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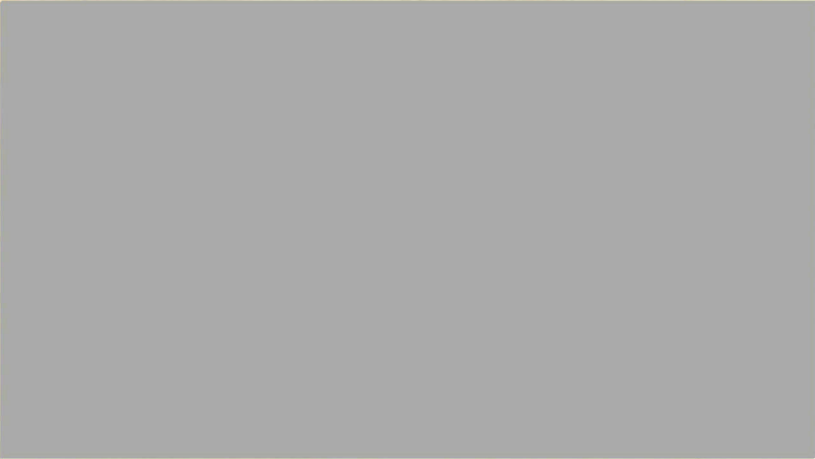
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WHO-WORLD BANK STRATEGY MEETINGS



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World Health Organization [WHO] / World Bank - Strategy Meeting

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WORLD HEALTH ORGANIZATION
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Tel.: 91 21 11 Telex: 27821
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WHO FACSIMILE

Message No. _____ Page 1 of 6 pages

Date: 13 August 1986

From: Mrs Ingar Brüggemann
Director, Programme for
External Coordination, WHO
To: Mr John North, Director, PHN, World Bank,
Washington, D.C.
Fax No.: (202) 477 8164

Our ref.: N55/372/1

Subject: WORLD BANK/WHO MEETING, Geneva, 3 - 4 September 1986

TEXT

URGENT FOR MR JOHN NORTH, PHN - ATTENTION DR TONY MEASHAM - FOR IMMEDIATE DELIVERY

Enclosed is the draft Annotated Agenda, as promised, and the first page indicates that the meeting will be held at the Ecumenical Centre (Centre Oecuménique), the home of the World Council of Churches, just a five-minute walk from WHO past the upper side of the ILO. This note also confirms that we are planning a two-day encounter on 3 and 4 September 1986.

We look forward to this meeting and to being with you.

Ingar Brüggemann
Ingar Brüggemann

Signed: Director, COR

Copies to:

- Mr W.E.Siebeck, World Bank Representative to UN Organizations at Geneva
Director, COR
- Dr J. Cohen, DGO
- Dr M. Jancloes, HSC
- Mr A. Creese, SHS

bcc: Dr Farouk Partow, ADG
Copies by mail too.

WORLD BANK / WORLD HEALTH ORGANIZATION
MEETING ON HEALTH POLICY
AND COLLABORATION
 * * *
3 - 4 SEPTEMBER 1986, GENEVA

Purpose: It was agreed between the World Bank and WHO to hold a joint meeting of two days in Geneva in order to discuss relevant health policies determining action in the health sector and ways of improving complementarity of the two organizations in countries.

Agenda: The attached, jointly agreed Annotated Agenda will serve as a guide for discussion.

Style of Meeting: It is understood that the Meeting will be informal and of a "brainstorming", open nature.

Participants: A provisional list of World Bank/WHO participants is attached.

Place of Meeting: The meeting will be held in Meeting Room 2 at the Headquarters of the World Council of Churches. The address is:

Centre Oecuménique
 150, route de Ferney
 1218 Grand-Saconnex
 Telephone: 91 61 11

Time of Meeting: The meeting is scheduled to start on Wednesday, 3 September, at 9:30 a.m. A joint lunch is planned for 3 September in the restaurant of the Centre.

DRAFT ANNOTATED AGENDA

1. District Health Systems -

- **Concretizing health systems based on Primary Health Care at the district level.**

As a corollary of its policy to commit major resources into building up health infrastructures, WHO is now concentrating on supporting countries in developing their **district health systems based on primary health care** for effective application of the scientific and technical tools of health development. This involves the planning and organization of the system as a whole, based on replications of the fundamental building block - the district. It includes the strengthening of community health care, training requirements, and the logistical and referral system. It offers the means for **concretizing the health system based on primary health care at the district level**, and for dealing with the political and administrative problems that arise. The district focus is a useful way to organize policy, strategic, managerial, technical and financial support to developing countries in health. The role of the private sector as well as domestic and international NGOs can usefully be examined in this connexion. This topic will provide a useful opportunity to share experiences and views, including the importance the Bank attaches to a "systems approach to investment", of which hardware is only a part.

2. Financing Health for All:

- **Facing the political and economic challenges for the attainment of health for all -- nationally and internationally.**

One of the weaknesses revealed by the recent evaluation of the strategies for health for all is the area of financing. This involves both

macro- and micro-economic analysis based on reasonable costing of strategies and their component parts: infrastructure and technology. Also involved are such aspects as programme budgeting, recurrent cost implications of investment, identification of realistic sources of financing, including cost recovery systems. Facing the political and economic challenge to match our vision with the actual attainment of health for all - at national and international levels - may mean that promises to provide free health care have to be politically swallowed.

3. **Strengthening management capacities in health systems, including monitoring, evaluation and information support:**

● **The Bank's role in supporting development and strengthening of national managerial capabilities.**

WHO has gained some experience in applying a common approach to strengthening the managerial process for national health development. That experience includes having set in motion a process of monitoring and evaluation, including the necessary information support, undertaken by Member States for the assessment of progress in achieving the objectives of national strategies of health for all. It will be useful to examine possible courses of future action by WHO and the Bank to ensure progress in this area.

4. **Review of the Research Agendas of the two Organizations:**

● **Comparing policies governing decisions on research priorities.**

The opportunities and challenges in health research continue to expand. This is the case in tropical diseases and human reproduction, in the development of drugs and vaccines, and also in the social application of health technology. There may be possibilities for new, complementary action and joint studies in research if the agendas of the

two organizations could be compared.

5. Bank Financing of International Health Efforts:

• **Identifying additional research areas for Bank financing.**

One useful and appropriate application of Bank financing has been the support provided for research and training activities in programmes such as TDR and HRP. WHO has had a crucial role in facilitating such collaboration among a variety of international partners. It may be useful to examine the prospects for other similar efforts or similar approaches for joint planning and financing.

6. WHO/Bank Collaboration and Communication:

• **Increasing complementarity of action in countries.**

There are many points at which the policies and programmes of the Bank and WHO converge in the health sector. This meeting might explore the potential for and limits to **complementarity** on the operational side, and how the two organizations could work more closely together in the future on health sector analysis, information exchange, project preparation, project implementation and donor coordination.

7. Other Matters:

7.1 The Effects of Adjustment Policies on Health and Nutritional Status

- Both Organizations should exchange views on this issue, recently brought forward to the Bank and to WHO by Dr A. Horvitz, Chairman of the UN/ACC Sub-Committee on Nutrition.

8. Concluding Observations for Future Action.

Participants:Participating for the **World Bank:**

Mr John North, Director of Population, Health and Nutrition Department
Ms Nancy Birdsall, Chief, Policy and Research Division, PHN Department
Mr Stephen Denning, Chief, Division I (S Asia, Eⁿ & Sⁿ Africa), PHN Dept.
Ms Ishrat Husain, Chief, Division II, (E Asia, Pacific, W Africa), PHN Dept.
Dr Anthony Measham, Health Adviser, Office of Director, PHN Department
Mr Emmerich Schebeck, Chief, Division III, (Lat. America, Carib., Europe,
Middle East), PHN Department

Participating for the **World Health Organization:**

Mrs Ingar Brüggemann, Director, Programme for External Coordination
Dr Joshua Cohen, Director, Senior Adviser on Health Policy, Office of the
Director-General
Mr Andrew Creese, Economist, Strengthening Health Services
Dr Michel Jancloes, Medical Officer, Health for All Strategy Coordination
Dr Stuart Kingma, Chief, Health Resources Mobilization, Programme for
External Coordination

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: August 13, 1986

TO: Distribution

FROM: John D. North, Director, PHNDR

EXTENSION: 61571

SUBJECT: Strategy Discussions with WHO, Geneva, September 3-4, 1986

1. This memo deals with the agenda for our strategy discussions with WHO/Geneva, proposes a division of labor among us for handling the agenda and distributes relevant documentation.

2. We understand that WHO agrees, with minor modifications, to the agenda proposed in my telex of July 24, 1986 (attached). We expect confirmation of the agenda in a telex which will be circulated when it arrives. I propose that we divide responsibility among ourselves as follows, assigning a lead discussant to each agenda item. The lead discussant should be prepared to provide a brief introduction to the topic of up to fifteen minutes, and to do his or her best to ensure adequate treatment of the topic. Lead discussants should provide a brief summary of discussions of their assigned topic to Tony Measham for inclusion in the back-to-office report.

<u>Agenda Topic</u>	<u>Lead Discussant(s)</u>
District health systems	Ishrat Husain and Emmerich Schebeck
Health Financing	Nancy Birdsall
Evaluating Impact of Health Projects and Programs	Tony Measham
PHN Research Agenda	Nancy Birdsall
Bank Involvement in International Health Research Efforts	John North
WHO/Bank Collaboration and Communication	Steve Denning

3. The following background documents are attached:

- a) WHO proposed agenda (Mrs. Bruggemann's letter of May 28, 1986)
- b) Draft Health Financing paper

- c) PHN Policy Group Work Program, FY87-88
- d) Section 3 on Environment from the briefing papers for Mr. Conable
- e) OPN 11.01 on Selection and Use of Pesticides in Bank-financed projects.
- f) WHO draft paper, "Hospitals and Health for All".

4. Composition of the WHO team with which we shall meet is not yet certain. However, I understand that Dr. Joshua Cohen, adviser to Dr. Mahler, and Mrs. Ingar Bruggemann and Dr. Stuart Kingma from External Coordination, will attend. Other possibilities include Dr. Mona Khanna and Dr. Michel Jancloes from the Health for All Strategy Group, and Mr. Andrew Creese from the Strengthening Health Services Division.

Distribution: Messrs. S. Denning, A. Measham, E. Schebeck
Mmes. N. Birdsall, I. Husain

Attachments

ARMeasham/cjm

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UNISANTE, GENEVA.

FOR MRS BRUGGEMANN. PLEASD TO RESPOND TO YOUR MAY 28 LETTER REGARDING AGENDA FOR SEPTEMBER MEETING. PROPOSED AGENDA LOOKS EXCELLENT. SUGGEST WE SUBSUME ITEMS UNDER FIVE OR MAXIMUM SIX TOPICS TO FACILITATE DESIGNATING LEAD DISCUSSANTS ON BOTH SIDES AND ENSURE SUFFICIENT TIME FOR DISCUSSION EACH TOPIC. DETAILED COMMENTS AND SUGGESTIONS FOLLOW. AAA) DISTRICT HEALTH SYSTEMS TOPIC WOULD PROVIDE USEFUL OPPORTUNITY TO SHARE EXPERIENCE AND VIEWS, INCLUDING IMPORTANCE BANK ATTACHES TO SYSTEMS APPROACH TO INVESTMENT OF WHICH HARDWARE ONLY PART. BBB) WE WELCOME OPPORTUNITY TO SHARE VIEWS ON CRITICAL ISSUE OF FINANCING HEALTH FOR ALL. DRAFT OF PHN HEALTH FINANCING PAPER MIGHT PROVIDE VEHICLE FOR DISCUSSION. WILL MAIL COPY. CCC) ELEMENTS OF YOUR ITEMS 3, 4 AND 6 MIGHT BE COMBINED TO ADDRESS CRITICAL QUESTION OF HOW TO EVALUATE IMPACT OF HEALTH PROJECTS AND PROGRAMS, DEVELOPMENT OF NECESSARY DATABASE, AND FUTURE ACTION OF WHO AND BANK IN ENSURING PROGRESS IN THIS NEGLECTED AREA. DDD) WE AGREE REGARDING IMPORTANCE OF DISCUSSING RESEARCH AGENDAS OF BOTH ORGANIZATIONS AND WILL SEND COPY OF POLICY AND RESEARCH WORK PROGRAM AS ONE INPUT. EEE) BANK FINANCING OF INTERNATIONAL HEALTH EFFORTS MIGHT USEFULLY FOCUS ON RESEARCH SUPPORT, E.G. TDR,

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SUBJECT WHO Strategy Meeting		PREPARED BY <i>ARMeash/m/cim</i>	EXTENSION 6t573
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PROSPECTS FOR OTHER SIMILAR EFFORTS, E.G. SUPPORT FOR HRP, AND WHO
 ROLE IN FACILITATING SUCH ASSISTANCE. FFF) A SIXTH TOPIC MIGHT
 DEAL WITH THE COLLABORATION AND COMMUNICATION PROCESS AND HOW WHO
 AND THE BANK MIGHT WORK CLOSER IN THE FUTURE ON SECTOR ANALYSIS,
 PROJECT PREPARATION AND PROJECT IMPLEMENTATION. GGG) WE SUGGEST
 INFORMALITY BE STRESSED TO FACILITATE OPEN COMMUNICATION AND
 WONDER WHETHER POSSIBLE TO MEET OUTSIDE WHO HQ AS DISCUSSED
 PREVIOUSLY. WE BELIEVE TWO DAYS SHOULD BE SUFFICIENT TO COVER
 AGENDA AND WOULD APPRECIATE YOUR SUGGESTIONS ON TIMING WITHIN
 AGREED SEPTEMBER 3-5 TIMEFRAME. HHH) MY COLLEAGUES NANCY BIRDSALL,
 STEPHEN DENNING, ISHRAT HUSAIN, ANTHONY MEASHAM, EMMERICH SCHEBECK
 AND EYE ARE LOOKING FORWARD TO PRODUCTIVE MEETING. REGARDS NORTH,
 INTBAFRAD, WASHINGTON.

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CLASS OF SERVICE Telex	TELETYPE NO.	DATE 7/24/86
SUBJECT WHO Strategy Meeting	DRAFTED BY ARMeasham, cjm	EXTENSION 61573
CLEARANCE AND COPY DISTRIBUTION cc: Bak, Birdsall, Denning, Husain, McDonald, Measham, Sai, Schebeck	AUTHORIZED BY Name and Signature John D. North	
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Téléphone Central/Exchange: 91 21 11
 Direct: 91

Mr John D. North
 Director
 Population, Health and Nutrition
 Department
 The World Bank
 1818 H. Street, N.W
 Washington, D.C. 20433
 Etats-Unis d'Amérique

In reply please refer to: COR-N55/372/1
 Prière de rappeler la référence:

28 May 1986

Dear Mr North,

If it were not for the event of the Thirty-ninth World Health Assembly, which took place from 5-16 May 1986, I would find it difficult to apologise for sending you only now, the draft annotated agenda for our meeting planned for 3-5 September 1986.

As agreed with Dr Measham in our short discussion on 24 April 1986, we have prepared a list of issues (that we feel are relevant) for discussion in the September meeting. As we agreed last year in planning for this meeting, we will review matters of a strategic nature which concern us both. We would appreciate your critical review of the subjects, as well as their annotation. You may wish to add other issues or raise particular questions in relation to the subjects mentioned in the agenda.

At this stage, I have not included any particular regional issue of collaboration as we had agreed that these would be more effectively dealt with directly with WHO's regional offices. I am sure you will have the feedback from Professor Sai on the meeting held in WHO headquarters on 26 May 1986 with the Regional Director for Africa, Dr G. L. Monekosso.

Once we have your reaction to the annotated agenda, we will give further thought on how to substantiate the various agenda items.

Looking forward to your response.

With kind regards,

Yours sincerely,

Ingar Brüggemann
 Director
 Programme for External Coordination

Encl: (1)
 cc: Dr A. Measham, PHN, World Bank, Washington

WORLD BANK/WORLD HEALTH ORGANIZATION
MEETING ON HEALTH POLICY AND COLLABORATION

3-5 SEPTEMBER 1986, GENEVA

DRAFT ANNOTATED AGENDA

1. DISTRICT HEALTH SYSTEMS

As a result of the policy to channel major resources into building up health infrastructures, WHO is now concentrating on supporting countries in developing their district health systems based on primary health care. This involves strengthening community health care and the referral system. In addition to planning and organization of the system as a whole, highly specific components are health facilities, such as: health centres; community health posts; hospitals (for both inpatient and outpatient care), and support for community care; and laboratories for clinical and public health support, etc.

Training of health personnel permeates all action. With respect to the health infrastructure, the Bank may support the physical components such as centres and institutions, while WHO could provide support to the "software" such as manpower development, training, training material, etc.

| The relevant roles of the Bank and WHO in the above could be reviewed.

2. NATIONAL FINANCING OF STRATEGIES FOR HEALTH FOR ALL

One of the weaknesses revealed by the recent evaluation of the strategies for health for all is the area of financing. This involves both macro- and micro-economic analysis based on reasonable costing of strategies and their component parts of infrastructure and technology. Also involved are such aspects as programme budgeting, recurrent cost implications of investment, identification of realistic sources of financing, including cost recovery systems. The Bank surely has great experience in this field and could possibly strengthen its involvement. WHO too has produced relevant guidelines based on national experience.

| Closer cooperation between the two organizations could therefore be envisaged and discussed.

COR

28.5.86

3. MANAGEMENT OF HEALTH SYSTEMS

Financing is only one part of the national managerial process and the evaluation of the strategies revealed great weaknesses in management in general. This includes: the planning of strategies based on health policies, the conversion of these strategies into plans of action for building up the health infrastructure, identifying the technology required, and ways of absorbing and using it, implementing health programmes, monitoring and evaluating the strategies and their component programmes and refining them in the light of the findings - all supported by realistic information systems. 'On the job' training is crucial.

This is another area where both Organizations have ample experience, which - if pooled - might lead to the total being greater than the sum of the individual parts.

