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DELIVERY OF HEALTH CARE IN LATIN AMERICA:
CURRENT PROBLEMS AND FUTURE PERSPECTIVES

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1. **Introduction**

During the last few years, the governments of a number of countries have been under increasing pressure from groups within their populations demanding the organization of health care services, to satisfy their medical needs. The problem is not only the establishment of new facilities but also the organization of a system to provide access to existing services and at the same time guarantee their scientific quality so they will be acceptable to the whole population.

It is therefore possible to foresee that in the next few years governments will make every effort to establish national health systems designed to achieve a maximum productivity from available resources at a cost compatible with the financial ability of the Gross National Product to pay for health services.

Coordination programs set up by different countries to achieve better results have been encouraging, but their goals have been limited by the administrative weaknesses of the Ministries of Health as well as by the reluctance of other public and private health care institutions to submit to supervision and control by the Ministries of Health. In addition, one cannot ignore the influence of different political pressures on the design of a national health system in which central planning, administrative controls, standardization of methodology, and evaluation of productivity bring the whole practice of medicine and allied professions within a basic structure, in which private initiative and free choice of doctors and patients are no longer applicable.

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2. Current Problems

2.1 The health care system

Three main elements have to be studied in order to analyze present health care services in Latin America. The first is the demand for services, which is expected to include the needs and aspirations of the population duly corrected by strong variables, such as the purchasing power of the people, the motivation of individuals to accept services, and the services' accessibility to anyone in need of health care. The second element in this analysis is the human, material, and financial resources, and the third is the administrative process for planning, organizing, and directing the services. An important part of this administrative process is the assignment of personnel to control the production and delivery of health services efficiently and effectively.

In most Latin American countries a plurality of health care systems exists. They are competitive among themselves and result in wasted resources and uneven coverage of different population groups, and contribute to raising costs. One can find health care services belonging to the Ministry of Health that theoretically cover the whole population but, in practice, are incapable of undertaking this responsibility, especially in rural areas. Social security institutions, following their basic concept of social solidarity, provide health care directly or indirectly to eligible contributors. Finally, the social assistance programs, usually financed by large grants from the national budget, take care of indigent groups. In addition to the foregoing, which are the most important, there are other services belonging to the armed forces, the police, the railroads, special groups of private enterprises' employees, Red Cross, etc. Moreover, the private practice of medicine still plays an important role in most of the Latin American countries and has to be paid for by the consumer or by a social security institution on his behalf.
These various health care systems exist in practically all countries, with a greater prevalence of one or another according to the stage of development of the country concerned. The common feature of all these systems is that they are combined arbitrarily and compete for resources and consumers. This results in almost chaotic delivery of health services—privileged groups that have at their disposal services of high quality, while others have no access to any kind of care at a time when the diagnosis and treatment of diseases have reached the highest degree of scientific development.

2.2 Demand for services

The demand for health care services is the result of past experience submitted to the careful weighing of conditioning factors, such as needs and aspirations of the community, availability of services, as well as their utilization, productivity, and accessibility. The interplay of all these factors may alter the capability of the system to provide universal coverage of the health needs of a given population.

Health needs are not always recognized by the individual unless an education program has taught him the benefits of good health. The perception of health needs by population groups in a given society varies according to the cultural level of the groups concerned, and within the same society there may be groups with entirely different aspirations concerning health services.

The accessibility of health services is another element that may have a great impact on the volume of the demand. If the services are not available at all, the population resigns itself to live without them, but as soon as a new service is established a new demand becomes apparent and very often is exaggerated by the accumulation of health problems that the population wants to have solved at once. The existence of health insurance programs for selected groups of the population is also a factor that distorts the demand, since services are accessible only to beneficiaries of the insurance system. The sense of co-ownership of these groups induces them to demand more services than necessary with the conscious or subconscious intention
of getting back in kind a part of the money they have contributed.

All these elements have to be considered in any study of the demand for services. However, usually, the only statistical information available is about final services, i.e. number of hospital discharges per 100 population and number of outpatient consultations per 100 population. Emergency services, domiciliary care, dental care, and other services are not included in these statistics. The present output of services in Latin America shows in only two countries figures of 10 discharges per 100 population and more than 200 outpatient consultations per 100 population.

