BIBLIOGRAPHIC DATA SHEET	1. CONTROL NUMBER	2. SUBJECT CLASSIFICATION (695)
	PN-AAJ-776	NC00-0000-0000

3. TITLE AND SUBTITLE (240)

A.I.D. strategies for health management improvement

4. PERSONAL AUTHORS (100)

Rizzo, E. E.; Davidson, Alfred

5. CORPORATE AUTHORS (101)

6. DOCUMENT DATE (110)	7. NUMBER OF PAGES (120)	8. ARC NUMBER (170)
1980	51	362.1.R627a

9. REFERENCE ORGANIZATION (130)

DS/HEA

10. SUPPLEMENTARY NOTES (500)

11. ABSTRACT (950)

12. DESCRIPTORS (920)

Management
Management training
Health
Health planning
Training methods
Health facilities
Strategy
Leadership

13. PROJECT NUMBER (150)

14. CONTRACT NO.(140)

DS/HEA

15. CONTRACT TYPE (140)

16. TYPE OF DOCUMENT (160)

A.I.D. Strategies for Health Management Improvement

Prepared by: E. Edward Rizzo
Alfred Davidson

Assisted by: Monteze Snyder

DATE: September 12, 1980

CONTENTS

I. Introduction

Objective of the Study. A.I.D. requested recommendations for a program strategy in alleviating management and administrative constraints in overseas health programs. Specifically, the strategy was to identify such critical constraints, indicate opportunities to resolve such problems, survey some of the activities underway dealing with health management problems, and recommend alternative courses of action that appear feasible for a program strategy for the central technical support bureau of A.I.D.

Study Team. The study was commissioned in 1977 and was to be accomplished by two analysts with the help of a research assistant. Each person of the group was contracted separately by A.I.D. but all were to work as a team in the conduct of the study. The study request contemplated thirty work days from each member and an effort based largely in Washington, D.C., for data gathering and analysis. No trips to field activities were authorized although field documents and field personnel could be contacted for data gathering. Travel was authorized to two locations in the U.S. (Boston and Chapel Hill, North Carolina) to interview personnel in universities and contract organizations relevant to the study.

Although the study was initiated in 1977 with a completion date foreseen in that year, two circumstances beyond the control of the Office of Health and the Study Team caused an extended delay. In the fall of 1977, one of the Study Team members' consultancy was terminated as part of an A.I.D.-wide reappraisal of consultant arrangements. The work of this project was halted for a period of sixteen months until the team member was reinstated under a new arrangement to complete the study. In the meanwhile, the second team member had accepted other responsibilities in other areas so that the team could not resume work on this study until this year (1980). As a consequence of this interruption, a large part of the data was gathered in 1977, while the analysis and writing occurred in 1980. During this interval, the Technical Assistance Bureau, Office of Health, that requested the original study was reorganized into the Development Support Bureau and the key technical personnel in that office concerned with this study had left. Nonetheless, the Office of Health maintained a steadfast interest and support in the study since its inception.

Scope of Study. The study was requested largely as a backdrop to provide the Office of Health with options to pursue in supporting assistance to collaborating countries for health management improvement. A.I.D. activities in health span four major areas of health: primary health care, water and sanitation, disease control, and health planning. Since the time and resources for this project were very limited, the scope of the project was focused upon health care delivery and health planning activities of A.I.D.

A further delineation of scope was made to include all the managerial functions of planning, programming, budgeting, organizing, implementing and evaluating together with the administrative support functions for personnel, supply, equipment, disbursement, accounting, information, transport and general services. The target systems for management improvement ranged all the way from intersectoral policy and coordination devices (e.g. health councils) to public health ministries, regional, district and local health units, and community outreach workers. Included in the scope are public sector health programs in health

education, communicable and enteric disease, maternal and child health, nutrition, family planning, curative and preventive activities.

Excluded from the scope of this study are:

- Social Security and welfare organizations.
- Capital investment and construction aspects of water and sanitation.
- Disaster relief programs and management.
- Private health sector clinics, services and manpower.
- Population planning and private sector family planning.
- Private sector drug manufacturing and distribution.
- Management activities in medical schools and public health schools.
- Medical research and occupational health activities.

Definitions. One of the constraints in health management improvement that was encountered early in this study was the lack of common understanding and lack of standard nomenclature for health management. This was so in and out of A.I.D., both for interviews and some of the documentation that was studied. This is not so much a criticism of anyone but a simple fact that reflects the early stage of evolution of this particular discipline. A simple question to a respondent - What do you think are the key problems of health management in the developing countries? - would bring on varying responses depending on what the respondent thought the word "management" included or excluded. To some, management means the support functions of supply, finance, transport, personnel administration, etc. To others, management means implementation but not policy formulation and planning. For these reasons, this Report attempts to define the key terms used herein, it spells out the functions and kinds of organizations within the scope of the study and it also tries to make explicit in Part III what body of knowledge is considered to form a part of the evolving discipline of health management.

The term "management", in its simplest form, refers to the direction of activities to achieve a desired goal. A more extended definition of health management is that it is a process covering planning, organizing, directing, controlling, and coordinating resources (manpower, money, facilities, equipment, information, etc.) for activities aimed at improving the health status of the population as a whole. Health management can occur within a single organization (a clinic) or within sets of many organizations (the public sector of health). Health management is a system of roles, functions and tasks carried out by individuals at various levels within and among health organizations.

Since "management" is not an end in itself, "management improvement" refers to any increase in the effectiveness or efficiency of the organization(s) managed. An organization is more effective if it increases the degree to which it meets its objectives. This concept includes the capacity to meet equity objectives such as equitable distribution of health services to urban and rural populations as well as equity for various age, sex, and income groups. Efficiency is increased to the degree that less resources (funds, manpower, supplies, time, etc.) are used to accomplish a given output. Although the final outcome desired is improved health status of a target population, the intermediate objective of health management improvement is the increased effectiveness and efficiency of the organization(s).

For a more complete statement of what is meant by the managerial process for national health development, see the draft statement by WHO on guiding principles for such a process. (Item #62 in Reference Sources, appended.)

Approach. Although "management" is the central focus of this Report, it is not believed that management is an end in itself nor is it necessarily the most important component of the action systems utilized to enhance health. It is important to dissolve this bit of myopia about the importance of management because it can produce as many problems as inadequate management. Management systems which are too sophisticated, complex, costly, unadapted to local realities, self-serving and control-oriented rather than service-oriented can be dysfunctional.

Management systems are not like machines that can be developed, exported, installed and repaired as in a machine model. They are not static, formal rules, procedures and methods that should be standardized and taught or applied per se. Management systems do follow principles, they employ techniques and methods--but all these are organic to the living social systems in which they are embedded. That means that health management in a U.S. hospital is intimately interwoven with the values, beliefs, expectations, authority patterns, resources, time perspectives, basic training, transportation, communications, road networks, job security, social mobility, etc. of the people in the community in which that hospital is located. The same variability holds true for health management in Afghanistan, Ghana or Honduras, etc. Thus, the approach to health management in this study is not to a body of principles in the abstract but to a living sub-system of a given social system in each specific context. In medicine, diseases can be studied in the abstract, but each patient is treated as a total organism and not as a disease. Likewise, management is referred to as a body of knowledge and techniques but it must actually be applied in concrete instances with attention to the "social organism" within which the process takes place.

The approach to the study was first to attempt to find common patterns among the problems and constraints to improved health management among the developing countries collaborating with A.I.D. What are the inter-relationships among these problems, if any? What management difficulties (challenges?) are brought on by the extensions of primary health care systems? What conclusions can be drawn from these patterns for purposes of designing strategies to deal with them? Part II deals with this set of issues.

Any response by A.I.D. (or any donor) to health management problems is conditioned by the state-of-the-knowledge base concerning the evolving discipline. What are the strengths and weaknesses in the U.S.-based theories of health management? How relevant is this knowledge base? Part III deals with this question.

What are the top priority needs for expanding the existing stock of knowledge and what are some strategies for going about the task? What should be the respective roles of developing-country and U.S.-based organizations in expanding the knowledge base and how can A.I.D. assist in this process? Part IV deals with these questions.

Apart from financing and supplies, the principle instruments of A.I.D. assistance in health management take the form of technical assistance, training and education. What assumptions are commonly made in the design of technical assistance

projects and how sound are these assumptions? What are the common pitfalls of such assistance and what are the key problems? What strategies are available to A.I.D. in providing technical assistance? Part V treats these issues.

The Office of Health was especially interested in strategies to train managerial manpower, particularly the means by which a central-level effort could expand the number and quality of health managers in collaborating institutions. The analysis in Part VI approaches the question by asking: Training for what? What should be the goals and principles for training in health management? What is the comparative advantage of a training approach versus an educational approach? What are the deficiencies of each approach?

Part VII then presents training strategies for A.I.D. at the project level (discreet activities of assistance to collaborating institutions in LDC's), at the host country level, the regional level and at central level. These activities should be interdependent and mutually supportive--and the strategies suggest means to accomplish these ends.

Part VIII deals with a concept of an international network for health management meant to be supportive of the strategies at country and regional levels, and collaborative with other major donors and assistance agencies. It sketches the functions, structure, inputs and beneficiaries of such a concept to illustrate the possibilities of such a strategy for A.I.D. and the international community.

Data Base. The data utilized for this Report come from interviews with key officials in the Regional Bureaus, A.I.D. Missions, and the Development Support Bureau. Interviews were conducted with officials of PAHO, HEW, associations like the APHA, the AUPHA, private contractors such as Management Sciences for Health, the Research Triangle, and university faculty at the University of North Carolina and the Harvard School of Public Health. The list of interviews is presented in Appendix B.

A review was made of A.I.D. project plans in health sector assessments and plans, Syncrises by HEW, sector policy papers for A.I.D. and for some Regions. The official documentation on field health assistance activities was not very helpful in responding to the specific detailed issues raised in this inquiry, which is to be expected since the project documents were not written for this purpose. Since field travel was not authorized, an attempt was made to obtain answers to a questionnaire mailed to selected Health Officers in A.I.D. Missions. Only a handful of replies came back, an insufficient number to permit any generalizations on the basis of such returns.

Much of the analysis therefore turned upon a survey of the literature on the issues raised by this Report. Some very useful and cogent documents by WHO, PAHO, contractors and universities provided the data base which in many instances was broader than that available in A.I.D. and relevant to the LDC context. It was in that process of searching for data that the authors discovered the existence of much information useful to A.I.D. and the lack of a system to facilitate retrieval and access to such information. There was found a fragmentation of knowledge and efforts that could be bridged by some collaboration with obvious benefits in time, cost, effort and accelerated advancement of health management efforts.

The sources that were consulted in A.I.D. documents and literature are listed in Appendix A.

Acknowledgements. We thank all those who gave of their time and wisdom to this effort: their names are listed among those interviewed. We especially acknowledge the assistance of Mr. Irving Taylor in the Office of Health, whose support, patience and encouragement have made this time-extended Report possible.

II. Health Management Problems in L.D.C.'s

A. The problems or deficiencies in the management of health institutions in the developing countries tend to vary according to the specific institution, the particular country and the time. Problems inevitably must be defined in a specific context in order to permit any successful prescription in dealing with them. Nonetheless, it is important for the purposes of an overall A.I.D. strategy to attempt to find recurring themes in the problems of management in order to address them with a generalized approach. An intensive analysis made of the available literature, A.I.D. projects, and interviews with experienced officials reveals a common pattern of problems in most of the L.D.C. institutions dealing with health activities. The following is a synthesis of such problems.