4. HEALTH SYSTEMS RESEARCH

Optimizing the use of resources is an essential feature of good management. Health Systems Research - if dealt with in a highly practical manner - is a useful tool for making optimal use of resources. For example, it is useful for arriving at the best ways of applying technology under given circumstances and of optimally organizing the health infrastructure to that end. Many endeavours in the field of health management and financing profit from relevant health systems research. An outstanding field for health systems research that is of great social relevance is family planning within the context of delivering mother and child care through primary health care.

Ways of building this research into national health development efforts could therefore be explored jointly by the two Organizations.

5. HEALTH COMPONENTS OF DEVELOPMENT PROJECTS

Some years ago, the Bank adopted a policy including health components in development projects in various sectors, such as agriculture.

It would be useful to consolidate the experience gained with a view to reinforcing national awareness and interest in this field and refining the support that both the Bank and WHO can provide.

6. REVIEW OF THE RESEARCH AGENDAS OF THE TWO ORGANIZATIONS

WHO is constantly expanding the promotion of health research. Recent additions are:

- the development of vaccines through the application of biotechnology, as well as the development of new drugs by similar approach, for example to combat viruses (AIDS!). Social and economic studies on drug use such as prescribing and consumption patterns are envisaged.

Research on tropical diseases and human reproduction continues unabated.

It may be useful to review the collaboration between the two Organizations in the field of health research.

7. INTERNATIONAL FINANCING FOR HEALTH

In addition to the general question of national financing of strategies for Health for All (see item 2 above), the possibility might be explored of increasing the Bank's involvement in international financing for health.

The Bank might consider lending its prestige and expertise to such initiatives as the revolving fund for drug and vaccine procurement sponsored by WHO and UNICEF. Another problem is that of hard currency for procurement of equipment and supplies by developing countries.

8. COMMUNICATION

Ways could be explored of improving the speed and intensity of information exchange between the two Organizations in order to maximize their support to developing countries.

9. OTHER MATTERS

PHN POLICY GROUP
WORK PROGRAM, FY87-88

Discussion by objectives

Objective: Improve quality and effectiveness of fertility reduction programs

A large literature on the determinants of fertility is heavily focussed on so-called demand issues -- the socioeconomic characteristics of those who want and use fertility control. Much less has been done on the supply or program side, i.e. on the effects of availability and quality of fertility reduction programs and their potential for generating demand. Yet most potential policy and program interventions are on the supply side. Tasks under this objective are designed to assist borrowers to improve the supply side, and include work on the cost-effectiveness of family planning programs, including the potential and appropriate roles of nongovernmental organizations and wholly commercial programs, and on incentives for small family size. A task on adolescent fertility is geared to development of improved programs for fertility reduction among teenage women in Africa, and will be carried out in part in conjunction with a project loan, possibly in Malawi. These plus the 1987 Population Lending Review (under the management of the Population Advisor) will provide the basis for a policy paper to be completed in FY89, tentatively titled "New Initiatives in Fertility Reduction." More thorough planning for this FY89 paper, which may require additional inputs, will begin early in FY88.

Objective: Health Sector Reforms

The work under this objective is divided between two closely-related topics: financing and efficiency.

Financing

The major policy paper on health financing (to be completed in FY87), clarifies Bank views on general directions for financial policy reform in the health sector in most countries -- toward more cost recovery, more use of private sector initiatives, and more reliance on risk-sharing schemes. However, further work is needed to provide detailed guidance on the institutional arrangements needed to support and reinforce reforms. Under this objective there will be new work on risk sharing, including alternative institutional mechanisms (such as health maintenance organizations) in the public and private sector, and studies of the political and administrative costs and feasibility of various reforms. The policy work will be designed to complement sector work planned in operational divisions of PHN, e.g. on health insurance in Latin America and the progress of financing reforms in Africa. This policy and sector work, along with the policy paper itself, will provide the basis for detailed guidelines on health financing reforms in developing countries directed to a technical audience, including project officers, and materials for training seminars for technical staff of health and planning ministries. Intermediate outputs discussing policy issues will also provide general guidance for operational staff.

Efficiency

A major task is directed toward increasing the internal efficiency of particular health sector programs (taking more or less as given the allocation of public resources to each program), and with increasing overall efficiency in the health sector through better allocation of resources across programs and institutions. The two approaches are not easily separated, but the distinction is a useful one.

Three individual programs, or subsectors, are receiving particular attention: pharmaceuticals, hospitals, and endemic disease control. Each of these takes up a substantial portion of overall sector resources, and each has a relatively distinct administrative or organizational institution behind it in most countries, so that it is for example a separate line item in a public health budget. In each of these areas, through coordination with WHO and other health groups, we are providing critical complementary work, generally emphasizing economic questions. For example, for the pharmaceutical and hospital subsectors, ours is the only major effort to address the issue of rationalization of public and private sector roles, the economics of regulation, and so forth.

Our work on overall resource allocation in the sector will pull together and relate to each other a large number of individual studies on cost-effectiveness of different interventions and modes of delivery sponsored over the last three years.

We hope, by FY90, to have enough material that fits together sufficiently well for a major paper on critical policy lessons in resource allocation. Ongoing or recently-completed work under the management of the Health Advisor will also be of relevance: on approaches to dealing with chronic diseases (including anti-smoking programs) and on cost-effective approaches to maternal mortality. We expect that in such an overview paper, at least one major theme will emerge (as it has on the health financing side): the need to avoid cost escalation by fostering institutions which use market signalling devices, particularly in resource-poor countries facing pressure to import costly technology and imitate inappropriate training and organizational arrangements.

Objective: Strengthen Health and Population Capability in Africa

A major policy paper on health sector management and finance will be based on a large body of PHN sector work (dealing with health sector finance and management issues in at least 15 African countries), the work described above under the health sector financing objective (much of which will focus on Africa), and work to be done on services at the periphery (under Poverty Alleviation objective), supplemented by additional effort as appropriate, e.g. detailed country case studies of reform implementation. Such a paper focussing on Africa will increase the credibility of the ongoing efforts of project staff to encourage health sector reforms, and provide detailed background specific to the African situation -- where resources are more

constrained than elsewhere, and institutional development (and rigidities) less advanced.

A second task is designed to strengthen the process of demographic and health data development in Africa. As emphasized in the Sub-Saharan Africa population report, population policy development has been poor in part because of poor demographic information and failure to exploit what data exists for policy purposes. A research project in Sierra Leone (to be undertaken only if cofinancing by UNICEF of an IDA project provides data collection funds) will provide a model for a sensible approach for demographic data collection, processing and analysis in Africa. Technical assistance will also be provided, in coordination with other donors, to encourage a new round of censuses in Africa.

Other Objectives

The three other minor objectives comprise about 20 percent of total resources, and about 12 percent of higher level staff time. A new objective entitled "Improving Demographic, Family Planning and Health Data" pulls together work on maintaining a demographic data base for Bank country economic and sector work and the annual World Development Indicators. The nutrition objective is heavily oriented to work on approaches to analyzing and where appropriate fostering inclusion of nutrition interventions in "health" projects, and is carried out largely by the Nutrition Advisor. The poverty alleviation objective includes, under the task "Services at the Periphery", a review of experience both within and outside the Bank with service delivery to poor groups far from normal service centers and synthesis of findings from a variety of recent and ongoing research projects (including LSMS studies in Peru and Ivory Coast) on access to and use of services by the poor.

Policy Papers

Summarizing from above, we expect to produce the following major policy papers:

Health Finance, FY87
 Health System Finance and Management in Africa, FY88
 New Initiatives in Fertility Reduction, FY89
 Allocating Scarce Health Resources, FY90

Attachment

cc: Messrs. van der Tak, Walters (OPSVP), Berg, Liese (o/r), Measham, Sai (PHND), Denning (PHND1), Mahar (PHND2), Schebeck (PHND3) PHNPR Staff

NBirdsall:am (6/17/86)

ENVIRONMENT

1. Environmental problems take many forms in developing countries. Overgrazing leading to deforestation, soil erosion, siltation of reservoirs and loss of agricultural productivity weakens the sustainability of development, especially in the Sahelian countries. Destruction of tropical forests and disruption of the life styles of indigenous peoples in the Amazon and Indonesia, and pollution of water sources and inadequate means of solid and liquid waste disposal in large cities throughout the developing world further illustrate the range of problems that are faced.
2. Major responsibility for ensuring that adequate consideration is given to the environmental dimensions of projects rests with the Bank's operational staff in the Regions. The Office of Environmental and Scientific Affairs in OPS, reviews projects and assists in their design to ensure compliance with Bank criteria, and also provides guidance on environmental aspects of country economic and sector work and technical assistance; it develops general policies governing the Bank's environmental activities and liaises with other international and government agencies and non-governmental organizations. The Bank's Energy, Agriculture, and Water Supply and Urban Development Departments are also actively engaged in addressing environmental problems.
3. The Bank has addressed environmental issues in a number of ways, but primarily by financing "environmental" projects such as pollution control, sanitation, reforestation and watershed management projects. It also finances project components designed to ameliorate the adverse consequences of an investment; examples include pollution control elements of power projects; protection of territories inhabited by indigenous peoples that are threatened by area development; and drainage works designed to avoid the waterlogging that might otherwise result from irrigation schemes.
4. To date, the emphasis has been on a project-by-project basis. While important, this needs to be supplemented by the integration of environmental, or natural resource management, into country economic work -- because environmental problems are caused by a myriad of small scale activities which cannot be handled on a case-by-case basis. In Ethiopia and Senegal, issues of resource management are being analyzed in the context of overall country development strategies. These analyses will help us to develop methodology for use in other country studies. Research is underway on appropriate ways to estimate the cost to society of depletion and destruction of natural resources.
5. In recent years environmental interest groups, and many of the Bank's major shareholders have shown interest in the Bank's environmental work -- for example, issues in the 'Polonoreste' (Brazil) and Indonesia Transmigration projects. In the Polonoreste Project, imbalances in implementation resulted in advancing the highway component, which accelerated immigration, while components of health, forestry and tribal protection lagged. The Bank suspended disbursements to force the Brazilian government to rectify the situation and resumed them when appropriate measures were instituted. In the Transmigration project to resettle 300,000 families from crowded regions of Indonesia to less developed ones, questions about human rights, land rights and equitable compensation were raised. The Bank addressed them and attached conditions to which the Indonesian government has agreed in the most recent phase of the project.

GUIDELINES FOR THE SELECTION AND USE OF PESTICIDES IN BANK FINANCED
PROJECTS AND THEIR PROCUREMENT WHEN FINANCED BY THE BANK

Introduction

1. Pest control is widely recognized as an essential element in improving human welfare in all areas of the world. A wide range of insects, weeds, disease microorganisms, nematodes and rodents reduce food and fiber yields by attacking livestock, forests, crop plants and stored agricultural products in addition to directly damaging human health. Throughout the history of agriculture a variety of techniques have been used to combat this threat; control of pests has traditionally been accomplished through a combination of cultural practices, selection and breeding of resistant plant varieties, encouragement of natural enemies and the introduction of biological control agents, as well as the application of chemical control materials (including insecticides, acaricides, molluscicides, nematocides, fungicides, bactericides and herbicides as well as poison baits for rodent control). Properly used, chemical pesticides are essential elements in a pest management program. However, there is now great concern over the ever greater reliance on chemical pesticides throughout the world. The problem is particularly significant in the developing world where exclusive reliance on chemical control is a common response to the increased levels of infestation by pests, diseases and weeds which have accompanied recent increases in the intensity of crop and livestock production and human settlement. This approach is frequently taken without adequate safeguards for those who handle or may be exposed to the pesticides or for the environment, and with little regard to pest-induced crop losses or the cost-effectiveness of chemical control.

2. It is becoming increasingly evident that the unilateral chemical approach, in addition to posing potential threats to human health and to the environment, does not lead to sustainable and profitable agricultural production. The rapidly increasing cost of pesticides as well as the development of secondary pest species and the growing incidence of insecticide-resistance in pest populations limit the effectiveness of chemical pest control. For this reason and in line with Bank policy to promote sound technologies which do not carry with them excessive environmental costs, it is important that use of pesticides in Bank projects should be consistent with sound pest management practices and accompanied by safeguards to protect the users, the general public and the environment. Sound pest management should aim to reduce dependence on chemical pesticides through the establishment of economic control thresholds and through the use, wherever possible, of agronomic or related practices which reduce the severity of pest attack. The Integrated Pest Management (IPM) approach, which includes the prudent use of pesticides when damage reaches unacceptable levels, should be the objective of Bank strategy in agricultural development. In addition, it is important that appropriate attention be paid to technical suitability, safety and efficient procurement during

the preparation, appraisal and supervision of all Bank projects which promote or increase the use of pesticides and particularly those which would finance the procurement of pesticides (either explicitly or through short term credit for production inputs).

3. The following sections provide guidance on the use of pesticides and their selection and purchases. Section A outlines the present state of the art in Pest Management Practices within the context of which a pest control program should be assessed. Section B concerns handling, storage and application safety. Section C discusses particular considerations in the selection of pesticides for a particular situation. Section D treats pesticide procurement. These sections may from time to time require more detailed treatment than is appropriate in this OPN. In such cases Supplementary Technical Notes will be issued jointly by the Agriculture Department (AGR) and the Environment Unit (PPDES) and will have the authority of this OPN with which they should be filed.

4. During appraisal and supervision of Bank lending operations in which financing is being provided for pesticides, it is the responsibility of Bank missions to ascertain whether pest management is or will be appropriate and safe, and if necessary, to make appropriate recommendations to correct the situation.

A. Pest and Pesticide Management Practices

5. Effective pest management involves maintaining quantity and quality of production or improving health by the least costly means and the maximization of net benefits should be the guiding principle of all pest management. While pesticides will continue to play an important part in pest management, an integrated approach combining the use of resistant varieties, biological control techniques and modified cultural practices where appropriate, together with judicious use of chemical pesticides, can offer better prospects for long term control and reduced environmental damage while increasing the margin between benefits and the costs of control measures.

6. The costs of pest control can be direct such as those for the purchase, distribution and application of pesticides and the increased costs of changing cropping practices, or indirect such as the harmful effects on human health and the environment which can arise from inappropriate and unsafe pesticide use. They can be short or long term, the latter including the cost of changing chemical control materials to combat increased pest resistance. Some costs are straightforward while others are difficult to quantify. Use of pesticides as well as other control measures should always be the result of a considered evaluation that the benefits to be gained outweigh the direct and indirect costs, in-so-far as these can be assessed.

7. Every effort should be made to promote the Integrated Pest Management concept within Bank agricultural projects by selecting pesticides and pesticide use patterns which are compatible with an IPM approach. Three major points should be considered:

- (a) pesticides should be viewed as a short-term response to the build-up of a particular pest species to threshold levels which have been found as a result of field trials and past experience to be economically damaging. The overall control of pest populations should be attempted by other methods such as the use of crop varieties which are resistant or tolerant to the pest, biological control, and cultural practices including crop rotation, timing of planting to avoid the coincidence of particularly susceptible growth stages of the crop with peaks in pest populations or disease incidence, and timing of irrigation to discourage susceptibility of the plants to fungal infection.
- (b) wherever possible, narrow-spectrum pesticide materials should be selected which are effective against the pest species but cause minimum harm to other useful insects (especially the important predators and parasites of the pest species). This approach requires that one or more key target pest species and, if possible, their principal natural enemies first be properly identified.
- (c) application methods and timing also should be aimed at minimizing the risk of harming these natural enemies.

8. The build-up of pesticide resistance, particularly in insect populations, is a serious constraint on chemical pest control. Measures to reduce the rate of this build-up and thereby prolong the usefulness of effective materials include:

- (a) using as few chemical pesticide applications as possible and delaying application until pest populations reach preset economic thresholds and susceptible life stages,
- (b) refraining from using for agricultural pest control chemicals which are also in use in the same vicinity for human disease vector control,
- (c) using application methods which minimize the area of pesticide exposure.

It has also been suggested that using combinations of chemicals which differ in mode of action may prevent or delay the development of resistance to any one material. This may involve changing chemicals from one season to another or using mixtures of chemicals, each at a relatively low concentration. However, the effectiveness of this approach remains uncertain.

B. Handling, Storage and Application Safety

9. Correct and careful handling and application of chemical pesticides is essential for safe and effective pesticide use. To reduce the risk of accidents and damage to health or environment resulting from

misuse of pesticides and to maximize the effectiveness of their application, it is essential that proper precautions be taken in the packaging, transport, storage and disposal of pesticides and surplus pesticide containers and that necessary equipment and proper training in application techniques be provided to the users.

10. Standards of packaging of pesticides should be specified in tenders and should be adequate to withstand the considerable abuse which can occur during transport and storage. Clear and durable labelling of all packages to depict the hazardous nature of the contents should always be required. The labels should be in an appropriate language and should be consistent with internationally accepted standards such as those specified in the FAO Guidelines on good Labelling Practices for Pesticides.^{1/} The distribution of pesticides in single dose packages or small containers should be encouraged to reduce the need for measuring out concentrates and alleviate some of the problems of on-farm storage of open pesticide containers. Repackaging should only be permitted in properly licensed and inspected facilities meeting acceptable safety standards and preferably under the control of the bulk supplier who should be fully responsible for the suitability of the new package including labelling and use instructions, the quality of the repackaged product and the safety of the repackaging process.

11. While all empty containers should be destroyed, it would be unrealistic to expect adherence to this rule in countries where empty containers suitable for storing liquids are in short supply. To avoid this hazard, manufacturers should be encouraged to design containers which discourage such re-use and to adopt this type of container where a suitable design already exists. When such containers are available, the borrower should be required to specify them in tender documents. The Bank does not approve of re-use of pesticide containers and strongly recommends that all possible deterrent measures be taken but, in instances where the only available and suitable package offered by suppliers is a non-returnable drum and where destruction of all sound empty containers cannot be ensured, their thorough washing with an appropriate solvent and numerous water rinses should be required to minimize the risk in the event of re-use. Flammable containers should be incinerated in a site where fumes will not be carried into occupied areas by prevailing winds.

