



directing council

PAN AMERICAN
HEALTH
ORGANIZATION

XXII Meeting

Washington, D.C.
October 1973

regional committee

WORLD
HEALTH
ORGANIZATION



XXV Meeting

Provisional Agenda Item 21

CD22/17 (Eng.)
17 September 1973
ORIGINAL: SPANISH

OBJECTIVES AND PRIORITIES IN THE PROGRAM OF THE ORGANIZATION IN THE LIGHT
OF THE RECOMMENDATIONS OF THE III SPECIAL MEETING OF MINISTERS OF HEALTH
OF THE AMERICAS

Resolution XIII approved by the XXI Meeting of the Directing Council of the Pan American Health Organization was worded as follows:

THE DIRECTING COUNCIL,

Having heard the statement by the Director of PASB on the III Meeting of Ministers of Health of the Americas, held in Santiago, Chile, 2-9 October 1972; and

Considering that the recommendations made by the Meeting constitute valuable guidelines on the direction to be taken by the programs of the countries during the next decade,

RESOLVES:

1. To incorporate into the policy of the Pan American Health Organization the recommendations of the III Meeting of Ministers of Health of the Americas.
2. To request the Director of PASB to study the implications of those recommendations and the consequent modifications in the objectives and priorities of the program of the Organization, and to report thereon to the XXII Meeting of the Directing Council.

3. To recommend to the countries that, within their planning process, they identify the priority health problems and establish objectives for each of them in accordance with the manpower, physical, and financial resources available, taking into account the regional health goals.
4. To request the Director of PASB to convene as soon as possible a working party of personnel responsible for planning and information and of health economists, with a view to designing an evaluation system that can be adapted to the conditions of each country and still be flexible enough to give comparable results and in turn permit a continent-wide evaluation of the achievements of the decade.
5. To recommend to PAHO that, in consultation with experts of the countries, general guidelines be drawn up for determining the present financing of health investments and the changes required to carry out the plans and programs envisaged in the Ten-year Health Plan for the Americas, 1971-1980.
6. To suggest to the health authorities of the countries that they initiate cost studies of their health services and, whenever possible, cost-benefit studies, particularly in areas with the largest investment.
7. To recommend to PAHO that it prepare the necessary designs to ensure comparability of the cost studies.
8. To recommend that PAHO furnish advisory services to countries requesting them, in all matters relating to the financing of the health sector, such as the financial analysis of the sector, analysis of health expenditures, programming of investments, management and financing of specific projects and of external credits, so that the countries will gradually come to know what financial resources are earmarked for health and how they are related to the benefits obtained.

In view of the importance of the decisions adopted, the Director considered it appropriate to report to the Executive Committee at its 70th Meeting on the activities under way and being promoted in regard to this matter. The Committee discussed the information presented and adopted Resolution VII. The text was as follows:

THE EXECUTIVE COMMITTEE,

Having heard the preliminary report of the Director (Document CE70/7) on the steps being taken to implement Resolution XIII of the XXI Meeting of the Directing Council of the Pan American Health Organization;

Considering that it is primarily the responsibility of the countries to adopt the necessary measures to formulate or revise their health policies for the purpose of achieving the goals of the Ten-year Health Plan for the Americas; and

Bearing in mind that the objectives and priorities of the Organization's program must also reflect the goals of the Ten-year Health Plan so that it can most effectively assist the Governments to meet these objectives,

RESOLVES:

1. To take note of the preliminary report of the Director (Document CE70/7) on the steps the Organization is taking to implement Resolution XIII of the XXI Meeting of the Directing Council of PAHO.
2. To urge the countries to review their health policies and adjust them to the goals of the Ten-year Plan, in the light of the national health situation and the resources available, and in line with the requirements of economic and social development.
3. To request the Director to assist the countries in (a) defining their policies and objectives and in establishing a permanent system and appropriate methodology for evaluating the results; and (b) carrying out studies required for the Ten-year Plan on income, costs, and financing of health services.
4. To request the Director to report to the XXII Meeting of the Directing Council on the progress achieved in this important matter.

It should be pointed out that Resolution XIII of the XXI Meeting of the Directing Council incorporates into the Organization's policy the recommendations of the III Special Meeting of Ministers of Health of the Americas. By adopting the resolution, the Directing Council established the terms of reference, that is, the guide for all PAHO/WHO activities in the Region until 1980. According to our interpretation, this means that it is the governments' responsibility to determine, on the basis of their health policy, plans and programs, what they expect from international assistance. Thus this assistance would supplement the national endeavor and would be channeled by the latter to those sectors where it would contribute to the achievement of the objectives set by each country.

In this connection it might be appropriate to refer to the PAHO General Program of Work for 1973-1977, approved by the XVIII Pan American Sanitary Conference. It is gratifying to note that its wording, the

terminology used and the standards it contains correspond, in terms of the Region, to the basic principles of the Ten-year Health Plan for the period 1971-1980.

Moreover, the "Basic Documents" submitted to the Governments for their consideration in preparing the above-mentioned Plan were drawn up taking into account an assessment of what had been achieved during the previous decade, the information contained in the Quadrennial Projections of 22 countries and background papers sent to governments not yet using this system.

With reference to paragraph 2 of Resolution XIII, it is obvious that once the countries have redefined their health policies and consequently determined their priorities and objectives for the ten-year period, and reviewed their needs with regard to international assistance, particularly PAHO assistance, the secretariat will be in a position to study the possible impact of the Ten-year Health Plan for the Americas on the orientation of the PAHO/WHO program, and on the amount and distribution of the Organization's budget.

A first analysis of the structure and evolution of the PAHO/WHO investment for the years 1964 and 1973,¹ in terms of the priorities set out in the Ten-year Health Plan for the Americas shows that there is little hope that the recommendations formulated by the III Meeting of Ministers of Health will modify substantially the objectives and priorities of the Organization's program, although there could be changes or emphasis in some areas of the program. This study reveals the following facts:

- The investment corresponding to PAHO/WHO assistance to service programs has increased in the same proportion as overall PAHO investments during the period under study. Investment in programs for development of the infrastructure has increased at a higher rate than overall investment, in that expenditure on administration and management and programs considered of low priority for the Ten-year Plan is increasing at a slower rate.

The above is reflected in the structure of investment: the service sector has remained more or less stable, representing 54% of total investment in 1964 and 55% in 1973. Investment in the infrastructure which amounted to 26% in 1964 has increased to 31% in 1973. The decrease in the proportion allocated to general administration and management of PAHO is notable: in 1964 it was 19% of the total investment and in 1973 only 15%.

¹1963 was the date of the I Meeting of Ministers, which produced the Health Plan for the Sixties, and 1972 the date of the III Special Meeting of Ministers, which produced the Ten-year Health Plan for the Americas for the Seventies.

- In the field of services to individuals, the most remarkable increase has been in maternal and child health and family welfare, considered as a top priority in the Ten-year Plan. Investment in 1973 was 14 times greater than that recorded in 1964; the 1964 allocation, about 2%, by 1973 had risen to 8% of the overall investment for that year. Investment in nutrition activities in 1973 was three times that in 1964, representing 9% of total investment in 1973. There were also substantial increases in allocations to dental and mental health programs.
- Expenditure on communicable disease programs did not increase in proportion with overall PAHO investments, due principally to the substantial fall in investment in the malaria program, now in its consolidation phase. Progress made in smallpox eradication has also had some effect over the last few years. Nevertheless, communicable disease programs accounted for 9% of PAHO investment in 1973.

This analysis shows that communicable diseases, nutrition and maternal and child health programs are the priorities for PAHO investment in the field of services to individuals.

- The allocation to environmental health projects as a whole increased from 19% in 1964 to 22% in 1973. Expenditure on animal health and veterinary public health programs, mainly aimed at increasing the availability of biologically valuable proteins, rose from 7% in 1964 to 10% in 1973. Projects for drug control have increased ninefold since 1964. Moreover, new areas of assistance such as regional development, pesticide control and accident prevention have been included in the program.
- With regard to supporting services, the most notable changes have been the increase in the allocation to nursing, which in 1973 was five times greater than that of 1964, and the incorporation of epidemiological surveillance programs into PAHO investment in 1973.
- Contributions to the field of infrastructure have grown from 26% in 1964 to 31% in 1973. There has been an obvious increase in programs aimed at increasing the operational capacity of national health systems (investment in such programs is eight times greater than in 1964), and new areas of assistance have been instituted concerning the development of financial and physical resources, particularly the production of biological substances and maintenance of equipment.

From this analysis it can be concluded that the PAHO investment proposed for 1973 was already following the guidelines of the Ten-year Plan, and that the strengthening of activities for development of the infrastructure has been made possible by reducing administrative costs and running down non-priority programs.

In paragraph 3 of Resolution XIII, the Directing Council recommended to the Governments of the countries that they review the order of priorities of their national health problems and make the necessary modifications to their respective programs to insure that, in accordance with their resources, they correspond to the proposals for the Hemisphere contained in the Ten-year Health Plan. This involves the ratification of national policies now in force or their reformulation and modification, by consolidating or redefining programs with attainable objectives and feasible strategies in national health plans, which together will contribute to successful implementation of the Ten-year Health Plan for the Americas. Several countries have already taken steps in this direction.

The Brazilian Government has analyzed the problem areas common to the whole country and the variations between the different geopolitical regions which make it up. Specific goals and strategies have been established together with the legal requirements necessary in a federalized country to implement them. The health authorities have drawn up a document which will shortly be presented to the National Executive for approval and putting into effect.

In Panama, the Dominican Republic, Honduras, El Salvador, Ecuador, Guyana, Trinidad and Tobago, Jamaica and other Caribbean countries, technical groups have been formed under the supervision of the health authorities to analyze the plan for the Hemisphere and draw up recommendations for determining and defining national goals.

Concurrently with these initiatives, the Mexican Government formed a National Health Convention made up of representatives of public and private health service delivery institutions, the universities, the trade unions, and community authorities and leaders. Its purpose is to review national health policy and to outline a national plan based on state and municipal health plans. The collaboration of the public and private subsectors in the health field and in other related economic and social sectors in an undertaking of this magnitude represents a unique and practical experiment, in that the various institutions and authorities concerned with or responsible for the health sector were committed to support it from the planning stage. This has established a solid basis for balanced coordination and improved utilization of the resources available and for the search for and development of new resources.

Similar initiatives are expected to take place in other countries, so that the Ten-year Health Plan, supported by national plans, will soon be put into effect.

In accordance with the decision of the Governing Bodies, PAHO is providing the technical assistance needed by the countries in this field. A simplified guide was prepared, designed to facilitate analysis of the

goals of the Ten-year Health Plan for the Americas, to make the necessary modifications to national policies, to assess the contribution of each country to implementation of the plan for the Hemisphere and to establish bases for a standardized system for comparison and evaluation of constraints as well as achievements.

To give effect to point 4 of Resolution XIII, the Director convened a working group on evaluation which met in Washington from 4 to 8 June 1973. The group was made up of eight specialists in planning, economics, information and evaluation from different countries of the Region.

The group first examined the scope and characteristics of evaluation of the Ten-year Plan, recommending that the system center on an assessment of the efforts made and the changes brought about by each country. Evaluation of the continental plan will take the form of the consolidated results of evaluation carried out for each country. The advantage was pointed out of beginning the process using information already available, at the same time promoting the development of the systems producing such information. Due attention was paid to an analysis of national strategies designed to achieve the objectives. It was also recommended that evaluation be used to provide feedback for the decision-making processes for policies concerning planning, budget and supervision.

With regard to recommendations for evaluation methods, the group established general guidelines, leaving to PAHO the responsibility for designing the method and procedures, which must be simple and capable of easy and immediate application by the countries. It must be a continuous process permitting an annual comparison of the activities planned with those carried out in pursuance of the objectives adopted by the country within the meaning of the Ten-year Plan. It is suggested that the analytic method accepted by the group be used for this purpose. Elucidation of the discrepancies between activities planned and those carried out will make it possible to incorporate the necessary modifications into the programs, objectives and strategies.

It is felt that it would be of advantage for the countries to determine the priority programs on which they intend to concentrate their efforts in each problem area, and for which more accurate information and evaluation systems would be established.

On the continental level, evaluation will be carried out in three stages. The first, in 1974, will try to determine how many countries have established their starting points, that is, the situation in 1971; how many are adopting objectives in the fields covered by the Ten-year Plan and are incorporating them into their policies; and how many are formulating the corresponding strategies. The method used for this purpose will be a simple, descriptive report on the extent to which the countries are referring to the Ten-year Plan and its objectives in formulating their own

programs. The discrepancies between continental objectives and those fixed by each country will be analyzed, together with the discrepancies between the latter and the situation at the outset, to assess the efforts the country proposes to make in each area.

The second stage, in 1977, will consist of a comparison between the intermediate objectives set by the countries for that year and the results achieved.

The method used for the final stage in 1981 will be a comparison of the objectives set by the countries with their achievements. Any discrepancies will be explained by the analysis carried out by each country and the way will be opened to the establishment of bases for formulation of a new Ten-year Plan, with the experience gained from studies on the operation of national strategies over the decade.

The group particularly recommended use of the system of Quadrennial Projections of activities carried out jointly by the countries and PAHO as an important element for evaluation.

With reference to the organization of the evaluation system, the group recommended that this activity be carried out in each country under the guidance of and in coordination with existing planning and evaluation units. These national systems would be coordinated with the continental system, whose organization would be the responsibility of PAHO. The continental system would collect information supplied by the countries, offer its assistance and advice for the creation and operation of national systems, prepare instruction manuals, glossaries, mathematical models, etc., and disseminate the results obtained.

The group particularly stressed staff training, recommending the organization of short-term courses, of a purely operational nature, research on important aspects of the evaluation process and dissemination of the results through more comprehensive seminars and courses.

The working group set out these recommendations in a report to the Director of PASB and the document was made available to the governments for their consideration. On the basis of that report, and with a view to implementing the provisions of Resolution XIII, the Director is working out a system for evaluation of the Ten-year Health Plan for the Americas. This will be finalized in December next in terms of the degree of success achieved by the governments in adapting the objectives of the plan for the Hemisphere to their national health policies. It is hoped that the scheme will facilitate organization and elaboration of the first evaluation of the plan, which is due to take place in the first quarter of 1974.

To give effect to the provisions contained in paragraphs 5, 6, and 7 of Resolution XIII, concerning health investments, costs and sectoral

financing systems, the Director has convened a working group made up of economists with experience in the field of health and social security and specialists in national accounting, with wide knowledge of the diverse characteristics of such systems in countries of the Region. The group will meet at the Organization's Headquarters during the first week of December next. To facilitate its work, an outline has been prepared based on the following concepts:

The studies on revenue must identify their sources and historical trends, and analysis of expenditures must include its size, structure, and trends, according to the areas of application. For both national and regional purposes, the studies should be as comprehensive as possible to obtain valid conclusions.

With reference to financing systems, it is proposed to study the processes of procurement, allocation, distribution and use of resources; the corresponding methods and procedures; the legal provisions or requirements which establish and maintain them and the formal and informal structure in which they are implemented.

The cost studies should be envisaged as an analysis of productive capacity. In the first stage production models for services or goods will be selected for a small number of countries and, on the basis of the experience obtained, methods of investigation into the subject will be worked out in a second stage for application to similar countries. At the request of the Colombian authorities a cost study has been initiated on laboratories manufacturing biological products, using the approach mentioned above. As the countries decide to carry out studies in the areas mentioned above with PAHO assistance, appropriate steps will be taken to provide the necessary support from PAHO/WHO.

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ORGANIZATION

XXII Meeting

Washington, D. C.
October 1973

regional committee

WORLD
HEALTH
ORGANIZATION

XXV Meeting



Provisional Agenda Item 21

CD22/17 (Eng.)
ADDENDUM I
5 October 1973
ORIGINAL: SPANISH

OBJECTIVES AND PRIORITIES IN THE PROGRAM OF THE ORGANIZATION IN THE
LIGHT OF RECOMMENDATIONS OF THE III SPECIAL MEETING OF MINISTERS OF
HEALTH OF THE AMERICAS

WORKING GROUP ON EVALUATION OF THE
TEN-YEAR HEALTH PLAN FOR THE AMERICAS

Washington, D.C., 4-8 June 1973

REPORT TO THE DIRECTOR



PAN AMERICAN HEALTH ORGANIZATION

WORKING GROUP ON EVALUATION OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

WORLD HEALTH ORGANIZATION

WASHINGTON, D.C., 4-8 JUNE 1973

REPORT TO THE DIRECTOR

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ANNEX

GUIDELINES FOR THE ANALYSIS AND INCORPORATION
OF THE GOALS OF THE TEN-YEAR HEALTH PLAN FOR
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AND ADJUSTMENT OF THE COUNTRY-PAHO QUADRENNIAL
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In helping to formulate national programs and projects, the Ten-Year Public Health Plan of the Charter of Punta del Este (adopted in 1961) was successful in promoting a consensus among the countries of the Region on the role played by health and the health sector in the process of economic and social development, in promoting joint efforts, and in demonstrating that the countries derive far greater benefits, visible as solid improvements in the peoples' health conditions, when these conditions of consensus and joint action prevail.

The Ten-Year Plan was examined at the first two special meetings of the Continent's ministers of health. It was evaluated on three occasions by the simple process of comparing goals with achievements, as revealed by the information furnished by the countries themselves.

The Third Special Meeting of Minister of Health, held at Santiago, Chile in October 1972, concluded its deliberations by proposing a second Ten-Year Health Plan for the Americas, based on the role to be played by the health sector in the activities envisioned for the Second United Nations Development Decade. The second Ten-Year Plan, along with other recommendations of the III Special Meeting of Ministers, was incorporated in the Organization's policies by resolution of the Governing Council.

When one examines the contents of the Ten-Year Plan with a knowledge of the process which led to its formulation, one notes the evolution and the progress that have taken place in the conceptual structure now guiding health activities in the countries of the Continent. For example, the Plan clearly establishes the need to view the health sector as a whole, with its internal and external relationships, but with this global view not engendering neglect of consideration of the subsystems within the sector. There is also a clear concern both for the objectives in the health field and for the tools needed to achieve them while maintaining equilibrium between efficiency and social justice. Profiting from each country's greater knowledge, information, and experience, acquired over the last decade, on its problems and means of solving them, the new Plan is significantly more precise in its objectives and in the strategies it proposes for meeting them.

The Ten-Year Plan drawn up by the Ministers and their technical staffs serves as a guide for orienting the programs and activities of the countries which conceived it and of the Organization. It proposes general objectives and strategies relating to practically all major aspects of national health systems and health problems, in the framework of a national health policy consistent with the level of economic and social development. Defining such a policy, weighing the possibilities for

action in each country, and selecting priorities for achievement of the established goals, are prerequisites for the formulation and fulfillment of national plans.

The intense activity of the countries in drawing up the Ten-Year Plan for the Americas is continuing with the formulation of national policies, the establishment of goals, the selection of priorities, and the designing of strategies. The next steps, therefore, are implementation and evaluation.

On the latter subject -evaluation- the Organization's Governing Council, at its XXI Meeting, adopted Resolution XIII, a pertinent part of which reads as follows:

"Request the Director of the PASB to call together, as soon as possible, a work group composed of planning and information authorities and health economists to design an evaluation system adaptable to the conditions of the various countries and sufficiently flexible to provide comparable results, making possible a continent-wide evaluation of accomplishments during the decade."

Pursuant to this mandate, the Director called a meeting of eight specialists in health planning, information, and economics from various countries of the Continent. The group met at the Organization's headquarters in Washington from June 4-8, 1973, to discuss, and to make recommendations upon, the method to be used and systems to be established by the countries and by the Organization.

