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HOSPITAL SERVICES IN THE WESTERN PACIFIC REGION[1]

by

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[1] Background document for reference use at the Technical Discussions on "The Role of the Hospital in the Community and the Financing of Hospital-Based Medical Care".

CONTENTS

1. DEFINITIONS AND TRENDS

Over 15 years ago, in the first report of the WHO Expert Committee on Organization of Medical Care, the hospital was defined as "an integral part of a social and medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose outpatient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for biosocial research"1/.

In the 1968 report of the WHO Expert Committee on Hospital Administration a much more functional and practical definition was adopted namely "an institution that provides inpatient accommodation for medical and nursing care"2/.

Conditions are so variable from one country to another within the Region that if the former definition is adopted some countries or territories would have to be regarded as not having a hospital service. However, if the latter is adopted all countries and territories have a hospital service.

It is evident that there is a trend in the Region towards centralized rather than localized control of hospitals, towards integration of hospitals into the health services as a whole and their use for preventive as well as curative purposes. That is, there is an evolution towards much that is embodied in the definition of a hospital fifteen years ago. This regional trend is thus similar to one found in a recent study of the hospital systems in 52 countries3/. In countries in which there is not a trend towards centralized control there is a trend towards more involvement centrally through subsidies and or the issue of materials.

2. PROBLEMS IN THE WESTERN PACIFIC REGION

There are a number of problems in the provision of hospital services, which although all are not peculiar to the Region, are worthy of mention.

These may be geographical, as in the extreme case of the Trust Territory of the Pacific Islands, where a little over 100 000 people live in three major archipelagos comprising more than 2000 islands, with a total land area of barely 300 square miles in an area of about 3 000 000 square miles of ocean.

The problems may be socioeconomic, as in the case of Laos and Western Samoa, which the United Nations have grouped among the 25 least developed countries of the world.

Man himself may have worsened the situation as in the Khmer Republic, Laos and the Republic of Viet-Nam where the ravages of war have created immense problems in the need for hospital services and the provision of facilities to meet the need.

Universally throughout the Region there appears to be a shortage of trained personnel, medical, nursing, other professional and auxiliary, to staff the hospital system.

In some countries the shortages are real. Papua New Guinea and Tonga are examples. The educational systems in these, among other countries and territories, are not sufficiently developed to produce a sufficient number of students with high school education who can be trained for the medical and allied professions.

In some other countries the shortages are apparent rather than real as a result of maldistribution of personnel between the large urban areas and those which are more rural, as for example in Australia, New Zealand and the Philippines. Maldistribution is accentuated in some countries by an undue proportion of highly trained professionals, practising in the private sector, serving a limited population group which can purchase relatively high quality hospital care while an unduly low proportion of professionals is available to serve in the public sector. This is particularly the case in the Philippines and the Republic of Korea.

Both the Philippines and the Republic of Korea are examples of countries in the Region which suffer severely from the "brain drain". In the former country the Government has now taken action to discourage the migration of professionals.

3. OWNERSHIP PATTERNS AND PATTERNS OF PAYMENT

The hospital service, as understood by "modern" rather than "traditional" medicine, is essentially a "young" service in the countries and territories of the Region. As such, the hospital services have not evolved, as for example in the United Kingdom, over several hundred years from shelters for the sick, the aged and the destitute in the days of the Poor Law to the highly complex social institutions which exist in many countries of the Region today. Nor, with certain exceptions, is there a clear cut ownership pattern of public, non-profit and proprietary hospitals as in the United States of America. There is, however, within the Region a wide diversity in patterns of ownership.

From a 1971 study of the hospital system in fifteen countries and territories of the Region, utilizing 1969 data[4], it emerged that the provision of hospital beds by governments was not necessarily related to the degree of socioeconomic development of a country, to any preceding or current pattern of colonialism or even to the political system of the country.

Considering Australia, Japan and New Zealand as the most developed countries of the Region, government ownership of hospital beds was found to range from 39% in Japan to 89% in New Zealand. Government ownership of beds was the same in Laos, a former French colony, as in Malaysia, a former British colony, namely, 83%. In the Kingdom of Tonga, 100% of hospital beds are government-owned and in French Polynesia, 96%.