12. Stores should protect containers and their contents from the elements, be fenced to discourage unlawful entry, have a nearby water supply and be adequately ventilated. Containers should be stacked on a hard standing with a sill to contain spills and containers should not be stacked beyond the recommended stacking height. Drainage from the storage area should outfall into an evaporation pond to eliminate contamination of streams, canals or groundwater. Where substantial quantities of highly toxic pesticide materials are stored, their presence may require a

^{1/} See FAO Plant Protection Bulletin No. 2 1983 Vol. 13.

Serious Hazard Assessment to be undertaken. This involves the consideration of the kinds of accidents which may occur, endangering the staff, people nearby and the surrounding environment. For such a situation the assessment would determine the adequacy of:

- (a) the warning systems installed which would alert staff and the public to an emergency;
- (b) the established procedures to deal with such an emergency including evacuation of people if it should be necessary;
- (c) the availability and working order of emergency equipment; and
- (d) the training of staff and their regular practice of emergency drills.

Guidance on this should be sought from PPDES.

13. To prevent contamination in the process of pesticide distribution, food materials should never be transported simultaneously with pesticides. Vehicles used regularly to transport pesticides should be clearly marked and should not be used to transport food products. When other, general purpose vehicles are used to transport pesticides they should be thoroughly decontaminated by washing immediately afterwards. When offloading containers into store, a ramp should be provided in the absence of fork lift equipment to avoid rupture and damage to containers resulting from dropping to the ground. Any damaged containers should be set aside and the contents transferred to sound containers under supervision.

14. Persons handling concentrated materials should have protective face shields or goggles, gloves, aprons and footwear and should be adequately supervised. It is unrealistic to expect workers to wear more complete protection and respirators in hot conditions but selection of pesticides should take into account the minimal protection which handlers will practice. Materials which are likely to become widely distributed should be made available only in relatively low-toxicity formulations. Arrangements should be made for the washing and decontamination of clothing and particular care should be taken to avoid workers contaminating their home environment. All spills should be promptly washed down.

15. Where pesticides are applied by contractors they should be required to take all necessary precautions to protect the public and the environment from damage due to spray drift or other accidental contamination. Licensing of operators on completion of an appropriate course of training is recommended when particularly hazardous materials are to be used. Operators and supervisory staff engaged in regular spraying operations should be trained in the specific first aid procedures for poisoning relating to the material being used. Medical services should be familiar with symptoms and treatment for such poisoning cases and specific antidotes should be readily available. With particularly toxic materials

it may be expedient to require the supplier to supervise the correct handling and application of the materials in accordance with accepted safety standards.

16. Where pesticides are being supplied to farmers it is essential that materials are selected which can be applied safely and effectively without close supervision and that the extension services are adequately supported and trained in the use of the materials so that they may demonstrate the correct techniques and give appropriate advice, including advice for on-farm storage of concentrates and eventual disposal of surplus pesticides and empty containers and calling on specialists in pest control when problems arise. Training should include the storage and handling of concentrates, dilution and mixing, application techniques and suitable application equipment, cleansing and maintaining spray equipment and precautions to avoid environmental damage through spray drift or leaching into streams or groundwater. Equipment and clothing needed for the safe and effective use of pesticides should be easily available and all reasonable measures should be taken to promote its proper use and maintenance. Farmers should be instructed on safety precautions, wearing of suitable protective clothing, the importance of decontamination and of avoiding introduction of pesticides into the household environment. They should also be able to recognize possible early symptoms of poisoning and be aware of the need to seek medical assistance quickly.

C. Selection of pesticide materials and pesticide formulations

17. The selection of chemical pesticides for use in agriculture should take account of the safety and effectiveness of alternatives under local climatic and environmental conditions, their compatibility with Integrated Pest Management, the existence of national or international regulations or recommendations regarding use of particular materials for particular crops and the reliability of potential suppliers to deliver products of a high quality, appropriately packaged and backed by well qualified technical advice and support. In addition the indigenous capability for handling toxic materials and regulating their distribution should be taken into account.

18. The World Health Organization periodically revises and reissues its Classification of Pesticides by Hazard. This lists technical products by their generic names, tabulating them in categories ranging from Extremely Hazardous to unlikely to present acute hazard in normal use. Guidance is given on use of the tables to assess the hazard of particular formulations. Materials listed in Categories 1a Extremely Hazardous or 1b Highly Hazardous are unsuitable for use by small farmers and should only be considered for use in large scale operations if all necessary training, protection and supervision can be assured. ^{1/}

^{1/} A current copy of the Classification is available for reference in the Sectoral Library.

19. Certain products, notably many of the chlorinated hydrocarbon insecticides have characteristics of excessive persistence in the environment, bioaccumulation in tissues, biomagnification in food chains and in some cases carcinogenicity or cause genetic abnormalities. They should not be used for agricultural purposes but some which have environmental hazards but low health risk may be considered for other purposes such as disease vector control where the risks are minimized and satisfactory alternatives do not exist. Compounds containing Mercury, Thallium, Lead, Cadmium or Selenium are all unsuitable for agricultural use. Fumigant products having high vapor pressures and relatively high toxicities are too hazardous for use by small farmers who do not have sealed storage compartments for grain. ^{1/}

20. Not only active ingredients but contaminants in the formulation may also be harmful. Suppliers should be required, in appropriate instances, to provide analyses by an independent and reputable laboratory showing the formulation to be free of such a contaminant or that the content of such a contaminant meets internationally accepted limits for use of the formulation for specific purposes under close supervision.

21. Preference should be given to products which are registered in the country of proposed use, if such regulatory authority exists, or which are already registered for an identical use in a country where capability exists to evaluate their efficiency, toxicity and long term effects. Products which do not meet this requirement should be considered only if their use for the same purpose has been reviewed by the FAO/WHO Joint Meeting on Pesticide Residues ^{2/} and acceptable daily intake and maximum residue levels subsequently recommended to the Codex Committee on Pesticide Residues ^{3/} or if the material has been registered or reviewed for a similar rather than identical application. In both these latter cases special provisions must be made to monitor crop residue levels and the manufacturer may be required to submit information regarding residue decline rates and tolerances and an analytical method suitable for monitoring residues of the pesticide and significant metabolites and degradation products.

22. When pesticides are to be used on food crops it should be ensured as far as possible that FAO/WHO maximum residue limit recommendations will not be exceeded. In the case of crops which make a significant

^{1/} AGR and PPDES intend issuing and periodically updating a Supplementary Technical Note listing specific materials and formulations, the use of which should be avoided or strictly limited.

^{2/} FAO publishes periodically reports and supplements recommending maximum residue limits in food and livestock feeds.

^{3/} The Codex Committee is responsible for development of international limits for residues in food within the Codex Alimentarius Commission which is a Joint FAO/WHO food standards program.

contribution to the diet, maximum residue levels must be viewed in the light of the need to ensure that acceptable daily intake levels are not exceeded. Where such materials are to be used on food crops for export, compliance with such accepted residue limits or tolerances established by the importing country must be assured. If a pesticide is being considered for which registration in developed countries precludes its use for treating forages and crop residues subsequently to be fed to animals, provision should be made to prevent such feeding of treated materials to animals.

23. If a proposed pesticide is not registered in the country of proposed use but a pesticide regulation authority exists, the necessary steps to assure registration should be taken before it is introduced into the country. Such registration should establish labelling requirements for the product and require the provision by the manufacturer of particular information on the material's toxicity and persistence and the movement of the material and possibly harmful breakdown products in the environment if it is not readily available in published literature.

24. Selection of pesticides should be based on a careful evaluation of possible hazard to the environment and to important natural resources. For example, materials having high acute toxicity to fish or aquatic invertebrates should not be used where there are aquatic resources which could be adversely affected by runoff, drift or soil erosion and those highly toxic to honeybees should not be used when they will present a threat to important pollinators. Information on toxicity to non-target organisms should be available from the manufacturer if it is not in the published literature. Any use of pesticides should be designed to minimize the area of exposure, but when materials known to present a significant environmental risk are used an environmental monitoring program should also be implemented.

D. Procurement of Pesticides

25. Wherever possible competitive tenders should be sought for the supply of pesticides. In order to evaluate tenders from different sources offering different materials for control of the same pest, prior comparison of the different materials in field tests is necessary to evaluate their relative efficiencies. Where adequate information is available, efficiency weightings may be given to different materials and used in the evaluation of bids but to do so, the weights must be made public in the documents supplied to potential bidders so that in making offers they are aware of the conditions under which their product will be evaluated. Such weights may be used to reflect the advantage a particular material might offer by controlling other pests besides the one for which the spray is intended, by being less harmful to predators, or by being less dangerous to handle and apply. Where data is insufficient to apply such efficiency factors, materials are compared on the basis of their cost per unit area when applied, in accordance with the local recommended practices in the country and taking account of the manufacturers recommendations, at the rate and frequency to control the pest concerned. Where one material has been shown in trials and in practice to offer a longer period of control than another,

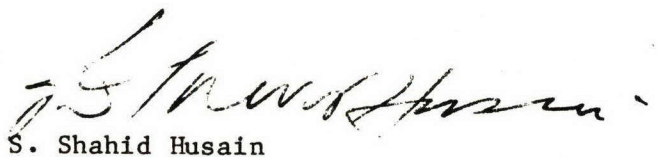
so requiring fewer applications, the saving in application costs needs to be taken into account in evaluating bids.

26. To enable different suppliers, each formulating a particular active ingredient under one or more different trade names to compete, the invitation to bid and tender documents should use the accepted generic name or names of the material or materials which would be considered. The specification should define all the critical characteristics in the formulation covering such aspects as solvents, emulsifiers, and surfactants in the case of emulsifiable concentrates, or particle size in the case of dusts or suspensions, which may affect the performance of the pesticide. The manufacturer should certify that the product is exactly the same (in terms of physical and chemical properties, formulating ingredients and manufacturing process) as that marketed and registered in the country of origin, or be willing to state any deviations and provide an acceptable rationale for them. Materials to be used for seed treatments should be formulated with warning colorants or dyes which will persist under anticipated storage and handling conditions.

27. The specification should indicate any special features of packaging and labelling which are necessary for product protection during handling and storage and to ensure effective use. It should require packaging and labelling to be consistent with accepted standards. Reference may be made to internationally accepted packaging and labelling standards such as those described in FAO Plant Protection Bulletin No. 2 1983 Vol. 13. In the case of products which are not water soluble, the manufacturer should be required to recommend and provide a suitable solvent for washing application equipment and containers. Where available, containers which discourage re-use for storing liquids should be specified.

28. Where only a single product from a single manufacturer is effective in controlling a particular pest or where a single product has such outstanding advantages over other products on the market that it would not be technically justified to use anything else, direct purchase may be resorted to following negotiations with the supplier. In such cases prudent enquiries should be made to determine the prices paid by other recent purchasers of the product in order to ascertain whether the price being quoted is a fair one, taking account of the quantity being ordered and delivery requirements.

29. Where quantities being purchased are small so that competitive bidding would not be an efficient means of procurement local shopping may be resorted to, obtaining quotations from at least three different suppliers.



S. Shahid Husain
Vice President, Operations Policy

March 1985

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8 Jan 1986

Hospitals and Health for All

Report of the WHO Expert Committee on
the Role of Hospitals at the First Referral Level
in support of Primary Health Care

WHO, Geneva

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AT THE FIRST REFERRAL LEVEL

Geneva, 9-17 December 1985

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Hospitals and Health For All

Report of a WHO Expert Committee

"It is clear that unless hospitals accept a partnership role and function in an integrated way with other services in the community, a fragmented local health system will persist. Hospitals should adjust to understand better the essential needs of the community they serve by developing an unprejudiced dialogue with all concerned with health, as equals, engaged in the quest for Health For All"

Dr T.A. Lambo
Deputy Director-General/WHO
Opening Statement to the
Expert Committee on
9 December 1985

Introduction and Executive Summary

A WHO Expert Committee on the Role of Hospitals at the First Referral Level met in Geneva from 9-17 December 1985.

The meeting was opened by Dr T.A. Lambo, Deputy Director-General on behalf of the Director-General and was chaired by Professor J.H. Bryant. Dr B.A. Supit elected Vice-Chairman and Professor J.M. Namboze Rapporteur.

The Expert Committee considered a sequence of issues and problems relating to the roles of hospitals at the first referral level in support of PHC. It reviewed the imperatives derived from Health for All:

that health services address the needs of entire populations
that PHC is the key to doing so through bringing effective and affordable services to bear on defined populations with full participation of the people involved,

and specified the components of the local health system based on PHC, including:

the levels of service delivery...home, community, first health facility, hospital;

the elements of PHC programmes...immunizations, growth monitoring, etc.

the functional infrastructure of PHC...information systems, management, etc.

These components must be interactive, and the role of the hospital should be seen as closely related to all other components - the other levels of health services, other sectors, various PHC programmes, and the methods and systems of the functional infrastructure.

This perspective introduces roles for hospitals that to many of them will seem entirely new, but which must be considered if hospitals are effectively to support PHC.

The Expert Committee identified some fundamental issues that stand in the way of closer integration of hospitals with local health systems based on PHC, and examined approaches to tackling them.

ORGANIZATIONAL AND FUNCTIONAL ISSUES

Currently, in most settings around the world, hospitals and local health systems are managed separately and their work is generally not well coordinated. One reason for this problem is that the hospitals may be under different authorities from the other levels of service delivery - for example, they are under different departments of government, or one is governmental and the other nongovernmental. Another contributory factor is that the traditions and technologies have kept them separated.

Now, however, compelling reasons for integration are emerging. The imperatives of reaching entire populations with effective health services cannot be achieved by either hospitals or local health systems acting independently of one another, and certainly the special resources of hospitals cannot be put to optimum use when functioning in isolation.

ATTITUDES, EDUCATION AND TRAINING, AND BEHAVIOURAL CHANGE

Substantial changes in attitudes and training are required if the gap between hospitals and other local health services is to be closed. Resistance to change has its roots in differing values, traditions and methods of work: the

hospital concerned with individual patients, technological requirements for caring for their needs, and the immediate provision of acute care; local health systems based on PHC concerned with entire populations, low cost and appropriate technologies, and with the long-term requirements for community development.

Changes will have to be brought about in attitudes through promoting better understanding of the rationale for increased interaction, including the benefits to hospitals and other health agencies, and to those that they all serve. Educational and training institutions will be very influential in shaping attitudes and capabilities of health personnel.

DEVELOPMENT OF MANAGERIAL AND SUPPORT CAPACITIES

A number of managerial processes and technologies - information systems, financial and resource allocation systems, for example - have traditionally been used separately for hospitals and other health services, each without regard for the other. But these processes are essential to decision making in both settings, and any consideration of integration of the two parts of the system demands integration of the technologies.

Another critical issue has to do with clinical referral. The movement of patients within a system or between components of a system is a touchstone of that aspect of the system that deals most directly with the perceived needs of the population. Whatever preventive or promotive goals the system may have, it must deal with the problems that patients consider of immediate and personal importance.

WAYS AHEAD

In addressing these three sets of issues (organization and function, attitudes, managerial and technical support) the Committee had the benefit of a mass of written evidence, reflecting countries' experiences particularly at the local level. These experiences were drawn together in 5 broad ideas; -

- that all local services, including hospitals at the first referral level, relate themselves to a defined population

- that communities be involved in the running of all these services, including the hospitals, in what can be called the District primary health care complex, or its local equivalent
- that hospitals in consultation with their communities and the relevant agencies determine what referral, management and support roles they need to play in their specific local situation
- that these arrangements be worked out so as to relate closely to other sectors at the secondary and tertiary referral levels and to governments
- that strong management processes and support be developed for the District primary health care complex or its local equivalent.

Several steps are called for to bring these ideas to bear upon the hospital in the context of its local health system. First, the ideas themselves need to be examined, adapted and developed in terms of their appropriateness in particular settings, for this integrative purpose. Second, greater awareness needs to be created among those working in the field, through workshops, educational programmes, and other means of sharing ideas. Third, practical applications of these ideas need to be pursued in field settings. The Expert Committee was convinced that organizational and functional interaction within what can be called the District PHC complex, or its local equivalent, is imperative if full and effective use is to be made of the resources of hospitals at the first referral level, so that the health needs of populations can be met.

In formulating recommendations, the Expert Committee recognized the great diversity and pluralism that exist among hospitals at the first referral level and the local PHC initiatives to which they would relate, and acknowledged the necessity for addressing these institutions and settings through a communion of interests rather than only through traditional WHO-government interactions. Accordingly, the Committee addressed recommendations to WHO, member governments, NGOs and hospitals.

The Committee recommended that WHO, among other things:

- continue and strengthen ongoing programmes of the Organization at Headquarters, Regional and Country levels that promote the role of hospitals as the first referral level in support of PHC

- develop a mechanism for consultative discussions and active development with governments, agencies, nongovernmental organizations and other interested parties, in order to ensure effective communication, sharing of ideas and pursuit of an agenda of further steps to be taken to advance this field

- establish a collaborative network, possibly organized on a regional basis, that could promote, reorient, support, monitor and evaluate efforts of both hospitals and District Health Systems to integrate their efforts in implementing Health For All strategies.

The Expert Committee also made recommendations to governments, nongovernmental organizations, and hospitals, calling on them to undertake initiatives, each in its own sector, that would be complementary to the work WHO, and would further the roles of hospitals at the first referral level in support of PHC.

I. BACKGROUND

1.1 Hospitals and PHC - a false antithesis

Hospitals represent, throughout the world, the main concentration of health resources, professional skills and medical equipment. How can they give greater help in the field of primary health care? That question is being asked increasingly often by people within the hospitals, who want to contribute to the health care revolution that is taking place outside the hospital walls. It is also being voiced with equal urgency by those involved in organizing and promoting health care outside the hospitals, who recognize their need for the technical skills, the scale of resources and the depth of support that only the hospitals could provide.

The apparent antithesis between hospital and community care is a false one, but it is common and of long standing. Moreover it has enough semblance of truth to be thoroughly dangerous. As the insistence on universal coverage of population intensifies, and resource constraints become increasingly obvious in almost all health care systems, it is clear that what is done within hospitals and outside them are interdependent and must be inter-related.

