directing council

PAN AMERICAN
HEALTH
ORGANIZATION

regional committee

WORLD
HEALTH
ORGANIZATION

XV Meeting

XVI Meeting

Mexico, D.F.
August-September 1964

Provisional Agenda Item 31

CD15/4 (Eng.)
18 June 1964
ORIGINAL: ENGLISH

STATUS OF NATIONAL HEALTH PLANNING

1. Introduction

While the planning process is not new in public health, attempts have recently been made to fit the grand strategy of health better into the context of national development planning. This process has brought the health worker into close association with other disciplines, particularly economic planning. This influence has resulted in the formation of new indices and methods of measuring health needs and evaluating available resources.

Contemporary planning method tries to fuse together harmoniously into one purpose traditional public health practice, epidemiology, statistics, health administration, hospital administration, health legislation, accounting, sanitary engineering, medical care, maternal and child health, and such special programs as malaria eradication, vaccination campaigns, and the many other elements constituting total health. Health planning has no intention of usurping the technical prerogatives of the medical and health specialties, but rather is intended to supply the medium through which these specialties can secure the maximum share of resources to which they are entitled.

The success of the action stage of the planning process depends upon the administrative skills and pattern of organization of health services. Without a competent administrative framework for implementation, the planning process would remain an academic exercise. It is in this regard that increased emphasis is being placed on assisting governments in training personnel in administrative methods concurrently with the development of national health plans.

The countries of the Americas accepted the obligation to draw up formal health plans within the framework of the Ten-Year Health Program of the Alliance for Progress at the Special Meeting of the Inter-American Economic and Social Council at the Ministerial Level, held at Punta del Este, Uruguay, in August 1961.

Before the end of 1961, the basic framework of the present Office of National Health Planning had been established at PAHO Headquarters, and by the end of 1962 the first international training course for health planners sponsored by PAHO/ECLA had been given in Santiago, Chile, a committee of experts had been convoked in Washington to provide guidance for the Organization in this new field of activity, and the present program of training, research, and technical assistance to countries had reached the operating stage.

The present document reports on the status of national health planning in the Americas as of mid-1964.

2. Health planning and policy-making

The planning process in 16 of the 22 countries covered by the present report has as its focal point a special planning unit within the Ministry of Health. These units act as a staff mechanism to supply technical information on the basis of which health policy decisions may be taken at the cabinet level. At this policy-making level an interplay of political as well as technical factors is involved.

The planning units facilitate a two-way flow of information: technical information is passed up in a form in which it can be assessed at the Ministerial level, and cabinet decisions are passed down for technical interpretation. In this way policy guide-lines for national health plans are developed.

Health decisions have been taken over many years, and an accumulation of historical policy rulings exists in most countries. The formal planning process involves a review of these often uncoordinated policy decisions with a view to establishing or clarifying the grand strategy of health.

Some of the national policies which are being defined or redefined in the course of the health planning process are the following:

1. Policy objectives for government health services as such.
2. The relationship between Ministry of Health and other central government services.
3. The relationship between Ministry health services, Social Security services, and voluntary health insurance.
4. The role of the private sector of health care.
5. The role of religious and voluntary health agencies.
6. The role of foreign aid in national health programs.
7. Reconciling the claims of health with the claims of other sectors in over-all national development plans.

8. Policy regarding the distribution of health effort among different groups of the population according to political, technical, and economic criteria.
9. The establishment of standards for the use of auxiliary personnel and the development of realistic national technical norms.
10. The review of patterns of administrative organization.
11. The career status of health personnel.
12. The respective roles of central government and the local community in health promotion.
13. Health policy for rural and community development.
14. Manpower problems -- education and the role of the universities in health development.
15. Relations with professional organizations, and the training and licensing of medical and paramedical personnel.

While very few of the above issues have yet been resolved definitively, national health planning has encourage coordinated and often multi-disciplinary efforts to resolve them. This has recently been reflected in the sending of a small number of Health Ministry personnel to general planning courses, the inclusion of non-medical personnel in health planning courses, the representation of economic interests in some national health planning bodies, and the inclusion of Ministry of Health representatives in some national economic planning bodies. The developing dialogue among health workers, economists, and public administrators has proved a beneficial by-product of the formal planning process.

