could be obtained for capitals, federal districts and large cities, for this presentation each country has been divided into two parts, namely (a) the capital or federal district and cities of over 500,000 population and (b) remainder of the country.[20]

[20] *PAHO Scientific Publication* **104**, 53.

Table 3 [21] shows data for 16 countries with an estimated population of 189,000,000, representing 90 per cent of the population of Latin American countries around 1962. The number of hospital beds in the capitals and other large cities of these countries was 5.8 per 1,000 population—two and a half times the number for the rest of their territory, which was 2.2 per 1,000. Though large cities are centers for hospital care, the rest of these countries—that is, the smaller cities and the rural areas where about 77 per cent of the population lives—is also in great need of services.

[21] *Ibid.*, p. 51.

Table 3. Number of Hospital Beds and Rate per 1,000 Population in Capitals and Large Cities in 16 Countries, around 1962.

Country	*Year*	*Total*		*Capitals and large cities (a)*		*Remainder of country*	
		Number of hospital beds	*Rate*	*Number of hospital beds*	*Rate*	*Number of hospital beds*	*Rate*
Latin America		572,137	3.0	255,637	5.8	316,500	2.2
Argentina	1962	129,435	6.0	57,639	8.2	71,796	5.0
Bolivia	1962	7,371	2.1	2,028	4.4	5,343	1.7
Brazil	1961	219,233	3.0	(b) 96,743	7.1	122,490	2.1
Chile	1962	(c) 28,434	3.5	12,686	4.8	15,748	2.9
Colombia	1962	(d) 44,226	3.0	19,375	3.7	24,851	2.6
Costa Rica	1962	6,016	4.7	3,780	8.6	2,236	2.7
Dominican Republic	1962	(d, e) 6,222	1.9	3,377	6.8	2,845	1.0
El Salvador	1962	(d, e) 5,787	2.2	2,924	6.0	2,863	1.3
Guatemala	1962	10,250	2.6	4,863	7.6	5,387	1.6
Honduras	1962	(e) 2,811	1.4	(f) 1,888	4.7	923	0.6
Jamaica	1962	6,825	4.2	(g) 4,645	12.0	2,180	1.7
Mexico	1958	47,505	1.4	21,499	2.7	26,006	1.0
Nicaragua	1959	2,738	1.9	948	4.5	1,790	1.5
Panama	1960	(h) 4,340	4.1	2,523	6.9	1,817	2.6
Peru	1961	(i) 23,481	2.3	11,018	4.8	12,463	1.5
Venezuela	1962	27,463	3.5	9,701	7.4	17,762	2.7

(a) Includes federal districts, capital cities or departments with capital cities plus other cities of at least 500,000 population or departments with a city of 500,000 population or more.

(b) State capitals and State of Guanabara.

(c) Government hospitals only.

(d) Source differs from that for preceding tables.

(e) Hospitals of Ministry of Health and Social Welfare only.

(f) Distrito Sanitario No. 1.

(g) Kingston and St. Andrew.

(h) Source: *Panamá en Cifras*, Dirección de Estadística y Censo, Panama, 1961.

(i) Beds in 215 hospitals.

Observation in eight Hemisphere countries confirms what has been said. There is evidence of change in Government and health authorities, who have begun, in some countries, to provide the remote regions or zones described above with resources, particularly with beds.

(iii) Size of hospitals

An attempt has been made to group hospitals by size, with respect to their number of beds. A knowledge of this dimension is related to the organization and administration of hospitals and to their cost of operation. Small facilities, with 50 to 100 beds, are known to have a high cost of operation because of the smaller return from their investment in facilities installations and personnel. Hospitals in excess of 400 to 500 beds (quite a number in America have more than 1,000) are difficult to manage and at the same time require a very large staff, often overlapping in function.

Very limited information is available with respect to size of hospitals. To Table 4, which is taken from the above-mentioned publication, have been added data on El Salvador for 1964.[22]

[22] *Ibid.*, p. 49.

Table 4. Number and Percentage of Hospitals by Size in Countries of the Americas, around 1962.

Country	*Year*	*Total*	*Under 50 beds*		*50-99 beds*		*100-199 beds*		*200-399 beds*		*400 beds and over*	
			No.	*Per cent*	*No.*	*Per cent*	*No.*	*Per cent*	*No.*	*Per cent*	*No.*	*Per cent*
Canada	1962	(a) 1,375	758	55.1	190	13,8	191	13.9	123	8.9	113	8.2
Chile	1960	(c) 217	97	44.7	38	17.5	33	15.2	25	11.5	24	11.1
Costa Rica	1961	(b) 45	24	53.3	4	8.9	10	22.2	4	8.9	3	6.7
Ecuador	1959	(d) 99	56	56.6	18	18.2	18	18.2	5	5.1	2	2.0
El Salvador	1964	51	27	53	8	15.8	5	9.8	—	9.2	5	9.0
Peru	1961	(e) 207	108	52.2	40	19.3	30	14.5	13	6.3	16	7.7
United States of America	1962	(f) 6,371	2,125	33.3	1,563	24.5	1,190	18.7	882	13.8	611	9.6

(a) *List of Canadian Hospitals and Related Institutions and Facilities,* Dominion Bureau of Statistics, 1962.
(b) WHO, International Study of Hospital Utilization.
(c) Excludes 35 hospitals.
(d) *Country Plan for Hospital and Health Center Coordination and Construction in Ecuador,* USOM/Ecuador, January 1960.
(e) Excludes 21 hospitals.
(f) Excludes 657 hospitals (101 mental hospitals, 11 tuberculosis hospitals, and 545 general and other specialized hospitals). *Hospitals,* American Hospital Association, August 1963.

Except in the United States of America and Chile, more than 50 per cent of the hospitals have fewer than 50 beds in the seven countries analyzed in Table 4. For hospitals with more than 50 beds and for the other groups, there is not enough material for useful comparisons or distinctions.

In quite a number of Central and South American countries, there has been a considerable increase during the past five years in facilities of this kind, aimed at providing medical care to rural communities and to the fringes of urban centers.

In Colombia in 1962 the total of 44,226 beds was distributed among the hospitals as follows:

Size of hospital	*No. of beds*	*Percentage*
Fewer than 50 beds	9,026	20.41
50 to 99 beds	8,696	19.66
100 to 199 beds	8,515	19.25
200 to 399 beds	5,872	13.28
400 beds and over	12,117	27.40

These figures were not included in Table 4 because the percentages refer to number of beds, not number of hospitals.

(iv) Ownership of hospitals

No complete information is available on hospital ownership in the American countries. This ignorance of the totality of resources available is being done away with in many of them by censuses and surveys that have been made in recent years for the preparation of sectorial or subsectorial health plans. It is particularly in the private subsector that this information either does not exist or is scarce and on occasion unreliable.

In Table 5,[23] which is taken from *Health Conditions in the Americas 1961–1962*, the figures for El Salvador and Uruguay have been added; in the latter, only Montevideo hospitals, which account for about 50 per cent of the beds in the country, have been considered.

In Latin America almost 45 per cent of the hospitals, with 67 per cent of the beds, are Government-owned; there are, however, marked differences in the proportion of beds in Government hospitals, ranging from 40 per cent in Brazil to 95 per cent in Costa Rica.

[23] *Ibid.*, p. 51.

Table 5. Number and Percentage of Hospitals and Hospital Beds with Government Ownership in 15 Countries of the Americas, around 1962.

Country	Year	Hospitals			Beds		
		Total	Governmental		Total	Governmental	
			Number	Per cent		Number	Per cent
Latin America		8,356	3,788	45.3	561,582	374,648	66.7
Argentina	1961	2,253	1,291	57.3	129,435	103,569	80.0
Bolivia	1962	107	62	57.9	7,371	4,547	61.7
Brazil	1961	2,654	416	15.7	(a) 210,872	83,826	39.8
Chile	1962	252	188	74.6	38,047	28,434	74.7
Colombia	1961	(b) 558	433	77.6	(b) 44,686	39,960	89.4
Costa Rica	1961	(c) 45	36	80.0	(c) 5,751	5,441	94.6
El Salvador	1964	51	35	67.1	6,503	5,889	90.4
Guatemala	1962	45	35	77.8	10,250	9,384	91.6
Mexico	1962	(d) 1,925	1,031	53.6	(d) 62,964	53,754	85.4
Panama	1962	27	16	59.3	(e) 4,168	3,488	83.7
Peru	1961	(f) 164	97	59.1	(f) 19,554	17,291	88.4
Uruguay (g)	1964	28	18	61.1	8,825	7,243	82.0
Venezuela	1963	326	183	56.1	28,484	24,954	87.6
Canada	1963	1,346	494	36.6	202,306	85,835	42.4
United States of America	1962	7,028	2,415	34.4	1,689,414	1,132,367	67.0

(a) Excludes beds in para-hospitals.
(b) Excludes two hospitals with no information.
(c) Source: *International Studies of Hospital Utilization*, WHO (A pilot study, 1961).
(d) Excludes 12 hospitals with no information.
(e) Source: *Plan Nacional de Salud Pública*, 1962-1970, Panama, 1963.
(f) Excludes 64 hospitals with no information.
(g) Montevideo only.

(v) Hospital installations and equipment —Status and distribution

Lack of information on the installations and equipment existing in hospitals and on their current status and their distribution hampers an orderly, quantified presentation of data. There are only isolated data on one or another zone, region, or hospital in a country, or on certain equipment and installations with respect to number but not to present status. The lack of accurate information is one of the handicaps in the preparation of health plans.

In all the countries of Central and South America, installations and equipment are known to be very poorly distributed, as are hospital beds, which are concentrated in

the large centers and are poor, scarce, or nonexistent in the small centers. In Colombia, in a study of resources conducted in 1962, it was found that, out of 560 hospitals surveyed, 274, or 48.9 per cent, had radiology equipment; 201, or 35.9 per cent, had clinical laboratories; and 125, or 22.3 per cent, had blood banks. Such data appear again and again in Hemisphere countries, but they are subject to gaps that should be filled.

With respect to uneven distribution of equipment and to the duplication accompanying this unevenness, in one of the countries visited it was noted that in a small city in the interior there were six hospitals belonging to different institutions; each had one or two X-ray machines, which were professionally attended by a radiologist who divided his time among the hospitals. Statistical analysis of the return on the 10 machines showed that on the average it did not exceed 2.3 examinations per day for each one. With coordination of services, the machines could be grouped, their number could be reduced, and the specialist could concentrate his schedule on one or two facilities, with resulting advantages for the community and for economy of service. Moreover, some of the machines could be sent to other hospitals that do not have any.

(vi) Organization and administration of hospitals

The organization and administration of hospitals in America follow various patterns, depending on the country and on the services available.

In general, the organization and administration of hospitals are based on laws and regulations, ancient or modernized, that depend for execution on the ministerial, regional, or local authorities and their staffs.

Centralization of standards and directives and decentralization of activities, with staff and budgetary authority delegated, exist mainly in theory in many Hemisphere countries.

In a number of countries the hospitals are directed by physicians specializing in public health and hospital administration; in others, by hospital administration specialists exclusively; and in still others, by physicians, generally service chiefs, distinguished for their clinical and/or teaching experience.

In Chile, where there is an integrated health service with preventive coverage of 100 per cent of the population and curative coverage of 70 per cent, the directors of the service's regional and local hospitals act also as health administrators for their respective areas. In other countries hospital directors do not perform public health functions. Some hospitals are run by a technical (clinical) medical director and an administrative medical director, a specialist in hospital administration and/or public health.

The division of hospital activities into technical and administrative is standard in Hemisphere countries. On the one hand is a team of physician service chiefs and other professional and technical heads and, on the other, a team of administrative officials; the hospital directors coordinate the activities. In some countries part of the administrative functions (procurement, supply, storage, maintenance, cleaning, transportation) have been placed in the hands of hospital superintendents or administrators, who are generally professionals trained in one- or two-year university courses.

In the technical organization of hospitals, the classic division into four basic services—medicine, surgery, obstetrics, and pediatrics—has been maintained; depending on their size and resources, they also have specialized services and diagnostic and therapeutic consultation. Of late years, in some countries general hospitals have adopted the concept of departmentalization, with diseases grouped as medical and surgical and with the obstetrical and pediatric services retained.

Because of scarcity of resources and lack of equitable distribution of those there are,

numerous areas or population sectors do not have the essential services of medical care and diagnostic and therapeutic consultation. For this reason, hospitals are being regionalized, in organized or in instinctive fashion, in the American countries. The lack is especially serious in the matter of diagnostic and therapeutic collaboration; because of their high cost, some of these services can exist only in the large population centers.

It is notable that in all the countries visited, hospitals of 400 beds and over do not use their services or departments to the best advantage with respect to hours of operation during the working day, which leads to useless and uneconomic duplication. This happens, for example, with outpatient clinics in several countries, which are open only in the mornings, for three hours, and are sometimes closed on Saturdays. The same thing happens with operating rooms, which are used for a few hours in the morning and reserved for emergencies the rest of the day.

Multiplication of facilities is frequent. Several laboratories in the same hospital, each with its own equipment and staff; several radiology services or departments, with independent resources and chiefs—these are often observed. Efforts at centralization, sometimes successful, have proved the worth of the procedure.

Fundamental to health planning are the two departments of clinical histories and records and of finance and budget. Clinical histories, which are essential for correct diagnosis and effective treatment, for knowledge of hazards (mortality-morbidity by discharge and by admission), for research, and for teaching, have been shown to suffer from gaps and errors that will have to be corrected. When 2,000 records or clinical histories kept by one hospital were reviewed for the purpose of preparing a program-budget, about 50 per cent of the diagnoses were tabulated under the heading "Other Diseases," according to the *International Classification of Diseases, Injuries, and Causes of Death.*

Though causes of death and discharges are fairly accurately tabulated in many countries, the records on presenting morbidity in outpatient services are very incomplete or nonexistent. However, this latter aspect is receiving consideration in connection with sectorial or subsectorial health plans. In some of the countries visited, the clinical history archives are not centralized but kept separately in the outpatient clinics and hospitals; in others, as is proper for good administration, they are centralized.

Cost accounting in a hospital is also very helpful for awareness of its financial condition, for good utilization of resources, and for the formulation of a health plan. In many hospitals cost accounting does not exist or is rudimentary. In others, the cost of the daily diet, for example, is established solely on the basis of ingredients, with general and personnel expenses omitted.