Factors which influence or have influenced the provision of beds by governments have undoubtedly varied from country to country. In the less developed countries and territories of the Region, of which Papua New Guinea, French Polynesia and Tonga can be cited as examples, because of the absence of local resources, hospital systems could only have been established by the Australian Government in the case of Papua New Guinea, the Colonial Government, in the case of French Polynesia and the National Government with bilateral aid in the case of Tonga. The role of the religious missions in the hospital service in, for example, Papua New Guinea and other countries in the South Pacific, has also been important.

The systems of sickness insurance which have evolved in Japan and Australia have not discouraged the private hospital system in those countries but have encouraged their development in partnership, so to speak, with the public hospital system. Government encouragement of the private hospital system exists in Hong Kong where nearly 75% of private hospital beds are subsidized by Government funds to enable the hospitals concerned to continue to function. Even in New Zealand, which was the first country in the world outside of the Soviet Union to establish a universal social security system, including hospital care prepaid through taxation, the private hospital system has been encouraged by successive administrations of varying political persuasion. As the Philippine system of hospital care is developing with the phased introduction of benefits under the Philippine Medical Care Act of 1969, both the private and public hospital systems are being encouraged to develop.

Each country or territory will undoubtedly evolve in ownership pattern suited to its needs and degree of socioeconomic development. Within the concept of man's right to hospital-based medical care there

is no place for the "proprietary" profit-oriented type of private hospitals which still exists in some countries of the world. On the other hand, where non-profit private hospitals exist there are very good reasons to examine their function in terms of patient groups which are served, in terms of standards, effectiveness and efficiency, and reach a decision on management grounds rather than political, as to whether they should continue to function, if necessary supported by government subsidy, or alternatively be replaced by government-owned institutions.

Although governments may own hospital beds there may be financial barriers to their use. The situation varies so greatly from country to country within the Region and sometimes within any one country that it is not possible to generalize for the Region as a whole.

In New Zealand, there are no direct charges at all to inpatients or outpatients of public hospitals except a part charge on prescriptions in certain instances and for some domiciliary services, of which 'meals on wheels' is an example. In the latter instance, the charge is a basic one to recover partially the cost of the meal. There is no charge for the service.

Within the Commonwealth of Australia the situation varies between Queensland and the remaining states. In Queensland there are no direct charges to patients in public hospitals. In Tonga and also Fiji the patient makes a nominal contribution towards his hospital care.

In several countries, of which Malaysia, the Republic of Viet-Nam and Singapore are examples, public hospital beds are "classed" according to the ability of the patient to pay for his care but a reasonable generalization is that the indigent patient is treated free of charge - provided of course that a bed can be found for him. There is, in general, considerable variation between the standard of accommodation and medical care of a patient in a Class 1 bed and a patient in an indigent bed. However, a recent praiseworthy trend in countries with "classed" beds is to attempt to give equal quality of care irrespective of the ability of the patient to pay, the only difference being in the standard of accommodation and other facilities which are not directly related to the standard of the medical and nursing care which is provided.

Changing patterns in the provision of hospital services are arising from advances in medical knowledge and technology and in increasing public demand for their application to the care of patients. As a result, costs of operating the hospital system are increasing in all countries. An inevitable result will be the decreasing ability

of the patient to pay for the service he receives which will in turn lead to increased control of hospitals by central authorities, increased government sponsorship, technical supervision, guidance and financial support, combined with planned development of the hospital system within the health sector of national socioeconomic development plans.

4. LEGISLATION

Locally adequate legislation, capable of application in each country, is essential to the building standards, operation and supervision of the hospital system. The words "locally adequate" were purposely chosen. One country of the Region has hospital legislation but little of it is being enforced. The legislation and regulations have been adopted from a highly developed country and cannot be implemented in the country in question because of its intermediate stage of socioeconomic development.

Public hospital legislation, largely because of historical and political reasons, varies greatly throughout the Region. Australia, Japan and New Zealand have well defined legislation and regulations, but the Australian situation varies from state to state because of the limited authority of the Commonwealth Government in health under the Australian Constitution. At the other end of the scale is Laos where regulations in existence when the country was a French colony have not been revised.

Legislation governing private hospitals varies considerably throughout the Region. There is adequate control in Australia, Japan, Malaysia and New Zealand. In the Republic of Viet-Nam, the Minister of Health has control only of technical standards and sanitation.

