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STATUS OF NATIONAL HEALTH PLANNING

1. Highlights of the past year

The general status of national health planning in the Americas is reported in subsequent sections of this document, but two events deserve special mention -the meeting of a Study Group on Health Planning in Puerto Azul, Venezuela, in February 1965, and the Technical Discussions held at the Eighteenth World Health Assembly in May.

Study Group on Health Planning*

Under the auspices of the Pan American Sanitary Bureau, and in cooperation with the Government of Venezuela, a Study Group on Health Planning met in Puerto Azul, Venezuela, from 1 to 6 February 1965 to review recent experience in health planning in the countries of Latin America and to recommend measures which would help these countries attain the health planning objectives established in inter-American agreements. The group included 14 senior health planners from seven countries of Latin America, six PASB planning specialists, a staff member of the Latin American Institute for Economic and Social Planning, and an observer from the Johns Hopkins University.

In reviewing the present status of health planning in Latin America, the Group found that some countries had made considerable advances, while in other countries difficulties had arisen from the lack of adequate data, the lack of personnel trained in planning at all levels, the need for wider knowledge of the PAHO/CENDES planning method and for improvements in the method itself, the deficient organization and administration of health services, the insufficient exchange of experience and information, and a variety of political problems.

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* The final report of the Study Group is reproduced in Annex I.

As regards the PAHO/CENDES planning method, the Group felt that difficulty in application was due in part to gaps or weaknesses in the method proper, and in part to a lack of scientific knowledge of the subject being planned. The Group considered it essential to establish a research program to remedy both kinds of deficiencies, and to establish a center to direct and promote such research with particular reference to field work being conducted in experimental areas of the different countries.

The Group felt that national health planning units should be basically advisory in nature, and at the service of the authorities who define and decide on sectoral policy, and that such units should have representation in general national planning units. Health planning units required the full-time services of the highest level personnel, owing to the technical quality required for the exercise of their duties.

Finally, the Group recommended that basic training of higher-level planning personnel should include the theory and practice of health planning together with other related disciplines, that training of intermediate-level personnel should have the same general content but with less emphasis on theory and more on application, and that training of third-level personnel should be essentially operational and given on an in-service basis. This would be facilitated if the center proposed by the Group for the direction and promotion of research would also assume the duty of organizing and directing international courses and advising and cooperating in higher-level national courses, preferably in close cooperation with schools of public health.

Technical Discussions at the Eighteenth World Health Assembly*

The Technical Discussions held at the Eighteenth World Health Assembly in Geneva, Switzerland, on 7-8 May 1965, were on the theme "Health Planning". PASB staff contributed to secretariat services, members of delegations of the Governments of the Americas to the Assembly participated actively in the Discussions, and a number of PASB publications and national health plans from various nations of the Americas formed part of the background documentation.

It was recommended that the World Health Organization institute or support research into the establishment of "norms" of provision for use in the planning of health services as well as training courses in health planning, and that it should provide guidelines in health planning with a view to facilitating planning operations in developing countries.

In the Region of the Americas, Table I indicates the growing activity in the development of norms or standards for health activity while Table III summarizes training activities. The publication for general distribution of Health Planning: Problems of Concept and Method (PAHO Scientific Publication No. 111, 1965) represents the first step in the provision of guidelines. Work in all three of the areas included in the recommendation to WHO is proceeding steadily in the Americas.

*The Report of the Technical Discussions is reproduced in Annex II.

2. General status of national health planning

The general status of national health planning in mid-1965 is shown in Table 1. Of the 22 Governments reporting, 16 had national planning units in operation and even in countries where there was no officially-designated planning unit for the health sector (e.g., Ecuador) a plan for health had been drawn up in collaboration between the national health authorities and the global economic and social planning unit.

A total of ten governments had completed the diagnosis stage of the planning process, while 11 had completed at least a short-term national health plan. The discrepancy between these figures arises from the fact that some of the earlier plans were based on readily available data and did not include the type of formal diagnosis that has been adopted more recently. While the initial aims of the Alliance for Progress had been framed in terms of a ten-year health program, it will be observed that a number of countries concentrated their planning on a shorter period, most commonly four or five years.

The adoption of the program-budget technique has been considered an important step in the planning process, both as a planning tool in itself and as a means of presenting planned activity in a coherent and orderly manner to the national financial authorities and the sources of external financial aid. It will be noted that 11 governments, including one whose plan had not yet been completed, had formulated program budgets.

Information on norms was compiled because the setting of standards for planned activity is increasingly being recognized as an indispensable step in deciding on the instruments to be used in carrying out a health plan and in the subsequent evaluation of performance. This was reflected in the Technical Discussions at the World Health Assembly cited above. Norms had already been established in six countries, while in four others they were being studied or had been established for at least some activities. In the Americas, the adoption of norms covered, in addition to the amounts of service to be provided, detailed standards for the output of the various instruments.

Finally, it will be noted that in eight countries the health plans had already reached the phase of implementation, and that the administrative and operational problems arising during the carrying-out of health plans will call for far more attention from public health administrators in general, and from planning officials in particular, in the future.

3. Health plans and general plans for economic and social development

The per cent of central government expenditure devoted to public health, as shown in Table II, was by and large unchanged from the previous year. The change in ranking of a few countries from the positions shown in 1964 in Document CD15/4 relates principally to borderline cases which rose or fell by a few percentage points. The relative stability of the

per cent of government funds devoted to health does not indicate stagnation, however, since in many countries government budgets as a whole were rising, and the relative share of health was unchanged simple because health shared the general increase in government activity in a wide range of economic and social sectors.

No attempt has been made this year to rank the countries by dollars spent per-capita for health in the public sector. Considerable doubt has been cast on dollar comparisons because of the influence of changes in exchange rates, and the estimates of the relative purchasing power of national currencies made by the United Nations Economic Commission for Latin America are based on the prices of the basket of goods and services that enter into economic life and cannot be applied to the rather special group of goods and services purchased by the health sector.

It had been hoped to initiate direct inquiry in 1965 so as to make inter-country comparisons of health expenditures, but in order to avoid duplication of effort it was decided to rely on the information that is to be collected as part of the studies of hospital construction and of Ministry of Health and Social Security health expenditure which are discussed under provisional agenda items 12 and 26.

As regards the integration of health plans with national plans for economic and social development, this has been greatly advanced through the mechanism of annual country reviews by the Inter-American Committee for the Alliance for Progress (CIAP). The first CIAP reviews of national investment plans for the public sector, held in 1964, were mainly concerned with balance-of-payments problems and the principal economic aggregates such as consumption, investment, imports, and exports. The 1965 country reviews, scheduled from July through October, however, will give separate consideration to the health sector and in the case of selected countries will involve exhaustive reviews of major health projects requiring external financial assistance or having direct impact on other investment programs. PASB is participating actively in the preparation of material for the CIAP secretariat.

While in the preparation of documentation for the CIAP by national economic and social planning agencies increasing attention has been given to the rôle and requirements of the health sector, two main gaps should be noted.

Firstly, the CIAP reviews are mainly concerned with investment programs. Investment in the field of health largely relates to the construction of hospitals and other permanent facilities, and even the scanty information now available for Latin America shows that, by and large, current operating expenses (with wages and salaries the principal component) are quantitatively more important than capital (investment) expenditure. Many preventive activities and "penetration" programs, in particular, have small investment components. In addition, one of the important effects of the systematic planning of health services has been

to concentrate effort on the improved utilization of existing facilities. When the effective number of available hospital beds is increased by shortening average stay in hospital, for example, this positive advance may involve no increase in hospital construction, or may even reduce the amount of planned new construction, so that it would not be apparent in the statistics presented to the CIAP.

Secondly, because the private practice of medicine is subject to very few restrictive controls and very little government intervention in most of the Americas, data for this important area of activity have thus far been lacking. While there is little likelihood of obtaining comprehensive information for the private sector in the near future, it is hoped that the PAHO studies discussed under provisional agenda item 26, in particular, will result in substantially improved information on health expenditures in the public sector.

Training

The international Spanish-language health planning course which has been given annually in Santiago, Chile, since 1962 in collaboration between PAHO and the Latin American Institute for Economic and Social Planning has been far and away the most important influence on the development of health planning in the Continent.

By December 1964, 70 senior national health officials as well as numerous PAHO staff members had received training in international courses. The record of utilization of planners is exceptionally favorable. Attrition has been exceptionally low-one planner died, one became Governor of a State, one national planner entered PAHO service and one PAHO staff member reentered national service, and the remainder of the Santiago graduates are actively engaged in health planning as members of sectoral health planning units, as high-level officials in other health services, as professors of public health or preventive medicine, and as PAHO consultants in health planning or in the general field of public health services. Details are given in Table III.