Outpatient clinics, in the same building or elsewhere, are the basic unit for the provision of integrated medical services. Since well-organized ambulatory medical care makes possible the rational use of hospital beds by preventing unnecessary and prolonged hospitalization, it has been taking on more and more importance. The care provided in outpatient clinics should be humane, rationalized, and economical: humane through an understanding of the individual's physical, phychic, and social needs and respect for his personal dignity and integrity; rationalized in offering scientific orientation and planned development; economical by means of better administration of human and material resources, with no reduction in the quantity and quality of care. Furthermore, outpatient clinics should be responsible for carrying out preventive activities in their districts or sectors, as is done in certain countries.

For lack of information, it is impossible to group clinics with regard to size, as was originally intended. Similarly, it has been impossible to quantify them as urban and rural. In some countries the social security

agencies have large clinics in the densely populated centers, where general and/or special medical care is given (sometimes with 2,000 to 3,000 visits daily). In the past five years a system of clinics has been built, particularly in rural areas, in several Latin American countries. This is an important effort, which has made possible a partial solution to the distressing problem of medical care for rural communities. Some of these clinics have from four to six or up to 20 beds. One serious obstacle to the normal functioning of the clinics is lack of resources—in particular, manpower, which will be dealt with in a separate chapter. They are generally poorly equipped, and to alleviate the deficiencies various procedures are employed that will be examined in the chapter on health expenditures.

To obtain a better return, emphasis has been placed on sectorized care of an area's or a district's population in the respective outpatient clinic. This procedure is useful when the clinics have adequate resources and the clinicians can be educated along these lines.

There has been a great deal of discussion about the advisability of promoting and stimulating domiciliary medical care. Contradictory opinions on its value are expressed in the American countries. Some argue that it should be limited to what is strictly necessary, since experience shows that the quality of care thus provided is unsatisfactory and that it considerably reduces the output per medical hour. It is this latter point that gives the argument its greatest force, in view of the shortage of doctors in almost all the countries of the Hemisphere. The social security agencies and private institutions have been the largest users of home medical care, demonstrating its high cost.

(vii) Output performances

Hospital output is measured by means of universally accepted indicators of performances. Together with demographic information and other local characteristics, this knowledge has made it possible to determine whether or not additional hospitals, clinics, and other health facilities should be built. It has also been used to classify hospitals as excellent, very good, ordinary, or poor. Finally, it is of the utmost importance in the preparation of health plans, in the setting of priorities, and so on, and in the drafting of hospital programs; specifically, then, it makes possible an evaluation both

Table 6. Admissions and Patient-Days, With Rates per 1,000 Population, Average Stay, and Index of Occupancy for General Hospitals in 15 Countries.

Country	*Year*	*Admissions*		*Patient-days*		*Average stay (days)*	*Index of occupancy*
		No.	*Rate*	*No.*	*Rate*		
Canada	1961	2,728,305	149.3	28,803,015	1,576.6	10.6	79.3
Chile	1961	604,636	79.3			12.0	85.1
Colombia	1962	803,485	54.4	8,792,319	595.3	10.9	64.1
Costa Rica	1962	136,220	106.9	1,260,393	981.3	9.3	
El Salvador	1962	116,068		1,575,109		13.5	
Guatemala	1962	130,570	32.5	2,256,716	561.8	17.3	
Jamaica	1961	83,697	51.2				
Mexico	1962	1,532,372	41.2				83.3
Panama	1961	53,615		1,306,195	1,225.3	(a)	(b)
Paraguay	1961	23,000	12.0				64.8
Peru	1962	313,207		5,976,842		19.0	76.0
Trinidad and Tobago	1962	65,132	75.1				
United States of America	1961	24,093,720	134.9	221,448,055	1,209.7	8.6	76.0
Uruguay	1963	143,472 (c)		4,456,823		31.1	80.0
Venezuela	1964	201,270		1,831,404		9.0	85.0

(a) In Panama the average stay was not indicated, but the data show it was 5.2 (?) for hospitals.
(b) In Panama the index of occupancy varied by hospital; in official or government hospitals it was 69.4, in social security hospitals 50.2, and in private hospitals 33.
(c) In Uruguay the calculation was based on 13,989 beds in general hospitals.

of the need and of the demand for services.

Table 6 [24] shows admission, patient-days and rates per 1,000 population, average stay, and indexes of occupancy for general hospitals in 15 countries.

Admission rates ranged from 12 (Paraguay) to 149.3 (Canada) per 1,000 population. Similarly, the number of patient-days varied from country to country. The average length of stay, judging by proportional figures, ranged from 8.6 to 31.1 days. Bed use, shown in the index of occupancy, was 64.1 and 64.8 in Colombia and Paraguay and 69.4 in Panama, rising above 75 per cent in the other seven countries for which information was available.

In mental and tuberculosis hospitals the admission rates were much lower than in general hospitals; in the United States of America, the rate for mental illness amounted in 1961 to 2.6 per 1,000 population. Patient-days in tuberculosis hospitals have been declining in most countries.

Outpatient consultations are given in Table 7.[25] They are divided into two groups: visits to hospital clinics and visits to health centers.

It is interesting to note that the demand for outpatient care has been increasing year by year. Several countries show more than one visit for each inhabitant—Chile, Costa Rica, Cuba, and Panama. In some countries there has been increasing attention in recent years to setting up peripheral outpatient clinics and health centers, which has caused this considerable rise in outpatient consultations.

Since one of the main demographic characteristics of the Hemisphere is the "population explosion," intensified maternal and child care has been considered opportune. According to the information available, in three Central and South American countries 60 per cent of the births were attended by physicians and midwives. In child care, if the number of infants under one year receiving services in clinics is compared with the figure for preschool children, the former are seen to enjoy more care, while the latter appear neglected; this would explain why childhood mortality is moving toward the group between one and five years of age.

[24] *Ibid.*, p. 53, with the addition of data on Chile, Uruguay, and Venezuela.
[25] *Ibid.*, p. 56.

Table 7. Total Consultations in Outpatient Clinics of Hospitals and in Health Centers with Numbers per 1,000 Population in 14 Countries, 1962.

Country	*Year*	*Total visits*		*Outpatient consultations in hospitals*	*Health center visits*	
		Number	*Rate*		*Number*	*%*
Argentina	1961	3,503,272	166	(a) 2,092,636	1,410,636	40.3
Canada	1962	. . .	. . .	6,001,919	. . .	. . .
Chile	1962	8,631,551	1,075	. . .	. . .	. . .
Costa Rica	1962	1,439,203	1,130	800,892	638,311	44.4
Cuba	1962	8,264,643	1,169	3,207,064	5,057,579	61.2
El Salvador	1962	882,459	336	676,935	205,524	23.3
Guatemala	1962	405,058	101	150,058	(b) 255,000	63.0
Honduras	1962	406,765	209	185,432	221,333	54.4
Jamaica	1961	1,083,361	663	546,701	(c) 536,660	49.5
Mexico	1962	22,005,451	591	8,395,472	13,609,979	61.8
Panama	1961	1,200,345	1,077	481,145	719,200	59.9
Paraguay	1962	. . .	. . .	. . .	(c) 579,535	. . .
Trinidad and Tobago	1962	674,318	754	310,446	(c) 363,872	54.0
Venezuela	1962	(d) 3,772,703	479	. . .	. . .	. . .

(a) Ministry of Social Welfare and Public Health exclusively.
(b) Excluding dispensaries.
(c) Incomplete.
(d) *Memoria y Cuenta.* Ministry of Health and Social Welfare, 1962: Outpatient Consultations in hospitals and health centers of the Ministry and consultations of curative medicine in "medicaturas rurales."

The crude mortality rates in the three regions of the Americas—that is, the number of deaths per 1,000 population of all ages—are similar. In 1962 it was 9.3 per 1,000 in North America, 10.3 in Middle America, and 9.6 in South America. There are, however, wide differences between countries within each region, which do not appear in the death registries and the age distribution of the populations.

In Central America the rates ranged from 6.8 per 1,000 in Nicaragua to 17.2 in Guatemala. In the other areas the range was from 2.8 to 13.0.

Analysis of the trend in the crude mortality rates over 10 years shows that it is remaining more or less the same in North America and has declined by 25 per cent in Central America and by 15 per cent in South America.

During the past decade there has been a distinct change in the specific mortality rates, in that certain noninfectious diseases have replaced certain communicable diseases as leading causes. Despite the decline in infectious diseases as a cause of death, they are still responsible for a mortality that could in large measure be avoided. In seven countries heart diseases are now the leading cause of death; in two, malignant tumors are in first place.

b. *Manpower*

In the preceding chapter, the material resources assigned to medical care were described in accordance with the information available. Emphasis was placed on their insufficiency in many of the countries, with particular attention to their poor distribution and in some instances the poor use made of them. There was stress on the importance of a knowledge of them in the preparation of national health plans as part of the national planning of economic and social development. Following the same general guidelines, an examination will now be made of the manpower resources available in Hemisphere countries, their indexes of distribution, present shortages, and training needs.

In the "General Considerations" [26] a point was made, with respect to the current conditions in the health sector in America, of the effort the countries are making to solve the worrisome problem of the shortage of manpower and also of its unequal distribution and unsuitable use.

An examination of the existing information on health care personnel in American communities shows that in many areas no valid studies have been made of the manpower available. Such studies are being conducted in some countries, covering various aspects of this field; in Colombia, for example, an investigation is being made to provide better information on manpower needs in relation to certain indexes.

In many places there are not enough professionals to expand programs in accordance with the established goals; a large number of technical or auxiliary personnel are therefore used or needed to handle some essential services. This makes it much more difficult to determine the real needs in each personnel group. Furthermore, though doctors can carry out certain health care functions, there are some others that could be effectively performed by other professionals or by auxiliaries; but in general these are in even shorter supply than physicians.

(i) Physicians

A study of medical personnel usually involves some effort to relate the supply of physicians to the need for their services. Among the methods used are the following:

——The physician-population or physician-patient ratio.
——The relationship of mortality and morbidity to medical services.
——The average number of patients seen per doctor per unit of time (producer approach).

[26] See pp. 74-77.

——The number of patient-doctor contacts per unit of time (consumer approach).
——Economic growth factors.
——The prevalence of preventable diseases.
——The number of vacancies in professional posts (as indicating needs for physicians in specific institutions, shortages of physicians in specific specialties, and so on).
——Studies of function or utilization.

Each of these methods may provide only limited information. With respect to the physician-population ratio, a report on manpower for health activities and medical education programs in Latin America says:

The supply of doctors is usually stated in terms of the ratio of physicians to population. The use of this ratio as an indication of the relative adequacy of the supply of doctors in particular localities has limited validity. The size of the population is not an accurate measure of the need for doctors in any particular locality. Patients frequently seek medical care in nearby communities. As the size of the area in question increases, this criticism loses force, since few individuals travel great distance for physicians' services. Nevertheless, the metropolitan areas, as well as certain other localities where comprehensive hospital facilities and large numbers of specialists are found, attract many patients from other areas. The amount and kinds of medical care which a community needs and seeks also vary, depending on such factors as the income, education, age, birth rate, cultural background, housing, environmental sanitation, and occupation of the residents, and even the climate.

The number of doctors in a locality does not measure the amount of medical care provided any better than the size of the population measures the care needed. Differences which may exist among states or regions in the quality of physicians cannot be measured. . . . The amount of care provided by each doctor also depends on prevailing patterns of doctor utilization, which is influenced in turn by the age of the doctors, the length of their usual work week, the character of nearby hospital facilities, and the supply of auxiliary medical workers such as nurses and technicians.[27]

[27] *Health Manpower and Medical Education.* Report of a Round-Table Conference held in New York in 1963. Milbank Memorial Fund, 1964, p. 29.

In short, no single indicator can be used to determine whether a given community or country has enough physicians or whether it should increase the number for the execution of programs in the health sector.

Table 8 [28] shows the number of physicians, schools of medicine, and medical graduates, together with ratios of physicians per 10,000 population, in the Americas during recent years.

Using the known figures of physicians in Latin America in 1962, an estimate has been made of the number that will be needed by 1980 if the same physician-population ratio is maintained. For a population of 244 million, there are today an estimated 134,000 physicians. To keep up the same services in 1980 for a population of 374 million (5.5 per 10,000 population), 206,000 physicians will be needed—that is, there will have to be an increase of 72,000 during this period. Are the medical schools equipped to provide that many physicians? The present 104 medical schools are graduating 6,500 physicians a year. In the next 15 years, according to this estimate, they will graduate some 100,000. Some of the physicians now active and some of the graduates will not be practicing, because of death, retirement, or other reasons. Supposing that this loss is 1 per cent a year, or practically 15 per cent in the period under consideration, 25,000 physicians will be needed to replace them. Hence, if the Latin American medical schools continue the training of professionals at their present rate, they can maintain the current status of health services.

The foregoing considerations might create the impression of a satisfactory picture; the reality in each country, however, shows that this is not valid. The physician-population ratio ranges from 14.9 per 10,000 in Argentina to 0.9 in Haiti and is under 3 in six countries.

[28] *PAHO Scientific Publication* **104**, 61.

Table 8. Number of Physicians, Schools of Medicine, and Medical Graduates with Ratios of Physicians per 10,000 Population in the Americas, Recent Years.