1.2 The need for hospital involvement

Many of the things that need to be done to promote health are a long step from the traditional activities of hospitals. If one considers only the much narrower field of curative medicine, most episodes of illness can be dealt with from start to finish without entering a hospital. These facts have contributed in an important way to shaping the PHC movement, but even at the level of personal health care no local health system can work well without hospital involvement and support. Thus it is essential that individuals who need more specialized care than can be given outside the hospital be referred to it. Equally, unless the hospital avoids doing things that can as well be done by others, it will rapidly become overloaded and will also add to existing inequities. In the health system at present prevailing in many countries, an individual is free to seek treatment for his or her ailments at any institution at any level. There is also a deep-rooted impression that one gets better advice and treatment at higher level health institutions. In order to maintain confidence among individuals and with the whole community in the primary health care approach, people have to be assured that in case the services of higher level institutions are truly needed, such services would be

made available to them on a priority and preferential basis through referral. A health system based on primary health care cannot be developed and cannot function without support from the first referral level ensured through a well organized system.

Moreover, primary health care does not simply mean community health services or primary medical care in a conventional sense. It has several different levels of meaning, including

- a level of care, the exact definition depending upon the country concerned, backed up by secondary or tertiary referral
- a strategy, to reorient the health system so as to achieve coverage with effective essential care, individual and collective self-reliance, and intersectoral collaboration
- a philosophy, based on principles of social equity, self-reliance and community development.

At each level of meaning, hospital involvement is essential. As a level of care, PHC will not work unless there is strong hospital back-up, to deal with cases referred from the primary level, and to refer back cases that have received or that do not require that kind of attention. As a strategy, it will not work without an adequate investment of skills and finance, which are mainly to be found at present in the hospital sector. As a philosophy, concerned with equity and self-reliance, it is just as relevant to what goes within hospitals, as to what happens outside them.

1.3 The Expert Committee

The Expert Committee that met in Geneva from 9-17 December 1985 has therefore had no hesitation about the timeliness and importance of its task, which was specifically to consider the role of hospitals at the first referral level in support of primary health care. It was, in fact, the first WHO Expert Committee on hospitals since 1968, and the first since 1959 to review the role of the hospital in the broader context of a health system. In the interim the whole revolutionary thrust towards primary health care has been instituted and has begun to gather pace, as described in the remainder of this chapter. Without increased hospital support at this stage, particularly that of the hospital at the first referral level, PHC cannot realize its full

potential. Meanwhile the ground beneath the foundations of hospitals is shifting, as it becomes increasingly clear that hospital care should only be used when there is no alternative, and economic constraints are increasingly strongly felt by hospitals and other health services. Hospital and community care have to be interdependent, with the accent on minimising unnecessary hospital use. Unless hospitals recognise this, and reach out beyond their walls to the whole network of services in the community, they will become increasingly inward-looking, isolated, and intolerably costly.

1.4 The evolution of health services

The evolution of institutional health services in many countries (for example in mediaeval Europe) started with a realization of the need to provide relief and sanctuary to the poor and infirm.

In the absence of much knowledge about the causation of disease or about effective preventive and therapeutic measures, all that could be done initially was to provide relief through dispensaries and to admit as inpatients those unable to care for themselves. At that date this was possibly all that governments and others (such as religious orders) could do. The epidemics of plague, cholera and other infectious diseases continued to be the major killers. The awareness of their infectious nature created the need to isolate the individuals suffering from such diseases, which was the only method then known to protect the remaining population. This led to the establishment of the infectious disease, quarantine or isolation hospitals. Thus from their origin, hospitals were established and intended to provide refuge for particular individuals who were unable to continue in the community, or who by their infection posed a threat to it.

Towards the end of the 19th century began the rapid advances in medical science and technology that have transformed the activities of hospitals, initially in anaesthetics and surgery, but later in every branch of hospital medicine. Meanwhile, the epidemiology of many diseases became better understood and preventive methods were also developed. The appreciation (already forming earlier in the 19th century) of the need to tackle epidemics on a community, as well as on an individual basis, led to the development of public health and community medicine. Thus, while the hospital has continued and enormously developed its role of providing intensive medical care to individuals, the responsibility for taking preventive measures and for dealing with the community as a whole was usually entrusted to separately created public health organizations and other local health services.

In the period after the Second World War came a further explosion of medical knowledge, and of opportunities to apply it, both in hospitals, and also in the fight to eradicate particular diseases. For many developed countries, this was a period of economic prosperity allowing sharp rises in health care spending. Meanwhile, large numbers of countries gained their independence. These new governments also sought to expand their health services, and to take advantage of increasing opportunities for medical treatment. Physicians and other professionals were eager to develop and adopt more sophisticated technology, sometimes (it seemed) almost irrespective of cost and without sufficient attention to priorities in their local situations. The technical imperative is a very powerful one, transforming hospitals into ever more complex and potent places. At the same time, other health services have also expanded their activities to control or eradicate prevalent communicable diseases, launching targeted programmes for malaria, tuberculosis, leprosy, smallpox, and so on. There has also been increased awareness in the developing world of the interdependence of health with broader social and economic development. But in many wealthier countries, public health departments have tended to decline in status, even though many community health problems remain to be tackled and new ones will undoubtedly arise.

Thus, community health became and has largely remained the concern of public health organizations and care of the individual has been the function of clinical practice, including the hospitals. Coordination between the hospitals and what goes on outside them has often been casual and even incidental. The relative isolation of the hospitals from the broader health problems of the community has its roots in the historical development of health services. It was due to a coincidence of many factors, including the dominance of the disease model of health care, the orientation of most physicians to the individual patient, the technological imperative to use rapidly expanding medical knowledge, and the tendency of all human organizations to expand and enlarge their own particular field of interest, whether for profit, prestige or service. Whatever the reasons for this isolation, it makes no sense today.

1.5 Expanding the hospital context

Relevant to this discussion are the contributions made by the Expert Committee on Organization of Medical Care almost three decades ago.

At its first session in 1956², the Committee studied the place the hospital should occupy in a programme of comprehensive health care for a community. A definition of the general hospital was accepted which emphasized that the general hospital cannot be an isolated institution, but should rather be a part of a social and medical organization intended to provide complete health care. While accepting that the restorative function still remains for the hospital the most important of all, the Committee agreed that preventive activities should also be developed, and that the training of health personnel and bio-social research were other indispensable functions of any general hospital. The organization of a regional system of hospitals, and the development of extra-mural activities for a defined population, were strongly recommended as a way to achieve integration of preventive and curative medicine.

The latter topic (extra-mural care) was further discussed at the second session of the Committee held in 1959³, and the scope of such services was considered to cover out-patient facilities, domiciliary care, after-care and medical rehabilitation. It was recognized that prophylactic examinations for the detection of undiagnosed diseases, health education and immunization (when provided to an individual as part of a medical consultation) all contribute to the field of community health care, and are activities that no hospital can afford to ignore.

1.6 Evolution of thinking on hospitals since 1959

In discussing the role of the individual hospital in relation to local health services, the Expert Committee on Hospital Administration - at its session in 1967⁴ - drew attention to three factors involved: 1) the selection of patients to be referred to the hospital service, 2) the follow-up of patients discharged from hospital, and 3) the exchange of staff and technical services linking the local health system with the hospitals. On the basis of experience gained from practice, it had been found that interaction of small local hospitals with other local health services presented relatively few problems, particularly in rural areas where all the health services may be provided by a single team. In such hospitals (and sometimes in larger ones) it has been found useful to unite the functions of public health officer and hospital director.

The Committee, considering the importance of hospitals in health programmes, also made some general recommendations, such as: 1) a study should be made of the relationships between basic health services and referral hospitals; 2) comparative international studies of hospital legislation should be continued; 3) research on the utilization of hospitals and medical care services should be pursued; and 4) consideration should be given to the establishment of global, regional, or intercountry mechanisms for programming and designing hospitals and other health care facilities, and for advising countries on such matters (possibly in cooperation with non-governmental organizations like the International Hospital Federation and the International Union of Architects). All these recommendations have been subsequently answered, to a meaningful extent, by the WHO-sponsored studies on: structure and organization of the rural hospital⁵, hospital legislation and hospital systems⁶, hospital utilization⁷, and planning and design of hospitals and other health care facilities⁸. These have been followed by relevant activities initiated by WHO regions⁹.

The WHO Executive Board's study on promoting the development of basic health services¹⁰ gave new guidance for developing various levels of health services under different national circumstances. This has been followed by the UNICEF/WHO study on alternative approaches to meeting health needs in developing countries¹¹. Both studies indicate that community health problems cannot be solved in isolation from their political and economic contexts. They set out, in conceptual terms, what countries can do to establish or reorient health systems in line with primary health care principles.

The evolution of thinking on hospitals since 1959 has not been confined to WHO and national governments. In many countries, non-governmental hospitals provide a considerable proportion of hospital services in rural as well as urban areas. As these hospitals became increasingly aware of the unmet health needs in the communities that they served, they have, on their own initiative, reconsidered their role in the community. As a result, many have been actively developing community health activities.

For example, the Christian Medical Commission of the World Council of Churches has extensive collaborative relationships with church related hospitals and governments, its major concern being to meet the needs of populations, with a special interest in underserved and deprived people in both urban and rural settings. In 1974 the CMC devoted an issue of its publication Contact to ways in which hospitals may become more deeply involved

in community health care. Through consultative visits, workshops and publications, the CMC has continued to move thinking and programmes of church related hospitals toward partnership with communities in primary health care.

The International Hospital Federation, an organization with members in about 90 countries, aims to promote improvements in the planning and management of hospitals and health services through its journal and other publications, conferences and workshops, management training courses, study visits and fellowships, information services, and research and development projects. In 1974, the IHF undertook surveys to identify problems and progress in health care in urban settings. High on the list of problems was that of PHC, particularly for the disadvantaged sectors of the urban population. Since then, the IHF and its member hospital associations and hospitals have been involved in a variety of hospital/PHC studies and activities.

These examples of involvement by non-governmental organizations are illustrative only, of a rising awareness among many organizations of the broader aspects of health care, and a determination to act.

1.7 Delineation of primary health care

The Alma-Ata Primary Health Care Declaration in 1978 called for acceptance of the goal of health for all, and identified primary health care as the key to its achievement. The efforts of the next few years resulted in the formulation and adoption, by the 34th World Health Assembly in 1981, of the global strategy for health for all,¹² with the purpose of turning the primary health care approach into reality.

This strategy makes it necessary to orient the whole health system to meet new challenges through an integrated approach to the preventive, promotive, curative and rehabilitative aspects of health. This approach envisages the full involvement of hospitals in the planning and delivery of primary health care. It also implies a sharing between hospitals and other local health services of the responsibility for individual care at home, in the community and at the first referral level.

Within the context of the strategy for health for all, the role of hospitals vis-à-vis primary health care has been extensively reviewed both by WHO¹³ and by non-governmental organizations¹⁴. As Dr Mahler pointed out in 1981, in his address to the Aga Khan Foundation/CIDA /WHO meeting in Karachi,¹ a health system based on PHC simply cannot be realized without a network of hospitals with responsibilities for supporting primary health care. The present Expert Committee meeting concentrated on the role in primary health care of the hospital at the first referral level, since that is the crucial link between other local health services and the hospitals.

1.8 Hospitals and PHC - a need for broader horizons

In considering the interaction of hospitals and other local health services, one must recognise that successful cooperation has often been hindered by differences in tradition, principles and skills. These differences are real and in many respects valid. However, both are needed within a comprehensive approach to health.

The hospital is traditionally concerned mainly with individual patients, and with acute curative care. It is resource intensive, and values high technology and well-trained professional manpower. The hospital tends to define quality in terms of individual care for those who are seriously ill, and the use of sophisticated methods. Ethical quandaries often focus on doctor-patient relationships and on the interactions of technologies and individuals.

By contrast, the PHC approach (which is just as relevant to hospitals as to other local health services) advocates promotive and preventive activities as well as treatment, and is oriented to the needs of entire populations. It seeks to maximize the impact of available resources in relation to all health needs through the use of appropriate technology, and a broad range of health personnel including paraprofessionals and community health workers. Quality is defined not only by appropriate care to individuals but also by improvements in health status of populations, and in terms of more equitable use of available health resources, wider coverage and greater personal responsibility for health. Ethical quandaries often involve the interactions of health systems and populations, and resource allocation questions.

At a more philosophical level there are also important differences in the hospital approach, where the resource for health is often viewed as being beyond the individual, resting with the providers of medical care. The service is professionally oriented. Individuals, seeking to help others, have invested substantial amounts of time and money in developing needed skills. The trained professional is seen as the most valuable instrument in a system which focuses on manipulation of forces within the recipient and in the environment that adversely affect health. The PHC approach, on the other hand, sees individuals and communities as providing a major resource for their own health. The service is community oriented. The community becomes a valuable partner in a system which focuses on nurture and development. The health provider is an enabler or facilitator.

Both approaches share a concern for health and a service motivation. Differences in belief systems which have formed the basis for the two approaches may result in conflict when they are brought together. But indeed they are complementary and must be reconciled in a more holistic understanding of health. Health professionals both within and outside hospitals can and should find common ground in a comprehensive view of PHC, despite their background differences in tradition and orientation, uniting around a common concern for the welfare of individual patients and for the welfare of the community as a whole.

1.9 Orientation towards the common goal of health for all

The delegates at Alma-Ata in 1978 identified PHC as the key to health for all. In reviewing the thinking at Alma-Ata and subsequently, five ideas capture the implications of health for all through PHC:

- because of the equity principle, there should be universal coverage with essential health services, and high cost care benefitting only a few must if necessary be cut back until universal coverage with minimum essential care can be achieved;
- health services should be effective, efficient, affordable, and acceptable in local cultural terms through the choice of appropriate technology, and through the manner in which care is delivered at all levels;

- health care activities should include disease prevention, health promotion, and curative and rehabilitative services;
- individuals and communities should participate in health activities in ways that promote self-reliance and reduce dependency;
- because of the close interrelationship between health and social, economic and environmental factors, efforts to protect health must reach far beyond health services alone to include many other developmental activities.

In discussing the role of hospitals in PHC, a basic premise is acceptance of these principles of Health for All. A hospital worthy of its name must be one that seeks to promote the health of the whole population that it serves, including the health of individuals who never enter it. Proceeding from that premise, what are the implications for the hospital? What opportunities and obligations should it recognise? How can the differing values of the hospital and other local health services - emphasis on the individual patient and on technical intervention in the one, and on the community and social equity in the other, for example - be complementary and mutually strengthening? How might full involvement in PHC change the nature and functioning of the hospital? What experiences are there on which to build?

2. COMPONENTS OF THE LOCAL HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

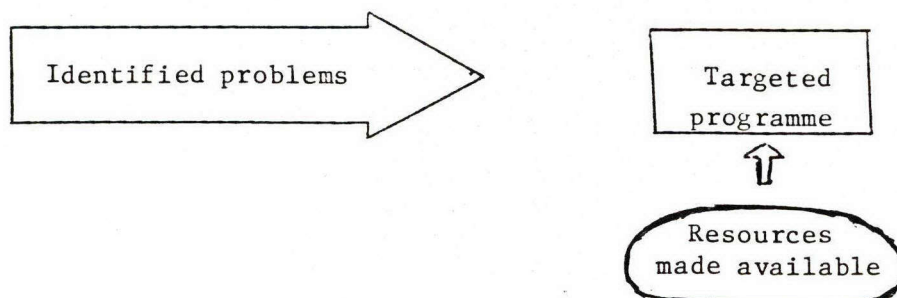
2.1 THE STARTING POINT

We have already referred to the basic principles of PHC: equity and universal coverage, comprehensiveness, community participation and so on. These ideas are fundamental. Nevertheless rendering them operational is by no means straightforward, as many previous WHO reports have recognized. We cannot discuss the subject adequately here, but we need to summarise a few basic concepts to provide a common framework for our thinking. In part, this means briefly recapitulating the development of ideas as people have wrestled with the essential process of translating PHC principles into action.

2.2 Targeted programmes

All health care should logically start from an understanding of the principal health problems of individuals, and hence of communities. An analysis of these problems, and of what can be done about them with the

knowledge and resources available, leads on to decisions about priorities and programmes. In essence this is how many powerful targeted programmes, such as malaria-control or polio immunization, have been conceived and carried into effect.



At Alma-Ata, eight broad programmes were defined as essential to PHC, namely:

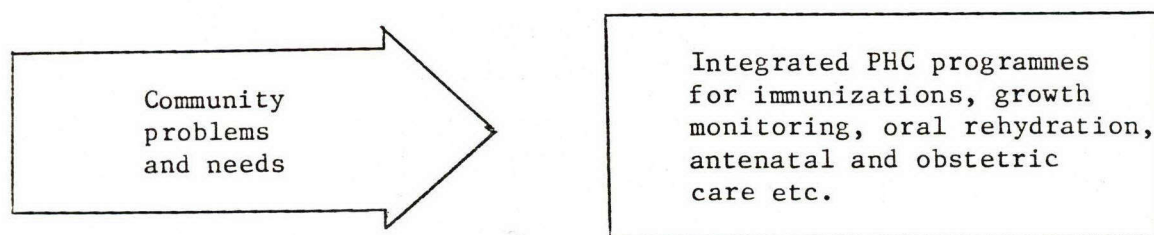
- education about prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- safe water supply and basic sanitation;
- maternal and child health including family planning;
- immunization against the major infectious diseases;
- prevention and control of locally endemic diseases, such as malaria or hypertension;
- appropriate treatment of common diseases and accidents, such as diarrhoeal diseases and common injuries in the home;
- provision of essential drugs.

These titles need not be used as such in actual delivery, and the list is not limiting but should be modified to fit local circumstances. Some nations have specifically included mental health, for example, in their list of essential elements, thus acknowledging the need for an initiative targeted at mental as well as physical well-being. Others may well include mental and physical handicap, and the health and social care of the elderly.

