

Mexican hospitals

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Abstract

In order to understand current medical and hospital care in Mexico, we need to know first their past and then compare that past to their present situation. We can attempt to glimpse into what their future should be. The evolution of Mexican health services from the time of the Spanish Conquest until the post-revolutionary period involved the creation of hospitals for both the poor and the rich. This continues to be the present goal. Public and private medical institutions evolved in part along with the legal reforms that were enacted through the passage of the Reform Laws in 1937. The Public Assistance Secretariat was established, which was dedicated to assist hospitals, nurseries, asylums and orphanages. In 1943, this Public Assistance Secretariat joined with the Public Health Department, forming what today is the actual Secretary of Health. The formation of private social health care for major medical needs together with governmental Social Security Health Care brought about a radical improvement in medical and hospital care; however, it is insufficient, overpopulated and outdated. It will be necessary during the coming decades that other alternatives to the models of hospitals and medical care that exist today in Mexico be enacted. The present models have not been able to satisfy the medical and hospital demands for present-day needs of the population.

Key words: public hospitals, medical care, health services.

Introduction

During 2005, we were requested to analyze Mexican hospitals, present and future. However, political-economic environments, both domestic and international, were very different then. Therefore, we consider our proposal is more advantageous now because both fully private hospitals and state-run services have proven to be far from ideal. The joint collaboration of private and public sectors (including users in some instances) should finance healthcare services.

To analyze the best alternatives for Mexican hospitals in the 21st century, we should review the evolution of healthcare services in our country. Also, it is essential to identify alterations in diseases that require hospitalization because of the increased morbidity associated with a longer life expectancy, which affects

the elderly population. There has also been an increase in the number of trauma patients as well as perinatal pathologies. Financing also plays an important role because private hospitals currently have gained greater importance along with easier access to resources than public hospitals.

What Is A Public Hospital?

A "public hospital" is an institution that attends the health needs of patients not covered by Social Security systems and depends on the Secretary of Health or its state equivalent.

A "private hospital" is an institution supported by enterprises or organizations and is open to the "public" who can pay for services or who pay for private insurance policies.

The 21st century hospital would resemble those in Mexico City or other large cities such as Monterrey, Guadalajara, Puebla, Leon, Torreon, or other medium-sized cities in Mexico.

The Mexican Constitution guarantees health protection and this is accomplished through Federal Secretary of Health programs that include promotion, opportune detection, specific prophylaxis and prevention, as well as hospital care services through Popular Insurance (Seguro Popular); however, without directly intervening in hospital structure.

During the Federal Administration (2000-2006), a plan was conceived to integrate State healthcare organizations into a hospital network.

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Received for publication: 11-14-2008

Accepted for publication: 4-16-2009

Hospital Origins

Hospitals were created during the “dawn of our era” by religious institutions and funded by charitable contributions. They took care of patients, the elderly and orphans, provided they had the appropriate religious affiliation.

Examples of the above are Byzantine Hospital, Islamic Maristan (considered the first Medical Center), Pantokrator Monastery hospital (1136 AD, the first hospital that combined medicine teaching and healthcare), established in Gandishapur in the 6th century.¹

In the 18th century, hospitals acquired a worldly philanthropic character and in Santo Spirito Hospital in Italy, each patient had his own bed. This model had a great influence in America, especially in Mexico and Peru.²

Medical Care prior to the Spanish Conquest

Inhabitants of the Mexican territory before the Spanish Conquest had their doctors, medicine men, priests and shamans who managed patients with a very different approach than “civilized Europe.” It is very likely that they better understood diseases from this part of the world and healed patients with more appropriate knowledge and better therapeutic results.

Hospitals in the Spanish Colony

Hernán Cortes founded the Hospitals of Immaculate Conception (current Hospital de Jesús) in the highlands. The Spanish Colony

created the San Andres province hospital in 1781, which was the last to be established in Mexico City (Figure 1).