Area	Year	Physicians		Medical Schools	
		Number	Ratio	Number	Graduates (annual) (a)
North America		281,441	13.8	98	7,940
Middle America		34,207	4.9	33	. . .
South America		88,936	6.9	70	. . .
Argentina	1962	31,831	14.9	9	1,770
Bolivia	1963	1,032	2.9	3	55
Brazil	1960	26,392	3.7	31	1,342
Canada	1962	21,000	11.3	12	817
Chile	1961	4,729	6.0	4	220
Colombia	1962	7,453	5.0	7	442
Costa Rica	1962	575	4.5	1	. . .
Cuba	1962	5,841	8.3	2	355
Dominican Republic	1960	(b) 442	1.5	1	85
Ecuador	1962	1,620	3.5	3	. . .
El Salvador	1961	526	2.1	1	29
Guatemala	1962	954	2.4	1	35
Haiti	1961	400	0.9	1	41
Honduras	1957	365	2.2	1	34
Jamaica	1961	655	4.0	1	25
Mexico	1961	20,590	5.7	21	1,011
Nicaragua	1960	524	3.5	1	22
Panama	1962	502	4.4	1	14
Paraguay	1962	1,082	5.8	1	97
Peru	1962	6,010	5.7	4	378
Trinidad and Tobago	1962	350	3.9	—	—
United States of America	1962	260,400	14.0	86	7,123
Uruguay	1962	2,700	9.3	1	91
Venezuela	1962	5,766	7.3	6	258
Antigua	1962	17	2.9	—	—
Bahama Islands	1962	65	5.9	—	—
Barbados	1962	82	3.5	—	—
Bermuda	1960	37	8.4	—	—
British Guiana	1960	145	2.6	—	—
British Honduras	1962	20	2.1	—	—
Cayman Islands	1962	3	3.8	—	—
Dominica	1960	8	1.3	—	—
Falkland Islands	1962	4	20.0	—	—
French Guiana	1962	23	6.8	—	—
Grenada	1962	20	2.2	—	—
Guadeloupe	1962	122	4.2	—	—
Martinique	1962	122	4.1	—	—
Montserrat	1962	3	2.3	—	—
Netherlands Antilles	1960	137	7.2	—	—
Panama Canal Zone	1962	103	22.9	—	—
Puerto Rico	1962	1,721	7.0	1	45
St. Kitts-Nevis-Anguilla	1962	12	2.0	—	—
St. Lucia	1962	10	1.1	—	—
St. Pierre and Miquelon	1962	4	8.0	—	—
St. Vincent	1960	10	1.2	—	—
Surinam	1960	149	5.5	1	6
Turks and Caicos Islands	1962	2	3.3	—	—
Virgin Islands (UK)	1962	2	2.5	—	—
Virgin Islands (US)	1960	24	7.3	—	—

(a) Data usually for 1960 from WHO *World Directory of Medical Schools*, Third Edition, 1964. Other sources include the following: *Supplement to the Second Report on the World Health Situation* (Cuba, Guatemala, Peru); *Anuario Estatístico do Brasil*, 1963, Brazil; *Servicio Nacional de Salud, Desarrollo Socioeconómico y Planificación*, 1963, Chile; *Medical Education in the United States*, 1961-1962, *JAMA*, Vol. 182, (Canada, United States, and Puerto Rico); *Demografía;* 1961, Dirección de Estadística y Censo, Panama.

(b) Ministry of Health only.

In a study conducted in Colombia [29] in February 1965 on needs for physicians, it was found that the country's medical schools are not capable of training the physicians needed. The enrollments in 1962 totaled 470; supposing that 400 physicians graduate annually, the number of physicians in Colombia would rise by 1970 to 10,000, including those eliminated by retirement, death, change of activity, and so on, estimated for the same period at 500.

Assuming that one physician is needed for each 1,000 population, there would at present be a shortage that is being accentuated by natural population growth. The authors of the study conclude that by the date in question the country will be about 10,000 physicians short.

An examination of the national health plan prepared by the Department of Health Planning and Evaluation of El Salvador for the next five years (1965–1969) shows that under minimum personnel needs it calls for an annual increase of 39 physicians, for a total of 195 in the period under consideration, whereas the average number of graduates of the country's medical school between 1930 and 1962 was 15.4 a year.

While El Salvador has 2.1 physicians per 10,000 population, a study made in Mexico [30] in 1960 concluded that the ratio there was 6.25 and that in 1970 there would be about 25,100 physicians. Supposing one physician to be necessary for each 1,200 population, there would be a shortage in that year of 7,713 physicians, including areas that have a surplus and those that have a deficit, owing to poor distribution in the various regions of the country.

Table 9 [31] shows the number of physicians and ratios per 10,000 population in the capitals, large cities, and remainder of some Hemisphere countries.

The uneven distribution of physicians in the various zones or areas of a country creates grave problems in fulfilling the goals indicated in the programs. In Chile the ratio of 6 per 10,000 seriously hampers the effective development of health care, and it will tend to fall even further as the population rises. The shortage of physicians is

[29] Ministry of Public Health of Colombia, Medical Care Division. *Factores a considerar para la elevación del nivel de atención médica en el país.* February 1965.

[30] *Estudio estadístico en relación con la necesidad y distribución de los médicos en la República Mexicana.* Ministries of Industry and Commerce and of Health and Welfare. Mexico, 1960.

[31] *PAHO Scientific Publication* **104**, p. 62.

Table 9. Number of Physicians and Ratios per 10,000 Population in Capitals and Large Cities and in Remainder of These Countries, in 13 Countries.

Country	*Year*	*Capital and large cities (a)*		*Remainder of country*	
		Physicians	*Ratio*	*Physicians*	*Ratio*
Total		56,653	15.1	48,159	3.4
Argentina	1962	20,353	28.8	11,478	8.0
Bolivia	1963	456	9.7	576	1.8
Brazil	1960	11,684	12.8	14,708	2.4
Chile	1960	2,929	11.4	1,692	3.3
Colombia	1962	3,784	7.4	3,669	3.8
Costa Rica	1962	408	9.3	167	2.0
El Salvador	1960	329	7.3	176	0.9
Guatemala	1958	571	10.1	159	0.5
Mexico	1960	10,047	11.9	11,094	4.2
Nicaragua	1960	246	9.0	278	2.3
Panama	1960	245	9.1	156	2.0
Peru	1957	2,843	19.2	998	1.3
Venezuela	1962	2,758	21.0	3,008	4.6

(a) Includes federal districts, capital cities or departments with capital city, and other cities of at least 500,000 population or departments with the city of 500,000 population or more.

made even more glaring by their poor distribution; 60 per cent of them are in the Province of Santiago, 10 per cent in the Province of Valparaíso, and 6 per cent in the Province of Concepción. In other words, three quarters of the physicians in Chile are concentrated in the three large cities, while only a quarter are left to serve the rest of the country—that is, 3,500 physicians for 3,400,000 people and 1,500 for 4,600,000. Examples like this are found in every single country in the Americas, with the natural consequences.

A serious problem has been created in many countries by the lack of specialists in public health and hospital administration. This is one of the factors that hinder integration of health activities (preventive and curative) and greatly impair the chances for speedy administrative coordination of the various health facilities. The opening of schools of public health in some countries, the development of courses in hospital administration in all these schools, and the training of physicians in administration through three-month courses in other countries are introducing new prospects in this field.

What measures have been adopted to alter the situation created by the shortage of physicians in the Hemisphere?

——In several countries the number of medical schools has increased in the past five years. This solution, however, will not begin to bear fruit for another 10 to 15 years, provided that at the same time the existing medical schools enlarge their enrollments.

——Emphasis has been placed on altering medical school curricula, shortening the course—which at present ranges from seven to eight years—and orienting instruction toward the training of a practitioner suited to the medical-social conditions of the country.

——Another proposal is to improve the geographic distribution of physicians. Chile has adopted the rule that no physician with less than five years' experience may join Health Service hospitals or other facilities in Santiago, Valparaíso, and Concepción, the three largest cities. This measure, together with the appointment of area general practitioners, has made doctors available to rural districts.

——Other measures conducive to proper utilization of medical manpower are greater financial incentives (including housing for physicians in interior communities), periodic fellowships for professional advancement in the large centers, and improved working conditions through larger resources for the facilities.

(ii) Other nonmedical professionals

To be considered in this group are dentists, of whom there are one seventh as many in Central America as in North America. In South America there are half as many. It has been estimated that in 1965 Latin America has 51,000 dentists, and that to maintain this minimum proportion to population by 1980 will require 28,000 more, for a total of 79,000. About 3,000 dentists a year are graduated in Latin America, and maintaining this pace would make it possible to increase the number by 45,000 in 15 years. Assuming that about 14,000 must be replaced during this period, for the same reasons as for physicians, this might be imagined to be enough for the needs arising out of population growth, provided present health conditions continued. But, just as with physicians, dentists are poorly distributed geographically in Central and South America, with conditions varying from country to country. The annual percentage of dental school graduates is only 20 in Central America and 40 in South America, which warrants the assumption that these schools could increase their annual enrollments.

Several other categories of health personnel are needed for community medical

care; these include pharmacists, veterinarians, sanitary engineers, and architects. Among the last three, the number working in the health field is limited, but has increased —especially veterinarians and engineers— as programs have grown.

(iii) Nurses and nursing auxiliaries

The Americas are conspicuously short of nurses, a fact that has important repercussions on community health care. Nurses are commonly confused with nursing auxiliaries, because in some countries a diploma or certificate as a nurse is awarded after one term in secondary school and a nursing course of no more than a year.

For purposes of this report, a nurse is considered to be a university graduate with three to four years of professional study. In a number of countries the term *graduate nurse* is used to prevent confusion. In Latin America nurses and nursing auxiliaries serve in hospitals and health centers, working chiefly in official Government institutions. The qualifications and education of each of these groups vary from country to country, which makes it difficult to gather comparable data on resources. Often information on the number of persons working in this field does not exist or is incomplete.

In Central and South America the number of graduate nurses per 10,000 population (3.5 and 1.5, respectively) is less than a tenth of that in North America.

Table 10,[32] which shows the number of nurses and nursing auxiliaries and ratios per 10,000 population in the Americas, indicates that in four countries the proportion is higher than 10 (United States of America, 29.6; Canada, 33.8; Jamaica, 21.0; and Trinidad and Tobago, 14.9). According to the data available, there were seven countries with less than one graduate nurse per 10,000 population, with the ratio dropping as low as 0.4.

A significant happening is the exodus of these professionals from their countries of origin in search of better financial prospects and professional advancement. Of the 488 nurses registered in El Salvador, 91, or 18.7 per cent, are working outside the country. In Chile, more than 25 per cent of the nurses were at one point working abroad. Furthermore, nurses are not being used for their own specific tasks; in many countries quite a number have been given teaching, administrative, and supervisory functions.

There are almost three times as many nursing auxiliaries as professional nurses in Latin America, whereas in North America there are only a few more. The reason for this is the need to provide some kind of nursing care in Latin America. Nevertheless, the rate per 10,000 population for this group is six times as high in North America (34.2) as in the other parts of America (4.3 and 6.9).

Despite the effort in Latin America toward a partial solution to the graduate nurse shortage through the use of auxiliary nursing personnel, there is obviously still a great need to increase the numbers trained in both groups. The shortage of physicians, particularly in rural areas, places more responsibility on nurses and auxiliaries. Moreover, the smaller proportion of graduate nurses to population increases the burden on them, as has been said, in the sector of teaching and supervision and accentuates the need for strengthening both basic secondary and professional education.

(iv) Other health personnel

In the countries at the southern end of America, university-trained midwives are used; they are variously called *parteras* in Argentina and Uruguay, *matronas* in Chile, and *obstetrices* in Peru. Since maternal care is one of the major health problems in South and Central America, because of rapid population growth, their services during pregnancy and birth are extremely useful in interior areas that have no doctors.

[32] *Ibid.*, p. 64.

Table 10. Number of Nurses and Nursing Auxiliaries with Ratios per 10,000 Population in the Americas.

Country	Year	Number		Number per 10,000	
		Nurses	Nursing auxiliaries	Nurses	Nursing auxiliaries
Northern America		611,765	697,583	30.0	34.2
Middle America		24,631	29,205	3.5	4.3
South America		20,260	94,939	1.5	6.9
Argentina	1961	6,176	18,000	2.9	8.5
Bolivia	1963	367	(a) 3,508	1.0	(a) 9.8
Brazil	1956	3,296	38,429	0.5	6.2
Canada	1961	61,699	62,553	33.8	34.2
Chile	1963	1,375	10,760	1.7	13.1
Colombia	1962	900	3,084	0.6	2.1
Costa Rica	1962	411	1,233	3.2	9.7
Cuba	1962	5,701	2,003	8.1	2.8
Dominican Republic	1962	207	1,171	0.6	3.6
Ecuador	1962	274	1,714	0.6	3.7
El Salvador	1962	500	1,333	1.9	5.1
Guatemala	1962	466	(b) 1,672	1.2	(b) 4.2
Haiti	1962	357	561	0.8	1.3
Honduras	1963	161	982	0.8	4.9
Jamaica	1961	3,424	. . .	21.0	. . .
Mexico	1962	6,000	12,304	1.6	3.3
Nicaragua	1962	263	868	1.7	5.5
Panama	1962	723	1,144	6.3	10.0
Paraguay	1963	76	1,200	0.4	6.3
Peru	1963	3,441	4,806	3.2	4.4
Trinidad and Tobago	1960	1,254	. . .	14.9	. . .
United States of America	1962	550,000	635,000	29.6	34.2
Uruguay	1962	340	2,921	1.2	10.0
Venezuela	1962	2,868	10,512	3.6	13.4
Antigua	1962	106	. . .	18.3	. . .
Bahama Islands	1962	248	102	22.3	9.2
Barbados	1962	248	355	10.7	15.3
Bermuda	1959	63	15	15.0	3.6
British Guiana	1960	(c) 325	. . .	5.7	. . .
British Honduras	1962	165	. . .	17.2	—
Dominica	1960	55	—	9.0	—
Falkland Islands	1962	4	5	20.0	25.0
French Guiana	1962	118	. . .	34.7	. . .
Grenada	1962	114	24	12.5	2.6
Guadeloupe	1962	215	. . .	7.4	. . .
Martinique	1962	245	218	8.2	7.3
Montserrat	1962	26	—	20.0	—
Panama Canal Zone	1962	208	343	46.2	76.2
Puerto Rico	1962	3,212	4,787	13.1	19.5
St. Kitts-Nevis-Anguilla	1962	132	56	22.0	9.3
St. Lucia	1962	84	5	9.1	0.5
St. Pierre and Miquelon	1962	3	15	6.0	30.0
St. Vincent	1957	74	32	9.7	4.2
Surinam	1960	700	. . .	25.9	. . .
Turks and Caicos Islands	1962	7	3	11.7	5.0
Virgin Islands (UK)	1962	6	9	7.5	11.2
Virgin Islands (US)	1960	19	. . .	5.9	. . .

(a) 1962.
(b) 1960.
(c) Government only.

In other countries, nurses may also specialize in obstetrics and are qualified to practice without losing their status as nurses. In one of the countries visited, basic minimum courses were given to "empirical" midwives, who received official recognition from the ministry of health; according to information furnished by the country's health authorities, the results were highly satisfactory, deaths of mothers and newborn infants having declined appreciably.

Among the nonmedical professionals rounding out the health staff are the social workers. This group has not been of marked importance in many Hemisphere countries. Their activities, now largely confined to individual casework, may perhaps find wider and more significant scope in community and group organization and in the provision of guidance to local sectional and neighborhood leaders.

