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Shortcomings in the Peruvian public health system that impose hurdles on anesthesia care

Falencias del sistema sanitario público peruano que dificultan la atención anestesiológica

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Abstract

Shortcomings in the Peruvian public healthcare system affect the care provided by Peruvian anesthesiologists. Shortcomings that have a negative impact on perioperative management, including time to medical consultation, the referral process, and drug availability, are identified and compared with other contexts in Latin America.

Resumen

Existen problemas en el sistema sanitario público peruano que afectan la atención de los pacientes llevada a cabo por los anestesiólogos peruanos. Algunas deficiencias del sistema público concernientes al tiempo de consulta médica, el proceso de referencia y la disponibilidad de medicamentos, son identificadas y comparadas con otros contextos de Latinoamérica dado que complican el manejo perioperatorio.

Introduction

This article describes the shortcomings of the Peruvian public health system in relation to the time to outpatient consultation, time for referral to higher complexity

centers, and drug availability. These problems pose a challenge to anesthesiologists in their everyday care of patients, and make anesthetic management more difficult for a significant number of patients taken to surgery under coverage of the public health insurance system. A search in the literature was also conducted in the LILACS and PUBMED databases and in Google search, with the aim of learning about this problem in the national context, and also in other Latin-American health systems.

Outpatient consultation time

In Peru, consultation time for patients seen by physicians outside the public health organizations is only 12 to 14 minutes in different medical specialties, including anesthesiology.^{1,2} In 2016, the average length of the medical visit (public and private centers) was even lower, at 11.87 minutes.³ Hospitals of the Peruvian Social Security System (SSP) work on the basis of a standard outpatient consultation schedule of 4 to 5 patients per hour, although there are no details of the criteria used to arrive at that number.⁴ Moreover, average waiting time to get an outpatient appointment ranges between 12 and 22 days¹; however, this time period may be significantly longer for

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some medical specialties in certain regions of the country, reaching up to 100 days.⁵

In other Latin-American countries like Argentina, the time allotted for clinical appointments is 15 minutes.⁶ In Colombia, regulations require that no general medical consultation should last less than 20 minutes.⁷

It is important to point out that performing medical work in less than 20 minutes goes against adequate performance⁶ and that a short visit may result in a lack of time to convey information regarding patient complaints, and also other comorbidities. This problem became evident when 92.61% of Peruvian patients seen in the outpatient clinic reported having received an explanation from the physician regarding their disease, problem, or health condition, but only 67.39% said that they had understood everything that was explained to them.³ Also, a consultation time shorter than 20 minutes was associated with a perception of poor quality care in Mexico.⁸

In our specialty, a time period of less than 20 minutes might not be enough to do a complete clinical history and physical examination, with emphasis on the airway. It is also important to consider that various issues are discussed during the visits, including relevant recommendations for surgery in terms of chronic medications, consults with other specialties, request for additional tests, choice of the anesthetic technique, informed consent, answers to the patients regarding scheduled surgeries and selected anesthesia techniques, and, in some instances, documenting patient care in the computer-based log and surgical waiting list.

Time for referral to higher-complexity institutions

It has been reported that the time devoted to paperwork for referral of cardiac patients from the provinces of Peru to specialized centers in the capital city for care in outpatient clinics and diagnostic procedures is 1 month.⁹ However, in other instances, patients referred for specialized care, and diagnostic and therapeutic procedures have to wait weeks and even months before they are seen by a specialist in a referral hospital.¹⁰ Regarding this situation, the SSP has recognized that it needs to improve timeliness for medical appointments.¹¹

Institutional referral regulations require that patients coming from regions outside the capital city should be given priority and receive medical care in referral centers within 72 hours. For this reason, the patient referral process must be revised in accordance with the institutional regulations.¹²

In Latin America, waiting time for outpatient consultation and the performance of diagnostic procedures is long, except in Colombia. In Brazil, access to specialized consultation in a peripheral area required an average of 244 days for the first consultation.¹³ In Mexico, average

waiting time for the performance of 4 diagnostic procedures in public hospitals (Mexican Social Security Institution, Health Secretariat, and State Workers Social Security and Services Institute) was 11 weeks.¹⁴ In Chile, an average of 141 days has been described for new consultations with several medical specialties in a public hospital.¹⁵ In contrast, in Colombia, time for appointment assignment at general medicine outpatient clinics was 3 days between 2009 and 2014, and the longest waiting time for specialized consultation averaged 12.11 days for internal medicine.¹⁶

Drug availability

Of the users who purchased prescribed medications in private pharmacies, 67.2% were seen in centers of the Comprehensive Health Insurance (SIS) attached to the Peruvian Ministry of Health (MSP), and 26.2% were seen in SSP centers. Moreover, 39.9% of the users of private pharmacies reported not being able to obtain the medications in the center where they were seen because of unavailable prescriptions.³ Consequently, medical treatment of various chronic diseases could be adversely affected by the unavailability of medications in the pharmacies of the Peruvian public institutions when demand for these medications is higher than supply.