While some programmes could be (and have been) established on a free-standing, self-contained basis, each with its own staff and supply systems, this is seldom sensible or cost-effective in the long run. Such individual or vertical programmes multiply to cover the variety of problems, and in that process duplications and inefficiencies also multiply.

One of the key challenges in the PHC field today is to bring separate PHC programmes together into clusters, and finally to integrate them entirely within the local health system for greater efficiency and effectiveness. This invariably involves some changes in organization and management.

Thus, our diagram of programmes designed to deal with problems must be broadened:



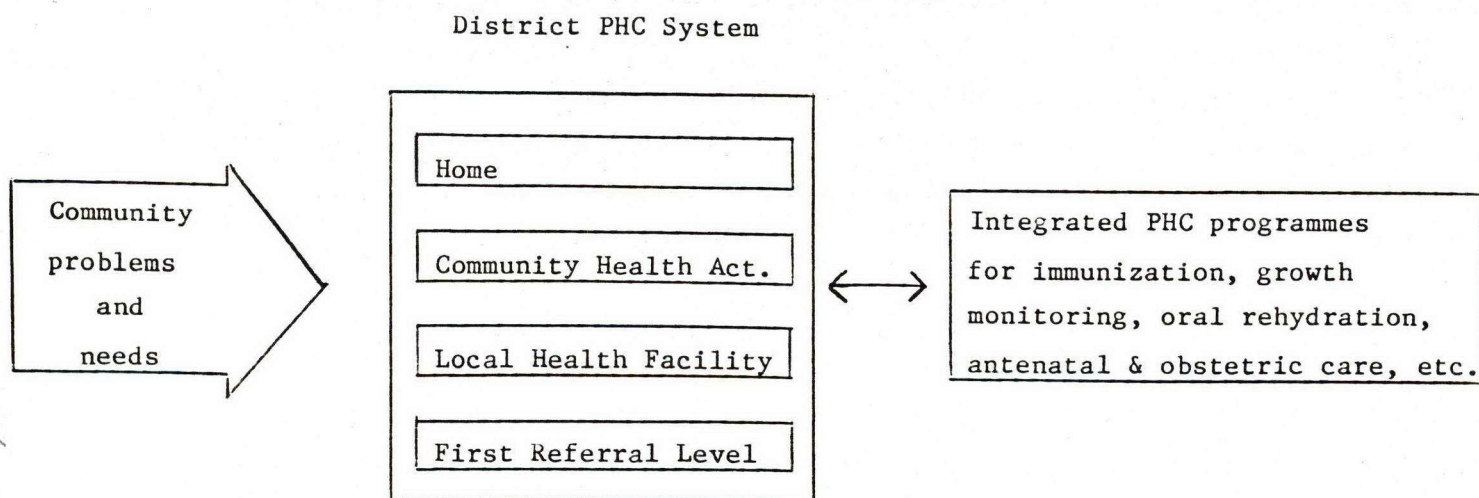
2.3 Levels of Service Delivery

Four levels have been identified in a local health system based on PHC:

- Family and home
- Community health activities (community health workers & community action of all kinds)
- Local health facility, usually a dispensary or health centre
- First referral level, usually a hospital in the case of curative services, alongside or related to a district health office for community and public health referrals.

In the present report, the Expert Committee is particularly concerned with hospitals at the first referral level and the way in which these hospitals can best support activities at the other three local levels of home, community health activities and health centre. Hence we have the concept of integrated programmes that are operational at four levels:

Levels of Service Delivery



2.4 The management infrastructure for PHC

To make sense in the real world, this set of ideas needs to be supported by what might be called the management or functional infrastructure of PHC¹⁶. This infrastructure can be defined in terms of support systems:

-Information, including community assessment, ongoing surveillance of health problems and needs, monitoring of programmes;

-Management activities, including planning, implementing, financing and evaluating programmes;

-Manpower development, including recruitment, training, supervision, continuing education;

-Logistics, including supplies, transport, communications;

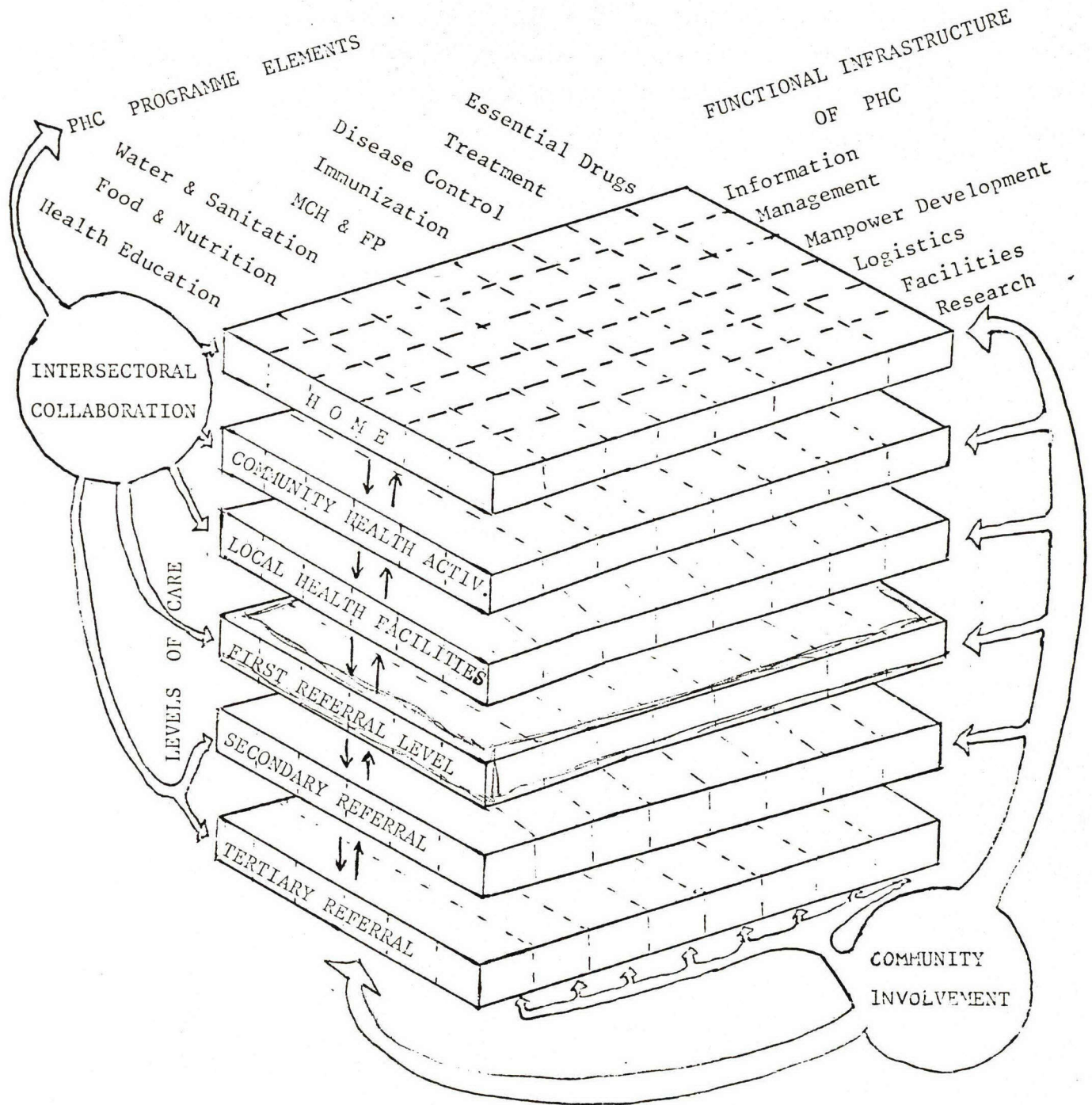
-Facilities, including physical planning and design, siting, equipping, maintenance;

-Research, a capacity for action-oriented research on day-to-day problems of PHC.

Essentially we are thus recognizing that a key management task is to organize the limited resources of manpower, facilities, equipment and technical skills across the various levels of service delivery, in order to carry targeted programmes into effect in an integrated way.

Conceptually, we have added another dimension and are now dealing with a matrix that interrelates three sets of parameters: PHC programmes; levels of local service delivery; and the management infrastructure.

A Conceptual Model of a Comprehensive Referral System in Support of PHC



Note: Community involvement should affect all three faces of the model: that is why it is shown influencing the elements of programmes, the running of institutions and the functional infrastructure. Intersectoral collaboration could be shown similarly but has been drawn on the service face of the model, since collaboration will usually be organized between agencies.

2.5 The place of the hospital

The disadvantage of a diagram like this is that it appears to have neat lines and solid edges. Reality is not like that. But on the other hand the diagram does usefully show how absurd it is to think of hospitals separately from other PHC levels.

Looking at the "slice" of the matrix labeled 'first referral', it can be seen that the hospital relates to three sets of parameters in order to meet community needs: the PHC programme elements (immunization, growth monitoring, etc.); the levels of service delivery (family, community health activities, health centre or other local health facility); and the various management support systems (information systems, manpower development, etc.). These relationships help structure answers to the question, what should be the role of the hospital in relation to other parts of the local health system and the broad needs of the community?

3. ROLE AND FUNCTIONS OF THE HOSPITAL AT THE FIRST REFERRAL LEVEL

3.1 ROLE

Hospitals are typically extremely busy places, doing the best that they can for the individual patients who have come to them, whether they came for emergency treatment, for an outpatient consultation or for inpatient care. Relatively rarely can people stand back from their work and consider their hospital's role in conceptual terms.

One way to do so, using the model illustrated in paragraph 2.4, is as part of a dynamic system with inward and outward flows:-

- Inward Flow: there is movement of patients, problems, workers, people for training, reports, monitoring, evaluation, ideas, equipment needing repair and maintenance, requisitions for supplies and so on. Here the flow is inward, from the home, community and health centre to the hospital.

- Outward Flow: there is movement of patients returned, problems hopefully resolved, instructions, policy decisions, feedback from analysis of reports, continuing training, supervision, requests for consultation, questions about the periphery, ideas and new technologies, equipment and supplies. Here the flow is outward, from the hospital to the health centre, community and home.

These interactions (which are illustrative rather than comprehensive, and would certainly differ between urban and rural hospitals) do not take place in a vacuum. The hospital at the first referral level relates also to the secondary and tertiary levels. Moreover relationships to other services (intersectoral collaboration) are vital, as is the social and political context of the community in which all this happens. The inward and outward flows are thus moulded in a particular setting by such forces as population density, economic development, the position of the medical profession, and the degree of decentralization and integration in the political system.

Another way to address this question of the hospital's role is by considering for specific PHC programmes, such as immunizations, what are the respective contributions of the family, community health activities, health centre and hospital, in terms of clinical care and functional support (information, management activities, manpower development and so on). In doing so, one is actually extracting from the multi-dimensional model of paragraph 2.4 a series of programme slices in order to review who does what, and where the gaps or overlaps may be.

Both approaches can lead to a definition of the hospital's role in terms of patient referral, health programme coordination, education and training, and management referral and support. We will consider each of these in sequence, and then turn to their organizational implications.

3.2 Patient referral

Normally a hospital receives some patients direct, through emergencies and self-referral, and some because they have been sent there, by a physician, nurse or other health care worker. In any of these instances the hospital's job is to treat the patient as best it can, discharge him or her as soon as is consistent with appropriate care, and explain to the referring practitioner its findings and the further care required.

This may sound simple, in theory, but it is by no means always so in practice. For example,

- The hospital may be almost overwhelmed with patients (through self-referral and through poorly judged referral), so that it has no time for other vital tasks, such as health promotion and consultation with health clinics and with health care personnel working in the community.

- There may be such barriers of distance, transport or payment that referred patients simply do not arrive or arrive only after undesirable delay.
- People may have very little confidence (sometimes justifiably) in the care that they would receive if they did not come to the hospital.
- The information-flow is generally inadequate. Evidence presented to the Expert Committee suggests that (based on one, not untypical study) at least half the letters of referral to hospital were inadequate, and that most discharge reports and summaries were either defective or late, or both.

We return to these problems, and approaches towards tackling them, later in our report.

3.3 Health programme coordination

Going beyond the individual case, are the planning, coordination and evaluation of health programmes (see the face labelled PHC programme elements in the model in paragraph 2.4). Without being exhaustive, there are four main possibilities for the hospital's role in such programmes.

- Programmes confined to hospital patients and their families, such as programmes in health education in the hospital.
- Single-function or special focus PHC programmes such as nutrition, maternal and child care, immunization, rabies prevention, or mental health.
- Comprehensive PHC programmes, as in hospitals given the responsibility for total health care within a specified geographical area of population.
- Community development programmes, including comprehensive actions to promote health.

We have already referred to targeted, disease-specific programmes in the context of primary health care. While they should not be conceived nor implemented in isolation, there is no doubt about their power, particularly when related to one another. Seen in programme terms, malnutrition, water contamination or infectious diseases of childhood are concrete problems to be tackled, by deciding what to do, mobilizing the resources to do it, and gauging the effect.

In the programme context, it is easy enough to see that the hospital at the first referral level often has a contribution to make. In nutrition, for example, this will include carrying out diagnostic tests (e.g. serum protein tests, the extent of anaemia), counselling, and treating referred cases. The hospital's contribution could also embrace a much wider range of nutrition-related activities, including educational and logistic support for health professionals and community health workers, and the analysis of information. Quite obviously the hospital's contribution will be of limited, even negligible, value if all it does is to treat referred cases without reference to the root-causes of malnutrition in the community and the conditions to which its patients are discharged.

The nutrition example is only one among many. Obstetrics, neonatal, infant and young child care and paediatrics all provide incontrovertible evidence of the essential interdependence between community-based and hospital-based activities. To quote from one of the papers prepared for the Expert Committee, "The hospital concerned with admission of obstetric problems should also be concerned with preventable factors at the periphery. Just as in any other accident, obstetric mortality is preventable." The same is true of much perinatal and young child mortality. Dealing with these problems effectively must involve outreach from the hospital. For every obstetric or neonatal emergency requiring sophisticated intervention many more will respond to first-line measures in the home or health centre. Moreover it is essential that the signs of high risk are recognised and that, when hospital referral is warranted, it takes place in time, with appropriate care meanwhile. Nor is all this a one-way process of information and instruction: it is equally important that the hospital-based obstetrics team know what the facts and the circumstances are, relative to birth and birth-related mortality and morbidity in the community. Unfortunately, to quote again from the same paper "District hospitals (often) lack precise information on what are the major problems presenting, where patients are referred from, or their mortality and morbidity

figures. They maintain no baseline information from which to evaluate progress in reducing these mortalities. Generally speaking district hospital staff are preoccupied with the daily caseload of hospital and private practice, and work in isolation from events in the community outside".

The same need to relate what the hospital does to what goes on outside its walls patently exists in paediatrics. To take acute diarrhoeal disease and gastro-enteritis as an example, which cause such high mortality among infants and young children, the hospital can achieve very little by itself. It cannot even know what it is achieving, since the threshold for referral to hospital may change without hospital-based staff being aware that this is happening, unless they have a much broader picture of patterns of need and intervention in the community.

Conceptually this is just as true in the fields of mental illness, mental and physical handicap, and care of the elderly. In all these fields the only approach to health care that makes sense is a community-based service, with hospital activities as an integral component. Moreover, from work in such fields as these come particular insights, that should influence all health programmes, concerning the importance of emotional, psychological and cultural sensitivity in dealing with "other people's" problems.

3.4 Education and training

Education and training involve many institutions that are not part of the local health system. Nevertheless there are at least three aspects of local involvement that the Expert Committee wished to take into account in its thinking, namely:

- Basic and continuing education for all health personnel working in the local health system
- The concept of a "teaching district", or a local health system as the setting for university and other professional education
- The need to develop the management and leadership capabilities of those who have positions of responsibility in the local health system, including ensuring that they have the breadth of vision required to play their roles in the context of PHC as a whole.

In each of these aspects the hospital have a part to play, and some hospitals will be involved in them all. At an absolute minimum it is responsible for the induction and continuing training of its own staff, including preparing its staff to play their roles in PHC.

3.5 Management and administrative referral and support

Managerial and logistical interactions of various kinds form a further class of interrelationships between other local health services and the hospital at the first referral level. This is the functional infrastructure dimension of the model shown in paragraph 2.4. Here there is a wide range of degrees of involvement by the hospital, depending on whether (a) the hospital is organizationally separate from the rest of the local health system, or (b) there is (as in some countries) a separate district health office which manages the local health system as a whole, or (c) whether the headquarters function is based within the hospital. If it is based in the hospital, then it must not be hospital-dominated, for supporting and directing the whole complex web of PHC activities calls for insight, sensitivity and skill that have little to do with hospitals as such. Included within the range of health systems management functions are resource allocation and control; working with other sectors for health purposes; manpower development and deployment; purchasing and distribution of supplies; and planning, monitoring and evaluation, based on an effective management information system and on research.

3.6 Main organizational implications

If (against this background) the hospital at the first referral level is going to discharge its role in relation to PHC, then a number of organizational implications follow:-

- (1) It needs to serve a defined population, within an integrated local health system. The hospital at the first referral level must be clear that, whatever its other functions (which may include secondary or tertiary referral), it is an essential part of one particular local health system, ready to accept patients from the health centres, dispensaries and community health workers, and actively supporting them in their roles.

(2) The hospital must help to make individual and community involvement a reality. People will not do all they can to safeguard their own health, nor will they use services sensibly, unless they understand the choices available to them and the ways in which they themselves are responsible for the choices that they make. This applies at the communal, political level, as much as it does to individuals. Not only are many aspects of health promotion communal: there are also important questions about what resources to make available for health care, and about priorities for their use, that are at least as much social and political as they are professional and managerial.

(3) It needs to define, for its particular local setting and in consultation with all the other parties involved, including the community, what specific roles it should seek to fill as the hospital at the first referral level. The headings that need to be considered are implicit in what we have already said namely the roles and relationships for patient referral; for coordination in the principal PHC programmes; for education and training; for management, and for administrative and logistic support. Intersectoral collaboration must be integral to these decisions about roles.

