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METHODS OF INCREASING HEALTH SERVICES COVERAGE IN RURAL AREAS

MEDICAL CARE IN THE RURAL AREAS

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There is general agreement among statesmen and economic and social development experts that the lagging development of the countryside continues to be the principal obstacle to the growth of the region.

Medical care services are a manifestation of the economic and social development of a region and necessarily reflect the general characteristics of its progress. The development of services to the community is usually consistent and parallel with the development of the output of capital and consumer goods. Medical care cannot be expected to be of high quality when educational and communications services are deficient, and it would be unrealistic to expect all of those services to attain an adequate stage of development when the industry, agriculture and trade of a region were in an utterly backward state.

This is especially true in the case of medical care services. It is a known fact that the cost of high-quality medical care has risen uncontrollably in recent years, owing to the progress of medical service and technology and the demands for service in a community increasingly knowledgeable in health matters. The cost of those services must of necessity be paid by the community that uses them, sometimes directly, by the individual patient at his own expense, and other times indirectly through social security schemes, which are essentially systems of income-distribution. Finally, in some countries the services are financed by the National Treasury, which recovers the cost from the community in the form of taxes.

This inexorable and invariable economic fact is responsible for the poor quality and insufficiency of the medical service rendered to the rural communities of Latin America. Population groups with a low per capita income, residing in small communities scattered throughout extensive agricultural regions with poor means of communication, and often isolated during times of the year, inevitably have scant ability to pay for medical services and offer little incentive to health professionals to settle there. In view of the limited number of physicians and other medical professionals in those countries, they concentrate in the urban areas, where the economic, social, scientific and cultural environment is more favorable to the practice of their professions.

The characteristics described above are common to the rural areas in most of the Latin American countries and adversely affect the problems of health in the countryside. Social tensions and unrest, created by these living conditions, are becoming a serious problem for all the American Governments, which assumes even greater proportions if the size of the rural population is considered. The latest available statistics show that in spite of all the efforts to foster industrialization, no less than 47% of Latin America's economically active population is engaged in agriculture and lives in the rural areas. (See Tables 1 and 2).

TABLE 1

THE AGRICULTURAL SECTOR AS PART OF THE ECONOMICALLY ACTIVE POPULATION IN THE AMERICAN COUNTRIES*

(Source: ILO, Yearbook of Labor Statistics, 1965)

(in thousands)

Country	Year	Agricultural Sector	Total economically active population	Agricultural Sector as % of total economically active population
Argentina	1960	1,461	7,599	19.2
Bolivia	1950	672	1,059	63.5
Brazil	1950	10,370	17,117	60.6
	1960	11,698	22,651	51.6
Canada	1965	619	6,911	9.0
Chile	1960	662	2,389	27.7
Colombia	1951	2,023	3,756	53.9
Costa Rica	1963	194	395	49.1
Cuba	1953	819	1,972	41.5
Dominican Republic	1950	466	826	56.5
Ecuador	1962	802	1,443	55.6
El Salvador	1961	486	807	60.2
Guatemala	1950	660	968	68.2
Haiti	1950	1,454	1,747	83.2
Honduras	1961	379	568	66.7
Jamaica	1960	237	655	36.1
Mexico	1960	6,144	11,332	54.2
Nicaragua	1963	283	475	59.6
Panama	1960	156	337	46.2
Paraguay	1962	322	617	52.2
Peru	1961	1,556	3,125	49.8
United States of America	1960	4,519	69,877	6.5
	1964	5,057	76,971	6.6
Uruguay	1963	182	1,016	17.9
Venezuela	1961	774	2,407	32.1

*Reproduced from: International Labor Organization, "Papel de la Seguridad Social y del Mejoramiento de las Condiciones de Vida y de Trabajo en el Progreso Social y Económico", Eighth Conference of American States Members of the ILO, Ottawa, 1966.