To have accurate information, more research is needed in the fields of cultural anthropology, social psychology, and utilization and productivity of health services.

2.3 Capacity to meet the demand

The ideal goal of universal coverage is far from being achieved, mainly because resources, both human and material, are wanting.

As far as hospital beds are concerned, in 1969 all countries of Latin America and the Caribbean had 632,771 beds, or an average of 2.3 per 1,000 population, ranging from 6.4 to 0.7. Only three countries in Latin America have a rate of 4 or more beds per 1,000 population, which might be considered a satisfactory minimum. What is still more important is the trend observed during the 1960s in which these rates have definitely decreased because the population increase has outstripped the increase in beds.

In 1969, there were 186,378 doctors--a rate of 7 per 10,000 population--in Latin America and the Caribbean area. The range was from 0.8 to 22.3 doctors per 10,000 population. Twelve countries in the region had an average of 5 or more doctors per 10,000 population. Although this ratio may be considered a satisfactory minimum the situation is aggravated by the fact that qualified nurses number 0.3 per physician and the distribution of professional personnel within each country is extremely uneven, with concentration in large cities.
Any program intended to extend coverage of the population and meet present and future demand for services will necessarily have to consider, as a first priority, increasing health manpower as well as physical facilities to an extent that can make health plans and programs feasible. Under present circumstances, it can be said that only a few countries in Latin America have the minimum resources to meet the demand for health care services completely.

What is questionable is the rationality of pegging health progress to the implementation of a construction program, which may cost billions of dollars, or to the development of professional manpower that may take 10 or more years.

The urgency of organizing a well-balanced health care system is such that solutions to the problem are needed now. The population cannot wait any longer. Models adjusted to national realities have to be designed and implemented within the next few years. Systems analysis, operational research, and studies of utilization and productivity should be started in every country as soon as possible to establish solid foundations for the political decision to launch a national health care system. Such a system should be feasible and viable with the resources available at present. What is needed is to ensure better utilization and productivity of resources and a fresh approach to health care and doctor-patient relationships.

2.4 Quality, quantity, and costs of services

Within present circumstances, the ideal goal of universal, comprehensive, adequate, and high-quality coverage of the population is probably unattainable. From the social point of view, there is always a tendency to extend the provision of health services to larger groups of the population in an effort to reach the ideal of universal coverage in the near future. Although some countries may have the resources to achieve such an objective, the fact remains that a system to make rational use of existing resources and make services available and accessible to the whole population is lacking
in every country. It is understandable that governments try to satisfy the aspirations of the population and make every effort to extend coverage as much as possible. Unfortunately, since human and material resources do not grow at the same pace, the result is that the increase in quantity of services provided is usually made at the expense of their quality. One has to recognize, nevertheless, that to reach universal high-quality coverage makes the costs of services so high that neither the institutions nor the individuals are able to pay the bill. There are, however, some elements that might be improved. Comprehensive national health plans are very often put into operation before the inadequacies and high costs of present programs are examined. There is no doubt that diagnosis and treatment may be provided through different means, and that a great number of diseases are simple enough to be treated ambulatorily, but only infrequently do countries make any attempt to reach uniformity in the quality of care provided by their different institutions or to qualify certain establishments for the treatment of certain diseases or to classify health services according to their facilities and resources in an effort to organize progressive patient care.

In practically every country the situation is becoming almost chaotic. Patients may die without any care in cities where there exist the best facilities for diagnosis and treatment. A significant proportion of babies in Latin America are born without any kind of professional care and a high percentage of deaths occurs without medical certification. From the economic point of view, the worst and most striking fact is that all these problems occur despite very substantial health expenditures by public and private institutions and individuals.

