

Commentary

ICUs worldwide: A brief description of intensive care development in Argentina

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Abstract

The present commentary reviews the development and present situation of critical care medicine in Argentina. Critical care has a long history in our country that began in 1958. Its development has not been uniform, and followed the political and economic troubles of the country, particularly those of its health system. Nevertheless, high quality care for critically ill patients, in both human and technological terms, has been achieved in Argentina.

Keywords Argentine National Health Authorities, Argentine Society of Critical Care Medicine, intensive care unit, Pan American and Iberic Federation of Critical Care Medicine and Intensive Care

The first intensive care units (ICUs) in Argentina were developed following the polio epidemics of the 1950s and subsequently in the 1960s. After those decades, surgical units and coronary care units began to provide critical care services. Despite the fact that the earliest efforts in critical care focused on developing respiratory units for the polio epidemics, today the critically ill are predominantly treated in multidisciplinary or general medical/surgical units.

During the 1960s and at the beginning of the 1970s large hospitals introduced modern equipment for respiratory and cardiovascular monitoring, with levels of care to match the growth and evolution of general health organizations. Later, with economic hardship, difficulties surfaced. Maintenance of equipment started to falter. Some institutions began to buy new equipment rather than replacing the old. In addition to this practice of replace rather than repair, economic protection of the national medical industry made it increasingly difficult to introduce new foreign technology. Argentine manufacturers of critical care equipment (e.g. ventilators and cardiac monitoring equipment) were thus allowed to evolve without pressure from outside competition, and critical care practitioners recognized a growing gap in technology as compared with hospitals in developed countries. These problems impacted on the evolution of

critical care practice such that hemodynamic monitoring and new modes of mechanical ventilation were available only in a few well developed centers. In some of the poorer provinces of the country, invasive hemodynamic monitoring was not implemented in critical care units until 1990.

Human resources have been another stumbling block in critical care development [1]. A shortage of nurses has been crucial. In order to resolve or mitigate the paucity of nurses, years ago health authorities promoted auxiliary nurses to contribute to patient care. However, as time passed some problems became worse, specifically low salaries, lack of incentives for nursing education, and bad working conditions (e.g. low nurse-patient ratios) are just some of the reasons for this. Currently, ICUs with a very low percentage of specialized nurses are still common. Large complex institutions have recognized that high-quality critical care is only possible with well trained, specialized nurses. However, only a few of these institutions are able to address the problem because of the persistence of low salaries for health care personnel [2].

Board examinations and specialist certification in critical care medicine have recently been introduced by the Argentine National Health Authority. Units are currently managed by

physicians who are trained in various specialties. Most physicians who manage units are trained in internal medicine, cardiology, and surgery (in that order). In addition, because of budget cuts, most private institutions units are managed by a coordinating physician and daily on-call physicians; each physician is usually responsible for eight beds. Low salaries drive physicians to hold more than one job; this renders academic and research activities very difficult for the majority of physicians in our country. Approximately 8 years ago the Argentine National Health Authority established regulations by which units should be managed by critical care specialists with the support of physicians and specialized nurses who are trained in critical care.

Most low-profile ICUs are 'open' units, in which patients are managed by external specialists. In the largest Argentine cities a growing number of complex units, with international standards of care and organization, encourage academic and research activities; these units are generally 'closed' units, in which patients are managed by a well trained, certified team. Economic stability, access to bank credit, and the possibility of importing new technology were the determining factors for the development of these modern units over the last 10 years.

Changes proposed and solutions

In response to the problems outlined above and the progressive lack of organization and funding of the health care system, several sectors involved in the assisting process began to submit proposals. The aim of such proposals was to unify the different partners involved in financing health care and to create a unique financing and medical assistance model with shared rules, which could be imposed in the entire country. Particularly in the field of intensive care, the Argentinean Intensive Care Society has been submitting proposals since 1985, both to the Ministry of Health of the Federal State and to social security health organizations that belong to the unions, the Province State and the Federal State with the purpose of categorizing critical care units according to the complexity of pathology that the institution may admit. The proposals were made with care not to introduce discordance between the organization of the ICU and the hospital's overall mission. The first documents were presented in 1986 to the National Institute for Regulation of Social Security Health Organizations, but they were never fully applied.

From 1989 to 1992 several sectors, including scientific societies, the Retired and Pensioners Institute, private clinics, private hospitals, and some Social Security Health Organizations (but not the Federal State), arrived at the idea of creating an accreditation program for private and public assistance institutions. This became the formulation of a mixed committee for improvement in quality of medical practice; this worked well for 3 years, and in 1993 the first Manual of Accreditation for Hospitals and Other Health Care

Providers in Argentina was published [2,3]. The Manual contains a concrete program that includes periods to cover, standards, accreditation regulation, and forms for evaluators. The Argentine Society of Critical Care Medicine participated actively in this mixed committee, drawing up standards for intensive care medicine and categorizing four types of unit that fit the level of institution that they belong to: resuscitation unit; polyvalent critical care unit, 1st level; polyvalent critical care unit, 2nd level; and specialized units (cardiology unit, burns unit, etc.).

In line with the Federal State, in 1993 the Health and Social Action Ministry instituted a program of quality control for medical assistance [4], which not only includes measures for categorization and accreditation but also, and for the first time in our country, involves periodic accreditation of professionals in the health care field. The first regulations on categorization to be admitted were those of our society, based on work conducted in 1986 with necessary modifications. The entire program is aimed at evaluating public and private hospitals; those institutions that subscribed to this program were able to begin a voluntary process of improvement in quality that would allow them to sign contracts with union and private health insurance companies.

These developments occurred in parallel with a progressive change in the way in which health care was paid for, during the early part of the 1990s. This change involved a shift from fee reimbursement for health care to payment by disease modules or by capita in a large proportion of the population. This shift involved both public hospitals and the private sector.

A detailed description of the categorization of ICUs is beyond the scope of the present commentary, and was published by the Health Department of Argentina [4]. Nevertheless, it would have been interesting to add, quality standards suggested, as that suggested by the Pan American and Iberian Federation of Critical and Intensive Care Medicine (FEPIMCTI) through its Accreditation Committee. These standards were published in the FEPIMCTI bulletin during the World Congress that took place in Madrid in June 1993 [5], and were based on the suggestions made by the Pan American Health Organization in their Accreditation Manual for Latin American Hospitals.

During the past 5 years, our society has established standards for accreditation of ICUs and has participated in a nongovernment, nonprofit accreditation organization – the Technical Institute for Accreditation of Health Institutions. This Institute has as its mission the task of accreditation in our country. Along with this aim we have also developed a voluntary quality improvement program for ICUs, with a central database located at the Argentine Society of Critical Care Medicine, in order to acquire knowledge of what the

quality of care is in Argentina, at least in those units that subscribe to this program. This is an important aim for us because of the impact of the economic crisis in our country on the quality of care for critically ill patients.

Competing interests

None declared.

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