1. Deficient Organizational Structure. There are many problems that derive from a deficient organization. There is an excessive number of institutions providing health services with little or no coordination. There is costly duplication, both of physical facilities and services, along with rising costs. There is over emphasis on centralization of authority, personnel and resources with a consequent isolation of the periphery from planning involvement and responsibility. The fragmented nature of the activities of the organizations impedes a coordination between ministries of health and ministries that may have related impacts on health, such as ministries of education, agriculture, community development, and human resources.

2. Planning, Programming, Budgeting and Financial Controls. The promise of health planning has not been fulfilled. This is due to a variety of factors including unrealistic plans, inadequate data base for planning, lack of participation in planning in the lower echelons resulting in planning from the top down without dealing with reality at the health delivery level. Plans also tend to be deficient because they do not take into account the implementation capacity of the institutions to carry them out. Planning is often done more to obtain loans, grants, and resources than to actually carry out the specific objectives. There is poor planning for setting quantifiable objectives that can be related from the top level down to the lowest operating level, as well as being deficient in establishing priorities among objectives. There are difficulties in translating plans or programs into operational projects, and executing operational budgets because they are unrealistically estimated. There also is a need for better cost accounting and cost standards by which to measure efficiency in operations.

3. Information, supervision and evaluation. These components often need extensive improvement or are lacking in their entirety. Information systems usually give an excess of data that is neither timely nor related to the actual decision-making needs of the organization. Supervision is of crucial importance yet it tends to be ineffective or inadequate for the kinds of decentralized operations that health services require. Evaluation of planning, budgeting or for progress reporting at various levels are usually deficient. Therefore, the essential feedback mechanisms are not available to enable self correcting management processes.

4. Lack of trained manpower in management. Not only is there a scaricity of this resource but the few people who have such training tend to be maldis-

tributed or not fully utilized. The manpower system is further aggravated because of low salaries, low motivation for service in public health, and difficulty in attracting highly competent people to the service. There is usually a lack of career progression and of in-service training facilities to upgrade the managerial capabilities of the staff. In Latin America it has been estimated that only fifteen percent of the health service managers have had any exposure to health management graduate education.

5. Supply and Transportation. These are deficient not only in quantity but in terms of maintenance and availability, especially to outlying units of the health infrastructures.

6. Attitudes and Behavior. The problems of management are not simply in the procedures of the organizations, but also in the attitude and behavior of the people in the organizations. There is a general rigidity and resistance to change. There are often negative attitudes toward the concepts of management. There is an inflexibility in the existing traditions and quite often conflicts of roles between professionals and non-professionals and between doctors and nurses. There is a tendency for the doctors of medicine to occupy the key executive roles without the necessary training or interest to become managers in those roles.

Although the foregoing list of deficiencies in health management is large and impressive, analysis of the problems that are brought on by extensions of health services through the primary health approach indicates an even more aggravated set of management difficulties for the developing countries. In order to understand the managerial problems implied in this trend, let us turn to an analysis of the impact of primary health care extensions.

B. Management Needs for Primary Health Care

For some years A.I.D. has been embarked on an increasing number of projects to expand primary health care for the host countries. The usual model for such systems is to expand the number of health auxiliaries, increase the number of health outposts and clinics at the periphery of the health system, give priority to the rural areas and the poor in the urban areas, and move towards further integration of the community and the non-traditional health workers into the health system of the central government. This approach puts the focus on operations at the outlying geographical areas of the government organizations. What may be underestimated in this process is the requirement for the health ministries and other public institutions to plan, organize, staff, train, supervise, supply and evaluate these extended efforts. The true management implications for health ministries by extension of the primary health services is beginning to be appreciated now by the literature, the practitioners and donor agencies.

In order to observe the true sweep of the management implications, note this statement in a W.H.O. study based on extensive analysis of actual experience in several countries:

> "Fundamental changes in health care of this kind in the developing countries will require correspondingly far reaching changes in the organizational structure and management practices of the health services. The entire health service system will need to be mobil-

> ized to strengthen and support these primary health workers by providing them with training, supervision, referral facilities and logistic support, including a simplified national health technology appropriate to their needs. Primary health services of this kind will also function in close coordination with other segments of the health services and other services that have a bearing on the health status of the masses, such as education, agriculture, public works and social welfare." (See Reference 12, page 104)

One of our respondents from the Pan American Health Organization reports from many years of observation that the rapid expansion of the primary health services is producing a revolution in the management of the health ministries. To better understand these new needs for management, let us examine, in more detail, the impact of change in primary health services at various levels of a health ministry.

At the field operational levels where the primary health care systems are being expanded, one may find the following required management innovations or changes:

1. The large increase in the number of auxiliary workers requires a definition of their roles, system of pay, training, incentives, supervision and quality control for the services they render. Frictions arise among the auxiliaries, the para-professionals, the nurses and doctors.

2. The outreach of the health services to the community brings on problems of how to organize the community itself to participate and receive these health services; problems of relations between the community and the health workers; problems of motivating the community to contribute resources to its own health care; and the need for systems providing technical assistance, financial resources and material to local communities in building the necessary facilities for health.

3. Where traditional healers are to be brought into the primary health care system, there are management problems in establishing their relationship with the more modernized health teams; the training, and if necessary, quality control over the activities of the traditional healers; and where they fit in the civil service structure.

4. The referral mechanism that links the health outposts, health centers, general hospitals and regional hospitals, in turn call for a major reorganization of the functions, authority and supervision in this pyramid of health facilities. For the key personnel with referral responsibility in a given geographic area, there is a requirement to change from clinicians to team leaders and executives. The referral mechanism requires that there be far more communication, coordination and information systems in place among the various echelons of the referral system. These systems in turn require extensive decentralization of authority from the headquarters of the ministry and extensive delegation of resources--money, manpower, and supplies.

5. The regional coordination of the health programs will also tend to require extensive coordination with other programs and institutions that impinge on the health of the community. This may involve establishing linkages among ministries of agriculture, welfare, public roads, education,

community development, social security, etc.

6. At the headquarters level there are many significant changes required in the operation of a given health ministry:

a. There is required a decentralization of authority over programs, resources and administrative functions.

b. The headquarters must develop controls for the field in programming, budgeting, personnel administration, information systems, and evaluation in order to maintain a cohesive organization dispersed geographically. Improvements are necessary in the control of supply, transportation, disbursing and general services to the field.

c. The functions of supervision increase in importance because of the extended nature of the operations. There is an increased requirement for coordination at policy and program direction levels among the various ministries and programs that have to be related in the field.

7. All of the foregoing management changes that have to do with the formal procedures and organizational structure have to be assisted by changes in behavior. The institutions find resistance to making the above changes in organizational structure and responsibilities so that institutions develop frictions and difficulties in adapting to the necessary management changes. The need becomes acute for increased managerial training to make these systems workable. Changes in attitude are necessary in the new roles for doctors, nurses, administrators and technicians because of the increased interdependence of all these professional groups and the potential for conflicts.

C. The Costa Rica Syndrome

The foregoing is just a partial list of the management needs and problems that may be confronted. In order to get a feel for the reality of the situation, it is helpful to go to a specific ministry in a given country and take a look at the problems as perceived by the top executives undergoing a fundamental expansion of their health care services. (See Reference 32)

All the top officials of the Ministry of Health in Costa Rica gathered for one week to define for themselves the key managerial problems that they faced. The list that follows was derived from a one week workshop in which all the top officials including all the technical department chiefs, heads of administrative units, and regional directors exchanged views about their key obstacles. The list is illustrative of what a ministry of health may face when it undertakes a massive program of expansion. Although the specific management problems may vary in intensity and priority according to the local situation, the Costa Rican experience nonetheless does show the magnitude and the depth of the managerial revolution brought about by the new trend in health delivery.

1. Insufficient resources -- human, physical and financial.

2. Insufficient training.

3. Lack of definition of roles for key personnel.

4. Deficient organizational structure.

5. Inadequate coordination within the sectors and among sectors of the government.

6. Lack of information feedback.

7. Lack of administrative resources.

8. Deficient human relations.

9. Lack of motivation.

10. Lack of contingency planning.

11. Lack of awareness of the communities' values regarding the acceptance of certain health services.

12. Lack of realism in programming.

13. A deficiency in the regulations stemming from the basic health law of the country.

14. Uncertainty on the part of the personnel regarding their future role and relationship with the social security health systems.

15. A failure to structure and explain the role of a national council for health.

16. A divorce between the political leadership and the technicians in the ministry of health.

17. The planning unit is unaware of the existence of certain programs in the ministry.

18. The statistical information is extemporaneous; this is related to a lack of central responsibility for health statistics at headquarters and the lack of mechanisms that permit the processing of health statistics at the regional level.

19. Political interference in the handling of personnel.

20. Lack of coordination between the department of personnel and training.

21. Evaluation mechanisms have not been formulated in any systematic form.

22. Individual idiosyncricies.

23. The common objectives of the organization are not clear nor are the supporting objectives.

24. A failure or lack of programming in the supporting administrative departments such as transportation and audiovisuals.

25. A lack of training capacity for nutritionists.

26. A lack of incentives to the personnel.

27. Deficient standards because they are developed without consultation; they are developed at the central level; they are changed too frequently; some programs have no standards, and finally the standards are not applied.

D. Conclusions

The rather long list of difficulties or management needs faced by institutions that undertake expansion of health care services poses a significant management problem for the countries and for donor agencies such as A.I.D.

The conclusions that can be drawn from the foregoing analysis can be stated as follows:

1. The managerial needs and problems in health management are broad in scope. They cover almost every aspect of the managerial process and administrative support functions. It is rare that these problems occur in just one particular activity such as planning, manpower or budgeting. The significance of this analysis is that the deficiencies usually appear as a syndrome. The deficiencies are not susceptible to treatment by improving a single function such as the planning process or the information system. This means that assistance strategies have to move from single function emphasis to a balanced management strategy.

2. The problems are not only broad in scope but they are fundamental in their nature. The management changes may require an overhaul of policies, regulations, plans, programs, budgets, manpower, procedures, methods, and behavior of those in the system. Hence, the management problems are fundamental to changes in the institutional performance. Here again, the development strategy has to deal with policy, structure and behavior in an integrated fashion.

3. Problems are not just in the primary health care echelons. As noted earlier, the management problems touch every echelon, including the regional level, headquarters, interministerial and intersectoral levels. Management improvement strategy must likewise deal with all the echelons.

4. The management problems are interdependent, both in terms of their cause and effect relationship, and in terms of improvement strategy. That is to say that the deficiencies, for example, in health statistics would not be remedied just by introducing changes in the procedures for collecting health statistics. Changes may be needed in manpower, in organizational structure, decentralization, systems of communication with the field, data processing capabilities, personnel management in terms of salaries, classification and transportation in the field. Hence, management improvement efforts require an interdependent strategy dealing with many support systems and managerial systems simultaneously.

