In and out: user fees and other unfortunate events during hospital admission and discharge

Entrando e saindo: honorários e outros contratempos na internação e alta hospitalares

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Abstract

In various countries it has been reported that patients who receive hospital care, for example assisted birth, are detained inside the health facility until they pay their bills. The practice of hospital detention, whose magnitude is unknown, has been criticized as anti-humanitarian by UNICEF and human rights organizations. However, according to the author, leaving the hospital with a confirmed diagnosis and the recommended treatment can prove more difficult than simply being detained, particularly when health budgets are allocated with disregard for the social conditions in which people live, as in Latin America and elsewhere.

Length of Stay; Patient Discharge; Hospitalization

Hospital detention following a clinical procedure

In reference to the *Humanitarian Action Report 2007*, the United Nations Children's Fund (UNICEF) featured a story from Burundi: "*Sixteen-year-old Carine delivered her son, Hugo, by caesarian section at Bujumbura's biggest hospital, in April 2006, but remained in hospital detention until the end of May, for inability to pay her bills of about US$ 300. Like hundreds of debtor mothers detained for the same reason, Carine lived in the hospital corridors and scrounged for money and food from visitors until she was finally freed following public pressure. Most debtor mothers were poor under-age girls like Carine, who underwent caesarian section because their pelvis was not wide or strong enough for normal child delivery. A caesarian operation costs from US$ 60 to US$ 200, two to six times the monthly income of the average government worker, yet the population is largely rural, poor, and dependent on subsistence agriculture*" [1]. This account was preceded by a Médecins Sans Frontières report from 2004 [2] and followed in 2006 by another from Human Rights Watch on the detention of poor patients in hospitals in Burundi [3] that mentions similar situations in Kenya [4], Ghana [5], the Democratic Republic of Congo [6], and Zimbabwe [7]. In May 2007, the president of Burundi announced the declaration of *Free Birth Delivery Services and Medical Care for Children Under Five Years* [1], while the president

of the Philippines signed into law *Republic Act 9,439*, or the Hospital Detention Law, which prohibits the detention of patients in hospitals and clinics due to nonpayment of medical expenses – except if they were staying in private rooms [8]. A search of "hospital detention" in the medical literature yields nothing. Given the scant publications on the matter, the extent of the practice of hospital detention around the world due to inability to pay is either not well known, does not occur frequently, or both.

What most of the above-mentioned cases have in common is that they involve women who give birth at hospitals. As a result of the risk of hospital detention, many of these women may prefer to avoid hospitals altogetherand deliver at home, despite their not having access to a skilled health professional. Whatever the causes that generate the practice of hospital detention, the consequences run counter to any imaginable public health argument, let alone to a human rights approach.

It is worrisome that the practice of hospital detention – even when it is less severe or of shorter length – may be more widespread than is documented, including in Latin America. While conducting research in Venezuela in 2006, I met Teresa at her home in one of the many shantytowns in Caracas. She had moved to the capital city in her late adolescence in search of a better life for herself and her three children. Teresa had been a seamstress since the age of 14, rising before dawn and returning home after dark for wages that kept her constantly below the poverty line. In 1995, Teresa suffered a stroke and managed to reach a public hospital and obtain treatment. Before the hospital administration would release her to return home, she was required to pay 25,000 *bolívares* as a *colaboración* (contribution) to the hospital. Because the fee was equivalent to three and a half times her monthly salary, she convinced the hospital's social worker to lower the amount to 10,000 *bolívares*. Teresa raised the funds among several family members to settle the fee and leave the hospital. Since 1999, a presidential decree prohibits charging user fees from patients in public hospitals in Venezuela [9], so the problem has been avoided altogether.

Hospital detention may occur for causes other than user fees. In June 2007, Carmen, a woman in Colombia who had the constitutional right to an abortion on grounds of rape, faced numerous hurdles until she obtained the surgical procedure, but was told that she would not be allowed to leave the hospital unless she carried a bag with her containing the dead fetus [10]. The newspaper columnist used the term *secuestro* (kidnapping) to refer to Carmen's hospital detention.

Hospital admission without the ability to pay

As difficult as their stories may have been, Teresa and Carmen were able to receive the care they needed before they were temporarily detained at the hospital. But to leave a hospital with a confirmed diagnosis and with the recommended treatment – a medical or surgical procedure or prescribed medicines – may be as difficult as it is to leave the hospital for those who are detained for lack of payment. Back in Caracas, Teresa's neighbor Luisa was less fortunate. Before the 1999 presidential decree went into effect, Luisa's mother was diagnosed with gastrointestinal cancer. Surgery and chemotherapy were indicated, but the surgery could not be scheduled unless it was paid for in advance. Luisa's mother died while her daughter was attempting to sell her shantytown dwelling to pay the hospital bill.

Teresa, Luisa, and many other people told me about how often their neighbors had engaged in fruitless attempts to receive health care in public institutions: sometimes a sick or injured person would die on the hillsides of Caracas or on a rural road while attempting to reach the health facility; other times, if patients appeared at public hospitals with problems that required medication, syringes, or an intravenous line, they would not be treated unless they purchased these materials; others were required to pay for laboratory tests they could not afford. "*Lamentable*" (pitiful) was the term a woman in rural Los Llanos in Venezuela used to describe the all-too-frequent situation. "*One had to beg the mayor or someone else to pay for the treatment or to get transportation to travel to a health center*", she continued. Because shantytown and rural dwellers could not afford the fees, they either became discouraged from seeking care in the first place or waited to present to the emergency room, when their condition was too advanced and complicated to treat.