While the subject matter and approach of the Santiago course have remained basically unchanged, major innovations in 1964 were the increasing emphasis on the administrative problems of carrying out health plans and on the program budget in particular, and the use of recent experience in Colombia and Peru as a guide to the use of stratified sampling in the preparation of health plans for large countries.

PAHO staff continued to participate in the international English-language training course which has been given annually since 1963 at the Johns Hopkins School of Hygiene and Public Health with the financial support of AID. This course also serves as a bridge between the Americas and the rest of the world because significant numbers of AID and WHO staff participate, together with health officials from many countries, and an exhaustive analysis of Latin American health planning forms part of the curriculum.

Heavy emphasis continued to be given to national training courses, and by June 1965, 253 officials had been trained in courses of at least six weeks duration, while 235 professionals and 361 auxiliary personnel had been trained in short courses. PAHO staff engaged in the third international course in Santiago also participated in a special course for training Chilean national personnel which was held simultaneously in the last quarter of 1964, and arrangements were completed for courses to be held in Trinidad, and in Brazil (for health officials of the northeast States), in July-August 1965. PAHO also collaborated in a national training course held in Venezuela in 1964. In addition, PAHO Zone and Project staff in a number of countries participated in the organization and presentation of short courses, round-tables, and lectures on health planning.

TABLE 1

STATUS OF NATIONAL HEALTH PLANNING IN THE AMERICAS, MID-1965

Country	Health planning unit in operation	Diagnosis completed	Plan completed	Program budget formulated	Norms Established	Plan being implemented
Argentina.....	X	-(2)	-	-	-	-
Bolivia	X	...	X(4)	X	...	...
Brazil	X	-	-	-	...	-
Chile	X	X	X	X	X	X
Colombia	X	X	X(5)	X	X	X
Costa Rica	X	X	X(6)	X	-	-(6)
Cuba	X	X(3)	X(3)	X	...	X(3)
Dominican Republic	-	-	-	-	-	-
Ecuador	-	X	X	X	X	-
El Salvador	X	X	X	X	X	X
Guatemala	X	-(2)	-	X	-	-
Haiti	-	-	-	-	-	-
Honduras	X	X	X(7)	-(2)	X	-(2)
Jamaica	-	-	-	...	...	-
Mexico	-(1)	-	-	-	-(2)	-
Nicaragua	X	X	X	X	-(2)	X
Panama	X	X	X	X(8)	X(8)	X
Paraguay	X	X	X(4)	X	-(2)	X
Peru	X	X	X(7)	X	X	X
Trinidad and Tobago	X	-	-	...	...	-
Uruguay	-	-(2)	-	-	-	-
Venezuela	X	-(2)	-	-	-	-

(1) Planning Unit being organized. (2) In preparation. (3) One-year plan for 1966. Diagnosis to 1970 in preparation. (4) Two-year plan. (5) Four-year plan; new plan in preparation. (6) Four-year investment plan; currently being revised. (7) Five-year plan. (8) For some programs only.

... = no information available

TABLE 2

DISTRIBUTION OF THE AMERICAN COUNTRIES BY PER CENT OF CENTRAL GOVERNMENT EXPENDITURE DEVOTED TO PUBLIC HEALTH, 1963/1964

Countries devoting 10 per cent of more of central government expenditure to public health:

El Salvador
Haiti
Panama
Venezuela

Countries devoting at least 5 but less than 10 per cent of central government expenditure to public health:

Chile
Colombia
Cuba
Dominican Republic
Guatemala
Honduras
Mexico
Peru
Uruguay

Countries devoting less than 5 per cent of central government expenditure to public health:

Argentina
Bolivia
Brazil
Costa Rica
Nicaragua
Paraguay

Source: 1963 and 1964 Annual Reports of the Social Progress Trust Fund of the Inter-American Development Bank.

TABLE 3

TRAINING AND UTILIZATION OF HEALTH PLANNERS IN THE AMERICAS, MID-1965

Country	International training courses			National training courses		
	No. trained	No. engaged in health planning	No. engaged in other health activities	No. trained in major courses (1)	No. trained in short courses	
					Profess.	Auxiliaries
Argentina....	5	2	3	-	-	-
Bolivia	4	...	...	...	...	...
Brazil	9	...	...	(2)	-	-
Chile	6	5	1	3	30	20
Colombia	5	2	3	-	19	-
Costa Rica ..	2	1	1	-	20	-
Cuba	1	1	0	...	...	...
Dominican Republic ...	2	...	...	-	-	-
Ecuador	2	1	1	-	-	-
El Salvador .	5	1	4	-	12	73
Guatemala ...	2	2	-	-	18	34
Haiti	-	-	-	-	-	-
Honduras	3	2	1	-	-	20
Jamaica	1	-	1	-	-	-
Mexico	3	-	3	-	60	10
Nicaragua ...	2	1	1	-	10	30
Panama	3	1	2	-	6	6
Paraguay	3	2	1	-	-	-
Peru	5	5	-	132	-	18
Trinidad and Tobago	-	-	-	(2)	-	-
Uruguay	3	1	1	40	60	100
Venezuela ...	7	2	4	78	-	-
Total:	70	29	27	253	235	361

(1) Major courses are considered to be those involving a minimum of six weeks of attendance
(2) Course held July-August 1965
... = no information available

FINAL REPORT

OF THE

STUDY GROUP ON HEALTH PLANNING

STUDY GROUP ON
HEALTH PLANNING

PUERTO AZUL, VENEZUELA
1-6 February 1965

FINAL REPORT

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau - Regional Office of the
WORLD HEALTH ORGANIZATION
WASHINGTON, D.C.

PS/18
6 February 1965
ORIGINAL: SPANISH

FINAL REPORT

OF THE

STUDY GROUP ON HEALTH PLANNING

Under the auspices of the Pan American Sanitary Bureau and in cooperation with the Government of Venezuela, a meeting was held of the Study Group on Health Planning at Club Puerto Azul, Naiguatá, Venezuela, from 1 to 6 February 1965, for the following purposes: a) to review the recent experience acquired in health planning in the countries of Latin America; and b) to recommend measures which would help these countries to fulfill the health planning objectives established in inter-American agreements.

Specialists in health planning from Argentina, Colombia, Chile, El Salvador, Mexico, Perú, and Venezuela were invited, with the agreement of their respective governments, to participate in an individual capacity. Also attending were temporary consultants and staff members of the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization (Annex A).

OPENING SESSION

The opening session took place at 9:00 a.m. on 1 February 1965 and was presided by Dr. J.L. García Gutiérrez, Chief, Zone I of the Pan American Sanitary Bureau in Venezuela, who welcomed the participants on behalf of the Director of the Bureau and in his own name, and gave a summary of the purposes and scope of the meeting.

OFFICERS

The following officers were elected at the opening session:

Chairman:	Dr. Alfredo Arreaza Guzmán (Venezuela)
General Rapporteur:	Dr. David Tejada de Rivero (Perú)
Secretary General:	Dr. James S. McKenzie-Pollock (PASB/WHO)
Technical Secretary:	Dr. Hernán Durán (PASB/WHO)

Dr. Alfredo Arreaza Guzmán, as Chairman, opened the working session and indicated the method to be followed in the deliberations, and highlighted the important technical contribution which the invited experts would make to the continent-wide program of health planning.

Dr. J.S. McKenzie-Pollock, Chief, Office of National Health Planning of the Pan American Sanitary Bureau referred specifically to the purpose of planning as the subject under study, and to the general program of work.

WORKING PARTIES

Also appointed at the opening session were the working parties, which elected their own officers.

AGENDA

The agenda consisted of the following items:

1. Present status of health planning in Latin America.
2. Method of health planning developed by CENDES and PAHO. Results of its application.
3. Health planning organization and administration.
4. Education and training of personnel for health planning.

STUDY GROUP SESSIONS

The Study Group held an opening session, five plenary sessions, nine working-party sessions, and a closing session.

CONCLUSIONS

Item 1

PRESENT STATUS OF HEALTH PLANNING IN LATIN AMERICA

1. To analyze the present status of health planning in Latin America, the Study Group considered it necessary to define what, in its opinion, were the health planning process and national health plans.

Health planning is a continuous process which begins when steps are taken to plan health activities within the economic and social development plan through the creation of a specific organization. The process thus acquires a dynamic character and generates its own improvement.

