Editorial

Some Thoughts on Health Planning and Development

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"He who will not reason is a bigot; he who cannot is a fool; and he who dares not is a slave" – SIR WILLIAM DRUMMOND.

A health service must benefit all the people. Health problems are numerous and have many facets. Needs and expectations differ from place to place and from group to group. A health plan needs therefore to be comprehensive and pragmatic, and the services well co-ordinated. Leaving pockets of population unserved or underserved is morally objectionable and socially unacceptable. To some this may sound egalitarian. But in the provision of a social service, one should be egalitarian, because this is the ultimate goal. What is intended here is not a polyclinic or a hospital at every village or a radiotherapy unit at every hospital, but rather equal opportunities to stay healthy and, when ill, equal opportunities to get treatment.

In the *Gerakan Maju* movement initiated by the government ill-health had been identified as one of the four major problems faced by the country; the other three being ignorance, poverty and apathy. Development of the health sector, during the past twenty years, had formed an important component of the government effort to improve the socio-economic status of the people.

There has been progress; the most significant perhaps being the provision of medical and health services in the rural areas, and control of major communicable diseases. Over the years there inevitably had been changes in emphasis and direction. The present service structure can be said to have taken its present form as a result of the following developments:

(a) Expansion of facilities and services in a regular, modular fashion, reflecting basic concepts;

(b) Sophistication and diversification of basic services resulting from changing technology;

(c) Development of vertical programs to tackle specific health problems, with varying degrees of integration with the basic service; and

(d) Adding new functions to existing facilities and staff.

If falling morbidity and mortality rates and lengthening of life span can be considered as indicators of health status, then it can be said development of the health services had contributed towards its improvement. The operative word is "contributed". There are many other agencies whose activities directly or indirectly contributed towards this achievement.

Could we have done better?

The question is not whether we could have built more hospitals or health centres; but whether with the same quantum of investment in health, we could have obtained better results. With the country going through a crucial stage of development, it is not out of place to the situation.

Matters of life and death are always emotionally charged, and one tends to be carried away by isolated incident or chance association with the sick. But when dealing with the health of a nation one cannot allow personal feeling or emotion cloud far reaching decisions. One has to look at the issue

objectively and in proper perspective. Promise of "nothing but the best" may benefit a few, but leaves untouched the vast, more often than not, inarticulate majority who may be in more need of consideration and assistance.

A country faces multifarious health problems, some more acute than others. For some the underlying causes can be removed by available technology. Others have only partially removable or non-removable causes. Certain health problems may be considered by the community to be of great importance; whilst for some the cost of solving may be beyond the reach of the country or out of proportion to the benefit that can be expected from the measures taken.

As a matter of principle a health service must be based on a country's need, and its ability to pay for and sustain such a service. Developing countries are in the fortunate (or unfortunate) situation of being able to develop their health services merely by technology transfer from advanced countries through imported skill or staff trained overseas. With the current rapid international dissemination of information, it does not take long for even the most remote underdeveloped countries to some to know about the latest thinking, scientific discoveries and advancement in medicine developed or detected in the laboratories of some distant land. The danger is that there may be attempts at wholesale importation of techniques or strategies spawned in quite different circumstances from those prevalent locally, with the resulting possibility of quite irrelevant and inappropriate service development. It has been said that the poor health services of certain countries are caused not so much by the lack of technology as its non-or wrong application. Huge, modern institutions equipped with the newest gadgets, supplied with the most up-to-date and expensive drugs, and staffed by the most highly trained and an abnormally high proportion of a country's available manpower in the town, the contrasting with the picture of neonates dying from preventable neonatal tetanus, children dying of bronchopneumonia in the rural areas because of non-availability of service, bear stark testimony to the lopsided and unbalanced planning that goes on in certain countries.

How can such a situation be prevented?

It can be prevented through proper health planning. Planning starts with an awareness of problems and their causes. It is essentially deciding in advance: (a) What to do; (b) How to do it; (c) When to do it; and (d) Who is to do it. It is fundamentally a process of choosing between alternative courses of action.

Health planning

Perhaps the most critical issue in health planning and also that which is likely to be most discussed about is priority setting. Given an array of health problems, how would one choose the health problems to be tackled first not only in terms of sequencing but also from the point of view of resource allocation?

Logically one would view each problem from the following angles:

(a) *Magnitude of the problem.* To what extent does the problem contribute to morbidity and mortality?

(b) *Social concern.* Is the problem distressing certain areas, groups etc., and hence the community is concerned about it?

(c) *Technology.* Are there technologies available to alleviate the problem?

