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I. Health Planning Situation

The Agency for International Development, (AID) currently is attempting to assist lesser developed countries improve the health of their poorest populations. These countries face a difficult task in accomplishing this objective due to several reasons. Much of the technology currently utilized in the health sector was developed to meet the health situation in richer countries. Many of the health personnel were trained to address other problems than those which exist in the populations most requiring health services. Due to these factors resources are allocated to central facilities and sophisticated personnel. There is no strong health professional constituency to support programs oriented toward health problems affecting the poor. There is inadequate understanding of the health technology required to improve health problems caused by poverty, lack of knowledge, and harsh environmental conditions. There is frequently no mechanism whereby the demands of the poorest can influence decision making and normally such demands emulate the inappropriate services provided to currently franchised populations.

Health planning, although it may well be equal to or superior to that of most developed countries, has had little impact. No engineer would think of building a dam without taking core samples for soil characteristics, design a road network without estimating how many vehicles are expected to go where, or design a factory without carefully calculating the equipment and supplies required to produce a particular product. Almost all similar decisions in the health sector are made without analysis of what is to be produced, for whom and at what cost.

Decision making in the health sector is normally based on the knowledge, experience and intuition of a few individuals without access to adequate information or staff assistance to make studied decisions. Ordinarily, little information feedback is built into health system design. The health sector, for the most part, remains victim of the limits of training and interest of physicians rather than systematically approach the problems of the poor.

Most individuals or organizations who have tried to improve this situation have seriously underestimated the inertia of the health sector.

The problems of attempting to introduce multisectoral planning concepts are even more difficult, although it is obvious that real improvements in health will come from improvements in other sectors than health.

In summary, the development programs which will improve the health of poorest populations in lesser developed countries require radical changes from current health program configuration. The possibility of such changes depends to a considerable extent, on the adequacy of the planning undertaken.

The major planning tasks, therefore, that the Agency sees as being requisite to its being able to assist LDC governments introduce appropriate innovations into the health sector are: 1) The identification of program configurations and mixes which most efficiently address the health problems within the resource constraints of a country; and 2) The development of a national constituency committed to support the proposed program.

The Agency has attempted to utilize some of the techniques and processes which have proven successful in other sectors.

II. Agency Approach

Ordinarily the preferable way to address the planning problems outlined above would be to invest in training health planners and to build up an improved planning capability over a few years. This approach, however, is not compatible with the urgency with which health problems require redress. What we have opted to do instead is: 1) To utilize the products of current national planning capability to try to plan as appropriate projects as is possible; 2) To demonstrate that the Agency feels planning is important by patterning our assistance according to the results of a collaborative planning effort; and 3) To concurrently improve national health planning capability by provision of guidelines and technical assistance. The process whereby these objectives are pursued is called health sector assessment. Health sector assessments as outlined in this paper, are collaborative analytical endeavors pragmatically structured in each country and fairly short term, lasting only about 12 months.

III. Priorities for Health Sector Assessment

It is a large task to analyze even superficially the health sector of a nation. Even our largest efforts which subsumed about 40 man years of effort each were unable to do anything like a comprehensive in-depth look at many aspects of the health sector. Priorities must be programmatically established.

The problems of setting up priorities for the content of a collaborative health sector assessment must be vigorously addressed if a focus on the most important issues is to be accomplished. In planning the assessment, choices must be made between both alternative problem areas and the type of information gathering and analysis activities to be applied to a given problem area.

A principal focus of the assessment must be on planning for the poor majority. The assessment must address the problems and alternative measures suited to the target groups of infants, children and pregnant and lactating women. The assessment must attempt to identify least-cost alternatives mitigating the health problems of the target groups. (These alternatives should include private commercial and/or indigenous sectors as they can be used in conjunction with public sector programs.)

The priority problems areas should be chosen from among: (1) major health problems of the poor as indicated by available data on morbidity and mortality, LDC interests, and AID program objectives; (2) the subset of those problems for which technological alternatives exist; and (3) the still smaller subset which are likely to be socially and politically feasible.

Once the problem areas are defined where scope exists for influencing policy, the following generic types of information must be considered:

- A. The identification of health problems which affect the poor majority;
- B. Social, economic and behavioral determinants of health status;
- C. Specification of potential health programs;

- D. The relationship of health problems and programs with the problems and programs of other sectors of the economy;
- E. Resources available and their costs;
- F. The resources required to produce units of health services or other health programs;
- G. The impact of health programs on health status; and
- H. The impact of health programs on population growth.

Experience to date indicates that generally, little additional effort is required in the areas of information on health status or identification of government priorities. The point is an important one to make because normally health planning activities get so bogged down in collecting information on magnitude of health problems that they never progress beyond this point.