Several preliminary studies prepared by PAHO staff for the meeting were used as reference documents. The "Discussion Guide," presented as a suggestion to the group, was accepted and, after amendment, included in the group's final report. The "Guide for Analysis and Incorporation of the Goals of the Ten-Year Health Plan for the Americas in National Health Policies and Adjustment of Quadrennial Country-PAHO Projections" (Appendix I) was also available to the group and is being used by the countries. The Organization's preliminary study on "Classification and Analysis of the Goals of the Ten-Year Health Plan for the Americas" (Appendix II) was also offered for the group's consideration, as was "Considerations relating to the Selection of Priorities as a Component of the Decision-Making Process" (Appendix III). Other documents used were the "Basic Reference Document of the III Special Meeting of Ministers of Health for the Americas" and the "Ten-Year Health Plan for the Americas," which had been approved by that ministerial meeting.

The group opened its deliberations after being welcomed by the Director of the PASB, who pointed out the importance of evaluating the Ten-Year Plan and the need for a simple method, easily applicable in

the various countries, and for a system that could be effectively used by existing facilities both in the countries and in the Organization.

Mr. Allen Pond was chosen as Moderator and Dr. Himbad Gartner as Rapporteur of the group. Discussion centered upon the three subjects suggested by the Organization's Secretariat and according to the agenda it had proposed, which the work group accepted. Item I, "Purposes and Characteristics of Evaluation of the Ten-Year Plan for the Americas," was discussed for three hours on the first day of the meeting. More time was devoted to Item II, "Recommendations on Elaboration of a Method of Evaluation," which was discussed during the latter part of the first day and during the second and third days. In view of the length of time spent on this subject, a subgroup was appointed to draft a resolution for the group's consideration; and editing committee, which worked outside the meeting hours, was also appointed. Six hours were devoted to Item III, "Recommendations on the Organization and Operation of the Evaluation System;" a special drafting subgroup was appointed for this item as well.

A draft of the final report was prepared by a drafting committee which met in the afternoon and evening of the next-to-the-last day. It was discussed and approved with minor modification in the morning of the last day. After the Moderator reviewed the meeting orally for the Director of the PASB, the Director gave his closing words of thanks, and the meeting was adjourned.

3. WORK GROUP REPORT

3.1 OVERALL FRAMEWORK FOR EVALUATION OF THE TEN-YEAR PLAN

The members of the Work Group made a series of observations on the status of the countries' decision-making and planning processes, evaluation practices, and the role of information systems in evaluation. This discussion led to the identification of factors that should be taken into account in organizing systems for evaluating the Ten-Year Health Plan for the Americas:

-As the Ten-Year Plan makes clear, its execution requires that each country establish policies, or adjust existing policies, so as to incorporate the goals in each pertinent section of the Plan, to provide for the identification of priority areas, and to state the strategies for achieving the proposed goals. In evaluating progress toward these goals at the national level, indicators based on information that is both simple and homogeneous in nature must be used. In most areas,

the Plan suggests indicators for evaluating its implementation. In other areas, however, criteria for making qualitative or quantitative comparisons will have to be found; this applies particularly to the development of administrative, planning, and information processes in the national health sectors.

-Despite the shortcomings in the information systems of the national health sectors, they may be able to provide sufficient information to assess the implementation of national and continental goals and strategies in the terms in which the Ten-Year Plan expresses them. It is possible and advisable to seek the greatest development of those systems, so as to improve the processes of evaluation and control, and, hence, the establishment and adjustment of policies and the processes of decision-making at all levels.

-In deciding how to evaluate the Plan, the current availability of information in the countries, as well as the information which will become available as national information systems are improved, should be considered. It is important to improve the use of available information on mortality, in-hospital morbidity, resources (availability, preparation, and use), and production and productivity, as well as information on health services organization, so as to improve the systems of decision-making, planning, and control.

-The same area categories should be used in evaluation as those into which the Ten-Year Health Plan for the Americas is divided.

In light of these and other considerations, the group adopted the following recommendations on the purposes and characteristics of evaluation of the Ten-Year Health Plan for the Americas:

-The evaluation system should focus on estimating the effort applied and change achieved in each country, as regards the resources, process, and production of the health system, as well as its effects in bringing about a higher level of health and a positive attitude on the part of participants in the process. The information obtained through the evaluation should be fed back into the system and serve as a foundation for the adjustments needed for planning and devising strategies to pursue the goals and purposes of the Ten-Year Plan at the continental level.

-The goals and purposes of the Ten-Year Health Plan for the Americas should be considered a point of reference and guidance for the goals and purposes selected for each government's health plan. The consistency and interrelationship of national and continental goals should be examined. To facilitate this examination, the goals and purposes should be studied and classified, bearing in mind that some of them can be measured and assessed only if certain operational criteria exist in advance.

-Achievement of the Ten-Year Health Plan for the Americas should be evaluated as a function of the number of countries and proportion of the population of the Americas which has achieved or surpassed the goals and carried out the stipulations of the Plan.

-Given the structure and concept of the Ten-Year Health Plan for the Americas, the evaluation must include an analysis of the national strategies formulated to implement the goals and targets of the Plan, as well as the analysis of the extent to which they are in fact implemented. Hence, the design of the system for evaluating the Ten-Year Plan should facilitate the evaluation by each country of the progress toward its goals and of implementation of its programs and strategies, with the comparability necessary to permit assessment of achievements at the continental level in the 1971-1980 period. In addition, the final evaluation of the Plan should make it possible to draw up recommendations on areas of continental priority at lines of strategy for modifying the situation in those areas during the following decade.

-At the national level, the evaluation system should also serve to improve the information systems that feed the processes of policy-making, planning, scheduling, and budgeting, as well as the supervision of implementation.

-It is deemed advisable for the countries to define the critical, high-priority programs in each problem area and to focus available resources on those programs, thus promoting accomplishment of their objectives and assuring the effort necessary to improve their administration and programming and the information system for their evaluation and control.

3.2 RECOMMENDATIONS ON ELABORATION OF A METHOD OF EVALUATION

The method of evaluation is affected by the very purposes of the evaluation, already stated; by the structure and form of expression of the goals of the Ten-Year Plan, which cannot be evaluated in terms different from those in which it is expressed; by the manner in which the various countries incorporate the goals of the Ten-Year Plan in their own policies and plans; by the time available for the initial and subsequent evaluations; and by the information available to the countries for each area of the Plan.

For evaluation purposed, it is suggested that PAHO urge the countries to define their health policies and to incorporate in them the goals and provisions of the Ten-Year Plan before the first evaluation effort takes place, which, according to the recommendation, would be 1974.

The evaluation proposed for 1974 is to be the start of the process, assessing the situation of the countries and of the Continent as of 1971 in relation to the goals of the Ten-Year Plan. Further, it is to verify the inclusion of these goals and purposes in their health policies and plans, indicating the national strategies adopted to achieve them.

The way in which the countries incorporate the goals of the Ten-Year Plan in their policies will determine the evaluation system at the continental level. It is therefore recommended:

-That the countries incorporate these goals prior to the date set for the first continent-wide evaluation.

-Evaluation should be considered a constantly on-going process within the countries and a process taking place at defined periods at the continental level, for the purpose of comparing the observed situation with the planned situation, of explaining the differences found, and of using these data to reformulate and adjust the plans.

Consequently, it is recommended that annual evaluations, coinciding with the budget cycle, be conducted in the countries. It will then be possible to make timely corrections in the implementation of the plans, to have feedback into the planning process and to improve it, and to evaluate the impact on the level and structure of community health.

-To practice and apply the evaluation method proposed, and to obtain the information needed for the initial evaluation, it would be useful to make use of the system of Quadrennial Country-PAHO Projections. It would also be advisable for the countries to adjust their Quadrennial Projections, or to draw them up if they have not yet done so, as they incorporate the goals and provisions of the Ten-Year Plan.

-So that all countries may have the same understanding of the proposed evaluation method, it is suggested that PAHO prepare a glossary of operating definitions of the terms used.

-In order to develop homogeneous, well-defined channels of information at the continental level, it is recommended that the attention of the countries be directed at obtaining information in the following areas:

-People exposed to the risk of illness and death, with particular attention to avoidable risks.

-Coverage of services

-Program areas:

Services to persons
Environmental sanitation programs

-Complementary services

-Infrastructure development:

Sector organization and administration:

Organization
Planning
Information
Research

Resources:

Human
Physical
Financial
Technological

Legal aspects

These areas should be examined in relation to intra-sector and extra-sector limitations.

3.2.1. Characteristics of the Analytical Method at the Continental Level*

-It is recommended that the following broad guidelines be considered in preparing the definitive, detailed design of an evaluation method.

-The continental analysis should focus on the progress of each country, using the goals proposed in the Ten-Year Health Plan for the Americas as the point of reference.

-Since the analysis of the state of the Continent as a result of the Ten-Year Plan will be based on an analysis of each country's effort to promote the desired national change, the evaluation should include a study of national strategies, so that operationally valid conclusions and recommendations may be drawn.

*The national efforts should follow the guidelines adopted for the continental level so that analysis at that level is feasible; but this should not prevent each country from designing an analytical plan appropriate to its needs.

-In view of the short time available for each evaluation, the rigidity of the evaluation deadlines, and the need to reduce operating costs, the analysis should be based on information that is already available and common to all or the great majority of the countries. Special research to obtain information should be kept to an absolute minimum.

-The shortage of resources and the limitations of technology and time make it necessary that simple, easily conducted procedures, feasible in all the countries, be selected and recommended. Further, it is recommended that the countries and PAHO apply new methods facilitating the procurement of the basic information needed to nourish the processes of decision-making, planning, evaluation, and supervision.

3.2.1.1 Time and Content of Evaluation at the Continental Level

-Initial Evaluation (1974)*

The basic purpose of this evaluation is to examine the gap between the situation in the countries in 1971 (considered to be the initial year of the period covered by the Ten-Year Health Plan for the Americas) and that which is sought for 1980.

This evaluation should look at the level and structure of health and the organization, resources, and operation of the countries' health systems in 1971, and at the changes which each country hopes to achieve in these areas by 1980. Additionally, it should determine how the countries are incorporating the goals and provisions of the Ten-Year Health Plan for the Americas in their own health policies. Examination of the latter aspect is vital, for it will permit adjustment of the system and method of continent-wide evaluation to the limitations initially imposed by the form and content of national health policies.

Therefore, the contents of the initial evaluation should include:

-The number and percentage of countries that have examined the goals and provisions of the Ten-Year Plan for the Continent and formally incorporated them in their national health policies.

*Evaluation of the 1971 situation will be made in 1974 because it is assumed that all the countries will be in possession of the necessary information by that time.

-The number and percentage of countries that have made explicit their national health strategies for achieving the proposed goals and purposes.

-The number and percentage of countries that have established intermediate goals for the 1971-1977 period.

-The number and percentage of countries (and of the population involved) that have set goals lesser than, equal to, or greater than those indicated in the Ten-Year Plan:

-Identification of the goals and purposes;

-Quantification and ordering of these goals in relation to the Ten-Year Plan;

-Analysis and categorization of the discrepancies.

-Analysis of the distance between the initial (1971) situation and the national goal or objective proposed for 1980. This analysis should be conducted by goal or objective and by country, specifying the percentage of the total population of the Americas involved.

-Analysis by country of the consistency between each established goal or objective and the strategy set for achieving it.

-Summary of the situation of the health sectors in the Americas in 1971. Number and percentage of the population affected, by goal and by country.

-Outline of the economic and social situation of the countries of the Americas in 1971.

-Intermediate Evaluation (1977)

The purpose of the evaluation at this intermediate point is to obtain some indication of the pace at which it is hoped to achieve the goals set, as well as of the sequence and intensity of the strategies designed to achieve them.

The major elements of this evaluation will be analyses of progress toward the goals set for 1977 (in countries which set such goals) and of the performance of the strategies designed for the 1971-1977 period.

-Final Evaluation (1981)

The fundamental aim of this evaluation is to examine progress toward the goals and objectives established by the countries for 1980,

which is considered the last year of the period covered by the Ten-Year Health Plan for the Americas.

This evaluation should focus on the changes achieved in each country by the efforts it has made. Change will be measured between the starting point in 1971 and the situation as of 1980, in relation to the objective established by the country for the latter year. Examination of the strategies initially set to pursue the objectives of change and of the modifications made during the period is also regarded as fundamental.

On the basis of the final evaluation in 1981, it should be possible to draw up recommendations on priority areas for the Continent and lines of strategy for modifying conditions in those areas in the following decade.

Therefore, the following should be among the components of this evaluation:

- The number and percentage of countries (and the percentage of the population of the Americas involved) that have achieved the national goals and purposes set for 1980.

- The number and percentage of countries (and the percentage of the population of the Americas involved) that have achieved or surpassed the goals and objectives of the Ten-Year Health Plan for the Americas.

- Analysis and categorization of the limitations internal and external to the national health sectors which affected the chances of achieving the goals proposed.

- Analysis by goal and country of the changes achieved during the 1971-1980 period (number and percentage of the Continent's population affected by the change).

- Analysis of variations in the strategies initially set, by goal or objective and by country.

- Review of the situation in the national health sectors in 1980. Number and percentage of the population affected, by goal and by country, and a comparison of the situation in 1980 with what existed in 1971.

- Outline of the economic and social situation of the countries of the Americas in 1980, comparing it with the 1971 situation.

-Comparative description of the evolution of indicators in the health sector and of the countries' socio-economic indicators in the 1971-1980 period.

-Suggestion for defining objectives and lines of strategy for the 1981-1990 period.

3.2.1.2 Work Sheet Components for the Analysis at the Continental Level

To facilitate the work of evaluation, the group suggests a list of items for inclusion in the basic work sheets for conducting the analysis at the continental level, along with a chart summarizing the comparisons which might be made.

<u>Item No.</u>	<u>Item</u>	<u>Remarks</u>
(1)	Country	
(2)	Population (number)	As of the year of the
(3)	Population (percentage of total population of the Americas)	evaluation
(4)	Goal of the Ten-Year Health Plan for the Americas	*
(5)	Situation of the country in 1971	*
(6)	National goal for 1977	*
(7)	National goal for 1980	*
(8)	Change desired by 1977	Based on (6) and (5)
(9)	Change desired by 1980	Based on (7) and (5) May be the same as the entry for (7)
(10)	Change desired if the country had accepted the goal of the Ten-Year Plan	Based on (4) and (5) May be the same as the entry for (4)

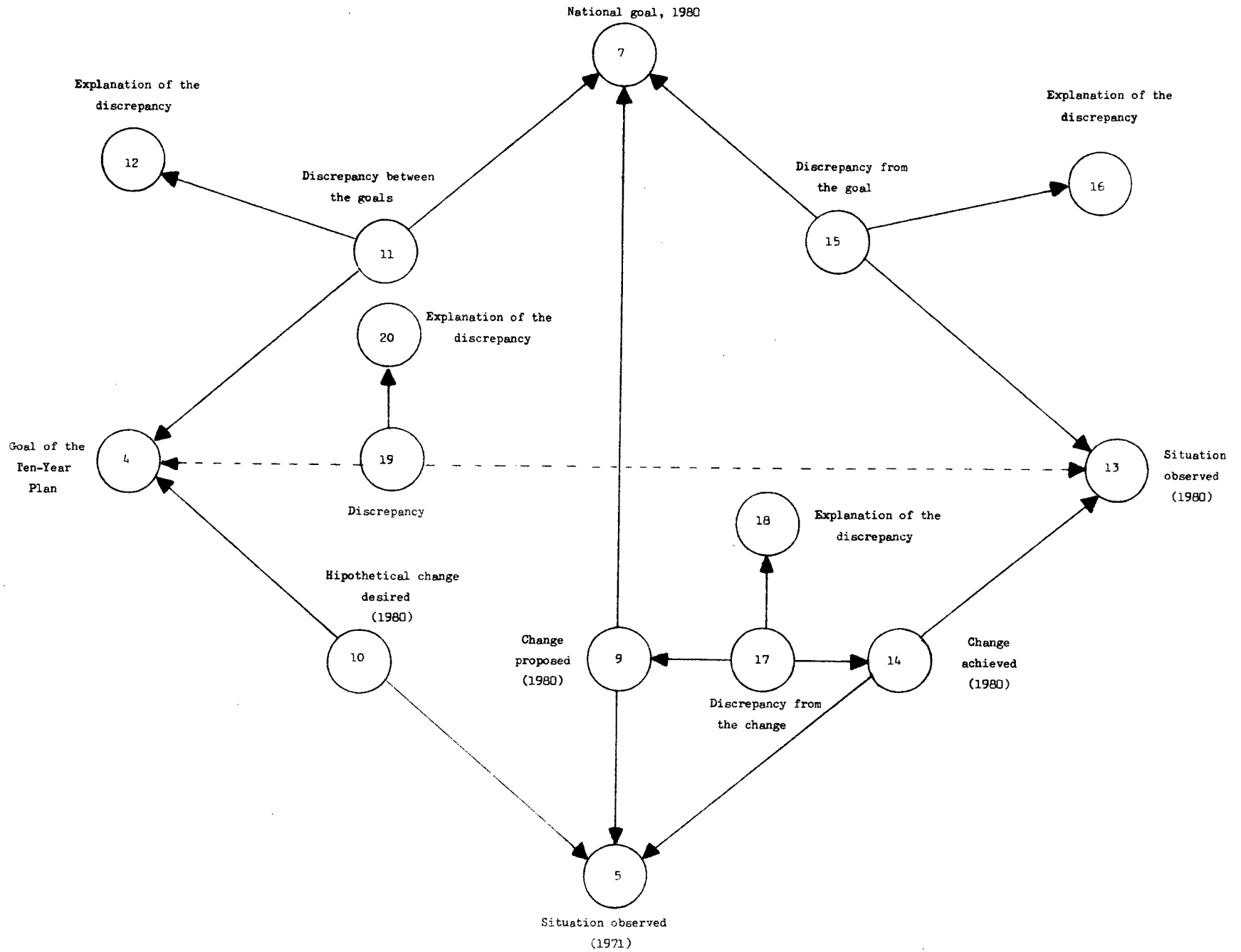
*Based on the information provided by the countries when they incorporate the goals of the Ten-Year Health Plan for the Americas in their national health policies and adjustment of the Quadrennial Projections.

<u>Item No.</u>	<u>Item</u>	<u>Remarks</u>
(11)	Discrepancy between goals of the Ten-Year and national plans for 1980	Based on (4) and (7)
(12)	Explanation of discrepancy indicated in (11)	Logical analysis
(13)	Situation observed in 1980	Data to be collected
(14)	Change observed in 1980	Based on (13) and (5)
(15)	Discrepancy between the national goal for 1980 and the actual situation then	Based on (7) and (13)
(16)	Explanation of discrepancy indicated in (15)	Logical analysis
(17)	Discrepancy between desired and actual change in 1980	Based on (9) and (14)
(18)	Explanation of discrepancy indicated in (17)	Logical analysis
(19)	Discrepancy between goal of Ten-Year Plan and national situation in 1980	Based on (4) and (13)
(20)	Explanation of discrepancy indicated in (19)	Logical analysis
(21)	Discrepancy between the change desired if the country had accepted the goal of the Ten-Year Plan and the change observed in 1980	Data from (10) and (14)
(22)	Explanation of discrepancy indicated in (21)	Logical analysis
(23)	National strategy proposed for 1977	*
(24)	National strategy proposed for 1980	*
(25)	National strategy observed in 1977	Data to be collected
(26)	National strategy observed in 1980	Data to be collected
(27)	Explanation of discrepancies between (24) and (26)	Logical analysis

*Based on the information provided by the countries when they incorporate the goals of the Ten-Year Health Plan for the Americas in their national health policies and adjustment of the Quadrennial Projections.