In several American countries, including some of those visited, there are very few dietitians; consequently, as could be seen in a number of hospitals, personnel and patient feeding pose serious and important problems.

One professional group that is becoming more and more important is the laboratory technicians, who are working in many medical-clinical disciplines with excellent results. Obviously, with the shortage of physicians in such specialties as pathology, laboratory, blood banks, and optometry, their assistance is highly useful.

While knowledge of how large the various professional and auxiliary groups are, and how they are distributed geographically, is useful as an indicator in drawing up a sectorial health plan related to plans in the other economic and social development sectors, it does not provide adequate information on their utilization and output. Hence, for each country and each health facility it is better to know how many hours each professional, technician, or auxiliary works. This information exists only in a few countries that have prepared their health plans and programs in accordance with the new method that employs this type of measurement. Such a manpower inventory is not generally used or known.

Another important element is the distribution of personnel in a health facility, hospital clinic, health center, and so on. An attempt has been made to distribute staff on the basis of indexes for each group—for example, one nurse for every 8-12 beds, one auxiliary pharmacist for so many prescriptions, and so on.

Before concluding this review of so important an aspect of health as the manpower available to it, events in two fields may well be mentioned. The first is the education and training of personnel; the second, the help provided by community volunteers, sometimes organized, sometimes not.

Mention was made above of some of the solutions that are being adopted by the countries to deal with the shortage of physicians, clinical specialists in certain fields, public health administrators, and hospital administrators. It was noted that in some countries the number of medical schools had doubled and schools of public health had been established. In others, emphasis has been placed on training the kind of doctor who can handle the problems of rural areas, senior medical students being required (with suitable compensation) to work in these areas, and so on. Advanced courses and fellowships for study within the country and abroad complete the picture with respect to physicians.

The training of nurses and nursing auxiliaries has also been intensified. Generally speaking, there is a trend in all the countries toward standardizing curricula and entrance requirements in nursing schools and nursing auxiliary courses. Two of the countries visited, however, required less basic education in both cases than the others.

Other professions and technical groups have been expanding as the capabilities, especially the financial capabilities, permit.

Social workers have found local leaders to be of the utmost help as assistants in con-

ducting programs. With proper guidance they can overcome difficulties and achieve desired goals. Working individually or with groups organized in the rural sectors (health centers, rural medicatures, health units, and so on) or in various hospital activities, they have proved their usefulness. In some countries with a serious lack of personnel, this help has permitted good temporary solutions.

In indicating the efforts that are being made in every Hemisphere country to increase the quantity and improve the quality of the manpower available for the development of health plans and programs, the need for guidance by the Pan American Sanitary Bureau emerges. This is given by providing, on request, the help of a coordinated group that can join with the interested health authorities in planning the organization of available resources and considering the programming of needs.

c. *Economic resources—Health expenditures*

This document would be incomplete if it did not present some background on the economic resources available in the health sector.

Reviewing health expenditures is not easy, since there are no figures on what they amount to. This is especially true in the private subsector, on which the available data are very scanty and of limited value. In the public subsector also the information on certain institutions is not altogether reliable for fear of its being used against the very institution that supplies it.

Various studies have been conducted in the Americas and elsewhere on the sources of financing and the cost of health services; these, together with the information gathered in the countries visited, serve as a basis for the following remarks.

The cost of the health services furnished to a community depends on the equipment, buildings, manpower, and financial resources that are absorbed by these services and that might instead be used for meeting other, perhaps less urgent, needs. Consequently, the monetary cost of health services is measured by pricing the resources, equipment, and labor used to provide them. This cost forms part of the rational distribution of the national income and is therefore limited by the capacity of a country's economy to finance services of all kinds. Among these, health services have a high priority, but they must inevitably be limited to what they can get without depriving other sectors or encroaching on resources for capitalization, industrial and economic development, or consumer goods. In other words, health problems must be looked upon from a financial standpoint, and the amount of activity adapted to the national ability to finance it.

Much discussion has taken place on the question of who should pay for health services—the State, social security, or the beneficiary. Arguments for and against each of these methods of financing have been used to justify a specific system. It must be borne in mind that the services are really paid for by the national income—that is, the country's economic ability to finance them. Obviously, then, the greater this economic ability, expressed in wealth, the better the health services; the higher the degree of the community's economic and social development, the higher its level of health.

Medical expenditures are of appreciable significance in most of the countries, amounting to and usually exceeding 5 per cent of the national product and tending to increase both absolutely and relatively.

The chief goal of medicine is to satisfy the ever-growing demand for services; its objectives are not limited to health problems caused by defective development, in which success is usually not achieved unless parallel steps are taken to produce harmonious social progress.

Figures on medical expenditures in several American countries follow.

Chile. The 1963 national income of Chile, according to studies carried out by the De-

velopment Corporation,[33] amounted to 4.4 billion escudos ($1.1 billion, on the basis of 4 escudos to the dollar), with a per-capita average of 560 escudos ($140). The country's two major health institutions, which cover approximately 87 per cent of the total population, spent 5.5 per cent of the national income in that year. According to a report of the Ministry of Finance,[34] 8.29 per cent of the total 1963 spending in the public sector was on health. The information available reveals that the expenditure per person by the public sector was 28.78 escudos ($7.19); the trend over a 10-year period is upward, with dips in some years. Per-capita expenditure on medical care in this sector varies in the different regions of the country, ranging from 132.29 per cent in the most densely populated province to 42.66 per cent in another southern province. An analysis of the structure of medical expenditures in the public sector shows that salaries amounted in 1963 to 51 per cent of the total, to which should be added, thus raising the expenditure for personnel, a percentage of transfers. Operating costs accounted for 25 per cent of the total, transfers 22 per cent, and capital expenses 2 per cent. It has been estimated that in the private sector the 1963 medical expenditure was 38.15 escudos ($8.53) per person per year. Of this, 66 per cent was spent on private consultations and the remaining 34 per cent in private welfare institutions. The National Health Service accounts for between 75 and 93 per cent of the expenditures in the public sector. The general costs in its hospitals, excluding salaries, amounted in 1964 to 45,455,480.53 escudos, the major shares of which were about 37 per cent for medicines, 26 per cent for patient and staff feeding, and 17 per cent for maintenance and upkeep. A little over 50 per cent of the total budget of the National Health Service goes into salaries.

[33] Development Corporation, Chile. "Cuentas Nacionales de Chile, 1958-1963."

[34] Ministry of Finance, Chile, "Cuentas Fiscales de Chile—1963."

Argentina. In 1963 the Argentine gross national product was 953.9 billion pesos ($557.8 million), with a family per-capita consumption of 29.7. The national Government's expenditures on health in that year amounted to only 3.8 per cent of the total spending in the public sector. Because Argentina has a federal political-administrative structure, medical expenses in the public sector break down into 38.2 per cent national, 35.5 per cent provincial, and 26.3 per cent municipal. These figures show that the provincial governments contribute an important share of the total. The national public health budget in 1964 was 1.9 per cent of the total national budget—lower than in 1960–1961, when it reached 3.09 per cent. For the 1964–1965 period, the budget of the Ministry of Social Welfare and Public Health was 12,247,257,261 pesos, which includes 59.5 per cent for personnel, 32 per cent for other expenses, 3.1 per cent for capital investment, and 5.4 per cent for the public works plan.

Uruguay. Uruguay is a country with a relatively high per-capita income level: $834 in 1963, when the rate of exchange was 10.20 pesos to the dollar. (It should be noted that at present the dollar is worth 48 pesos, but the per-capita income has not increased at the same rate.) Expenditures on health in 1963 stood rather high in the international scale, both in percentage (5.36) and in dollar value per capita. This spending is poorly distributed, however, and is not altogether translated into services because of low returns in some sectors and lack of planning.

The private sector accounts for two thirds of the national outlay on health and is concentrated mainly in the capital. Fifty per cent of the private expenditures go into mutual facilities of the voluntary-insurance type, which are showing signs of financial strain and deteriorating services.

Peru. In the 14 Workers' Social Security hospitals, the average bed-day cost in 1963 was 400 sols ($15), a little lower for the

hospital in Lima. The cost per discharge in the same year was 757.8 sols ($28) and the cost per consultation 101 sols ($3.70). The budget of the Worker's Hospital in Lima was 922 million sols in 1963, of which 68.3 per cent was spent on personnel, 19.4 per cent on goods and services, 9.8 per cent on medicines, and 2.5 per cent on patient and staff feeding. The Lima Employees' Hospital, a subsidiary of the Employees' Social Security Fund, spent 225 million sols in 1964, paying out 63 per cent on salaries and 37 per cent on transfers and operating costs. On medicines 18.2 per cent was spent, and on patient and staff feeding 4 per cent. The bed-day cost per patient was 448 sols ($18.20), and the cost per consultation 127.8 sols ($4.80).

The report of the Board of Directors of the Lima Public Welfare Society, which has several major hospitals in the Peruvian capital, makes the following statement:

> From the foregoing comparison it may be seen that during the past 16 years the expenditures of the institution have risen to 130 million sols, and, as income has risen only to 80 million sols, there is a budgetary imbalance in excess of 50 million sols.[35]

This deficit is covered by the Ministry of Public Health and Social Welfare through a change in the national budget.

Colombia. Expenditures on health in Colombia in 1963 amounted to 728 million pesos in the public sector, including 231 million spent by the "beneficencias." In the private sector medical outlays have been estimated at 462 million pesos—a figure subject to correction, as in the other countries, because of the lack of complete, reliable information. Thus the total spent on health in Colombia in 1963 was 1.2 billion pesos, or (at the rate of 17 Colombian pesos to the dollar) $75,880,000.

Since 98 per cent of the hospitals belong to the country's 21 "beneficencias" and since these are autonomous and independent, information on costs is only approximate. It is estimated that in 1964 the "beneficencias" spent 231 million pesos. Some figures on the Colombian Social Security Institute, which has roughly 3,000 beds, are known. This institution invested 172 million pesos ($10 million) in medical care in 1963 and spent 271 pesos ($15.80) per patient per day per bed.

The 1962 summary of expenditures of the 411 agencies receiving official aid shows the proportions of this money spent on major items: salaries, 40.55 per cent; feeding, 15.03 per cent; medicines, 17.86 per cent; and maintenance and repairs, 7.56 per cent.

The bed-year cost was estimated at $5,677.08 and the bed-day cost at $15.55.

Venezuela. Public expenditures on health in Venezuela were 1,098,773,000 bolivars in 1964, including medical care and public health. Excluded from this figure are the beneficiaries' contributions to the Venezuelan Social Security Institute, which amounted to about 200 million bolivars. With the bolivar at 4.50 to the dollar, the Government's health outlay came to $244 million.

The Ministry of Health and Social Welfare, which controls 80 per cent of the country's hospitals, distributed its expenditures on these institutions as follows in 1964:

Hospitals for acute diseases, 101,546,219.92 bolivars, of which 65.2 per cent was for personnel, 7.30 per cent for feeding, 6.20 for medicines, and 21.18 per cent for other costs; the cost per patient per day was 65.25 bolivars ($14.49). Health centers, 11,497,564.17 bolivars, of which 72.14 per cent was for personnel, 9.20 per cent for feeding, 7.12 per cent for medicines, and 11.54 per cent for other costs; the cost per patient per day was 89.97 bolivars ($19.99).

Mexico. The Mexican statistical yearbook for 1962–1963 gives all expenditures on health in the public sector except those of social security, which are published later, as in some other countries. The partial figures are as follows:

[35] Statement, by the Board of Directors of the Lima Public Welfare Society, 1964.

Ministry of Health and Welfare, 566,-010,547 pesos; curative care, 452,707,761 pesos; educational social welfare, 28,322,092 pesos; social welfare in homes for the aged, 11,361,398 pesos; social welfare in foundling homes, 4,763,464 pesos; miscellaneous social welfare, 32,682,226 pesos. The total comes to 1,095,846,438 pesos. According to the present exchange rate of 12.50 pesos to the dollar, the outlay was $87,667,683 in 1962.

The 1965 budget of the Ministry of Health and Welfare calls for 891,278,000 pesos ($72,122,240). Of this total, 827,660,770 pesos ($66,212,860) are distributed as follows: health, medical care, and hospital services, 520,265,623.73 pesos; hospital construction, 89,712,290.23 pesos; maternal and child care, 38,552,256.97 pesos; social work, 83,650,899.43 pesos, and supplementary services, 95,479,699.64 pesos; and social welfare, 47,282,000 pesos.

The bed-day cost per patient for the three major institutions that operate hospitals was as follows: Ministry of Health and Welfare, 70 pesos ($5.62); Mexican Social Security Institute, 200 pesos ($16); and Government Workers' Social Security Institute, 400 pesos ($32).

Panama. In the past five years, the share of the national budget allocated to the National Department of Public Health has been gradually rising in relation to the national income. In 1962, 12,195,000 balboas were spent on public health, estimated at 11.60 per capita. (The balboa is equal to the dollar.) With Social Security spending 7,321,000 balboas in its health facilities in 1962, the total amount invested in health that year by the public sector was 19,516,915 balboas, or 17.6 per capita.

In the private sector, all the outlays were on restorative medicine, and the amount per capita is believed to have been 11.4 balboas.

Investments in the public sector are expected to rise because of the larger number of persons covered by Social Security, institutional contributions, and direct payments by patients at the time of receiving outpatient or hospital care, which has been estimated at an average of 15 per cent for the country.

In 1964 the 778-bed Santo Tomás Hospital, which is operated by the Ministry of Labor, Social Welfare, and Public Health, spent 2,254,135 balboas; in the same period the 269-bed Social Security Hospital spent 1,843,071 balboas, not counting the salaries of medical specialists. The cost per day per bed was 35 balboas in the latter hospital.

El Salvador. Public medical expenditures in El Salvador in 1964 were 30 million colons, or (at 2.5 colons to the dollar) $12 million. The Ministry of Public Health and Social Welfare accounted for 24 million colons (80 per cent) and the rest was divided among Social Security, the Army, the Ministry of Education, the Ministry of Labor, the General Provision for the Poor, the Ministry of Agriculture, and other agencies. There is no information on outlays in the private sector. The per-capita expenditure on health in 1964 is estimated at 5.51 colons ($2.10).

In the same year, the Ministry of Public Health hospitals invested 12,224,408 colons ($4,889,760).