3. General status of national health planning

Table I shows the general status of national health planning in the Americas as of mid-1964. Of the 22 countries covered, 16 had national health planning units in operation and an additional country may have established such a unit by the time this report is distributed. Six of the 16 countries with national health planning units had already completed their comprehensive health plans, and were in the review and/or implementation stage, while the first national health plan was still in preparation in nine countries. Three countries could best be described as in the pre-planning stage, with preliminary or pilot studies being made in selected areas.

Unlike those sectors of national life where organized programming activity had not been undertaken prior to the Charter of Punta del Este, the health sector in most American countries was able to count on substantial background information collected in previous years by Ministries of Health, and to incorporate a variety of on-going projects into the new comprehensive health plans.

TABLE I

STATUS OF NATIONAL HEALTH PLANNING IN THE AMERICAS, MID-1964

Country	National health planning unit in operation	First national health plan in preparation	Completed plan in review and/or implementation stage
Argentina	X	X	-
Bolivia	X	-	X
Brazil	X	*	-
Chile	X	*	-
Colombia	X	-	X
Costa Rica	X	X	-
Cuba	X	-	X
Dominican Republic	-	-	-
Ecuador	-	X	-
El Salvador	X	-	X
Guatemala	X	X	-
Haiti	-	-	-
Honduras	X	-	X
Jamaica	-	-	-
Mexico	-	*	-
Nicaragua	X	X	-
Panama	X	-	X
Paraguay	X	X	-
Peru	X	X	-
Trinidad and Tobago ...	-	-	-
Uruguay	X	X	-
Venezuela	X	X	-
Total	16	9	6

* Pre-planning or pilot studies under way.

Owing to the lag involved in collecting statistical information on health expenditures, it is not yet possible to show in quantitative terms the changes in the health activity of Member Governments which have resulted from their commitment to national health planning. Table II, however, shows some base-line data on the share of government expenditure devoted to health work in 1962, and on the dollar value of tax receipts committed per-capita for health work in the same year. It is hoped that by 1965 it will be possible to show the changes in these items from 1962 to 1963 and perhaps 1964.

As can be seen from Table II, countries devoting a high percentage of central government expenditure to health may not be spending a great amount of money for the purpose if national income is low.

It should be noted that the measure "tax receipts spent per capita" has been chosen instead of "total expenditure" as an indication of national commitment to health. Total expenditure, of course, includes grants from abroad, which do not represent a national contribution. It also includes amounts which are spent in excess of tax receipts and grants; the excess may in some cases be financed by loans from abroad, in others by domestic borrowing through the sale of bonds, etc.

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

One of the keystones of the Ten-Year Health Program of the Alliance for Progress is planning for health within the framework of general plans for economic and social development. While the health authorities of the Americas may take legitimate pride in the advances made in health planning, it must be admitted that their situation at the start was more favorable than it was for social and economic planning as a whole. For a number of reasons, including relative freedom from political controversy, support by all levels of the population, relatively greater availability of trained personnel, and important quantities of multilateral and bi-lateral aid, the establishment and the first steps toward implementation of plans for health have been easier than for a number of other sectors of national life.

Paradoxically, some of the countries which made the greatest progress in general planning have been relatively slow to formulate specific health plans, while in a number of countries health planning has been in advance of the general planning process. In a review of progress in planning in Latin America, the United Nations Economic Bulletin for Latin America (Vol. VIII, Nº 2, October 1963) lists Bolivia, Chile, Colombia, Ecuador, Mexico and Venezuela, as having formulated medium - or long-term economic plans, but of these countries only Bolivia and Colombia have already completed national health plans. A review of the development plans for the remaining countries in this group generally shows the health sector inadequately represented in the national investment program--at times only by programmed investment in water supply projects and a limited range of other activities.

TABLE II

CENTRAL GOVERNMENT EXPENDITURE ON HEALTH IN 1962

RELATIVE EXPENDITURE	ABSOLUTE EXPENDITURE
Countries devoting 10 per cent or more of central government expenditure to public health El Salvador Haiti Panama	Countries spending $5 or more of tax receipts per capita on health Panama Uruguay Venezuela
Countries devoting at least 5 but less than 10 per cent of central government expenditure Brazil Chile Colombia Dominican Republic Ecuador Guatemala Mexico Nicaragua Peru Uruguay Venezuela	Countries spending at least $1 but less than $5 per capita Argentina Brazil Chile Colombia Costa Rica Dominican Republic Ecuador El Salvador Guatemala Mexico Nicaragua Peru
Countries devoting less than 5 per cent of central government expenditure Argentina Bolivia Costa Rica Honduras Paraguay	Countries spending less than $1 per capita Bolivia Haiti Honduras Paraguay

Source: Computed by PAHO from data published in the 1962 and 1963 Annual Reports of the Social Progress Trust Fund, Inter-American Development Bank.