(d) *Existing health policy.* Since priorities will have to be politically endorsed, is the prevalent health policy conducive to the solution of this problem?

This would be the rational approach to priority setting. But unfortunately this is not always the case. Personal impressions and unvalidated data had been allowed to cloud the whole planning process.

For accurate planning, one requires reliable information and data. But more often than not, data are not available, incomplete, unrepresentative or just not analysable. It is ironical that countries most in need of correct health planning to maximise benefits from the meagre investment in health are the ones without reliable medical and health data.

Data collected routinely for day to day health administration, for compiling annual returns, or reports often cannot be used as the basis of health planning. Hospital statistics are notoriously unrepresentative and misleading. So also are returns of attendances at polyclinics, health centres and similar institutions.

There are many statistical techniques which can provide reliable information Surveys and sampling techniques properly designed can simplify data collection and processing and at the same time avoid the laborious, routine submission of returns which can be unreliable anyway. It is advisable for a health administration to make more use of these statistical tools; and develop an effective information or data bank.

Strategies

Having identified the problems, and the priority in which they are going to be tackled, the next stage in the planning process is determining strategies to be used. In deciding, one needs to consider technology available and resources in hand. Examples of strategies are the following:

(a) Control water-borne diseases, and parasitism by providing safe, adequate and easily accessable water supply and promotion of the use of toilets;

(b) Control communicable diseases by increasing individual and herd immunity through immunisation;

(c) Improve nutritional status and reduce toddler mortality rates through a multi-agency food and nutrition program;

(d) Use community development principles to promote community participation in and use of services provided.

Strategies thus can be considered as broad statement of approaches in solving problems, and can therefore be called derivative plans.

There are a number of assumptions implicit in a strategy. Firstly the overall goal or objective is clear, though targets i.e. expected achievement over a time frame are not stated. Secondly, there is a general indication of approach. Thirdly, before adopting the approach to be used, it is assumed that all possible alternatives have been thoroughly studied and the one which is most logical and rational in all respects had been decided on. Strategy formulation is an important step in the planning process. On it will depend whether a program will achieve its ultimate objective. It requires a clear balancing of pros and cons, a complete analytical review of resources as well as an understanding of socio-cultural forces operating in the community. Many a program has failed not because of non-availability of technology, but for organisational and operational reasons.

When confronted with a number of health problems, different techniques of intervention can be adopted. One is the broad frontal attack, tackling a number of basic or related problems at the same time, typified by the rural health service of this country, wherein the government attempts to give preventive and curative primary care through a multiplicity of staff and techniques. The other is through vertical programs to solve health problems causing large scale morbidity or mortality, typified by the malaria eradication, tuberculosis, yaws and filariasis control programs. This strategy utilises special organisation, staff and techniques to reduce sickness or mortality to acceptable and managable proportions; at which stage the program will be integrated with the basic health service. Health services of many developing countries have in fact started as vertical programs, the unifunction organisation gradually taking on the added responsibility of providing a more comprehensive health service. In this country both techniques have been used.

Transition from a vertical to a more frontal approach or integration of a one disease program with the basic health service requires an elaborate re-organisation, restructuring, re-training and re-orientation of staff and resources. Lack of adequate planning and proper preparation create many administrative or operational problems, or even resurgence of diseases.

Integration of the health service means different things to different people. Broadly it can take any of the following forms:

(a) All the services are under one administration;

(b) All the services are provided under one roof, with personnel working quite independently;

(c) All the services are provided under one roof or by one organisation, with the personnel working as a well-coordinated team;

(d) All the services are provided by one multi-purpose worker.

I suppose all these definitions are valid at different times and under differing circumstances. But it must be made abundantly clear that administrative integration does not necessarily result in service integration. Merely placing people under the same roof or in the same organisation will not integrate services, unless they are trained, organised and facilitated to work as a team.

How one can provide an integrated service depends upon circumstances. Problems requiring a high level of diagnostic, therapeutic and control technology from many different disciplines are best tackled under one administration, one roof and one team to bring about a oneness of purpose. On the other hand, a relatively simple problem which can be solved by relatively simple procedures can be handled by suitably trained multipurpose workers. In this country a good example is the jururawat desa (community nurse). Originally she was a midwife providing care to the mother and the newly born child. With retraining, she has taken on added

responsibilities in providing simple medicare, family planning, health education, child health care including immunisation and a host of other related duties. In this way she can deliver a wider range of services. In the remote rural area, she is the frontline worker servicing practically the whole family, though admittedly at a relatively low level of care.