It is interesting to report some figures on medical outlays by the social security agencies in the American countries, as furnished by the respective institutes. It should be recalled that the financing of social security is bi- or tripartite, varying in proportion according to the laws of the different countries.

In Peru, Workers' Social Security is financed by a payment of 3 per cent of his wage collected from the worker, 6 per cent paid by the employer, and 2 per cent contributed by the State. Of the 11-per-cent total, 6.3 per cent goes to cover illness, maternal care, and lactation, the latter two constituting 30 per cent. The financing of Employees' Social Security differs, with the beneficiary contributing 3 per cent of his salary, the employer 4 per cent, and the State ½ per cent.

In 1963 the Salvadorian Social Security Institute, with an income of 7,897,240.20 colons ($3,158,891), spent 4,488,430.11 colons ($1,795,372.10) on medical care, or 58.5 per cent of its total income. Compensation for sickness and maternity is not included.

The Colombian Social Security Institute had a total income in 1961 of 141,467,975 pesos ($8,321,645) and its medical benefits amounted to 101,434,663 pesos ($5,966,741), or 71 per cent. As in the preceding case, compensation for sickness and maternity is not included.

In the report presented by the Social Security Fund of Panama to the country's National Assembly in October 1964,[36] the institute's activities for the period 1961–1964 are summarized; the figures therefore cover the entire period, without being broken down by year. The total income from all sources between January 1961 and June 1964 was 63,813,455 balboas, with sickness and maternity benefits amounting to 20,012,-826. If compensation is eliminated from this total, the figure comes down to 17,906,128 balboas (28 per cent) as the net outlay on medical care during the period under consideration. In a paper published in a Panama City newspaper on 4 May 1965, Dr. Osvaldo Velázquez wrote: [37] "The estimated income of the Social Security Fund for 1964 was about 27 million balboas. The national budget for the same year was 81 million balboas—that is, Social Insurance handles a budget more than a third as large as the national budget. . . . Social Security invested during that year 9,200,000 balboas on medical care, for a per capita of 97.5. That year, Public Health invested 8,015,000 balboas for the entire population minus the insured, which makes for a per capita of 7.2. . . . The funds allocated per capita for medical care to the insured population are 13.5 times more than those assigned per capita to Public Health for the rest of the population. . . ."

It is also useful to note some figures on specific medical care expenditures. In Argentina, in 1961–62, the sales of 145 associated laboratories amounted to 12,648 million pesos, of which 11,498 million were billed to private pharmacies and institutions and 1,150 million to Government agencies; if the druggists' profits are added, it may be estimated that the population spent something like 15 billion pesos on medicines.

In Chile, the Development Corporation estimated that the 1963 pharmaceutical outlay was 159,855,000 escudos, of which the private sector spent 145,396,000 and the public sector 14,459,000. The purchase of drugs accounted for between 25 and 33 per cent of the country's total medical spending and was 10 times higher in the private sector than in the public.

Table 11 shows the total expenditures on health in several American countries, in local currencies.

The very incomplete background that has been given on health expenditures and certain specific aspects of medical care shows the differences between the various American countries with respect to their investments in preventive-curative programs. Greater or smaller economic capacity, the plans of the other sectors, the Government's economic policy, community demand for medical care, the available material resources and manpower—these are some of the elements responsible for the difference.

In some countries, the bed-day cost per patient varies with the institution, as do expenditures on personnel, medicines, feeding, and other items.

Many examples could be cited to supplement what has been said regarding the urgency of channeling the available resources in a coordinated and rational manner for the

[36] *Report of the Director-General of the Social Security Fund to the National Assembly.* Panama, October 1964.

[37] "Estudio económico de las prestaciones médicas del Seguro Social en relación a la Asistencia Médica en un plan nacional. Recomendaciones." *La Estrella de Panamá,* 4 May 1965.

Table 11. Government Total and Health Expenditures in Countries of the Americas (*National currencies*).

Country	Year	Total general Government consumption expenditure	Government health expenditure					
			Central Government				Intermediate administrations	Local authorities
			Total	Total	Ministry of Health	Other ministries or departments		
Argentina (millions)	1961	191,565	14,129	4,718	4,200	518	5,762	3,649
Bolivia	1963	643,229,926	17,760,000	. . .	. . .	. . .	. . .	. . .
Brazil (a) (millions)	1964	2,110,257	. . .	. . .	77,208	. . .	. . .	. . .
Canada (millions)	1961	7,183	1,109	421	368	53	623	65
Chile	1962	133,888,858	. . .	. . .	. . .	. . .	. . .	. . .
Costa Rica (b)	1962	543,000,000	. . .	26,945,412	10,367,137	16,578,275	. . .	. . .
Cuba	1962	1,853,733	109,024	109,024	109,024	—	—	—
El Salvador	1962	173,823,680	19,063,348	. . .	5,922,520	. . .	. . .	. . .
Guatemala	1962-63	105,905,000	. . .	. . .	(c)9,867,349	. . .	. . .	. . .
Haiti	1962	. . .	18,765,609	16,701,755	. . .	. . .	2,063,853	. . .
Honduras	1962	104,917,977	9,384,063	8,240,555	6,832,860	1,407,695	2,809,943	. . .
Mexico	1962	12,319,783,000	(d)1,710,584,616	. . .	. . .	. . .	25,289,221	. . .
Panama	1962	92,312,377	. . .	15,061,750	. . .	. . .	. . .	. . .
Peru	1962	11,291,165,000	. . .	. . .	(e)1,174,366,840	. . .	. . .	
United States of America (millions)	1960-61	114,016	6,940	3,070	1,088	1,982	3,870	

(a) Amounts budgeted.
(b) Includes expenditures in the Social Security.
(c) From another source it is known that in 1962 there was an expense of 6,322,906 quetzals for appropriations for Government hospitals and subsidies to other hospitals, which probably is a part of the total budget shown in the table.
(d) Of this amount, 637,240,244. (Mexican pesos) is devoted to health care and hospitals.
(e) Of this amount, 40,613,509 Peruvian sols are devoted to Government hospitals and 12,816,100 Peruvian sols to Beneficencia and other hospitals.

best possible utilization in gradually meeting the demands for new health services.

Along the same lines as this appraisal, the First Latin American Regional Assembly of the World Medical Association, held in Chile from 3 to 10 April 1965, resolved as follows in the conclusions of the topic "Medical Expenditure in Latin America":

Considering:

The health sector, the product of which is the provision of integrated medical services, constitutes a fundamental sector of socioeconomic relations, granted that socioeconomic development has as its central object an increase in the well-being of the community.

The level of health care is related to the resources available to the sector, which depend on the degree of economic development; therefore, it is essential to promote economic and social development as a condition of improving the levels of health and medical services.

In Latin America, the national medical expenditure is generally on the order of 5 per cent of the gross national product, which in absolute terms is very variable. However, the figures presented make it possible to state that resources are far from being channeled or directed toward an adequate return.

Recommendations:

There is agreement that the integration of medical resources would permit better utilization of them, and this is consequently recommended as a goal that should be achieved in Latin America in the shortest possible time. While this objective is being approached, the coordination of medical services on the various levels should be promoted as a temporary stage. The integration should be guided by a National Health Policy and expressed in planning of the sector as a constituent of the economic and social development plans.

In the planning process, the country's physicians, through their representative organizations, should participate with the public authorities. In the organizations responsible

for high-level administration of the plans of the sector, physicians should occupy a majority position.

While the goals indicated are being pursued, medical expenditures should at least maintain their share of the gross national product, provided that this does not mean a decrease in medical spending per person.

Believing that studies of medical expenditures are of basic importance to evaluation of the health policy and to care of the population's health, the Assembly recommends that the countries adopt the necessary measures toward the regular conducting and progressive improvement of these studies.

4. PLANNING

A close look at Resolution XXV of the XV Meeting of the PAHO Directing Council, as was said in Part I of this report, shows how broad in scope it is. Its stated principles imply the following considerations: Orderly incorporation of medical care into the national or local plans for economic and social development; improvement of health services, hospitals, and outpatient clinics as a result of the technical integration of preventive and curative activities. Construction of new health facilities and remodeling of existing ones so as to increase population coverage on a continental, national, and local level; improvement of their organization and administration through adequate coordination of the institutions involved, so that better use can be made of available resources. Planning of health services with an eye to the present and the future, determining the initial investment required for buildings and installations, operating budgets, and personnel needs.

On the basis of these principles, a sequence has been followed in this report that makes it possible, despite the insufficiency of data, to come to certain conclusions and propose some solutions to the problem of planning hospitals and health facilities, as explicitly called for in the resolution that led to the report.

Since information on the points to be discussed is more precise for the eight countries visited (Uruguay, Chile, Peru, Colombia, Venezuela, Panama, El Salvador, and Mexico) than for the rest of the Americas, the material to be used will deal chiefly with them.

In order to arrange the account in an orderly fashion, the following material has been considered:

(a) Legal systems and regulations for the construction of hospitals and other health facilities.

(b) Construction and remodeling of hospitals and other health facilities during the past five years. Costs. Special expenditures on foreign advisory services.

(c) General construction and remodeling plans for the next few years. Capacity to undertake these projects.

(d) Equipment and installations.

(e) Maintenance, repairs, and renovation.

(f) Requirements for normal financing of facilities after completion of construction or remodeling.

a. *Legal systems and regulations for the construction of hospitals and other health facilities*

A review of the legal procedures and regulations followed in various Central and South American countries shows a variety of systems. This makes them difficult to classify and also to incorporate into a sectorial health policy as part of the national development plans. In general, the health ministries and secretariats have regulated construction and remodeling for their own facilities. In some countries there has been an attempt to require all construction and remodeling carried out by other public-sector institutions and by the private sector to be authorized and supervised by the ministry of health. Up to now this provision exists in theory only; very rarely does a nonministerial institution abide by it.

But the ministry of health, through its architecture divisions or departments, is not

the only agency preparing programs, sketches, plans, and specifications and establishing bases for public proposals or bids; the other ministries or bureaus proceed in the same manner on the construction or remodeling of their own medical care facilities. And so do the social security agencies and private organizations. Usually, when any of these institutions builds a hospital, a clinic, or a health center, the facility is not part of a national hospital construction plan; thus a given locality may for no real reason, as the rates of return demonstrate, have several hospitals. Often local political pressure or pressure by leading community groups results in the building of a hospital for which the need is debatable or that is unnecessary there but fully justified somewhere else.

In certain countries, foreign firms have sometimes been brought in to draw up programs and building plans and even, as will later be described, to contract loans to finance the projects.

Following are the systems used in the above-mentioned countries, according to the available information. It should be noted that the systems described are those used by the Ministries or Secretariats of Health.

Uruguay. Up to now there have been no formal programs of hospital construction. The main reason is that the economic resources do not cover all the needs of the existing facilities, so that plans are basically a response to urgent needs according to a list of priorities.

The Architecture Division of the Ministry of Public Health, together with the Welfare Division, at one time outlined a minimum program of new construction, which has not been put into effect for the reason mentioned above.

Two systems are followed on construction:

(i) By the Ministry of Public Works (annual plans with resources voted by Congress for Ministry programs); in this case the Architecture Division of the Ministry of Public Health supplies programs and sketches.

(ii) Directly by the Architecture Division of the Ministry of Public Health, which plans and supervises construction with the Ministry's own funds (from grants, revenues, and so on).

At present the Architecture Division is attempting to establish organic planning, whereby programs covering the needs of the entire country are studied and formulated, as standard practice.

In addition, the Committee on Investment and Economic Development (CIDE), which is studying the Economic Development Plan, is including a hospital construction program in the plan.

Design and supervision are in the hands of specialized architects in Government agencies: the Architecture Division of the Ministry of Public Health and the Hospitals Section of the Architecture Bureau of the Ministry of Public Works. This is clearly a duplication of services, which means both failure to use resources to good advantage and higher costs. Construction as such is done by private companies after public bidding.

Chile. Since long before the National Health Service was established, there has been an autonomous institution, the Society for the Construction of Hospital Facilities, in charge of building hospitals and other health facilities. This agency is financed by law through Government allocations and through the sale of 8-per-cent bonds to the National Health Service, the Social Security Service, other public institutions, and the private sector. When the Society was set up, it was thought that the interest would attract the private sector, which would buy a large share of the bonds. But the general impoverishment caused by the country's perennial inflation has resulted in the Treasury's holding 90 per cent of the bonds.

For the construction of hospitals, clinics,

and other facilities the National Health Service follows a plan subject to a list of priorities. Its Department of Architecture draws up the plans and specifications for the buildings programmed; after approval by the Council of the Service, the plans are sent for execution to the Society for the Construction of Hospital Facilities. Under its regulations, the Society must build on land of its own acquired by purchase or, if public, by transfer from other Ministries. It sets the terms on which it calls for proposal or bids, and builds in accordance with its financial capacity. In 1964 the Society had 17 million escudos ($5,230,700) at its disposal. The National Health Service uses its interest on the bonds to equip the hospitals built.

Remodeling of hospitals and health facilities is handled directly by the National Health Service with funds from its own budget. Either its own Department of Architecture is used or the hospital directors contract for the services of private architects, who are paid according to a previously determined scale.

It is believed that the Society for the Construction of Hospital Facilities might be incorporated into the National Health Service, a step that would do away with administrative procedures and personnel payments that increase construction costs.

Peru. The National Health and Social Welfare Fund was established some years ago by Law 11672 as an independent public agency, its main purposes being to carry out projects and services aimed at improving the country's sanitary conditions, to promote health protection, and to advance social well-being. Its resources come from various taxes, such as the antituberculosis stamp, a share of the income from fiscal stamps, a share of the tax on alcohol and alcoholic beverages, and an allocation of 3.5 per cent of the tax on all salaries and fees paid by private employers for retribution of services.

The Fund has cooperated in the eradication and control of communicable diseases (malaria and smallpox), has helped in the development of health and housing services, and has carried out considerable construction in the welfare field, including the building and equipping of 12 hospitals. A recent law freed the Fund from the construction of hospitals and health facilities—it is still wholly responsible for subsidies to public "beneficencias," which in 1964 were in excess of 100 million sols; it subsidizes other services to the extent of 38 million sols; and it has lost 25 per cent of its income to the National Economic Development Fund.

Draft programs for the building of health facilities are prepared in the Fund's Office of Health Programs, which also conducts pilot programs in social development and promotes medical teaching and scientific research. The programs then go to the Technical Office, which draws the architectural plans and blueprints, including installations and costs, and supervises construction.