(4) It must fit into the broader organizational context of regional or national health systems in the country concerned. This may be obvious enough in the case of governmental hospitals, but can be a real problem for others. Major problems can arise for voluntary agencies in relating to governmental health units and in drawing logistic support with them. Even in the case of governmental or other public hospitals (such as social security hospitals), relating to other essential agencies may be by no means straightforward, especially where this involves intersectoral collaboration. Where there is a district health office, the relationship between it and the hospital at the first referral level is another crucial element.

(5) Appropriate management processes need to be established in the local health care system. Specifically, these include mechanisms for defining health care needs; designing programmes to meet them; establishing referral patterns between services; allocating scarce resources, or at least coordinating their use if they derive from a variety of different agencies; and evaluating utilization patterns, alternative treatment methods, and outcomes.

In the section that follows, we deal with each of these five ideas in turn, based on the evidence available to the Expert Committee.

4. FIVE FORMATIVE IDEAS DRAWN FROM COUNTRIES' EXPERIENCES

4.1 SERVING A DEFINED POPULATION

We have already emphasised the requirement that all the relevant services that contribute to primary health care should be oriented towards serving a defined population. Unless this is the case, it is hard to see how the precepts of Alma-Ata can be carried into effect, particularly the pursuit of universal coverage; the assessment of health needs and the impact of services; and the participation by communities in the governance of health care institutions.

The population to be served could be defined in at least four different ways:-

- Part of a district, where a hospital chooses or is given a specific group of villages or a deprived urban area in which to develop, or to be involved in, a PHC programme.
- A specified risk group or entitlement group, for example, in relation to an employer or an industry or a group of subscribers.
- Vertical or special programme involvement in a whole country or a large part of it, such as the BCG vaccination programme organized by a small hospital in Haiti that immunized 80% of all persons under 21 years old in that country, in eight years.
- A whole district or province, where a hospital (along with other relevant agencies) is given responsibility for curative and preventive services for the whole geographic area.

Advantages of a geographic definition, with total population coverage

In general, the last of these options is preferable when it can be achieved, particularly when the boundaries are natural ones, and relate to other sectors of the public service and of government.

Intersectoral collaboration then becomes easier, and data analysis can be far more straightforward and the results richer. Moreover unless the whole population is included, the inverse care law will operate, by which resources tend to be most used by people who are already relatively advantaged, while others with relatively greater needs are underserved.¹⁷ Without studying a defined population, the hospital at the first referral level cannot examine sufficiently critically its own performance in the context of other health services. To take an example from one of the papers prepared for the Expert Committee - on Gestational Risk, Antenatal and Delivery Care in a Brazilian City - a critical examination of the role of hospitals in the city showed, in that instance, that antenatal care was inversely correlated with risk, and that caesarean sections were positively correlated with family income, rather than with risk. A conclusion drawn by the authors was that neither the poor nor the rich received optimal care: broadly the first group received too little, and the latter too much. Deeply disturbing mismatches of that kind may well go unrecognized unless the work of hospitals is studied in the broad context of community needs and other health care provision.

Even when a mismatch is recognized, it can be extraordinarily difficult to relate the activities of the hospital to the specific contributions that it can best make, complementing the activities of others. This is especially so where hospital resources are small and where the population is widely dispersed. For example the paper prepared for the Expert Committee on Patan Hospital, Nepal explains the hospital's role in support of primary health care for a population of 210,000. It is exceedingly difficult to provide effective support to health posts that are up to two days' journey from the hospital, and equally difficult to avoid becoming wholly absorbed in providing services for those who happen to live close by. To quote the paper submitted: "There is considerable demand for the treatment of simple diseases within the hospital, even though there is no real need in most cases for hospital facilities". This problem is also recognized in the paper from Kasongo, Zaire where simple treatments of this type are seen as "operational loopholes" to be worked out of the system, if the hospital is to concentrate on its referral functions.

In some countries it is accepted practice that patients will be referred to the particular hospital that serves their neighbourhood. In many others the patient and the referring practitioner can choose to use another hospital if that is preferred: the right to refer across boundaries is often seen as an important protection against bureaucracy. It would be sad to see such freedom eliminated. Nevertheless it is reasonable that incentives should encourage, rather than discourage, rational patterns of referral. Thus, for example, patients referred from remote health posts, such as in the Nepal case, might have preference at the hospital in being seen more quickly and being seen by a specialist, if necessary, compared with those who are self-referred. Charges also are important since many patients are reluctant to incur additional expense. In the Kasongo case, therefore, referral and hospitalization charges are included in the initial fee paid by the patients at the health centre.

There are, of course, a number of examples around the world of systems that are so organized that the hospital forms an integral part of the local health system. The USSR (whose system is also reflected with variations in the other democratic republics of Eastern Europe) is one of the clearest examples of all. While there are naturally major differences between rural and urban areas, in both cases there is a complete system from the feldsher-midwife health post and the occupational health service to the hospital and the public health institutions, for preventive as for curative purposes. China's system is as complete, but in a different way, with a three-tier health system in the rural areas at the production brigade or village, commune or township and county levels. The village health stations are self-reliant economically, in that the villagers support the costs, but they are integrally linked to the township health centre and the hospitals at county level, for referral purposes, and for professional and managerial guidance and support. In India, the Government decided in 1975 to integrate the curative and public health/PHC services at three main levels, which in India's specific case are the "patch" (1,000 people served by village health guides (community health workers), health centre (5,000 people) and first referral (30,000) people levels.

Some of the barriers and their implications

While there is no comprehensive information on the extent to which hospitals at the first referral level meet these criteria, the survey carried out in 14 countries in tropical Africa by the Royal Tropical Institute, Amsterdam is suggestive. The majority (roughly three-quarters) of the hospitals responding did indeed have formal referral arrangements with health centres, dispensaries or village health workers. In many respects, however, the contacts fell short of a close partnership and suggested far too narrow an understanding of health care. For example only about half were involved in training village health workers, less than half collected health data at the village level, and forty per cent did not involve local communities in any way in health decisions.

Effective cooperation is of course harder to achieve where the hospitals and other institutions and health care workers that together would comprise a local health system, work within separate organizations, separately funded and controlled. The variations are too great in the economic, social and political settings, for there to be any one best model for a local health system. For example we do not think it would be appropriate to prescribe a population size for such a system.

Nevertheless we think that it is fundamental that every hospital at the first referral level should relate to a defined population, with a special commitment to the health of the community that it serves and to other local health services and health workers in its area. Whenever possible, the basis of definition should be geographic. In urban areas with many hospitals, there are special problems which may be best resolved by some form of consortium, rather than by seeking to create artificial boundaries. Even if a hospital does not have a major role in clinical referral at the first level, it should have a role in promoting PHC for its patients and their families. Even tertiary and university hospitals may, by agreement, be involved in PHC as first referral hospitals for purposes of service, teaching and research, and will then have to learn how to discharge this role well, and to hold it in balance with their other activities. Where PHC is weak, hospitals may have a role in reaching out to strengthen or even to help create it.

4.2 MAKING COMMUNITY INVOLVEMENT AND HEALTH PROMOTION A REALITY

Community involvement is a fundamental article of the Alma-Ata declaration: "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care".²⁰ The case certainly need not be argued here. It has a strong base in human rights, as well as in pragmatic evidence about the nature of health and illness: health can never be adequately protected by health services, without the active understanding and involvement of the individuals and communities whose health is at stake. Action to promote health depends on a broader resource base than the health sector alone, and also needs to tap each community's determination to help itself. A partnership is required between those working in the health sector and the community, based on mutual understanding and trust.

That is as much true for hospitals as for the rest of the health care system. However, accepting the argument does not make community involvement easy in practice, as the working papers prepared for the Expert Committee and extensive experience indicate.²¹ Many serious and sustained attempts at community involvement have ended in disappointment. Among the reasons have been that people have not always been encouraged to think and choose for themselves: the "solutions" have often been imposed on them by experts. Nor have sufficient effort and imagination been devoted to developing the structures and methods by which people can in fact participate in more than token ways. Among the key issues of community involvement are: what kind of participation to seek, for what kinds of goals, who is to participate and how.²¹ Some radical changes of thinking are required, in the community as well as among health professionals, for example towards the notion of upward planning and downward support. In other words, experts can and should provide information and support, but in the end it is individuals and communities who must decide.

The record of hospitals

Difficult as the whole field of community involvement unquestionably is, hospitals have on the whole lagged behind. There are all sorts of explanations, such as the overemphasis on the disease model of hospital care and the lack of relationship with a defined community, but no explanations are adequate for the future. Hospitals cannot do their job effectively if they seek to deal only with the effects of diseases rather than also with their causes, and with repair alone rather than comprehensive care in a context that also includes prevention and promotion. Moreover with resources becoming increasingly scarce, hospitals have no right to decide for the communities that they serve what should have priority. Technical decisions are one thing, but choices of priority are generally at least as much social and political as technical.

The need for real community involvement provides one good argument for the definition of the population to be served by each hospital at the first referral level. That at least makes clear what the community is that the hospital must involve. In governmental systems, greater decentralization than now exists may often be required, if it is going to be worth the community's while to participate. Community leaders often start from initial scepticism, and are quite right not to waste their time unless their involvement pays off for their community. Equally, local communities will not want to influence health services alone, and thus intersectoral collaboration is also a pre-requisite.

Paradoxically, while independent hospitals may in many cases seem less closely linked to local health systems and specific catchment populations, they may also be less constrained by central regulations. They may therefore be in a particularly good position to innovate in making community involvement real.

More generally, hospitals are not remote like some institutions of government. Communities readily identify with them. Hospitals thus have a substantial prestige and strong leadership positions in most communities. So do the hospital-based medical and nursing staff. If the hospitals and the professions are serious about community involvement, that will itself influence the community's response.

This is also true of health education and health promotion. For many health problems, ranging from malnutrition to cardiac disease, and from alcoholism and violence to loss of independence in old age, hospital repair is not an adequate or effective response. Hospitals have their part to play in health education and health promotion, and their example will be important.

Despite the real difficulties, there are some encouraging examples of community involvement in hospitals, and of hospital involvement in community development and health promotion, in many parts of the world. In China, for example, there is no doubt about the direct links between health agencies at each level, community councils or committees, and intersectoral development. Although the mechanisms and traditions are different, the same is true in the USSR. In many other parts of the world, the examples are of single institutions rather than whole systems: for instance, in some of the "patch"-based projects and the "hospital without walls" in Costa Rica, and in hospital-based projects as far apart as New York²², Sierra Leone,²² and Hong Kong.

Some reflections based on countries' experiences

Without being exhaustive, the following reflections may be helpful:

- (1) Many hospitals try to gauge the opinions of those who use their services and learn from their comments. This should be part of standard good practice, as should be the prompt, thorough and impartial examination of complaints.
- (2) Health promotion and preventive activities should have more emphasis than is common in hospitals, otherwise a key opportunity for informing and influencing people's behaviour will be missed.
- (3) Communities should be more strongly involved in the direction and control of hospitals than is common, for example through representation in their governing bodies.
- (4) Hospitals have potentially an important role to play in community development, because of their authority and the loyalty that they command.

- (5) New organizational mechanisms for collaboration between the health sector and the community should not be set up without exhausting or adapting traditional processes and existing bodies for community involvement. Otherwise community development may actually be weakened rather than strengthened.
- (6) The respective roles of hospital-based personnel, community health workers and other front-line workers should be carefully negotiated, involving the community in the process.
- (7) In many cases it is inevitable that local communities will have to pay for first contact health care. Whatever the pros and cons may be, a local contribution can strengthen the feeling of community self-confidence and of the right to be involved in governance.
- (8) The primary health care approach is more than an extension of basic health services meant to bring simple effective health care to village health posts; rather it recognizes the two-way interrelationship between health and socio-economic development. It is essential, therefore to adapt health institutions to this broader role so that "health" becomes both a promoter and a consequence of socio-economic development and an improvement in the quality of life. Such a realignment is particularly vital at the district level.
- (9) Community involvement is essential. It is also difficult. Hospitals and hospital-based personnel have, in general, much to learn before they can interact effectively with their communities. In this respect (among others) the learning within a local health system will be by the hospitals and the professions, from community-based workers, students of community development and community leaders.

There are, we recognise, many barriers to overcome before strong local health systems, including a hospital at the first referral level, can be created throughout the world. We return later in our report to considering some of these barriers in more detail and suggesting how progress can be made.

4.3 DEFINING AND DISCHARGING SPECIFIC ROLES

Choices

From what we have already written, it is clear that we can classify a hospital's role in relation to its local health system under some broad headings, relating to individual patient referral, the management of broad health programmes, education and training, management, and administrative and logistic support. What we want to emphasize here is the idea of choice, and the need for considered and shared choice. Within the specific local context, choices should be made of what roles will be played by each agency, including the hospital, so as to do the jobs that need to be done. Because the range of contexts is so great, we aim only to suggest some of the questions that need to be considered, and to illustrate an approach to reviewing them.

In the Appendix we include a list of "self-audit" questions that hospitals may find it helpful to consider. These are not classified by function, but closely relate to the idea of reviewing what are the main problems within the local health system, how they can be tackled and who is going to tackle them. For example: -

- Patient referral: What problems are there? How adequate is the information that comes with the patient when he or she is referred, and on discharge? (A working paper from Israel suggested that at least half the letters of referral were inadequate, and that most discharge reports and summaries were either defective or late, or both). What can be done to correct this?
- Health programme coordination: What are the key health problems (for example infant malnutrition, diarrhoeal diseases, and prenatal mortality)? In what population groups do they occur? Which agency can best intervene to take corrective action? (An obstetrics example, based on a city in Brazil was included in the working papers for the Expert Committee, and highlighted the need for radical change in the obstetrics services of the city's hospitals).
- Education and training: What needs are there for change in attitudes and skills, and how can these best be reflected in education and training? Which agency should do this, and by what means? (A basic reorientation of many professional training programmes is needed. It

is already reflected in some medical schools, and in nurse training that has a broad community orientation. Hospitals can, by agreement, also play an important role in training community health personnel, as in the cases cited in the papers prepared for the Expert Committee (community health nurse practitioners in the Republic of Korea, and of village health workers and other personnel at the Bethesda Hospital, Indonesia).

- Management: How are local services to be planned? How will decisions be made about the allocation of scarce resources, and who will act on those decisions? How will the resulting performance be monitored? (Examples of these questions being answered would mainly come from fully integrated health care systems, such as those of the USSR and China. The need to act and answer them arises in all health care systems, including those that are much more loosely coordinated).

- Administrative and logistic support: Who should do what in each of the main supporting functions? What are the main problems, if any? And what can the hospital contribute? (Specific examples raised in the working paper and in the Executive Committee's discussions concerned pharmacy, laboratory services, supplies and equipment, facilities planning and transport).

Implications

Every hospital at the first referral level will fill a combination of the roles that we have just reviewed. Circumstances are too varied for any one prescription to be appropriate, or even for general guidelines to be much help. Appropriate roles in clinical referral, which may seem at first sight the least ambiguous, will actually vary among clinical services and programmes. Moreover they will depend crucially on the strength or weakness of primary care outside the hospital.

Equally, there will be great variations in the appropriate roles in administrative and logistic support, and in education and training.

What we would suggest, returning to the model in paragraph 2.4, is that matrices extracted from it can be helpful in determining roles and in diagnosing where problems lie. For example, taking an integral PHC programme, one can discuss among all the relevant parties, who will do what:-

Example

Name of Programme: MATERNAL AND CHILD HEALTH

Programme element: Diarrhoeal Control in children

<u>Examples:</u>	
Family	Food supply Food preservation Feeding process hygiene Diet (quality and quantity) Oral rehydration
Community Health Activities	Health education Advising community leaders Lay personnel training Oral rehydration training Data collecting Epidemic control Referring to health centres
Health Centres	Training of community health workers Ambulatory treatment for moderately severe diarrhoea Referring to hospital
Hospital	Diagnosis and treatment of severe diarrhoea Parenteral rehydration Training on preventing diarrhoeal treatment side-effects Feed-back to health centres Programme coordination
Other Sectors	Water control Sewage control Food inspection

It should also be possible to review together relevant indicators of performance, and to decide what are the key items for action.

Equally, a different pair of dimensions can be extracted to consider for the same integrated PHC programme, or for all programmes, who will do what in relation to management information (or some other aspect of administrative and logistic support) or for education and training:-

Example

Name of Programme: MATERNAL AND CHILD HEALTH

Type of Function: INFORMATION SYSTEM

Programme contents Level	1 Vital Events: Births and Deaths	2 Immunizations	3 Ante & Post Natal Care	4 Growth and Development
Family	Report to levels B & E	Immunization record in road to health card	Family record (ante-post natal chart)	Road to health card (family record growth chart)
Community Health Activities	Community report on birth and death rates	Community immunization rate report	Community ante & post natal status report	Community nutrition status & activity report
Health Center	Report on birth and death rate in catchment area	Health Centre immunization data plus rates in catchment area	Health Centre A/P data report with data from catchment area	Catchment area nutrition status and activity report
Hospital	Hospital data combined with district birth and death rates	Hospital immunization data with district immunization rates	Hospital A/P data combined with district A/P data	Therapeutic feeding data combined with district nutrition information
Other Sectors	Registration of vital statistics	Mass Media immunization motivation	Mass media health education reports	Food production availability & econ. trends. school health reporting

Whether or not such an approach is helpful, roles obviously have to be agreed among the various parties, and problems identified. Nor can that be a "once only" discussion. People must meet fairly regularly to review how the arrangements are working, consider how to overcome any difficulties and decide what should be done to improve performance.

4.4 FITTING INTO THE ORGANIZATIONAL CONTEXT OF THE HEALTH SYSTEM

Obviously the hospital at the first referral level and the related network of primary health care do not exist in isolation. They have to fit into some broader organizational context of health services and indeed influence the rest of the health system towards PHC. What this context is, however, varies immensely, depending on history, and on the social and political systems of the country concerned.

