THE BASIC HOSPITAL: ITS ROLE IN PROGRAMS FOR EXTENDING HEALTH SERVICE COVERAGE

Antonio Hernández Prada

The basic hospital, where health care first assumes stepped-up degrees of complexity, occupies a key place in the health services chain. This article describes the basic hospital’s role—first in terms of expanded primary care, next in terms of the need for regionalization, and third in terms of the special functions that the truly effective basic hospital performs.

Introduction

Health care is a public right, and it is the responsibility of governments to see that all enjoy it in equal measure. Likewise, health itself is not a privilege; instead the right to health is universal, and due recognition of this right is an important attribute distinguishing society that is civilized from that which is not. These assertions, in one form or another, have been made by nearly all the Governments of the world on the basis of principles enshrined in their respective constitutions.

In keeping with these principles, and with the recommendation of the Ten-Year Health Plan for the Americas that a start be made on “installing machinery... to make it feasible to attain total coverage of the population by the health service systems in all the countries of the Region,” the Governments of the Americas are devoting a substantial share of their resources to meeting this urgent goal while it is still possible to attain. Hence programs for extending health service coverage have come to receive priority in nearly all the countries of the Region, and the execution and development of these programs is giving them steadily increased momentum at all levels of health services administration.

Needs of the Health Care System

Proliferation of public and private health institutions, with little or no coordination, is a common denominator of medical care in the developing nations of Latin America. Logical consequences of this are resource waste, duplication of services, rising health care costs, and uneven coverage of different parts of the population.

With only a few exceptions, the countries of the Region are providing less than one consultation per inhabitant per year and less than 10 hospital discharges per 100 inhabitants per year. This indicates that large masses of people are unable to exercise their right to health.

Also, 68 per cent of all hospital discharges involve cases of communicable, parasitic, or infectious disease; pregnancy, childbirth, and prenatal or perinatal complications; and accident-related physical or mental problems. Since many of these conditions can be dealt with adequately outside of hospitals, it is reasonable to conclude that hospital services are being put to unnecessary uses, despite the limited supply of these services.
In addition, inadequate distribution of hospital services renders the situation even more critical. This is especially true in rural areas, where many small units (85.6 per cent of them with less than 100 beds) are thinly scattered over large territories. As a result, these units tend to have a very limited productivity and proportionately high costs. Such maldistribution also hinders suitable allocation of resources and application of appropriate technology.

In response, there is a general tendency at present among the countries of the Hemisphere to "improve the supply of medical care through a system of regionalization enabling distribution of resources according to levels of care... [so as to] make it feasible to apply the principle of providing high-quality care on an egalitarian basis to the entire population." In almost all the countries, health policies developed with this aim in mind have produced significant advances in the comprehensive human, material, and financial resource planning needed to deliver adequate health care.

Level of Care

Whatever its nature, an institutional system of public services must provide the individual and the community with different types of care by means of actions performed at different intervals and involving varying degrees of complexity. In the health sector these different types of care, grouped on the basis of predetermined criteria, give rise to what are known as levels of care. The basic purpose of this stratified form of organization is to satisfy specific needs; solve the health problems involved; achieve maximum efficiency; strike a sound balance in terms of the quantity, variety, and quality of the care provided; and combine resources in such a way that they can be equitably distributed and shared.

In general, when the concept of care levels is applied in practice to the organization of health services, two things tend to be clarified. One of these is the nature of the problem to be solved—that is, the features of the health situation that require attention; and the other is the level of technological complexity required to provide an appropriate response. In theory these things happen, first, because individuals and communities have multiple health needs or problems, some of which occur more frequently than others and most of which, considered individually, are relatively simple; and, second, because there is a natural relationship between the complexity of health needs or problems and the complexity of the services required to cope with them.

This ranking of health problems and health service functions for operational purposes provides the basis for defining health care levels; and this definition of levels, in turn, leads to the establishment of a scale on which the more elementary actions, considered collectively, become the "primary level of care" and are performed by means of the less complex resources available to the health system. This same approach, designed to attain the most efficient possible resource use, can also be used to define other more complex levels of care. In increasing order of complexity, these are known as the "secondary" level of care, the "tertiary" level, and so on. As this implies, they are intended to handle possible health problems that are more complex but less frequent.

Most countries of the Region have established three to six levels of care or health service delivery. Naturally, there has been considerable variation in the clarity and effectiveness with which these levels have been defined. Moreover, the health systems in some relatively small countries contain only one level—this generally being nationwide in scope; and in some other countries the levels are organized in terms of operat-
ing areas, these latter generally being de-

defined according to political and administra-
tive jurisdictions, and also at times in terms of
epidemiologic consideration.

Despite the fact that the higher levels of
care deal with increasingly complex prob-
lems, however, there is not necessarily any
direct relationship between the level or
levels of care provided at a facility and the
type or physical characteristics of that
facility. The only direct relationship is be-
tween the levels of care provided at the fa-
cility and the functions the facility is re-
sponsible for carrying out.