The city of Veracruz was the only contact with Spain and a number of small hospitals were built there. They were not managed by friars; however, they cared for beggars, orphans, and the needy.

This originated the idea that hospitals administered by patronages were dedicated to patients only, and several hospitals were open for diseased persons along with asylums for the elderly, with a minimum participation of official authorities.

Charity

The Royal Indian Hospital was built in Mexico City for the “indigenous poor” and the God Love Hospital was built for Spaniards. The San Andrés hospital was built for the military.²

New hospitals with similar characteristics were created during the Spanish Colony while new cities were founded; however, control over these institutions gradually returned to the clergy. The last hospital built in Mexico by Spaniards was “San Sebastian” (Veracruz, 1799), which retained its functions until 1986 (Figure 2).³

Hospital management returned gradually to the clergy who subsisted on charity, but this assistance was never sufficient. This is still currently practiced.

Mutuality

Before the Industrial Revolution, unions contributed with quotas to finance expenses; however, during epidemics, natural disasters or serious accidents, resources were insufficient to keep hospital services in operation.



Figure 1. First and last hospitals built by Spanish Conquerors in Mexico City.

Private Charity

Laws from October 25, 1856 and February 4, 1861 generated disengagement of assets and properties of religious institutions, and Reform Laws prepared the nationalization of the assets of the clergy; therefore, church properties that carried out private charity were included in the process.⁴

On May 27, 1899 the Congress of the Union granted Executive Power, extraordinary capabilities to promote the Law on Private Charity. Citizens from other countries who lived in Mexico founded charitable societies such as the English Hospital, Spanish Charity Society, American Society of Charity, French, Swiss and Belgian Association, Italian Charity Association and Mount Sinai Alliance.

On March 2, 1861, Mexican President Benito Juárez commanded the creation of the Public Charity Funds Directorate, which depended on the Ministry of Government and, therefore, hospitals, hospices, reformatories and charity establishments would be protected under such Directorate.

During January 1877, the Public Assistance Directorate was created and replaced the aforementioned structure, now dependent on the Superior Healthcare and Vaccination Service Council. This dependence was abandoned because of lack of financial resources and, in 1920, became part of the Secretary of Government (Figure 3).

In the 1930s, the concept of charity was replaced by care and recognized the State's obligation to intervene in health care and social aid as well as the right of citizens to request it.⁵

All of the above have generated a tradition in Mexico where "public hospitals" are only for poor or needy people.

At the beginning of the 20th century, after the discovery of anesthesia, several physicians decided to create their own hospitals. These were small at the beginning but with a higher level of comfort for patients along with the discontinuation of

surgery at wealthy residences. This gave rise to "sanatoriums," which transmitted the idea of healing rather than of the natural evolution of disease.

Official public hospitals incorporated annexes to assist wealthy patients and, therefore, increased their revenues and created specific pavilions such as "Gastón Melo" annex to the General Hospital of Mexico.

Secretary of Health and Assistance

In the 1917 Constitution, part 76 mentions in its XVI article (first through third paragraphs) that the Healthcare Council depends directly on the President of the Republic and should intervene during epidemics and natural disasters.

In 1928, President Emilio Portes Gil created the Department of Public Health, which was known in 1930 as the Department of Health. In 1934, President Lázaro Cardenas created the Secretary of Public Assistance, which was independent of the Department of Health.⁶

The Secretary of Health and Assistance was created in 1943, consolidating the Secretary of Public Assistance and Department of Health and, in 1983, the Secretary of Health and Assistance changed its name to Secretary of Health.⁷

Federal Public Charity was responsible only for Mexico City and Federal Territories, but the General Healthcare Council had a health representative at the Mexican ports to avoid possible epidemics. This generated that each State created its own Public Charities.

Veracruz was the first state to promote laws to protect Public Charity and created municipal assemblies of Public Charity that were responsible for the management of hospitals and asylums.⁸

The National Lottery was created during the time of the Spanish Colony and in 1920 was established as the National Lottery for Public Assistance. All its revenues were delivered to



Figure 2. Last hospital built during the Spanish Colony in Veracruz called San Sebastian Hospital and later named Aquiles Serdan Hospital. It was closed during 1986.



