INSTRUCTION ON MEDICAL CARE ORGANIZATION IN THE BASIC M.P.H. CURRICULUM OF LATIN AMERICAN SCHOOLS OF PUBLIC HEALTH

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On the basis of data obtained from nine schools of public health in Latin America, a comprehensive study is presented on the curriculum content in the field of medical care organization and hospital organization.

Introduction

Organized programs of medical care have been developing at an increasing tempo in Latin America, and the schools of public health have responded by developing formal instruction in this field of study. Perhaps there is a lag between the vitality of action programs and the degree of academic attention to them in the schools, but the content of curricula in the problems of medical care organization is clearly enlarging and developing.

The focus of this paper will be on one basic aspect of this academic development: instruction in medical care organization in the basic curriculum leading to the M.P.H. degree—that is, the curriculum followed mainly by physicians who are undertaking general public health studies at the Master's level. No attempt will be made to examine other related aspects of the same question, such as the education of personnel for specific work in hospital administration and the training of professional specialists who would devote themselves exclusively to medical care administration.

The focus here is intended to shed light on the degree to which general public health administrative physicians in Latin America are being oriented in the tasks of planning, organizing, and directing the curative services. The importance of knowledge and sophistication about the preventive services requires no defense. The entire public health movement, from its beginnings in 19th century Europe, has directed its main attention to the prevention of disease, especially communicable disease. This obviously remains the top priority in Latin America, where so much remains to be done in environmental sanitation, immunization, health education, and other measures of disease prevention.

Increasingly, however, it has become clear that effective provision of the preventive services, as well as the curative services, requires first of all a firm administrative structure of health services throughout a nation. An intensive "one-shot" campaign against malaria or intestinal parasites in a province will not have lasting effect if there is not a sound, permanent structure of health services to continue to meet all the health needs year in and year out. Such a firm structure cannot be built with a mission of preventive services alone. It must satisfy the needs of the people, as they are felt by the people, and this means that the pain and distress of sickness that has not been prevented must be confronted. Treatment must be given for sickness and injury to the ambulatory patient and to the patient requiring a hospital bed.

Effective delivery of these treatment services cannot be left to the random efforts of
physicians. It calls for careful and systematic organization, no less than do the preventive services. Indeed, the costs of the treatment services—especially the operation of hospitals—are so high that their delivery demands rational and systematic organization even more than do the preventive services. Otherwise, there can be vast extravagance of expenditure of both money and resources which no nation—not even the richest—can afford.

Yet the curative services in Latin America and elsewhere in the world have been characterized by a highly diversified and even chaotic development. Special groups of people and special diseases have attracted energetic programs, but these programs are usually unrelated to each other, are often competitive rather than cooperative, and their separate claims on the nation’s limited resources are uneven and inequitable. Underlying all of these programs is a large “free market” of private medical care, in which services go first not to those in greatest need but to him who can pay the bill. Aside from the lack of coordination among these public and private sectors, within each of them there are numerous inefficiencies and failures to achieve quality and continuity in medical care.

The task of the schools of public health, therefore, is to educate physicians and other administrative personnel about the problems of medical care organization—including hospital administration—as well as about the problems of disease prevention. The degree to which this is currently being done in Latin America has recently been examined, but before reporting the findings we should first summarize the main characteristics of the medical care system or systems now in operation.

Medical Care Systems

No two Latin American countries, of course, are exactly alike with respect to medical care organization or any other important aspect of life. It is possible, however, to sketch briefly the principal systems that are seen to operate side-by-side in varying proportions within each country. At least 11 distinguishable systems can be identified:

1. Indigenous healing by untrained traditional personnel in the villages is found in every country. Where there are more people living in isolated tribes, such as Indians in the Andes Mountains, this practice is more important. Different kinds of healers, with various degrees of magical versus empirical practice, are found in different regions.

2. Beneficencia or charity hospitals are a second pattern of medical care. Started originally by the Catholic Church, they have come to be operated by voluntary boards, deriving their money from bequests, lotteries, and other sources. Central governments have come to subsidize them increasingly and, in some countries, these hospitals and their associated property have been taken over entirely by the government. In other countries, beneficencia societies are essentially money-raising organizations that contribute funds to the operation of governmental hospitals.

