MEDICAL CARE AND SOCIAL CLASS IN LATIN AMERICA

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Few services or commodities an individual may procure for himself or his family are as intimate and often critical as medical care. The way it is obtained involves not only decisions about money and judgments as to whether a given expenditure is worth the attainment of a certain degree of relief from pain or discomfort, but may be a matter of life or death. It is small wonder, therefore, that in any culture the pattern of procurement of medical care—both its financing and its scheme of provision—will vary with the social class of the person involved.[1]

The class structure in Latin America and other economically underdeveloped parts of the world is more rigid, more sharply defined, than that in the mobile society of northern America. One need not hew strictly to a unidimensional definition of "class"—whether based on relationship to the means of production, educational-occupational index, or status ranking—to recognize several different groupings of the population in Latin America, which differ in their standards of living, power, and relative claims on a nation's resources.[2]

In most Latin American countries one can identify at least the following six social classes of people:

1. Pure-blood Indians who live in rural settlements quite isolated from the mainstream of economic life. Their languages and customs have been only slightly influenced by the dominant Spanish culture.
2. Peasants, peons, and urban underemployed who are largely mestizos, who work the land as laborers, share-croppers, tenants, or very small owners, and who sometimes migrate to the cities in search of unskilled jobs.
3. Manual industrial workers who have learned some industrial skills, lived in the city for some time, and acquired relatively steady employment.
4. White-collar workers and small entrepreneurs who have had some education, are upwardly mobile with increasing social expectations, and constitute a rising middle class.
5. Military personnel, police, and selected civil servants, the agents of state power whose loyalty is important for the maintenance of that power and social order.
6. The elite—landowners, large merchants, industrialists, and upper-level professionals—who demand the best that the nation can offer.

These six classes are, of course, not absolutely rigid; there is some mobility among them, and as Latin America becomes increasingly urbanized, industrialized, and democratized the rate of this mobility is increasing. There are important variations, of course, among different countries and regions. At present, however, one can delineate these groupings with little difficulty.

Associated with each of these social classes is an equally distinguishable system of medical care—a pattern of social and economic organization by which medical personnel and facilities are applied to the diagnosis and treatment of sickness. For certain classes—because of the march of history and the persistence of old patterns along with new ones—there may be more than one system, but the social fit is still quite clear. Indeed, in my field observations throughout Latin America during the past year, I got the impression that one could readily identify a person's social class (and all the concomi-

tants of this identification) by examining the way that he obtained medical care.

The following brief account of medical care patterns, associated with each of the six social classes listed above, is based on field observations, interviews, and documentation review in five countries chosen to "represent" the Latin American constellation: Peru, Chile, Brazil, Mexico, and Costa Rica. Space does not permit an explanation of the rationale of these selections, except to point out that they err, if anything, on the side of selection of countries with higher development—both technical and social—in medical care organization. This brief exposition, moreover, cannot offer over-all quantitative data, but it may clarify the *relative* characteristics of the medical care systems serving each of the social classes.[3]

INDIANS

Outside the mainstream of economic life in Latin America are hundreds of Indian tribal groups who depend on the ministrations of various indigenous healers for most of their medical care. Roughly speaking, these *curanderos* are of three types: 1. those using empirical methods of treatment, like herbal concoctions, heat and cold, or even cutting procedures; 2. those using magico-religious rites to exorcise evil spirits; 3. those using manufactured drugs, with a glimmer of modern knowledge but quite without ability at scientific diagnosis. There may be combinations of these approaches by the same practitioner or by different practitioners in the same locality. The provision of this type of health care may command payment of a fee or may be done free as a neighborly gesture. Midwifery is a related service of older women, while the *curanderos* are usually men.

This is the old and established pattern of medical care for Latin American Indians, like those who dwell in Andean villages or the river settlements in the interior of Brazil, and it doubtless accounts for most of the service these people receive. Along with it, however, some contact is being increasingly made with two other systems of medical care—the *beneficencia* system and the government system—which will be described in the next section.

PEASANTS, PEONS, AND URBAN UNDEREMPLOYED

The largest segment of the population in most Latin American countries are the mestizos and others of mixed racial background who work the land of the large *latifundias* or sometimes operate small plots on a share-crop, tenant, or ownership basis. They contribute to the national economy, in that their products—coffee, bananas, and sugar—constitute the major exports of the country. To serve their health needs there is a system of medical care based on charitable or *beneficencia* hospitals, which were established by the Catholic clergy who accompanied the conquistadors. Later these facilities came to be operated by local boards of wealthy citizens, in a spirit of noblesse oblige, with only indirect ties to the Church. Still later, to keep going, the hospitals began to depend increasingly on subsidy and even direct control by units of local and central government.

The *beneficencia* hospital system (*santas casas* in Brazil) is the largest component of institutional care in most Latin American countries, even though in several it is rapidly evolving into a governmental system. The quality of care provided in most of these hospitals is minimal; large barren wards, small staffs, meager diagnostic equipment, and deficient supplies of drugs and food characterize most of them. The patient's family must often provide some food and nursing care. Some of these hospitals in the large cities are used as teaching institutions for medical schools, so that they are stronger on the technical side but little different on the human side. Ambulatory service is also provided in frugally equipped outpatient departments which are overcrowded and understaffed.