Figure 3. Former building of public charity.

the Secretary of Public Assistance and Secretary of Public Healthcare and Assistance.⁹

The National Medical Center was sold to the Mexican Institute of Social Security and the Secretary of Healthcare and Assistance built the largest number of medical centers in rural and urban environments, identifying them as healthcare centers and hospitals, achieving for the first time that better healthcare services were offered to the Mexican population. These services were under the subsidiary of the Federal Government, recovery quotas and voluntary cooperation.

Private Insurance

Financial companies offered insurance to organizations in England and Germany after the Industrial Revolution to protect workers from work-related risks. This was also promoted in Mexico before Social Security, and this type of insurance evolved into life insurance; however, in other countries insurance companies have promoted major medical expense policies. This included medical care and hospitalization, reaching such a degree that currently they represent the chief financing source in developed countries. Mexico has also followed this trend.

Social Security

Social Security in Mexico was created through the Mexican Institute of Social Security (IMSS) and, without an important hospital infrastructure in our country, the IMSS was forced to rent buildings and private hospitals and built medical units throughout Mexico, achieving the largest number of hospital beds and modernization of healthcare in the country. However, in Mexico City, there were already prestigious healthcare centers such as the National Institute of Cardiology, National Institute of Nutrition, and Pediatric Hospital. The first “tower” hospitals were Military Center Hospitals and “Colony” Hospital from the National Railroads.

The Institute of Social Security to Service State Workers (ISSSTE) was born as a complement to Social Security. This institution acquired the building of a private hospital to build the specialized “20th of November” Hospital.

Health as a Constitutional Right

Article IV of the first chapter of the Mexican Constitution mentions that “every person has the right to healthcare protection...”. The law defines the bases and modes to access healthcare services.¹⁰

There have been several programs in Mexico to grant medical care following World Health Organization (WHO) recommendations from Alma-Ata Declaration: “Health for all in year 2000”. However, efforts and resources were dedicated to primary care

hospitals in an informal system and there was minimal investment in hospitals in order to increase their resolution levels.

Rural Solidarity Hospitals built by the IMSS initiated hospital services in marginal zones, financing with surpluses from actuarial provisions of the IMSS.

Building of modern state hospitals began during the last 20 years and some received federal funding. It was not until the year 2000 that a plan was devised through the Secretary of Health to build regional hospitals because pathologies associated with a longer life expectancy demanded more specialized medical care than 50 years ago.

With the promulgation of the Popular Insurance Law, several hospitals have been reinforced in areas where the program has been applied. Unfortunately, not all rural hospitals have appropriate facilities.

Therefore, investment or financing is still required to develop hospitals throughout Mexico.

Hospital Evolution in Mexico

During the first half of the 20th century, hospitals in Mexico remained as they were centuries ago, and the General Hospital of Mexico City (the most modern public hospital) still had isolation pavilions with criteria dating from the 19th century. During the 1930s and 1940s, a building model was developed that was used throughout the 20th century to build tower-like hospitals with certain variations (Figure 4).

During the 1940s after WWII and using American investments, modern hospitals were built through the Gulf of Mexico in Tampico (Tamaulipas), Tuxpan, Coatzacoalcos, Veracruz and Chimonco (Veracruz).⁸ Others were built along the Pacific Coast in Mazatlan (Sinaloa) and in Mexico City with the Manuel Gea Gonzalez Hospital.



Figure 4. Veracruz Regional Hospital was begun in the 1940s and was completed in 1952.

At the end of WWII, hospital building was suspended, but the Secretary of Healthcare and Assistance, taking advantage of that infrastructure, developed a project to build a Federal Network of Regional Hospitals. Some of these hospitals were never completed and others still operate with changes and modernizations. The Secretary of Healthcare and Assistance built hospitals in several states, even though there were state institutions that offered hospital care through public charity.