3. Governmental networks of hospitals and health centers for general medical care are a third pattern, which is found in every Latin American country. Usually under the ministry of health, these are in a sense the 20th century counterpart of the 19th century beneficencia system. Typically there are regional hospitals in the larger cities, health centers in the smaller towns, and small health posts staffed by one or two auxiliaries in the villages.

4. In addition to the central government, local units of government in the municipalities sometimes operate medical facilities. These may be small emergency rooms or, in great cities like Mexico City, special hospitals for indigent children.

5. Special occupational groups, comprising servants of the State, usually have their
own medical care programs operated by the central government. In almost every country this includes the military forces, for whom first-class hospitals are constructed and operated. The national police also often have their own facilities. Governmental railroad systems have networks of hospitals and health centers for their employees. Sometimes a ministry of education will sponsor a special health service for schoolteachers, or other ministries will do the same for their personnel. In all these programs the families of the soldiers or other government workers are also served.

6. Very important in nearly all Latin American countries are the social security systems, which have been developing for the protection of specified workers since the first such medical care program was started in Chile in 1924. They are usually confined to industrial workers, with the employer, the government, and the worker making periodic contributions to an autonomous fund. The social security organization may purchase medical care from existing public or private hospitals, but more often it builds new hospitals of its own. It also usually operates special polyclinics for ambulatory care in the main cities.

7. In some countries there are separate social security medical care programs for white-collar employees, as distinguished from manual workers. Within this class there may be separate administrative arrangements for employees of private enterprise and for government staff. Doctors may be paid under these white-collar insurance programs by the fee-for-service method, instead of salaries.

8. Private industries, especially in isolated locations, may also operate hospitals for their own workers—both white-collar and blue-collar—and their families. Mining and oil companies are sometimes required by law to do this, independently of the social security program. Small health centers also may be maintained for workers on certain large sugar or coffee plantations.

9. Voluntary insurance for medical care is a small development in most Latin American countries, designed for an emerging middle class that wishes to use private physicians and private hospitals. In one country, Argentina, voluntary mutualidades are a major form of health insurance for industrial workers, in contrast to a governmental social security system.

10. Middle class people of particular nationalities—such as German, Spanish, or Portuguese—may operate nonprofit hospitals for members of their own group. The great majority of patients may pay for this care, but some beds are reserved for poor families on a charity basis. Voluntary cancer societies or societies for crippled children also operate hospitals on the basis of charitable donations and sometimes with governmental subsidies.

11. Finally, there is a substantial purely private sector of medical care in all Latin American countries, with the possible exception of Cuba. Physicians, who may earn most of their income in employment by one or more of the organized programs described above, also engage a few hours a day in private practice; some few physicians are exclusively in private practice. Likewise small private hospitals or private clinics—often owned by doctors—are found in the large cities. Beneficencia or governmental regional hospitals may also reserve a few beds for privately paying patients. The patients who use these services are either those of high income, who are ineligible for the organized systems, or those who are eligible but dissatisfied with the quality of or delays in services within these systems. In the private sector there are also dental offices and a few private nurses. Pharmacies, selling prescribed and non-prescribed drugs, are another part of the private sector in which the population spends large sums of money.

This brief summary may serve to point up the complexity of medical care programs in Latin America. There are great differences
in the quantity of resources allocated to each of these systems, and therefore great variations in the scope and quality of services that each produces. There are obviously large differences in the availability of services between urban and rural areas and among the several distinct social classes. Administrative mechanisms for financing and technical organization of services differ greatly among the systems.

In several countries, notably Chile and Cuba, important steps have been taken to integrate the delivery of medical care which had been formerly dispersed among these diverse systems. In Brazil the programs of seven separate institutes of social security are being coordinated. In Costa Rica and El Salvador closer ties have been developed recently between ministries of health and social security agencies. In Venezuela a unified national health service is being discussed. The commonest administrative mechanism for such integration is based on the concept of regionalization which, in a word, means that health services, both preventive and curative, should be systematically organized in geographic areas through a logical network of facilities, connected by efficient transportation. The people would receive services within this regional network on the basis of their health needs and place of residence, rather than on the basis of the source of financing or their social pedigree.

Administration of such integrated regional health service programs obviously requires knowledge of the several medical care systems reviewed above. Within each system there are scores of problems involved in the effective organization of health personnel, in the operation of clinics, laboratories, and pharmacies, in the adjustment of services to the social ecology of the population, in the maintenance of proper records, in the promotion of quality standards. Integrated health service administration demands also knowledge of the internal operations of hospitals. It requires an understanding of the relationship of preventive to curative service, the complexities of financing, the human needs of sick people, and all the other elements of comprehensive medical care.