Naturally, applying this "levels of care"
concept to the organization of health serv-
ices requires careful selection of technology
that is appropriate—with regard to both the
available resources and the socioeconomic
and cultural characteristics of the setting
for which the system of levels is designed.

The primary care level provides the con-
necting link between the institutional and
community health systems, as well as the
point at which cases too complex to be
handled at that level are referred to higher
levels. This provision of appropriate re-
ferral for cases that cannot be resolved is a
fundamental and necessary function, one
that assures continuity of care and provides
the coordination needed to make extension
of coverage an effective reality. Moreover,
because it is the technical level in direct
contact with the community, development
of the primary care level is of paramount
importance in extending health services and
expanding the coverage that those services
provide. It also constitutes the level at
which most health situations or problems
are dealt with and resolved.

In this same vein, extension of health
services to a given population requires not
only appropriate development of the pri-
mary level but also a reorientation of the
traditional primary care components so that
they will be adjusted to the new primary
care strategy and activities as well as to an
intersectoral approach. Such extension also
requires that other health care levels be
adjusted so that they support and comple-
ment the actions carried out at the primary
level, and so that they provide smooth,
efficient organization and appropriate co-
ordination of the resources and technology
available at all levels.

Regionalization of Services

A basic measure helping to meet these
requirements is functional regionalization
of services. The primary objective of
regionalization is to coordinate available
resources—so that they can be used more ef-
ficiently and without unnecessary duplica-
tion to make the services of the region's
health establishments available to all upon
demand. In this context regionalization
serves as an administrative tool that permits
consolidation of national health programs
at the intermediate level in such a way as to
facilitate their execution at the local level.
Also, functional regionalization of health
services—regionalization based on clearly
defined and coordinated levels of care—
permits establishment of an effective link-
age between the institutional and tradi-
tional health system, a development that
favors rapid extension of coverage.

In this same vein, administrative region-
alization of services (in both the health care
and other fields) brings those services closer
to the people and permits a high degree of
self-sufficiency in specific sectors—to the
extent that appropriate resources and a
potential for improvement of those re-
sources are available in the region. When
used as an instrument for health services
coordination, administrative regionaliza-
tion implies distributing work and respon-
sibility among agencies in a mutually sup-
portive manner for the purpose of maxi-
mizing the productivity of equipment and
installed capacity in the course of program
execution. Among other things, this implies
that the regional hospital should become the
principal operating center, and that its outpatient services should provide an effective liaison between the hospital and peripheral services.

**The Hospital as the Central Element in Regional Health Care**

Utilized first as a "guest-house for the sick" and even in our own times erroneously considered a "repair shop for human machinery," the hospital has been a perennial subject of controversy as well as a focal point for dissemination of scientific knowledge and a center for the research and study of technological advances in medicine. Very little can be added to existing descriptions of the hospital's main structural features. Despite this, however, it is still not easy to explain the hospital's role or function relative to changing reality. That is because the hospital does not operate in a vacuum. Instead it acts as a receptor, magnifier, and reflector of the virtues and defects of the system to which it belongs, and its future is inextricably bound up with the entire complex plan of organization established for its particular territory or region. Therefore, it is important that this regional or territorial plan clearly define the hospital's objectives; the category, capacity, scope, and complexity of its functions; the resources allocated to it; and the hierarchic relationships governing performance of its activities and tasks.

**The Basic Hospital**

The basic hospital is the facility in the chain of health services where health care first assumes added degrees of complexity. It also constitutes the health care unit requiring the greatest structural and organizational flexibility—because its work is heavily conditioned by the needs in its area of influence and by the type and degree of development of its region. Therefore, plans for constructing such a hospital must be based upon careful study of all extrinsic and intrinsic factors affecting its program—so that the project will be consistent and will result in suitable architectural expression of the hospital's desired function. In particular, the building that houses a basic hospital should serve as a place for establishing contact with the various operating health care levels and for referring cases to them.

To the extent that they are able, all hospitals perform the following functions: health promotion, disease prevention, patient cure and rehabilitation, teaching, and research. However, because of the particular characteristics of the basic hospital and its key position as the initial link in the chain of health services, it assumes functions that differ in quality and scope from those of other hospitals. This means that the basic hospital must be well-prepared to solve preventive health and diagnostic problems and to provide timely treatment up to the limit of its predetermined operating capabilities, while at the same time accommodating and referring on those patients whose problems must be solved at levels of health care that the hospital itself does not provide.

**Accessibility**

It is important to note that the mere physical presence of a basic hospital offering health services carried out with an adequate quality and quantity of resources does not necessarily ensure that everyone will have access to these services—unless the factors that influence accessibility are first taken into account. That is, the accessibility which is a prerequisite for maximum health service coverage depends first on the continuing and systematic offer of services utilizing an adequate combination of resources; but it also depends on these services being available to the community in a variety of ways. That is, they must be geo-
graphically available (in terms of distance, travel time, and means of transport); economically available (no fees should be required when a service is provided or at the time of recovery); culturally available (meaning that technical and administrative standards need to be compatible with the social values, habits, cultural patterns, and customs of the communities served); and functionally available (that is, the services must be timely, must be permanent, must employ appropriate technology, and must make use of referral mechanisms assuring easy passage to whatever level of care may be required). Accessibility also requires that the quantity and structure of the services provided be adapted to the number of inhabitants served, the population's structure and health needs, and community acceptance of the types of services being offered—as indicated by utilization of those services.