The ECLA review lists Brazil and Panama as having two- or three year economic development plans. In the case of Panama a comprehensive health plan is also in existence. El Salvador and Guatemala are listed by ECLA as having general investment plans, rather than comprehensive development plans, but in the case of El Salvador health planning is clearly in advance of general planning.

Countries whose economic programming is thus far limited to individual investment plans are Argentina, Costa Rica, Haiti, Honduras and Peru. In this group, Haiti has an emergency health program but no comprehensive plan, Honduras has its original health plan under revision, and the planning process is under way in Argentina and Costa Rica, and advanced in Peru.

Of the cuntries classified by ECLA as having only an "embryo planning system", the Dominican Republic, Nicaragua, Paraguay and Uruguay, health planning units are in operation in all but the Dominican Republic and, with PAHO assistance, the preparation of the national health plan for Nicaragua is well advanced.

In terms of operational machinery and instruments for implementing development plans, the health sector enjoys a distinctly more favorable position. The ECLA review observed that none of the 19 countries covered had machinery for formulation of economic policy in terms of plan objectives or to achieve investment targets, that only three had machinery for formulating projects for the relevant investment plans, and that four had provision for program budgeting at one or more levels.

Clearly, the setting up of machinery to implement a general economic plan is more difficult than in the case of a health plan, for a general plan has to deal with a wide variety of activity in the private sector while programmed health activities usually relate to the public sector alone. Owing to the fortunate circumstance that the Ministry of Health is at the same time the planning agency and in large part the operating agency, it would be fair to say that all of the national health plans thus far formulated in the Americas have involved a reshaping of health policy and the establishment of specific investment targets, plans and projects, although the development of program budgeting has been rather slower than might be desired.

5. Training and utilization of health planners

By the end of 1964, more than 100 national and international senior health officials from the American countries will have received formal training in health planning methods -- the great majority in the special three-month international course in health programming held annually in Santiago, Chile, by PAHO and the Latin American Institute for Economic and Social Planning. Smaller groups have been trained in English-language international courses given with AID and PAHO participation at the Johns Hopkins University in 1963 and 1964.

Table III provides a summary of the training and utilization of national and international personnel in international courses. It will be noted that 20 of the countries had national personnel with such training, and that 11 could count on the assistance of either specialized PAHO planning consultants or of Country Representatives or resident Zone office staff with similar training. Assistance to the remaining countries was provided by visiting Headquarters and Zone office personnel, and it was planned to provide formal training to the remaining Country Representatives and a number of Zone project staff by the end of 1964.

In most countries, utilization of national personnel trained in planning has been high. Owing to the high potential of the candidates selected for planning training, however, a number have been promoted to higher responsibilities in their national health services where their background stands them in good stead. A relatively small number of cases of non-utilization are attributed to faulty selection of candidates largely during the first more or less experimental year of the training operation.

In addition to the international courses, serious training efforts have been made within the different countries. A pioneer national course in health planning was held in Venezuela in 1962, and large-scale courses have since been organized in El Salvador and Peru.

TABLE III

TRAINING AND UTILIZATION OF HEALTH PLANNERS AS OF MID-1964

Country	One or more senior health officials trained in international planning courses	Course graduates employed in national health planning unit	Graduates employed in other functions in health services	PAHO staff in the country trained in international planning courses
Argentina	X	X	X	X
Bolivia	X	X	...	X
Brazil	X	-	X	X
Chile	X	X	X	X
Colombia	X	X	X	-
Costa Rica	X	X	X	X
Cuba	-	-	-	-
Dominican Republic	X	-	X	-
Ecuador	X	-	X	X
El Salvador ...	X	X	X	X
Guatemala	X	X	X	X
Haiti	-	-	-	-
Honduras	X	X	X	-
Jamaica	X	-	X	-
Mexico	X	-	X	X
Nicaragua	X	X	X	X
Panama	X	X	X	-
Paraguay	X	X	X	-
Peru	X	X	...	X
Trinidad and Tobago	-	-	-	-
Uruguay	X	X	X	-
Venezuela	X	X	-	-