We may examine now the degree to which the Latin American schools of public health are offering instruction on these matters.

Background of the Curriculum Survey

Information on the curriculum content with respect to (a) medical care organization and (b) hospital administration was obtained in two ways. In 1964 visits were made to five of the Latin American public health schools to obtain detailed information. In 1967 more current information was sought by correspondence with all of the schools. At the time of this writing, replies had been received from 10 of the 11 schools. In some of these replies, however, the meaning of the responses was not entirely clear, so that this summary will be based on the practices reported in nine of the schools. These are the schools of public health at:

- University of Buenos Aires, Argentina
- Ministry of Health, Rio de Janeiro
- University of São Paulo, Brazil
- University of Chile, Santiago
- University of Antioquia, Medellín, Colombia
- Ministry of Health and Welfare, Mexico City
- Ministry of Public Health and Welfare, Lima, Peru
- University of Puerto Rico, San Juan
- Central University of Venezuela, Caracas

It is regretted that time did not permit collection of all the necessary information on the subjects of medical care organization and hospital administration from the Schools of Public Health in Belo Horizonte, Brazil, and in Havana, Cuba.

Before stating the findings, we must clarify the distinction made here between instruction in medical care organization and instruction in hospital administration. In a strictly logical sense, the latter is a part of the former. That is, the organization of medical care includes concern for all the elements in treatment: the services of physicians, dentists, nurses, pharmacists, etc., and
the provision of those services in hospitals, ambulatory units, private homes, or elsewhere. But the specific tasks of administering hospitals are so numerous and complex that this subdivision of the larger field has been singled out for special academic attention. Moreover, the hospital sector of medical care is the costliest and often the most decisive in the patient's survival—further reasons for establishing special instruction on it. The first formal university curriculum in hospital administration anywhere in the world was developed at the University of Chicago in 1934, and since then it has spread to many countries in both the Western and the Eastern Hemispheres, including Soviet Russia and Japan.

The focus of instruction in hospital administration is naturally on the many tasks of managing a hospital. Within its walls, hospital operation requires a blending of scientific technology, business management, and humanistic care. All three of these fields are essential and, without proper achievement in any one of them, the hospital fails in its mission. The hospital administrator, therefore, must be educated about the problems and functions in all three domains. Like the clinical physician he must understand technology; like the industrialist he must understand management; and like the nurse he must understand human sensitivities. He must also acquire enough knowledge to judge—when there is a conflict between considerations in these three spheres—which consideration should temporarily prevail for the long-term service of the hospital.

But beyond these requirements for effective internal management, the hospital is obviously part of a larger system. The boundaries of this larger system are both geographic—the community, the province, the nation—and conceptual, that is, political, economic, cultural, etc. To provide proper leadership even within a hospital's walls, the administrator must understand the relationship of the hospital to this larger health care system. His university training, therefore, should include studies of this overall system, which constitute the academic discipline of medical care organization.

Even more important is this discipline for the public health administrator who is faced with the task of planning and directing total health services, curative and preventive, in a region or nation. Much that is taught in the new courses on "health planning" is equivalent to medical care organization. The modern health administrator should understand the broad features of health service organization as well as he understands the broad features of disease in populations (epidemiology) or the broad impacts of the physical surroundings on man's health (environmental sanitation). A knowledge of internal hospital operations is also desirable for the general public health administrator, but the broader discipline of medical care organization would seem to be essential.

With this background, we may examine the findings of the curriculum survey for the nine Latin American schools of public health listed above.

Findings of the Curriculum Survey

In all nine of the schools some instruction is offered both in internal hospital administration and in general medical care organization. The relative strengths of these courses, however, differ greatly among the schools, as do their status as mandatory or optional and their placement within the curriculum for different types of students. Our attention in this paper, it will be recalled, is directed to the inclusion of these studies in the curriculum of physicians earning the M.P.H. degree for general public health administration.