These *beneficencia* hospitals are built in the main cities and towns, and of course they serve only the people who can make their way to the door. Sometimes ambulance service is available through the Red Cross or a governmental service (*see* below). Occasionally Indians, whose illnesses have not responded to the efforts of village *curanderos,* will come for help. But the main clients are the rural agricultural families around the towns and the low-income underemployed or unemployed families who fill the slums or *barrios* of the larger cities. The guiding philosophy of this charity system is paternalistic succor for the poor in their hour of distress.

Parallel with this older system of medical care is a twentieth century counterpart—a public service operated directly by units of government, preventively oriented, and geared essentially to the needs and demands of the low-income social classes. Partly because of the influence of international agencies (especially those of the United States), and partly because of a growing enlightenment of governments on the value of welfare services in allaying social discontent, most Latin American nations have now established ministry of health programs of preventive and curative medicine. Typically these consist of large regional hospitals which are quite well designed, equipped, and staffed; rural health centers with a few beds for minor illnesses, medical observation, or childbirth; and a network of small health stations staffed by auxiliary personnel (aides, *practicantes,* sanitarians), to give immunizations, first aid for minor illnesses or injuries, and sanitation advice.

There is usually a heavy rural orientation to this governmental service, which aims to fill the gaps of the *beneficencia* system and also to counteract the discontent behind agrarian revolutionary movements. In the rural health centers and health stations, the ambulatory services tend to be comprehensively preventive and curative, but in the main cities—where *beneficencia* hospitals are at hand for treatment of the sick—the focus is more exclusively preventive. The trend is clear in several countries toward a gradual replacement of the charity hospital system by these governmental networks of hospitals, health centers, and health stations. For the present, however, both systems usually operate side by side to serve the low-income country- and city-dwellers of this depressed social class.

MANUAL INDUSTRIAL WORKERS

As Latin America, like Europe and North America before it, has become industrialized, a class of more or less steady urban wage-earners has developed. These people tend to acquire a certain political and class consciousness; they form labor organizations, and

make articulate social demands. In response, almost all Latin American countries, starting with Uruguay in 1919, have established systems of social insurance to meet certain critical needs. Unlike policy in the United States, old age is not usually regarded as one of these needs, but disability and sickness are. The principal benefit of the Latin American programs of "social security," as they are called, is the provision of medical care. The funds are usually derived from contributions by employers, workers, and government. Sometimes the worker's family is covered, sometimes not; but, in general, the program protects between 10 and 20 per cent of the national population.

There are intricate variations in the administration, coverage, and benefits of these systems but they usually provide a higher quantity and quality of medical care than that available to the previously discussed social classes. The care is given in two ways: 1. Through use of the existing charitable or governmental hospitals—or sometimes private facilities (*see* below)—in which special quarters and personnel are reserved on a high-priority basis; 2. through the establishment of separate polyclinics and hospitals for the exclusive use of insured persons. The trend is clearly toward the second approach. The entire staffing and technical level of these facilities tend to be rather good by North American standards.

Parallel with this medical care system of *seguro social obrero,* which is heavily concentrated in the main cities (often largely in the national capital), there is usually another pattern of care for the workers employed in isolated factories and mines. This involves the self-contained hospital and clinic for the complete care of the company's workers and usually their families. There is also the managerial white-collar class in the enterprise to be served. The arrangements often antedate the social security system. They spring from another motivation—the need of modern industrial management for a healthy work force. Because of their isolation from the cities, these enterprises—usually run by foreign corporations—have had to take the initiative for medical care; otherwise none would be available. The staffing and equipment of these facilities are usually very good. Laws in many countries have made these services manda-

tory at isolated factories or mines. In recent years these industrial programs have come to be financially co-ordinated with the social security systems that theoretically cover the same workers.

WHITE-COLLAR WORKERS AND SMALL ENTREPRENEURS

One of the most striking reflections of the force of class lines in Latin America is the pattern of social insurance that has been evolving for wage-earners on a higher level than the manual worker. Using the same legal and fiscal mechanism, many Latin American countries have established separate and parallel systems of medical care for white-collar employees.

These systems are not only physically and organizationally separate from the *obrero* systems, but they are usually more generously financed. The salary levels taxed are higher, in the first place, and the governmental contributions to the insurance fund are also usually higher and more regularly made. Hospital facilities are spacious, often elegant. The doctor-patient relationship is more permissive than in the *obrero* programs. The policy allows "free choice of doctor" with fee payments from an insurance fund, rather than requiring that all care be rendered exclusively in organized polyclinics.