TABLE 2

ECONOMICALLY ACTIVE POPULATION ENGAGED IN AGRICULTURE

IN LATIN AMERICA *

Year	Percentage of Total Active Population
1936	59.2
1940	58.0
1945	55.9
1950	53.2
1955	49.9
1960	47.0

Source: ECLA

*Reproduced from: Inter-American Conference on Social Security, "Memoria de Labores" (Proceedings), Vol. II, Reports and Documents, VII Meeting of the Conference and XII Meeting of its Permanent Committee. General Secretariat, Mexico, 1964.

In the last 20 years the Latin American Governments have shown increasing interest in promoting the development of rural communities. The national and international plans for achieving this purpose have been directed chiefly to the promotion of agricultural technology, construction of roads and other transport facilities, electrification, housing, and, in the sanitation field, water supply and the elimination of certain insect vectors of disease.

No one can deny the importance of these programs, which have doubtless helped to raise the standard of living in Latin America's rural communities. More recently, however, the governments have recognized the necessity of providing medical and educations services to these communities to satisfy their most pressing needs. As a result of this new approach to the promotion of rural development, various Latin American countries have, in the past few years, undertaken programs to build the necessary infrastructure that will serve as a basis for the network of medical and educational services, allowing them to extend the benefits of health and culture to communities hitherto deprived of those fruits of progress.

The types of health services most commonly found in the rural areas are described in Document CD17/DT/1 and will therefore not be discussed in this paper.

1. Coverages provided by Social Security Medical Services

One of the risks traditionally covered by social security institutions is the risk of disease. While the extent of this coverage varies widely from country to country, it can generally be said that there is a tendency to postpone the coverage of rural communities, not as a deliberate decision of the social security institutions, but rather for well-known financial and administrative reasons, including the inability of the rural communities to pay the premiums for health insurance. Another reason for this postponement has been the shortage of physicians and other medical professionals in the rural areas. And a no less important factor is the shortage of adequate roads and other transport facilities, which makes it extremely difficult to reach the rural areas.

Table 3, prepared by the Organization of American States, clearly shows the inadequacy of health insurance coverage in the rural areas of certain Latin American countries. Since the figures in the table are not based on a representative sample of Latin America as a whole, no general conclusions can be drawn from them, but it is still impressive to note the almost negligible coverage of farm workers in the countries considered. In those countries where the social security institutions have extended medical insurance coverage to the rural communities, they did so primarily by providing out-patient service and also, in some cases, by leasing beds in hospitals operated by Ministries or charitable institutions, e.g. beneficencias, santas casas, patronatos, etc. Unfortunately, these services are absolutely inadequate, in both quantity and quality, to meet the needs of the population.

TABLE

SOCIAL SECURITY IN THE RURAL AREAS OF LATIN AMERICA: RISKS COVERED AND NUMBER OF INSURED CONTRIBUTING WORKERS, 1962 *

Country	RISKS COVERED							Number of insured contributing workers
	Old Age	Disability	Death	Illness	Maternity	Work Accidents	Family Allowance	
Argentina	X	X	X			X a/		450,000
Chile	X	X	X	X	X	X a/	X	358,900
Colombia				X	X	X a/	X	38,000
Costa Rica				X	X	X a/		55,200
Dominican Republic	X	X	X	X	X	X a/		...
Guatemala				X b/	X c/	X		132,973
Haiti						X		...
Mexico	X	X	X	X	X	X		138,082
Paraguay	X	X	X	X	X	X		10,047
Peru	X	X	X	X	X	X a/		...
Uruguay	X	X	X			X a/	X	150,094
								1,333,296

Sources: Direct information from the social security institutions. For Guatemala: Boletín Mensual, Guatemala (Actuarial and Statistical Department of the Instituto Guatemalteco de Seguridad Social), No. 4, April 1963, p.5.

a/ Some farm workers are covered by the labor laws.
b/ Non-work accidents only
c/ Department of Guatemala only.

* Reproduced from: Pan American Union, General Secretariat of the Organization of American States, "Estudio Social de América Latina 1962", prepared by the Department of Social Affairs. Washington, D. C., 1964.