Ordinarily, however, considerable attention should go to gathering information concerning the social, economic and environmental causes of poor health; new data may be required to elucidate these relationships. The area of social and cultural perceptions of health problems should be addressed vigorously if viable strategies are to result from the assessment process.

Most assessments have tended to concentrate on the economics of choices between program alternatives because of the historic dearth of information on the economics of production of health services, or the impact of programs on health status. This is also the area where assessment-like activities of other organizations are weakest.

Assessments have also concentrated on administrative capacity of health institutions. This concentration partly reflects the significant

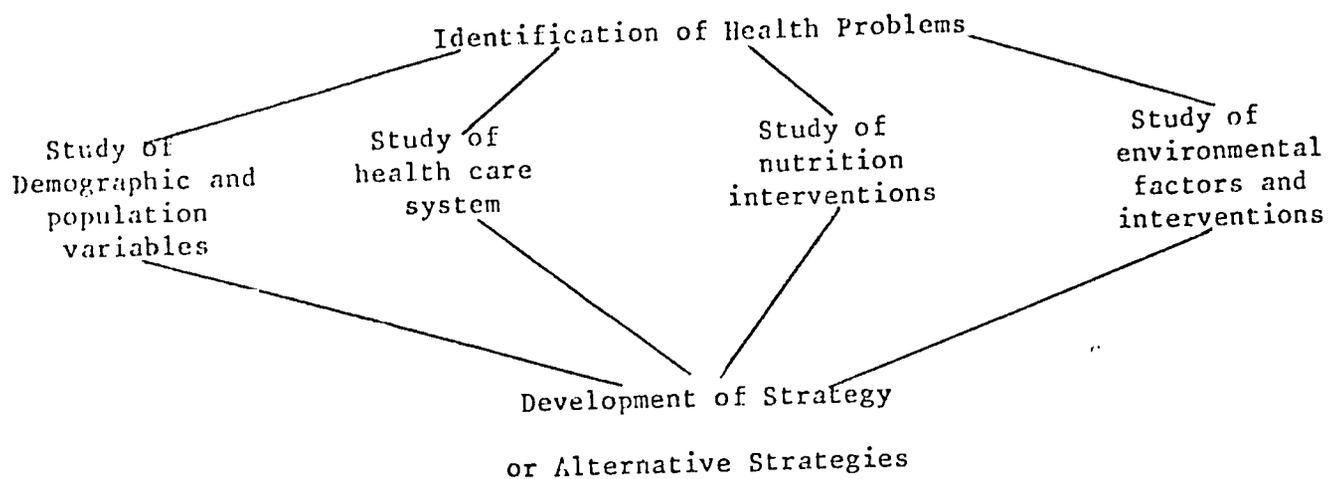
gains of efficiency that can be made in health services in LDCs through improved management. Assessments must provide AID with knowledge of the capacity of host institutions to manage the financial and other inputs from foreign assistance.

A related need is that of choosing between the various data sources or data gathering activities to be utilized. Choices have to be made between (1) existing data, (2) expert judgement estimates, or (3) collection of new data. Normally some new data gathering activities are incorporated into health sector assessments.

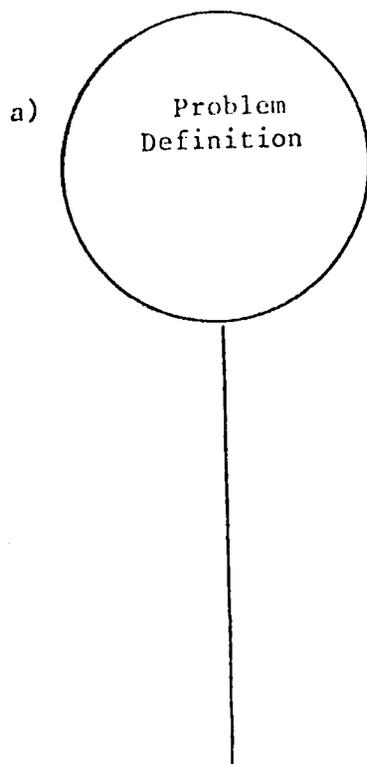
IV. General Content and Organization of Health Sector Assessments

1. Health sector assessments should be structured in such a way as to:
 - A. Accurately identify national health policies and health problems of the population and their causes;
 - B. Estimate the resources available to the nation and to address health problems - considering both community and government resources;
 - C. Identify and study administrative solutions to health problems;
 - D. Identify and study administrative and other infrastructure bottlenecks to the improvement of health; and
 - E. Synthesize the proceeding stages to develop a health sector strategy or alternative strategies.