5. Many of the management problems are rooted in the culture itself, such as behavior problems; some are rooted in the political system, such as

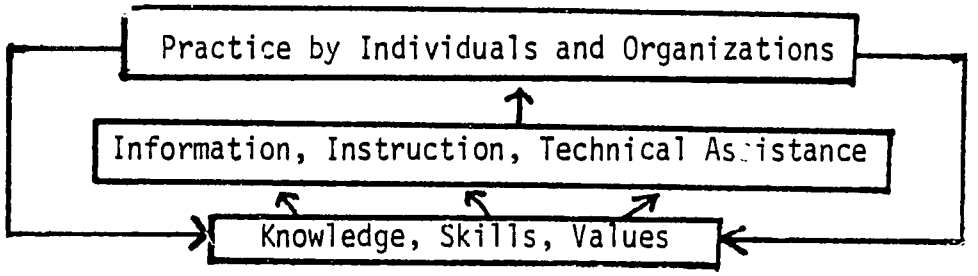
the issue of priority for health and the political will to improve the health system; and some problems are rooted in the governmental administrative systems. For example, processes for budgeting, personnel, procurement and accounting derive some of their strengths and weaknesses from the general system of government that dictates these systems. Thus, there are limits to which management improvements can go in any health system when the administration is embedded in the general systems of government. This leads later in this paper to a consideration of alternaitve strategies for separating such organizations from governmental rigidities of administration.

III. The State-of-the-Art

A. Basic Concepts

Before AID can determine how to improve health management in its host countries, it is important to know the knowledge base from which such prescriptions are made. Health management is a newly emerging discipline, largely borrowed from generic management sciences and behavioral sciences in the U.S. To begin with, this body of knowledge has two salient characteristics. It is embedded mostly in the U.S. culture and experience, and it comes mainly from non-health sectors. The U. S. is the leading contributor to the fast-growing body of theory, techniques and values in health management. For example, the International Directory of Programs and Centers for Advanced Study in Health Administration shows that 63 out of the total 133, or 47 percent of the world's centers and programs are U.S. based. The U.S. impact is felt both by its size and also because so many of the foreign faculty and directors are graduates of U.S. programs.

It is helpful to make some basic conceptual distinctions. There is a stock of knowledge, skills and values about health management. There are at least three major conduits for this knowledge, skills and values: 1) information, 2) instruction by training or education, and 3) assistance in the application of knowledge to specific situations as in technical assistance. What individuals and organizations in health management actually do may be called the state of practice. This diagram depicts these relationships.



Ideally, the stock of knowledge would be relevant to the needs and realities of health management in the LDC's, it would be available in sufficient quality and quantity, through various forms of dissemination; and actual experience in practice would be fed back to help correct the state of knowledge. This simple paradigm helps in asking some basic questions affecting strategy. Is it worthwhile to increase the number of expert consultants, and the number of training courses if the knowledge that is being transmitted through these means is either irrelevant or ineffective? Conversely, is it useful to increase the body of knowledge if the transmission systems for training, for technical assistance and publications are deficient in delivering that which is already known. Hence, strategies in health management must take into account where the deficiencies in knowledge, or its transmission may occur.

This section deals briefly with the limitations of the state of knowledge as it applies to health management for the developing countries. Before going to such an analysis, it might be helpful to set out explicitly what the content of health management theory and methods are in the United States at this time.

B. Health Management Content

A simple way to reflect the subject matter of health management is to list below the names of courses at a leading university of the United States in the field of health administration. (52) The titles for the subject matter may vary by university, by textbo ok, by practitioner, since there is no definitive nomenclature of the subject matter. Nonetheless, the list illustrates the scope, depth and variety of topics that are covered in this emerging discipline.

Health Planning and Evaluation

The structure and functions of community health organizations. The theory and methods of health planning and evaluation.

Health manpower planning.

Quantitative methods for planning and evaluating health services.

Medical Care and Facilities Administration

Introduction to health facilities administration.

Organization, financing and delivery of health services.

Health facilities planning.

Management Theory and Methods

Administrative theory applied to health services.

Quantitative and analytical methods for health administration.

Hospital administration.

Budgeting and financial management.

Personnel administration.

Health law.

Organizational Behavior of health institutions.

Interpersonal and group process skills in health administration.

Management information systems for health administrators.

Organizational pathology.

The politics of health organizations.

Organizational analysis and development.

Operations research in the health system.

Public policy analysis for health.

Population Program Administration

Population policy and process.

Population program development and administration.

Family planning program evaluation.

C. Evaluation of the State of Knowledge

The analysis of the state-of-the-art in health management revealed a paradox. A number of respondents indicated that the U.S. literature in health administration is the largest and richest in the world. Doctor Filerman of the AUPHA said that there is more health administration knowledge in the U.S. than there is in the rest of the world combined. One Latin American expert in the field said that the U.S. is the source of most of the literature and the management theory in the field. Any review of the literature in the field indicates that there is a fast growing body of techniques and theory emanating from the U.S. which has great utility in this country.

At the same time, many of our respondents (including those cited above) and international organizations with extensive experience in the developing countries point out that U.S. management theory and practices are in large part irrelevant to the culture, to the political systems, administrative systems, and to the resources available to the health institutions in the developing countries. This view was expressed not only by foreign experts but by many experienced AID technicians who said they would usually prefer to send participant trainees to some third country institution rather than study at a U.S. school for health management. These same experienced AID officers said they would prefer quite often to have expertise drawn from third countries where the management practices had been adapted to the culture and the scale of resources of the developing countries. The preponderant opinions of the people interviewed and the literature in the field leads to the following conclusions:

1. The U.S. has the richest body of theory and techniques in the field of health management.

2. This body of U.S. theory and practice is valuable for the developing world only when adapted to the specific culture, politics, institutions, and scarcities that are common to the developing countries. Until such adaptation occurs, many of the developing countries and donor agencies do not consider that the U.S. training and expertise is the most appropriate for their needs.

3. Many of the leading institutions and experts for health in the developing countries feel that they must develop their own body of knowledge adapted to their specific circumstances. However, there is a fragmented and newly emerging body of theory and techniques to meet the needs for large scale extension of primary health care and the proper management of health services for the developing countries. (51)

B. Health Management Content

A simple way to reflect the subject matter of health management is to list below the names of courses at a leading university of the United States in the field of health administration. (52) The titles for the subject matter may vary by university, by textbo ok, by practitioner, since there is no definitive nomenclature of the subject matter. Nonetheless, the list illustrates the scope, depth and variety of topics that are covered in this emerging discipline.

Health Planning and Evaluation

The structure and functions of community health organizations. The theory and methods of health planning and evaluation.

Health manpower planning.

Quantitative methods for planning and evaluating health services.

Medical Care and Facilities Administration

Introduction to health facilities administration.

Organization, financing and delivery of health services.

Health facilities planning.

Management Theory and Methods

Administrative theory applied to health services.

Quantitative and analytical methods for health administration.

Hospital administration.

Budgeting and financial management.

Personnel administration.

Health law.

Organizational Behavior of health institutions.

Interpersonal and group process skills in health administration.

Management information systems for health administrators.

Organizational pathology.

The politics of health organizations.

Organizational analysis and development.

Operations research in the health system.

Public policy analysis for health.

IV. Expanding the Knowledge Base

As indicated earlier, the knowledge base in health management is derived from that which is taught or transmitted through technical assistance. Thus, any improvement in the state of knowledge about health management should help to improve the effectiveness of training, technical assistance and practice. This section raises two questions about expanding the state of knowledge: First, what are the top priority needs for expanding the existing stock of knowledge; and second, what are some strategies for going about the task?

Let us first turn to some of the most urgent needs for increased knowledge.

A. Priority Knowledge Needs.

Professor Timothy Baker has noted, "There are few administrative and management techniques of the developed countries that can be transplanted unchanged to less developed countries with any hopes of success. Therefore, what is needed are research and development projects which will provide solutions to basic problems and pilot projects and demonstrations to adapt general solutions to differing specific situations." (Reference 6, pp 5)

The following list is by no means an exhaustive one of the potential contributions that could be made to improve the state of knowledge for the developing countries. Moreover, the list is not presented in terms of any particular priorities, but more as an attempt to identify what seems to us to be among the most significant areas for knowledge building:

1. In the field of health planning there are a number of specific issues that need to be examined and alternative solutions sought:

    a. What are the optimum mixes of community and professional inputs into health planning decisions in various systems of government? Related to this question are the difficult and sensitive issues of what authority and participation various echelons of the health system should have in the planning process. An additional question that surfaces in this issue is the degree of decentralization that is feasible for planning under various systems of government.

    b. What is the minimum data necessary to measure the cost of inputs and service outputs in health services?

    c. How can planning and budgeting be linked so that the real processes of resource allocation and authorization be utilized to implement plans? Note: In many governments the budget is not the real resource allocation mechanism.

2. There is a great need for a simple, timely, tailored information system to meet the needs for decision making in health service organizations. The system should try to collect the minimum data necessary but provide for a fuller analysis to permit decision making at various echelons in the system.

3. How to increase the effectiveness of support systems in supply, transport and communication?

a. The literature is full of techniques for inventory control and optimum maintenance schemes, but there is needed a simple, practical application of existing knowledge to LDC situations where there may be a scarcity of supplies, communication, maintenance mechanics, etc.

b. Primary health services need quick and reliable transport in order to permit both supervision and effective outreach work by the auxiliaries. Motor vehicles are often unavailable and expensive to operate and maintain. Roads are often impassible. Public transportation is not always available. There is a need for developing alternative forms of transportation that are low cost to operate and simple to maintain.

c. In rural areas, especially those with dispersed population, there is a need for communication links among remote units of health workers, supervisors and communities. There has been some experimentation with two-way radios, but their use may be limited by the initial investment required, the lack of maintenance and repair facilities. What alternative schemes could be found to make communication more effective and reliable?

4. What are the real costs of planning and management processes in relation to the outputs of services for the health system? The tendency for technical assistance and donor agencies to promote sophisticated planning, sophisticated data systems and sophisticated management processes is likely to incur a much greater cost that is feasible for the value of the service outputs in the health system. Are there any self-evaluation and self-measurement techniques available to donors and recipient institutions that would help in determining what scale of improvements in management are worthwhile?

5. How far and how rapidly can and should health services move from a clinic-based to a community-based organization? Presently most organizational models involve an outreach of clinics to the community, wherein the community is seen as the passive receiver of services. A second model involves the community to organize itself to better receive health services. The third model involves the community as the center of concern, activity and responsibility rather than the clinic and the outreach worker. In this last model, the health service provides backup technical support while the community assumes responsibility for more of its health activities such as family planning, nutrition, sanitation, clean water, health education, disease prevention, etc.(25)

6. How far can and should health services be part of an integrated regional development model wherein health services are only part of the effort at balanced social and economic development? This approach shifts emphasis from development of the health ministry to development of whatever physical infrastructure, schools, roads, income levels, jobs, transport, agriculture, housing, and so forth that the region needs. Such a model may have more positive effects on health than extension of health services.

7. What alternative models of organizing health services are there that provide public accountability and at the same time free the health organization from the inefficiency, rigidities and poor management of governmental administration? This issue is bound to become acute as public expectations for health services are frustrated by the inability of governments to deliver. This issue requires model building, action research and evaluation of comparative experience. Possible options include public corporations, autonomous agencies, public boards giving franchises in controlling private organizations that provide health services.

8. How can medical personnel be convinced to delegate more responsibility to paramedical and auxiliary personnel? This is obviously a crucial problem in moving towards the use of non-professional personnel and yet there is little that is known on how the resistance to change can be overcome.

9. How can decentralization of program and administrative functions be accomplished? This is a critical and complex issue but there is little understanding of the needs, the problems, the resistance and the alternatives by which it can be brought about.

10. How can health services become more cost effective? This is a key concern as costs rise, while needs increase and and budget competition increases.