The ability of the social security institutions to extend their benefits to rural communities is subject to limitations of various kinds. In the first place, the legal concept of "coverage" by social security institutions is subject to a financial condition imposed on the insured, who must contribute a "quota", usually a percentage of his salary, for the support of the services. In some countries the social security laws have extended coverage to dependents, i.e. the immediate members of the family of the insured. All of these legal and financial concepts of social security are subject to definitions, interpretations, identification of the insured and his family, etc., and to a series of cumbersome administrative procedures which are extremely difficult to apply in the rural communities, especially in agriculture, because of the characteristics of farm management and operation in Latin America. For all of these reasons the system is almost impracticable and, if established, unduly high in cost.

Recognition of all these limitations and difficulties by the social security institutions is leading to the conviction that it is essential and urgent to introduce a substantial change in the juridical, financial and legal arrangements which are currently hindering the extension of medical benefits to rural communities. If the agricultural worker cannot afford to contribute to the support of the social security institutions, it will be necessary to seek some other source of financing, which would logically be the proceeds of collective operations under the new systems of land tenure established by land reform in several Latin American countries. Moreover, if it is recognized that the rural inhabitants are entitled to health regardless of whether or not they contribute to a social security system, it is obvious that the term "beneficiary" or "insured person" must also be redefined to make it clear that the entire rural population, with no exceptions, is entitled to benefits.

2. Coverage of Medical Benefits by Government Services

Although the purpose of the Latin American Governments is to bring about a fundamental change in the agrarian structure of their countries, the fact is that structural change in the conditions of land tenure has yet to come about on a substantial scale and that poverty continues to dominate the rural scene in Latin America, particularly because of the underutilization of human and natural resources. As a result of this, social security has not been able to extend its medical care benefits and the countries are confronted by a *de facto* situation which obliges them to provide medical services in order to meet an increasing demand which threatens to erupt into social violence unless it is satisfied with sufficient speed.

The medical care coverage offered by the Ministries of Health is theoretically universal. The benefits have been provided through hospitals or other health facilities operated by the Ministries themselves, or by charitable institutions regulated or supervised by the Ministries. This coverage has been universal only in theory, since the public and philantropic services combined have rarely been able to meet the demand or to provide reasonably good medical care. Despite, this, however, the coverage has been

more extensive than that provided by social security institutions and, even though insufficient, has had the virtue of establishing a potential entitlement to which all the inhabitants of the rural community may legitimately aspire.

From a conceptual point of view, the health services of the Ministries have introduced combined preventive and curative services in the rural areas and have accounted for undeniable technical progress and for substantial improvements in the health conditions of rural communities. This can be readily verified by examining the infant and child mortality curves, water supply statistics, rates of immunization against communicable diseases and other health indexes for rural communities having integrated health services.

3. Reforms adopted by the Countries

A problem common to both groups of medical services -those organized by the Ministries of Health and those operated by the social security institutions- is the lack of sufficient funds and the difficulty of obtaining skilled personnel to provide high quality benefits. The solutions adopted by various countries have tended to pool all the human and material resources of the different institutions of the public sector responsible for providing medical benefits to rural communities. However, the degree of actual coordination or integration has varied from country to country.

In Peru, for instance, a system has been in effect since July 1965 in which the Ministry of Health and the National Security Agency have entered into local agreements, to which the Ministry of Labor and Indian Affairs and the Worker's Social Security Agency have some times also been parties, establishing local health districts headed by a Chief who is in turn assisted by an Advisory Committee, a small consultive and coordinating group established at the local level by government decree.

Venezuela, too, has long had a system of agreements between the Ministry of Health and Social Welfare and the State Governments to establish Cooperative Public Health Services, which are decentralized organizations especially designed to provide comprehensive health protection to rural communities through hospitals and rural health centers by means of the system known as "simplified medical care". More recently the country has been planning for greater coordination with the intention of eventually establishing a unified health service with the participation of the Ministry of Health and Social Welfare and the Venezuelan Social Security Institute.

In Mexico the National Social Security Institute decided several months ago to extend its medical facilities to the agricultural workers, which will probably be done by making more intensive use of 1,539 rural health centers, built in the last few years by the Ministry of Health and Welfare, that have only operated at partial capacity. At the present time a preliminary survey of service requirements and available resources has been made as a preliminary step to the actual implementation of this new program.