A national health plan, as an integral part of a general development plan, should define the existing health problems and include every activity aimed at their solution under the responsibility of the agencies comprising the health sector. The plan should be the result of a complete diagnosis of the health situation, which makes it possible to formulate a basic policy for establishing the targets to be met within the time periods set forth in the general development plan.

In terms of the above definition it may be said that effective progress has been made in Latin America in the past three years, even though the degree of development of the process differs among the countries. Most countries have already taken initial steps; they have trained personnel and have entered the stage of plan formulation, but only one country has a composite health plan which is being implemented.

In general, the advances made are creating factors which help to promote and consolidate the process itself, and it is the opinion of the Study Group that the outlook for the immediate future is optimistic.

2. The Study Group considered that the different stages of development in health planning in the countries are due to various factors, some of which are favorable, and others of which present difficulties that need to be analyzed.

Generally speaking, some of these difficulties are inherent in the requirements of the method, while others arise from general administrative and political factors.

2.1. Lack of adequate data.

The Group recognized that the lack of adequate data was due in large part to the under-development of the Latin American countries. At the same time it felt that the planning process was basic to improving the production and use of statistical data. National health plans should therefore include programs to improve the statistics involving personnel training and the provision of supplies and equipment, as well as suitable coordination with other data-producing agencies.

Although the lack of adequate data is a serious problem, it was considered that it should not be viewed as an obstacle to initiating the health planning process.

The Group considered that advantage should be taken of the techniques of sampling and special surveys to supply missing basic data or to complement existing data to the degree necessary.

2.2. Lack of personnel trained in planning.

It was recognized that the shortage of trained personnel affects not only planning but the entire field of health. This fact is directly responsible for the slowness in initiating and developing the planning process. The situation is further aggravated by the fact that, although training has begun in most countries, the selection and utilization of personnel has not been entirely suitable, and this is partly due to the fact that trained personnel are not being placed where they can utilize the knowledge acquired, and partly that such personnel fall victim to political and administrative instability.

The Study Group considered it evident that such a situation can only be overcome through intensive training in planning at all levels, including not only the personnel directly involved in plan preparation but all other officials of the services with executive duties.

2.3. Lack of a suitable method.

One of the obstacles to initiating the planning process in Latin American countries was the lack of method for planning for health within the framework of economic and social development planning. Because of this, there was no conceptually appropriate unit for evaluating problems within the health sector and intersectoral relations.

The method developed by CENDES/PAHO solved many of these difficulties, but in spite of this it is not fully accepted because it is not universally known or fully understood. The improvement of this method and its dissemination will be an important step in removing some of the obstacles encountered in initiating the planning process.

2.4. Defaults in the existing administrative structure.

The present structure of health services in some countries is, no doubt, not suited to the planning process, because of their heterogeneity, multiplicity, and deficient organization and administration. A central mechanism and the necessary legal provisions to promote and develop the general and the sectoral planning process has been lacking.

Experience in some countries has shown that planning provides motivation for making changes, substantial ones at times, in the administrative organization of the sector. Nevertheless, radical changes in administrative structure should not be made a precondition for initiating the planning process. Such changes should be gradual and take into account the institutional rigidity of the countries. If they are gradual, they will avoid a resistance which could be detrimental to the process, and will facilitate making adjustments on the basis of the results obtained by the plan.

2.5. Insufficient exchange of experience and information.

The Study Group considered that the lack of sufficient exchange of experience and information among those who work in health planning has been one of the difficulties which have limited the rapid spread of the planning process in Latin America.

2.6. Political problems.

Notwithstanding the interest in planning expressed by governments, especially in international agreements, in practice not all of them have given due support to the initation and development of the process. Several factors have been responsible for this, among them the lack of knowledge about the advantages of planning, the erroneous assumption that planning is simply a means for requesting external financial assistance, the fear of loss of political power, and so forth.

The Group considered it necessary, among other things, to establish closer ties with government authorities in order to show them the political and social value of the plan and of the concrete actions derived from the process which, in addition, indicate the importance of the activities of the planner.

Much of the resistance is due to the unwitting tendency of the planner to adopt positions that exceed his advisory functions. The planning process should be considered as an instrument for improving decision-making, and in no way a substitute for administrative and political mechanisms.

Item II

METHOD OF HEALTH PLANNING DEVELOPED BY CENDES AND PAHO. RESULTS OF ITS APPLICATION

1. The Study Group considered that a review of experience in the application of the CENDES-PAHO health planning method first called for a definition of its bases and of the methodological requirements which inspired it, as follows:

1.1 Measurement of the health level in an area, region, or country in quantifiable terms.

1.2 Establishment and quantification of the relationship between the health level and the physical, economic, and social environment. This in turn requires the following:

1.2.1 An expression of the health level in terms of its component elements.

1.2.2 An identification of the factors which give rise to each of the hazards to health.

1.2.3 The establishment of coefficients of relationship between these hazards and the conditions which create them.

1.2.4 The establishment of the relationship between the health level and the economic and social context of the area, region, or country through the relationship between the economic and social context and the factors which affect the health level.

1.2.5 The definition of the minimum geographical unit for programming purposes, so that the knowledge of the relationship between the health level and the environmental conditions which affect it may be as realistic as possible and avoid the abstraction implicit in the use of country-wide averages.

1.3 Establishment of the amount of resources used, and analysis of the health policy followed in their utilization. This process includes:

1.3.1 Determination of the total amount of resources in use, their distribution among techniques and activities, their cost, and the way in which they are utilized -- i.e., composition, concentration, coverage, degree of utilization, output, etc.

1.3.2 Establishment of the amount of resources allocated to combat each hazard which affects the level of health.

1.3.3 Establishment of the efficiency of the health policy, by measuring the effects produced on each health hazard through the use of the resources, expressed in terms of cost/effect.

1.4 Formulation of a basic health policy which leads to the establishment of the plan targets. This requires the following:

1.4.1 A prognosis of the health level based on anticipated changes in its conditioning factors and on the effect of the general development plan.

1.4.2 The establishment of a normative model, and evaluation of the present health policy, by comparison with the model in order to see how far it meets the standard of the model and how much it needs to be changed.

1.4.3 The establishment of the most effective techniques for combatting each health hazard.

1.4.4 The establishment of priorities for each health hazard according to its magnitude, susceptibility to attack, social importance, and cost.

1.5 Establishment of plan targets, considering possible alternatives, the length of time required to achieve them, and their importance from the viewpoint of the relation between the health plan and the development plan.

2. The CENDES-PAHO method cannot at present be judged by the results obtained because of the short period of its application. Nevertheless, the Study Group considered that conceptually it meets the methodological requirements for health planning within the framework of development planning and that it should therefore be judged in terms of the ease or difficulty of its application. It was stated that most difficulties arose from the limited scientific knowledge of the subject being planned, and that a basic knowledge of the subject is essential for any planning process. This limitation therefore cannot be imputed to any defects in the method as such.

Comparing the difficulties of applying the CENDES-PAHO method with the methodological requirements listed earlier, the Study Group considered the following:

2.1 That the method expresses the health level in terms of mortality and of the amount and structure of the demand for medical care. This measurement, the only one available at present, does not take into account such aspects as morbid conditions which do not come to the attention of the medical services or the after-effects of disabling or debilitating diseases. Experience shows that, despite these limitations, the indicators which are used at present provide a sufficient approximation for planning purposes.

2.2 That the method clearly shows the need to establish the relationships between the health level and the physical, social, and economic environment. The fact that these relationships have not as yet been expressed quantitatively, is due in the first instance to the lack of scientific knowledge previously indicated. The method nevertheless fulfills the purpose of making explicit the need to express these relationships numerically and also makes it clear in what areas such a quantitative expression should be made.

2.3 The knowledge and measurement of the resources used for health has thus far presented the least difficulty and one of the major contributions of the method is that it provides a highly satisfactory analysis of the use of resources. The difficulties are confined to the lack, or lack of clarity, of the required data. It should be noted, however, that there are still some points which require additional study and refinement.

2.4 There are difficulties in making the prognosis, since this has to take into account the factors which affect the health level and their changes. The difficulty of weighing such factors, and the absence of a development plan which would make it possible to visualize future variations in the environment, greatly reduces the precision of the forecast.

2.5 That the establishment of a normative model has presented serious obstacles owing to the lack of technical standards and the difficulty of setting them.

2.6 That operational difficulties exist for establishing priorities for health hazards, especially hazards which cause no mortality but endanger health, and that it is therefore necessary to establish criteria aimed at overcoming this deficiency.