A welcome recent development within the Region is an increasing awareness by governments of the need for review of hospital legislation and regulations. Requests for WHO assistance are increasing. A number of fellowships in this field have been granted to nationals of Member countries and in 1973 consultants will assist Brunei and Malaysia with consolidating and updating their hospital and other health legislation.

5. FUNDING

The public general hospital system may be funded in one or more ways - often several in combination.

In only two countries or territories of the Region is the public general hospital system funded wholly by the central government without any direct contribution by the patient, New Zealand and the Trust Territory of the Pacific Islands. In Tonga, a similar system virtually exists because patient contributions amount to only 2% of central government expenditure on the hospital system. The Philippines is an example of hospital funding by central government, provincial government, local authority and the patient. In the case of Australia, with the exception of Queensland, there is also funding by the Central Government, state governments, the local authority and the patient. However, the local authority contribution is minimal, 0.2% and part of the patient contribution is, for those who are insured, reimbursed to the patient.

6. AVAILABILITY OF BEDS

The availability of hospital beds is important in the provision of hospital care. With the exception of French Polynesia where in 1969 the bed/population ratio was 7.50/1000, there is a close correlation throughout the countries and territories of the Region between availability of beds and socioeconomic development.

In 1969, New Zealand, Japan and Australia led with ratios of hospital beds of all types, public plus private, of 14.20, 12.51 and 12.01 respectively/1000 population. At the other end of the scale, in 1969 Laos had beds available at a ratio of only 0.60/1000 population.

Formerly in many countries, especially in Europe, there has been a tendency quite wrongly to equate availability of hospital beds directly with the quality of medical care. This trend was also enhanced by politicians because a hospital is much more of a status symbol and evidence of political patronage, than for example an efficiently operating tuberculosis or venereal disease control programme. Much evidence is available, also from Europe and the United States of America, that if hospital care of a reasonable standard is made available, a willing public and a compliant medical profession will ensure that the beds are filled to a reasonable occupancy.

The trend in some countries of Europe today is one which is evident in some of the more developed countries of the Region, namely, to examine the function of the hospital system and use available beds more efficiently rather than to continue to increase the bed/population ratio to meet demands which often an examination can meet without supplying additional beds.

It is important that a country not build beds in excess of its financial ability to maintain them or in excess of the country's ability, in terms of trained personnel, to staff them.

The demand for hospital beds varies greatly from country to country according to many variables of which age group, population distribution, morbidity patterns, standard and availability of non-hospital based medical care, geography and communications facilities are but a few examples.

No definite norms have yet been established in the Western Pacific Region but it is highly likely that beds of all types in ratios of 10-12/1000 in the more developed countries, 4-5/1000 in countries at an intermediate stage of development, and about 2/1000 in the less developed countries would be reasonable at the present time.

7. THE HEALTH BUDGET AS A PROPORTION OF THE NATIONAL BUDGET AND THE PUBLIC HOSPITAL BUDGET AS A PROPORTION OF THE HEALTH BUDGET

It is unfortunate that data which would enable a detailed comparison of all the countries and territories of the Region in terms of the above indices are not available.

In terms of the health budget as a percentage of the national budget some interesting trends and comparison for the years 1964 and 1969 are possible with some countries. Among the lesser developed countries, Fiji has been able to spend a high proportion of the national budget on health, 13.54% in 1964 and 11.65% in 1969. Japan over the same period showed a remarkable increase from 13.3% in 1964 to 18.6% in 1969. In 1964, two countries at greatly different stages of socio-economic development spent nearly the same proportion of their national budget on health, namely, Malaysia, 6.3% and New Zealand, 6.8%. By 1969 Malaysia had increased health expenditure to 7.8% of the national budget but the equivalent proportion for New Zealand had fallen to 4.9%. The New Zealand figure would appear to indicate more efficient operation of the health services, erosion of the health services, or the two in combination.

It is noteworthy that in 1969, in the two countries of the Region in which the Government assumes the total cost of hospital care and hospital services, namely, French Polynesia and New Zealand, the hospital budgets absorbed 60%-70% of the total health budget. Regrettably, comparable figures are not available for other countries and territories.

The hospital budget in many countries of the world for which reliable data are available is in the region of 70% of the total health budget, a clear indication of the need for countries to examine most critically the cost effectiveness and the cost benefit of those aspects of the hospital system in which these management tools can be utilized in relation to other systems of health care which exist or may be developed.