11. There is a need to improve the management diagnostic techniques for the developing countries, and a dissemination of these techniques to host countries and AID. The management improvement efforts must really begin with an accurate definition of the problems. It is axiomatic in management as it is in medicine that good diagnosis is essential for proper treatment. The present state-of-the-art is at an early stage of development in appraisal techniques of this kind and it is often manifested in the difficulty in defining problems (finding causes not symptoms) and even in the terminology in talking about them. To meet this need there is already underway an AID contract with the AUPHA, presently under the sponsorship of the Development Administration Unit. The outputs of this research should be closely coordinated with the Health Office and Regional Bureaus so that maximum benefits may be obtained from these results.

12. A more effective and efficient strategy needs to be developed in order for organizational change to incorporate the management improvements into existing bureaucracies. The problems of how to change organizations is generic to all organizations in both developing and developed countries, but public health institutions have acute problems of change for a variety of reasons:

- medical services are considered a sensitive technology affecting lives and human welfare and hence require special caution in "disturbing" ongoing services.

- medical professionals are entrenched with key roles but may not be sympathetic nor knowledgeable of how to improve organizational performance.

- management is seen in terms of professional disciplines that may be controlled by doctors or by nurses or by dentists or by administrators or by any other specialized groups. These groups tend to resist change if they believe their roles may diminish.

- organizational change is impeded by geographic dispersion and the complexity of health services. The need for coordination within the health organizations with other institutions makes the problem of change more difficult.

- organizational change strategies too often are planned and executed by outside experts without ample participation by the persons who must live with the new systems and make them work. The consequences may be extensive reports and plans that remain on the shelf or are inadequately translated into lasting improvements.

- organizational change is often blueprinted and installed as a revised set of documents, procedures, rules, organizational structure and policies. Insufficient attention is given to the human attitudes, skills and behavioral changes necessary to make the formal systems work. Thus, it becomes important to consider the changes in leadership style, communication, coordination, motivation, acceptance of responsibility, exercise of authority, ethics, team work, etc., in producing organizational improvement. This topic is an important and potentially high payoff area for AID. There is a growing interest in more of the behavioral techniques in producing change but there has been little systematic experimental effort in a variety of cultural settings to determine how these techniques can be utilized effectively. This topic requires both experimental and pilot efforts in a variety of institutions and cultural settings to identify the methods and benefits.

B. Strategies for Expanding Management Knowledge

The techniques used for expanding the knowledge base in health management are probably as important as the substance of the knowledge itself. The temptation to approach knowledge-expansion as an academic exercise in research and development usually results in less than effective results. The strategy suggested here is based on extensive experience of both AID and the developing world which indicated that certain approaches will tend to be far more effective than others. The approaches least likely to work are those that utilize literature research rather than action research in the LDC context.

A preferred strategy would have these elements: (1) a problem-solving approach rather than theory-building, (2) develop the solutions in actual settings of the LDC's with the collaboration of a local management institution and an operating agency to bring technical and methodology aspects together, (3) an information exchange of comparative experience in other countries, and (4) assistance from the U.S. in terms of theory, methods, and problem solving to be used more as ideas to shape the research rather than a full scale transplant of U.S. techniques.

These four principles or methods of expanding the knowledge base can be translated into operation as follows:

1. AID country projects and loans should stimulate the host country and/or regional institutions related to the host country to collaborate in the

solutions of health management problems. It is not necessary to send the problem to a U.S. institution to solve here. It is preferable to give the responsibility to the host institution and then to provide for backup collaboration either by the local institutions, if they exist, or by a combination of U.S. institutions and regional institutions as appropriate. The purpose of this strategy is to stimulate a local innovation and adaptation within the total political, economic, cultural, and administrative setting of the country where the solution must be made to work. This is preferable to a transplant of inappropriate techniques from foreign countries.

2. Stimulate a working relationship between the operating health institutions and such other local institutions in the country that can provide a future backup through training, research and consultation to the local institutions. This kind of linkage assists the host country to continue to find its own solutions to its own problems rather than importing them. This normally can be done with some effort and imagination in the design of AID projects or loans, by seeking to link and incorporate local institutions in the field of health management, business administration or public administration or medical schools as the case may be. Usually there are a number of innovative individuals who are concerned about management problems of their own institutions who are eager to collaborate with the operating officials in finding better solutions. The U.S. role in such instances can be to help link up these elements within the country, and to assist them through financial means, methodology and with comparative information from abroad.

3. Combined with the foregoing two strategies, there should be a regional or U.S. based information center which can provide up-to-date data on how certain management problems have been resolved in countries with similar problems and similar settings. This kind of memory and referral system is invaluable in that it can reduce the time and the cost to the local institutions in finding appropriate solutions and at the same time it provides a stimulus to the imagination, the innovation and quite often the hope of the host country institutions in searching for solutions. Since the U.S. has the predominant proportion of health management knowledge, a U.S. based center could serve as the key referral mechanism to facilitate an information network with the LDC institutions.

4. As a back-up to this strategy of national and regional efforts, AID needs a mechanism to make a systematic collection of information and provide a referral service of the results of health management efforts, alternatives and comparative data. One of the greatest contributions that can be made at this stage is systematic information gathering and dissemination on health management questions. For example, a joint study conducted by WHO and UNICEF, concluded with the following recommendation: "WHO and UNICEF should study in detail not only the innovations described in this study, but also those that are occurring continuously in different parts of the world under different sponsorship: They should record and monitor them; learn from them; evaluate them; make their results widely available; assist them when necessary; adapt them; build upon them; and encourage similar endeavors even though some may present some risk in the sense that their favorable outcome is not clearly predictable." (12: pp 106)

In conducting this study, the authors found that much of what is going on in the way of health management improvements are scattered in random documents

and that there is no central point where this information can be gathered and distributed. A great deal is going on at WHO and expecially at PAHO, efforts that are significant and innovative, but not known to AID. There is also much ferment in developing the management of family planning programs that has applications to similar problems in health programs. If that experience were captured and made available to AID, consultants, practitioners, trainers, and host country institutions, the expansion of existing knowledge would accelerate significantly.

Rather than the usual research and development approach, the foregoing suggests a different strategy which we might call the information network strategy. This new strategy has equal utility as a back-up to the training and consulting efforts in which AID spends most of its money for health management improvement. As such, the strategy needs to be elaborated somewhat and will be touched on again in later sections of this report to identify the potential benefits of this approach.

V. Technical Assistance in Health Management

A. Untested Assumptions

Technical assistance to improve management is not a goal nor an end in itself. In the case of health, the overall goal is the upgrading and maximizing of the health status of the community in general and of individuals specifically. The purpose of assistance is to improve or change those systems which provide the desired health benefits. One of the objectives of technical assistance is change in the organizational system and the individual's performance in that system. To the extent that the organization works effectively and efficiently, technical assistance will prove successful.

In surveys of health programs in developing countries, the problems cited as most critical are those pertaining to inadequate management, failures in existing systems to address local conditions and unsuitable technology for LDC problem solving. In only a minority of instances are failures attributed to the inability of individuals to perform stated tasks. In WHO and PAHO reports, references are constantly made to irrelevant technology for solving current problems in a specific country setting.

In the transfer of technology from the technologically advanced countries to the LDC's, experience and results have shown a minimum of concentration on cultural and technological receptivity of the recipient countries.

Traditionally, the approach of U.S. managerial institutions (including AID and its contractors) has been to mobilize U.S. experts recruited from the managerial profession in private, governmental and educational institutions, in some cases focusing on narrow areas of management specialties such as logistics, personnel, finance or records management and in other cases on broader aspects of planning and organization, seldom approaching problem solving as holistic alteration of organization behavior. In providing these technical services, certain assumptions are made:

a) that health management problems have been properly defined.

b) that the health project outputs, strategy and design are correct.

c) that U.S. expertise is relevant to the project needs, the culture and the context.

d) that the body of knowledge concerning appropriate health management techniques and solutions are in fact known and relevant to the particular problem.

e) that the traditional technical assistance methodology of working on the procedures and rules and organizational structure will in fact upgrade organizational performance.

Unless A.I.D. has tested the above assumptions, it may fall into danger of mobilizing the wrong U.S. expertise to deal with the wrong problems with the wrong advice and in the wrong way. Here is a hypothetical example of what could happen by following untested assumptions: The A.I.D. Mission gets a request from the host country Ministry of Health to help it expand its rural health delivery system using paramedical and outreach workers. Since this fits an A.I.D. priority, the Mission is anxious to respond rapidly. The

usual Project Paper is formulated placing emphasis on the organization of the outpost clinics, outreach workers, the necessary training, supply and staffing of the periphery units and whatever seems necessary for a viable field operation.

To implement this project, the Mission called upon the Regional Bureau for a public health team and it stressed that the team leader should be an M.D. with proper credentials in public health, have white hair to impress the counterparts and if possible have some knowledge of the language. The project is written hastily and approved rapidly to evidence a fast response to the host. There is little time for reconnaissance and the paper is written with minimum input from the Ministry of Health - but the project design contains all the proper phrases that are likely to secure bureau approval of the project. A private firm is contracted in A.I.D./W based on RFP's. A team eventually arrives in Country to begin implementation. Now the real life problems surface.

The U.S. team and counterparts start to develop an operational plan. They learn that the health statistics they need for the two pilot field regions are too old, suspect in accuracy and incomplete. The chief of statistics apologizes but says half of his staff does not show up for work and he cannot replace them because they have political patrons. Moreover, the field units are lax in submitting data and he cannot do anything about it.

The personnel office informs them that it will take a year to get government approval of the new category of health workers, the grade and salary levels. Also, the hiring is done at headquarters and the minister himself must approve each selection.

The budget office points out that there are no funds for salaries of the new health workers and that it will take a year to have a budget approved. They cannot predict how much of their requests will be approved, so the planners don't know if they can safely plan on the 1,000 additional staff.

Similar constraints appear in transport, supply, facilities construction and maintenance. The project was well planned technically but no one had defined the problems in administrative support. Now what?

Let's leave headquarters and visit the health region, district and villages where the project is to be installed. It is always a relief to go where the action is, "where people are getting things done." At the outposts, the planning team learns that the M.D.'s are either on one-year assignments required of newly graduated physicians, or M.D.'s who put in a few hours a week away from their private practice. Neither of the two types has much interest in becoming a health team leader supervising nurses, paramedics, etc. They prefer to treat patients, not supervise people. Besides they are not sure what quality health service one can get out of auxiliary workers. The team is not surprised at this resistance but how do you go about changing attitudes, reducing friction between professionals and non-professionals, and how do you make executives of physicians? There is little in the literature that helps to solve this one.

At the Health Region headquarters, the planning team was confronted with more problems. The regional director was all for the new primary health care

concept but - how could it be run out of the capital city? She was having a rough time getting authority and funds delegated to her. Besides there was a constant fight among the technical division heads at headquarters giving her conflicting instructions and norms. There was a Rural Health Division, a Maternal and Child Health Division, a Community Health Division, and a Family Planning Division, etc. - all of whom could have overlapping jurisdictions affecting programs in her area. Her hands were tied.

The U.S. advisor had a wistful thought: wouldn't it be better to start with a new organization, one not enmeshed in this impossible government bureaucracy? Was there some new organizational model that could get going sooner and operate more efficiently than the ministry? He did not know of any - besides A.I.D. had already decided on this model and this ministry and it was his bad luck to have to make it work.

The above social science fiction is familiar to "field hands" because the problems themselves are real. The scenario could continue illustrating the pitfalls of:

- inadequate diagnoses of management obstacles partly because of the lack of experience and insufficient use of health management expertise in the diagnostic stage.

- poor diagnoses leads to faulty project design, often overlooking the key constraints that most often are in the political and administrative context within which health services operate.