2.7 That in addition to methodological criteria, the Study Group considered it necessary to propose other criteria which make it possible to delineate the health sector so as to avoid the exclusion of health activities and the inclusion of activities relating to other sectors. It was further noted that the problem of the quality of the services presented operational difficulties.

In conclusion, from the experience gained in Latin America it is clear that the CENDES-PAHO method is contributing new conceptual and operational elements for defining the relationships between health and the economic and social context and for the attempt to articulate health plans with development plans, and that the method is applicable to the formulation of health plans integrated into social and economic development.

3. The difficulty in applying the methodology is due mainly to a lack of scientific knowledge of the subject being planned, and the other difficulties can be attributed to gaps or weaknesses in the method itself. In both cases, the Study Group considered it essential to establish a research program so as gradually to remedy both kinds of deficiencies. It was therefore considered necessary that a center be established to direct and promote such research, and that this center be linked to the field work being conducted in the countries, especially in experimental areas.

The Study Group further considered that the use of the method helps to improve the coverage and quality of statistical information and that this improvement is an important factor in improving the application of the method and in executing and evaluating plans. The data must be related to the requirements of the method and of the plans.

Finally, special emphasis was placed on the international exchange of communications on the experience gained in applying the method as a priceless aid for solving operational problems.

Item III

ORGANIZATION AND ADMINISTRATION FOR HEALTH PLANNING

1. The Study Group considered that the process of economic and social development planning, and within this the process of health planning, requires the institutionalization of certain administrative mechanisms by means of which the continuity and permanence of the process can be assured, and that Health Planning Units are the answer to this need.

2. The Study Group considered it necessary to study those factors which either facilitated or impeded the establishment and operation of Health Planning Units in the countries of Latin America. Among the favorable factors the following were pointed out:

2.1 The positive attitude of some governments in the hemisphere towards the need for planning.

2.2 The existence in some countries of national development planning systems.

2.3 The inter-American agreements adopted in recent years to meet the need for institutionalizing the planning process, and the pertinent recommendations of the technical agencies involved.

2.4 The national awareness in some countries of the need for planning as a means for overcoming underdevelopment.

On the other hand, one of the factors which had delayed the establishment of Planning Units is the natural resistance to change, which gives rise to mistrust of the planning process, and to fear of possible loss of position and freedom of action, as well as of limitations in the use of resources.

3. A Health Planning Unit should be an administrative entity that is basically advisory and at the service of the authorities who define and decide on sectoral policy. To fill its advisory role, the duties of the Unit may be grouped according to its participation in the formulation of long-range and intermediate plans, the formulation of the program aspects of functional budgets, and the evaluation of planned activities, all of which are stages of the planning process.

Moreover, since health planning needs to be integrated into general development planning, the Sectoral Planning Unit should be represented in the general National Planning Unit. An effective operational coordination among these units will ensure a satisfactory articulation of health plans with general development plans.

5. Because of its duties and responsibilities, the Sectoral Health Planning Unit should be placed at the level of the highest authority, which defines and decides on sector policy.

6. To better fulfill its functions, the Sectoral Health Planning Unit should utilize the technical and administrative resources established within the sector organization by means of coordinating mechanisms and the establishment of committees and commissions for given functions or tasks.

7. The structure of the Sector Planning Unit will be conditioned by the magnitude of the institutional administrative apparatus for executing health activities and by the availability of suitable human resources. Its structure, however, should rest basically on the duties it must fulfill and on the stages of the planning process, which will require a certain minimum of internal differentiation.

8. The Sectoral Health Planning Unit should have the highest level staff owing to the technical quality required for the exercise of its duties. Professional health personnel should possess the following: specialization and experience in public health, training in health planning techniques, and a knowledge of general planning. The incorporation of specialists in the techniques of other disciplines is recommended to facilitate and refine the planning process, and it is also of importance that planning staff be engaged full-time.

Staff for the Sectoral Health Planning Unit should be selected in accordance with these conditions, and above all on the basis of their technical and personal qualifications and not on the basis of representing all the different professions and specialties in the field of health.

Item IV

EDUCATION AND TRAINING OF HEALTH PLANNING PERSONNEL

1. The Study Group considered that the planning process in the Latin American countries will require a sustained effort in personnel training to make available the minimum number of personnel to initiate and later carry on the tasks which the process involves. It was considered, however, that personnel involved in programming activity at the local and regional levels should not be added to existing health services, but rather that service personnel should adapt themselves to the new ways of health planning. For this purpose, all the staff should, if possible, receive the training indicated by their responsibilities.

2. The Group considered further that the following three distinct levels of personnel would be engaged in the planning process, as follows:

2.1 A higher level composed of persons specifically assigned to planning, with the highest responsibility for advisory and normative aspects. This level also includes planners engaged in teaching and research.

2.2 A second level composed of persons who, although not engaged full-time in planning, participate in the planning process because of their administrative responsibilities.

2.3 A third level composed of auxiliary or operating personnel who are required for such supporting tasks as data collection, primary analysis, etc.

Training for the three levels of personnel should have the following characteristics:

2.4 The basic training of higher-level personnel should include the theory of planning and the practical application of the method together with other related disciplines, in order to provide the basis for an over-all understanding of the problem.

2.5 The basic training of intermediate level personnel should have the same general content as that of the higher level, but with less emphasis on theory and more emphasis on application. The course thus would be aimed mainly at teaching the method of health planning with the principles of general planning introduced only as a frame of reference for sectoral planning.

2.6 Training of third-level personnel should be elementary, and essentially operational in the specific aspects of the duties persons in this group will be called on to perform and may be given as part of in-service training.

Depending on the administrative structure of the countries, they themselves should define the level of training to be given to officials with different levels of responsibility in the planning process. Thus, for example, training at the higher level should be given to the staff of the Sectoral Planning Unit and to those chiefs of central or regional health services who will have an advisory and decision-making rate in plan formulation and execution.

It was considered advisable to emphasize the fact that in all training courses, the health planning method cannot be taught in a purely theoretical way and must be supplemented by practical training.

3. In view of the importance of the international courses given by the Pan American Health Organization and the Latin American institute of Economic and Social Planning for promoting the health planning process in Latin America, the Study Group considered the need to institutionalize this effort. To this end it considered that the recommendations contained in point 3 of Item II should be expanded to the effect that the agency which was proposed to direct and promote research in health planning should also assume the duty of organizing and directing the international courses, and advising and cooperating in higher-level national training courses, preferably in close cooperation with the schools of public health.

4. There is no doubt that the introduction of planning concepts and their application in the health services will have deep repercussions on the traditional programs of schools of public health, as these will have to incorporate the teaching of health-planning method into their curricula on a permanent basis. Moreover, the schools of public health should urgently face the need for giving training in planning to those of their graduates who are holding or will be holding executive positions in health administration.

5. To facilitate a better understanding of the concepts of planning by professional personnel who will have to participate in some way in the planning process, the Study Group considered it necessary to recommend that schools of medicine and of other disciplines related to health attach importance and give appropriate orientation to the teaching of such basic sciences as epidemiology and statistics, whose content helps to develop the planning mentality.

It was considered indispensable that the teaching of preventive medicine in medical schools include a general appreciation of the problems arising from health planning which are directly related to the future duties of the students as professional staff in health services.

VOTE OF THANKS

The Study Group expressed its appreciation to the Government of Venezuela, and to the Ministry of Public Health and Social Welfare in particular, for its contribution to the organization of the meeting; to the Pan American Sanitary Bureau, Regional Office for the Americas of the World Health Organization, for its interest in the field of health planning; to the officers of the meeting for the excellent manner in which they directed the work of the Group; to the Rapporteurs for their correct interpretation in preparing the conclusions; and to the secretariat personnel for their efforts and cooperation towards the success of the meeting.

CLOSING SESSION

The closing session was held on 6 February 1965.