2. Operationally many of the above steps are accomplished in a parallel fashion as shown below:



3. Each programmatic area diagrammed above in the assessment should be analyzed, taking into consideration the conceptual elements identified in the following outline:



1) determination of relative magnitude of

b)

Analysis
of National
Policy

- 2) description of epidemiological, social, economic and cultural causes of health problems;
- 3) description of social and cultural perceptions of health problems by the population and health care providers;
- 4) identification of factors to be modified in order to ameliorate health problems.

- 1) identification of national policy objectives which influence health problems and interventions to solve problems;
- 2) description of decision making process in health, analysis of factors which have influenced health sector decisions;
- 3) description of bureaucratic processes and their effect on implementation of health sector programs.

c)

Evaluation of Existing Programs

- 1) description of current programs to impact on health problems;
- 2) evaluation of impact of program activities;
- 3) identification of population affected;
- 4) identification of resources available and utilized;
- 5) identification of bottlenecks to improving services ;
- 6) description of social and cultural acceptability of existing programs;
- 7) identification of probable impacts of program activities on the target populations.

d)

Identification of new Technologies

- 1) identification of new technical alternatives;
- 2) description of probable program activities, resources and costs;
- 3) prediction of social and cultural acceptability of proposed new program alternatives;

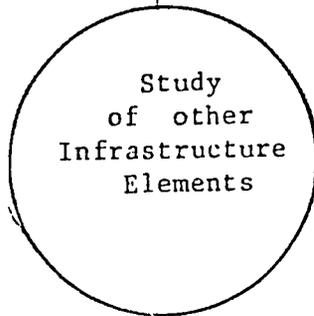
e)



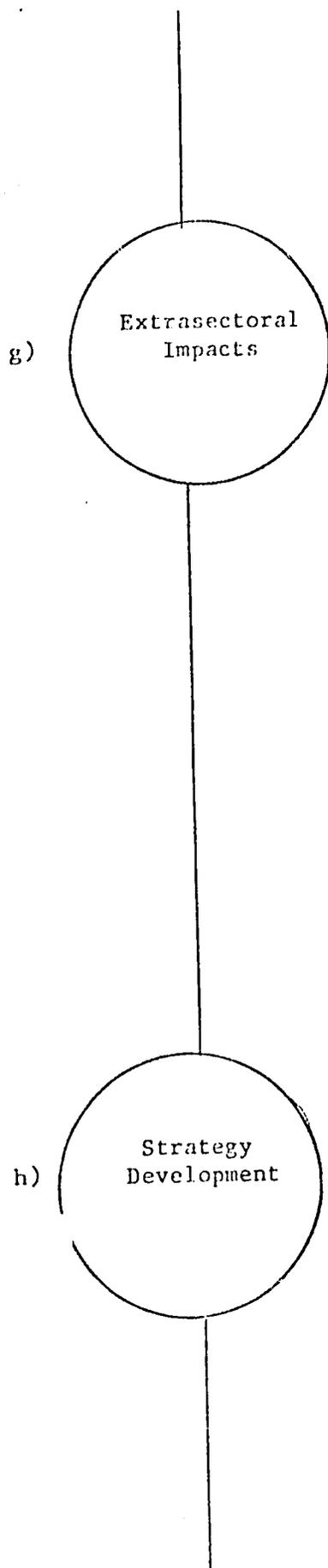
- 4) description of probable program impacts;
- 5) estimate of new infrastructure requirements.

- 1) development of health manpower projections and current distribution;
- 2) inventory and description of equipment available to the sector and its distribution;
- 3) inventory and description of hospitals and other facilities and their current distribution;
- 4) identification and study of critical resource constraints and bottlenecks;
- 5) description of possible financial resources in both community and various levels of government.

f)



- 1) identification of administrative bottlenecks including logistics and supply systems;
- 2) study of financing systems, projections of finances available and impact of various