The standard of care

The medical profession is justifiably concerned with the standard of care given to the public. A falling standard must be viewed with concern. But sometimes we tend to confuse "standard" with "level" of care. A "standard" is determined by the technology available. "Levels" are decided by the ability to provide. If we may borrow an analogy from air-conditioning, we may set the thermostat high or low. The heating or cooling mechanism and insulation can be said of a high standard if it is possible to maintain room temperature at the desired level. The health planner would be interested in the level as well as the standard of care. What is important is to set and maintain a standard of service for a particular level of development.

What do we do when a country is short of professional workers? A doctor takes six years to train, a specialist a decade. Do we have to wait that long to provide a modicum of service? Cannot this be provided by less qualified people? If it can, what would be the role of the few fully trained professional worker? Should he continue to provide service only? Or should not he, in addition, try to increase work output through less trained people by training them; whilst at the same time maintaining standard through effective supervision of sub ordinate officers and by giving the necessary consultative support?

Similar consideration must also be given when determining the type of instrumentation to carry out the various procedures. Much expensive equipment lies unused because there are no people who can use them, or because they are in a state of disrepair through lack of maintenance personnel or non-availability of spare parts.

Target setting

Target setting is one of the most difficult exercise in health planning. This is because health or ill health is an amorphous entity, outcome of intervention cannot be accurately predicted and rapid technological changes may invalidate planning assumptions. We tend to measure health status by the absence or reduction of ill health (falling morbidities and mortalities) and longer life span; and expansion of the health services by the number of new hospital beds added or the number of new health centres or midwife clinics built, assuming that the facilities provided will meet with public response. And yet without specific targets it is difficult to evaluate effectiveness and efficiency of programs. There are, albeit, elaborate methods of quantifying services, if not in all, in the majority of areas. It is necessary to explore these possibilities to bring about a more realistic planning. The targets set should be in terms of coverage, levels of care and standards of service.

"Who should do what?"

In other words what type of manpower pattern should we have.

Many health programs have floundered because manpower planning had been unrealistic or inadequate. Poorly staffed programs or bad service are evidence of flaws in manpower planning. One tends to be too pre-occupied just with numbers of staff; without at the same time considering the appropriateness of type and mixture of manpower. Traditional staffing patterns have been accepted totally, without analysing the roles and functions of each worker in the health delivery system.

Experience in this country and studies in others have clearly shown how effective paramedicals and auxiliaries can be in the delivery of health service. We use them extensively. In the Ministry of Health, for every professional worker there are about 8-9 paramedicals/auxiliaries. Every year we are adding between 2,000 and 2,500 new workers to the existing pool. The use of paramedicals/auxiliaries is not a stop gap measure, because there are many simple, routine procedures which they can do. What is needed is a recognition of their roles by the profession, and the structuring of the service which will facilitate and maximise their contribution.

The role of the doctor nowadays goes beyond the direct providing of service. He has to be a planner, manager, supervisor and a team leader. Unfortunately most medical education does not equip him with this expertise.

Any training program must satisfy local needs. But many had been based on foreign experiences or are virtually copied from abroad. Local officers take foreign examinations, or are actually sent abroad because local facilities are absent or inadequate. So long as a country continues to depend on externally trained manpower, or bases its training on alien models and thus engages in manpower production for the world market rather its own needs,

it is difficult to see how it can ever satisfy its own requirement. Here the health planner and administrator may be against people who are morbidly concerned with up so called standard, foreign recognition, opportunities for further training abroad and a host of other reason for keeping the status quo. Recognition by others is most welcome and sometimes even sought; but let it not drown our primary objective and replace pragmatism of approach with a servile glorification of and identification with things which are beyond our reach or even irrelevant to our circumstances.

There is a great need to build up our own training capability both for professional and the non-professional categories.

Evaluation

Every plan, whether health, education, or agriculture must be evaluated. The evaluation can be continuous, periodic or both. This means every plan must have a built in assessment component and machinery which must be structured before the plan is implemented. Unfortunately many plans have no such built in evaluation techniques, or plans have been implemented without purposeful evaluation being done. This can be quite understandable as many plans have no specific measurable targets either. This lack of evaluation is one of the weaknesses of many programs, and one of the causes of ineffective and inefficient services. More serious thought should be directed to evaluation, as it is only through such exercise that one can detect weaknesses and flaws in planning to be cycled back into the system for rectification in order to obtain a better service.

It has not been my intention to touch on every aspect of health planning and development. The field is extensive, and cannot be dealt with in a few pages. Numerous references on this subject are available. What has been highlighted are merely certain important issues relevant to a pragmatic and rational approach in health planning and development.