The situation is widespread in Latin America. It has happened in oil-rich Venezuela, impoverished Haiti, and middle-income Mexico and Colombia. In March 2003, at a meeting in which I participated on maternal mortality in Haiti, a physician complained about the fee that women had to pay to give birth at a public health facility. "*The user fee is the first cause of maternal mortality in Haiti. We cannot address maternal mortality without getting rid of the fee*", he said. He was the head of the local Cuban Medical Cooperation – the largest purveyor of medical doctors in rural Haiti – and knew far too well that any effective plan to lower the maternal mortality rate would require lowering or abolishing the

hospital fee. The root cause was clear to him, even though "user fee" rarely appears as an etiological factor for disease and death. In Haiti, we found more evidence that inability to pay continues to deter sick people from seeking health care at public hospitals. In a study we conducted with people who presented to a public hospital and who were diagnosed with HIV, it was common to find comments such as: "*In December 2003 I went to the hospital, the prescriptions they gave me cost money. I didn't have any money. So they sent me to steal. I could not follow the treatment*" [11] (p. 489).

Anyone who lives in poverty or who has spent time witnessing poverty has experienced similar unfortunate events or has encountered other Teresas in their lives. These are not isolated events. A colleague in Mexico, a country with an extended public health care network, told me about Alberto, an indigenous 21-year-old from the highlands of Chiapas. Alberto felt ill in the late 1990s and was taken to a public hospital, where he was diagnosed with active pulmonary tuberculosis and a lesion in one of his lungs. The hospital physician prescribed a three-month course of treatment (already too short by any international standards), but Alberto only received drugs for less than two months and then went untreated. A year later, after a long and costly trip, Alberto sought care at a charity hospital. He was asked to come back in two weeks to obtain treatment, but he could not afford to leave his job and pay for transportation. He tried more affordable traditional medicines, but his condition deteriorated. In the meantime, four members of his family were infected and diagnosed with tuberculosis. An ethnographic study of people diagnosed with tuberculosis in a hillside slum in La Paz, Bolivia, showed how patients interrupted or abandoned treatment regimens due to their inability to pay for the drugs, difficult geographic access to public health facilities, and racism and disrespect by health professionals [12].

At a national conference on maternal mortality in Mexico organized by the Safe Motherhood Committee in the summer of 1998, a physician-anthropologist from Chiapas publicly denounced that indigenous women from that state preferred to die at home during childbirth than be exposed to the widespread abuse in public hospitals. She later clarified that these women feared racist humiliation, political interrogation, and forced sterilization – fears that have been documented in several publications [13,14,15,16,17,18]. Under the rubric of *Misión Chiapas*, an intensive birth control campaign initiated in 1995, public hospitals, were stocked with contraceptive methods, but were depleted of other essential medicines. Freyermuth, who has written extensively about these issues, explained that when a woman in Chiapas wanted to have a tubal ligation, the hospital would arrange for transportation, whereas this arrangement would not be provided for women in labor with severe complications who did not want to be sterilized [13]. Others have reported that, in Chiapas, "*Pressure is placed on physicians to urge poor women to accept birth control and IUDs immediately after they have given birth, irrespective of the patient's wishes or responses*" [16] (p. 419), which has also been documented in Mexico City [18]. Early in 2003, a Mexican newspaper reported that health care workers employed by IMSS-Oportunidades, having to meet sterilization quotas, had to entice indigenous women to submit to sterilization and pay their transportation costs to the hospital from their own pockets, for fear of losing their jobs [19].

In Colombia, the expression "*paseo de la muerte*" (death trip) is not about the endless civil war or other manifestations of armed violence, but about the increasingly common circuitous path of patients as they are bumped from one health facility to the next, repeatedly denied the urgent care they need and dying while begging to survive (César Abadía, 2006; personal communication). They are denied their right to life because they do not have the appropriate health insurance or because they cannot pay the hospital fee upfront. Some have argued that if it were more expensive for hospitals to let people die at their doorsteps than to care for them, the "death trips" would probably end [20].

Provision of care with inadequate budgets

Most physicians and nurses working on the frontlines of poverty suffer from the lack of full-fledged resources they need to conduct their jobs. But their jobs should be rewarding. They did not study medicine or nursing to send patients home without treatment or to lock them inside the hospital until they pay their fees. Still, many of these clinicians either accept or accommodate to the resource limitations imposed on them by those allocating budgets.

This is not always the case, however. While attending an international meeting on access to medicines in 2006, I overheard a conversation between two local physicians. The female doctor was telling her colleague: "*In other countries, when you go to the doctor or to a hospital, before you leave you need to pay the doctor or the hospital*". The male doctor looked at her in bewilderment and asked: "*Why?*". This conversation

did not take place in a high-income country, but in Cuba, where health care was demonetized as part of a wide array of public policies aimed at bringing universal access to health care throughout the island.

When those who allocate resources first assess the health needs and social context of a population *and then* plan their budgets accordingly, the outcomes of the population will vary greatly compared to when health budgets are allocated *and then* health professionals and patients struggle to make do with what is left.

Resumo

Segundo relatos, em vários países os pacientes que recebem tratamento hospitalar, inclusive durante o parto, podem ficar detidos dentro do hospital até saldarem suas contas. A UNICEF e diversas organizações de direitos humanos já denunciaram como anti-humana a prática da detenção hospitalar, cuja magnitude é desconhecida. Entretanto, de acordo com o autora, receber alta com um diagnóstico confirmado e a garantia do tratamento indicado pode ser mais difícil do que a simples detenção, particularmente quando os orçamentos da saúde são alocados sem levar em conta as reais condições da população, como ocorre na América Latina e em outras regiões do mundo.

Tempo de Internação; Alta do Paciente; Hospitalização

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