Certainly, the major development of the Mexican Institute of Social Security triggered new projects for hospitals and created the school of hospital architecture, bringing modern hospitals to several states.⁵

Between 1970 and 1976, the Secretary of Health resumed the Federal Hospital Network, building and completing those hospitals already mentioned and financing the projects without intervention from state or municipal authorities.

With decentralization of healthcare services between 1996 and 1997, federal, state and municipal hospitals integrated into healthcare networks, allowing that state investments grant medical care in areas far away from main hospitals. This has allowed closing the gap between hospitals in Mexico City and hospitals in northeast, west and “bajío” regions where modern hospitals have already been developed.

Between 2000 and 2006, new financing schemes were considered to consolidate the National Hospital Network project.

Current Hospitals

Mexico has different types of public hospitals: Municipal, State, Federal, and a large hospital network from the IMSS and ISSSTE. PEMEX (government-owned Mexican petroleum company) has its own “underused” hospital infrastructure. The Armed Forces also have their own hospitals.

There are several private hospitals throughout Mexico; however, most have a small number of beds and a low level of satisfactory resolution.

Mexico City has the largest number of private hospitals with a satisfactory level of resolution and companies that currently operate those hospitals have begun to expand their services to other large cities.

The bloom of this new healthcare model has been influenced by changes in the demographic profile of Mexico because public facilities are insufficient to provide healthcare for everyone and investment costs have resulted in that public hospitals fall behind current technological advances.

Also, neoliberal economic politics favor the development of private hospitals rather than Social Security facilities and public hospitals.

Unfortunately, private hospitals operate as “for profit” organizations and there are specific investor groups in Mexico that empower them; however, their goal is to obtain high revenues

to invest in other states. Most Mexicans cannot afford to use these hospitals so the gap between Public Hospitals/Social Security and Private Hospitals grows wide every day.

Hospital Structure

Hospital structure must adapt to new technological changes and social well-being requirements.

Hospitals will lose the large dimensions of those built in 1960s and 1970s, becoming open, flexible institutions with a close and bidirectional relationship with the outside hospital environment (Figure 5).

New hospital buildings, keeping in harmony with their environment, focus on aesthetic and functional buildings directed to patients who are frequently seen as “customers.”

Natural light usage, open areas and balance are factors reinforced by the aforementioned ideas. The modern hospital abandons its rigorous “assistance” character, avoiding overcrowding in favor of patient comfort.

Ambulatory trends and conditions have impacted the development of new hospitals. Ambulatory major surgery, minimally invasive surgery, “day hospitals,” home-hospitalization, etc. all highlight a change toward open hospitals. New hospitals favor activities without admission (70%) and only 30% of their facilities are dedicated to hospitalization for complex cases and those patients who require specialized technology. There is a trend to reduce hospital admission, avoid unnecessary hospital stays, reduce the number of beds and, paradoxically, increase mid-term stays.

Admitted patient should have a complex condition: transplant, cardiopathy, oncology, surgery, trauma, etc. Outpatient medicine plays an important role in this change of medical care, triggered by social pressure where it is part of the hospital as a whole. Many prophylactic and therapeutic procedures will be performed outside the hospital and referral centers will be part of comprehensive care.



Figure 5. Modern Regional Hospital in Veracruz, Hospital Regional del Puerto de Veracruz, opened in 2003.

Specialized technology is available to the community and the development of telecommunications opens the hospital bidirectional. The balance between care and patient well-being will take the lead in the provision of healthcare in coming years.

The modern hospital should combine high technology and ambulatory services, individual hospitalization with day-hospital activity, molecular and genetics research with a focus on prevention, robotic surgery, and distant activities and care using telemedicine.¹¹

Clinical Administration in the 21st Century

Bioethics underlines the importance of establishing the goals of medicine in this century. According to Diego Gracia, bioethics function in the 21st century will be to educate professionals and the population in general about the goals of medicine and management of body and life.