8. THE FUNCTION OF THE HOSPITAL

The function of the hospital system is implicit in the two definitions quoted in the first section of this paper. The first definition may be regarded as the ideal, the second as the basic and practical.

Conditions and systems vary so much within the Region that it is possible to generalize on principles only, rather than on situations as they exist.

The goal should be that hospital systems be developed towards the ideal, namely "an integral part of a social and medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose outpatient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for biosocial research"1/.

In this respect some of the developing countries are fulfilling only the basic function at present, namely - "An institution that provides inpatient accommodation for medical and nursing care"2/. In this latter group there is an excellent opportunity to lay the foundations of a system which will eventually evolve, as socioeconomic development and national health planning are developed, towards attainment of the ideal.

Acceptance of the principles of the concept of regionalization is almost certainly universal throughout the Region and many countries are developing their hospital systems at a local, intermediate and regional level with varying adaptations to suit local conditions.

Many factors influence variations in details of the function of the hospital from country to country, for example, socioeconomic, cultural, the degree of development of extramural services, the degree of development of the rural health units or the general practitioner medical service and the role of the local authority.

In some countries of the Region hospitals have general outpatients and specialist outpatients, and the patient has free access without referral to the general outpatients which provides doctor of first contact care to the ambulant population. This is particularly true of the developing countries. In other countries with a well-developed general practitioner service, of which New Zealand is an example, outpatients departments are specialized and patients are seen on referral only but doctor of first contact care is available through the accident and emergency departments (casualty departments) for those who need care of this nature.

Similarly the pattern of preventive services available from the hospital system varies considerably from country to country throughout the Region. Immunization, for example, may be limited to BCG. Alternatively a comprehensive range of immunizations may be made available. Some countries do not offer a family planning service as part of the maternal and child health services available from the hospital. In others it is part of an integrated family health programme.

Coordination between institutional and extra-institutional health services to ensure continuity of individual care, and to relate preventive and promotional health activities to curative and rehabilitation care is one of the most challenging problems with which health administrators have to deal.

Various systems are applied in the Region to handle this question wholly or partly. In countries where hospital and district nursing services are well organized, as for example in Australia and New Zealand, district nurses take over when patients leave the hospital. Domiciliary medical care is being provided through referral to the personal physician or through a home care programme organized by the hospital.

In the public health field, particularly in the MCH, paediatrics and tuberculosis control programmes, a two-way referral system is being tested in the Philippines. The coordinating functions are assured either by a member of the nursing services specifically in charge of this work or by public health nurses visiting the hospital.

Records systems vary considerably throughout the Region. Broadly speaking, adequate records systems of two types are necessary - medical records of patient care and the business records of hospital management. With deficiencies in either system the epidemiology of patient care cannot be studied nor can the costs of such care be analyzed and one related to the other. Use of the International Classification of Diseases

is not yet universal throughout the public hospital systems of countries of the Region. Hospital-accounting in some countries leaves much to be desired. Countries and territories are aware of deficiencies in these areas and it is noteworthy that some are taking steps to initiate improvement. The importance of hospital records within the overall system of vital and health statistics cannot be overemphasized. Developments in Member countries could well be a subject for discussion.

The role of the hospital as a centre for teaching and research is recognized throughout the Region. The degree of development in these respects, especially in teaching, tends to be related largely to the degree of socioeconomic development of the country but in research it may be related also to the enthusiasm of workers in a particular field. In the training of undergraduate medical personnel in particular it should be recognized that although over 10% of the population of a country may be admitted to hospital in a year, in the region of 90% of illness may be treated outside of the hospital. Progressive medical schools are exposing their students to the practice of community medical care by the general practitioner or rural health unit in addition to the highly specialized medical care that is practised on the hospital inpatient. Discussion of the role of the hospital and the community in training could prove most fruitful.

9. COSTS

International comparison of costs of hospital care can be extremely misleading and none will be attempted. However, some statements of a general nature can be made. In countries from which information is available the capital costs of hospital construction are increasing. The cost per occupied bed per day is increasing in individual countries. In countries which can supply the relative information the cost per patient treated is steadily increasing.

Capital costs can be controlled by regional planning and the provision of facilities within an overall national plan combined with relating construction and design to function within the concept of progressive patient care.