Much research is needed to establish a sound health system that respects the rights of the health workers and at the same time distributes resources rationally to make services available, accessible, and acceptable to the whole population. Still, the system should be kept within a reasonable financial investment.
2.5 Coordination

Regardless of all the recommendations made by international bodies during the last 10 years, lack of coordination is the rule in practically every country. Coordination is necessary not only between different health institutions, but also within the institutions themselves and sometimes between different departments in a hospital. To ensure coordination of the administrative process, proper medical administration is essential. We have to realize that when we speak of delivery of health services we imply the adoption of a system in which the administrative process takes place with the ultimate goal of improving the quality of the care provided to the population. Coordination means a rational use of resources and the application of modern knowledge of behavioral sciences and social psychology. Coordination is not a word to be applied to structures, but rather a mental attitude to be developed and preserved by the members of the health team. The final result of coordination is the delivery of good health services that users generally accept.

2.6 Availability, accessibility, and acceptability

The shortage of resources we have already described makes most Latin American countries unable to provide the amount of health care services required by the population. Nevertheless, in some countries, especially in those that have developed health insurance systems, health care services exist but are available to only one segment of the population and are not to the great majority. In these cases, unavailability is a legal and financial problem derived from the basic concepts of social security legislation. The right to receive health care from health insurance institutions is obtained through the payment of a contribution. Therefore, those who are not able to pay or who are not covered by its laws do not receive benefits. To correct this situation social security institutions in Latin America are making a commendable effort to extend their coverage to new groups and have actually improved their
coverage from 11 to 18 per cent during the 1960s. Yet this percentage is still very low and in some countries does not go beyond 5 per cent of the working population. New efforts will probably be made to incorporate new groups. Nevertheless, it has become obvious that certain groups of workers, especially in rural areas, are incapable of paying contributions to the social security institutions because their cash income is too low to permit the allocation of part of the family budget to insurance purposes. This is an extremely serious factor in a region where 46 per cent of the population works in rural areas.

New approaches to the financing of health care services will have to be investigated and perhaps one of them might be the allotment of a certain percentage of the collective income from land reforms or from the cooperative management of industrial enterprises.

For most countries the problem of financing health care services is usually the most acute and insoluble one and becomes the major obstacle in organizing a rational system for the delivery of health services. Health economics is a broad field still open to research and one in which doctors usually do not attempt to intrude and that economists are only recently beginning to explore trying to find suitable solutions.

Even if the services become available, they mean nothing to the population if they are not accessible. The delivery of health services to small groups of less than 1,000 individuals living on small islands or in remote places in high mountains is a financial and administrative problem that has yet not received any satisfactory answer in any country. It is probable that with social and economic development during the present decade, when communications become available and surface or air transportation becomes easily attainable, these small groups can be introduced to the benefits of civilization. But the problem of accessibility is not confined to rural and isolated communities. Sometimes urban and suburban services are so crowded and the waiting lists so long that for all practical purposes existing services are not accessible to a majority of the people.
Finally, the kind of services provided to the population should be acceptable to both patients and health professionals. In this aspect, the problem of quality is more important than the problem of quantity. In fact, doctors and other health workers are no longer willing to reduce the quality of services provided and refuse to practice their respective professions in poor, unsatisfactory conditions. In turn, the population is becoming more aware of the importance of health care and of their social rights. They, therefore, demand health care services of high quality. The need for quality evaluation of health care thus become apparent and, when introduced, it should be carried out with full participation of the producers and consumers of health care, in other words, of the health professions and the population covered.

3. Future Perspectives

3.1 The regional system for health care delivery and medical education

As mentioned before, more factual information and greater research are needed to design the future system of health care services. The general diagram of the structure of a system should be a pyramid at whose apex the executive authority is invested with power to formulate policies and design national plans. At the middle level, the health region is in charge of program coordination and budget consolidation, and at the base of the pyramid we can find the local health services, where health activities are carried out and doctor-patient relationships are developed.

Regionalization is the administrative instrument to implement national health plans through a national health system. In a modern approach the concepts of regionalization should be applied to health care delivery as well as to medical education systems. The main objective of regionalization is to coordinate human and material resources within the region and to design regional programs for a rational utilization of the resources available. To achieve this, the regional system will have to be incorporated in the national
system and the administrative process should provide a smooth continuity between the higher levels of administration, the regional level, and the local level.