COMPONENTS OF ANALYSIS FOR EVALUATION AT THE CONTINENTAL LEVEL

(Final Evaluation - 1980)



There are two formulations of different origin for each goal or purpose. They may or may not coincide:

-That expressed in the Ten-Year Health Plan for the Americas.

-That established by each country.

They must both be examined to determine:

-The discrepancies between the situations (and/or changes) desired and those observed.

-The explanation for those discrepancies.

The examination may be by means of comparisons between absolute or relative numbers or between rigorously defined qualitative factors. The type of examination decided upon will depend basically on the way in which each goal is expressed.

3.2.1.3 Items for the Continental Analyses by Country

-Level and structure of health and the health sector situation

- (1) Initial situation (1971)
- (2) Situation observed in 1980
- (3) Situation desired in 1980
- (4) Analysis of discrepancies between (2) and (3)

-Socio-economic situation

- (1) Initial situation (1971)
- (2) Situation observed in 1980

As an example, the group offers a tentative list of socio-economic indicators which fulfill the requirements of being available in most countries of the Americas and which have demonstrated their relevance to the definition of socio-economic profiles:

OVERALL INDICATOR

- (1) Live expectancy at birth

HEALTH INDICATORS

- (2) Mortality rate, age 1-4
- (3) Percentage of death from infectious and parasitic diseases

- (4) Inhabitants per physician
- (5) Inhabitants per hospital bed

ENVIRONMENTAL INDICATORS

- (6) Percentage of population in localities of over 20,000
- (7) Percentage of population supplied with water
- (8) Calories per capita
- (9) Grams per day of protein per capita

EDUCATIONAL INDICATORS (level and structure)

- (10) Percentage of literates
- (11) Percentage of primary school enrollment, population aged 5-14
- (12) Percentage of secondary and vocational school enrollment, population aged 15-19
- (13) Percentage of university enrollment, population aged 20-29

ECONOMIC INDICATORS (level and structure)

- (14) GNP per capita
- (15) Percentage of GNP generated by secondary sector
- (16) Population employed in the sector
- (17) Sectoral productivity

DEMOGRAPHIC INDICATORS (structure)

- (18) Percentage of population under 15 years old
- (19) Percentage of population over 55
- (20) Rate of population growth
- (21) Rate of fertility

OTHER FACTORS

- Population (in thousands)
- Territorial area (including interior waters) (in thousands of square kilometers)
- Land farmed (in thousands of square kilometers)
- Population density per square kilometer
- Ratio of farmed area to total area
- Population per farmed square kilometer
- Percentage of surface that is arable

3.2.2 Characteristics of Analytical Method at the Country Level

The method of evaluation designed by each country should be capable of supplying the continent-wide evaluation method and meeting all its conditions.

At the national level, it is recommended that the contents of the evaluation in each country be such as to permit:

- Analysis of problem areas, critical programs, and priorities.
- Analysis of the activities conducted, with a view to utilizing the information gathered to adjust national goals and strategies, considering the funds and other resources available.
- Explanation of discrepancies and progress in relation to the goals set.

In evaluating the progress toward a goal, one should keep the following steps in mind:

- Compare the goal with the situation achieved.
- Explain why the goal was or was not achieved.
- Feed this information back into the system and start another cycle.

It is recommended that PAHO suggest to the countries that the explanation of discrepancies and achievements should be based on an analysis of the nature of the goal and of the strategies used to pursue it. Hence, the countries should consider both the procedure by which it was adopted and the factors of feasibility, viability, degree of definition, degree of consistency, and degree of dependence on the achievement of other goals.

The operational treatment of the goals and purposes of the Ten-Year Health Plan for the Americas should follow the classification given on page 7. This would facilitate an examination of the consistency and interrelationships of the goals and purposes established by each country.

For certain goals and purposes of the Ten-Year Health Plan for the Americas, the countries will have to identify additional operational criteria by which to measure or estimate their fulfillment.

Though each country must retain the flexibility it needs in working through the process of incorporating the goals of the continental Ten-Year Plan in its health policies, the Group deems it advisable for each country to follow, to the extent it may consider appropriate, the procedure suggested for this purpose in the Guide furnished by PAHO* in order to facilitate the process and assure the comparability necessary to the continent-wide evaluation.

3.3 ORGANIZATION OF THE EVALUATION SYSTEM

In the spirit of the Recommendations of the Third Special Meeting of Ministers of Health of the Americas and the Resolutions of the Governing Council of the Organization, the chief purpose of the evaluation system is to strengthen the national mechanisms for continuously observing and assessing efforts to achieve the goals established by the countries themselves in their health plans. It is designed also to produce results which can be made uniform at the continental level so as to permit evaluation of the progress made during the decade.

Organization of the systems should be based on the principle that evaluation is an essential component of the planning process. As such, it cannot be divorced from the process. Whatever structure the countries may have to conduct the process, evaluation must be an integral part of the administrative and planning process.

The conduct of evaluation has been deficient in the countries: the methods used have been inadequate, there has been a shortage of trained personnel, and feedback of the results into the process has been inadequate.

On these grounds, and considering the current state of evaluation in the countries and the resources which they and PAHO may have available for the development of evaluation systems on the Continent, the Group makes the following recommendations:

3.3.1 At the Country Level

-Develop and strengthen the evaluation function as a component of the information, evaluation, supervision, and decision-making systems which are required by national administrative and planning processes.

*"Guide for Analysis and Incorporation of the Goals of the Ten-Year Health Plan for the Americas in National Health Policies and Adjustment of Quadrennial Country-PAHO Projections".

-To this end, maximize the use of currently available resources, improve their organization and, if necessary, create additional resources consistent with the country's abilities and capacity.

-The evaluation function should be coordinated and advised by the planning units, making certain that all levels of the health system's structure participate.

-Despite the individual characteristics reflecting the peculiarities and needs of each country, the national evaluation systems should have certain common characteristics, stemming from the use of basically shared methods and procedures, so that their results may be made compatible for continental purposes.

-The training of personnel in the methods, organization, and operation of evaluation systems is an urgent need if the process is to become widely and effectively used beginning in 1974. The organization of short courses essentially operational in nature, is deemed advisable. Within the limits of its capacity, PAHO should participate in these initial efforts when requested by the countries.

-Similarly, in the basic courses in health services administration, and particularly the planning courses, that are conducted in the countries, special stress must be placed on the concepts and methods of evaluation, viewed as an integral part of the information, evaluation, decision-making, and supervision process.

3.3.2 At the Continental Level

PAHO has an important role to play in the continental evaluation system. It is therefore recommended:

-That it serves as a clearing house for information from all countries and coordinate the establishment and development of the continental evaluation system at its central point.

-That its field officials participate in the processes of collaboration, consultation, and coordination between the national planning system and Headquarters.

-That it plan the implementation of the evaluation system, bearing in mind the need to conduct the following activities:

-Informing the governments and other interested institutions of the characteristics of the evaluation system that is proposed.

-Drawing up an instruction manual succinctly describing the purpose and manner of organizing the evaluation system. Drawing up a glossary of the terms used in the manual.

-Creating the patterns of computation, forms of presentation, printed forms, etc., for the proper functioning of the continental evaluation system.

-Drawing a schedule for establishment of the system.

-Maintaining contact with the countries so as to consult as needed while their systems are being established.

-Analysing the information supplied by the countries to the continental level, and publishing the results.

-Developing and advising on training programs in the subject.

-Promote, assist, and conduct research on methods in the field of evaluation.

ANNEX

GUIDELINES FOR THE ANALYSIS AND INCORPORATION OF THE GOALS
OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS IN THE
NATIONAL HEALTH POLICIES AND ADJUSTMENT OF THE
COUNTRY-PAHO QUADRENNIAL PROJECTIONS

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I. NATIONAL HEALTH POLICY

1. BACKGROUND

The Third Special Meeting of Ministers of Health of the Americas (Santiago, Chile, October 1972), the basic purpose of which was to draw up the Ten-Year Health Plan for the Americas for the period 1971-80 (see Annex I) resolved "To consider, as a basic requirement for achieving the goals under the plan,^{1/} the definition in each individual country of the health policy, in the light of its economic and social development, specifying clearly the objectives and structural changes necessary to achieve them".

The decision to perfect the national health policies as effective instruments for the implementation of the Ten-Year Health Plan for the Americas and its corollary of evaluating the common efforts and measuring their results, generate in their turn the need to establish a procedure for analysis and reformulation of those policies which is common for all the countries, yet sufficiently flexible to take into account the characteristics and needs peculiar to each one.

2. SOME ELEMENTS TO BE CONSIDERED WHEN FORMULATING A NATIONAL HEALTH POLICY

To facilitate understanding of these guidelines an operational definition of policy is adopted and certain of its components

^{1/} The Ten-Year Health Plan for the Americas

are enumerated. Thus, a POLICY is considered as an:

Ordered and coherent set of aims of a general nature, which orient the carrying out of actions or the creation of favorable situations for the solving of the problems which have to be overcome in the light of a desired situation for a given period.

Such general aims as arise from analysis of the differences between the present situation and the situation desired for a given future are set forth.

In the case of a sectoral policy, the analysis of the discrepancies between the present and the desired situation will be conditioned by the goals of the overall national development policy (explicit or implicit) and will lead to identification of the sector's problems. Once the problems are identified, those considered to have priority will be selected, which will entail analysis of the possible solutions for each of them. The analysis of the possible solutions --which includes that of the technological alternatives-- constitutes a link between the policy and the formulation of the strategies needed for its application.

Study of the internal and external constraints which affect the health system is essential for evaluation of the viability and feasibility of the proposed changes and their subsequent solutions

The precise definition of the situation which it is desired to achieve within a given time, the identification and ranking in order of importance of the problems and the selection of the possible solutions constitute the very essence of policy formulation. They therefore form the initial and essential stage of a process which triggers off a sequence of decisions which concludes with the programming of the

specific activities and investments required for bringing about the desired change. In other words, the clear and precise definition of a National Health Policy is a vital prerequisite for setting in motion a process of sectoral planning and its formal embodiment in a Health Plan.

3. PURPOSES AND CONSTRAINTS

3.1 The specific purposes of these guidelines can be summed up as follows:

- To facilitate the analysis of the goals of the Ten-Year Health Plan for the Americas and review of the national health policies in the light of that analysis and of the national development policies.
- To facilitate estimation of the contribution expected from each country for the fulfillment of the Ten-Year Health Plan for the Americas.
- To facilitate the systematic evaluation of the Ten-Year Health Plan for the Americas.
- To facilitate the adjustment of the Country/PAHO Quadrennial Projections to the national health policies.

3.2 From these goals is derived the need for establish a common procedure for the analysis, as well as a common basis with that of the Ten-Year Plan for the definition of categories, indicators, etc., to be used in each country.

3.3 The following criteria condition and the preparation of these guidelines:

- Time available for completing the analysis of the goals of the Ten-Year Health Plan for the Americas and updating of the national policies:

Completion of this process is a matter of urgency, as it is an essential prerequisite for the practical application of the changes envisaged which, according to the approved Ten-Year Plan, have to produce the expected results within the period ending in 1980.

- Present availability of information and resources:

The evaluation of the availability of resources and information for this process, bearing in mind the urgency as noted, means that the setting up of complex procedures and research in depth will not be possible.

- 3.4 Because of their form, application of these guidelines is restricted exclusively to certain operational aspects of the analysis of the goals of the Ten-Year Plan, their incorporation into the national health policies, and to the subsequent adjustment of the Quadrennial Projections to the joint Country and PAHO activities.

II. SCHEME FOR THE ANALYSIS OF NATIONAL HEALTH POLICIES
AND THEIR ADJUSTMENT IN THE LIGHT OF
THE TEN-YEAR PLAN FOR THE AMERICAS

1. BASIC CONVENTIONS AND ASSUMPTIONS

1.1 At the Third Meeting of Ministers (Santiago, Chile, October 1972) the governments undertook to carry out the Ten-Year Health Plan agreed upon at that meeting, and to evaluate it at regular intervals. (See Annex I and Annex III, under 3).

1.2 All the countries possess a national health policy, either expressed explicitly in a health plan, the Quadrennial Projections or in some other set of documents, or simply being implemented on a de facto basis.

1.3 The tools for analysis (categories, definitions, indicators, goals, etc.) and adjustment currently used for the updating or reformulation of the national policies must be the same as those set forth in the Ten-Year Plan for the Americas. Nevertheless, individual countries may split up the categories and indicators used in the Plan and/or include other items, as dictated by their requirements, for the formulation of their particular health policies.

1.4 The targets which each government fixes for the ten-year period must be expressed in national averages, but both the analysis and the adjustment of the national health policy can be performed and expressed in regional terms, in accordance with the characteristics of the country and with the requirements imposed by its national development plan.

1.5 The level or depth of the analysis and the extent of the adjustment will extend, at least, to the general goals for the solving of the country's health problems and their classification by order of priority and will include the main strategic elements.

2. GENERAL STRUCTURE OF THE SCHEME (See Shart 1, page 15)

This scheme was based on the items making up the Ten-Year Health Plan for the Americas and those included in the Quadrennial Projections prepared for 22 countries and territories of the Americas. In line with the Ten-Year Plan, these components were grouped in the following areas:

Area 1: General Goal

1 Life expectancy at birth (see Annex I, point III, pp. 8)

Area 2: Main Goal

Coverage of services (see Annex I, Goals I.1, pp. 2)

Area 3: Program Areas

3.1 Services to individuals (see Annex I, Goals I.1.1 through I.1.4, pp. 2 and 3)

3.2 Environmental sanitation (see Annex I, I.2.1 through I.2.11, pp 4 through 5)

Area 4: Supporting Services (see Annex III, Goals I.3, pp. 5)

Area 5: Infrastructure Development

5.1 Development of the organization and sectoral administration (see Annex I, II.1 through II.4, pp. 6)

5.2 Development of resources (see Annex I, II.5 through II.9, pp. 6 through 8)

Once the Plan components were grouped in the above areas, the chief (or primary) interrelationships between them were defined, as shown by the vectors in the Scheme (see Table 1).

The constraints (or factors) which condition the areas and their interrelationships were grouped into two large areas:

Area 6: Internal health sector or intrasectoral constraints ^{2/}.

Area 7: Constraints that are external to the sector or extrasectoral ^{2/}.

2/ Intrasectoral (or internal) constraints are considered to be those over which the Health Sector has control, within certain limits, as regards removing or overcoming the obstacles involved and the achievement of the purposes or goals the Sector sets itself.

Extrasectoral (or external) constraints are considered to be those over which the Health Sector does not have control, as their removal requires decisions which come under the competence of other sectors or of the social system as a whole.

Analysis of the internal and external constraints is the key for the evaluation of the feasibility and viability of the proposed changes which comprise a policy and are the essence of the strategies which have to be formulated to implement it.

3. SEQUENCE OF THE ANALYSIS AND ADJUSTMENT SCHEME (Table 1)

The analysis of the above-described components is based fundamentally on the play between the objectives and goals which the country wishes to achieve --compared with the aims of the Ten-Year Health Plan for the Americas and the present situation of the country making the analysis-- and the requirements in terms of resources and organization which those aims presume. Both the goals and the requirements for achieving them are conditioned or limited by the internal and external constraints peculiar to the Health Sectors of the individual countries.

The carrying out of the analysis also presumes that use will be made of the method of successive approximations, with a final adjustment stage to achieve the necessary consistency between the aims.

3.1 First Approximation:

3.1.1 Life expectancy at birth (Table 1, Area 1)

The goals proposed by the Ten-Year Health Plan for the Americas will be compared with the present situation of the country and with the previously defined proposed change. It will be estimated what level life expectancy at birth could reach in 1980 if it is decided to change certain components of the mortality structure with an intensity and at a rate considered feasible. Such a decision conditions, as a first approximation, the priorities and goals of certain of the components of Area 3.

3.1.2 Coverage of Services (Table 1, Area 2)

For analysis of this area it is first necessary to prepare definitions of the levels of service (minimum, basic and

specialized), in terms of installations, characteristics of the main human resources, functions or types of care to be produced by these units, and potential coverage of each type of service, depending on the national definition of the accessibility of the communities.

Once the above definitions have been prepared, the present position of the country, in terms of national coverage, will be compared with the Ten-Year Plan goals, according to the levels defined. In the first instance priorities will be fixed for coverage goals by level of service: minimum, basic and specialized. A rough estimate will be made of the requirements implied by these goals as regards direct services (Table 1, Area 5.2), demand for supplementary services (Table 1, Area 6) and exigencies in the sectoral organization and administration (Table 1, Area 5.1)

At this stage the first analysis of the internal (Table 1, Area 6) and external (Table 1, Area 7) constraints will be made with a view to obtaining a preliminary estimate of the feasibility and viability of the goals fixed in this first approximation.

3.1.3 Program Areas

The analysis of these areas will be based fundamentally on comparison of the present position of the country with the goals of the Ten-Year Plan for the Americas and the position it wants to reach. The goals as regards services to individuals will be expressed in terms of level and structure of mortality and morbidity and population coverage; those relating mainly to environmental improvement will be defined mainly in terms of coverage. In certain countries of given levels of development the requirements in terms of change in specific mortality derived from the general goal set forth (life expectancy), can be effective means

for determining the order of priority of the specific program areas.

In this first approximation the possible solutions for the specific problems considered to have priority must be analyzed and the infrastructure requirements these solutions set must be estimated. An initial evaluation of the internal and external constraints these set for the feasibility and viability of the solutions proposed will also have to be made at this juncture. One of the fundamental constraints for the definition of priorities and goals in Area 3 is formed by the priorities and goals already fixed for Area 2. In this first approximation, the constraints determined for Areas 2 and 5 (mainly 5.2) will make it possible to orient the preliminary selection of alternative technologies for the possible solving of the specific problems considered to have priority.

3.1.4 Complementary Services

The analysis of this area must be centered on the estimating of the feasibility of meeting the requirements, or demands, presumed, in terms of supplementary resources, by the coverage goals for final services and the specific program areas considered to have priority in a first approximation.

3.1.5 Infrastructure Development

In this area the analysis has to be made in three different but necessarily complementary levels:

- In the first level the present position of the country must be analyzed in each of the categories making up the area and it must be compared with the exigencies (or requirements in terms of resources and their organization) arising from the priorities and goals fixed as a first approximation for Areas

2 and 3. It will be endeavored to estimate the critical resources (human, financial, economic, technological) and the sectoral and institutional organization that will be most suitable, in the light of the coverage goals, the program area goals and the supplementary services and production functions (combination of resources according to a given technology) already defined on a first approximation basis. In essence, the aim will be to evaluate the possibility of forming additional resources and/or reorienting the use and combination of resources presently available. The purpose will be to estimate the feasibility of the goals proposed and/or to obtain data to guide decisions on changing the order of priority, the intensity and rate of change, or regarding the selection of other alternatives.

- In the second level the requirements in terms of resources imposed by the decisions taken concerning development of the sectoral organization and its administration will have to be analyzed. Then, in their turn, the organization and administrative requirements arising from the need for efficiency in the use and formation of the resources necessary for achievement of the goals will have to be analyzed.

- In the third level the analysis will be focused on comparison of:
 - (1) The manpower training and availability goals and the aims for development and perfecting of the Sector's organization and administration as derived from the national priorities and goals for Areas 2 and 3, with

 - (2) the manpower training and availability goals and the aims of the organization and administration as set forth in Ten-Year Health Plan for the Americas.

In the first two levels referred to, the analysis of the sectoral constraints is particularly important because they are determining factors for the feasibility and viability of the goals adopted. In this area, as in that of the complementary services, a selection of priorities is not required as for the coverage areas (2) or the program areas (3.1 and 3.2), since they constitute requirements for the achievement of the purposes and goals in those areas.