In Table 1 the findings are summarized. Except for the qualifications listed in the footnotes, the classroom hours indicated are required instruction for all general M.P.H. candidates. It may be noted that the tendency is toward somewhat greater attention
to hospital administration than to medical care organization. A simple average among the nine schools shows 47 hours per year assigned to the former and 29 hours to the latter. We all know the fallacies of averages, but my personal observations and discussions with Latin American professors would tend to confirm these relative proportions. Nevertheless, the simple numbers in Table 1 must not give the impression that the course content is the same in every school, the differences applying only to course duration. Obviously there are great variations in course content, depending on the background and viewpoint of the professors.

The content of the courses in hospital administration, since they have been offered for several years, has become somewhat standardized. Perhaps this is due also to the availability of a very widely used textbook in the field—Hospital Organization and Management by Malcolm MacEachern.

**TABLE 1—Instruction in medical care organization and hospital administration within the general M.P.H. curriculum of nine Latin American schools of public health, 1967.**

<table>
<thead>
<tr>
<th>School</th>
<th>Medical care organization</th>
<th>Hospital administration</th>
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</thead>
<tbody>
<tr>
<td>Buenos Aires</td>
<td>63</td>
<td>39</td>
</tr>
<tr>
<td>Rio de Janeiro</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>São Paulo</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Medellin</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td>Mexico</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td>Lima</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>San Juan</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Caracas</td>
<td>6</td>
<td>63</td>
</tr>
<tr>
<td>Santiago de Chile</td>
<td>30</td>
<td>45</td>
</tr>
</tbody>
</table>

* Source: Documentation provided by each school in March 1967.

Despite its North American orientation, this book has been used extensively in Latin American universities. These courses usually discuss a little about the history of hospitals, the different types of hospital, their general purposes, etc., but they give their main attention to a systematic examination of the various departments within the administrative structure of a general hospital and how they operate. There is also usually some discussion of architectural design, of hospital service financing, and of hospital legislation. Field visits are also often made to different institutions.

The content of the courses in medical care organization is much less standardized. The categories for analysis are not so well defined as in hospital administration. In some courses, the discussion is very general and examines mainly theoretical principles; in other courses there is more discussion of specific organized programs in a country, with presentation of data on medical care resources, utilization, costs, etc. All of the courses, however, seem to take a broad national view of medical care as a task to be planned and integrated with the preventive services.

The course in “Medical Care Administration” offered at the University of Antioquia in Medellín, Colombia, seems to strike a very good balance, so that its outline may be presented as an example. It is taken by all M.P.H. candidates and requires 30 classroom hours. The outline of subjects is as follows:

3. Analysis of medical care in Colombia.
tute of Social Security. Voluntary insurance funds. Private medicine.

b. Medical and paramedical personnel. Availability and production.

c. Facilities: Number of institutions (centers, hospitals, etc.).

d. Resources in equipment, supplies, and locations.

e. Budget: Total for medical care and by category. Sources of financing.

f. Productivity of these resources. Indexes.


6. Analysis of systems of medical care in other countries.

The course in Colombia, it may be noted, is clearly complementary to and not duplicative of the subjects usually covered in courses on hospital administration. In other schools there may be a little duplication of subject matter, but this is not a serious problem. Since the two courses are usually taught by different professors, the points of view toward the idea discussed are likely to be somewhat different.

It is of interest to note that, with respect to these two disciplines—hospital administration and medical care organization—the Latin American schools of public health are more advanced than the North American schools. While our judgment may not be typical, we believe it is an excellent idea to require all M.P.H. candidates in general public health administration to take basic instruction in these two fields, for reasons suggested earlier. Some of the schools in the United States of America and Canada include required courses in medical care organization in their curricula, but we do not know any which requires a course in hospital administration. This may perhaps reflect the wider role that is envisaged for the health officer in the Latin American countries. 

While other speakers at this Fifth Conference will analyze the curricula for hospital administrators and even for full-time specialists in medical care administration, it should be stated here that in all the Latin American schools curricula for training hospital administrators—either medical or non-medical or both—are offered. Among the schools analyzed above, moreover, these curricula all include (with the possible exception of one) also a course in medical care organization. Having the academic program for hospital administration located within the same school as that for general public health administration has obvious advantages for both students and faculty.