FINAL REPORT
OF THE
STUDY GROUP ON HEALTH PLANNING

PS/18
ANNEX "A"

LIST OF PARTICIPANTS

Dr. Alberto Aguilar R.
Secretario Coordinador
Departamento de Planificación de Salud
Ministerio de Salud Pública y
Asistencia Social
San Salvador, El Salvador

Dr. Ramón Alvarez Gutierréz
Sub-Director General de Salud
Secretaría de Salubridad y Asistencia
Mexico, D.F., Mexico

Dr. José Luis Aponte Villegas
Médico Jefe, Servicios Regionales
de Salud
Ministerio de Sanidad y
Asistencia Social
Edificio Sur, Centro Simón Bolívar
Caracas, Venezuela

Dr. Juan José Barrenechea
Asesor Coordinador del
Consejo Nacional de Desarrollo
Buenos Aires, Argentina

Dr. Federico Bresani
Planificador, Oficina Sectorial de
Planificación de Salud
Ministerio de Salud Pública y
Asistencia Social
Lima, Perú

Dr. Ricardo F. Cibotti
Instituto Latino Americano de
Planificación Económica y Social
Santiago, Chile

Dr. Humberto Córdoba Wiesner
Jefe, Oficina de Evaluación
y Organización y Método
Ministerio de Salud Pública
Bogoté, Colombia

Dr. Juan Motezuma Ginnari
Director de Planificación
Ministerio de Sanidad y
Asistencia Social
Edificio Sur, Centro Simón Bolívar
Caracas, Venezuela

Dr. Aurelio Pabón
Jefe, Sección de Bioestadística
Ministerio de Salud Pública
Bogoté, Colombia

Dr. Armando Petrozzi
Planificador, Oficina Sectorial de
Planificación de Salud
Ministerio de Salud Pública y
Asistencia Social
Lima, Perú

Dr. Mario Pizzi
Asesor del Departamento de
Demografía y Epidemiología
Ministerio de Sanidad y
Asistencia Social
Edificio Sur, Centro Simón Bolívar
Caracas, Venezuela

Dr. Abigail Romero Medina
Coordinador en la Unidad
de Planificación
Ministerio de Sanidad y
Asistencia Social
Edificio Sur, Centro Simón Bolívar
Caracas, Venezuela

Dr. David A. Tejada de Rivero
Director, Oficina Sectorial de
Planificación de Salud
Ministerio de Salud Pública y
Asistencia Social
Lima, Perú

Dr. Mario José Testa
Planificador
Corporación Venezolana de Guayana
Chacao, Estado Miranda, Venezuela

OBSERVER

Dr. Thomas L. Hall
Division of International Health
School of Hygiene and Public Health
The Johns Hopkins University
Baltimore, Md. 21205, USA

SPECIAL CONSULTANT PAHO/WHO,OPS/OMS

Dr. Alfredo Arreaza Guzmán
Profesor de Administración Sanitaria
Escuela de Salud Pública
Universidad Central
Caracas, Venezuela

PAN AMERICAN SANITARY BUREAU
WHO REGIONAL OFFICE FOR THE AMERICAS

Dr. Hernán Durán
Planning Consultant, Zone IV
Lima, Perú

Dr. Norberto Espinosa
Representative in El Salvador
San Salvador, El Salvador

Dr. Alfred Gerald
Planning Consultant, Zone I
Port Spain, Trinidad

Dr. José Luis García Gutiérrez
Chief of Zone I
Caracas, Venezuela

Dr. James S. McKenzie-Pollock
Chief, Office of National Health Planning
Washington, D. C.

Dr. Armand Peter Rudermen
Economic Advisor
Washington, D. C.

Secretarial Services

Mr. Carlos E. Urrutia
Washington, D. C.

REPORT OF THE TECHNICAL DISCUSSIONS

AT THE EIGHTEENTH WORLD HEALTH ASSEMBLY

"HEALTH PLANNING"

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

A18/Technical Discussions/6 Rev.1
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REPORT OF THE TECHNICAL DISCUSSIONS AT THE EIGHTEENTH WORLD HEALTH ASSEMBLY

"Health Planning"

INTRODUCTION

History and organization of the Technical Discussions on "Health Planning" at the Eighteenth World Health Assembly

In accordance with resolution WHA10.33 of the Tenth World Health Assembly, the Executive Board at its thirty-second session decided, by resolution EB32.R15, that the subject to be discussed during the Eighteenth Assembly would be "Health Planning".

The choice of "Health Planning" as the subject of the Technical Discussions at the Assembly was in itself a reflection of the current interest of Member States and Associate Members in the trend towards the movement for the systematic organization and rational deployment of national resources both in material and manpower.

The discussions were opened on Friday, 7 May 1965, by Dr Karl Evang, Director-General of Health Services, Norway, who had been nominated as Chairman by the President of the Seventeenth Assembly, and appointed by the Executive Board (resolution EB34.R10).

In accordance with the customary practice, a document entitled "Suggested outline for use by countries in discussing 'Health Planning' at the Eighteenth World Health Assembly" was circulated by the Director-General to Member States, Associate Member States and interested non-governmental organizations in official relation with WHO (C.L.33.1964, dated 28 August 1964). These recipients were invited to forward any comments which they wished to make on the issues raised in the document, and to report, where appropriate, their own experience of Health Planning and of planning for Economic and Social Development. Fifty-nine Member States and Associate Members, and five non-governmental organizations replied to this invitation and their various observations were analysed, reviewed and presented in summary form

in the "Background Document" for the Technical Discussions (A18/Technical Discussions/1). In accordance with normal procedure, this document was sent on 31 March 1965 to all Member States, Associate Members and to inter-governmental and non-governmental organizations in official relationship with WHO.

The "Background Document" after presenting an analysis of the replies received to the "Outline", focused attention on six major questions and issues which appeared to arise therefrom. These in their turn were further summarized in the six items of the "Agenda for the Technical Discussions" (A18/Technical Discussions/2).

Prior to the opening of the Technical Discussions, 203 persons entitled to do so had registered as intending participants.

It had been decided, in consultation with the Chairman that, owing to the range and content of the subject and the variety of approaches used by countries in planning health services, some departure from the usual arrangements for discussion of the topic by groups would be necessary in order to obtain as comprehensive an expression of views and experience as possible.

It was felt that, subsequent to the opening plenary session of the Technical Discussions on 7 May, the eight groups into which the 203 participants were divided should consider the agenda items during two sessions on that day. These individual group discussions would be followed by a Joint Meeting of the groups on the morning of Saturday, 8 May, at which, after a general review by the Chairman of reports prepared by the groups, a somewhat more general discussion could ensue. This procedure was accordingly followed, and the present report sets out, as succinctly as possible, the content of the observations and experience brought forward at these several meetings, and the general consensus of opinions arrived at. (A list of the officers of the Technical Discussions, and of the Chairmen, Rapporteurs and Secretaries of the eight groups is given in Appendix A of this report.)

CONTENT OF THE TECHNICAL DISCUSSIONS ON "HEALTH PLANNING"

Chairman's introductory address

As a preface to his introductory remarks at the initial plenary session on 7 May, the Chairman, Dr Karl Evang, drew attention to the fact that the great scope of the subject, its relative novelty, its complexity, which could lead to undue

emphasis on detail, were all factors which might have suggested its somewhat late appearance in the series of Technical Discussions. Nevertheless, the urgent situation of many developing countries had caused them to commence organized planning for their Economic and Social Development, with which Health Planning should not fail to be associated, and had suggested to the Executive Board that an early discussion of the subject might be both timely and helpful.

Its decision to that effect had been justified by the unprecedented response of governments. From their replies and those of the interested non-governmental organizations, as well as from their imminent deliberations, there would become available a body of most interesting and important information on Health Planning, which in its extent and comprehensiveness would greatly exceed anything hitherto available to the World Health Organization. The characteristics of the countries which had replied to the "Outline" document, and of the many more now participating, constituted a range of races, cultures, traditions, of natural and human resources, of affluence, of poverty and above all of experience which was almost unique.

There were countries which, in so far as their health services were concerned, were still in the "emergency" stage of development - there were those at the other end of the spectrum where the provision of health services was lavish and almost at "saturation" point. Obviously for countries at these two extremes their respective goals for health services, and their methods of planning must be very different.

Nevertheless, in one field of health service provision hardly any country could as yet claim full success in the attainment of its objectives, or even proclaim its complete satisfaction as to its achievements. The three main components of the health services - personnel, institutions and equipment - must be adequate and in a properly balanced relationship, and of these three, personnel, as regards adequacy in numbers and grades, facilities for training, and equity in distribution, presented the greatest difficulties. Nor did the most highly developed and well-endowed countries in the health field escape these difficulties. Whatever their resources, as for example in numbers of trained physicians - whether the supply was apparently abundant or obviously meagre - the cry was always for more, and these needs extended to every type of health personnel. Modern medicine made enormous demands for

trained, partially-trained and auxiliary manpower. Yet the often suggested solution, namely the building of educational facilities of larger capacity, might be faced with the possibility that the recruiting potential of the health professions was not attractive enough to fill them.

In another context it was necessary to ask what was the object of Health Planning. And the answer was to provide health services for people, and in that connexion always to bear in mind the wishes of the individuals at the receiving end.