The Fund handles construction by means of public bidding.

According to the obligations fixed by law and those conferred by the Council of the National Health and Social Welfare Fund, this independent agency has a standard-setting and executive authority and economic resources that make it seem to be in competition with the Ministry of Public Health and the Health Service. If these institutions were integrated, the results would probably be more positive and the resources of both could be used to better advantage.

Colombia. Because of the characteristics of Colombian health services, the multiplicity of agencies having facilities and hospitals, the lack of an adequate construction plan, and a shortage of economic resources on the part of the Ministry of Public Health, there has been very little building in the past 15 years and even that has been chiefly rural health centers.

Construction is in the hands of the Ministry of Public Health. Its Department of Architecture prepares programs, sketches, and plans that usually wait for years to be

executed. Sometimes another public institution or a private one asks the Department of Architecture to draw up hospital plans.

Venezuela. The table of organization of the Venezuelan Ministry of Health and Social Welfare shows a Department of General Services, which includes Sanitary Architecture, Construction, and Maintenance. This Department is one of the agencies participating in hospital construction.

The procedure employed in the building of health facilities may be summarized as follows:

The need for building a hospital is determined by the Office of Coordination and Economic Planning (CORDIPLAN), the executive bureau that coordinates development plans and in which there are technical representatives of the agencies related to health. The Ministry of Health prepares the program in its Department of Sanitary Architecture, in which there is a representative of the Ministry of Public Works. This program is sent by the Ministry of Health to the Ministry of Public Works—the real builder—which on approval sends it to the Office of Health Planning. With or without change, the Office returns it to the Ministry of Public Works. The Ministry of Public Works develops plans, specifications, and so on, and submits the terms for public bids to the Comptrollership General of the Republic; on their approval, they are returned to the Ministry of Public Works, which calls for bids and gets construction under way. Inspection is carried out by the Office of Sanitary Architecture.

As in the case of Uruguay, a new element has been introduced in Venezuela—the important role played in the process by the Ministry of Public Works.

Panama. In Panama, as in Venezuela, hospitals and health facilities are built by the Ministry of Public Works, subject to programs, plans, and specifications drawn up in the Architecture Department of the Ministry of Labor, Social Welfare, and Public Health, with the Director General of Public Health participating directly. The Ministry of Public Works handles the construction through public bidding.

El Salvador. In El Salvador it is the Office of Planning that determines the need for building a health facility or hospital, and the Ministry of Public Health and Social Welfare obtains the necessary financing from the Ministry of Finance. Once the resources (domestic or foreign) have been authorized, the Department of Engineering and Architecture prepares the programs and draws up the plans. When this step has been completed and a bid by a national firm has been accepted, construction is started. The work is supervised by a supervisory institution contracted for an agreed-upon fee.

Mexico. Until recently Mexico had a National Hospital Commission (set up in 1954) attached to the Ministry of Health and Welfare. Its purpose was to provide technical assistance to and supervise programs and plans for new hospitals or for enlargements or alterations, whatever their auspices, so as to bring about more effective functioning. It was also to conduct a hospital census on which a nationwide hospital construction policy could be based. The hospital census was quickly taken by professional groups and technical specialists, and its results were published in 1958.[38]

The National Hospital Commission was replaced in 1964 by the Building Commission of the Ministry of Health and Welfare. This is now in operation, with functions similar to those of its predecessor.

The Building Commission programs construction, draws up plans and specifications, and calls for public bids from contractors or construction firms. Supervision is carried out by Commission architects and engineers, and this control goes so far as constant sampling, in the Commission's own concrete

[38] Ministry of Health and Welfare of Mexico, National Hospital Commission: *Censo y planificación de hospitales.* 1958.

laboratory, of the material used by these firms.

Mexico is advising several Central American countries on hospital construction. The parties are mainly the Mexican Social Security Institute and the social security agencies of these countries.

The foregoing review of the legal procedures and regulations employed in some Hemisphere countries for the programming and construction of hospitals shows the variety of methods employed and the necessity of finding an adequate system that will permit an advantageous use of economic resources through the development of programs uninfluenced by outside factors and circumstances.

b. *Construction and remodeling of hospitals and other health facilities during the past five years. Costs. Special expenditures on foreign advisory services*

By means of the procedures that have been described, numerous hospitals, health centers, and other facilities have been built in the Latin American countries—sometimes in accordance with national, regional, or local programs and sometimes in response to factors quite unrelated to a program.

For the countries visited a survey design was set up that would reveal construction during the past five years, with number of beds, time spent on construction, cost of construction, cost of equipment, and cost per bed, all of which is summarized in Table 12.

Only general data are available on construction in Uruguay. The Architecture Division of the Ministry of Public Health invested, during the period 1961–1964, the sum of 10,765,000 pesos; this is equivalent to about $500,000 at the rate of 20 pesos to the dollar (at present it is 48). Between 1960 and 1962, inclusive, the Ministry of Public Works had 43,800,000 pesos ($2,190,000) budgeted for construction. This latter figure, however, does not show what was actually spent, since certain items in the Ministry's budget were not carried out.

To estimate the cost of beds in Chile in U.S. currency, the rate of 3.50 escudos to the dollar was used. The figure on construction outlays did not include the building of 11 clinics in various cities or certain general facilities in some hospitals, which cost 1,360,741 escudos. Also omitted were the investments made by the Housing Corporation (CORVI), which built four clinics.

Information on construction in Peru

Table 12. Construction during the past Five Years in Eight American Countries. Number of Beds, Time Spent in Construction, Total Cost, Cost of Equipment, Cost per Bed.

Country	*Period*	*No. of beds*	*Time spent in construction*	*Construction cost*	*Cost of equipment*	*Total cost*	*Cost per bed*	
							National	*$ USA*
Uruguay	1961-64	363	—	—	—	$ 54,565,000	$ 150,000	7,500
Chile	1959-64	2,901	3 years 3 months	21,213,753 (escudos)	4,102,000 (escudos)	25,315,757 (escudos)	17,410 (escudos)	4,970
Peru	1962-63	1,678	2 years	193,437,160	199,272,658 (German credit)	392,709,818 (sols)	2,950,173 (sols)	10,631
Colombia	1960-63	1,463	3 years	—	—	$ 1,281,500	$ 87,544	5,149
Venezuela	1959-64	3,588	2 years	139,872,000 (bolivars)	32,645,000 (bolivars)	172,517,000 (bolivars)	58,960 (bolivars)	13,500
Panama	1959-64	355	2 years	—	—	1,011,235 (balboas)	2,848 (balboas)	2,848
El Salvador	1959-64	36	1 year 5 months	—	—	208,986 (colons)	5,805 (colons)	2,322
Mexico	1959-64	10,410	—	—	—	—	—	—

covers the period 1962–1963. Facilities built by the social security agencies, which deserve separate comment, are not included. The exchange rate was 26.70 sols to the dollar.

The Colombian peso was estimated at 17 to the dollar. In the period shown in Table 12, 50 health centers, the cost of which is not known, were built, in addition to the beds indicated. Furthermore, the information in hand, issued by the Office of Evaluation, does not specify figures in this regard.[39]

In Venezuela the exchange rate was taken as 4.50 bolivars to the dollar. In El Salvador, with a rate of 2.50 colons to the dollar, six health units bere built at a cost of 406,021.16 colons, in addition to the beds shown in Table 12.

In Mexico it was not possible to obtain data on the cost of the 10,410 beds and other health facilities built during the period 1959–1964. Only information on what was accomplished is available.

To determine the time spent on construction, the number of years between start and completion was averaged; in some countries it fluctuated between 1 and 15 years.

Although there are figures on cost of equipment for only three countries, its relationship to cost of construction varies greatly from country to country. According to what is known and to estimates made by officials in the architecture departments of several countries, this range might be from 17 to 100 per cent. It depends on what is considered necessary and adequate equipment for a hospital and on the amount, quality, and complexity of the equipment installed, as could be observed in many of the hospitals visited (radiology equipment with motion pictures and television, while other hospitals in the same country do not have a single fluoroscope).

Within any one country, the cost of construction varies as a result of such factors as difficulty of transporting building materials, difficulty in finding skilled labor, type of construction, and length of time.

The cost of hospitals built by the social security agencies, in the countries where this is known, is interesting, being significantly higher than the usual costs incurred by the ministry.

In Peru, the Employees' Hospital, which was eight years in building (it was opened in 1958) and has a capacity of 1,247 beds, cost 300 million sols to build and 80 million sols to equip; at the present rate of exchange, this is $11,236,000 and $3,348,200, respectively. The conversion is not precise, for it should be based on the value of the dollar in Peru during the construction period. Furthermore, the per-bed cost of a little over $11,000 is fallacious, for only 898 beds out of a capacity of 1,247 are functioning. Workers' Social Security has in recent years built 200 to 300 beds at a cost of 200,000 sols each.

In Panama the Social Security Hospital, with 269 beds, had a construction cost of 2,700,000 balboas (1 balboa = 1 dollar), just over $10,000 per bed.

Another item that should be stressed is the expenditure on foreign advisory services incurred by some American countries for the construction and equipping of hospitals.

Though hospitals and health facilities have generally been built with domestic resources—technical and economic—foreign firms have sometimes been contracted for program studies, the preparation of plans and drawings, and on occasion financing. In most cases, the cost of construction and installations has been much higher than for buildings executed by the ministries; among the factors responsible are interest payments, requirements for specific types of equipment, and fees to other firms supervising investments (financial control).

Good examples of this are such hospitals as the Clinics in Montevideo, the Employees' Hospital in Lima, the Military Hospital in

[39] Republic of Colombia, Planning Department: *Encuesta de las instituciones del Gobierno local. Fuentes y uso de fondos.* 1964.

Bogotá, and the Social Security Hospital in Panama City. In all of these the cost per bed was in excess of $10,000, whereas, as has been shown in Table 12, most hospitals built by the ministries cost half, or just over half, as much. At the Employees' Hospital, it developed, 100 beds could have been built with the architects' fees. A visit to this hospital reveals many high-cost installations, the expense of which could have gone into equipping other hospitals that are not fitted out to provide good-quality integrated medicine. This situation is common with radiology equipment, laboratories, operating tables, milk-pasteurizing plants, and so on.

The Governments of Peru and El Salvador have negotiated cash loans—the former with a foreign consortium, the latter with a Government—to carry out plans for the building of hospitals and health centers or units.

Part of the Peruvian plan, which was formulated by the Health Bureau and the National Health and Social Welfare Fund, has already been fulfilled. According to the agreement with the consortium, the loan is for Dm.66,002,532.29, payable in 10 years at 7-per-cent interest. Over the 10-year period, the interest to be paid by the National Health and Social Welfare Fund will amount to 32 per cent of the total. With regard to equipment, one clause provides for Dm.21,571,150.69 to be allocated for this purpose and Dm.15,135,849.31 for costs of installation, shipping, clearance, local transport, and so on. It is further provided that installation may be done by consortium or national personnel. Another clause exempts the consortium from all taxes.

In El Salvador, an agreement was reached about a year ago with a foreign Government for the financing of a hospital and health-unit construction plan. The conditions differ from those obtained by Peru. The credit is for 6,450,000 colons and is payable over 20 years in semiannual installments at 3-per-cent annual interest, with four years' grace. To this sum the Government of El Salvador will add 4,300,000 colons for a total of 10,750,000, which will be invested in a program drawn up by the Ministry of Public Health and the Department of Health. In Venezuela, some hospitals built by foreign firms cost 50 per cent more than those constructed by the Ministry of Public Works and were found to have a series of defects caused by the construction firm's ignorance of conditions in the country.

c. *General construction and remodeling plans for the next few years. Capacity to undertake these projects*

In estimating bed needs in future years, two factors must be taken into account: (i) expected growth of the population to be served; and (ii) the proportion or percentage of the population to which it is essential to give adequate medical care. Up to now there has been no single index that can be recommended for estimating these needs, since each country presents so many variables. Among these should be mentioned *the structure or age distribution of the population, the causes of morbidity in outpatient consultations and hospitalization, the organizational systems of the health services, manpower, the geographical distribution of the population, the utilization of existing hospitals, and the demand for medical-hospital care in relation to the country's cultural background and economic resources.*

Use of the first factor alone, the expected population growth, leads to the following estimates of needs for new hospital construction in Latin America between 1965 and 1980. In this period the population will increase by 53 per cent—from 244 million to 374 million. Maintenance of the present very low ratio of 3.2 beds per 1,000 population will necessitate 1,200,000 beds by 1980; if it is estimated that there are 780,000 beds at present, 420,000 more will be needed, which means that between now and 1980 the present number of beds must be increased by 28,000 annually.

By country, the need for an increase in beds depends on the present supply and the

relationship to population. For example, population growth in Argentina is slower than in Mexico and the total population is smaller; nevertheless, to maintain its present high ratio of beds per 1,000 population, it must construct more beds than Mexico in the 15-year period (1965–1980). On the other hand, the current bed level in Argentina is sufficient, whereas in Mexico an increase over present ratios is advisable. Data on hospital construction during recent years in several countries illustrate the progress that has been made: in Mexico, between 1958 and 1963, hospital beds increased by 45 per cent; in Venezuela, between 1957 and 1962, by 28 per cent.

What has been said about meeting bed needs is also applicable to health centers. In 20 countries, with a population of about 196 million, there were 11,618 health centers and other outpatient facilities in 1963–1964. The population coverage represented by these facilities is not known; but assuming that, as in certain countries, each one serves 17,000 people, the 1965 need is for 14,000 such centers and by 1980, when the population will have risen to 374 million, it will take 22,000 to maintain the present ratio. This means building 8,000 in 15 years, or 530 annually.

On material resources, expressed in buildings, beds, and equipment, the subsectorial, sectorial, and national health plans should consider (i) better utilization of existing facilities; and (ii) the construction, remodeling, and equipping of new ones in accordance with needs. In setting goals, consideration should be given to the feasibility of achieving them with domestic resources, with or without foreign aid, or with outside resources exclusively. The current meager planning method limited to existing resources is unsuitable in this connection; it would lead to decay and stagnation in the fulfillment of goals that vary from year to year.

Some background on construction plans for the coming years about which there is direct or indirect information will show the efforts being made in the countries to eliminate shortages of beds and other health facilities.

In two countries, El Salvador and Chile, and particularly the latter, construction plans must be very short-range, because earthquakes make it necessary to alter the programs, to postpone those already under way, and to invest a large part of the resources that had been allocated in repairing earthquake damage and replacing what was destroyed.