- U.S. technical expertise may be exporting irrelevant experience. There is no one model that can be bought from the shelf, or from management contractors or from technical assistance missions. Most often, there is only a general body of principles and prior experience of how to adapt this knowledge to specific situations. What is really required is problem-solving capacity - rather than transplanted health management models.

- large and expensive doses of training and technical assistance when we are not sure that either of these methods produces significant improvement in organizational performance. Most technical advisors are expected to deal with management as an impersonal machine, change the roles and procedures and the forms and the employees will perform. The management diagnosis and prescription is carried out by outside experts with the common result that the plans are shelved. Organizational improvement is more effective and lasting when the outside expert is merely an input to an inside team that has political backing and detailed knowledge of the people, the institution, the culture.

B. Problems with Technical Assistance

-- The U.S. experience is not always relevant because of vast difference between the U.S. health system and the LDC situation.

-- The U.S. body of theory and techniques are the largest in the world but need adaptation to the LDC. So the transfer of this body of knowledge either through

management consultants or academic institutions is not adequate unless there is an adaptation. Some experienced AID officials and foreign officials actually prefer not to draw upon U.S. experts for this reason. Two AID Regional Health Offices expressed preference for LDC experts in this connection.

--The importance of language, cultural adaptability and inter-personal skills for successful technical assistance makes it difficult to find U.S. expertise that fits well with the host country institutions. Often the host institution accepts U.S. technicians only because they are required or paid for by AID- but not because they are the first choice of the host country. This is not always so - but often. This is not a criticism of the U.S. technicians since no one country could possibly meet all the needs of the LDC's.

-- There are too few health management technicians in AID missions - this is where the action is and that is where one or more resident technicians need to be present to help diagnose, plan and evaluate the assistance projects. This help can be by direct hire or contract but it should be resident for the reasons noted earlier, i.e., that knowledge of the local conditions is crucial for technical assistance.

While there was insufficient AID field responses to indicate any pattern of difficulties with technical assistance (only four responses), the responses of the Regional Bureau interviewees disclosed that they question reliance on the U.S.-based expertise - be it a person or a firm. There is no ready supply of qualified individuals or firms to whom the Bureaus can turn for help so they tend to work by personal referrals, e.g., "who do you know that can speak Spanish and can work on a management information system?" Despite an inadequate system of referral now relied upon by AID and other international organizations, there is a body of tested firms and individuals which have proven themselves in overseas technical consultation and assistance. These firms and individuals should be incorporated in a roster provided by some central mechanism, possibly an International Center for Health Management. (See Section VIII)

The question has been raised by a number of persons interviewed in this study as well as in the literature as to whether management can be improved in a single Ministry or Department of a Government without first improving the central services by a comprehensive management improvement program of the entire government. There is much that can be said in favor of this approach and where possible it should be undertaken as a holistic management reform. But the practical obstacles to such an approach are almost insurmountable according to a number of the technicians interviewed. Even with top level political support of the government, the reform of all ministries with vested interests and strong, sometimes hostile, personalities would make such an endeavor a very long-term if not impossible enterprise. A Ministry requesting and eager for reform is much more receptive to management improvement. In addition, experience has proven that if a management improvement program in a single Ministry proves successful, other units of a government will follow and pave the way for comprehensive change in the whole establishment. Techniques of applied management in health while common to all sectors do have unique application to the delivery of health services and are more likely to be acceptable to the practitioners of health.

C. Strategies

The basic strategies proposed for technical assistance are similar to those of training and are interdependent with them.

1. U.S. management expertise has a comparative advantage in problem-solving methodology, organizational strategy and systems concepts rather than in specific management skills and techniques based on western technologically advanced systems unless these are adapted for local use. It is not sufficient for AID to put together a stable of consultants and firms with managerial know-how. There is no assurance that they will be relevant to the LDC needs. However, there may be some individuals with the required LDC experience, language and sensitivity to provide technical assistance, but a better referral system is required than now exists.

2. Since technical assistance requires long-term continuity of effort to achieve results (some experts say 10 to 20 years for organization impact) and since the effort should not be uni-functional (emphasis on planning or supervision alone, etc.), the preferred strategy for technical assistance is to work with local entities - either within the host government, or in-country - that can provide both continuity and local adaptation of the management processes used where necessary. The U.S. technical input can be called upon for an input to such local institutions or to work collaboratively in both the technical assistance and training effort. A.I.D. should encourage more utilization of local and regional institutions such as the PAHO/Kellogg Foundation Centers and INCAE in Central and South America for technical assistance.

3. The AUPHA state-of-the-art study on management appraisal signals the potential for self-assessment instruments to be utilized by health service organizations in defining their own problems. (15) Such instruments should be developed and made available to LDC collaborating institutions, to AID project personnel, contractors and trainers to promote more self-help in management improvement.

4. One of the needed mechanisms for AID in providing technical assistance is an effective referral system together with evaluation and information retrieval to identify and fit the providers of assistance to the needs of specific recipients. Such a system should be available to all Bureaus and Missions of AID as well as to other providers of technical assistance and indeed to the recipient countries.

5. As a key to the broader strategy of technical assistance and training, an International Center for Health Management should be considered to provide a technical information network to U.S. private firms, consultants and universities. This International Center can be utilized to provide a reference pool of expertise for both the donors of technical assistance, and the LDCs. The IDHM would bring together U.S. European and LDC Institutions and individuals to focus on appropriate technologies and approaches to LDC problems and their solutions. (See Section VIII)

VI. Training for What?

A. Strategies of Organizational Change

There tends to be confusion both in concept and practice in the complex business of improving organizational performance, at a severe cost in money, time, lost opportunity for health services and in sub-utilization of the human potential in health organizations. Before dealing with training, it is important to clarify means and ends relationships in the choice of strategies for AID - namely, what is training for?

Basically, training is not a goal for AID - no more than technical assistance is a goal. What purpose do they serve? They are (or should be) instruments for upgrading organizational outputs (in this case the outputs are health services to be provided to more people and at a given quality level). Training is a strategy usually designed for individuals. Technical assistance usually emphasizes the changes in systems - the formal structure of rules and procedures within which the employees operate. Training focuses on individuals by transmitting to them knowledge, skills and attitudes that may be useful to them and perhaps to the organization - but the usual assumption is that by education or training, the organizational system will change. This rarely happens - and thus there is a great deal of controversy about the efficiency or effectiveness of management training. Actually, training health managers in ideal concepts of management and then returning them to their organizations where they are un-supported and usually frustrated leads to escape - either physical escape by leaving the job or mental escape by retreating into apathy.

Training goes wrong because it usually tries to change individuals in the abstract (theory and techniques) rather than changing the organizations' systems and the way people perform in those systems. The target for change has to be the organization - not the individual - and the target is organizational performance which in turn requires both system changes and behavioral changes developed in consonance with one another.

The key question for health management improvement in LDC's is not how do we mobilize expertise for technical assistance, nor how should we train more managers. The key question is how can we assist LDC institutions to define their management problem and make the necessary changes in systems and individual performance in an integrated fashion to bring about the desired results.

This approach does not diminish the importance of training and technical assistance. On the contrary, both processes now become far more relevant and targeted in a coordinated fashion to deal with concrete obstacles.

The foregoing exposition seeks to make clear a strategy that is often applied and found to be very effective in AID even though the reasons for its effectiveness are not understood. For example, a senior AID Health Officer in the field reported that one of the more effective methods of improving an LDC institution is to bring in a resident technician and keep him long enough so that he could help his counterparts upgrade the particular function (let us say health statistics) and train the people in its use. Please note the implicit strategy:

-- the focus is on the organization - not training.

-- the system and individual performance shortcomings are defined in operational terms, not theoretical.

-- a new system is designed with counterparts - thus helping to adapt the changes to the specific setting.

-- the employees are trained in the new procedures - to bring individual performance into consonance with the system.

-- the designers and trainees have to live with the system and the employees to help make it work. The direct and specific feedback from both people and system helps to make specific corrections in either element.

B. The Educational Strategy

A common approach for improving health management is the education of top and middle-level officials in health management. How does "education" differ from "training"? Education usually is longer term than training; it is usually in an academic setting, it usually leads to a credential such as a graduate or undergraduate degree, it emphasizes a body of knowledge rather than its application to a given setting, it tends to emphasize theory more than skills, and finally it is more for individual career development than for organizational improvement. Let us present that comparison in the form of a table showing characteristics of academic-based education and in-service training.

Characteristics of Education and Training

Education	In-Service Training
- Academic setting	- Organizational setting
- Transmits a Body of Knowledge	- Emphasizes application
- Greater emphasis in cognition	- Emphasizes job-skill
- Long-term	- Short-term
- Obtain a credential	- Improve performance
- Individual career development	- Organizational improvement
- Educate the individual	- Train the team

There is a need for both education and training approaches - but they are different in approach and in results for the organization. In appraising the rather low quality of health management in host countries, a common observation is that there is a need for more competent executives and therefore the need for

more top-level personnel to receive health management education and training. This common diagnosis leads to a common prescription: let there be more health management education and if there are not enough courses, programs and institutions providing this education, let us create more. The International Directory of Programs and Centers for Advanced Study in Health Administration shows 138 programs in the world, of which 63 are in the U.S. In Latin America there are 45 programs that have trained 12,500 graduates between 1929 and 1976. Despite an extensive, expensive and still-growing investment in that strategy, the results are usually disappointing in terms of improved organizational performance. What goes wrong? Why does such an obvious and common sense prescription not prove effective?

To our knowledge, the most extensive and penetrating analysis of health management education was conducted by the Kellog Foundation and PAHO for Latin America. (35) A study was made of 45 programs in 11 countries that provide graduate-level courses in health management. Here in brief are some of the findings:

1. There is a complete lack of connection between all aspects of the educational programs and the health delivery systems in their respective countries. No program is close to the real national health problems and there are no mechanisms to bridge this gap. It should be noted that the 45 programs are given in the following institutional settings:

   -- Schools of Public Health: many are patterned after the U.S. and most Deans are graduates of prestigious U.S. schools.

   -- Medical Schools: most of the programs were sponsored by PAHO and Kellog Foundation.

   -- National Hospital Associations.

   -- Schools of Public Administration

   -- Schools of Business Administration

   -- Specialized Institutions - one was a consortium of medical schools and the other a private corporation.

2. The faculty includes 250 full-time and 1800 part-time members, the latter usually top level practioners with executive responsibility. Despite this heavy practitioner component, there is very little feed-back from this experience to the educational programs. Most of the practitioner faculty are not graduates of the programs, and only 40 percent have had any formal training. There is "chaos" between theory and practice, although the accepted ideal is for theory to guide practice and practice to correct theory. What practice is given is the poorest portion of the educational programs. There is no apprenticeship although the graduates go to top-level positions. The preceptors are not faculty members, and know less theory than the students.

3. The faculties suffer from obsolescense of 5-20 years in their specialties and they have no training in how to teach.

4. There is a scarcity of teaching materials in all fields except medical.

Books are scarce in Spanish. There is a great need for textbooks. Libraries are inadequate or lacking, they have poor facilities, meager collections and students lack English language skills. Since 95 percent of the literature is in English, this is fatal.

5. There is a lack of research in the programs. Except for a few persons, there was no program involved in research and no policy to do so. Most programs dropped a thesis requirement for field research. Thus, the faculties do not know the problems nor the solutions to them. Even the rudiments of the scientific method are lacking.

6. There are no programs for continuing education, not even for the faculty. Thus, obsolescence is aggravated.

7. There is a lack of information dissemination among the educational programs or from the health delivery systems. There is no lateral flow within country or among countries. Not even PAHO is authorized to reveal the health systems information they gather on management diagnosis. The health management periodicals number six or seven, are irregular and poor in quality. There is a need for a clearinghouse operation on information.