What sort of people were to be the subject of the planning process? What were their health needs? What was the stage of their political, social and economic development? How, in relation to individuals at the receiving end, does the planner take into account the initial discrepancy which so often can be noted between their essential needs and their limited demands? How too does the planner provide for the increased demands which can be expected when needs have been met? All these were factors which had to be taken into consideration, and the weight attached to them individually might determine the purpose and form both of the economic and of the health planning.

How, in the broader field of economic and social development, should the essential problems of the population be attacked? Previously, it had been accepted policy to think in terms of attacking the weakest link, namely ill health. Now the multiphasic attack was favoured, whereby change and improvement were stimulated in as many sectors of human life as resources would permit.

But it was also necessary to have some idea as to the broad philosophy of the planning of health services. What sort of organizational background was it intended to create or, if existing, to support or to enlarge? How would it be financially based - on taxation, insurance, voluntary contributions, direct out-of-pocket expenditure, or on a combination of all or some of these measures?

Admittedly the consequences of Health Planning could be revolutionary. They could be beneficial, they could also create problems of their own and even be dangerous or at any rate troublesome. Some of these difficulties were associated with short-term planning, say for a period of one year, but many more were to be encountered in long-term planning.

In short-term planning, however, it was advisable that there should have been some previous long-term planning, namely for the provision of the necessary operating staff, but apart from that, the risks inherent in definitely limited short-term plans were few. Very often these short-term plans took the form of annual budgeting and were in essence simply the execution of a limited programme.

The difficulties in long-term planning were of another kind and order. The data were liable to be out of date. The interval between their collection and the finalization of the plan was often so long that the conclusions based upon them were possibly no longer sound. Furthermore, particularly in the health field, scientific developments occurred at such a breath-taking speed that earlier ideas quickly became obsolete. Long-term plans tended to be rigid, unless the utmost care was taken to keep them under constant review. This constant review was at the heart of the whole concept of planning as a continuous process.

Finally, there was also the possibility that the association of Health Planning with Economic and Social Planning might result in the senior health administrator being relegated to a subordinate role. Related to this was the unfortunate possibility of the emergence of the professional health planner - the creation of a new branch of the medical profession.

These then were a few additional thoughts on the subject of Health Planning which the groups might wish to consider. They might be regarded as provocative, but they were based on experience. Experience had also shown that it was imperative that the health administrator should always be prepared to stake a claim for a fair and proper share of the national budget, and should not be deterred from doing so, even though Health Planning was part of a co-operative effort towards the achievement of national economic and social security.

(Dr Evang's address has been published <u>in extenso</u> as document A18/Technical Discussions/4.)

THE DEVELOPMENT OF THE TECHNICAL DISCUSSIONS

The "Suggested outline for use by countries in discussing 'Health Planning'" did not set out to be a comprehensive treatise on the subject of planning in relation to health services, more particularly in association with planning for Economic and Social Development. It was not intended to be a text-book of the methodology of planning, though it did follow to a considerable extent the general principles as outlined in the Fourth Report of the Expert Committee on Public Health Administration, which was concerned with the planning of public health services. The experience of six countries in Health Planning and certain of the methodologies adopted were described in that report. There is scope for the application of other and more scientific methodologies in tnis field, though obviously local traditions, knowledge and experience will dictate the precise form of the methodology which is applicable. The six chapters of the outline document were concerned with the following aspects of Health Planning:

Range of governmental activities as regards planning for economic and social development and for health.

Information and legislative powers as a prerequisite for planning.

The preparation of the health plan.

"Planning" and "programming".

Information of the public and popular and professional participation.

Evaluation.

These chapters were accompanied by an annex containing a series of 25 related questions appropriately grouped which were submitted as guide lines for the comments of the recipients of the "Outline".

The replies of the 59 Member States and Associate Members and the five non-governmental organizations were in the main strictly relevant to the 25 questions mentioned, and only occasionally and incidentally were further points raised. The "Background Document" presented in summary form the material so collected and pin-pointed the more important issues which appeared to require further elaboration and discussion. These issues could be comprised under six separate heads, as follows:

(i) the pre-conditions and prerequisite data for Health Planning;

(ii) the approach to Health Planning - the choice of the planning organization and the arrangements for co-ordination;

(iii) Health Planning and environmental improvement;

(iv) standards and norms of provision for ensuring health care, staffing of institutions, etc.;

(v) the characteristics of a realistic Health Plan;

(vi) the financial aspects of the Health Plan.

With only minor changes in phrasing, these topics were adopted as the six items of the agenda which was submitted for discussion to the groups (document A18/Technical Discussions/2). The comments of the groups, as reported by the Rapporteurs, were collated by the General Chairman, together with a number of new points of significance. These were then presented by him with illustrative commentary to the Joint Meeting of the groups on Saturday, 8 May, and were the subject of further observations and additions.

It is proposed in the subsequent sections of this report to present a résumé of the collected commentaries on each of these agenda items, and finally to bring to notice the several new points which emerged from the discussions and are relevant to Health Planning.

THE PRE-CONDITIONS AND PREREQUISITE DATA FOR HEALTH PLANNING

Experience suggests that certain conditions and data are essential prerequisites for the economic and social planner at the outset of his task. They are equally necessary, with certain obvious additions, for the Health Planner. The following summary sets out a list of these pre-conditions and prerequisites which were generally accepted.

Pre-conditions for planning

1. An understanding of the government's interest, aims and assessment of objectives, in national socio-economic development, and of its policy in respect of Health Planning as one of its integral parts. The Fourth Report of the Expert Committee on Public

Health Administration points out that "this fundamental step in planning public health services is the determination of government health policy".[1] Strategical decisions should be taken by the governments - especially where a new system is being introduced.

2. Enabling legislation for planning and subsequent implementation.

3. A planning organization for over-all socio-economic planning at policy- and decision-making level, and a health planning organization which is part of the former or equivalent to it.

4. Arrangements for co-ordination between all planning organizations and between these organizations and the government departments concerned.

Prerequisite data

1. Demographic data - national, regional or provincial and for local districts.

2. Vital and health statistics (crude and infant mortality rates, deaths by causes, morbidity data, hospital admissions, etc.).

3. An inventory of public and private health service institutions, including training institutions, and a complete statement by categories of health service manpower, whether employed officially or practising independently.

4. National economic background. Information regarding the present national economic background and general manpower position.

5. A statement of the financial allocations to the health services.

Some authorities, however, would regard them as too restricted in scope and would request the addition of the following:

(i) hospital morbidity and mortality data;

(ii) the results of mass screening investigations as to the prevalence of certain specified or asymptomatic diseases and the physical fitness of certain vulnerable groups, data as to the growth of urbanization, and information as to the extent of nomadism.

The usefulness of surveys under certain conditions was stressed, and the undertaking of some research into suitable forms of methodology for the intended planning process was also advocated. A warning was given as to the doubtful reliability of

[1] Wld Hlth Org. techn. Rep. Ser., 215, p. 9.

hospital statistics particularly in developing countries because of their selective character. Finally, the need on occasions to undertake planning with only the minimum of data was reiterated and emphasized. However, these data should not be regarded as final. Upon simple and even primitive data it was possible by patience and persistence to build over the years reliable statistical systems for the periodic review and correction of operating plans, from which future plans would benefit.

HAVING REGARD TO THE STATE OF DEVELOPMENT OF A COUNTRY, THE APPROACH TO HEALTH PLANNING - THE CHOICE OF THE PLANNING ORGANIZATION AND THE ARRANGEMENTS FOR CO-ORDINATION

The subject of governmental planning in the socio-economic field was discussed at some length in the replies to the relevant questions in the "Outline Document". The location of both the general and the health planning units in the governmental machine and their respective constitutions were also described. The agenda item as stated above was more limited in scope. It was accepted as axiomatic by participants in the Technical Discussions that the national ministry of health (subject only to cabinet approval) should be finally responsible for the Health Plan and its implementation. Consultation, collaboration and co-ordination of plans with the organization concerned with economic and social development planning was not excluded, and, in fact, should be considered essential.

The "Background Document" had outlined three main lines along which "Health Planning" as a process could be instituted and organized. These comprised, respectively, contractual arrangements with non-governmental planning specialists or consultants, the establishment of an ad hoc planning unit within the ministry or in close functional relationship to it and under the minister's jurisdiction, and the employment of a small committee or a larger conference for the purpose.