One final note with respect to the findings of this brief survey: the academic field is obviously in great ferment. Even since 1964, when the visits were made to five Latin American schools, the changes have been great. At that time three of the five schools surveyed had instruction on hospital administration in the general M.P.H. curriculum although all of the five had curricula for training hospital administrators. None of the five schools required instruction on medical care organization in the general M.P.H. curriculum and only two of them did so even in the hospital administration curriculum. It is evident that appreciation of

4 The confinement of this summary to the findings in nine of the 11 Latin American schools of public health should not imply that the other schools ignore the subjects of medical care organization and hospital administration. It has been due simply to lack of clear information on all 11 schools at the time of this writing. The school in the Ministry of Health of Minas Gerais at Belo Horizonte, Brazil, offers over-all curricula in the field of hospital administration. One could not be certain from the documentation, however, whether specific instruction in this subject or in medical care organization is included in the M.P.H. curriculum for general public health administrators. Documentation from the School of Public Health at Havana, Cuba, had not been received when this report was prepared. The impressive development of comprehensive health services in Cuba during recent years would suggest that academic instruction in these fields is probably well developed. At this Fifth Conference of Directors of Schools of Public Health, it has been learned from the Cuban delegates that in the basic public health curriculum are included 14 weeks of study in polyclinics and eight weeks in hospitals.
the importance of both these subjects in the training of general public health administrators has heightened over the last few years, and this trend may be expected to continue into the future.

Some Conclusions on the Teaching of Medical Care Organization

A few words might be said about a future academic policy toward instruction in medical care organization within the general M.P.H. curriculum. There seems to be no further need for argument—as there might have been a few years ago—about the importance of the subject. Virtually all of the faculties of Latin American schools of public health appear to agree on this and have modified their curricula accordingly.

The chief questions now are: what content should be included in such courses, how much time in the curriculum should be devoted to them, and what teaching methods should be applied? In connection with the 1964 study, a topical outline for a course in medical care organization was proposed. With slight modification, this outline is attached as an appendix to this report. Without reviewing all the details, a basic course in medical care organization might cover three main aspects as follows:

1. Basic medical economics
   - The burden of sickness
   - Receipt and costs of medical care
   - Medical personnel
   - Medical facilities
   - Other
2. Medical care programs
   - Conceptualization
   - Charity programs
   - Governmental programs
   - Social security
   - Industrial programs
   - The private sector
   - Other
3. Administrative problems in medical care
   - Ambulatory services
   - Drugs
   - Hospital operations
   - Dental care
   - Quality review
   - Regionalization
   - Planning
   - Other

There are many more detailed topics than this, of course, but the above framework would provide the essential foundation. For very brief treatment, the subject could be covered in 30 classroom hours. For more careful analysis, 60 or 90 hours would be required, with extra time for field visits to medical care organizations and seminar discussions.

Any one of these topics could, moreover, be treated in greater depth in special supplemental courses that might be elective. To give some idea of the range of such courses that may be developed, here is a list of courses in the medical care field currently offered at the School of Public Health of the University of California at Los Angeles:

<table>
<thead>
<tr>
<th>Hours</th>
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<tbody>
<tr>
<td>Fundamentals of medical and hospital organization</td>
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<tr>
<td>Medical care organization</td>
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<tr>
<td>Problems of medical care administration</td>
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<tr>
<td>Seminar in medical care practice</td>
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<tr>
<td>Seminar in medical care research</td>
</tr>
<tr>
<td>Economics of health and medical care</td>
</tr>
<tr>
<td>History of public health and social medicine</td>
</tr>
<tr>
<td>Area-wide planning of health facilities</td>
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<tr>
<td>Social work in public health</td>
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<tr>
<td>Rehabilitation of the disabled</td>
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<tr>
<td>Administration of ambulatory services</td>
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<tr>
<td>Medical care in international perspective</td>
</tr>
<tr>
<td>Field observations in medical care</td>
</tr>
<tr>
<td>Special group studies</td>
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<tr>
<td>Special individual studies</td>
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Of the above 15 courses, the first five are required for all M.P.H. students whose major study is in medical care organization, while the rest are elective.

There are other specialized courses which may also be developed in the field of hospital administration, beyond the basic review of internal hospital operations. These may include: mental hospital administration, administration of long-term care facilities, medical records, hospital law, hospital finance and accounting, etc.
Final Comments

One of the difficult problems in developing courses in medical care organization in the Latin American schools is the lack of convenient textbooks in Spanish. This problem was faced also in the United States until a few years ago, but now a number of texts are available. They would not be appropriate in Latin America, however, even if they were translated; medical care organization—more than other aspects of public health—is intimately tied to the culture of a country and writings about the North American scene would have only small applicability elsewhere. It is up to Latin American scholars to develop such books. A relatively rapid solution is to assemble collections of articles, already published, about diverse aspects of medical care organization in Latin America. Many such articles have appeared in the literature of public health, social security, hospitals, and medical education. This could be done and prove very useful, pending the production of more integrated textbooks by one or two authors.