In terms of very rough estimates, this analysis makes it possible to obtain sufficient data for preliminary decisions to be taken regarding:

- .1. Life expectancy at birth which it is desired to reach in 1980.
- .2. Coverage goals for integral services for the period, classified by type of service and technology.
- .3. Order of priority and goals for specific program areas.
- .4. Goals for reorganization of supplementary services to meet the requirements deriving from 1, 2 and 3.
- .5. Changes and improvement of the sectoral and institutional organization and administration necessary for achieving the goals adopted.
- .6. Goals in terms of training of additional manpower for the achievement of 1, 2, 3, 4, and 5.
- .7. Strategy lines for achieving the goals set.

3.2 Second Approximation

Analysis of this second approximation must center around study of:

- 3.2.1 Consistency between the goals set for each area of analysis and consistency between these areas.
- 3.2.2 Feasibility and viability of those goals in the light of the internal and external constraints.
- 3.2.3 Overall and specific consistency of the goals with the national development policy.

3.3 Final Adjustment

These are the factors to be considered in proceeding to the final adjustment of the goals in each of the areas and the definition of the general considerations which condition formulation of the strategies for achievement of the purposes and changes decided upon.

3.4 Results Expected

It is considered that this analysis scheme should make it possible to obtain:

- 3.4.1 Consistency in the adjustment of the national health policy in terms of changes envisaged and national priorities with the national development policy and the Ten-Year Health Plan for the Americas as regards:

- Level and structure of health
- Supply of services
- Training of national manpower
- Organization and national administration of the sector's resources

- Guidelines for definition of strategies and their translation into programs of activities.

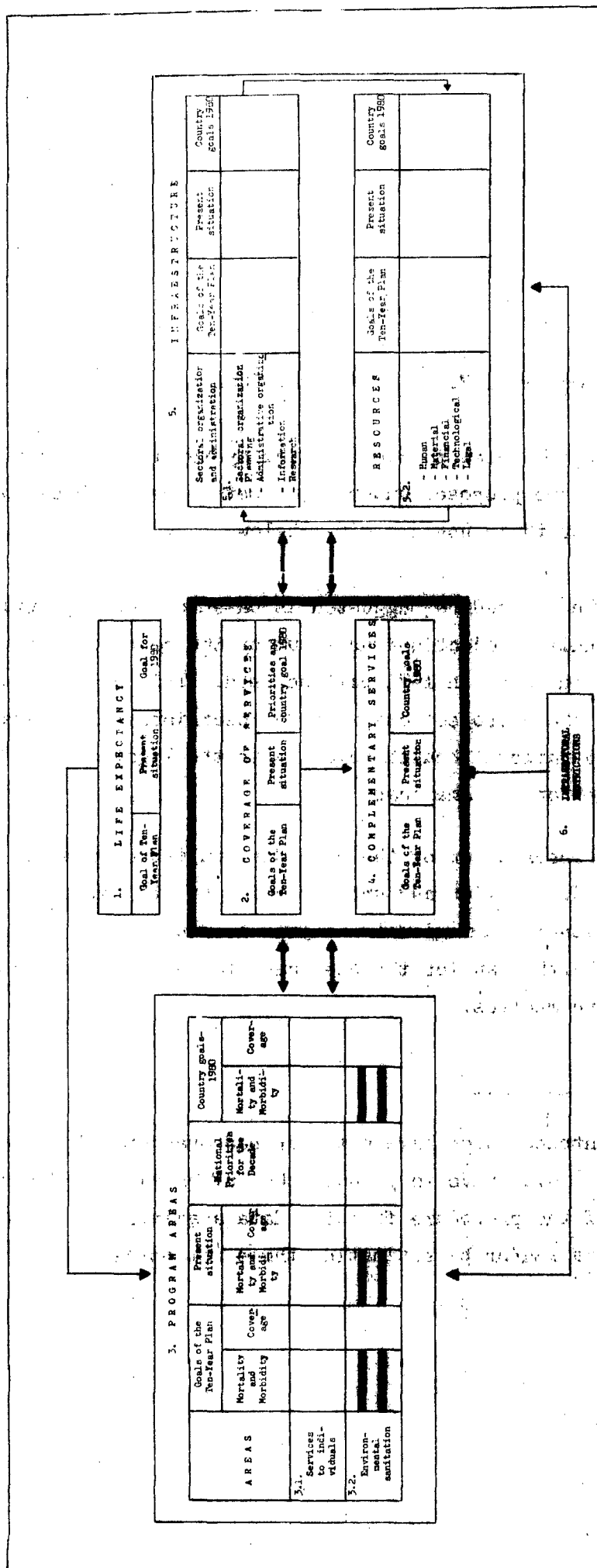
- 3.4.2 Determination of the contribution toward the implementation of the Ten-Year Health Plan for the Americas expected from each country.

- 3.4.3 Determination of the national data necessary for systematic evaluation of the Ten-Year Plan for the Americas.

- 3.4.4 Adjustment of the Country/PAHO Quadrennial Projections to the national health policies and subsequent reprogramming of the joint Country/PAHO activities.

CHART No. 1

DIAGRAM FOR THE ANALYSIS AND INCORPORATION OF THE GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS IN NATIONAL HEALTH POLICIES



III. PROCEDURE

1. SOME PRELIMINARY CLARIFICATIONS

With a view to facilitating systematic application of the analysis scheme proposed under II, a set of work tables and some instructions for their use are given below.

The procedure suggested is based on the assumption that the Quadrennial Projections drawn up by the countries of the Americas Region and adjusted in 1971 will be used. This will allow the harmonization of these projections with the decisions taken regarding adjustment of the national health policies in the light of the Ten-Year Health Plan for the Americas.*

Presentation of the procedure in table form was adopted to facilitate description and understanding of its components, and also of the national and regional analysis needed for the evaluation of the Regional Health Plan for the Americas, to which the governments have committed themselves.

* The countries which have not prepared Quadrennial Projections (1971 Revision) will have to produce the information needed for columns 2 and 3 of the procedure from the data available in various official documents and/or by estimating those not obtainable from such sources.

2. DESCRIPTION OF THE PROCEDURE

2.1 Table 1

Area 1: GENERAL GOAL: LIFE EXPECTANCY AT BIRTH (See Annexes I and II).

This table will have to be the first to be made up, and will have to be adjusted if necessary in a second approximation.

Column 1: The life expectancy at birth proposed by the Ten-Year Health Plan for the Americas, for the area corresponding to the particular country, is to be entered here.

Column 2: The estimated life expectancy for the country at the time of the revision of the Quadrennial Projections (1971) is to be entered here. Those countries which have not prepared Quadrennial Projections should enter the figure closest to 1971 that they have available.

Column 3: The life expectancy at birth fixed as the goal for 1980 in the Change Hypothesis Section of the Quadrennial Projections (1100 Series) is to be entered here. Countries which have not fixed this estimate in either their national plans or in the Quadrennial Projections or any other official document should do so on this occasion.

Column 4: The national goal for 1980 resulting from analysis of the likelihood of the country achieving or exceeding the goals proposed in the Ten-Year Health Plan for the Americas should go here. Countries which have already exceeded this goal should estimate the higher goal which they consider they could achieve.

Column 5: Any discrepancy, either way, between the goal proposed in the Ten-Year Plan and that adopted by the country should be explained here. This explanation can be given in terms of observed national trends, expected changes in overall and/or sectoral socio-economic development, etc.

Column 6: In this column it should be stated how the country expects to achieve the goal fixed, and in which age groups and through control of which specific causes of mortality it is expected to obtain the increase in life expectancy at birth. It is particularly important that this strategy be set out explicitly, as it can command the priorities and intensity of action in the specific program areas directly connected with the strategy, and fix requirements as regards coverage and infrastructure, especially in countries with less developed health structures.

2.2 TABLE 2

AREA 2: COVERAGE OF MINIMUM, BASIC AND SPECIALIZED SERVICES

This table should be completed after Table 1, in the first approximation.

Column 1: The goals of the Ten-Year Health Plan for the Americas as regards coverage of minimum, basic and specialized services (see Annexes I and II) should be copied here.

Column 2: A summary should be given here of the present national situation regarding coverage for each of the types of services in which the goals of the Ten-Year Plan are expressed (column 1). The data defining this situation should be

the closest to 1971, if available. It is vitally important that explicit details be given concerning existing obstacles which determine the present coverage, both those intrinsic to the health sector and those due to the particular level of socio-economic development of the country concerned (internal and external constraints).

This information corresponds to that given in the Quadrennial Projections under the analysis by areas chapter, Sections 1, 2 and 3.

Column 3: The salient features of the policy, objectives and goals fixed for the period 1970-80, regarding expansion of the coverage of services (as set out in Section 4 of the Quadrennial Projections for 1971) should be stated here. Also, the aims, objectives or goals designed to minimize the obstacles to expansion of the coverage, as described in column 2, in relation to internal and external constraints, should be entered here.

Columns 4 and 5: The goals in terms of coverage of minimum, basic and specialized services which the government thinks it can achieve by 1980 (column 5) should be entered here, together with the priorities decided upon in terms of quantity and time for each of these types of services. In column 4 the proportion which it is expected to achieve by 1977 of the goals fixed for 1980 should be included. The purpose of column 4 is to present data prior to the analysis of the progress toward the goals fixed for 1980 with regard to starting point (coverages observed in 1971 -- column 2) for the preliminary appraisal proposed for 1978.

The data required in columns 4 and 5 require prior definition: type of services and accessibility, as expressed in the "analysis scheme" (Chapter II, page 8, 3.1.2) together with a very thorough analysis of the requirements for removing the internal and external restrictions.

Column 6: The same considerations as under column 5, Area 1 (Table 1).

Columns 7 and 8: In these columns explicit details must be given regarding how it is expected to achieve the national goals given under columns 4 and 5. It is essential to state the main lines of action designed to overcome the internal and external constraints indicated in column 2. The strategy will have to be spelled out for each analysis period: 1971-77 and 1978-80.

It is important to take into account that both the priorities and the goals fixed for 1980 and the estimates for 1977 as regards coverage of minimum, basic and specialized services, together with the strategy fixed for reaching a certain life expectancy, commit or condition the goals and strategies of the other areas included in the analysis.

2.3 TABLE 3

AREA 3: PROGRAM AREAS

The layout of Tables 3.1 and 3.2 is identical, so the instructions given apply equally to both of them.

Column 1: As in Table 2, the goals of the Ten-Year Health Plan for the Americas are to be copied here, following the classification and order as in Annex II (columns 1 and 2). All the goals included in the Plan are to be entered here. Those which

are not considered to have priority on account of the characteristics of the country, and which are accordingly disregarded, must also be entered.

Columns 2 and 3: The same considerations as for Areas 1 and 2.

Columns 4 and 5: The same considerations as for Areas 1 and 2. In the particular case of the goals for the program areas 3.1 and 3.2, special account must be taken of the conditions or requirement both as regards priorities and the scope of the specific goals, imposed on these by the decisions taken in Areas 1 and 2. In their turn, the goals decided upon will impose requirements on Areas 4, 5.1 and 5.2.

Column 6: The same considerations as for Tables 1 and 2. It should include an explanation of why the country does not assign priority to the goals excluded.

Columns 7 and 8: The same considerations as for Tables 1 and 2. It must be borne in mind that, as with the goals proposed, these strategies laid down in Tables 1 and 2.

2.4 TABLE 4

AREA 4: COMPLEMENTARY SERVICES COVERAGE

This table should be completed after Tables 2, 3.1 and 3.2 in the first approximation.

Column 1: As in the preceding tables, the goals of the Ten-Year Health Plan for the Americas are to be copied here, following the order given in Annex II (columns 1 and 2).

Columns 2 and 3: Same instructions as for the preceding tables.

Columns 4 and 5: The goals in terms of coverage of complementary services are to be entered here.

Their essential nature as support to the final services, which is their function by definition, makes it necessary that the national goals fixed for the complementary services be consistent with those decided upon for Areas 2, 3.1 and 3.2. Any factor which may become apparent, in the first approximation, that would make it impossible to maintain this consistency will render it essential to revise the goals fixed for Areas 2, 3.1 and 3.2, or else to modify, in a second approximation, the requirements of these as regards the type of supplementary services required.

Column 6: Any discrepancies between the national goals adopted (columns 4 and 5) and those proposed in the Ten-Year Plan (column 1) must be explained in the light not only of columns 2 and 3 but also, and fundamentally, in that of the estimated requirements which Areas 2, 3.1 and 3.2 (coverage of minimum, basic and specialized services, services to individuals and environmental sanitation) impose on the supplementary services.

Columns 7 and 8: The same instructions as for Areas 2, 3.1 and 3.2. In the particular case of complementary services it must be taken into consideration that the strategies defined are conditioned as regards content and time of application by the strategies fixed in Tables 2, 3.1 and 3.2. The analysis of the possible solutions for the restrictions noted in the area of supplementary services could lead, in a second approximation, to

revision and adjustment of the strategies selected for Areas 2, 3.1 and 3.2.

2.5 AREA 5: DEVELOPMENT OF THE INFRASTRUCTURE

TABLE 5.1: SECTORAL ORGANIZATION AND ADMINISTRATION

This table should be completed after Tables 2, 3.1, 3.2 and 4, in the first approximation.

Column 1: As for Tables 3.1 and 3.2.

Column 2: A summary of the present national position for each of the items included in column 1 should be given here. It is particular important that explicit details be given regarding the existing obstacles, both those intrinsic to the sector (internal constraints) and those connected with the particular national organization and administration, especially in the public sector (external constraints).

Column 3: The salient features should be stated here of the policy, objectives and goals fixed for the period 1970-80, as given in Section 4 of the 1971 revision of the Quadrennial Projections, referring to the items in column 1, including the plans and actions designed to help remove the constraints noted in column 2.

Columns 4 and 5: In these columns should be marked the change goals that it is hoped to achieve by 1980 and 1977. The fixing of these goals makes it necessary to estimate carefully the type of organization and administration required by the goals and strategy set for Areas 2, 3.1, 3.2 and 4. Special

attention should also be given to the possibility of removing the constraints noted in column 2. The form in which the goals of the Ten-Year Health Plan for the Americas are expressed in this area (5.1) also renders essential additional definitions, for each of them, that will provide specific details concerning the requirements or conditions to be satisfied in order that these goals may be considered achieved. Precise definition of these criteria is indispensable for evaluation of the goals fixed.

Column 6: The explanation of any discrepancy must be based mainly in the analysis of the requirements imposed by the decisions adopted in regard to Areas 2, 3.1, 3.2 and 4.

Columns 7 and 8: Definition of the strategies for removing the internal and external constraints is fundamental for the completing of this column.

TABLE 5.2: DEVELOPMENT OF RESOURCES

This table has to be made up after the others because the data to go in it depend on the requirements in terms of resources which result from the proposals set out in the other areas. Analysis of the extent to which these requirements can be satisfied is the first approximation toward evaluation of the feasibility of those proposals.

Column 1: Same instructions as for Tables 3.1 and 3.2.

Columns 2 and 3: Same instructions as for Table 2.

Columns 4 and 5: The setting of goals depends entirely on the requirements in terms of resources imposed by the national goals set for Areas 2, 3.1, 3.2, 4 and 5.1. Analysis of whether or not it is possible to meet these requirements is a major factor for the possible adjustment of goals and strategies in those areas, to be effected in a second approximation.

Column 6: The explanation of any discrepancy must be based mainly on the analysis of the requirements imposed by the decisions adopted in regard to Areas 2, 3.1, 3.2, 4 and 5.1.

Columns 7 and 8: Definition of strategies is also conditioned as to content and time of application by the resources required in Areas 2, 3.1, 3.2, 4 and 5.

Once the first approximation is completed the tables will be analyzed and such adjustments as are necessary to ensure the internal consistency of the proposals in each area and also that the proposals for all the areas are consistent among themselves will be made.

Table 1

AREA 1: GENERAL GOAL: LIFE EXPECTANCY AT BIRTH

Ten-Year Health Plan for the Americas GENERAL GOAL LIFE EXPECTANCY AT BIRTH	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY:		ADJUSTMENT TO NATIONAL GOAL (column 3), in light of the Ten-Year Health Plan for the Americas for 1980 (Column 1)	EXPLANATION OF the discrepancies between columns 4 and 3	STRATEGY FOR ACHIEVING the national goal set in column 4
	HYPOTHESIS OF CHANGE (1100 Series)				
	Present position	Goal fixed for 1980			
(1)	(2)	(3)	(4)	(5)	(6)

Table 2

AREA 2: COVERAGE OF MINIMUM, BASIC AND SPECIALIZED SERVICES

Ten-Year Health Plan for the Americas COVERAGE GOALS FOR MINIMUM, BASIC AND SPECIALIZED SERVICES	QUADRENNIAL PROJECTIONS -----1971 REVISION----- COUNTRY: ANALYSIS BY AREAS		SELECTION OF PRIORITIES * AND ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the pre- sent position (column 2) and the goals of the Ten- Year Health Plan for the Americas for 1980 (Column 1)		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consider- ation that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints. *		
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS			1977	1980	
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980				
			(1)	(2)	(3)	(4)	(5)	(6)

(* See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 3.1

AREA 3: PROGRAM AREAS

3.1: SERVICES TO INDIVIDUALS

Ten-Year Health Plan for the Americas PROGRAM AREAS GOALS FOR SERVICES TO INDIVIDUALS	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY ANALYSIS BY AREAS		SELECTION OF PRIORITIES * AND ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals and strategies set for Coverage of Services and Life Expectancy.		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This Analysis should take into consider- ation that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS			1977	1980
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980			
	(1)	(2)	(3)	(4)		(5)	(6)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 3.2

AREA 3: PROGRAM AREAS

3.2: Environmental SANITATION

Ten-Year Health Plan for the Americas PROGRAM AREAS ENVIRONMENTAL SANITATION GOALS	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY ANALYSIS BY AREAS		SELECTION OF PRIORITIES* AND ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals and strategies set for Coverage of Services and Life Expectancy		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This Analysis should take into consider- ation that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS			1977	1980
	Present position	Policy, aims and goals set for 1970-80	Estimate 1977	1980			
	(1)	(2)	(3)	(4)		(5)	(6)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 5.1

AREA 5: DEVELOPMENT OF THE INFRASTRUCTURE
5.1: SECTORAL ORGANIZATION AND ADMINISTRATION

Ten-Year Health Plan for the Americas INFRASTRUCTURE DEVELOPMENT GOALS SECTORAL ORGANIZATION AND ADMINISTRATION	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY: ANALYSIS BY AREAS		ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (column 2) and the goals and strategies set for Services Coverage, Program Areas and Supporting Services		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consideration that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Sections 1, 2, 3	Section 4	OBJECTIVES AND GOALS			1977	1980
	Present position	Policy, aims and goals set for 1978-80	Estimate 1977	1980			
			(1)	(2)	(3)	(4)	(5)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making".