Technological advances and the genetics revolution can lead us to an irrational use of ever-limited resources. If we want to survive the present and next millennium, we must learn how to preserve and prioritize the growing use of these resources.

Our future points towards prophylaxis and excellence in medical care, and this action is directly proportional to participation and political commitment regarding resource distribution. Decision making in the new era of medical care should be based on bioethics, developing principles such as autonomy, non-maleficence, justice and charity.

The next decades will establish alternative models for hospital management that will replace the current paradigm. Self-management formulas according to public health areas are regarded as an organizational model: audacious, modern and effective. These models, with decentralized clinical areas, are having their first experiences in some public hospitals with the participation of professional healthcare personnel to manage resources in those areas they become integrated into. These models also include decentralized decision-making and responsibility surveillance, implementation of a new work scheme focused towards managing processes, self-evaluation and continuous improvement.¹²

This demands the development of a new organizational model that focuses on the process as a whole and is patient-centered instead of being structured around classic services.

This management model more evenly allocates hospital administration duties, provides higher autonomy and requires delegation from hospital directors. According to Carreras et al.,¹³ these self-managed area models attempt to close the gap between organization and "client", improving resource management. Perhaps the implementation of self-managed clinical areas will be developed over the next years and from their results we will be able to evaluate them as an alternative to the current model,

starting a total-quality project that supports their effectiveness.

Finally, we must accept that the new century bears a different concept for hospitals and we should make an effort to adapt to this new situation. We should not forget that future hospitals will be centered around a knowledgeable administration with the sole purpose of satisfying the user.

Current public hospitals should modify their organization gradually, according to the aforementioned models. Neither Federal nor State and Municipal Governments should reduce their contributions. Resources obtained by self-management will be used to correct the shortages from very constrained budgets. As financial resources increase, government support should be redirected to other facilities (suburban and rural) where additional resources will be difficult to obtain.

Hospitals in the 21st century should work within the machinery that supports hospital and out-patient care. Involvement of professionals and "clients" in the model design will be imperative. Total quality, technological development, genetic revolution, a hospital with more ambulatory services and self-managed clinical areas appear to be part of the new hospital paradigm for this century.

Conclusions

1. The origin of all hospitals was religious charity, housing patients in convent annexes.
2. Beginning from the 4th century, Christians began to build institutions for the poor.
3. Public hospitals retain the impression that their aim is to provide services for indigent persons or persons with low to medium economic resources.
4. Private hospitals are identified with persons with high socioeconomic resources.
5. Public hospitals depend on federal, state and municipal budgets as well as on recovery quotas controlled by the national public charity that receives 5% of these.
6. Private hospitals are a for-profit organization that obtains and manages its own resources, charging the user directly or through private insurance carriers.
7. Employees in public hospitals receive wages controlled by collective contracts.
8. Salaries of professional healthcare personnel in private hospitals are self-established along with negotiations with insurance companies.
9. Public hospitals are managed by administrators, who in most cases, are not properly trained and educated.
10. Private hospitals have medical and administrative specialists, allowing them to better manage their revenues.
11. Public hospitals ordinarily exhaust their economic resources by the end of the year.
12. Private hospitals usually recover their resources at the end of the budget cycle and use them to renovate or increase their

equipment and facilities, as well as to provide revenues to investors.

13. Public hospitals have patronages or committees that obtain resources to support patients.
14. Private charity hospitals receive funds from large institutions, foundations or companies, as well as new equipment and facilities expansion.
15. It is feasible that, with appropriate programs, many public hospitals can be transformed into medical care service companies.
16. It is mandatory to create true state and regional medical care systems.
17. Hospitals tend to be more important in their diagnostic and treatment facilities, which are expensive investments; therefore, they should switch from buying to renting or co-financing from vendors.
18. The only current coincidence between public and private hospitals is they assist patients or carry out prophylactic services to detect possible health problems. Public hospitals regard the users as "patients" and private hospitals refer to them as "customers."

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