While one can classify the ways in which health services are organized into a few main types - most basically governmental and non-governmental - great variations of detail exist between countries, and even within countries, as the papers prepared for the Expert Committee show, and as we sought to reflect in our discussions about organizational change and in Section 5.4 of this report. Among governmental systems, some show very close integration between hospitals and primary health care: China, Hungary, Kenya and the USSR all provide examples. Thus in China the township health centre (or hospital) is directly responsible for the work of village health stations and village health workers; it must also develop the health plan for the whole township, and is responsible for occupational and school health, and for training and management of rural doctors. In Hungary district health services and general practice are increasingly integrated with their local hospital, through senior consultants in PHC, mobile specialist clinics and hospital-based continuing education. In many other countries, however, hospitals are separately organized from some aspects of primary health care, in parallel public sector delivery systems: Finland and the United Kingdom are illustrations. India is an interesting example of the relatively recent attempt to link parallel systems, that have grown up separately, into an integrated whole.

While the picture in governmental systems is quite diverse, it is enormously more so in mixed systems that also contain non-governmental organizations. Employment-related or social-security based delivery systems are extremely common in parts of Europe, in Japan and in much of South America. For historical reasons, touched on earlier in this report, such non-governmental organizations tend to be stronger in hospital provision than in the provision of health care outside hospitals, although this is changing.

The same can be said of church-related provision, which is particularly important in parts of Africa and Asia. And then there are the investor-owned, for-profit providers that tend to be strongest in urban centres and in market-based economies. Quite separate, but also of growing importance, particularly in relation to care of the handicapped and the elderly, are the non-profit, independent providers, who tend to be community rather than hospital-oriented.

The more complex the organizational mix, the less straightforward is it to achieve effective interaction of the various parts of the system. Nevertheless effective interaction can be achieved in mixed systems, between non-governmental organizations and government and between other local health services and hospitals. Moreover, mixed systems can sometimes be particularly innovative. The general trend, however, is towards more closely integrated systems, including a movement towards hospital/local health services integration. Some of the general ideas included in working papers prepared for the Expert Committee are:

- Area Health Boards (as in New South Wales, Australia and in New Zealand, and the Republic of Ireland) which are created to take responsibility for a range of hospital and non-hospital services that have historically been managed separately;
- District Health Management Teams (as in Kenya) which draw together key health care professionals and managers from the district as well as the hospital to cooperate closely in the running of related institutions and services;
- Locating the district health office within the hospital building or complex when there are separate or parallel structures of hospital and community health services;
- Having a single chief medical officer for both hospital and community health services (as in Negev, Israel and in India);
- Establishing a community health department in hospitals provided that this is truly linked with other parts of the local health system in an integrated approach (as in Chunchoo in the Republic of Korea);

- Mechanisms of community involvement and control Wherever these are truly representative of the community served and have real authority over hospital and other health services personnel, so that they become a powerful integrating force, not only within the health sector, but also for intersectoral collaboration;
- Regional experiments in collaboration (as in Turkey) that can, if successful, be extended nationally;
- Designation of selected Governmental and non-Governmental hospitals as district hospitals for the purpose of developing an integrated approach to PHC; see, for example the case of the United Christian Hospital, Hong Kong.

Applications

The organization that will work best in a particular place at a particular time depends on the history and values of the country concerned. There is no one right answer.

In general, the Expert Committee has a clear preference for health care systems that achieve close coordination of local services, whether this is achieved through the more straightforward path of an integrated organization, or through team-work towards agreed goals. It emphasizes, as so many previous WHO reports have done, the vital need for intersectoral collaboration. It also believes that sufficient authority and flexibility must be delegated from government to the local level to make it possible (with full community involvement) to manage the local health system effectively.

Later in our report we return to detailed questions of how local health systems of this kind can (where they do not already exist) be created.

4.5 ESTABLISHING APPROPRIATE MANAGEMENT PROCESSES

A general hospital of any size is inevitably a complex organization to manage, because of the diversity of its work and staffing, and because of the importance of the matters that are being dealt with, including matters of life and death. A health system that comprises a whole range of primary health care activities, including one or more hospitals, presents an even more formidable management challenge, and one that cannot be ignored. Resources for health care are constrained throughout the world, often sharply so. To use them in one way involves not using them in another. Unless people are

prepared to look at the way the whole system works, and to the hospital at the first referral level in that context, it is most unlikely that the available resources will be well used. Indeed, all the evidence suggests that ineffectiveness, inefficiency and inequity will result.

Managing primary health care and hospitals together, in an integrated way, requires at a minimum a determined insistence on a comprehensive approach to policy formulation to promote the health of a defined population; programme planning and budgeting that are based on such a comprehensive approach and are prepared to reallocate resources between institutions and across sectors; and evaluation of efficiency and impact on an equally broad basis, rather than institution by institution or programme by programme. One way to carry out these tasks is through a district health office, which may or may not be based on the hospital at the first referral level. Wherever based, it must take an overall view.

Drawing upon the working papers prepared for the Expert Committee, the following are some of the approaches that people seem to be finding helpful:

- Data gathering and analysis on a population basis, integrating the concerns and responsibilities of other local health services and of the hospital at the first referral level. Partly this a matter of developing the necessary technical systems, but even more it is a question of approach and attitudes. For example, a paper from the United Christian Hospital, Hong Kong indicated the shift in approach, particularly the contribution that the hospital can make in the analysis and transmission of data for the community that it serves:-

"The most valuable service which the hospital can perform under this heading is to transmit local statistics. In a territory-wide government system statistics are collected from all hospitals, combined together and presented without any area break-down. In this way the local value of statistics collected from a particular community is lost, and any impact is blunted. There is a clear need for local statistics to be presented locally, so that the course of health problems in the district can be monitored. The statistics from our hospital relate to a highly industrialized, overcrowded urban area, and they lose some value if they are mixed with information from semi-rural districts, business areas and domestic

suburbs. We need to study our own figures, and deduce what lessons can be learned from them before we go on to communicate with the district board on, for example, the frequency and cause of industrial injuries, the prevalence of different kinds of cigarette-related illnesses, the types and profiles of psychiatric breakdown and so forth".

Other interesting examples of data collection and analysis came from the USSR, China, the Philippines, the Republic of Korea and Ecuador. In the USSR, for instance, family information is gathered by the fieldshers, and is combined with other district information. The supervising hospitals have statistical units that compile the data and these are regularly analyzed by the chiefs of health care at various levels, from district to national.

- Policy formulation and programme planning that integrate preventive activities, primary and acute care, rehabilitation and long-term support, taking a broad intersectoral view when appropriate. Without doubt hospitals at the first referral level can contribute to such an integrated approach, or even initiate it. A paper from Indonesia illustrated the effect in a particular instance, where the Bethesda hospital has become intimately involved in the full range of PHC programmes in a large number of remote villages. The paper made in that specific case clear that the first approach for help normally came from a village to the hospital (so that the hospital was not improving its help) and that, in an area such as this, the intensity of the various programmes differs considerably, with priorities having to be set in terms of the available resources and the circumstances of each village.

Experience in a number of countries has demonstrated the value of what is sometimes called the "patchwork approach" to health care, with the community being divided into natural units or "patches" of 100-500 families in well-defined geographical areas. Each unit is served by one or more community health workers (CHWs) chosen from and by the local community. As part of their role in health promotion, each CHW has the responsibility for preparing, under professional supervision, a community map for his or her area. This shows all dwelling places and other buildings, and is accompanied by simple statistical and other information about standards of housing,

sanitation, social conditions and so on, and listings of the main causes of morbidity and death for that particular community. Examples of similar approaches can be seen in a wide range of countries such as China, Costa Rica, India, Korea, Mexico, the Philippines, and the USSR.

Gathering relevant information in this way on the health of families is essential to the identification of the true needs of the district. In this respect, the hospital at the first referral level can have a vital role to play in aggregating the information to form the data base for a district programme of priorities and targets to improve standards of health and social welfare. This was well expressed in one of the working papers prepared for the working committee from the United Christian Hospital, Hong Kong. In many districts, especially in urban areas, there may be more than one hospital involved in PHC. In such cases, one hospital, or one agency in the district, should be designated as having the responsibility for gathering and analyzing the information from patches and transmitting it to all components of the local health system including the hospitals.

- Budget-allocation based on careful economic evaluation and on policy objectives and programme plans, not on past patterns of provision or professional and administrative aspirations for expansion. This may mean, in the PHC context, that nobody has a right to assume a continuation of past funding unless that is the best use of available resources in the context of community needs. This should not imply that resources are easily moved in the short term, nor that there should be arbitrary and sudden switches of funding. Major changes must be carefully prepared and planned. There are four questions that need to be addressed (difficult as that will usually be in practice):

- i) what services are to be provided?
- ii) how much of each service is to be provided?
- iii) how is each service to be provided (what input mix) and by whom?
- iv) to whom are the services to be provided?

The answer to these questions will require careful evaluation of the relationship between input-costs and outcomes. While that concept maybe theoretical, two reference papers from the United States show the dramatic current movement from inpatient to ambulatory and home care in that country, as a result of recent changes in financial incentives based on concerns about high health care costs.

Hospital costs have in many countries continued to increase rapidly in the last few years and great attention has been paid to their containment. Hospitals absorb the dominant share of health budgets in most countries. Yet they serve directly only a small number of people. The issue of balance therefore arises, especially in developing countries where hospital services may well relate to quite a narrow range of conditions that are not necessarily typical of illness and handicap in the community. How much should be spent on hospital care, and how much on other activities to promote health, including expenditure in other sectors? This issue has attracted the attention of many health and political authorities in recent years. It is time for this subject to be brought to the attention of hospital professionals and for them to be involved in studies of community health needs, health priority identification and resource allocation. This could become a useful promotional strategy and orientation means for hospital professionals in support of primary health care. It may result in shorter hospital stays and lower admissions, and also in budget reallocations, cost reduction or increased effectiveness.

- Improved facilities planning: Case studies and workshops conducted by WHO and other institutions have documented the current problems found in respect of the siting, construction, lay-out and operation of health care facilities. These problems have an adverse effect on the relevance and accessibility, the adaptability, the technical functioning and economic efficiency of the whole health care system, including hospitals and other facilities at the local level. A considerable proportion of the scarce available resources may be wasted due to lack of concerted teamwork in the initial planning, and to errors in financing, budgeting and procurement procedures and in the application of architectural and construction know-how. To this should be added the lack of maintenance, repair, cleaning and proper operation of some facilities, which not only shortens the useful life of the building but creates an unacceptable image of health services.²⁴ Decisions on investment shape the recurrent

expenditure of future years. The size of the problem is enormous; in proportional terms it is much larger for the developing than for the industrialized countries, given the insufficiency of their present stock of facilities. On the other hand, many elements of solutions to these problems of facilities planning already exist. A network of national training institutions in both developing and developed countries has been formed, with WHO sponsorship;²⁵ technical responses, have been prepared and are being utilized by developing countries, such as Kenya, Mexico, Sudan and a number of other countries. What is required now is a powerful impulse - perhaps in the shape of a WHO action programme - that will help close the many gaps that remain and will coordinate and use all the existing instruments to make a major impact on this problem.

- Sound logistic support, which does not give inbuilt preference to the hospital. One expert commented on how frequently hospitals seem to receive the "lion's share" when they are distributing points for dependent units. Even if this is not the case, it will only too readily be suspected. The bias may need to go the other way. An example which to the Expert Committee (but not necessarily appropriate elsewhere) was the case of pharmacy supplies at Kasongo where a common pharmacy for health centres and the hospital is run by a single nurse, with the guidance that priority on conflicting issues should be systematically given to the health centres. Other points raised in papers submitted to the Expert Committee included the case for a micro-computer for logistics functions at the first referral level hospital; the need for standardization; the case for quality assurance in supplies; and the advantages of two-way radio communication, where funds permit this, between hospital and health centres.

- Evaluation and health services research that are broad in approach and sound in method, and dare to ask fundamental questions. As a paper on obstetrics indicated, one simply cannot assume, without good evidence, that established programmes and clinical practices are achieving their objectives. That need to question incidentally applies as much to field-based as to hospital activities, and as much to health promotion as to treatment. The evidence from Jamaica described an approach to quality assurance, examining hospital treatment and outcome for 12 tracer conditions, ranging from gastroenteritis in children to hypertension and stroke.

Some of the findings were surprising - for example that case-mix severity was less in the hospitals with higher mortality rates for gastro-enteritis in children, thus increasing the likelihood of a causal relationship between poor process performance and poor outcome in these hospitals. Such quality assurance initiatives should, of course, reach out from the hospital to examine the effectiveness of the whole network of care in the local health system. The selection of tracer conditions and the comparison against outcome of explicit process criteria (as in the Jamaican example) indicate one possible way to do this.

* * *

The Expert Committee emphasizes how much each of us can learn from the experience of others. In particular the so-called developed countries have much to learn from the developing world, where the need for choices is more starkly apparent, and where much progress is being made towards Health for All. We could not in the time available, pursue more than a handful of the matters suggested by these five themes, arising from the rich experience presented by countries. It did, however, review a selection of them, to which we turn in the next section.

5. SOME PERSISTENT PROBLEMS AND APPROACHES TO SOLUTIONS

5.1 INTRODUCTION

The Expert Committee identified a series of problems that stand as obstacles to the more effective involvement of hospitals at the first referral level in local health services. The problem list was much too long to be considered in detail; the Committee chose rather to deal mainly with some of the more important questions. Here the nature of the problem list will be noted briefly, and then the work of the Committee on selected problems will be reported in detail.

Deficiencies in Organization and Structure. The organizational and structural linkages between hospitals and other local health services are often inadequate to support PHC. A major contributing factor is the differing authorities under which various parts of the system operate - under different departments of government, or under governmental and

nongovernmental authorities. Even when organizational changes are undertaken to bring them together, functional gaps may remain. The concept of the District PHC Complex is introduced here as a prototype setting in which such organizational and functional problems may be addressed.

Attitudes and Orientation. There tends to be an in-built bias in favour of institution-based services. Community-oriented services are seen as something apart from hospitals and possibly even in competition or conflict with them. A key factor in moving past such a conflict is the recognition of interdependency between the two--that the local health services are dependent on hospital support, and the hospital is dependent upon local health services to enable it to use its resources more effectively in meeting the needs of the population.

Deficiencies in resource allocation, information systems and other management issues. A number of management areas are seriously inadequate at the PHC level of health services. A common problem is that methods may have been developed for the hospital or local health services but not for both together. For example, information systems or resource allocation methods deal with one or the other but not both interactively. Since the health of the population is the object of health services, including the hospital, then it is appropriate to develop management methods that encompass the entire population and relevant health resources.

Inadequate Clinical Referral Systems. A serious deficiency in local health systems has to do with patterns of referral. Patients often lack confidence in local health workers and by-pass them to reach larger facilities, particularly hospitals. Even when referral is initiated by local health workers, it tends to be one-way - the patient is sent but is not returned - and in either case, accompanying information is lacking. The consequence of faulty referral is the underuse of peripheral facilities and overuse of the hospital to the detriment of both.

Failure to use known methodologies in relation to population needs. The key concepts of HFA and PHC, such as universal coverage, serving a defined population, identifying and responding to differential needs, and using improvements in health status as a measure of programme effectiveness, require mastery of specific methodologies. These methodologies are known, in the fields of epidemiology, statistics, economics, planning and so on, but they need to be adapted and applied to the local health services setting.

Hospital management Financial constraints are causing hospitals to pay ever-increasing attention to resource allocation, cost containment, cost effectiveness, quality assurance and related matters; so that limited funds can be deployed to the best advantage. Although there are good examples of success in each of these fields worldwide, the managerial skills to achieve these and other management objectives are still insufficiently developed, either in quality or quantity. Priority needs to be given to improving standards of hospital management and management training.

After first reflecting on these and other problems, the Expert Committee focussed its attention on three main problem areas:

- Organizational and functional Issues
- Attitudes, Training and Education
- Information, Financing, and Referral Systems.

5.2 PROBLEMS OF ORGANIZATION AND FUNCTION

To bring together all the relevant agencies (including the hospital) into an effective local health system is much more difficult in some cases than in others. The Expert Committee therefore considered a range of likely situations, the barriers that occur in them, and how these might be overcome.

Nature of Problems

1. Lack of organizational integration or coordination between other agencies and the hospital

- (1) In situations where the local health system is under government control

In such situations, the health system is usually one sector within the overall social structure, and government's responsibility is translated into a number of government programmes. These programmes may be changed or expanded from time to time, not necessarily in step with each other, and programme management may be fragmented and scattered amongst different authorities. Conversely there may be problems of a different nature when some programmes have not undergone major changes, but have been continued in traditional or out-dated ways, thus making it difficult to link all the programmes together so that they make the most impact.

- 2) In situations where the local health system is composed of a mixture of governmental and non-governmental bodies

There are very few countries where the government has succeeded in comprehensively co-ordinating the local health system. In most countries the system consists of a pluralistic mixture that can include government, social security, voluntary, proprietary, industrial and other types of ownership and control. In these circumstances, the possibilities of unified or co-ordinated action to support PHC are likely to be weak and are often subordinated to each party's special interests. In that case, health priorities for the local population are not determined by the community but by the goals or interests of the individual institutions.

Lack of functional coordination between other agencies and the hospital

- 1) Differences in behaviour between hospitals and other agencies leading to a lack of coordination of their activities

There are inherent differences in the organizational behaviour of hospitals and other health services, and the conflicts between the two have their roots in differences in values, technology and functions. Activity at the hospital level has to do with individuals, technology and intensive treatment, and it is often fast-paced. It requires control by the provider and involves dependency of the patient on the provider. Activity at PHC level has to do with populations as well as with individuals, uses simpler forms of technology and is generally slower in pace. People are required to be self-reliant and less dependent upon the providers. The traditional separation (and even antagonism) originates from differences in organization, inhibits interaction between the two, and acts as an obstacle to their working effectively together.

- 2) Lack of organizational integration in relation to functions

In these circumstances, policies and actions are unlikely to be as well integrated or co-ordinated as the principles of PHC require. These problems relate to integration on the functional infrastructure face of the model in paragraph 2.4. Each institution or service at community level, even if it is government-owned, will tend to go its own way in the light of its own doctrine and interests. This in turn will provide further obstacles to functional integration.