Table 5.2

AREA 5: DEVELOPMENT OF THE INFRASTRUCTURE

5.2: DEVELOPMENT OF RESOURCES

Ten-Year Health Plan for the Americas INFRASTRUCTURE DEVELOPMENT GOALS RESOURCES AND LEGAL ASPECTS	QUADRENNIAL PROJECTIONS 1971 REVISION COUNTRY: ANALYSIS BY AREAS		ADJUSTMENT OF THE NATIONAL GOALS (column 3) in the light of the present position (col- umn 2) and the goals and strategies set for Services Coverage, Program Areas, Supporting Services and Sec- toral Organization and Admini- stration		EXPLANATION OF THE DISCREPANCIES between Columns 1 and 5 This analysis should take into consider- ation that stated in columns 2 and 3	NATIONAL STRATEGY FOR achieving the objectives and targets stated in columns 4 and 5 in the light of the internal and external constraints.*	
	Selections 1, 2, 3	Section 4	OBJECTIVES AND GOALS			1977	1980
			Present position	Policy, aims and goals set for 1970-80			
	(1)	(2)	(3)	(4)		(5)	(6)

(*) See "Some Considerations on the Selection of Priorities as a Factor in Decision-Making

ANNEX I

GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE
AMERICAS FOR THE PERIOD 1971-80

The III Special Meeting of Ministers of Health of the Americas:

BEARING IN MIND:

That the General Assembly proclaimed the 1970's as the Second United Nations Development Decade, beginning on 1 January 1971, and simultaneously adopted an International Development Strategy for the Decade;

That the objectives of the Ten-Year Health Plan contained in the Charter of Punta del Este have been achieved to a considerable extent, and that the 1960's yielded valuable experience on the ways and means for the solution of health problems, as well as a better knowledge of the dynamics of health and disease in the Americas;

That "the mutual relationship between health, economic development, living standards, and well being" has been more clearly recognized;

That the ecological concept of health has been generally accepted as a continuing process of adaptation of human beings to their environment, which they can either damage or enhance;

Bearing in mind also the expected trends in socioeconomic development and in the planning processes in the Hemisphere;

CONSIDERING:

That the general view of the problems in the light of the experience gained indicates that major health efforts must be devoted to the consolidation of the existing services and to their extension so as to ensure the provision of comprehensive health care to communities not yet covered, in both rural and urban areas;

That programming for the decade should bear in mind that the increase in the population by 1980 is estimated at 24% in the Hemisphere and 33% in Latin America and the Caribbean area;

That some of the health problems contributing most to mortality and morbidity can be prevented or controlled by simple and economical techniques applied through the organization and operation of effective health systems endowed with adequate funds;

That there is an awareness of the need for plans and programs to be formulated not for isolated problems but on the basis of a careful selection of priorities, a clear definition of objectives, the application of efficient standards and techniques and the development of evaluation and information schemes within a single system of program articulation and institutional coordination;

That there should be close association between Ministries of Health and universities for the reform of teaching in the health sciences, designed to bring it more into line with the situation of the countries of the Continent.

That the imbalance between needs and human, physical, and financial resources makes it imperative to obtain the highest possible yield from existing resources, and at the same time to seek new patterns for the delivery of health services and sectoral financing;

That in order to provide comprehensive medical care, investment of national funds and external capital must inevitably be increased;

That health planning must be integrated into economic and social development planning from the preinvestment stage, particular attention being paid to regional development, whether national or international;

That as in the past decade the attainment of the objectives established will depend in each country on its particular characteristics, possibilities and experience, and that health progress in the Region will therefore appear as a great mosaic of national achievements in accordance with each country's economic and social development policies;

RESOLVES:

To recommend to the Governments the following goals for the Ten-Year Health Plan covering the period 1971-1980:

To consider, as a basic requirement for achieving the goals under the plan, the definition in each individual country of the health policy, in the light of its economic and social development, specifying clearly the objectives and structural changes necessary to achieve them.

I. PROGRAM OF SERVICES

1. SERVICES TO INDIVIDUALS

EXTENSION OF COVERAGE, INCLUDING MINIMUM COMPREHENSIVE SERVICES, TO ALL THE POPULATION LIVING IN ACCESSIBLE COMMUNITIES OF LESS THAN 2,000 INHABITANTS, AND PROVISION OF BASIC AND SPECIALIZED SERVICES TO THE REST OF THE POPULATION, BY MEANS OF A REGIONALIZED HEALTH SYSTEM, PRIORITY BEING GIVEN TO THE FOLLOWING:

1.1 Communicable Diseases:

- Maintain smallpox eradication;
- Reduce mortality from measles, whooping cough and tetanus to 1.0, 1.0 and 0.5 respectively per 100,000 inhabitants;
- Reduce morbidity from diphtheria and poliomyelitis to rates of 1.0 and 0.1 respectively per 100,000 inhabitants;
- Reduce mortality from tuberculosis by not less than 50%;
- Reduce the rates of mortality from enteric diseases by 50%;
- Cut down the incidence of venereal diseases, especially gonorrhoea and syphilis, and eradicate yaws and pinta;

- Cut down the incidence of leprosy, typhus, schistosomiasis, oncocercosis, Chagas' disease and jungle yellow fever, and keep plague under control;
- Eradicate malaria in areas where there are good prospects of reaching this goal, involving a population of approximately 75 million inhabitants. Maintain eradication where it has already been achieved. Apply in the "problem areas" the new techniques derived from research, and give intensive stimulus to research activities.
- Eradicate Aedes aegypti in the countries and territories still infested, and prevent the penetration of the vector into areas from which it has been eliminated.

1.2 Maternal and child health and family welfare:

- Develop sectoral and promote intersectoral programs with a range of 30-50%.
- Reducing mortality in children under one year of age by 40%, with a range of 30 to 50%.
- Reducing mortality in children from one to four years of age by 60%, with a range of 50 to 70%.
- Reducing maternal mortality by 40%, with a range of 30 to 50%.
- Offering families the opportunity - provided this is not at variance with national policy - to obtain adequate information and services on problems related to fertility and sterility.

1.3 Nutrition:

- Reduce grade III protein-calorie malnutrition in children under five years of age, on a regional average, by 85% and grade II by 30%. In countries where it is feasible, these goals will be separated for children under one year and from one to four years.
- Reduce by 30% the prevalence of nutritional anemias in pregnant women, and that of endemic goiter to less than 10%, eliminating cretinism and hypovitaminosis A in vulnerable groups at an average regional rate of 30%.

1.4 Other areas:

- As far as the availability of resources permits and in accordance with national policies, it is suggested that each country should establish priorities and targets corresponding to chronic diseases, cancer, mental health, dental health, and rehabilitation.
- Pay special attention to the medico-social effects of the growing dissemination in some countries of the use of alcohol and dependency-inducing drugs, and the increase in mental health problems caused inter alia by urbanization and industrialization.

2. ENVIRONMENTAL SANITATION PROGRAMS

2.1 Water Supply and excreta disposal services:

- Provide water services with house connections for 80% of the urban population, or as a minimum, supply half the population at present without services.
- Provide water for 50% of the rural population, or as a minimum, supply 30% of the population at present without services.
- Install sewerage for 70% of the urban population, or as a minimum, reduce by 30% the proportion of the population at present lacking such services.
- Install sewerage systems and other sanitary facilities for the disposal of excreta for 50% of the rural population, or as a minimum, reduce by 30% the number of inhabitants not possessing any adequate facilities.

2.2 Solid waste:

- Establish adequate systems for the collection, transport, treatment and disposal of solid wastes in at least 70% of cities with 20,000 population or more.

2.3 Environmental pollution:

- Establish policies and carry out programs for the control of water, air and soil pollution, noise abatement, etc., in line with basic environmental sanitation and industrial development and urbanization.

2.4 Regional development:

- Ensure the active and systematic participation of the health sector in the formulation and execution of regional, national and multinational development plans.

2.5 Occupational health:

- Ensure protection for 70% of workers exposed to presumed or recognized occupational hazards in countries already having programs fully operating, and 50% in countries which still have not developed programs adequately.

2.6 Animal health and veterinary public health:

- Help to control and eventually eradicate foot-and-mouth disease in South America and prevent the introduction of the disease into the countries free of it.
- Help to reduce the incidence of the most common zoonoses, with special emphasis on rabies, brucellosis, bovine tuberculosis, hydatidosis and equine encephalitis.

2.7 Biologically based food policy:

- Increase the availability and consumption of food through a food and nutrition policy, priority being given to the biological needs of the population.

2.8 Quality control of foodstuffs:

- Reduce human diseases and the economic losses caused by biological, physical and chemical pollution of food and by-products, at the same time maintaining their quality.

2.9 Quality control of drugs:

- Carry out programs in all the countries for the quality control of both nationally produced and imported drugs.

2.10 Control of the use of pesticides:

- Reduce morbidity and mortality caused by the undue use of pesticides.

2.11 Accidents:

- Reduce the proportion of traffic and industrial accidents and of those occurring in the home and in places of recreation and tourist resorts, and thereby reduce the number of deaths and disability cases.

3. SUPPORTING SERVICES:

3.1 Nursing:

- Organize nursing in at least 60% of countries, as a system in which the level of nursing care and the staffing required to meet the health goal of each country are defined.

3.2 Laboratories:

- Extend coverage and organize as "systems" the laboratories responsible for diagnosis, production of biologicals for human and animal use, and maintenance of blood banks needed to support health programs.

3.3 Epidemiological surveillance systems:

- Creation and maintenance of epidemiological surveillance units in accordance with the national organization and regionalization structure of each country, so as to ensure a continuous supply of information on the epidemiological characteristics of health problems and the factors governing them, and thus enable timely action to be taken.

3.4 Health education:

- Organize health education as part of the process of active and informed participation of communities in all action for the prevention and cure of disease.

II. DEVELOPMENT OF THE INFRASTRUCTURE

To ensure the achievement of the proposals under the plan, it is essential:

1. To install and develop in each country a health system adapted to its national peculiarities and determined in the light of the sectoral policy.
2. To establish and expand in each country the health planning process as an integral part of the socioeconomic development plan. To organize systems of information, evaluation and control. To improve health statistics.
3. To undertake research with a view to determining the effects of various alternatives within the sectoral policy and defining methods or techniques calculated to increase the productivity and effectiveness of services. To develop systematic studies on costs and financing.
4. To increase operational capacity at the institutional and sectoral level through:
 - 4.1 Coordination or integration of the State, para-State and private institutions which together make up the health sector.
 - 4.2 Initiation or strengthening of the processes of administrative, sectoral and institutional reform.
 - 4.3 Formulation and execution of programs for services, infrastructure, external assistance and preinvestment studies
 - 4.4 To promote the proper communication among the infrastructures of the various sectors in order to achieve, through coordinated programs, the concentration of intersectoral resources to the high risk population, with the aim of preventing illnesses and deaths.

5. DEVELOPMENT OF HUMAN RESOURCES

- 5.1 Achieve a regional average of 8 doctors, 2 dentists and 2.2 dental auxiliaries, 4.5 nurses and 14.5 nursing auxiliaries per 10,000 inhabitants, and improve their geographical and institutional distribution.
- 5.2 Train in the course of the decade a minimum of 18,000 veterinary surgeons and 30,000 animal health auxiliaries.
- 5.3 Train in the course of the decade a minimum of 360,000 nursing auxiliaries and produce 125,000 nurse graduates, especially at the intermediate level.
- 5.4 Train 3,200 professionals in the course of the decade in postgraduate programs and 30,000 professionals and technicians in short courses in sanitary engineering and other environmental sciences.

- 5.5 Train during the decade 300 professional level statisticians; 100 professional medical records officers; 4,000 intermediate-level medical records officers; 250 intermediate-level statisticians and 40,000 statistical auxiliaries.
- 5.6 Train during the decade 3,000 planners and 3,000 administrators at the professional level; train 1,000 professionals in health information systems.
- 5.7 Promote development of general medical practice to the extent required by the organization of the services and the goals proposed in the present plan. To promote the necessary changes in order to provide better training on this matter, in accordance with each countries' priorities.
- 5.8 Set up in at least 11 countries national systems of scientific documentation in the health sciences, linked together among themselves and with the Regional Library of Medicine (BIREME).
- 5.9 Provide textbooks of high scientific and instructional quality for students of medicine, nursing and other disciplines, in a program to cover 75% of students by 1980.
6. PHYSICAL RESOURCES
 - 6.1 Create within the regionalization systems a series of minimum comprehensive health service units, until a coverage is achieved of one unit per 5,000 inhabitants in localities with less than 2,000 inhabitants; health centers with comprehensive basic minimum services for localities with between 2,000 and 20,000 inhabitants; and institutions with comprehensive basic and specialized services to communities with more than 20,000 inhabitants.
 - 6.2 Increase the installed capacity by 106,000 beds in general hospitals by reorganizing and converting long-stay beds when this is feasible.
 - 6.3 Gradually incorporate specialized medical care services into general hospitals in accordance with levels of care within a regionalization scheme
 - 6.4 Establish systems for maintenance of installations and equipment.
7. FINANCIAL RESOURCES
 - 7.1 Develop financing systems for providing the sector with new sources of funds and ensuring wider collaboration by the community and participation by the health sector in key national development projects.
8. TECHNOLOGICAL RESOURCES
 - 8.1 Develop and utilize health technologies in keeping with the conditions obtaining in each country with a view to increasing the coverage and productivity of the services;
 - 8.2 Organize multinational programs of scientific and technological research.

9. LEGAL ASPECTS

Submit for consideration to the competent bodies of each country the systematization, regulation and adaptation of the legal provisions in force in line with the processes of administrative improvement.

III. LIFE EXPECTANCY AT BIRTH

Establish as a general goal for the decade the following increases in life expectancy at birth:

To develop the sectoral and promote the intersectoral programs in order to:

1. Increase life expectancy at birth by five years in those countries where the present figure is under 65 years.
2. Increase life expectancy at birth by two years in those countries where the present figure is between 65 and 69 years.

In order to obtain a reliable estimation of life expectancy and the progress to be achieved:

1. Improve registration of births and deaths, adopting measures to ensure completeness and more realistic estimates.
2. Develop alternative methods of estimating life expectancy in countries where registration of births and deaths is inadequate.

IV. GENERAL

1. The goals and strategies appearing among the recommendations adopted by the III Special Meeting of Ministers of Health will be regarded as an integral part of the present Ten-Year Health Plan for the Americas, even though they are not specifically included in it.

2. In the light of the studies to be carried out and of the economic and social situation in the countries, each Government will evaluate its possibilities and determine the priorities to be set for attaining the goals of the present Ten-Year Health Plan.

3. To request the Member Governments to quantify the targets included in this document which have not been identified numerically and ask them to transmit information to PAHO in order to establish averages for the Americas.

ANNEX II

CLASSIFICATION AND ANALYSIS OF THE GOALS
OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS
(prepared by the Pan American Center for
Health Planning)

CLASSIFICATION AND ANALYSIS OF GOALS OF THE TEN-YEAR HEALTH PLAN FOR THE AMERICAS

(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			(4)	(5)	
(1)	(2)	(3)	(4)	(5)	(6)
1. <u>LIFE EXPECTANCY AT BIRTH</u>	Increase life expectancy at birth by 5 years for those countries where the present level is less than 65 years, and by 2 years in those countries where the level is between 65 and 69 years.	This is an overall goal reflecting the mortality level. It is established for each country, on the basis of the anticipated feasibility and effectiveness of programs to reduce mortality. Among those playing an important part are programs directed to the most vulnerable population groups and to attack on diseases that are reducible through techniques of prevention and protection.	<ol style="list-style-type: none"> 1. Life expectancy at birth on initiation of program. 2. Goal established by the country. 3. Strategy to achieve the goal. 4. Reasons for variance from regional goal, if any. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980. 	The quality of vital statistics and the degree of consistency between strategies those of the program areas and of the overall development, in helping to reduce mortality, should be kept in mind. Criteria for analysis and achievement of the goals are needed.
2. <u>COVERAGE OF SERVICES</u>		The goals in this regard are designed to initiate, during the decade, the installation of mechanisms that will make it possible for the health services to achieve maximum coverage of the populations in all countries of the Region.	Definition of overall minimum, basic and specialize services, their consistency with ideas expressed in the Basic Reference Document, Meeting of Ministers, pp.11-14. Definition of "accessibility" criterion adopted by each country.		<p>Achievement of goals for population coverage by systems of services is closely related to certain prerequisites that render the goals viable and feasible, such as:</p> <ul style="list-style-type: none"> - Definition of policy for development of health services systems. - Planning and programming of activities. - Programming and implementing programs for education, training and utilization of manpower - Formulation and implementation of plans for plant investment. - Research and experimentation in health technology. - Improvement of systems of administration and their legal bases. - Exploration and incorporation of new funding sources national and international. - Increasing productivity and efficiency of services through sectoral systematization, functional regionalization, decentralization, intersectorial coordination, especially with social security institutions, etc. - Establishing efficient information, decision-making and control systems.
2.1. <u>MINIMUM SERVICES</u>	Expand coverage with minimum integrated services to all inhabitants of accessible communities of less than 2,000 population.	This is a goal that it is hoped all countries can establish, and one that seeks to deliver at least a minimum of medical care to rural populations not now covered. The goal is limited by the criterion of accessibility of the said populations. The goal implies coverage of the population in each country and consolidation of the totals at the Regional level.	<ol style="list-style-type: none"> 1. Population and number of localities with less than 2,000 inhabitants. 2. Accessible population in such localities, according to accessibility definition adopted. 3. Population accessible to delivery of minimum services. 4. Goal established for 1980. 5. Strategies for such purpose. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980. 	
2.2. <u>BASIC SERVICES</u>	Extend coverage in localities of 2,000 to 20,000 population with minimum integrated health services, complementing such services with delivery of basic services, and extend basic services coverages in localities of 20,000 to 100,000 population to all inhabitants not as yet receiving such services.	It is also anticipated that this goal can be set for all countries, seeking to provide some type of coverage to all inhabitants in localities of 2,000 to 100,000 population. A minimum unit of services is suggested for each 5,000 inhabitants and one of basic services for each 10,000 to 15,000 inhabitants. This goal implies coverage of the population of each country and consolidation of totals at the Regional level.	<ol style="list-style-type: none"> 1. Localities of 2,000 - 100,000 population, a according to size. 2. Number of minimum and basic services in the these localities. 3. Goal established for 1980. 4. Strategies formulated. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal for 1980. 	