To implement this complex concept of regionalization of health care delivery and medical education, it is essential to ensure the cooperation of health workers and the population so that both those providing the services and those using them are aware of the importance of harmonious, coordinated effort within the region to provide the highest possible quality of health care and at the same time to instill in the necessary personnel an adequate mental attitude toward the philosophy of the health system. As far as possible, the region should be self-sufficient and should comprise urban, suburban, and rural sectors.

Insofar as health care delivery is concerned, the region should be equipped to design regional programs within the framework of the national health plan and to implement these programs locally through a rational use of all the establishments within the region that avoids competition, duplication, and waste.

From the viewpoint of medical education, the regional system attempts to make available for educational purposes the regional hospital and the peripheral services within the region. Of course, a mechanism should be established for the accreditation of hospitals and regional services for teaching purposes. Moreover, by bringing the training to regional hospitals belonging to Ministries of Health or social security institutions, the medical student will receive a much more practical kind of training through direct contact with the population and with the social, economic, and emotional problems involved in health or illness. Furthermore, hospitals and other health services always benefit from their association with teaching activities because the result of this merging of health interests is improvement of the quality of the care provided.

Regionalization basically implies administrative decentralization for the purpose of simplifying bureaucratic procedures and achieving
budgetary consolidation at the regional level to distribute resources to carry out regional health programs more rationally. A great deal of delegation of authority should be entrusted to the regional director, who should be personally responsible for the success of the regional programs. In addition to administrative skills and technical knowledge, the regional director should possess the personal ability to become the leader not only of the health team but also of the population to be served. He should also have teaching aptitude, especially if the regional hospital is involved in teaching activities.

In every region there should be a regional hospital, which, in some instances, could also be a teaching hospital. It should be a general hospital with all the specialties of medicine in which the patients should be classified according to the seriousness of their illness. It should include intensive care units, emergency services, recovery rooms, outpatient services, etc.

Most health care delivery should be offered to the population in peripheral ambulatory services that bring it as close as possible to the place of residence, work, or study of the population. Regional hospitals should collaborate in the teaching of health sciences and for this purpose the teaching-learning process should also be regionalized. This implies that the faculties of medicine should designate certain establishments of the health system as clinical and social fields for student practice. In this way, the scientific quality of health care is raised and at the same time more realistic practice of health sciences in the social field can be offered to the students.

Systems analysis and operations research are both required to develop models of regionalization of health care and medical education services to serve better the populations of different countries that live in varied social and epidemiologic conditions. Economic studies should also be carried out to ensure reliable financial support to the health system. Health insurance may in some countries be the basis, but it should be kept in mind that the high cost of health services makes it imperative to resort to a plurality of financial
sources to carry out the variety of health services needed to cover all the needs of the population.

3.2 Professional careers for doctors and nurses

Together with regionalization, a professional career for doctors and nurses should be organized to train the personnel actually needed by the country according to the development of the health care system. The systematic teaching of health sciences together with rotating internships and the teaching of epidemiology, and health and social security administration should enable medical and nursing schools to produce doctors and nurses well trained to carry out medico-social services in local areas at the beginning of their professional career. From there on, alternate periods of service and training should orient these professionals toward the different specializations of medicine including public health.

In addition, the regional system of medical education and health care services should be equipped to train, at the regional level, medical allied personnel to meet the needs of the region.

Planning of health resources parallel to national health planning should be the subject of studies and research to organize training in a coordinated and harmonious way.

3.3 Financing the health sector

This is probably the most difficult problem in the organization of the health sector. Different sources of financing should be explored; costs should be carefully analyzed against quality, and a policy should be established to distribute responsibility for financing the care costs of different groups of the population according to their financial capacity. Health insurance might be the answer in some places, while in others the national budget appears as the main source.
Health economics is a very broad field of studies relating to cost and means of financing medical care. In this field there is no single model available but rather a model has to be designed for each country using a process of rational organization of their health care services and training of personnel, adjusted to their cultural traditions, legal dispositions, and administrative and financial capabilities.
BIBLIOGRAPHY