Another more serious problem is the lack of good statistical data on medical care resources, utilization, and costs in many Latin American countries. One must admit that the formulation of an academic discipline of medical care organization in the United States followed upon the production of a mass of quantitative data by the monumental studies of the Committee on the Costs of Medical Care, 1928-1931. In the decades since then data have continued to be produced, so that teaching materials are abundant. It should not be necessary, however, to await the production of such comprehensive data for each Latin American country before good instruction can be offered. Statistical information within specific medical care programs, especially those of the social security systems, is now widely available. The ministries of health usually have good data on hospital facilities and the national medical associations often have valuable tabulations on physicians. Studies on selected medical care problems have been made by sociologists in one country, or by political scientists in another. Economists in the national planning agencies have done valuable studies on the expenditures for medical care.

These materials from several different Latin American countries can be assembled by teachers, even if the picture for any one country is not complete. Of special interest this year is the completion of the comprehensive Study on Health Manpower and Medical Education, sponsored by the Ministry of Public Health and the Association of Medical Schools in Colombia, with the assistance of the Milbank Memorial Fund and PAHO/WHO. This impressive study has 10 distinct parts as follows:

1. Census of doctors
2. Census of nurses
3. Medical school survey
4. Nursing education study
5. Mortality study
6. National morbidity study
7. Inventory of health facilities
8. Socioeconomic aspects of health services
9. National health service plan
10. Reorientation of medical education

The first eight of these parts were based on field investigations to collect new data, including a massive household survey of illness throughout Colombia. This over-all study will provide abundant material for teaching medical care organization in any Latin American country, and studies of comparable scope may soon be conducted in other nations.

A final methodological question confronts public health faculties in Latin America and North America alike: since the viewpoint of public health administration is now broadening to include active concern for the curative services as well as the preventive, should the separate teaching of medical care organization or hospital administration be continued at all? Should not this whole field of administration of all types of health service
be coalesced under the umbrella of "health service administration"?

The answer, in my view, must be sought in the strategy of specialization. There are, of course, certain principles that are common to all branches of health administration or, indeed, all branches of general administration. These can be taught in a basic introductory course on "principles of administration," just as basic anatomy and physiology are taught in the early years of medical education. But the application of those principles to specific fields of action requires a knowledge of many facts and relationships. To master these applications requires specialized study. Even though the principles of anatomy and physiology are the same throughout the human body, one still undertakes specialized study in ophthalmology, cardiology, urology, gynecology, etc. In the same sense, special courses are still required in hospital administration and medical care organization, even though we may regard these simply as facets of health service administration.

The rising tempo of interest in medical care studies at the schools of public health of Latin America is matched elsewhere in the world. The Association of Schools of Public Health of the United States and Canada devoted the technical discussions of its last two annual meetings to this subject. This Association decided that adequate instruction in medical care organization should henceforth be included in the basic requirements for the M.P.H. degree. In the European schools, similar attitudes are being shown. These academic policies are fundamentally a reflection of trends in the world of social action. In all nations there is a movement toward more systematic and effective organization of medical care, in the interests both of humanism and economy.

To plan and operate such systems, sophisticated administrators are urgently needed, and will be increasingly needed in the future. This is the challenge for sound instruction in medical care organization that faces schools of public health everywhere.

Summary

A growing interest in the effective training of future health administrators and in the coordination of medical services to include both prevention and treatment has been evident in Latin America for a number of years.

In 1964 a study was made on curriculum content in the field of medical care organization and hospital administration in five public health schools. Subsequently, in 1967, additional data were received from those and other public health schools. The study in question was based on the data from nine public health schools located in Argentina, Brazil (2), Chile, Colombia, Mexico, Peru, Puerto Rico, and Venezuela. It was found that curriculum content changed rapidly, and that variations among the schools were substantial. Generally there is a tendency to pay greater attention to hospital administration than to medical care organization. The results of the survey are presented in detail.