For medications used in anesthetic care in Peru, there is total absence at a national level of drugs such as hypobaric and isobaric bupivacaine for spinal use, etomidate, and phenylephrine. This situation has existed for a long time. These drugs are not on the national SSP and MSP listings of essential medications.^{17,18} Moreover, these anesthetics are neither manufactured in the country nor imported by pharmaceutical companies for purchase by private pharmacies. Other drugs found to be absent in these listings are spinal levobupivacaine, remifentanyl, and cisatracurium; however, they are available in private pharmacies.

Another important point concerns the availability and distribution of drugs within the SSP, including opioid analgesics (morphine, meperidine, oxycodone, and codeine), except for tramadol, and also antiemetics (Ondansetron), because, in the author's experience, these drugs are unavailable in local SSP hospitals. However, many patients need epidural, intrathecal, or intravenous analgesia for the treatment of severe postoperative pain, and postoperative nausea and vomiting (eg, after abdominal hysterectomy), or medical treatment of chronic pain (as in the case of diabetic neuropathy). Unfortunately, these drugs mentioned above are only supplied in hospitals with pain treatment facilities (regional and national SSP hospitals). Despite this challenging context, this situation is expected to improve with the implementation of a new regulation regarding comprehensive pain treatment which requires all SSP centers, including primary care, to have a pain treatment unit.¹⁹

Proposals for improving the problem

As a result of these challenges described above, medical care quality declines and there is increased risk of malpractice events.³ Likewise, the limited drug armamentarium is a source of concern for anesthetists who face a myriad of patients and intraoperating situations that required anesthetic regimens suited to each particular patient situation.

The main health institutions of the Peruvian public system are the SSP and the MSP, and they cover the health needs of the vast majority of the population. The SSP reported coverage of a population of 10,754,665 inhabitants in 2015, whereas the number of people covered by the MSP was 11,610,000 in 2013.^{11,20} In 2016, 67.9% of the Peruvian population was affiliated to these 2 large public health networks.²¹

The following are some of the proposals for solving the above shortcomings of the Peruvian health system:

1. Make distinctions among outpatient consultations depending on whether it is the first appointment with the physician or follow-up for a chronic disease. This way, a minimum of 20 minutes could be allotted to first visits.
2. Increase the supply of appointments in outpatient clinics, and for diagnostic and therapeutic procedures by means of additional shifts and a higher number of specialists.
3. Increase the number of physicians in high demand specialties or who care for patients with diseases that are highly prevalent in the country and have been identified as the main causes of death, including respiratory disorders, heart conditions, stroke, gastrointestinal diseases, renal diseases, and diabetes mellitus.²²
4. Identify those regions of the country where there is a deficit of specialists. The unequal distribution of physicians in the country is noteworthy considering the highest density in Lima and Callao with 24.5 and 18.3 physicians for every 10,000 inhabitants, respectively, in 2015, compared with border areas such as Piura and Loreto, with the lowest density (6.6 and 5.1, respectively).²³
5. Simplify paper work for patient referral to higher complexity hospitals and reduce overcrowding of emergency services through immediate care consultation (CAI) for patients coming to the emergency service.²⁴
6. Implement access to opioid analgesics for health centers with anesthesiology services for adequate control of acute postoperative pain and ambulatory care for patients receiving treatment for chronic pain (to reduce the strong demand for appointments in referral units).
7. Request the inclusion in the national drug lists of anesthetics used for neuroaxial blocks, currently unavailable in the country. While this inclusion

materializes, a transient measure would be to request authorization for use by the Pharmacotherapy Committees of the decentralized public health institutions.

It is of the utmost importance to recognize that the need to increase the supply of human resources (specialized physicians) and medications will require an increase in the budget allocated to health care in the country, as has been described in previous publications. One of those publications recognized the problems with surgical care in low and middle-income countries (including the majority of the Latin American countries): a segment of the population with no access to safe surgery, anesthesia care, or to coverage to protect citizens against the catastrophic expenditure derived from surgical care. Other problems identified were the need for additional surgical procedures aimed at saving lives and avoiding disability, and the need to invest in increased surgical supply.²⁵ Additionally, it is important to recognize the growing population trend in Peru, and, therefore, the growing number of people who join the public healthcare networks.

Another study concluded that increasing surgical care supply was needed to solve the problem, and also identified the need for substantial government investment, estimated at 4% to 8% of the total annual healthcare budget of the countries.²⁶ In this regard, per capital healthcare spending in Peru has been increasing (from \$int 371 in 2007 to 626 in 2013), just like the percentage of the population with health coverage grew from 42.1% to 65.5% during the same time period.^{27,28} Notwithstanding, total health spending as a percentage of the gross domestic product was only 5.47 in 2014, and public health spending was 3.32 in 2014, in what was 1 of the smallest government health budgets in South America.²⁹

In conclusion, should the Peruvian government allocate the additional financial resources needed to improve outcomes in the public health system, the result will be improved health care for the majority of the inhabitants, including surgical and anesthetic care, not to mention protection against the catastrophic and impoverishing expenses associated with surgery. This improvement would increase well-being and economic productivity, and contribute to the shared goal of other middle-income countries of achieving development.

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Conflict of interest

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