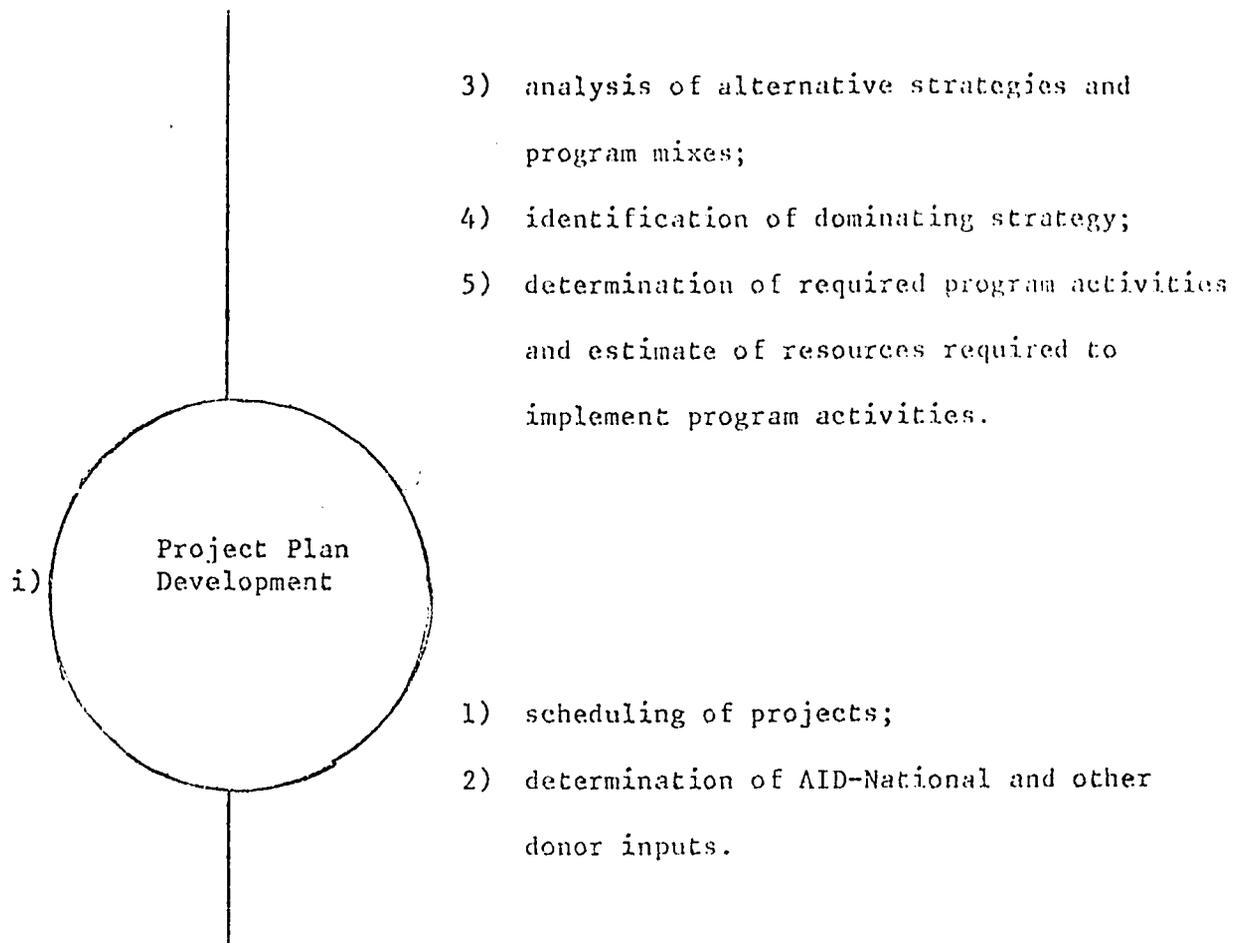


systems on utilization and efficiency of health care;

3) study of health information system.

- 1) identification of aspects of other sectors which influence health and estimate of the extent of impact;
- 2) study of programs which could ameliorate or improve the effect of other sectors on health and specification of their cost and probable impact;
- 3) identification of health program impacts on other sectors;
- 4) estimates of benefits or disbenefits of extrasectoral impacts

- 1) synthesis of proceeding stages;
- 2) elaboration of alternative strategies and program mixes;



The specific scope of work and responsibilities of all parties must be clearly defined prior to initiating the assessment. This is ordinarily done by an AID scope of work team in collaboration with national planners and decision makers.

It is necessary to involve busy decision makers but it is unrealistic to think of their doing much of the actual analysis. This is ordinarily handled by establishment of a full time staff capability under the guidance of a national policy group made up of decision makers of national institutions. In many instances, this appears to have promoted a more active inter-action and development of a national constituency for integrated planning.

V. Conclusions and Future Directions

At the current time our perceptions are that the health sector assessments have been surprisingly successful. Balanced innovative programs including potable water supply, non formal education, para-medical training and nutrition programs have resulted which appear to be superior to programs developed in the absence of an assessment. National support constituencies have been successfully developed in some countries. Health planning capability has been improved in a few countries.

In the short term future we expect to undertake several critical activities to reinforce our efforts. They are: 1) The formal external evaluation of experience to date; 2) The development of more formal methodology orientation and guidance materials to expedite health sector assessments; and 3) The introduction of aids to efficient group processes at the staff and policy group levels.