A wealth of information was provided under this head, but one point was stressed repeatedly, namely that, whatever the form of planning organization, planning was a continuous process. It was obvious, however, that there was no one pattern of health planning organization which was universally acceptable. Arrangements varied from the very simple three-person unit composed of whole-time experts, through combined teams of equal numbers of health experts and economists, to large bodies of which every technical member of the ministry of health staff was a member. There was a general consensus of opinion that planning - whether for economic development or for health -

affected the lives of communities both local and national. It was therefore a social and democratic process which concerned not only politicians and health experts at the centre, but was also of vital importance to men and women at the local level and to health workers in the field. It was stated that, in effect, there should be a continuous dialogue between the base and the summit.

Special reference was made to the need in many countries to take into account the existence of regional administrations, as a result of which national planning must often be a co-ordinated aggregation of regional plans. Very often it could be seen that differences in national health plans reflected both the political and administrative structure of a country. The question of the initiation of the planning process in a country was discussed and it was suggested that in many developing countries it had been found necessary to invoke assistance in this highly technical field from outside. In certain cases this might be unavoidable, but where this was so, special care must be taken to ensure that the national ministry of health staff were actively associated in the formulation of the plan, which at a later date they might be called upon to implement. This was another indication of the need for continuity.

THE PLACE OF ENVIRONMENTAL IMPROVEMENT IN THE HEALTH PLAN

There was a general agreement with the thesis of the "Background Document" that the environmental deficiencies of many developing countries, particularly in the tropical zone, are undoubtedly responsible for much of their burden of morbidity and deaths, and that projects for economic development, such as irrigation systems, can have repercussions in the health field in that they may alter the biological and ecological environment. Nevertheless, there was a marked difference of opinion as to the role of ministries of health with regard to environmental improvement, and the place of the latter in the Health Plan.

On the one hand there were participants who accepted the full responsibility of the ministry of health for the planning, financing and supervision of schemes for environmental improvement, particularly as regards water supply, sewage and refuse disposal and to a limited extent for housing. There were others who suggested that health ministries should carefully distinguish between the environmental health services which are an integral part of public health activities, and those undertakings which involve major engineering and constructional works, and substantial

capital investment. The former, such as vector and rodent control, food hygiene, and general sanitary supervision of environmental conditions are well within the domain of public health administration, are relatively cheap, and can be incorporated in the Health Plan and budget. Major constructional works, particularly as regards water supply, sewage disposal and housing, are very expensive and can give the health budget such a formidable appearance as to act detrimentally upon its other financial allotments for hospitals, training institutions, laboratories, etc.

In brief, there was much to be said for these potentially heavy commitments in the environmental field being primarily the financial responsibility of ministries of public works or their equivalent. Where this was done, the duty of supervision, and of requiring the maintenance of proper standards should rest with the ministry of health. If legal powers to this end were not already at the disposal of the ministry of health, the necessary provision for their acquisition should be made in the Health Plan.

THE USE AND PRACTICABILITY OF STANDARDS AND NORMS IN THE PREPARATION OF A HEALTH PLAN

The "Outline" document disclosed that there was a marked difference between developed and developing countries as regards their attitude to the application of standards of provision in the planning of health services. This was also the view of the participants in the Technical Discussions. The acceptance of definite (though not necessarily high) standards of provision appeared to be to some extent related to the general state of national development. Where this was at an advanced level, standards tended to be applied regularly and rigorously. In the developing countries there was much greater flexibility, and the standards could be adjusted to correspond with the resources available.

It was clear that international standards of staffing or of provision of beds or equipment were as yet hardly practical, and certainly not applicable in developing countries. National standards, which could be varied from time to time were much more feasible, but in certain circumstances standards might have to be different in the various regions of the same country. For developing countries international standards could be frustrating, and at best might be used to measure progress and to serve as guide posts to objectives which might be achieved in the future.

In certain developed countries it has been found possible to establish and to use "norms" of provision, which have been scientifically determined by research. (In contradistinction, "standards" of provision are fixed arbitrarily.) There is in fact an increasingly large field of health activities in which these "norms" could be established, through, for example, research, statistical analysis of hospital data, and time-motion studies of performance of health personnel. Research is necessary not only to discuss new "norms" but to prevent earlier established norms from becoming "static" or traditional.

The planning of health services in principle must base itself on scientific evidence as to the total needs of human beings, including physiological, psychological and sociological requirements. Many of these needs or requirements have not yet been scientifically quantitated. Short-term and realistic operational plans as a matter of necessity must, in most cases, accept lower standards for first and subsequent stages.

THE CHARACTERISTICS OF A REALISTIC HEALTH PLAN

The chief characteristics of a realistic Health Plan had been described at some length in the "Background Document", and were generally endorsed by the groups. Attempts were also made to state these features more concisely with a view to emphasizing the more significant desiderata.

One synoptic description stated that such a plan must be simple, comprehensive, flexible, phased, costed, limited in time as regards each step, fully acceptable to the community, and capable of evaluation at each stage.

Another stressed the importance of the following characteristics:

comprehensiveness and balance in considering objectives and arranging priorities;
flexibility;
efficiency in the use of resources;
adequate consideration of manpower requirements, both existing and potential.

There was almost universal insistence on the paramount importance of the determination of priorities. If special priority were to be assigned to any feature of the plan, it should be to the provision of educational and training facilities, and to the gradual building-up of the necessary manpower. Without such provision no plan could be described as realistic.

Attention was also directed by certain groups to the possibility of drawing up either alternative plans, or of providing within a plan certain interchangeable segments, which may facilitate the decision-making of responsible authorities.

The completeness or comprehensiveness of the plan was summarized in one statement which defined its range as covering population problems from paediatrics to geriatrics.

The time factor was also regarded as important. There should be the minimum of delay between the completion of the plan and its final implementation. No defence could be offered for the building of hospitals, which by reason of delay in implementation of the plan, were already 10 years out of date by the time they were completed.

THE FINANCIAL ASPECTS OF THE HEALTH PLAN

At one time, the financial implications of plans and programmes prepared by public health administrators tended to be stated in general terms. That phase is undoubtedly passing, and the necessity of providing a financial statement of costs, both at the first implementation of a plan, and over a subsequent period of years, is now more commonly appreciated. There is also an increasing recognition of the fact that the statement of the capital cost of a project carried with it the responsibility for an indication of the annual recurrent expenditure which will be involved.

These developments are due in many cases to more close collaboration with the economists concerned with national economic development. This collaboration has helped to create a greater degree of understanding of the functions and motives of the economist in the planning process, and reciprocally a more informed and sympathetic regard on the part of the economist, for the difficulties of the health planner. The economist has learnt that money spent on health services can be of positive benefit to the national economy, and is not merely unproductive expenditure.

Nevertheless, it is still difficult to state the relationship in economic terms between the expenditure on health services and the benefit which accrues to the health of the community and the individual. There is a steady demand for information on these matters both from economists who wish to receive it, and the health planner who is more than anxious to provide it.

Admittedly, money is in theory only of minor importance when matters of the national health are concerned, but such a view is apt to receive scanty consideration when the more productive sectors of the national economy - agriculture, trade, the exploitation of natural resources - are concerned. The position of the health planner and administrator is strengthened if his budgetary demands are clearly stated, detailed, and supported by reliable data as to needs of the population, both for the promotion of health and the prevention of disease. His arguments should be directed to convince the economist that expenditure on health is an investment with great potentialities.

Furthermore, the humanitarian aspect of health services should never be lost sight of. Health is a human right, and it is not always possible to use money as a yardstick for measurement.

Much of the discussion in the groups reiterated and emphasized these statements. Some consideration was given to the somewhat academic question of the proportion of the national expenditure which could reasonably be regarded as the fair share of the health services. Information on this point is as yet defective, and is also confused by a lack of clarity as to what is meant by national expenditure - whether it is limited to governmental expenditure alone or includes expenditure by other public bodies or by private individuals. Here again, there would appear to be scope for definition of terms and for research.

One question of special concern to the participants from developing countries was the possible methods of augmenting the financial resources of governments which embark on Health Planning and seek assistance more particularly in implementing schemes requiring large capital expenditure. It was felt that information should be readily available as to possible sources of international, bilateral, multilateral or voluntary aid for this purpose.

One final point which was made related to the acceptance of external assistance in the form of gifts of buildings or expensive equipment, without an appreciation of the fact that their subsequent maintenance became a national responsibility.

SPECIAL POINTS ARISING IN THE DISCUSSIONS

The foregoing summaries are concerned with the discussions on the six points of the agenda. They do not attempt to include all of the many informative and often illuminating comments which were made by participants on the basis of their personal experience and knowledge. An attempt has been made, however, to distil the essence of these contributions.