In Chile, before the earthquake at the end of March 1965, the construction of 36 hospitals, with a total of 3,531 beds, had been programmed; work on five of these, with 272 beds, was begun in 1965; eight, with 322 beds, had been put out for bids; and plans were being drawn up for the rest. The building of eight clinics and ten rural posts was also under discussion.

Similarly, El Salvador, before the earthquake in May 1965, had programmed for the period 1965–1969 the building of three general hospitals, with a total of 500 beds. The cost of construction was to be 8,184,492.30 colons and the cost of equipment, 2,575,507.70 colons, for a total of 10,760,000 colons ($4,300,000). The cost per bed constructed and equipped was 21,500 colons ($8,600). Also during this period, it was intended to build 50 health posts and units and to do 8,363,765 colons' worth of construction, expansion, and remodeling in other hospitals. The three hospitals mentioned at the start were to be financed in part by the Salvadorian Government and in part by a loan from a foreign government.

Uruguay has no hospital construction programs arising out of a national health plan.

The Colombian construction program, related to the Alliance for Progress, calls for the construction and completion, excluding equipment, of 23 facilities with 4,183 beds. The total cost is 394,780,000 pesos, and the

cost per bed $5,551, not counting equipment.

Peru, continuing with its biennial programs initiated in 1962, has planned for 1964–1965 a program, financed by a consortium, that contemplates the building of 11 hospitals with a total of 1,450 beds. The investment comes to 346,571,000 sols, and the cost per bed is more than $10,000.

The 10-year (1958–1968) program of medical and welfare construction in Venezuela, formulated by the Ministries of Health and of Public Works, calls for building 28 hospitals. Eight of these were started, but not completed, during the period 1960–1964, and the 20 others were to be built beginning in 1964. This plan, which comprises 8,271 beds built and equipped, represents an expenditure of 533,028,000 bolivars, with a cost per bed of 64,445 bolivars ($14,320). The cost may vary according to local and other conditions, as stated in the program.

The Ministry of Health and Welfare of Mexico has made a study of investments for hospital construction and equipment for 1966–1970. This contemplates an investment of 571 million pesos, with the Federal Government contributing 400 million and the state and municipal governments and private sources 171 million. Rehabilitating 9,700 beds is to take 245,616,000 pesos. There is also to be an investment of 174,795,000 pesos to equip new and rehabilitated beds. The total expenditure for the period is 745,795,000 pesos.

It is of interest that in their construction programs Chile, Colombia, Mexico, Panama, Peru, and Venezuela have all included health centers, health units, rural medicatures, outpatient clinics with or without beds, and medical posts, so as to furnish medical care to small communities with low population density.

In Panama a construction plan was initiated in March 1963 and is to be completed in February 1967. Under this five-year plan, 25,844,000 balboas are to be spent on building a new hospital in the eastern region, a nursing school, health centers with beds, and health subcenters scattered over the country.

In each of the countries visited, there was said to be the technical capacity and the labor to carry out the planned construction. The main stumbling block in all was economic capacity; hence the agreements signed by some countries with foreign consortia and governments. As to how much of the equipment could be manufactured in the country and how much must be purchased abroad, the replies were very diverse. In Mexico it was estimated that 80 per cent could be produced domestically and only 20 per cent would have to be imported—the reverse of the situation in some countries, where practically all the equipment must be imported. Others can produce 40 to 50 per cent of their equipment.

d. *Equipment and installations*

Mention was made above of the difficulty of determining how much equipment there was in the countries, because of the lack of adequate, reliable information. An account was given of what is being done in various countries to obtain background material, through an inventory of resources, that would make it possible to formulate national or sectorial health plans. Emphasis was also placed on the lack of an equitable distribution of equipment among the hospitals and on the existence of some equipment that was considered useless, inadequate, or superfluous. With respect to the latter point, in one of the countries a number of kerosene sterilizers and resuscitators that had been imported stood idle for years, for lack of instructions on how to use them, and other equipment was electrically operated in areas where there was no electricity. In other countries, costly apparatus that requires special techniques and experts to run it, and that is expensive to operate because

of its low return, tends to mount up to inexplicable numbers—machines for extracorporeal circulation, for example. In one country an electronic microscope was bought when some hospitals did not have even an ordinary microscope. These examples might be multiplied indefinitely; they show the need for rational programming through advisory services that will promote the acquisition of what is needed for the normal development of health facilities and services.

Frequently, moreover, various pieces of equipment of the same type originate in different countries or come from different manufacturers in a single country. This creates serious repair problems, with parts impossible to obtain because of lack of foreign exchange or because the factory is no longer in existence. Thus apparatus and instruments often go out of service after a short time. Clearly, purchases should be standardized to prevent such waste, which drains a significant proportion of a facility's expenditures.

e. *Maintenance, repairs, and renovation*

The maintenance and upkeep of buildings and equipment are a problem that health authorities have not fully come to grips with. In some countries it is handled centrally in the health ministry or bureau by divisions or departments that have their own budgets and specialized staffs, with a small allotment to the hospital director for minor outlays. In others, maintenance and upkeep are the direct responsibility of the facility itself. The percentages granted for this purpose vary, but even in the countries that designate larger amounts these are still below what is required—especially for the many hospitals in Latin America that are from 25 to 200 years old.

Renovation of equipment is not done as often as necessary. Legal procedures have been established in some countries for using a percentage of the hospital's receipts for this purpose, or for contracting loans. In others, interest on the bonds of construction societies is used for equipment renovation.

f. *Requirements for normal financing of facilities after completion of construction or remodeling. Functional operating budgets. Staff requirements and training expenses*

It is not unusual to see a hospital, clinic, or health center or unit standing unused for a long time, perhaps years, after the completion of construction or remodeling, with resulting deterioration of the building. This is due to failure to work out an operating budget in time and to include it in the budget for the pertinent year, and also to lack of sufficient trained personnel for prompt and effective medical care.

It has been estimated that the operating budget for the first year after construction ranges from 25 to 50 per cent of the total construction; it is therefore essential to include this estimate in building programs. Only the Mexican plan for 1966–1970 includes this expenditure; it is not mentioned in the programs of other countries.

Supplying an adequate staff is much more difficult. Though the requirements may be determined, there is a notorious shortage of professionals, technicians, and auxiliaries in all the Latin American countries. Mention has been made of the efforts under way in South and Central America to remedy this lack, which will continue to be a dominant factor in the development of health plans and programs.

C. CONCLUSIONS

In the course of this review of the current status of the health sector in Latin America; the structure and organization of health facilities; the most salient aspects of the material, manpower, and economic resources available to these facilities, with particular reference

to hospitals; and, finally, the background relative to the planning of them, emphasis has been placed on the following points:

(a) The need for planning health activities and programming them in accordance with the existing resources and the needs, so as to meet the demand for medical care and reduce mortality.

(b) The desirability of the health plans' being sectorial, not subsectorial, and to their being related to and coordinated with the national plans for economic and social development.

(c) Establishment of the principle, as a foundation in the development of these plans, that preventive and curative health activities be integrated.

(d) The achievement, in the shortest possible time, of effective coordination of health facilities, particularly between the ministries of health and the social security agencies, which have the largest resources and the responsibility for providing the people with medical care.

(e) Adequate distribution of material, manpower, and economic resources and provision of the means to cover the needs arising from population growth and from each country's individual characteristics.

(f) The view that hospital planning is closely related to health plans and is part of medical care programs and their execution and development.

(g) The planning of hospital building, remodeling, and equipping to increase population coverage, with improved organization and administration.

(h) The planning of health facilities with an eye to the present and the future, with a determination of initial investments, construction and installations, operating budgets, and personnel needs.

(i) The recommendation, in view of the foregoing conclusions, that a regional organization be set up within the Pan American Health Organization to provide technical assistance, on request, to Governments, oriented toward the study of their prevailing problems, their major characteristics, the recommended solutions, and the part that should be played by the Pan American Sanitary Bureau in advising on the planning, construction, remodeling, equipping, organization and administration, personnel training, operation, and national and international financing of hospitals and other health facilities.

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III. FINAL REPORT OF THE ADVISORY COMMITTEE ON PLANNING OF HOSPITALS AND OTHER HEALTH SERVICES

INTRODUCTION

On 26 July 1965, at 8:30 a.m., the Advisory Committee convoked by the Pan American Health Organization met in the Conference Room of the Pan American Sanitary Bureau to discuss the topic, "Planning of Hospitals and Other Health Services," in compliance with the provisions of Resolution XXV adopted at the XV Directing Council of the Organization.

The meeting was opened by Dr. Abraham Horwitz, Director of the Pan American Sanitary Bureau. (*The Director's address is given in full on pages 65-67 of this publication.*)

Then, on behalf of the President of the Inter-American Development Bank, Mr. Alfred C. Wolf spoke of the Bank's interest in the programs concerned with health care and medical care in Latin America, outlining the achievements of the Bank in this field.

Dr. Sotero del Río (Chile) was elected Chairman of the Advisory Committee and Dr. Guillermo Arbona (Puerto Rico), Rapporteur. Dr. del Río took the Chair, and both thanked the Committee for the honor conferred on them.

The Coordinating Secretary of the Advisory Committee indicated the method of work arranged for the Committee meetings, and once again explained the frame of reference for the accomplishment of the work, as follows:

1. The discussions, opinions, and recommendations of the Advisory Committee are to be transmitted to the Governing Bodies, in compliance with Resolution XXV of the XV Meeting of the Directing Council, on planning of hospitals and other health services.

2. The chief purpose of the Meeting of the Committee is the issuance of a statement on the need, advisability, and feasibility of establishing, within the Pan American Sanitary Bureau, a regional agency to provide technical assistance, on request, to Governments, oriented to the study of their prevailing problems, their major characteristics, the recommended resolutions, and the chief functions that the Bureau should assume in this area.

3. Ideas are requested for the establishment of the necessary structures, both permanent and temporary, by means of which advisory services can be given on the planning, construction, remodeling, equipping, organization and administration, training of personnel, operation, and national and international financing of hospitals and other health facilities.

4. Standards are sought for the setting of minimum requirements and methods of analysis for the requests received, in order to orient the studies on preinvestment and to broaden an experience from which all stand to benefit.

The Special Adviser then summarized the contents of the working document,[1] in its general aspects, and outlined the chapters contained therein. In a succinct description of its contents he spoke of the current state of the health sector, health care in general, resources in health, planning of hospitals and other health services, and general considerations included in the document.

The Advisory Committee thoroughly analyzed the working document and considered that it properly covered the basic aspects of the problem under discussion. Although the pertinent information is incomplete, it is sufficient to establish that the health situation in Latin America reveals serious deficiencies in its various aspects. The high indices of morbidity and mortality that prevail throughout the Hemisphere are incompatible with the minimum levels desired by present-day society, and although there are important improvements in several countries, the picture as a whole is highly unsatisfactory. Clearly, this situation is the result of a series of historical, cultural, and economic factors, of the policy of national Governments, of attitudes and habits of various population groups, either organized or unorganized, of a country or region; sustained, intense efforts are therefore needed to cope with this entire situation. The Committee thus adopted the recommendations and suggestions contained in the document, which it decided to annex in its entirety to the present report.

The Committee also agreed to emphasize the following supplementary points that gave rise to discussion; they are analyzed in the following pages of this report.

A. GENERAL CONSIDERATIONS ON HEALTH

As a conceptual delimitation with which to begin, yet without failing to take into account the substance of Resolution XXV submitted to it for consideration, the Advisory Committee expressed its conviction that there is a basic unity in health problems. As a result of improved public health techniques, an increased knowledge of health matters by the people, and the development of international cooperation in this field, the Latin American countries have made significant progress in environmental health and the control of communicable diseases. Nevertheless, these problems continue to show a degree of severity in certain areas, while in others chronic diseases of a degenerative nature are becoming a health problem of first magnitude. In the face of this, medical care takes on the dimensions of a basic health service that must be developed. All action undertaken in this field in the future must be aimed at bridging the traditional divisions, which are in varying stages of evolution in Latin America, even though the tendency toward unity is observed in most of the countries.

The Committee believed that, in line with this unifying trend, the hospital is being incorporated to an ever greater degree into a single health structure.

B. PLANNING AS THE BASIS OF TECHNICAL ADVISORY SERVICES

The Advisory Committee agreed, in principle, on the need for the Pan American Sanitary Bureau to establish an adequate structure to strengthen and enlarge the technical advisory services that the Governments are requesting more and more.

Nevertheless, and before considering this fundamental objective of the Meeting, the Committee considered those aspects that imply a close relationship between planning and technical advisory services, as a matter worthy of prior consideration.

The Committee made a clear distinction

[1] See p. 68.

between planning of the health sector and planning of health activities.

With regard to planning of the health sector, it took up the problems related to the development of a national "system" for creating a well-formulated structure of the public subsector, designed to insure the effective functioning of the services offered to the people. It was pointed out that in the Latin American countries the public subsector is not generally controlled by a single agency, and this occasionally leads to a high degree of dispersion of effort. It is urgent to solve this problem and then to assure internal coordination, both technical and administrative, so that administrative activities will not hamper, but rather facilitate, the technical ones. Health services must be provided on the basis of adequate regionalization, supplemented on the higher level by a degree of centralization that will assure the necessary unity of directives.

An important problem is the coordination between the public and private subsectors, directed toward greater effectiveness of the national system. To that end, it is essential that the private subsector be incorporated into the general plans established for the public subsector, in accordance with that which each country deems most necessary and feasible.

A second point has to do with the administration of the system as such, that is, the need to develop and apply techniques that will insure maximum effectiveness in the use of the resources of the health sector. This calls for a full knowledge of the available resources, and of their yield and distribution, and the greatest possible degree of integration of activities, as a technical requisite to their proper utilization.

A third group of problems deals with personnel, in regard to training, working conditions, and recruitment and remuneration policy. Because of the active role they are called on to play, qualified health workers are needed in sufficient numbers. Finally, problems of construction, equipment, and functioning of the executive units, by whatever name they are known, were considered.

As to the planning of activities, there are three basic aspects to consider, the classic aspects of planning: demand; capacity for service; and short- medium- and long-term goals. Present demand is generally considered to be the volume of services furnished the population at any given moment, without overlooking the potential demand corresponding to real needs, in accordance with desirable and feasible levels. The capacity for service with regard to quantity and quality implies a study of available resources, of both the public and private subsector, and their yield in present-day terms. As for the determination of the goals desired by the community, their level is established as a result of combining the potential demand with the present and future capacity for providing health services, the magnitude of which determines the extent and orientation of the necessary effort. It is in regard to these points that technical advisory services take on special importance in insuring the improvement of the health services currently being provided.