The future health administrator of Latin America should be informed on the over-all organization of medical care, as well as on the problem of disease prevention and the internal administration of hospitals.

A topical outline for a course in medical care organization in Latin American schools of public health is suggested as a guide; it consists of 14 sections, and more than 50 subdivisions or subjects which deal with the planning, organization, operation, and coordination of medical care services. For very brief treatment, the subjects could be covered in 30 classroom hours. For more careful analysis, 60 or 90 hours would be required, with extra time for field visits to medical care organizations and seminar discussions.
Annex 1

PROPOSED COURSE IN MEDICAL CARE ORGANIZATION FOR A LATIN AMERICAN SCHOOL OF PUBLIC HEALTH

1. The Burden of Sickness
   b. Socioeconomic variables of disease (social class, occupation, urban-rural location, seasonality, etc.).

2. Receipt and Costs of Medical Care
   a. General experience of population in rates of receipt of services of physicians, dentists, cultists, drugs, hospitalization, etc.
   b. Behavior of people in response to symptoms. Variations with social class, educational level, rural-urban location, etc.
   c. Costs of medical care to families. Expenditures by individuals for privately purchased services of different types.

3. Medical Care Resources: Personnel
   a. Types of personnel and their training (physicians, dentists, nurses, auxiliaries at various levels, technicians, social workers, etc.) Standards and licensure.
   b. Personnel: numbers, geographic distribution, and trends.
   c. Problems of recruitment and placement.
   d. Traditional medicine: human resources.

4. Medical Care Resources: Facilities
   a. Hospitals: number and types (general, special, mental, etc.) Bed ratios and geographic distribution.
   b. Hospitals: classification by sponsoring agency and characteristics of different forms of control.
   c. Health centers and other ambulatory care facilities. Laboratories.
   d. Pharmacies.

5. Medical Care Programs: Conceptual Analysis of Organizational Pattern
   a. Historic development.
   b. Relevant legislation, if any.
   c. Administrative structure (organogram, etc.).
   d. Eligible population.
   e. Scope of services (and rates of utilization).
   f. Personnel and facilities involved (appointment and remuneration).
   g. Financing (source of funds and actual costs).
   h. Regulations and methods of enforcement.
   i. Quality controls (including education and research).
   j. Special problems and evaluation.

6. Medical Care through Charity
   a. Beneficencia pública or similar programs, analyzed by concepts of Section 5.
   b. Other voluntary or charitable programs (Red Cross, cancer society, children's funds, etc.).

7. Governmental Medical Care for the General Population (following outline of Section 5)
   b. Provincial or state.
   c. Municipal or other local unit.
   (Be sure to include special emergency services, public assistance; also relationships to preventive programs.)

8. Governmental Programs for Special Groups (following outline of Section 5)
   a. Military services and police.
   b. Railroad systems.
   c. Governmental employees (national and state).
   d. Special governmental corporations (e.g., oil or electric power).

9. Social Security and Health Insurance (following outline of Section 5)
   a. Oldest systems (obreros).
   b. Newer systems (empleados).
   c. Voluntary health insurance programs (mutualidades, commercial insurance, etc.).

10. Medical Care in Private Industry (following outline of Section 5)
    a. Mining and other isolated industries.
    b. Agricultural plantations.
    c. Manufacturing companies in large cities.
11. The Private Sector of Medical Care
   a. Private medicine and private clinics.
   b. Pharmacies and self-medication.

12. Administrative Problems in Medical Care
   a. Organization of ambulatory services (physical layout, appointment systems, etc.).
   b. General practitioner and specialist responsibilities.
   c. Laboratory and X-ray services in health centers.
   d. Public pharmacies.
   e. Family health records.
   f. Quality review (medical audits) and promotion of effective doctor-patient relationships.

13. Planning of Medical Care Systems
   a. Achieving reasonable geographic distribution of personnel and facilities.
   b. Regionalization and its administration.
   c. Integration of preventive and curative services in health centers and hospitals.

14. International Comparisons in Medical Care Organization (Review of other countries as "laboratories" demonstrating different approaches)
   a. Free enterprise pattern (U.S.A.).
   b. Social insurance pattern (Norway or France).
   c. Other Latin American countries (select two or three, including Chile with its National Health Service experience).
   d. British National Health Service.
   e. Socialist services in the USSR.