During the period 1929-1976, the above programs "trained" 12,500 graduates. Despite this, 85 percent of the top level practitioners are without training and about 18 countries have no programs.

The findings of the PAHO/Kellog study are devastating! By the way, many of the Schools of Business and Public Administration in the LDC's suffer many of the same deficiencies; a most common one is teaching from U.S. textbooks, providing theory and techniques with little or no application and relevance to their own country setting. Teaching is by canned lectures, with little application and little feed-back from the practice of management in their own countries.

The findings in Latin America demonstrate the pitfall of taking an educational approach to improving health management when the education is conducted apart from the health delivery organizations. If AID follows the same strategy (i.e., let us educate more people and/or create more educational programs and institutes) it is likely to fall into the same snares. This would be true whether the programs are created in the U.S. or in the developing countries.

Please note: It is not training and education that are bad; it is their separation from the reality which they are supposed to assist that brings about their irrelevance and futility.

C. Training Deficiencies

Unfortunately, we are not aware of the existence of a penetrating and extensive analysis of training in health administration similar to that conducted by Kellog/PAHO for Latin America education in health management. However, the concern for more adequate training in health management is manifested in a WHO program on the same subject. WHO gathered a number of experts from around the world in October, 1977 to consult on such a program and in their deliberations they reported the following set of deficiencies with current management training activities. (60)

1. The existing body of knowledge and skills almost always needs translation and adaptation to make it useful and relevant to particular countries. "Moreover, many countries have unique requirements that cannot be met from existing expertise". This is a polite way to say that the training content is usually not relevant.

2. "Materials, knowledge and pedagogy have to be adapted according to whether they are being used to train upper level management personnel or operating level manpower."

3. "Just as there are difficulties in transferring health management technology from country to country and level to level, there are also difficulties in transferring to the health sector management technology from other sectors."

4. Many training activities are not aligned with the managerial needs of the health system. This is similar to the gap noted in the section on education.

5. Where training is conducted abroad, little benefit accrues "partly bacause the training may be inappropriate and partly because the personnel trained are too few to constitute the critical mass needed to make an impact..." This comment should be related to the statement earlier in this report about the "culture-bound" characteristic of much U.S. management technology. The point about the need for "critical mass" reflects one of the important strategy considerations in organizational improvement: people in organizations are usually working in inter-dependent relationships so that training one or two persons in a given function such as planning or evaluation does not change the "system" or the "teams" in the organization.

6. In some countries, the existing training system "requires substantial reorientation and recapacitation". The WHO Report does not amplify this assertion - but it implies a need for change in direction and a need for quality upgrading.

7. In some cases, there is no plan for manpower development so that those who are trained are poorly utilized. Note here the danger of separating training from the system needs. It is common to select trainees who are the least needed in the organization; if a person is urgently needed, he cannot be spared for training, yet he may be the key person for a given function.

D. Goals of Training

Before delineating strategies for training in health management, it is necessary to make explicit what overall goal training should serve and by what principles it should be guided. This section spells out these goals and principles as a foundation for the succeeding section that applies these principles for country-level, regional and AID central-level training strategies.

The goals of training should be to:

1. increase organizational effectiveness defined as providing increased health services and/or an increased clientele at a given quality level or service.

2. increase efficiency for a given level of services by reducing resources either in terms of money, or manpower, time or physical facilities.

Both technical assistance and training should be evaluated in terms of their contribution to the above goals. For example, the test of whether health planning in a ministry of health is improved is not the number of planners trained, nor the quality of the plan - though these are necessary inputs to an effective process. The criteria are the contributions of health planning to improving the organizations effectiveness and/or efficiency in the delivery of health services to the beneficiaries.

In attempting to reach the overall goals of improved organizational performance stated above, there are certain principles that will help determine the most appropriate strategies of training.

E. Principles of Training for Management Improvement

1. Because so much of management training is not related to organizational needs, a key principle is to link training to the organization thru two means: make explicit the organizational changes desired and then translate these changes into the performance desired at the job level, i.e., the knowledge, skill and attitude requirements.

2. Determine whether the performance changes can be accomplished by training or whether changes in policies, procedures and incentives are required. The determination of performance desired which can be accomplished thru training then become the training objectives. This distinction is crucial because training is not always the remedy for poor performance.

3. Training should be viewed as a systematic and continuous process to impart knowledge, skills and values relevant for individuals and groups to help meet organizational objectives. Note that training is not a one-time effort -- but a continuing process over time to help develop, maintain, correct or reinforce the desired behavior. The consequences of this principle is that a sound training strategy should enable a maximum of self-learning opportunities and continuing education linked to job requirements, preferably at the job site. This method would be more flexible, less costly, permit more simultaneous training and relate training both to individual need and job need.

4. Training should involve both a "critical mass" of the individuals necessary to make the change work (at various hierarchical levels) and a group or team focus to involve the individuals who must later work together in the organization. This principle has profound implications for the selection of trainees and their placement after training. The common practice of selecting trainees according to who can be spared most or who has the most influence in securing training would be supplanted by a conscious decision by the Health Organization to upgrade an organizational function and then taking the necessary steps to upgrade both the processes involved (rules and procedures) and the persons involved. Thus the selection of trainees, the content of training, the critical mass and the utilization of the training on-the-job are all aligned for maximum pay off to health services.

5. The above decisions should be made by the Health Organization involved and

not by trainers or advisors, although the latter may advise and assist. This principle implies that the selection of trainees, the training objectives and content is a function of the using organization and not of donors or outside institutions. Hence, training is best done in close coordination with client institutions whether it is on-the-job training or done elsewhere.

6. The training materials (texts, cases, readings, etc.) should be adapted to the culture, the health sector and the organizational needs. This principle is often violated because such materials either do not exist or have not been adapted to the training objectives of a particular organization. This is one field where AID, WHO and other donors can assist greatly in collaboration with national or regional institutions. This is a high priority and a high pay-off area since it will greatly increase the effectiveness of any training underway whether sponsored by AID or not.

7. The training methods should reflect the fact that management is a performing art and not an intellectual discipline. Thus, the transfer of knowledge is not enough; it is necessary to include practice. Methods should include role-playing, case analyses, programmed instruction, simulation, management games, field work, etc. Here again is an area in need of donor assistance to develop the materials, the methods and to help adapt these to different cultures.

8. The training program can be managed in-house by a health agency as in-service training or by an outside institution so long as the training institution is dedicated to meeting the client's training objectives. This is very difficult for outside training institutions to accomplish because it means that the faculty must tailor the content, the schedule, the hours, the setting, the methods and the practice to the particular needs of the client organization.

9. The training organizations should preferably be local institutions to permit better adaptation to local needs and culture. In order to keep training programs relevant to country needs, there are three functions that should be intimately related in the training program:

   a. Research and development to adapt the knowledge to local conditions.

   b. Consultation and technical assistance to apply and test theoretical knowledge.

   c. Dissemination of information through publications, seminars, self-learning materials as well as training. Training strategies should wherever possible link and strengthen all three of the above functions in local institutions or programs that are responsive to the needs of health agencies, provided that the economy of scale is appropriate.

VII. Training Strategies

Based on the goals and principles for training identified in the preceding section, there are a number of approaches that AID can use in training for health management. The strategies proposed are for the field project level(referring usually to technical assistance and training given to health organizations by AID Missions), the country level strategies, regional strategies and central office strategies.

A. The Bilateral Project Level

1. A central proposal of this report is that training should be viewed primarily as a prescriptive device for improving performance of health organizations rather than increasing individual knowledge, though the two can be harmonized. It follows then, that an important prerequisite to training is a sound diagnosis of what the health organization may need for upgrading its effectiveness and efficiency. AID can assist in this by several means:

   a. Help to develop methods for appraising managerial strenghs and weaknesses of health organizations, and provide expertise and information for such diagnoses. The project with AUPHA and other opportunities for field support in management assessment should be utilized to generate such methodologies. Trip reports and other technical reports of various contractors should give special attention to the methods used in the assignment and recommended changes in these methods.

   b. These appraisal methods should be utilized in developing loan programs or projects for health servicrs. Sound training begins with proper diagnosis so that this organizational appraisal is a fundamental aspect of any good training strategy.

   c. The Office of Health, The Office of Rural and Administrative Development and the Regional Bureaus should utilize the products with careful diagnosis to guide future technical assistance and training in bilateral programs.

2. Training is most effective when linked to organizational changes that top officials desire. Thus, a high payoff target is to upgrade the training intrinsic to AID projects (or loans) for health organizational changes. There is training already underway as a normal part of management improvement projects of AID. The single most cost-effective strategy would be to apply the principles suggested in this report to training as a part of AID projects in health management. Special backstop assistance could be given in tne form of specialized training advisers, appropriate training materials and adaptation to local use. This is an area where Regional Bureau and DSB backstop information and expertise could greatly increase the impact of the resources already dedicated to training.

3. Since there is more to training than a set of general principles, there should be a referral system available to AID Missions not only for training materials but specialists in management training to help in the proper design and conduct of training programs whether a part of technical assistance project or loans. Contractors for a technical assistance project may or may not have the specialized expertise to design the kind of training that avoids the common pitfalls described in this report. A high priority task of DSB and Regional Bureaus is to develop and provide this back-up for training materials and training specialists.

B. Country Level

1. The foregoing actions are aimed at strengthening the training process as a part of a management improvement effort in a health organization. This is the level where most of AID's funds are spent for technical assistance and training related to health management improvement. The second level consists of the supporting institutions in or near the host country which provide the training, research, development, consultation and information dissemination for health administration. Assistance to these supporting institutions or programs can be provided by obtaining their participation in working with the health organization's management improvement effort. The major objectives here are to assist these institutions or programs to overcome the usual deficiencies found in the Kellog/PAHO analysis cited earlier and to make their training and consultation more relevant to the real problems of the health agencies, more problem oriented and job-centered rather than conveyors of abstract knowledge. An example of this strategy was found in Nicaragua (prior to the revolution) where the AID Mission linked an excellent training institution in business administration (INCAE) to the needs of the national health ministry. The project was a developmental one for both institutions since both had to first determine the priority management needs of the ministry, translate these into manpower training objectives, and then adapt the INCAE curriculum to the specific needs of the Ministry rather than enlist trainees to attend the normal courses of INCAE. The benefit of this strategy for AID is that a capacity is created in a local institution to continue serving the clientele after the project terminates and also stimulates the adaptation of management training materials and techniques to the specific needs, language and culture of the country involved.

2. Assistance to the country-level training programs or institutions can be a good strategy even when it is not related to a specific management improvement effort in a particular health organization. For example, where a considerable training load is foreseen for a number of health organizations in the host country, and where considerable adaptation to local language, culture and administrative systems is required for any management technologies from abroad, then a fruitful strategy is to develop such a program. The basic principles to follow here are the same as noted at the beginning:

- Assure the relevance of the training by getting top health officials (both political and career levels) to participate in program development.

- Link the training program with consultation, research and development functions to help develop local adaptation of management technology, and to test it in practice and feed it back through training. The danger to avoid is importation of sophisticated Western management models which may not be workable in the local environment. Simplification, testing and adaptation of these to local realities is a major contribution of in-country management training programs.