Chile enacted a law as far back as 1952 establishing a National Health Service with the participation of the Ministry of Public Health, the Social Security Service and the former Social Welfare Services. In fulfillment of its legislative mandate the National Health Service has established 76 rural hospitals and 461 rural health centers devoted to providing integrated medical care to the rural communities within a regional health system for the entire country.

4. Regional Planning of Health Services

The current trend in the planning of economic and social development has made it necessary to plan the health services on an integrated basis, coordinating the use of all the human and material resources available in both the public sector (including the social security institutions) and the private sector, for the provision of health benefits. Administratively, regional organization implies coordinating all the health establishments of a given region so that together they will be self-sufficient in providing integrated health benefits to all the inhabitants of the region. Each region should include an urban, a suburban and a rural sector. The rural hospitals should be designed to serve as a focal point from which all the health services to the community will emanate. As a logical corollary, the establishment of rural hospitals should be based on a reasonable expectation that the hospital can develop and maintain the highest standards of medical care and that its location will be the natural center of attraction for the surrounding rural area.

5. Training

As already stated, it is unrealistic to expect highly specialized services in the rural areas. Medical specialties are restricted to the base hospitals of the health regions, which are usually in the urban areas.

In the rural areas there can only be general medical services, and because of the scarcity of medical personnel in the Latin American countries, these should be operated by a general physician who should be trained by the School of Medicine and given the knowledge required to diagnose and treat common diseases, along with sufficient good judgement to refer the more complicated patients to the regional hospital if they cannot be treated at the local level, and with sufficient knowledge of preventive and social medicine and of medical service administration to be able to cope effectively with problems of epidemiology, rehabilitation, social security and administration that will inevitably arise in the course of his one-man professional practice in a rural community.

The direct auxiliary of this general physician in a rural community should be a university-trained obstetrical nurse with sufficient knowledge of public health work and care of the sick, including midwifery, to be able to handle the more common problems of illness without supervision. An adequate number of nurses' aids will complete the minimum team for providing medical benefits to a rural community.

6. Limitations of Health Services in Rural Areas

A survey of regionalization and rural health*, sponsored by the W. K. Kellogg Foundation in three communities of the State of Michigan, mentions the following limitations, which are equally applicable to the health services in the rural areas of Latin America:

1. Low productivity. In view of the low results, the cost per unit of medical care is very high.

2. Rural health services find it difficult to attract and retain qualified professional and administrative personnel.

3. There are too few physicians, which makes it impossible to encourage critical discussion of clinical cases, a key to success in larger hospitals.

4. The inability to purchase costly equipment and installations results in a lack of sufficient resources to provide good-quality medical care.

5. Rural communities have a strong tendency toward self-sufficiency, and it is a matter of local pride for a community to have its own medical services. The result is an inevitable tendency toward duplication, and a danger that the rural health service will assume responsibilities which it is not capable of performing.

6. Distance, although still a phsychological factor, is rendered increasingly unimportant by the progress in highway construction and transport facilities.

In order to surmount the difficulties described in the preceding paragraphs, which affect rural hospitals and health centers and make it all but impossible to extend high quality health service to the rural areas, the following measures have been suggested:

1. Establish fewer but larger hospitals. This will facilitate coordination, afford more attractive working conditions to medical and administrative personnel and make it possible to organize a medical team with sufficient diagnostic and therapeutic resources at its disposal to cover a larger area. An essential condition is that the area have relatively good roads and that the hospital have a sufficient number of ambulances for the movement of patients.

*"Regionalization and Rural Health Care", by Walter J. McNerney and Donald C. Riedel, The University of Michigan, Ann Arbor, 1962.

2. The regional hospital and its satellite, the rural hospital, should be owned and operated by a single, non-profit authority.

3. The physicians and other personnel of the rural services should be an integral part of the health team of the regional hospital, so that the closest working relations will exist and the physician in the rural service can be entirely free to improve his knowledge and care for patients in the regional hospital. Only in this way will he accept the technical and administrative supervision that the regional hospital must exercise over the rural hospital.

4. The financing of rural services must be based on assured sources of funds and must encompass, along with first-class medical care, the financial protection of the patient and his family.

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