The Advisory Committee bore in mind the different level that the countries of Latin America have reached with regard to structures for the national planning of economic and social development, intersectorial collaboration or understanding, or subsectorial dispersion, and the urgent need for a closer interdisciplinary bond between professionals and technicians, both in the national and in the international field.

With relation to this point, the Advisory Committee discussed the advisability of intensifying and strengthening the technical advisory services that the Pan American Health Organization has been furnishing to the Governments. Without a doubt the new ideas of economic and social development planning, with the health sector considered as one of its components, will bring as a consequence an increase in such requests in

the near future. How can this need be met with a view to improving the health services?

The Committee agreed that the application of known techniques would permit an efficient solution of problems of organization and administration, of personnel management and training, of constructions or expansive programming of the services, and more effective utilization of the installed capacity. In principle, after considering the existence of these techniques, the group concluded that technical advisory services of the Organization to better serve the Governments requesting them were entirely feasible.

It should be borne in mind, however, that the economic situation of the countries seriously limits their possibility of devoting the necessary resources to health care; that limitation can only be partially overcome by means of international assistance. For this reason, the Committee deemed it necessary to recommend that technical advisory services to the countries be directed, basically, toward improving the use of resources allocated for health, as the most effective and accessible means of increasing their return.

C. COORDINATION OF HEALTH SERVICES

Much of the Advisory Committee's discussions was devoted to an analysis of this problem, mentioned in another part of this document, in terms of a dispersion of energy produced by the lack of understanding, on the various levels, between the different agencies of the public and private subsectors that provide health services in one way or another.

The Committee called attention to a common situation in many countries, where there is a lack of coordination between the various branches of the ministries themselves, and also in their relations with other subsectors, especially the private one. This lack of collaboration and understanding between the various subsectors of the health sector leads to a deterioration of the health sector and to defective planning of field activities.

The secretariat of the meeting informed the Committee that a Study Group [2] had met between 12 and 16 July, under PAHO/OAS auspices, to analyze the relations between the medical programs of social security institutions and the ministries of health or other governmental health agencies. The Committee took a stand in favor of those conclusions, among others, that are related to the topic under discussion in order to assure that the various institutions of the health sector will make rational use of available resources, indicate the methods that will produce the greatest possible yield from those resources, see to it that future investments and contributions will be in keeping with needs so as to guarantee their maximum utilization, and build in common the future health services in areas not yet covered.[3]

With regard to the foregoing, the Advisory Committee adopted the following general recommendations:

1. Initial coordination of services pertaining strictly to the public or governmental subsector (nation, states or provinces, towns), as being the most feasible.

2. Operative and interdisciplinary coordination of the technicians of the different sectors, especially physicians and economists, within a single program.

3. Promotion or improvement of health legislation, as needed, to avoid duplication of services and unnecessary constructions.

4. Use of applications for loans from abroad to promote a better health organization within the requesting Governments or agencies.

5. Intensification of efforts at coordination or active collaboration that the Pan American Health Organization has been pro-

[2] See first part of this publication.

[3] See pp. 51-52 and 53-54.

moting between various international agencies.

Finally, the Advisory Committee decided to support the concept of coordination adopted by the above-mentioned Study Group: "By coordination should be understood the methodical and orderly use of all available human and material resources in the different public and private institutions for health care."

D. HEALTH RESOURCES

The Committee discussed the major problems related to the human resources of health in terms of personnel. In general, personnel are in short supply and poorly distributed in the various countries, being concentrated mainly in the capitals and large cities, to the detriment of smaller communities with low population density, especially the rural sectors.

It was believed that a study should be made of personnel needs and of the optimum proportion that should exist between the various medical groups, nonmedical professionals, nurses, and auxiliaries, to obtain a better yield from health services and to permit more effective programming of their activities. There is also a need for better utilization of personnel, who should be assigned specific functions in keeping with their capacity and training, and not be charged with other unrelated duties. It was recognized that the personnel should have fair remuneration, better working conditions, and opportunities for advancement.

With regard to the personnel shortage in the various groups, the Committee saw a need to promote the training of medical personnel specialized in administration, nonmedical personnel to be assigned administrative functions, auxiliaries, and others. The Committee took note of the fact that the Inter-American Development Bank is lending financial support to an educational program that might be extended to the health field.

As for material resources, the Committee thought it advisable to standardize the current terminology with regard to health services, hospitals, equipment, and so on, in order to facilitate the advisory work of international organizations in this field. It stressed the role of the hospital as a component of a health service.

In view of the lack of information on the full extent of existing resources and their distribution in the countries, the Committee called attention to the urgent need for periodic surveys conducted by specialized personnel, both national and international, in accordance with jointly established standards. Such a survey would deal with quality and utilization as well as quantity.

During the discussions, the members of the Committee stressed the various aspects of the organization and administration of hospitals and health services and the use of certain specific indices to indicate the yield and effectiveness of the programs. Attention was called also to the importance of the outpatient clinic and home care as basic factors in a more rational and economical use of health resources.

The Committee agreed on the need to apply modern methods and techniques of business administration to health services.

The Committee was aware that health expenditures should be considered in terms of operation and of capital or expansion. Services can be financed by public funds, mutual funds, and direct assessment of the beneficiary. In analyzing these last two sources, the group noted that, unfortunately in many cases, the quantity and quality of the services received by the beneficiary still depend on his financial resources. The Committee stressed the urgent need to correct this situation.

E. PLANNING OF HOSPITALS AND OTHER HEALTH SERVICES

The Advisory Committee, taking cognizance of the good relations between the Inter-American Development Bank and the Pan American Health Organization, studied the statement of the Representatives of the IDB concerning the need for an understanding between both organizations whereby the Bank would receive advice from PAHO concerning the frame of reference and criteria for the consideration of projects submitted by countries in this sector and on the machinery for their implementation. The Committee believed that such an understanding between the two agencies could be reached in the near future, but that its implementation would have to await the results of the preliminary investigations to be carried out in the countries themselves.

The Committee analyzed all aspects relating to procedures, constructions completed in recent years, their cost, equipment problems, future construction, extraordinary expenditures for foreign advisory services, and maintenance, renovation and repair of buildings used for health purposes.

In this regard, it stressed:

1. That all construction or remodeling should be part of a national construction plan designed to put into effect and/or improve the medical care services of the community.

2. That requests, from any institution whatsoever, must be a part of, and a definite role in, the national construction plan.

3. That staffing, equipment and installations, and operating budgets should be taken into account during the preinvestment stage.

4. That special attention should be given to the expenditures that, in certain cases, result from foreign commercial advisory services and to the contractual arrangements involved.

5. That, with regard to construction costs, the most suitable indices should be established to control the margins of acceptable variation.

6. That it is imperative to move toward standardization as a means of reducing the costs of equipment and supplies, and of construction wherever possible, so as to achieve a better utilization of the resources.

7. That the foregoing statements regarding new buildings apply also to the repair, maintenance, and remodeling of existing facilities.

8. That national resources should be utilized to the fullest extent possible in carrying out these construction plans, with international credit being requested to promote a better mobilization of domestic resources and in no case as a substitute for them.

F. CONCLUSIONS AND RECOMMENDATIONS

The terms of reference and background for the work of the Committee, the questions formulated by the Director of the Pan American Sanitary Bureau in his opening speech, and the analysis of the concepts and problems set forth in the present report serve as the basis for the following recommendations:

1. The Pan American Sanitary Bureau should strengthen and expand its present organization in order to intensify its work in these areas:

Studies and advisory services to countries and international organizations on the following matters:

(a) Planning and organization of national health services based on adequately regionalized systems, in which existing resources would be utilized more effectively and costs and priorities in expenditures and investments would be established.

(b) Administration of hospitals and other health services as a means of achieving greater efficiency and yield from the resources.

(c) Study of manpower needs, in terms of personnel of various categories, and possibilities for education and training.

(d) Efforts to promote the incorporation of these concepts into the curricula of medical schools and to interest universities and other educational centers in research on these matters.

(e) Costs and financing of the various systems, including the participation of social security.

(f) Utilization of international resources so that, in addition to their immediate purpose, they will serve to promote an increase in and more effective use of national resources being applied for the same objectives.

2. To carry out these functions, it is suggested that the Pan American Sanitary Bureau establish a department with personnel trained in administration and planning (physicians, economists, architects, and other professionals) who are specialists in the activities outlined above, drawing upon all of its present organizational structures that further this end. There should be two types of personnel: permanent and temporary. The Bureau should also maintain a roster of individuals and firms that specialize in such matters.

3. This branch, so conceived, should maintain and intensify its working relations and liaison with the Organization of American States, the Inter-American Committee on the Alliance for Progress, the Inter-American Development Bank, the United Nations agencies, and other public and private international agencies interested in this matter.

4. A permanent Advisory Committee should be established, composed of outstanding persons in the field and representatives of public and private international agencies that lend financial and technical assistance in this area. The functions of this Committee would be to advise the Bureau in carrying out the tasks outlined in the preceding paragraph and to promote coordination in the use of national and international resources.

5. The minimum requisites for recommending priority standards for the approval of country requests might be:

(a) Existence of national or local economic and social development plans, under study or in progress, which show a proper relationship and balance between the different sectors.

(b) Willingness and ability of the requesting Government to adopt the structural, organizational, and administrative measures required for the attainment of goals, by means of appropriate reforms.

(c) Status of preinvestment studies.

(d) Willingness to contribute demonstration and application areas, and size and importance of such areas.

(e) Technical integration of preventive and curative activities and administrative coordination of the various health institutions.

On 30 July at 9:00 a.m., the Advisory Committee held its final session to discuss the draft of the Final Report, which was unanimously approved with the addition of several clarifying statements.

Speaking for the members of the Committee, the Chairman expressed satisfaction and pleasure at the manner in which the working sessions had been conducted and at the atmosphere of harmony and understanding that had prevailed. He expressed the hope that the recommendations made by the Committee in the Final Report would help the Organization comply with Resolution XXV.

Mr. Alfred C. Wolf, Program Adviser to the President of the Inter-American Development Bank, offered the apologies of Mr. Felipe Herrera, who was unable to be present to discuss the work that he and his colleagues on the Advisory Committee had been describing in the various working sessions. "We are ready," Mr. Wolf said, "to collaborate with the Organization in defining terms, conditions, and standards for carrying out the programs, and in preinvestment

projects formulated by the Member Governments through the Pan American Sanitary Bureau."

In bringing the activities of the Advisory Committee to a close the Director of the Pan American Sanitary Bureau thanked the Chairman and the members of the Committee and the Inter-American Development Bank for contributing their experience and authoritative views to the sessions. He then said:

"We are going to do everything in our power to see that the ideas you have left recorded in this report will become a reality. I like to think that this matter will acquire within the Organization a structural, budgetary, and functional identity which, naturally, will have to be expanded to the extent and in the manner that the Governments determine. I should also like to make special mention of the representation of the Inter-American Development Bank, the statements I was privileged to hear in the first session, and subsequent conversations with the IDB Representative on this Committee, and to say that I am confident that your recommendations can be carried into effect. Thanks to the interest, policy, and initiative of the Bank, a number of activities in the health field are now being conducted in Latin America, in a manner hardly thought possible. A few days ago, at a meeting of officials of two Zones held in Montevideo, a summary was made of water service activities to June 1965. It was pointed out that national and international investments in excess of $600 million have improved the quality, quantity, and distribution of water to more than 40 million persons in Latin America. I believe that the same thing is going to happen in this field, in which, naturally, there are far more experience, a long tradition, and therefore old habits. I hope that your ideas will serve as guidelines for the modernization of the systems to benefit the largest number of persons."

MEMBERS OF THE ADVISORY COMMITTEE

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IV. RESOLUTION OF THE XVI MEETING OF THE PAHO DIRECTING COUNCIL

Resolution XXXVII [1]

Planning of Hospitals and Health Facilities

THE DIRECTING COUNCIL,

Having considered the Final Report of the Advisory Committee on Planning of Hospitals and Other Health Facilities (Document CD16/24)[2] prepared pursuant to Resolution XXV [3] of the XV Meeting of the Directing Council;

Bearing in mind that one of the basic health services is the provision of medical care and that, because of its importance and the financial burden it represents for the economic development of the countries, measures will have to be taken on a continental scale to strengthen medical care services in the countries and to coordinate their activities for the sake of timely provision of services, reduction of costs, and efficiency; and

Considering that the construction of new health facilities and the remodeling of existing ones, including hospitals, and the improvement of their organization and administration, are an indispensable part of any continental, national, or local policy,

RESOLVES:

1. To take note of the Final Report of the Advisory Committee on Planning of Hospitals and Other Health Facilities (Document CD16/24) and to thank the Director of the Bureau and the members of the Committee for the work accomplished.

2. To recommend that the Pan American Sanitary Bureau, within the limitations of existing program priorities, expand its present resources for this purpose so that it can cooperate in studies and provide countries and international agencies with advisory services in the following fields:

(a) The planning and organization of national health services, which should be based on appropriate regional systems with a view to achieving optimum utilization of resources by establishing costs and priorities in expenditures and investments.

(b) The administration of hospitals and other health services with a view to increasing their efficiency and performance.

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[1] Approved at the fifteenth plenary session, held 7 October 1965.
[2] See pp. 124-132.
[3] *Official Document PAHO* **58**, 78-79.

(c) The assessment of the need for various types of personnel and for facilities for their education and training.

(d) The incorporation of the above-mentioned subjects into the teaching programs of medical schools and the encouragement of research on these subjects by universities and other educational centers.

(e) The costing and financing of various medical care systems, including independent and semi-independent services, and of the construction and equipping of hospitals.

(f) The utilization of international resources so that, in addition to meeting the purposes for which they are intended, they stimulate the increase of national resources for the same purposes as well as better use of those resources.

3. To request the Director of the Bureau to establish suitable machinery for putting these objectives into practice, and to avail himself for that purpose of the currently available resources connected with this type of activity.

4. To recommend that the Pan American Sanitary Bureau strengthen its working relations with public and private international agencies active in this field, with a view to ensuring that the planning of hospitals and other health facilities occupies its appropriate place in medical care programs and, consequently, in national health programs.