3. Closely related to the foregoing strategy is the notion of National Centers for Health Development. This concept, currently under discussion among a number of international assistance agencies, entails networks of existing institutions, departments or schools within a given country dealing with aspects of health development such as national policies, strategies and plans, management of primary health care and related health services research. Such centers could

provide an information exchange service not only within country but serve as a conduit for information exchange from external sources. The Center could serve in an advisory capacity and training for preparing manpower for all aspects of management in health and for developing the managerial systems. It could train or assist at all levels of health management - policy, top management, technical and middle-management - and have entree within or outside the usual boundaries of the public sector health administration. Thus, the Center could help not only in bridging the public and private sectors, but also multi-sector participation in health development. If such Centers could avoid the pitfalls of isolation from the real problems and needs of the health service agencies, they provide a potentially helpful institutional buttress since they have the freedom to operate, to innovate, to provide continuity and a variety of training and organizational development services.

C. Regional Level

The term "regional" as here used is not necessarily coterminous with the geographic regions used by AID for Bureau jurisdictions. The regional concept intended refers to a number of countries who have a similarity of culture and/or health institutional needs which makes it feasible to provide training, consultation, research and development in the management of health services. Hence, a "region" can be flexibly defined in operational terms according to the area to be served.

At a "regional" level, defined in the above manner, a number of strategies can be pursued not only for training but also for consulation, research, development, and adaptation of imported management technologies. Although preference should be given to country-level institutions, there are time where the economy of scale and scarce resources make it advantageous to work through regional level programs or institutions in providing the kind of support noted above. What are some of the activities where regional effort may be supportive of country-level effort and at the same time more economical?

-- Training for advanced management and for certain specialties where the number to be trained in any one country may not be large enough to warrant a sustained program.

-- Action research and development or adaption of management techniques suitable to the specific region. A regional program may have access to a larger number of institutions and situations from which to draw experience and lessons. Since qualified researchers and developers of management approaches are scarce and expensive to train, there is a comparative advantage to a regional approach.

--Develop and adapt training materials to the language, culture and sector problems of the region. These materials can be used not only for its own programs but also for the collaborating country institutions or programs. Thus the regional effort can speed up the laborious task of adapting training materials for a number of country programs in its area of influence.

-- Develop and disseminate self-learning materials for the region to facilitate self instruction and continuing education programs in the area.

-- Provide a technical information service for some of the material from outside the region, especially by translating and sifting relevant material for the region. Serve also as a clearinghouse for relevant data and experience within the region.

-- Give technical assistance in health management to collaborating countries. This direct experience by faculty and associates serves to bridge the theory - practice gap to the benefit of both.

-- Help develop and upgrade in-country programs and institutions of health management training. Since most training will continue to be given to the country level, anything that upgrades that activity has a great multiplier effect.

The PAHO/Kellogg Foundation strategy for health education in Latin America is a combination of the regional level and country level approach. The plan is to attempt a massive, non-traditional approach to training health managers and trainers through an advance training network. There will be two Centers in Brazil (Rio and Soa Paolo), one each in colombia, Mexico, Central America (Costa Rica) and Chile. The Centers will actually be new programs based on consortia among several organizations in each locale. To help bridge the separations among health sciences and management sciences, between practice and teaching, the model calls for participation in the Center by a health service operation, a health science institution such as a Medical School and a management institution such as a School of Business or Public Administration. The Center Network programs are to be heavy in research, continuing education, information dissemination and offer a Master's level core program of education. This approach should be monitored by AID to determine its utility and also as a possible resource for training and technical assistance in the region. The experience also provides possible models for country-level and regional level centers or networks that could be applied in other regions.

D. Central Bureau Level

What training strategies would be appropriate at the level of the Development Support Bureau? Since the most cost-effective training in health management is one that links training as an integral part of organizational system improvement, it follows that whatever is done to assist that process is the best pay-off strategy. The Development Support Bureau (DSB) contributions could be as follows:

1. Organizational Development and Training. The primary objective is to validate and demonstrate the benefits from such an integral approach to training in actual field conditions. There may already be one or more such activities in developing countries - either underway or contemplated - under the aegis of AID, or other institutions. Such experiences need to be identified - or projects created for this purpose - in order to obtain the following outputs:

a. A body of tested methodology and the training content used for the development of health organization.

b. A group of persons capable of providing technical assistance to those interested in such an approach.

c. A field demonstration site and hopefully a laboratory for further development and testing of management development and training approaches.

The DSB could conduct the above development either in concert with a Country Mission and/or a Regional Bureau or in collaboration with other international agencies (WHO, IDB, World Bank, etc.).

The follow-on stage is one of dissemination by providing a service mechanism to other interested intitutions. This can be done by making available the methodology, training content and technical assistance for adaptation. One way to do this is to find an organization(s) to do both the development and also to serve as the service mechanism for the extension of such techniques elsewhere.

2. Country and Regional Health Management Networks. The Development Support Bureau can undertake three kinds of assistance with regard to the crucial infrastructure for training, research and consultancy in health management in the developing countries: report on what is being done, identify resources for AID Missions and Bureaus and finance services to such networks through a central mechanism herein called an International Center for Health Management. These three approaches are elaborated below.

a. Missions and Bureaus will benefit from reports on the actual experience with such national networks, their potential for assisting host country and AID projects and possibilities for initiating similar efforts in their host countries. For example, the five advanced training centers planned by PAHO/Kellogg for Latin America should be closely tracked for possible utilization by AID Missions in Latin America and possible adaptation elsewhere.

b. As experience is accumulated, Missions and Bureaus will need information on available resources, expertise, demonstration models and documentation for possible utilization in their respective areas. The Office of Health can help identify such resources -- not just for the planning of such projects, but also for organizing, training, or evaluation assistance.

c. National or Regional networks or Centers will benefit from a variety of inputs from abroad: training materials for local adaptation, document exchange, curriculum development, teaching methods, audio-visual aids, library materials, faculty development, etc. A means of providing this technical collaboration would be through a U.S. based network center calling upon the great diversity of resources in schools, associations, government agencies, in-service training centers, libraries, consulting firms, etc., available in the U.S. Such a Center could also tap resources in other developed countries (a number of relevant organizations in Europe), tap resources in other international organizations and in orther developing countries. The Office of Health could establish such a Center with core financing and then supporting services to Missions, Bureaus or other users could be financed by them as required.

3. Alternatives. The preceding two strategies are considered to be the most cost-effective for AID because they move training assistance first to the national institutions that are responsible for health services and second to those supporting institutions at national or regional levels that will directly provide the training, advice and research for health management. Alternative approaches such as expanding training capacity of U.S. based institutions, or conducting increased training and education in the U.S. is not proposed because of the relevancy issue discussed earlier, the need for local adaptation of training content and the higher cost required for massive training of teams from any given health organization.

Expansion of training in single functions such as planning or logistics or financial management or statistics, etc. is not proposed because of the syndrome noted earlier under problem analysis: namely, that the management problems and training needs usually are inter-related covering many if not most of the managerial functions. Thus, a strategy that increases training of any single function -- even policy analysis and planning -- is not likely to produce effective and efficient health organizations so much as a balanced response to the organizational deficiencies.

Direct use of U.S. training materials, curriculum, cases, etc. are also not proposed because of the need to adapt these inputs to the local problems, culture and administrative realities of the various countries. Hence, U.S. materials are only inputs to local training institutions and not outputs.

VIII. International Network for Health Management

At several points in this report, reference has been made to the need for some central location where AID and other interested parties can go for information, documentation, referral services for technical assistance and training related to health management in the developing countries. When dealing with expansion of the knowledge base in Section IV, for example, it was suggested that there is a need for a systematic collection of information and referral services regarding the results of health management improvement efforts, alternatives, and comparative data. These data must go beyond the scope of AID projects because most of such experience is outside of AID and scattered throughout the world. Such data also goes beyond the comparative data collected by the APHA International Health Division for its low-cost health delivery system since information is needed about management at the regional, ministerial and sectoral level as well as the primary health care level.

Although reference to some central network for health management has been made in several parts of the Report, it may be helpful to elaborate the concept in a more complete manner. It is not the intention herein to present a plan or program for such a mechanism, but it may be possible to identify the kinds of functions such an entity could perform and some possible approaches to its design.

A. Functions

1. Compilation and dissemination of health management information relevant to LDC's on:

- Research in health management.
- Health management development projects underway.
- Training and self-learning materials.
- Management theories, techniques and applications.
- Organizational development theories, experiences and techniques.
- Organizations and individuals providing technical assistance.
- Health sector institutional management approaches.
- Management appraisal methodologies and applicantions.
- Organizational models for various health activities.
- Management systems for supply, transport, information, supervision, evaluation, etc.

2. Provide referral services and/or contracting for services in health management.

3. Promote standard nomenclautre in health management and quidelines for health management systems.

4. Publish materials of interest to health management.

5. Establish communication links with training and assistance and research institutions for health management in the U.S., Europe and developing countries.

B. Beneficiaries. Those who use the services of such a Center could include AID/W, AID Missions, contractors and individuals employed by AID, institutions collaborating with AID in the U.S. and in host countries. In addition - other users could include:

Donors: World Bank, IDB, Foundations, and other governments.

Private Sector: Schools, practitioners, libraries, voluntary organizations, consultants, private firms, etc. in this country and abroad.

Government Agencies: HHS, State Governments, Foreign Governments to include Ministries of Health, regional and local governmental bodies.

International Bodies: WHO, Church Associations, Associations in Management, Health and Training, U.N. activities, Population and Family Planning Groups, Regional Development Banks in various parts of the world.

C. Structure: The Center should consist of a very small core of permanent staff who can draw upon the resources of the larger community of organizations and individuals, according to the task. The Center could be a unit within an existing organization or set up independently but dependent on a larger body for administrative services and facilities. Some of the functions enumerated above are already being performed in part by a number of U.S. organizations: APHA, AUPHA, National Council for International Health, WHO, the Development Project Management Center, the Center for Educational Development in Health, etc. The Center need not duplicate any services now available but simply refer others to them. Hence, the Center has a catalytic role reaching out to all organizations. It should not be a major organization involved in providing services in management training, research or management assistance in order to avoid conflicts of interest.

D. Sponsors. The Center could be sponsored and financed by more than one organization. For example, the major donors in the health field could either sponsor or finance the core operation -- AID, World Bank, the IDB, Kellogg Foundation, etc. Others could be major subscribers for the services - such as WHO, universities, government agencies, etc. - to assure a stable financial base.

E. Financing. The core staff and expenses could be shared by the sponsors while expansion beyond the core could come from users of the services as demand grows. AID financing, for example, could stipulate that information services to AID and collaborating host country organizations would be provided without charge, but that other services would be paid for by the specific Mission or Bureau requesting such services.

F. Location. The Center site could well be the Washington, D.C. area since Washington is a communications hub for the free world and already has a number international headquarters in the area (PAHO, World Bank, IDB) and a number of national headquarters for health related associations (APHA, NCIH, AUPHA). Moreover, the Washington area provides easy access to great stocks of knowledge in medical libraries, management sciences, health science, etc.

The foregoing design is obviously only an example of what a Center could be since its actual design would require consulatation with a number of potential users and sponsors and a studied plan for its creation and operation. This hypothetical sketch of the concept does serve to demonstrate the potential benefits to donors and users alike of accelerating health management improvements in the developing countries.

A5

Reference Sources

1. APHA. Proposal for Development and Evaluation of the Integrated Delivery Systems, "PEIDS" in Ecuador. March 12, 1974.

2. American Public Health Association, Barry Karlin, Project Director. APHA Summary: The State of the Art of Delivering Health to Less Developed Countries (draft). American Public Health Association, September, 1976.