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ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
2.3. SPECIALIZED SERVICES	Extend basic services coverage to all of the population in localities with more than 100,000 population, and expand the field of specialized activities that are demanded by new problems of urbanization.	This goal is designed to provide basic services coverage to the entire population in localities with more than 100,000 inhabitants and to organize the specialized services. The goal also implies coverage of the population in each country and its consolidation at the regional level.	<ol style="list-style-type: none"> Localities of more than 10,000 inhabitants, in order of size Number of basic and specialized services in such localities. Established goals for 1980. Strategies for achieving such goals. 	<ol style="list-style-type: none"> Number and percentage of countries that have established their goals. Number and percentage of countries that have formulated their strategies. Consistency with regional goal. Gap between initial situation in 1971 and proposed national goal for 1980. 	Other measures for developing the infrastructure and technical and administrative operating standards.
3: PROGRAM AREAS					
3.1. SERVICE TO INDIVIDUALS					
3.1.1 Communicable Diseases					
3.1.1.1 Smallpox	Maintenance of eradication				
3.1.1.2 Measles	Reduction of mortality rate to 1.0 per 100,000 inhabitants.	All goals related to the communicable diseases are regional averages and could be adopted by each of the countries in the terms set forth, whenever the problem exists. However, it is to be hoped that those countries in position to exceed the proposed goals will set more ambitious figures for this purpose.	<ol style="list-style-type: none"> Current status of the problem: morbidity and mortality rates, problem eradicated, in attack phase, maintenance, etc. Programs currently in process of development. Goal established for the country in 1980. Strategies for attaining the goal. Variance from regional goal and reasons therefor. 	<ol style="list-style-type: none"> Number and percentage of countries that have the problem, and that have established their goals. Number and percentage of countries that have formulated their strategies. Number and percentage of countries that have adopted the regional goal, or higher or lower levels. Gap between the initial situation in 1971 and proposed national goals for 1980. 	With exception of the goal of eradication, which is an absolute by definition, all other goals in communicable diseases do not have definable deadlines and must be taken only as indicators of the desired level. Hence it is essential to establish criteria for the evaluation of achievement of the goal. For example, if the country establishes as its goal the reduction of mortality rate of measles to 1.0 per 100,000 inhabitants, could it be said that the goal is achieved if a rate of 1.1 per 100,000 is attained by 1980? What is the permissible deviation and how can appropriate weight be given to projection of the indicator curve in time? Note also that there are goals that do not have an indication of magnitude, such as "control" or "reduction" of incidence. It is necessary, therefore, that criteria for evaluation be studied and established. It is recommended that criteria contained in Chapter IV, (pp. 116-160) of the Basic Reference Document and the recommendations in the Final Report of the Meeting of Ministers, pp. 29-34 be reviewed.
3.1.1.3 Whooping Cough	Reduction of mortality rate to 1.0 per 100,000 inhabitants.				
3.1.1.4 Tetanus	Reduction of mortality rate to 0.5 per 100,000 inhabitants.				
3.1.1.5 Diphtheria	Reduction of incidence to 1.0 per 100,000 inhabitants.				
3.1.1.6 Poliomyelitis	Reduction of incidence to 0.5 per 100,000 inhabitants.				
3.1.1.7 Tuberculosis	Reduction of mortality rate by 50 %				
3.1.1.8 Enteric Infections	Reduction of mortality rate by 50 %				

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.1.1.9. Yaws and pinta	Eradication				
3.1.1.10. Leprosy, typhus, schistosomiasis, onchocerciasis, Chagas' Disease and jungle yellow fever	Reduction of incidence				
3.1.1.11. Plague	Control				
3.1.1.12. Malaria	Eradicate malaria in areas where the outlook for success is favorable; maintain eradication where it has been attained, encourage research and application of resulting techniques in "problem areas"				
3.1.1.13. Aedes aegypti	Eradication in countries where infestation persists and prevent reintroduction of the vector where eradication has been achieved.				
3.1.2. <u>Maternal and child health and family welfare</u>	Develop sectoral programs and foster intersectoral programs necessary to: -Reduce mortality in infants under 1 year by 40%, within a range of 30 to 50%. -Reduce mortality in the 1-4 age group by 60%, within a range of 50 to 70%. -Reduce maternal mortality by 40%, within a range of 30 to 50%.	These are goals for all countries and for each one of the countries.	1. Current infant mortality rates for the 1-4 year age group, and maternal mortality. 2. Programs currently in operation. 3. Goals established for 1980. 4. Reason for variance, if any exist, from regional goals. 5. Strategies for achievement of such goals.	1. Number and percentage of countries that have established goals 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980.	The degree of compatibility between the goals established in this field and those related to reduction of mortality for communicable diseases or those in other program areas including medical care must be kept in mind. They must have been incorporated in the strategy.
	-Provide families with the opportunity to obtain adequate information and services on problems related to fertility and sterility, provided such programs are not contrary to established policy in each country.	This goal is delimited by conditions of the prior existence of a policy definition in the countries that adopt it.	1. National policy with regard to family planning. 2. Programs currently in operation. 3. Goals established for 1980. 4. Strategies formulated.	1. Number and percentage of countries that have adopted a policy. 2. Number of countries that have established goals. 3. Number of countries that have formulated their strategies.	See Basic Reference Document, pp. 162-172 and recommendations of the Meeting of Ministers, pp. 39-42.

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.1.3 Nutrition					
3.1.3.1 Protein-calory malnutrition	Reduce the third-grade protein calory malnutrition in children under 5 years, by an average of 8% and second-grade malnutrition by an average of 3% over the region.	These are goals for all countries, and for each country. The country goal may not coincide with the percentages for reduction mentioned for the Region.	<ol style="list-style-type: none"> Level of protein-calory malnutrition and prevalence of nutritional anemias in pregnant women. Programs currently in operation. Goals established for 1980. Strategies for achieving the goals. 	<ol style="list-style-type: none"> Number and percentage of countries that have established their goals. Number and percentage of countries that have formulated strategies. Consistency with Regional goals. Gap between the initial situation in 1971 and proposed national goal for 1980. 	See Chapter VIII, pp. 173-180 of the Basic Reference Document, Meeting of Ministers, and recommendations on program areas in the Final Report of the said meeting, pp. 42-46 to suggest criteria for analysis and evaluation of goals achievement in the field of nutrition.
3.1.3.2 Nutritional anemias in pregnant women	Reduce the prevalence of nutritional anemias in pregnant women by 30%.				
3.1.3.3 Endemic goiter	Reduce the prevalence of endemic goiter to less than 10%, eliminating cretinism.				
3.1.3.4 Hypovitaminosis A	Reduce the incidence of hypovitaminosis-A in vulnerable groups by an average of 30% throughout the Region	This goal is expressed as a regional average, which may be established by each one of the countries, after a study of its feasibility.	<ol style="list-style-type: none"> Present situation of the problem. Programs in operation. Goals established for 1980. Proposed strategy. 	<ol style="list-style-type: none"> Number and percentage of countries that have established their goals. Number and percentage of countries that have formulated their strategies. Consistency with regional goal. Gap between initial situation in 1971 and national goal proposed for 1980. 	

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.1.4. <u>Other areas</u>					
3.1.4.1. Chronic diseases, cancer, mental health, dental health, rehabilitation	Establishment of priorities and goals according to the availability of funds and in consonance with national policies.	It can be seen that these goals are established more in the nature of recommendations for all countries than as goals that will have impact on the population with regard to morbidity.	<ol style="list-style-type: none"> 1. Current status of these problems. 2. Policies that have been established. 3. Specific programs in process. 4. Proposed goals for 1980. 5. Assigned priorities. 6. Strategies for achieving the goals. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established priorities for dealing with each problem. 2. Number and percentage of countries that have established goals. 3. Number and percentage of countries that formulated strategies. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980. 	See chapters V, IX and X of the Basic Reference Document, Meeting of Ministers, and recommendations of the Final Report of the same meeting, pp. 37-38 and 46-48.
3.1.4.2. Use of alcohol and drugs; problems of urbanization and industrialization.	Give attention to the medical and social aspects arising from the increase in alcoholism and drug dependence, and increasing mental health problems caused by urbanization and industrialization, among other factors.				
3.2. ENVIRONMENTAL SANITATION					
3.2.1. <u>Water supply and sewage disposal services</u>					
3.2.1.1. For urban population	1. Provide water supply services to the homes of 80% of the urban population and supply such services to at least half of the entire population now without such service.	All goals relating to water and sewage disposal are goals for population coverage - urban or rural. They are designed to be adopted by all countries and each country individually and the regional goal is consistent with this purpose.	<ol style="list-style-type: none"> 1. Urban population with and without service, with and without house connections. 2. Programs in progress; proposed and approved investment plans. 3. Goals established for 1980. 4. Strategies. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with the regional goal. 4. Gap between the initial situation in 1971 and proposed national goal for 1980. 	See chapter XI, pp. 191-205, of the Basic Reference Document of the Meeting of Ministers.
	2. Install sewerage systems to serve 70% of the urban population or, as a minimum, reduce by 30% that portion of the population now without such services.				
3.2.1.2. For rural population	1. Provide potable water to 50% of the rural population or, as a minimum, supply 30% of the population without such service.		<ol style="list-style-type: none"> 1. Rural population with and without service. 2. Programs in progress. 3. Goals established for 1980. 4. Strategies. 		
	2. Install sewerage systems and other sanitary measures for the disposal of human waste for 50% of the rural population, or as a minimum, reduce by 30% the number of inhabitants that do not now have adequate facilities.				

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.2.2 Solid Waste	Establish adequate systems for the collection, transportation, treatment and final disposal of solid waste in at least 70% of the cities of 20,000 or more inhabitants.	The goal is coverage of the cities, a goal for the Region that may be adopted by each country.	<ol style="list-style-type: none"> 1. Cities of 20,000 and more inhabitants, with and without adequate systems. 2. Projects in operation or approved for implementation in the future. 3. Goal established for the country. 4. Strategy for its achievement. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980. 	A series of technical criteria should be set up to define when and "adequate" system has been attained. See pp. 200-205 of the Basic Reference Document Meeting of Ministers.
3.2.3 Environmental pollution	Establish policies and carry out programs to control water, air and solid pollution and for noise abatement, compatible with environmental sanitation and industrial development and urbanization.	The goal has no implication of population coverage and is more in the nature of a recommendation that each country give priority attention to the problem.	<ol style="list-style-type: none"> 1. Existing policies and programs. 2. Intersectoral coordination. 3. Level of participation by the health sector. 4. Established goals. 5. Strategies. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established policies and proposed programs. 	See Basic Reference Document pp. 206-212 and recommendations on program areas in the Final Report of the said meeting, pp. 49-52.
3.2.4 Regional development	Assure active and systematic participation of the health sector in formulating regional, national and multinational development plans.	Goal for each country, that is more a recommendation and recognition of the need for participation by the health sector in regional development plans.	<ol style="list-style-type: none"> 1. Regional development plans in process of formulation or in operation. 2. Participation of the health sector in formulation or operation of such plans. 3. Strategy for participation in such plans. 	<ol style="list-style-type: none"> 1. Number and percentage of countries with regional development plans. 2. Number and percentage of countries that have formulated strategies for health sector participation in such plans. 	See Basic Reference Document pp. 243-249 and recommendations in the Final Report of the said meeting, pp. 54-55. Criteria should be established for evaluation of this goal that would incorporate an assessment of the "degree of participation" of the health sector.
3.2.5 Occupational Health	Obtain protection for 70% of the estimated or known workers exposed to occupational risks in countries that already have programs in operation, and 50% of such workers in countries that have not yet sufficiently developed their programs.	Goal for each country, individually adjusted to the current level of development of their occupational health programs.	<ol style="list-style-type: none"> 1. Labor force and risks to which it is exposed. 2. Programs in operation and populations or risks covered by such programs. 3. Goals established for 1980. 4. Strategies to achieve these goals. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the initial situation in 1971 and the proposed national goal for 1980. 	It would also be appropriate for this goal to set up some evaluation criteria to include a description of the present stage of development of these programs, the level of "protection" afforded, etc. See Basic Reference Document, pp. 224-226 and the Final Report of the Meeting of Ministers, recommendations on program areas, pp. 53-54.

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.2.6. <u>Animal health and veterinary public health</u>	<p>Help to control and eventually to eradicate foot-and-mouth disease in South America and to prevent its introduction into presently disease-free areas.</p> <p>Help to reduce the incidence of the most frequently occurring zoonoses, with particular attention to rabies, Brucellosis, bovine tuberculosis, hydatidosis and equine encephalitis.</p>	Goals for each country	<ol style="list-style-type: none"> 1. Current status of foot-and-mouth disease, and of the zoonoses. 2. Programs currently in operation. 3. Goals proposed for 1980. 4. Strategies to achieve these goals. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Consistency with regional goal. 4. Gap between the situation in 1971 and proposed national goal for 1980. 	<p>These goals also require the establishment of criteria that will define the degree to which each country contributes to control of foot-and-mouth disease or reduction of incidence of the zoonoses.</p> <p>See Basic Reference Document pp. 250-262 and recommendations on program areas, Final Report of the Meeting of Ministers, pp. 55-58.</p>
3.2.7. <u>Food and nutrition policy</u>	Obtain in each country the formulation and implementation of a biologically oriented food and nutrition policy that will make it possible to attain the approved nutrition goals, assuring the availability and consumption of food that meets the nutritional needs of all population groups.	Goals for each country	<ol style="list-style-type: none"> 1. Food policy now in effect and degree to which it meets requirements of the regional goal. 2. Degree of participation by the health sector in formulation of this policy. 3. Strategy to obtain such policy formulation. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that do not have an adequate policy, and propose to develop such policy. 2. Number and percentage of countries that have formulated their strategies. 	Criteria must be defined to determine when a health policy may be considered formulated, and when such a policy is being implemented.
3.2.8. <u>Quality control of food</u>	Reduce human disease and economic losses caused by biological, physical and chemical contamination of food and food products, at the same time preserving the quality of such foods.	Goal for each country	<ol style="list-style-type: none"> 1. Programs currently in operation. 2. Programs being proposed 3. Strategies. 	<ol style="list-style-type: none"> 1. Number and percentage of countries proposing to develop activities. 2. Number and percentage of countries that have formulated strategies. 	See Basic Reference Document, pp. 225-230.
3.2.9. <u>Quality control of drugs</u>	Carry out programs in all countries for quality control of drugs, whether nationally produced or imported.	Goals for all countries and for each country.	<ol style="list-style-type: none"> 1. Programs currently being developed. 2. Goals established for 1980. 3. Strategies. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 	See Basic Reference Document, pp. 231-233 and recommendations of the Final Report, Meeting of Ministers, pp. 64-66.
3.2.10. <u>Control of the use of pesticides</u>	Reduce morbidity and mortality resulting from the indiscriminate use of pesticides.	Goal for all countries	<ol style="list-style-type: none"> 1. Estimate of morbidity and mortality attributable to use of pesticides. 2. Goal established for 1980. 3. Strategy. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated their strategies. 3. Gap between the initial situation in 1971 and proposed national goal for 1980. 	See Basic Reference Document, pp. 248-251 and recommendations in the Final Report, Meeting of Ministers, pp. 61-62.

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
3.2.11 Accident Prevention	Reduce the percentage of traffic and industrial accidents as well as those that occur in the home and in recreational and tourist areas, and thus reduce deaths and disability.	Goal for all countries.	<ol style="list-style-type: none"> 1. Current status of the accident problem. 2. Control program currently in operation. 3. Established goals for 1980. 4. Strategies. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established their goals. 2. Number and percentage of countries that have formulated strategies. 3. Gap between the initial situation in 1971 and proposed national goal for 1980. 	See Basic Reference Document, pp. 227-230 and recommendations in Final Report of Meeting of Ministers, pp. 64-65.
4. <u>COMPLEMENTARY SERVICES</u> 4.1. NURSING	Organize the nursing profession in 60% of the countries, as a minimum, with a system in which the level of nursing care and staffing needs to achieve the health goals of the country are defined.	The goal implies coverage of the countries.	<ol style="list-style-type: none"> 1. Status of the nursing system at the beginning of the period. 2. Existing development programs in the nursing field. 3. Definition of levels of nursing care to be attained. 4. Established goals for the decade. 5. Strategies formulated. 	Number and percentage of countries that have defined their levels of nursing care and adopted a development plan in this field.	Evaluation of this goal requires that criteria be established to define what is understood by a "nursing system." Study Basic Reference Document, pp. 271-277 and recommendations on program areas of the Ten-Year Health Plan for the Americas pp. 65-66.
4.2. LABORATORIES	Expand coverage and organize laboratories as systems with diagnostic functions, production of biologicals for human and animal use and blood banks essential to support the health programs.	This is a goal for all countries and for each country individually.	<ol style="list-style-type: none"> 1. Status of the system in 1971: - Minimum and basic care services, with or without laboratory. - Regionalization and reference system. 2. Status of blood bank. 3. Plans currently being implemented. 4. Established goals for 1980. 	Number and percentage of countries that have formulated their plans for development of laboratory systems.	Final evaluation of achievement of this goal requires that operational criteria and definitions be established for what is meant by a "laboratory system." See Basic Reference Document, Meeting of Ministers, pp. 266-270 and recommendations on Program areas in the Ten-Year Health Plan for the Americas, pp. 66-67.

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(Prepared by the Pan American Center for Health Planning)

ASPECT TO WHICH THE GOALS REFER	GOALS FOR THE TEN-YEAR PLAN	CHARACTERISTICS OF THE GOALS	INITIAL EVALUATION (1974)		CRITERIA FOR ANALYSIS AND EVALUATION OF GOALS
			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
4.3. EPIDEMIOLOGICAL SURVEILLANCE	Create and maintain epidemiological surveillance units, according to the national organization and regional structure of each country, in order to obtain continuing information on the epidemiological characteristics of health problems, and factors that condition them, for the purpose of taking timely action.	This goal must be established for all and each one of the countries.	<ol style="list-style-type: none"> 1. Current status of epidemiological surveillance system. 2. Plans now being implemented for the organization and development of the system. 3. Goals established for 1980. 4. Strategies for their achievement. 	Number and percentage of countries that have formulated plans for the development of their epidemiological surveillance systems.	<p>Evaluation of this goal also requires establishment of operational criteria and definitions for the organization and functions of epidemiological surveillance units.</p> <p>See Basic Reference Document, Meeting of Ministers, pp. 263 .</p>
4.4. HEALTH EDUCATION	Organize health education as a part of the process of active and informed participation of the communities in all of the activities designed for the prevention and cure of disease.	This goal is also proposed for all and each one of the countries.	<ol style="list-style-type: none"> 1. Current status of the health education service. 2. Plans currently in process for organization and development of the service. 3. Goals established for 1980. 4. Strategy for achieving such goals. 	Number and percentage of countries that have formulated plans to develop their health education services.	<p>Consideration of this goal requires operational criteria and definitions of what constitutes a "health education service" in order to devise mechanisms for evaluating its achievement.</p> <p>See Basic Reference Document, pp. 278-281 and recommendations in the Ten-Year Plan, pp. 69-70.</p>
5. <u>DEVELOPMENT OF INFRASTRUCTURE</u> 5.1. <u>SECTORAL ORGANIZATION AND ADMINISTRATION</u> 5.1.1. <u>Health Systems</u>	Install and develop a health system in each country, appropriate to the national needs.	Goal for each country, that implies a decision with regard to the structure and operation of the most effective system.	<ol style="list-style-type: none"> 1. Current status of the health system; institutional composition, coverage, productivity, policies to which it is subject, directing agency. 2. Plans for organization and development. 3. Proposed strategy. 	Number and percentage of countries that propose to organize and develop their systems.	<p>Evaluation of achievement of this goal requires establishment of criteria of "existence" of such a system, and its concordance with the policy directives that set it up.</p> <p>See Basic Reference Document pp. 1-15 and recommendations in the Final Report, Meeting of Ministers, pp. 72-77.</p>

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.1.2 <u>Planning</u>	Establish and expand in each country the health planning process, incorporating it into social and economic development plans.	Goals for all and for each one of the countries, leading to the development and refinement of the planning process, of information, evaluation and control systems, and of health statistics.	1. Status of the health planning process.	Number and percentage of countries that formulated strategies for development and improvement of: 1. The planning process. 2. Information, evaluation and control systems, and 3. Health statistics systems.	Evaluation of this goal requires criteria for determining the status of the planning process and the information, evaluation and control systems, as well as the degree of efficiency of the latter as tools leading to the implementation of the established policy. See Basic Reference Document, pp. 27-56 and recommendations of the Final Report of the Meeting of Ministers, pp. 77-81.
5.1.3 <u>Information, evaluation and control systems</u>	Organize information, evaluation and control systems.		2. Plans for the expansion and improvement of the process and its goals.		
5.1.4 <u>Statistical systems</u>	Improve health statistics.		3. Proposed strategies.		
5.1.5 <u>Research</u>	- Make studies to determine the effects of various alternatives in sectoral policy. - Develop methods and techniques to obtain an increase in the productivity and efficacy of services. - Make systematic studies of expenditures and financing.		1. Current status of the systems.		
			2. Plans for their improvement and proposed goals.		
			3. Strategies for achieving such goals.		
			1. Current status of statistical systems.		
			2. Goals for their organization and development.		
			3. Proposed strategies.		
			1. Existence of a research program, and subjects to be studied.	1. Number and percentage of countries that have formulated a research policy.	Establishment of criteria for determining priorities in areas to be studied is needed. See Basic Reference Document, pp. 60-64 and recommendations of the Final Report of the Meeting of Ministers, pp. 81-82.
			2. Plan to promote and implement the proposed research.	2. Number and percentage of countries that have set up research programs on: - sectoral policy - techniques - methodologies, and - financing.	
			3. Strategy for completing such studies.		