But in addition to the comments on the agenda items, there were a number of observations on other matters relevant to Health Planning. Here again, it has not been possible to record them all, but a number of general interest will be mentioned briefly.

Methodology

At various stages of the discussions reference was made to the absence of any details as to the methodology, or rather methodologies, of Health Planning. This deficiency is to a great extent due to the fact that the information provided by countries in reply to the "Outline" document was very limited on this point. It is, of course, recognized that in the development of their respective plans, the responsible authorities in certain countries, more especially the Socialist Republics, India and certain of the Latin-American countries, have evolved their own planning techniques, often based on mathematical and scientific principles, and have applied them in practice. There is an undoubted interest by other "planning" countries in these techniques, and they would welcome more information as to these several methodologies. It is true that in the ultimate resort each country may seek to develop its own approach to its planning problems, but knowledge of the experience of other planners, and an understanding of their techniques would undoubtedly be helpful.

Research

The development of a methodology is usually based on research, and in the case of the Socialist Republics, has resulted in the establishment of many research institutions. These have served not only to discover and explore the usefulness of new planning techniques, but have been concerned to keep established procedures under constant review.

Apart from these foci of research, many other developed countries have undertaken operational research into many of the activities of their health services. This has often been done with a view to improve operational efficiency, to obtain reductions in cost of services, and to ensure the better use of personnel. In this respect, research is an essential component of the "evaluation" process which should be applied to all health service activities.

Health service economics

This subject has already been touched on in the summary of "The financial aspects of the Health Plan". It is undoubtedly a matter which closely concerns health planners in their contacts with their economist colleagues over the financial implications of the Health Plan for the general economic situation. But it is also a subject worthy of study in its own right. At present, there is only a limited amount of accurate information as to the economic benefits, both immediate and future, which can or will be attributed, for example, to the reduction of the infant mortality rate, the elimination in certain countries of diphtheria as a major communicable disease, and especially to the eradication of malaria. There are also questions arising as to comparative operating costs of differing types of health services, which are of particular interest to developing countries. Here again, there is scope for research, whose results can be of considerable assistance to the health planner.

Population

The effect of population increase on Health Planning was not stressed during the discussions. Nevertheless, a warning was issued as to the importance of making population projections wherever possible, not so much from the point of view of creating institutions of adequate capacity, but in order to anticipate the number of personnel which will be required to staff the steadily enlarging services. It is also necessary to know what will be the size of the manpower pool from which potential health personnel can be obtained at specific dates in the future.

Health education

Reference has already been made to the participation of the local people - the men and women at the receiving end - in the preparation of the plan. Their later co-operation in the implementation of the plan is also desirable, and their interest in the successful operation of the services is to be encouraged. All this implies health education, which it is suggested might reasonably constitute one of the pre-requisites for Health Planning.

Nutrition

The role of the health authorities in the nutritional problems of their communities was discussed. Reference was made to the study of the epidemiology of nutritional disorders, of measures for their control and to education of the public in these matters. It was also agreed that health authorities should participate in the planning and execution of programmes for food production and nutritional improvement.

CONCLUSIONS

During the course of the discussions many helpful suggestions were made with a view to facilitating the task of the national organizations concerned with Health Planning. A number of these have been incorporated in the preceding sections of the report. The following suggestions, however, which are in fact specific recommendations for action by the World Health Organization, are set out in detail:

Research

It is recommended that the World Health Organization should institute or support experimental research into the establishment of "norms" of provision for use in the planning of health services. Despite the great need for quantifiable objectives and goals, it must be emphasized that the quality of the services should be safeguarded.

Training

It is recommended that the World Health Organization should institute or support courses of training in Health Planning.

Planning procedures

It is recommended that the World Health Organization should provide guide lines in Health Planning with a view to facilitating planning operations in developing countries.

APPENDIX A

LIST OF THE OFFICERS OF THE TECHNICAL DISCUSSIONS AND OF THE CHAIRMEN RAPPORTEURS AND SECRETARIES OF THE EIGHT GROUPS

General Chairman: Dr Karl Evang, Director-General of Health Services, Norway

Secretary: Dr Arne Barkhuus, Chief, National Health Planning, WHO

Consultant: Sir John Charles, former Chief Medical Officer, Ministry of Health, United Kingdom

Rapporteurs of the Joint Session of the groups:

Dr C. Quiros Salinas, Director-General of Health, Ministry of Public Health and Social Welfare, Peru

Dr H. Bâ, Médecin Inspecteur de la région du Cap Vert

Chairmen:

Group 1 — Dr A. Arreaza Guzman, Ex-Minister of Health and Social Welfare, Professor of Health Administration, Venezuela

Group 2 — Dr G. Popov, Chief, Department of Health Planning, USSR Ministry of Health, USSR

Group 3 — Dr K. N. Rao, Director-General of Health Services, India

Group 4 — Dr S. Al-Wahbi, Specialist Physician and Director of International Health, Ministry of Health, Iraq

Group 5 — Dr J.-S. Cayla, Inspecteur général au Ministère de la Santé publique et de la Population, France

Group 6 — Mr M. A. Pond, Assistant Surgeon General for Plans, Public Health Service, Department of Health, Education and Welfare, United States of America

Group 7 — Dr T. Bana, Directeur de la Santé publique, Niger

Group 8 — Dr L. W. Jayesuria, Deputy Director, Medical Services, Malaysia

Appendix A

Rapporteurs:

Group 1	Dr C. K. Chang, Director, Department of Health, Ministry of Interior, China
Group 2	Dr A. Adeniyi-Jones, Senior Lecturer, University of Lagos Medical School, Nigeria
Group 3	Dr R. M. F. Charles, Principal Medical Officer (Preventive), Ministry of Health and Housing, Trinidad and Tobago
Group 4	Dr P. A. Jennings, Senior Medical Inspector, Department of Health, Ireland
Group 5	Dr A. Daly, Sous-Directeur des Services Médicaux au Secrétariat d'Etat à la Santé publique, Tunisia
Group 6	Dr A. G. R. El Gammal, Director of the Planning Section, Ministry of Public Health, United Arab Republic
Group 7	Dr T. Alan, Directeur général des Relations extérieures, Ministère de la Santé, Turkey
Group 8	Dr G. H. Josie, Consultant, Planning and Evaluation, Department of National Health and Welfare, Canada

Secretaries:

Group 1	Dr A. Mochi, Programme Formulation and Evaluation, WHO
Group 2	Dr L. Bruce-Chwatt, Chief, Malaria Eradication/Research and Technical Intelligence, WHO
Group 3	Dr S. Falkland, Public Health Administration, WHO
Group 4	Dr F. A. Soliman, Chief, Public Health Administration, WHO
Group 5	Dr V. Z. Tabona, Chief, Programme Formulation and Evaluation, WHO
Group 6	Dr A. C. Eberwein, Public Health Administrator, WHO Regional Office for Europe
Group 7	Dr R. F. Bridgman, Chief, Organization of Medical Care, WHO
Group 8	Dr J. S. McKenzie Pollock, Chief, Office of National Health Planning, WHO Regional Office for the Americas

directing council

PAN AMERICAN HEALTH ORGANIZATION

XVI Meeting

regional committee

WORLD HEALTH ORGANIZATION

XVII Meeting

Washington, D. C.
September-October 1965

Provisional Agenda Item 13

CD16/15 (Eng.)
CORRIGENDUM
20 July 1965
ORIGINAL: ENGLISH

STATUS OF NATIONAL HEALTH PLANNING

CORRIGENDUM TO ENGLISH TEXT ONLY

See new page 8, TABLE 2

Attached: page 8,
CORRIGENDUM

TABLE 2

DISTRIBUTION OF THE AMERICAN COUNTRIES BY PER CENT OF CENTRAL GOVERNMENT EXPENDITURE DEVOTED TO PUBLIC HEALTH, 1963/1964

Countries devoting 10 per cent or more of central government expenditure to public health:

El Salvador
Haiti
Panama
Venezuela

Countries devoting at least 5 but less than 10 per cent of central government expenditure to public health:

Chile
Colombia
Cuba
Dominican Republic
Ecuador
Guatemala
Honduras
Mexico
Peru
Uruguay

Countries devoting less than 5 per cent of central government expenditure to public health:

Argentina
Bolivia
Brazil
Costa Rica
Nicaragua
Paraguay

Source: 1963 and 1964 Annual Reports of the Social Progress Trust Fund of the Inter-American Development Bank.