The social security *institutos* that operate these programs for white-collar workers or *empleados* are entirely different from those protecting manual workers, although in some countries limited measures of co-ordination are being explored. Since the remuneration these agencies can offer doctors, nurses, and technicians is usually relatively high, more and better personnel can be attracted to them. Unlike the systems for the lower social classes, these systems are often involved in controversies with private practitioners of medicine, who see them as strong competitors for clients. Nevertheless, this controversy is less bitter than in the United States, since the great majority of Latin American physicians are pleased to receive steady salaries from a social insurance agency, on either a full-time or part-time basis.

MILITARY PERSONNEL, POLICE, AND CIVIL SERVANTS

On a socio-economic level that is perhaps midway between the manual worker and the white-collar employee is the class of people who are essentially servants of the state. Since their personal loyalty and physical well-being are important for the maintenance of state power, special programs of medical care have been developed for them. This pattern, of course, is seen in countries throughout the world, including the free-enterprise United States, where a system of highly "socialized" military medicine has been peacefully accepted for years.

The programs in Latin America for army, navy, and police are usually quite distinct, with their own special hospitals, militarized medical personnel, and sometimes even separate schools for training commissioned physicians and nurses. They usually antedate the social security programs. The ratio of personnel and beds to the eligible population tends to be much higher than the national average. For other civil servants, there may also be separate facilities and staffs, or contractual arrangements may be made with existing resources for top-priority care. There are also often separate, well-endowed programs for railroad workers or for employees of special governmental corporations, like the petroleum industry in Mexico. Sometimes these services for servants of the state are offered through a mechanism resembling an *instituto de seguro social* in form, but actually are financed mainly by general tax funds, since the so-called "employer contribution" comes from the government itself.

THE ELITE

Finally, there are the well-to-do and upper classes who obtain their medical care through purely private arrangements. They see doctors privately and pay personal fees. They are hospitalized in the private rooms of hospitals, and they purchase prescribed drugs in commercial pharmacies. They see private dentists and are tended by private nurses.

Only a small percentage of physicians in Latin America is engaged exclusively in private practice, but the great majority spend a part of each day in such practice. Since their financial awards per hour are usually much higher for private service, doctors naturally tend to give private patients a disproportionately large share of their available time. There is no question about the more painstaking and solicitous attitude to patients seen in private offices, compared with those in public clinics.

The hospital services for the elite may be given in three ways: 1. in small, proprietary private clinics operated for profit, usually by physicians themselves; 2. in private nonprofit hospitals operated by associations (often called *beneficencias privadas,* not to be confused with the *beneficencia* hospitals for the poor) based on ethnic or religious affiliations; 3. in private or *pensionado* sections of governmental or charity hospitals. It is a striking reflection on Latin America's class structure that, even in the newest governmental hospitals designed largely for the mass of the people, there is usually a handful of private rooms; in them the local elite are treated by their personally chosen and privately remunerated physicians.

This private sector of medical care, while largely devoted to the social elite, may also serve the other social classes—the white-collar workers rather frequently, others occasionally. It represents a kind of safety valve to which members of the other classes may have recourse when their anxiety is especially great and when they can scrape up the money (free service in private practice is virtually unknown). With the rising expectations of Latin America's enlarging middle class, therefore, the private sector of medical care remains significant, despite the steady expansion of social security and other organized services. It must also be recorded that the "upper, upper" elements in the social elite go abroad for their serious medical care, to Zurich, to New York, to the Mayo Clinic, or they may finance the flight of a renowned foreign surgeon from the United States to Rio, for example.

This completes an all-too-brief account of the diverse systems of medical care operating side by side to serve the several social classes

of Latin America. The inequities in application of available resources to human needs are obviously enormous. It is grossly apparent that at the lower end of the class spectrum the populations are large and the quantity and quality of resources are small, while at the upper end the numbers are small and the resource allocation is great.

But it is not just a question of human inequities that must be faced. It is a question also of wastage and inefficient use of over-all resources, which means that the total population receives less service than it might. The separate and unco-ordinated operation of these class-oriented systems of medical care, side by side in the same towns and regions, means extravagance in the use of scarce medical personnel, technical facilities, and administrative leadership. There is waste in travel time, in communication, in recruiting, in training, in procurement of supplies, in the whole logistics of providing services. To nourish the class-bound wishes and attitudes of people, an enormously complicated and inefficient structure has been built—quite aside from the human misfortunes and the handicaps for national economic development.

A rational organization of medical care, as well as preventive health services, in Latin America—as in other parts of the world—would have to be built on a concept of geographic regionalization. Resources should serve people in relation to where they live and work, rather than according to their social pedigree. This is, of course, easier said than done, but the bright light on the horizon is the initiative being taken by the health leadership of several Latin American countries in systematic planning. The greatest progress has been made in Chile, with its National Health Service, and a number of important co-ordinating measures have been undertaken elsewhere, that time does not permit us to review. The critical challenge facing Latin American leadership today is to undo the ropes of medical care systems tied to social classes and particular systems of financing, and to retie them on the basis of regionalization. The question is how rapidly and smoothly this can be done while class distinctions and attitudes run deep. This is a task for high statesmanship—both medical and political—but the pressures are certainly being felt in Latin America today to grapple with it.[4]

REFERENCES

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