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.1.6. <u>Operating capacity</u>	<p>Coordination or integration of the state, para-governmental and private institutions that together constitute the health sector.</p> <p>Initiate or strengthen the processes of administrative, sectoral and institutional reform.</p> <p>Formulate and carry out programs for services, infrastructure, foreign aid and pre-investment studies.</p> <p>Promote communication among infrastructures of the various sectors, designed to bring about, by means of coordinated programs, intersectoral concentration of resources to those population groups most exposed to preventable risks of illness and death.</p>	Goals for all countries, designed to perfect the administrative processes, and overall direction of health systems.	<p>1. Existing coordinating mechanisms and their level of efficiency.</p> <p>2. Plans for the decade.</p> <p>3. Strategies.</p>	Number and percentage of countries that have established their goals and strategies.	Establishment of criteria for the evaluation of the level of operating capacity, with indicators of the efficiency, the coordination mechanisms, programming of services and investments, administrative systems, etc. (See reference listed under item 5.1.2. Planning).
5.1.6.1. Sectoral Coordination			<p>1. Description of the existing programs for administrative reform.</p> <p>2. Goals for the decade.</p> <p>3. Proposed strategies.</p>		
5.1.6.2. Administrative reform			<p>1. Characteristics of current programs in relation to policies and plans. Levels.</p> <p>2. Future plans with regard to programming mechanisms.</p> <p>3. Proposed strategy.</p>		
5.1.6.3. Programming			<p>1. Current communication mechanisms and existing coordinated programs.</p> <p>2. Mechanisms proposed to attain such communication.</p> <p>3. Proposed strategy.</p>		
5.1.6.4. Inter-sectoral communication					

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2 RESOURCES DEVELOPMENT					
5.2.1 Human Resources					
5.2.1.1 Personnel in 1980:	attain a regional average per 10,000 inhabitants of				
- physicians	3.0		1. Current number, and institutional and geographical distri- bution (1971).	1. Number and percentage of countries that have established their goals.	
- dentists	2.0		2. Established goal for 1980.		
- dental auxiliaries	2.2		3. Variance from regional goal and reasons therefor.	2. Number and percentage of countries that have formulated strategies.	
- nurses	4.5		4. Strategies for achiev- ing the goals.		
- nursing auxiliaries	14.5			3. Consistency with regional goal.	
5.2.1.2 Distribu- tion	Improve manpower distri- bution, geographical and institutional.	All manpower goals are average goals for the Region that should serve as indicators for the establishment of each country goal.		4. Gap between initial situation in 1971 and proposed national goal for 1980.	
5.2.1.3 Training	Personnel to be trained in the decade:	It should be kept in mind that in all cases the manpower goals are designed to attain a population coverage level.			
- veterinary doctors	15,000		1. Current number and estimated deficit (1971).		
- animal health auxiliaries	20,000		2. Goal for 1980.		
- nurses	125,000		3. Variance from regional goal and reasons therefor.		
- nursing auxiliaries	500,000		4. Current training programs.		
- sanitary engineers	2,200		5. Proposed training programs.		
- other pro- fessionals in sani- tation	20,000		6. Strategies for implementing the programs.		
- statistical profes- sionals	200				
- medical records pro- fessionals	100				
- medical records auxiliaries	4,000				
- statisti- cians, in- termediate level	250				
- auxiliaries in statis- tics	40,000				
- profession- als in planning	3,000				
- profession- als in ad- ministra- tion	2,000				
- profession- als in in- formation systems.	1,000				

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2.1.4. Practice of Medicine	Strengthen development of general medical practice to the extent required by the organization of the services and the goals proposed in the Ten-Year Plan.	Goal for each country designed to make the practice of the medical profession more satis- fying in relation to the goals of the Ten-Year Plan.	<ol style="list-style-type: none"> 1. Relationships at the decision-making level of the sector with the medical profession. 2. Mechanisms for informa- tion and participation in decisions. 3. Strategies to encourage and develop the prac- tice of medicine. 	Number and percentage of countries that have for- mulated strategies.	
5.2.1.5. Teaching of Medicine	Promote the necessary reforms to provide maxi- mum training in this field, according to the priorities set forth for each country.	Goal for each country, designed to raise the quality of medical manpower and its adjustment to the health needs of each country	<ol style="list-style-type: none"> 1. Priorities assigned. 2. Coordination with the Schools of Medicine. 3. Plans for changes in medical education. 4. Strategies for achieve- ment of such goals. 	Number and percentage of countries that have for- mulated strategies.	
5.2.1.6. Scientific Documenta- tion	Create national systems for scientific documenta- tion in the health sci- ences, in at least 11 coun- tries, interrelated among these countries and with the Regional Library of Medicine (BIREME).	Regional goal.	<ol style="list-style-type: none"> 1. Existing systems. 2. Outlook and plans for organization. 3. Proposed goal. 4. Strategy adopted. 	Number and percentage of countries that have de- cided to set up documen- tation systems.	
5.2.1.7. Textbooks	Supply high-quality sci- entific and pedagogical textbooks to students of medicine, nursing, and other disciplines, so as to cover with this pro- gram 75% of the students in 1980.	Regional goal.	<ol style="list-style-type: none"> 1. Number of students expected. 2. Existing program and outlook for its develop- ment. 3. Proposed goal. 4. Strategy for its achievement. 	Number and percentage of countries that have for- mulated programs for the period, 1971-1980.	

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2.2. <u>Physical Resources</u> 5.2.2.1	Within the systems of regionalization, create minimum integrated health service units, designed to attain coverage of one unit for each 5,000 inhabitants in towns of less than 2,000 population; health centers with integrated minimum and basic services for towns of 2,000 to 20,000 population; and institutions with integrated basic and specialized services to communities of more than 20,000 inhabitants.	Regional goal of population coverage that can be adopted by each country. The goal refers to construction and equipment of installed capacity.	<ol style="list-style-type: none"> Localities, according to population and number of minimum, basic and specialized units operating in each. Investment plan: approved projects and projects in operation. Established goal for the country and its consistency with regional goal. Strategies. 	<ol style="list-style-type: none"> Number and percentage of countries that have established their goals. Number and percentage of countries that have formulated their strategies. 	This goal is an expression in concrete terms of investment in plant construction for delivery of service to which the coverage goals mentioned in 2. "coverage of services", refer.
5.2.2.2	Increase the installed capacity by 106,000 general hospital beds, by remodeling, and conversion of long-stay beds whenever possible.	Goal for the entire Region. Breakdown for each country required.	<ol style="list-style-type: none"> Number of general and long-stay hospital beds. Planned investment. Goal established for the country. Strategy. 	<ol style="list-style-type: none"> Consistency with regional goal. Gap between initial situation in 1971 and proposed national goal for 1980. 	See Basic Reference Document, pp. 15-22.
5.2.2.3	Gradually incorporate specialized medical care services into the general hospitals, in consonance with the health care level and within the regionalization system.		<ol style="list-style-type: none"> Country policy applicable to this topic and progress made in its implementation. National goal established for 1980. Strategy. 		
5.2.2.4	Establish systems for the maintenance of installations and equipment.	Goal applicable to each country, for coverage of establishments.	<ol style="list-style-type: none"> Status of the systems. Goal established for 1980. Strategy. 		See Basic Reference Document, pp. 23-26.

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			Information needed from each country	Indicators to be employed	
(1)	(2)	(3)	(4)	(5)	(6)
5.2.3. <u>Financial resources</u>	Develop financial systems that will seek out new sources of funds for the sector and ensure fuller cooperation of the community and participation of the health sector in key national development projects.	Goal to be adopted in each country for 1980.	<ol style="list-style-type: none"> 1. Current status of health funding. 2. Financial policy now in effect. 3. Goals with regard to total amount, sources, origin and allotment of funds. 4. Strategies. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have established goals. 2. Number and percentage of countries that have formulated strategies. 3. Consistency with regional goal. 4. Gap between initial situation in 1971 and proposed national goal (1980). 	
5.2.4. <u>Technological resources</u>	Develop and utilize techniques adapted to conditions in each country, to increase coverage and productivity of the services.	Goal for each country. This refers in essence to the need to study and experiment with such techniques.	<ol style="list-style-type: none"> 1. Research programs in progress. 2. Proposed plans. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have formulated programs. 2. Number and percentage of countries that have formulated strategies for development of such programs. 	
	Organize multinational scientific and technological research programs	Regional goal.	<ol style="list-style-type: none"> 1. Programs in which the country is now participating. 2. Topics in which the country would be interested. 		
5.2.5. <u>Legal aspects</u>	Submit the systematization, regulation and adequacy of legal provisions now in effect to the competent agencies of each country, as a part of process of improving administration.	Goals for each country.	<ol style="list-style-type: none"> 1. Current status of health legislation. 2. Programs now in operation in this area. 3. Established goals. 4. Strategy. 	<ol style="list-style-type: none"> 1. Number and percentage of countries that have formulated programs. 2. Number and percentage of countries that have formulated strategies for development of such programs. 	See Basic Reference Document, pp. 56-60 and recommendations in the Final Report of the Meeting of Ministers, pp. 95-96.

ANNEX III

RESOLUTION XIII OF THE XXI MEETING OF
THE PAHO DIRECTING COUNCIL

RESOLUTION XIII

REPORT ON THE III SPECIAL MEETING OF MINISTERS
OF HEALTH AND STEPS NECESSARY TO IMPLEMENT
THE DECISIONS ADOPTED

THE DIRECTING COUNCIL,

Having heard the statement by the Director of PASB on the III Meeting of Ministers of Health of the Americas, held in Santiago, Chile, 2-9 October 1972; and

Considering that the recommendations made by the III Meeting of Ministers of Health of the Americas constitute valuable guidelines on the direction to be taken by the programs of the countries during the next decade,

RESOLVES:

1. To incorporate into the Organization's policy the recommendations of the III Meeting of Ministers of Health of the Americas, held in Santiago, 2-9 October 1972.
2. To request the Director of PASB to study the implications of the recommendations of the III Meeting of Ministers of Health, and the consequent modifications of objectives and priorities in the program of the Organization, and to report thereon to the XXII Meeting of the Directing Council.

3. To recommend to the countries that, within their planning process, they identify the priority health problems and establish objectives for each of them in accordance with the manpower, physical, and financial resources available, taking into account the regional health goals.
4. To request the Director of PASB to convene as soon as possible a working group of personnel responsible for planning and information and of health economists, with a view to designing an evaluation system that can be adapted to the unique conditions of the countries and still be flexible enough to give comparable results, which in turn will make possible a continent-wide evaluation of the achievements of the decade.
5. To recommend to PAHO that, in consultation with experts of the countries, general guidelines be drawn up for determining the present financing of health investments and the changes required to carry out the plans and programs envisaged in the Ten-Year Health Plan for the Americas, 1971-1980.
6. To suggest to the health authorities of the countries that they initiate cost studies of their health services and, when they deem it possible, cost-benefit studies, particularly in areas with the largest investment.
7. To recommend to PAHO that it prepare the necessary designs to ensure comparability of the cost studies.
8. To recommend that PASB furnish advisory services to countries requesting them, in all matter relating to the financing of the health sector, for example: the financial analysis of the sector, analysis of health expenditures, programming of investments, manage-

ment and financing of specific projects and of external credits, so that the countries will gradually come to know what financial resources are earmarked for health and how they are related to the benefits obtained.

(Approved at the sixth plenary session,
12 October 1972)

ANNEX IV

SELECTION OF PRIORITIES AS AN ELEMENT IN THE
DECISION-MAKING PROCESS

PURPOSE

The purpose of this paper is to present some thoughts on the nature of the decision-making process in the health sector, a process in which the establishment of priorities plays a fundamental role. It was deliberately decided not to include an in-depth analysis of the procedures and techniques for establishing priorities, but rather to present a very general but systematic discussion of the underlying assumptions and implicit criteria which may be regarded as having substantive importance in this stage of the decision-making process.

1. THE SELECTION OF PRIORITIES AS AN ELEMENT OF THE DECISION-
MAKING PROCESS

The identification and selection of the problems to be solved in order to achieve an overall objective are the very essence of the work involved in defining a policy and therefore constitute the initial stage of a process which triggers off the sequence of necessary decisions to attain the desired objective. This sequence includes decision-making with regard to selecting the best solution to the problem, the programming of the activities and investments which these solutions imply and their implementation.

The initial decisions are based on a system of values and cultural norms, on an ideology, and on the requirements of the political, technical and operational systems.

The study of the decision-making process goes back to the beginning of recorded history. However, it was only two decades ago that the analysis of the process of administration and the development of logically constructed mathematical instruments applicable to this process linked again in a formal way the decision-making process with administration. This development had - and continues to have - greater influence on business administration than on public administration. Moreover, in the analysis and development of instruments the primary emphasis continues to be placed on operational aspects rather than on the formulation of policies and of guidelines for their application. During the 1960's a concern with analyzing the decision-making process in the area of public administration began to emerge. Many of the conceptual, methodological and instrumental efforts in this field were in essence merely direct application of decisional techniques in use in private industry to particular cases arising in public administration. This approach poses a number of problems that cannot easily be solved because of the differences in nature of public administration and business administration. In business the processes to be analyzed are relatively simple, the aims and results are easily identifiable and quantifiable, and the inter-relations are less complex and numerous. Public administration, on the other hand, especially in the social sectors, operates in the context of a complex and ill-defined system involving a vast number of inter-relations.

Quantitative instruments proved inadequate for the analysis of processes aimed at achieving higher levels of social well-being, an objective which is difficult to reduce to quantifiable variables and which presupposes cultural values expressed in ideologies.

The realization of this fact is leading to the development of instruments appropriate for the treatment of problems of this type,

the solution of which depends essentially on being able to perform qualitative analyses. The tools of quantitative analysis should be utilized mainly in support of qualitative analysis, in the taking of decisions at the operational level, and in certain aspects of the definition of guidelines.

2. QUALITATIVE AND QUANTITATIVE ANALYSIS

It is proposed that the health sector be defined as a "system composed of a large number of complex elements interrelated in many ways, an ill-defined system in which the relationships among the various components cannot be represented in only one way, but in as many ways as there are points of view and in which each point of view depends on the philosophical and political prism through which the relationship is seen. And that very context in which the system evolves and which stipulates the relationships is itself variable, and its inter-relations with the system are little known."(+) If this definition is accepted, the conclusion is valid that quantitative approaches, used alone, are not effective tools for measuring the realities of the system and do not provide a basis for decision-taking at the stage of defining a policy and the guidelines required for its implementation. It is therefore necessary to resort to a type of systematical analysis, other than quantitative analysis that will bring the elements into a more logical arrangement as a basis for decision.

Figure 1 (see next page) depicts the process for a systematic selection of priorities under this approach.

2.1. Desired versus present situation

A process or a decision to bring about a change can be represented in terms of the distance from a present situation considered unsatisfactory to a situation which it is desired to attain.(++)

In the case of public health it is obvious that both situations are conditioned by the overall frame of reference in a country.

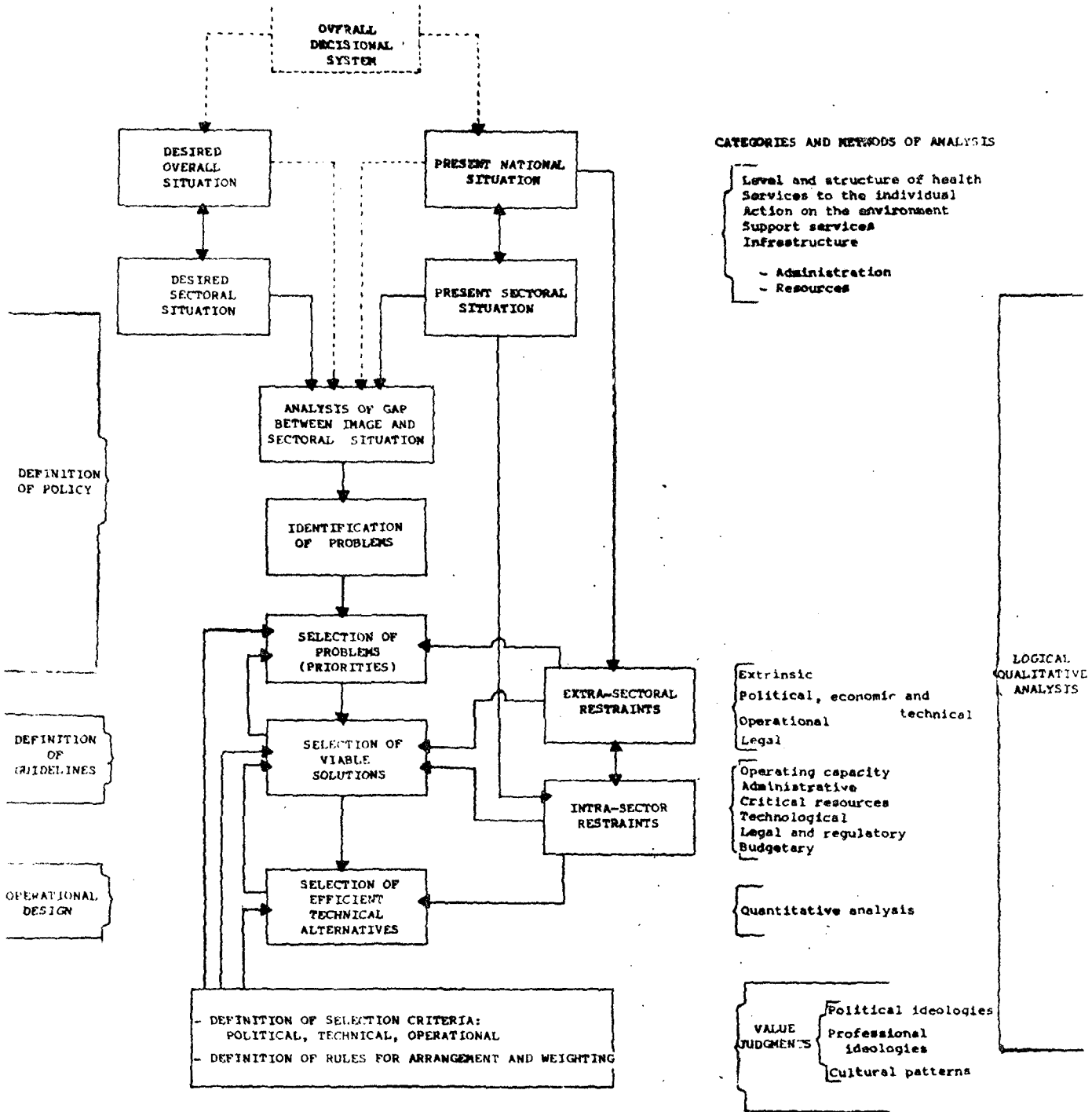
Although the images of the desired situations, overall and sectoral, are not always formally defined, they are always necessarily utilized, either implicitly or explicitly, in evaluating the need for a change from existing situations.

(+) Latin American Center for Medical Care Administration (CLAM).
Program for the Development of Models for Medical Experimentation,
Buenos Aires, Argentina, 1972.

(++) By desired situation it is meant the type of society, defined in terms of its economic, social and cultural interrelated characteristics which a country proposes to achieve within a given period through a given growth and structural change.

Figure 1

THE SELECTION OF PRIORITIES
IN THE DECISION-MAKING PROCESS



2.2. Identification of problems through analysis of the gap between the desired situation and the present situation in a sector

A comparison of the present situation in a sector with that which it is desired to attain is the basis for determining the existing gap between one and the other. This analysis should permit in an initial approximation the identification of problem situations through the estimation of the gap and the systematic analysis of the obstacles that it would be necessary to overcome in order to attain the desired situation.

The analysis of the sectoral gap must be done in such a way that a very careful account is taken of the overall national framework that shapes the sectoral situation, or at least conditions it within certain parameters.

This analysis is the methodological path leading to the identification of the problem-situations that have to be solved in order to bring about the desired change.