Since it is the element linking the system together, it is especially vital that the basic hospital include a referral mechanism that ensures accommodation for all patients—patients requiring treatments ranging from the relatively simple to the most complex—by referring them to the appropriate level. This is necessary if the hospital unit is to be considered efficient and is to be accepted by the community.

If all these factors are considered and handled appropriately, it is reasonable to assume that the desired degree of accessibility exists. However, in this and other situations the true extent of the coverage provided to the community can be estimated by determining how much the health services are actually being used. Experience has shown that breaking the harmonious interplay of these various factors tends to create conflicts within both the hospital and the system that it serves.

Other Functions

As already noted, one of the basic hospital's most important functions in this respect is to provide a referral mechanism linking the various levels of the system. The hospital is thus responsible for receiving patients—either directly or from units providing lower levels of care—and referring them to a higher level. The hospital's prestige, as well as community acceptance and support, depends on the effective performance of this function.

In addition, the basic hospital clearly needs to provide a suitable setting for the interaction of various groups with different roles and interests. These groups include the medical staff—responsible for providing medical care that takes advantage of the most nearly optimal conditions and the best technical and scientific resources available; the nursing staff—responsible for providing care in compliance with medical orders in accord with established standards of quality; the administration—responsible for providing efficient care to the maximum number of people at the lowest possible cost; the health workers—responsible for seeing that the community is served efficiently by techniques of primary prevention and environmental control; the community itself—seeking efficient and timely treatment; and political leaders seeking the most effective possible health care for their constituents. It is only natural that the complex interactions between these groups should give rise to frequent conflicts inside and outside the basic hospital concerning its procedures, stature, usefulness, and the quality of services it provides.

Within the basic hospital, the preparation of technical and professional health sciences personnel should be grounded upon practical experience well-adapted to the reality prevailing in the country involved. This is especially true because the basic hospital's special working conditions and location in the health care chain place it in a very good position to execute joint teaching, research, and health care functions that will greatly benefit the individuals and
community served. Hence there is good opportunity for a two-way flow of benefits between providers and receivers of services in the fields of training and health care.

In sum, the basic hospital can and should contribute to extension of educational, research, and teaching programs in and around the community served; to the work of establishing health care levels; and to the general process of consolidating regionalization for the purpose of developing both extended coverage and the necessary strengthening of health systems administration.

SUMMARY

The primary level of health care is the level in direct contact with the community. Hence development of this level is of major importance in extending health services and expanding the health coverage that those services provide. At the same time, this expanded coverage requires that other health care levels be adapted to support and complement the actions carried out at the primary level.

Within this context, the basic hospital occupies a key position. It is the facility in the health services chain where health care first takes on added degrees of complexity, and also where an effective mechanism must exist for referring patients to higher health care levels. In addition, since the basic hospital’s work must be strongly influenced by the needs of the area it serves, very great structural and organizational flexibility is required.

Of course, the mere presence of a well-equipped and staffed basic hospital in a region does not guarantee universal access to its services. That is because universal access—a prerequisite for maximum health service coverage—depends on more than a mere ongoing offer of services; it depends on the offered services being administratively available, economically affordable, geographically reachable, culturally acceptable, and technologically suitable for the whole population served. In addition, the basic hospital clearly needs to provide a setting appropriate for the interaction of various groups—including medical and nursing staffs, health workers, the administration, members of the community, and local political leaders—each with different roles and interests.

Also, the basic hospital’s special place in the health care chain affords it a fine opportunity to execute joint teaching, research, and health care functions that will greatly benefit the individuals and community served. Overall, the basic hospital can and should contribute to a general process of regionalization; to the work of defining and coordinating levels of health care; and to the actual extension of educational, research, and teaching programs into and around the community served.

BIBLIOGRAPHY

THE ELDERLY

The April 1979 issue of World Health, the illustrated magazine of the World Health Organization, was devoted to the elderly. The articles quote figures of 26 million who were 80 or older in 1970. By the year 2000, there will be that many in the developing countries alone, and in the same 30-year period the world’s total of people 60 and over will nearly double (from 304 million to 581 million). An even higher proportion of women is expected to compose this age group than it does today.

A major study in Sweden has shown that 70-year olds were generally in good health, and that only about 3 per cent needed care in institutions. Soviet studies have found that people who are pensioned off suffer a sharp decline in vitality and may age prematurely, while socially useful employment gives a big boost to their morale. Community health workers, in addition to preventing ill health and social breakdown, will also help “society as a whole to “recognize that old age is not a disease but the fulfillment of every individual’s birthright.”