3. Association of University Programs in Health Administration. AUPHA Faculty Directory. AUPHA, March, 1977.

4. AUPHA. Proposal for Development of an Evaluation System for the Ministry of Health of the Republic of Panama. April, 1974.

5. Association of University Programs in Health Administration. The International Directory of Graduate and Undergraduate Programs and Centers for Advanced Study on Health Administration. Washington, D.C.: 1975-1976.

6. Baker, Timothy. "Managerial Barriers to Better Health in the LDCs: A Challenge for U.S. Technical Cooperation ." Johns Hopkins University, Department of International Health -- School of Hygiene and Public Health.

7. Beckles, Frank N. Haiti Health Sector Analysis. U.S.A.I.D., 1975.

8. Blanpain, Jan E. Report on the Implications of Multiple Unit Hospital Systems for Health Management Education and Health Services Research. U.S. Department of Health, Education and Welfare, August 27 - September 24, 1977.

9. Blase, Melvin. Institution Building: A Source Book. Washington, D.C.: Department of State, U.S. Agency for International Development. Contract No. AID/csd 3392.

10. Bryant, Coralie. Participation, Planning, and Administration Development in Urban Development Programs. USAID, February, 1976.

11. Central Treaty Organization. Symposium on Management Training in Public Administration. Lahore, Pakistan: CENTO, January 6-11, 1964.

12. Djukanovic and E.P. Mach (editors). "Alternative Approaches to Meeting Basic Health Needs in Developing Countries." UNICEF and WHO Study, Geneva, 1975.

13. Eason, John C. et. al. Feasibility Study Rural Health Service Delivery Service. CAR. AID, December 1975.

14. Edwards, Charles P. Development Administration -- A systems approach for "organization and management" -- implications for the Management Services Center. June, 1971. USAID.

15. Emrey, Wilson-Scott, Bernhart, Fallow. "New Methods for Assessing Developing Country Health Services Management Needs." AUPHA, July, 1979.

16. England, Roger. "More Myths in International Health Planning." AJPH, 68:2, pages 153-165. February, 1978.

17. Filerman, Gary L. "What Can We Learn from the International Health Experience?" Hospital Health Services Administration. Fall, 1977, 6-23.

18. Family Health Care. Planning for Health and Development: A Strategic Perspective for Technical Cooperation. Volume 1, Washington, D.C. September, 1979.

19. Gish, Oscar. Guidelines for Health Planners, pages 21-22.

20. Gish, Oscar, et. al. A Review of the Health Sector of Lesotho. APHA, September 29 - November 8, 1975.

21. Hanlon, John and Alfred Davidson. Report and Recommendations Regarding the Administration, Organization and Management of the Department of Health of Ghana. USAID, June 1973.

22. Heegaard, Fleming and Malcolm J. Odell. Toward Developing a Methodology for Combining Action, Research, and Participation in the Management of Family Planning Programs. Storrs, Connecticut: Conn. LL, 1974.

23. Howard, Lee M. United States Policy and Programs on International Health as Related to Development Assistance, Draft #2, Washington, D.C.: Office of Health, Development Support Bureau, Agency for International Development February 1, 1978.

24. Institute of Medicine. Strengthening U.S. Programs to Improve Health in Developing Countries. National Academy of Sciences, April, 1978.

25. Korten, David C. "Management Issues in the Organization and Delivery of Family Planning Services: International Perspective." Harvard University Unpublished Paper. October, 1976.

26. Koteen, Jack. Management Capability in Agricultural Development; Action Programs and Work Plan. February, 1971.

27. Kuhl, Ingrid. The Executive Role in Health Service Delivery Organizations. Washington, D.C.: Association of University Programs in Health Administration, August, 1977.

28. Lederer, A.M. World Program for Development of Human and National Resources Through Managerial Action.

29. Loomis, Scott A. and Karen Cox. Comparative Analysis of Health Manpower Issues in Latin America. Office of International Health, Department of Health, Education, and Welfare. April, 1977.

30. Management Sciences for Health. Implementing a National Rural Health System: Management Experiences from Afghanistan. Management Sciences for Health. 1979.

31. Management Sciences for Health. Problem Action Guidelines for Basic Health Care: A Tool for Extending Effective Services Through Auxiliary Health Workers. Cambridge, Massachusetts: Management Science for Health, 1974.

32. Ministry of Health, Costa Rica. "Workshop on Organizational Development" San Jose, Costa Rica: February, 1977. (Unpublished document — Spanish)

33. Palmer, George R. "Postgraduate Education for Health Administration: the U.S. Experience." AUPHA, Washington, D.C., January, 1978.

34. PAHO. Extension of Health Service Coverage Using Primary Care and Community Participation Strategies: IV Strategies: IV Meeting-of Ministers of Health of the Americas. Washington, D.C.: PAHO, September 26-27, 1977.

35. PAHO. "Study of 44 Programs in Health Administration Education." Working Paper (Spanish). Washington, D.C., July 1977.

36. PCI. The Management Improvement Program of Nicaragua's Ministry of Public Health September 1976 - April 1975. (A Final Report). June 18, 1976.

37. Pumpus, Eva J., et. al. Health Sector Assessment for the Dominican Republic. U.S. Agency for International Development, February 19, 1975.

38. Reed, Allan. Low Cost Health Delivery Systems: Where Have We Been and Where Are We Going? (memorandum). U.S. Agency for International Development, TA/DA, September 30, 1977.

39. Reinke, William A. "Research Issues in Management." (memorandum). September 15, 1977.

40. Roemer, Milton. Evaluation of Community Health Centres. Geneva: World Health Organization, 1972.

41. Stifel, Lawrence D., Joseph E. Blade, and James S. Coleman. Education and Training for Public Sector Management in Developing Countries. New York: The Rockefeller Foundation, March, 1977.

42. Storms, Doris. Training and Use of Auxiliary Health Workers: Lessons from Developing Countries. APHA Monograph Series, No. 3, 1979.

43. United Nations. Report of the Interregional Seminar on the Development of a Senior Administrators in the Public Service of Developing Countries. Volume II, Country Papers, Geneva: August 19-29, 1968. (Publication No. CHRA) 76-638.

44. U.S. Agency for International Development. Highlights of Agency Health Programs Up to FY 1979. Mimeograph, Agency for International Development (no date).

45. U.S. Agency for International Development. Report of the A.I.D. Work Group on Management Improvement and Development Administration. U.S.A.I.D., Washington, D.C.: August 11, 1975.

46. U.S. Agency for International Development/Bolivia. Bolivia: Health Sector Assessment. U.S.A.I.D., January, 1974.

47. U.S. Agency for International Development/Colombia. 1974 Colombian Health Sector Analysis. U.S.A.I.D., May, 1974.

48. U.S. Agency for International Development/Nicaragua. Nicaragua Health Sector Analysis. U.S.A.I.D., 1976.

49. U.S. Department of Health, Education and Welfare. Health Services Systems in the European Economic Community. Washington, D.C.: DHEW, (DHEW Publication No. CHRA) 76-638.

50. U.S. Indian Health Service. Consolidated Training Program for Tribal Health Program Administrators and Tribal Health Planners. Tuscon, Arizona: Indian Health Service (undated).

51. University of Hawaii. "Management of Primary Health Care in Developing Countries" Annotated Bibliography. Health Manpower Development Staff, School of Medicine, University of Hawaii, October, 1979.

52. University of North Carolina. "Teaching Population Program Management" Chapel Hill, North Carolina: International Faculty Workshop, March 1975.

53. Vachrotai, Somboon and Ronald G. Wilson. New Horizons for Integrated Health Services and Primary Care in Thailand: The Lampang Development Project. Presented at the Second Annual Review Lampang Project, December 12, 1976.

54. Walsh, John E. Guidelines for Management Consultants in Asia. Asian Productivity Organization. 1973.

55. Weaver, Jerry. Conflict and Control in Health Care Administration. Beverly Hills: Sage Publications, 1975.

56. Westinghouse Health Systems. National Health Planning Jordan Phase II: Health Policy Strategy. U.S. Agency for International Development, February 3, 1977.

57. World Bank. Health Policy Paper. Washington, D.C. 19

58. World Health Organization. The Development of Studies in Health Manpower. Geneva: WHO Technical Report Series No. 481, 1971.

59. World Health Organization. Guiding Principles for the Managerial Process for National Health Development. (Draft Paper, May 30, 1980).

60. World Health Organization. "International Programme for Training in Health Management." Geneva: October, 1977.

61. World Health Organization. Modern Management Methods and the Organization of Health Services. Public Health Papers No. 55, Geneva: World Health Organization, 1974.

62. World Health Organization. Organization of Local and Intermediate Health Administration. Geneva: WHO Technical Reports No. 499, 1972.

63. World Health Organization. Personal Health Care and Social Security: Report of a Joint ILO/WHO Committee. Geneva: WHO Technical Report Series, NO. 480, 1971.

64. World Health Organization. Planning of Public Health Services: Fourth Report of

the Expert Committee on Public Health Administration. Geneva: World Health Organization, 1961. WHO Technical Report Series, No. 215.

65. World Health Organization. Special Courses for National Staff with Higher Administrative Responsibilities in the Health Services. Geneva: WHO Technical Report Series No. 311, 1965.

66. World Health Organization. Training in National Health Planning. Geneva: WHO Technical Report Series No. 456, 1970.

Appendix B

PERSONS INTERVIEWED

AGENCY FOR INTERNATIONAL DEVELOPMENT

Latin America Bureau
- John Daly
- William Feldman
- Barbara Sandoval

Africa Bureau
- Ed Cross
- J. Fine
- Edward Parfrey
- Julius Prince

Asia Bureau
- James Brady
- Isaiah Jackson
- Don MacCorquodale

Office of Health
- Joe Davis
- Irving Taylor

Office of Population
- Willard Boynton
- Gerald Winfield

Office of Rural Development
- Kenneth Kornher
- J. Weaver

AID/Cameroon
- Al Henn

AID/Liberia (contractor)
- J. Kontos

AMERICAN PUBLIC HEALTH ASSOCIATION
- Herbert Dalmat

AMERICAN UNIVERSITIES FOR PUBLIC HEALTH ADMINISTRATION
- Robert Emrey
- Gary Filerman

GEORGE WASHINGTON UNIVERSITY
- Olajide Agbede
- Bertley Barrow
- Jack Millar
- Linda Parent
- Ignatius Obrapi

HARVARD UNIVERSITY
- Steven Joseph
- David Korten
- Kocha Kotel

JOHNS HOPKINS UNIVERSITY
- Timothy Baker
- William Reinke

MANAGEMENT SCIENCES FOR HEALTH
- J. Lambskin
- Ronald O'Connor
- J. Warner

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of International Health
- Ken Farr

OFFICE OF HEALTH RESOURCES
- J. McCarthy

PAN AMERICAN HEALTH ORGANIZATION (PAHO)
- Mangel Bobenreith
- Miguel Segovia
- Charles Williams

PRACTICAL CONCEPTS, INCORPORATED (P.C.I.)
- Michael Dalmat

RESEARCH TRIANGLE (N.C.)
- Ray Iseley
- R. Wakeley

UNIVERSITY OF DUBLIN - SCHOOL OF PUBLIC HEALTH (IRELAND)
- Colm O'Nuallain

UNIVERSITY OF LOUVAIN (BELGIUM)
- Jan Blainpan

UNIVERSITY OF NORTH CAROLINA
- Sagar Jain

UNIVERSITY OF PITTSBURGH
- John Cutler

WESTINGHOUSE HEALTH UNIT
- Mike Reardon

BLANK PAGE