Salaries of staff are a major proportion of hospital costs in all countries; in many there can be rationalization by the training and employment of auxiliaries and, by following the principle that no staff member should carry out a function for which he has not been trained, no staff member should carry out a function which a person with a lesser degree of training could carry out equally well.

In some countries more adequate bed utilization with increased bed occupancy is offsetting apparent needs for more beds. There is a tendency towards a shortening of the average duration of stay per patient treated without detriment to the standard of care.

Strengthening of extramural hospital services, outpatient and rehabilitation services and the integration and coordination of hospital-based activities with the activities of those providing community care can do much to lessen that hospital care which is most expensive, namely, inpatient care.

10. WHO ACTIVITIES IN THE REGION

The regional programme of assistance in this field varies greatly according to the needs of Member countries of which the most important determining factors are the degree of socioeconomic development, population, relative isolation and internal stability.

Technical assistance to ministries deals primarily with hospitals, hospital-based activities and legislation related to them, namely hospital design and management, rehabilitation and related social security legislation within the broad field of medical services administration and the organization and delivery of health care.

In the highly developed countries WHO assistance is usually limited to fellowships to enable nationals to observe trends and activities in these fields in selected countries throughout the world.

In countries at an intermediate or lower level of development, advisers or consultants may be assigned to strengthen activities in the country while nationals are being trained overseas in specialized fields or alternatively advisory long-term staff may be assigned. In the latter instance, through local training combined with fellowships, the aim is to strengthen the organization of medical care and its delivery so that long-term advisory assistance from WHO will not be necessary beyond, for example, a five-year period.

Countries that have been or are at war pose a special problem because of the needs in medical rehabilitation of civilians and former military personnel.

In the 1973 programme of assistance four countries have or will have advisers in the following fields: medical services administration, physical therapy, prosthetics and orthotics and organization of medical

care. Consultants are or will be provided to a number of countries in the following fields: physical therapy, hospital administration and management, medical rehabilitation and organization of medical care. A total of 18 fellowships in different organization of medical care fields have been awarded to nationals of six countries.

In two countries of the Region, Laos and the Philippines, WHO is assisting in establishing coordination between hospital nursing and community nursing through assisted projects which are developing the general health services.

A regional seminar on hospital design and management was held in Manila in 1971 and a regional project in the same field is planned to commence in 1973.

11. WHO FUTURE ACTIVITIES IN THE REGION

As with assistance in other areas of health and medical care, WHO activities will be aimed at responding to the needs of individual countries and territories in the field of hospital-based medical care. In view of the pressing needs of the basic health services and special programmes in many countries, by comparison, hospital and related care has tended to receive relatively little attention in the past. Special programmes are now being integrated with the basic health services both the quality and quantity of which are being steadily improved. A reasonably confident forecast is that an increasing amount of WHO assistance will be in the general area of hospital-based medical care, particularly in view of the proportion of the national health budget which is spent on such care.

In the more developed countries it is highly likely that activities will continue along present lines with the major emphasis on fellowships in highly specialized areas of which rationalization of national rehabilitation programmes, operations research into aspects of medical care and hospital and social security legislation are but a few examples.

In those countries at an intermediate stage of socioeconomic development WHO activities are more likely to be of assistance in the form of consultants rather than the assignment of long-term advisers. There will almost certainly be a trend towards greater specialization both with the assignment of consultants and especially with the award of fellowships as is already the case with the more developed countries.

Until such time as basic hospital medical care in those countries which are relatively underdeveloped can be strengthened through the return of fellows with sound generalist training, it is likely that WHO

upon request, will assign either generalist advisers or alternatively specialist consultants in such areas as laboratory services and medical records.

The most pressing needs in the immediate future in those countries ravaged by war are assistance in medical rehabilitation and the reconstruction of hospital and health centre facilities.

In most countries and territories of the Region there is a need for strengthening hospital administration and for rationalization of hospital and health centre architectural design and supply and maintenance of equipment. These needs have been recognized by the Regional Office. A regional seminar has been recently held on the former and an inter-country project is planned for the latter. WHO Headquarters in Geneva has also expressed interest in the latter area and a series of publications are planned.

In summary, WHO activities in all aspects of hospital systems can be expected to increase rather than diminish both quantitatively and relatively in relation to other areas of assistance in the health field and will evolve to meet the needs of individual countries and territories of the Region as a whole.

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