2.3. Selection of problems

The identification of problems is but one of the necessary elements in the decision-making process, since the health sector, like all other sectors of society, faces the classic economic problem of multiple needs versus a scarcity of resources available for possible application to each need. Due to this imbalance between few and relatively unchangeable resources and multiple needs, it is necessary to arrive at an order of priorities in which the problems may be solved through the allocation of combinations of resources. That is, it is necessary to establish priorities among problems.

For many years the efforts of research workers and administrators in the health sector were aimed at finding out a "summary" element with "economic" connotations and "technically rational" characteristics that would enable them to establish priorities.

The experience gained and the progress achieved in the understanding of the nature and the interrelations of social phenomena support the assertion that priorities in the health sector cannot accurately be determined on the basis of a single summary indicator. Health problems have a social connotation as well as economic characteristics, since their solution is a substantive factor in the degree of well-being that a community can achieve.

Recent analyses would seem to provide rather clear evidence that three types of rationality - political, technical and operational - play a part in the decision-making process, the relative influence of each depending on the stage of the process.

If it is accepted that establishing priorities among problems is one of the fundamental aspects in the definition of a policy, it is logical to conclude that political rationality should prevail at this stage over the other two types of rationality, which should support and complement the former (see Figure 2, next page). This conclusion presupposes the need to define political, technical and operational criteria to govern the selection among problems and make it possible to systematize them in some way that will facilitate the decision-making process.

It is proposed that the "political criteria" be regarded as consisting of the entire series of variables which are of concern at the political level of the administrative apparatus responsible for deciding on priorities between problems and among alternative solutions; that "technical criteria" be regarded as referring to these variables that concern the technical level of the administrative apparatus responsible for the programming of decisions, the principal purpose of which is to assure maximum efficiency through efficient solutions; and that "operational criteria" be considered as being the variables which are the responsibility of those who carry out the decisions aimed primarily at obtaining the most productive use of resources.

Figure 2

RELATIVE WEIGHT OF THE CRITERIA
FOR SELECTION OF PRIORITIES AT
THE DIFFERENT LEVELS OF THE PROCESS

SELECTION LEVELS	C R I T E R I A		
	POLITICAL	TECHNICAL	OPERATIONAL
PROBLEMS	Diagonal Hatching	Diagonal Hatching	Diagonal Hatching
SOLUTIONS	Diagonal Hatching	Diagonal Hatching	Diagonal Hatching
TECHNOLOGICAL ALTERNATIVES	Diagonal Hatching	Diagonal Hatching	Diagonal Hatching

On this basis it would be possible to construct for each of these types of criteria a subclassification that would facilitate the determination of the weight to be given to each variable in the decision-making process. It is obvious that this subclassification of relevant variables for the decision-making process, in accordance to the types of criteria we have proposed, will differ with the characteristics of the health sector in each country and that, therefore, each decision-planning-implementation system would have to draw up its own classification in the light of national and sectoral characteristics. However, it would seem possible and desirable to establish, by way of illustration, certain sets of variables into broad categories which are sufficiently universal to lend themselves to general use, such as the categories proposed in Figure 3.

It is important to emphasize that the definition and selection of criteria such as these is essentially a matter of value judgments, regardless of the degree of sophistication involved in its formalization and use. These value judgments reflect the political and professional ideologies of those participating in the decision-making process, as well as the cultural patterns influencing the situation in each country.

This proposition is not always accepted as valid. There is still a tendency to speak in terms of a supposed "rationality" as opposed to the "subjectivity" inherent in all value judgment. However, when we call a decision "rational" or "irrational," we are doing so from the standpoint of a given system of values. It is important to recognize that the concept of "rationality" or "irrationality" in decision-making is relative and is based on values and ideologies.

None of the present techniques of quantitative analysis contain the "magic" that will solve all "value" problems inherent to a society and therefore in its health sector. It is therefore necessary to recognize and make explicit the presence of these "values" that influence the establishment of priorities, in order that we may evaluate them and thus bring the necessary realism to decisions.

A system of values is the result of a complex process of relations between cultural patterns and the processes of professional and political socialization. It is hardly necessary to emphasize that in high level political decisions these values are strongly present, but even though less is known of what might be termed "professional ideologies," the analysis of reality shows that these, too, strongly influence the decision-making process.

Public health problems, like those in other social sectors, must be analyzed and evaluated in terms of values and social patterns because these values and patterns, observed or desired, are the point of departure in all social planning.

It would seem important to stress the influence of the political component in the decision-making process because this component is responsive to an ideology or a concept of society that could be closer to reality than the fragmentary vision usually offered by highly specialized technicians. But it is also important to keep in mind that the more criteria are brought to bear on the analysis leading to a decision, the greater is the likelihood that the decision will be correct. This explains the tremendous importance of including technical and operational criteria in the analysis of problem situations at the political level.

Definition of political, technical and operational criteria, regardless of the subclassification adopted, is a necessary prerequisite for the selection of problems (priorities), but it is also essential to confront these criteria with a careful analysis of the extra-sectoral restrictions, presumably beyond the control of the decision-making level in the sector. This type of logical analysis may be sufficient for arriving, in a first attempt, at an initial arrangement of problems. However, this arrangement should be reviewed after the possible solutions are analyzed, in order to introduce whatever changes seem advisable in the light of this analysis.

To sum up: the establishment of priorities is one of the fundamental stages in the definition of a policy. At this stage the political criteria predominate and the technical and operational criteria are secondary, although necessary supporting elements. Its analysis is strongly influenced by value judgments which should be made explicit, and it is essentially of a logical and qualitative nature.

2.4 Selection of feasible solutions

In view of the fact there can be several feasible solutions to a problem, it will be necessary to choose one of those possible solutions as part of the process of decision-making.

It is proposed that the term "solutions" be understood to refer to the possible ways or paths for obtaining a given result. This definition implies that there are a number of possible options. The problem is to decide which of the options are feasible and, of these, which is the most useful. This judgment on feasibility includes the category of desirability. "A dimension of purpose which cannot be ignored is thus introduced. Useful for what and for whom?" (+)

(+) L. A. de Souza, "Los insumos políticos para una estrategia para el desarrollo," ILPES, ECLA, draft, 1971.

It is evident that we are again faced with the question of a value judgement on which a decision at the political level is based. Moreover, "feasibility is not only a problem in the short-term; it must be analyzed over a certain period of time and within the context of a specific experience. The feasibility of a solution is therefore not to be determined solely on the basis of present possibilities" (+) but must be viewed from the perspective of change over the time required to achieve the desired image of a future national society. Otherwise the decision-making process will be confined within the limits of the status quo.

In the selection of feasible solutions, as in the selection of priorities, the political, technical and operational "rationalities" also play a role, but the technical criteria of effectiveness, efficiency and social cost are more influential (see Figure 2, page 6, and Figure 3, next page) and thus technical rationality carries more weight. Here the technical considerations assume equal importance with political ones and it becomes possible to add to the indispensable qualitative analysis the use of some type of instruments of quantitative analysis, provided sufficient information is available on effectiveness, efficiency and social cost.

The selection of feasible solutions is one of the fundamental aspects in the definition of guidelines to be followed in implementing a policy.

As in the case of the selection of problems, the determination of political, technical and operational criteria for selecting solutions must be complemented by analysis of extra-sectoral restrictions over which the sector has no control. Equally important and essential is the analysis of restrictions within the sector, restrictions representing obstacles that can and should be solved through the various solutions offered for the problem, since in this case the sector does have control over them.

It should be kept in mind that the analysis of feasible solutions may lead to a modification of the scheme of priorities between problems as it was determined in the first attempt.

2.5. Selection of technological alternatives

Just as it is possible that there may be a number of solutions to a given problem, it is equally possible that there are various technological alternatives for a given solution and that it will, therefore, be necessary to decide which of the latter is the most efficient for the solution chosen.

(+) L.A. de Souza, "Los insumos políticos para una estrategia para el desarrollo," ILPES, ECLA, draft, 1971.

Figure 3

EXAMPLES OF MAJOR GROUPS OF VARIABLES FOR CRITERIA FOR THE SELECTION OF PRIORITIES AT DIFFERENT LEVELS OF THE PROCESS

LEVELS OF THE PROCESS	CRITERIA		
	POLITICAL	TECHNICAL	OPERATIONAL
PROBLEMS	<ul style="list-style-type: none"> - Impact on pressure groups - Impact on policies - Social impact 	<ul style="list-style-type: none"> - Technical relevance - Technical possibilities of solution 	<ul style="list-style-type: none"> Administrative relevance
SOLUTIONS	<ul style="list-style-type: none"> - Impact on pressure groups - Consistency with policies - Relationship to political and technical stages of development 	<ul style="list-style-type: none"> - Effectiveness - Efficiency - Social cost 	<ul style="list-style-type: none"> - Critical resources - Efficiency
TECHNICAL ALTERNATIVES	<ul style="list-style-type: none"> - Impact on pressure groups - Relationship to stage of political and technical advance 	<ul style="list-style-type: none"> - Efficiency - Social cost 	<ul style="list-style-type: none"> - Critical resources - Administrative requirements - Legal and regulatory requirements - Efficiency - Operating capacity

In the selection of the most efficient technical alternatives, although political criteria are present, the most relevant criteria are the technical and, even more, the operational (see Figure 2, page 6 and Figure 3, page 10).

The nature of a technical alternative is generally such that it lends itself to and indeed requires quantitative analysis, since it frequently involves situations that are well-defined, quantifiable and structured according to relatively simple inter-relations. In this instance of analysis for decision-making, the tools of "operational research" are a valuable adjunct, especially cost-benefit analysis and its by-products, as well as optimizing mathematical models.

It is in this area, which belongs to what might be called the operational sphere, that the investigation and design of instruments is today centered. Most of this methodological arsenal has been specially conceived and designed for the operational microsphere of modern business administration.

Owing to the differences between business and public administration, the application of these instruments to the selection of technical alternatives for the health sector will be possible only if they are suitably adapted.

3. DISCUSSION OF CERTAIN METHODS THAT CAN BE USED IN THE DECISION-MAKING PROCESS

The following discussion deals with certain methods which can be used for measuring qualitative variables and which, judging from experience to date, would seem to constitute highly useful methodological approaches. These methods, if further developed through application, offer excellent prospects for improvement of the decision-making and planning processes.

The discussion will be limited to two methods that we regard as having the greatest potential relevance: Numerical Experimentation Models and the DELPHI Method with its variations.(+)

(+) It is not considered necessary to comment in detail on the quantitative methods, since they are sufficiently well-known and there is abundant literature on them.

NUMERICAL EXPERIMENTATION MODELS(+)

If it is accepted that the health system is open, poorly defined and complex, it would appear valid to apply the following comments to it: (++)

-".... Description of a complex system requires the use of an appropriate language. Verbal language is insufficient because it does not permit a description of the full complexity of the relationship among the components of the system. This requires the formalization of an overall view or model that makes it possible to describe the behavior of those components and their inter-relations.

-"The type of formalization or model selected should be adapted as far as possible to the characteristics we have described in reference to poorly defined systems.

-"Models are appropriate instruments for investigating and describing reality and testing possible changes. By utilizing them it is possible to introduce a greater element of rationality into the management or operation of a system...

-"For a single system there are as many models as there are parameters that can be handled endogeneously. All these models will have a basic common scheme reflecting the undeniable relationship among the variables defining the system.

-"The models thus prepared are not intended to be a tool for arriving at precise quantitative predictions. They are designed to be used in taking qualitative decisions involving a choice among various action alternatives the effects of which can be compared by using the model.

-"At an initial stage it is possible that the greatest usefulness of models of this kind will lie in indicating previously unanticipated pitfalls. This would be done in the following way: one would begin by testing policies similar to those already in use. The results obtained may be used as a basis for comparison. As a second step, new experiments with innovative policies are designed. Some of these policies may yield undesirable results. By comparing a basic experiment with the one yielding the undesirable results, it is possible to arrive at conclusions as to the causes of those results

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- (+) Since 1968 the Pan American Health Planning Center has been carrying out a research program on the formulation of numerical experimentation models, for the use of the Health Sector.
- (++) Latin American Center for Medical Administration (CLAM), Program for the Development of Numerical Experimentation Models, Buenos Aires, 1972, and Research Program of the Pan American Center for Health Planning, Santiago, Chile, 1971.

and, consequently, to make a special effort (in reality) so that those results that one wishes to avoid will not come about.

- "However, although these models will not permit a prediction in the traditional sense of a determination, subject to a certain margin of error, of the quantities of each of the variables making up the system, it is still possible to arrive at some type of prediction. For example if various policy experiments lead to results which are approximately the same, it may be considered that the model is predictive in a qualitative sense and even in certain semi-quantitative respects, as when a certain arrangement is consistently predicted.

"Usefulness of the Model

"A model having the characteristics described makes it possible to:

- Select a suitable alternative from among various policies or various strategies for a single policy, by comparing the probable results of applying them.
- Detect, in relation to fields of knowledge which have not been studied in depth thus far:
 - (a) Areas whose behavior is not relevant to an explanation of the operation of the system under study;
 - (b) Priority areas in which further investigation is needed.
- Predict bottlenecks in the behavior of the system, under given conditions.
- Test, correct and adjust the existing hypothesis on the system, and analyze the characteristics, interrelations and operation of the relevant components thereof.
- Check the formal consistency of hypotheses.
- Facilitate the application of existing methods of planning and programming in the field, by permitting the above possibilities to be brought to bear on such specific fields as financing, investments, human resources, etc."

These models have the drawback that great experience and skill is required in order to formalize them and adapt them to large computers. However, they offer the advantage of facilitating a combination of qualitative with quantitative analysis, a combination which, as noted above, is necessary throughout the decision-making process.

The participation of the various persons composing the decisional levels, technical and operational, of the sectoral system will lead to a number of secondary results which are of fundamental importance for achieving an improved knowledge of health phenomenon and the administration of the sector. These by-products, once formulated, are highly effective tools for checking the probable consequences of policies and strategies and determining key areas in the operation of the system.

The application of these models presupposes a definition of the health system to be analyzed. A clear delimitation of its components and structures is the basic substratum for arriving at an approximation of the qualitative and quantitative relationships between them. Utilization of instruments of this kind makes it possible to identify the major areas in which the system must be adjusted in order to increase its effectiveness and efficiency.

THE DELPHI METHOD

One of the qualitative methods whose use opens up tremendous possibilities for the setting of objectives and the prediction of economic, social and cultural change under different levels of uncertainty and different degrees of sophistication is the Delphi method.(+)

It is designed to make possible the formulation of a group opinion on matters regarding which no precise and adequate information is available.

The Delphi method operates as follows: A group of experts is formed. The group must be composed of persons either directly or indirectly concerned with the problems to be investigated. Each person receives a questionnaire which he must fill out within a given time. The content of the replies is used to modify the original questionnaire and draw up a second one and a summary guide, which are sent to the experts. This system is repeated many times, and anonymity is maintained in each of the events. In this way each participant receives feedback from the ideas of the others and feels free to accept or reject those ideas or to modify or adjust his earlier opinions.

This is a way of averting the rigidity of behavior created by the use of panels of experts faced with the need to provide group opinions.

(+) This method was developed at the Rand Corporation, Santa Monica, California, early in the 1950's and has been extensively used in recent years.

In this way the reply obtained will not be based primarily on an extrapolation of the past. A number of innovative elements will have been generated through the exchange of opinions that comes about each time a new questionnaire is sent.

This method offers the following advantages in the taking of decisions on formulation of policies and strategies:

- It permits the inclusion and treatment of key qualitative variables.
- It fills the gaps in the "formal" information available.
- It requires the participation of a large number of persons from the various decisional levels, technical and operational, so that, by drawing on the experience acquired by them it contributes to the realism of the decision and fosters a positive attitude on the part of the various participants.
- It has great flexibility in terms of the resources and time required.

The method can therefore be adapted readily to the various operative capabilities of the national health systems and to the political requirements of the decisional levels, as far as time is concerned.

However, it calls for considerable imagination and extreme prudence on the part of the analysts responsible for drawing conclusions, and like the numerical experimentation models, it is specific, that is to say, once the exercise is carried out for a given problem in a given space and time, the results cannot be generalized to other similar situations.

The chief drawback in this type of instrument is the basic underlying assumption that the experience and present opinion of the "experts" is valid for a definition of a future change and an assessment of the possibility of bringing it about. This poses the risk that the material on which the judgment at the decisional level is based may be slanted toward a non-change. Nonetheless, instruments such as these may constitute excellent reference material for gauging the possible action-reaction of putting a proposition into effect. In spite of this risk and the relatively brief experience with its use in the health sector, the nature of this sector and the analysis of the possibilities offered by this type of instrument warrant the assumption that the method, if systematically applied, can make a contribution to a gradual improvement of the decision-making process and to sectoral planning in the countries.

Shortage of operational capacity and the pressing demands of politics in the health sectors of the country may make it necessary, at an initial stage, to resort to extreme simplification, but it is to be expected that systematic use of approaches of this type will, through a sustained process of repetition, help to improve not only the decisional and planning process but also the knowledge of the complex sectoral interrelations in health itself and in the administration of resources assigned to the health sector. Important by-products may also be expected in the form of a definition of substantive problems meriting investigation through other methods. The mere fact that the use of these instruments makes it necessary to explicitize, and possible to examine, behavioral variables strongly influencing the possibilities of behavioral change that cannot be weighed through quantitative methods would be sufficient reason for using them systematically.

It should be emphasized once again, however, that regardless of how excellent the available information is, how sensitive and sophisticated are the instruments used, and how expert are the specialists in the handling of these instruments, in the taking of decisions nothing can replace sound judgment and a genuine will to develop a process of change with the object of achieving a clearly defined situation which it is desired to bring into being.

BIBLIOGRAPHY

- B. Abel-Smith:** "Health Priorities in Developing Countries: The Economist's Contribution". International Journal of Health Services, Vol.2, Nº1, Greemood Periodicals Co., 1972.
- Closter Barnard:** Organization and Management - Harvard University Press, Cambridge, Mass., 1949.
- M. L. Blum:** "Prioriting Setting for Problems, Solutions, and Projects by Means of Selected Criteria". International Journal of Health Services, Vol. 2, Nº1, Greemood Periodicals Co., 1972.
- J. Bronowski:** The Common Sense of Science, Vintage Books, New York.
- Centro Panamericano de Planificación de la Salud:** "Métodos y Modelos", División de Investigación, 1970.
- Ricardo Cibotti y Oscar J. Bardecci:** "Un enfoque crítico de la Planificación en América Latina", ILPES, 1971.
- Bertham M. Gross:** The Managing of Organizations, New York Free Press, 1964. Organization and their Managing, New York Free Press, 1968.
- José Medina Echeverría:** Filosofía, Educación y Desarrollo, Textos del ILPES, 1965.
La Planeación en las Formas de Racionalidad Cuaderno ILPES, Serie II Nº13.
- Naciones Unidas:** Interregional Seminar on the Use of Modern Management Techniques in the Public Administration of Developing Countries, Wahsington, D.C., 27 de octubre - 6 de noviembre de 1970. Volumen II: Documentos Técnicos ST/TAO/M/52/ADD.1.

- A. Rapoport: "Methodology in the Physical, Biological and Social Sciences, Global Systems Dynamics", Charlottesville, 1969 (Vorges, Basel, Munchen, New York, 1970).
- A. Schutz: "The Problem of Rationality in the Social World", Economics Chicago, Vol. 10, 1943.
- Huns-Jürjen Seraphin: "Política Económica General: Los Juicios Valorativos para la Política Económica", Apuntes Programa de Capacitación, ILPES, 1965.
- Herbert Simon: The New Science of Management Decision, Harper, New York, 1960.
- Oscar Varsavski: Modelos Matemáticos y Experimentación Numérica, Buenos Aires, Argentina, 1969.
- Sir Geoffrey Vickers: The Art of Judgement, Basic Books, New York, 1965.