Approaches to solutions1. Analyzing and understanding the global diversity of local situations

The health system of any country is deeply influenced by its history, traditions and culture, and by its social, economic and political structures. Consequently, there are great differences between the health systems of different countries, both in philosophy and in organization. However, mechanisms can and should be developed whereby one can analyze the global situation more easily, understand the differences between systems, and develop alternative solutions for solving these problems of organizational and functional integration between hospitals and PHC in different local situations. Recognizing that there is such a variety of local health systems in different countries, it might be considered too bold or crude to try to group the systems into several categories. However, it may help to achieve better understanding of the problems if one attempts to categorize the different types of systems in an illustrative rather than exhaustive manner.

2. Identifying the variables for categorization

We have selected five variables for categorizing the level of organizational and functional integration of the hospital and community health components in the local health system

- level of completeness of referral and coordination between other services and the hospital
- level of definition of the population served
- single or multiple hospitals in the area
- types of ownership of hospitals and other elements in the system
- level of completeness of development of hospital and other health care components.

3. Identifying types of local health system

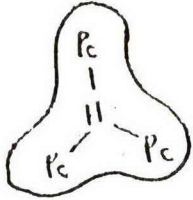

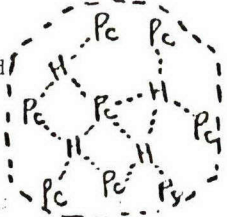


Five main types of system are suggested (as shown in the diagram):

- I. Systems with good coordination between hospital and other local health services and with well defined boundaries
- II. Systems with less good coordination and less clearly defined boundaries
- III. Systems with multiple hospitals, with less good coordination and less clearly defined boundaries
- IV. Systems in a developing stage with peripheral services weaker than hospitals
- V. Systems in a developing stage with hospitals weaker than peripheral services.

4. Re-orientation of organization and functions

Each country is encouraged to review its health system in general, and in particular the role of the hospital in relation to PHC and its supporting infrastructure. The results of the review could be used as the basis for preparing options for reorienting the organization and functions of the local health system, taking into account issues of feasibility and effectiveness in relation to the current political and socio-economic situation of the country.

The Expert Committee appreciates the difficulty of bringing about change in such circumstances, but believes, nonetheless, that the effective interaction of hospitals and local health systems is so important as to warrant thorough exploration of the possibilities of improved integration.

Type	Illustration	Sub-types	Examples	Needs for Strengthening																
I. Local Health System - well coordinated - well defined boundary		1. Unified service of hospital and community care	USSR China Cuba																	
		2. Parallel systems but integrated	UK Finland Chile	Fuller integration																
II. Local Health System - Less well coordinated - Less well defined boundary		By Governing Body	Rural parts of	Relationship between Pc and Hosp																
		<table border="1"> <thead> <tr> <th></th> <th>Pc</th> <th>Hosp</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>GO</td> <td>GO</td> </tr> <tr> <td>2.</td> <td>GO</td> <td>NGO</td> </tr> <tr> <td>3.</td> <td>NGO</td> <td>GO</td> </tr> <tr> <td>4.</td> <td>NGO</td> <td>NGO</td> </tr> <tr> <td>5.</td> <td colspan="2">Various mixtures of 1 - 4</td> </tr> </tbody> </table>		Pc	Hosp	1.	GO	GO	2.	GO	NGO	3.	NGO	GO	4.	NGO	NGO	5.	Various mixtures of 1 - 4	
	Pc	Hosp																		
1.	GO	GO																		
2.	GO	NGO																		
3.	NGO	GO																		
4.	NGO	NGO																		
5.	Various mixtures of 1 - 4																			
III. Local Health System - multihospitals - Less well coordinated - Less well defined boundaries		By Governing Body	Many parts of	Relationship between Pc and Hosp																
		<table border="1"> <tbody> <tr> <td>1.</td> <td>GO</td> <td>GO</td> </tr> <tr> <td>2.</td> <td>GO</td> <td>NGO</td> </tr> <tr> <td>3.</td> <td>NGO</td> <td>GO</td> </tr> <tr> <td>4.</td> <td>NGO</td> <td>NGO</td> </tr> <tr> <td>5.</td> <td colspan="2">Various mixture of 1 - 4</td> </tr> </tbody> </table>	1.	GO	GO	2.	GO	NGO	3.	NGO	GO	4.	NGO	NGO	5.	Various mixture of 1 - 4		Western Europe USA Japan Mexico Argentina South Korea	Defined population Coordination of different governing bodies	
1.	GO	GO																		
2.	GO	NGO																		
3.	NGO	GO																		
4.	NGO	NGO																		
5.	Various mixture of 1 - 4																			
IV. Local Health System - developing stage with relatively weak primary care			Some developing countries	<ul style="list-style-type: none"> - Pc network - Relationship between Pc and Hosp - Defined population may need coordination of different governing bodies - Funding 																
V. Local Health System - developing stage with relatively weak hospital			Some developing countries	<ul style="list-style-type: none"> - Hospital - Relationship between Pc and Hosp - Defined population may need coordination of different governing bodies - Funding 																

Key: GO = Government organization
 NGO = Non-governmental organization, including e.g. voluntary, private, or employment-related hospitals.
 H = Hospital
 Pc = Primary care

The next stage would be to formulate an action programme for hospital/PHC reorientation including:

- organizational and functional inter-relationships
- manpower development
- resource allocation
- financial mechanisms
- information systems
- referral systems
- logistical support
- management processes

The programme could also determine the degree of centralization or decentralization that should be sought and the levels of involvement and integration of community and providers within the system. Programme implementation will not be an easy task. It may generate an enormous number of reactions from the many "players" in the system. It will require the involvement of the key players from the start, strong leadership and a high level of teamwork. It may need an intensive political effort to achieve consensus in the community.

In many instances, it may be best to implement the programme step by step starting with a pilot or demonstration project. In this way it may be possible to reconcile potentially conflicting components of the programme and also to educate the community into new styles of thinking and of action.

A number of countries have experimented with different types of reorientation programme for realizing the PHC concept, some with more success than others. The Expert Committee has collected a variety of experiences in this field, and these can be classified into several categories. The following are a few examples from a wide variety of possible approaches:

1. Government direct involvement

When both components, (hospital and PHC) are under the control of government, then government can be the main body for initiating the programme for reorientation. The programme can take one of two directions:

- total unification of hospital and PHC system under one management
- or
- maintaining two parallel systems, and creating some linkages between them to promote functional coordination and integration.

2. Health council

In situations where the local health system is controlled by a mixture of governmental and non-governmental bodies, a council could be created to take overall responsibility for controlling or coordinating the whole range of services in a defined area, in pursuit of health for all.

The council would be likely to include representatives of the providers of hospital and other health services; the local community; government; insurance agencies; voluntary organizations and other bodies that are active in health and related sectors in the area.

3. District health management team

In this example, the health professionals and managers from the community as well as the hospital would be appointed by central or local government or other relevant authorities, to act as a team and to co-operate closely, formally and informally, in the management or coordination of the hospital and other local health services in a defined area.

4. "Contract" between hospital and other health care providers

In situations where the local health system is controlled by a mixture of governing bodies, a "contract" (meaning an operating agreement, which may be informal) can be made between the hospitals and other providers, based on mutual agreement and safeguarding the interests of each. However, some experiments with contracts of this nature have shown that such arrangements may require some mechanism to oversee the process of contract implementation. In some cases, such contracts have served to protect the interests of the providers other than to promote the welfare of the community. That means that the community should be party to the contract.

5. A selected non-government hospital acts as the hospital at the first referral level and PHC coordinator for a defined area

In countries where government health services are weak or absent and a strong non-government hospital is present in the area, that hospital can be encouraged and supported to act as the hospital at the first referral level and to help coordinate the PHC programmes in the area.

6. Legislation and regulation

Even in situations where the local health system is controlled by a mixture of governing bodies, a new order or discipline can be created through mechanisms of legislation and regulation. This can define such matters as allocation of responsibilities, patterns of organization, and methods of coordination of functions between the different components of the system. Once the legislation and regulations are officially approved, the road to implementation is open. However, it is obviously important that such rules are formulated only after extensive analysis of the local situation, and are based on consensus from the various components of the health system.

3 PROBLEMS OF ATTITUDES, ORIENTATION AND TRAINING

When people have been separated by longstanding differences of activity, loyalty and outlook, it would take much more than structural changes to bring them into an effective local partnership for primary health care.

Nature of Problems

Amongst the obstacles to the development of such a partnership are several problems that interlock to present strong resistance to change:

1. Lack of knowledge and understanding of existing facilities and resources

Patients who attend hospitals often come there directly because they do not trust the local health centres or facilities, are not aware of existing alternatives, or are attracted by the glamour of the hospital, thinking they will get better treatment there (even if that is not in fact the case). Sometimes people come simply because they have nowhere else to go, or because they will not be charged a fee in the hospital. This may be a particular problem in places where private medicine (official and traditional) is widely involved in primary care and where the hospital is the only public or free-of-charge facility. In some cases also, patients may have had a long way to come, and their families may have come with them, which raises other problems of transport, cost, accommodation and so on. Thus some of the barriers to change lie in the ways that hospitals and other health facilities are perceived and used by the public.

2. Institutional pressures and limited hospital awareness and competence in PHC.

Within the hospital, especially at the local level, health professionals may be overburdened with work and not closely familiar with unmet health needs outside the hospital walls. If they fail in their therapeutic endeavours, then they may ask about their patient's environment, but often they do not know what to do with the information that they get. They cannot, or they do not know how they can, maintain a follow-up of their patient, nor how to prevent similar occurrences in the community from where he or she comes. Health auxiliaries in the hospital and other support staff are particularly concerned with this latter problem. They (more than the professionals) may have the insight and training to understand the patient's health status within its local context - but as they work on a hospital basis, they have no way to act upon their knowledge.

On the other hand, in some regions health professionals (physicians, nurses) who have been well trained for hospital work are sent directly to work in community settings (dispensaries, health centres, etc.) where they do not know how to use their skills, as they are accustomed to a range of equipment and support that is simply not available. So their work may be inadequate or useless in relation to community needs.

3. Weak primary care services

In some cases the services outside the hospital are so weak that people have little option but to rely on what the hospital can provide. Similarly hospital staff find themselves on a treadmill of routine work from which they cannot escape, until strong community-based services are developed. This can be a particular problem in remote areas and (paradoxically) for the poor in the cities.

4. Resistance to change

It also needs to be recognized that hospital structures are powerful, influential, and long established - and hence intrinsically resistant to change. It is not enough simply to say that hospitals should change. Powerful levers and incentives are going to be required

in terms of appropriate structural and administrative changes; reorienting job loyalty and responsibility towards health districts and away from buildings and institutions; and parallel changes in the structure of training and teaching systems. Financial and status rewards and incentives are also of great importance and are in general lacking.

5. Difficulties in achieving re-orientation and inducing change

Some countries have set up field-oriented programmes for their health professionals but these are not always effective. Given the difficulties people meet in their working area, the weak relationships with their colleagues in institutions, their isolation, and often the poor financial rewards and social status, they may well become eager to return to a better and more secure base and ask to be moved back into the hospital.

Another problem concerns health managers - whoever and wherever they are - at the local, regional or national level. They usually are more concerned with managing the existing hospital facilities adequately than with running the whole health system. Hospitals are a physical entity, requiring expensive equipment and maintenance, consuming health goods (drugs, laboratory materials, etc.) and producing accountable services, whereas community health services are not, except for specific tasks (immunization, water control, etc.). It is only too easy for managers to be totally absorbed in the problems of running existing hospital facilities, and trying to achieve economies within them. This preoccupation may be even more acute at the national level: each country is now trying to keep down hospital costs, which consume more than 50% of the health budget, and in some cases as much as 80%. Because of this economic pressure, there is a stronger will to consider any solution which would contribute to lower costs. The potential savings may be great - one regional study quoted to the Expert Committee suggested as much as a third of total hospital costs - but only if a major shift were to be achieved in the whole health care system, so that people who do not need hospital care are treated elsewhere.

Hospital management not only absorbs the main managerial attention within most health systems. It actually calls for different skills and different perspectives than does the less certain, more developmental world of primary health care management. Thus it is not only the professions and the institutions that need to change, but also those who hold management and other leadership positions.

Approaches to Solutions

1. Changing attitudes

Resistance to change can sometimes be a sign of inward strength, for instance in long established hospitals, medical schools and nursing schools. If this strength can be turned towards new purposes, for example through strong leadership, then it can become a force for change, rather than against it. One way to initiate change is from within, another is to give to the institution more involvement outside its walls. Attitudinal change could also be caused by peers or leaders who have the respect or affection of the key players. These are some approaches that could be used to promote interdependency between two such different structures as community health and hospital services.

2. Re-defining roles in service and education

The hospital as an institution might benefit from being newly defined as a community-health-oriented institution, which means that it is not only disease-oriented, but also given responsibilities in the field of preventive medicine and health promotion. It could also be a good base for the provision of continuing education and training (professional, technical and managerial) for community personnel. In this way the surrounding district can benefit from having highly qualified advisers, available to provide advice at the community level, or to supervise community health auxiliaries, or to contribute to their training.

3. Data-gathering

It is important that this increased back-up for community health professionals and auxiliaries should serve to meet the real needs of the community. In this respect it is vital that field workers at various levels have the training and ability to collect and transmit appropriate data to the relevant levels in the system, whether it be simple household health and socio-economic information, or more complicated epidemiological and technical data. In time this becomes a routine way of collecting and analysing essential information. However, it can also be a way to broaden radically people's awareness, by seeing needs in the community of which they were unaware, and hence promoting changes in attitudes and in services.

4. Emphasis on community health in training

All this means that a bigger share should be devoted to community health in all institutions which deal with health training. This increased emphasis should be seen both in curriculum content and in the site of training - with trainers and students based for say 20% or 25% of their time in PHC settings. Training institutions which deal with health personnel should not only select their trainees on their scientific and technical abilities, but also, and in some cases mainly, on their commitment to the welfare of people. Sensitive social and emotional attitudes have to be widely developed as essential for health personnel who are involved in PHC. In addition to individual psycho-social skills, it is important to give people the tools to succeed in effective teamwork. Since initial training may not be immediately translated into desirable working practices, it is important that mechanisms for continuing education be established which repeatedly reassert the principles of community-oriented practice.

5. Modification to teaching structures

In existing systems it is usually the case that teachers and lecturers (for example in Medical Faculties) are appointed, firstly to Universities (or other institutions) with a clinical base located in a hospital. It is worth considering whether this clinical attachment could be to an entire health district, with teaching and clinical responsibility to the district, not merely to a hospital.

6. Defining effectiveness

It is more difficult to define effectiveness in the field of PHC than in the classical curative sector. The aim being to meet population needs, it is a duty for training structures and health administrations to help to define appropriate performance indicators, just as it is a duty for health agencies and administrations to define precisely the in-field tasks which are required from health personnel. Performance indicators concerned with whether a hospital has become an effective part of a district health complex are particularly important.

7. Collaboration in training

In places where training resources are scarce, it may be necessary and desirable to encourage several institutions to collaborate together in new forms of training, such as: visiting professors from other universities and from business schools or management schools, joint courses, multidisciplinary field practice, and so on. Sometimes, it may be useful to share experiences among universities and any other training institutions which are innovative in the field of PHC training programmes, including institutions which are willing to introduce such programmes but do not know how to do so. WHO might help by designating certain training centres or health districts as collaborating centres in terms of the concept of integrated health care. This could be a powerful incentive to other centres and facilities to do likewise. WHO could also promote the exchange of information between institutions that have pioneered innovative curricula in the field of hospital/PHC education and those institutions which are beginning to develop in this way, or are interested to do so.

8. Incentives to change

None of these training processes, even if they are continuous, will meet the objective of better integration of preventive and curative services within the PHC complex, if there is no explicit incentive to change. It is necessary for countries to consider as a priority the need to improve both the status and the financial rewards for those working in the manner envisaged here, so that differences between hospital and community personnel in these two respects are lessened. Such people deserve special consideration and support from the rest of the community. If key senior professionals who now work in hospitals were expected through, for example, their terms of appointment, to work part-time in community settings, their involvement in the basic problems of communities could only help to enrich the social standing of community-trained and oriented personnel, and enhance integration in training and service. Similarly, people in management and leadership positions need opportunities and incentives to take a broad view of health needs, and of ways in which (within resource constraints) they can be better met than they are currently. Among other things, this may call for changes in the recruitment of managers and in their training, terms of appointment and performance appraisal.

Finally, in suggesting solutions, it needs to be remembered that inducing social change is a long-term process, the beneficial results of which will not be realized by hasty or premature evaluation of education and training policies and programmes.

5.4 PROBLEMS OF INFORMATION, FINANCING AND REFERRAL SYSTEMS

This section deals with problems in some of the processes and systems that are needed in a local PHC complex. The Expert Committee focussed its discussions on three critical subjects: (1) information, (2) financing and (3) referral.

5.4.1 INFORMATION SYSTEMS

The information field is, of course, enormous. We did not attempt to deal with the whole range but only with the need to have an established process to obtain, analyze and disseminate relevant information on health and socio-economic status, resources and activities covering the whole population in a defined geographical area. This information system could include data on:

- The demography of the whole population
- Health and socio-economic status of people (including but not confined to those receiving treatment) and households
- Existing health and social resources (human, material and financial) within the four PHC levels (family, community, health posts/centres, first referral level hospitals)
- Health care activities, processes and interactions
- Results and outcomes.

Nature of problems

Some of the main problems identified in current information systems indicate that:

(a) too few systems:

- get data from households
- feed back information to the community
- show sufficiently disaggregated mortality and morbidity rates and other relevant data

(b) too many systems:

- are hospital or clinic oriented rather than people oriented.
- do not cover the most needy groups
- are under-utilized
- try to collect too much data, mainly for centralized decision-makers

- need highly qualified people to get or interpret data (over-professionalized)
- present numerical information without comparative data
- may have incorrect information, because of inappropriate methodologies and/or inadequate training and supervision of information-gatherers.
- collect data about inputs and activities, rather than health status and outcomes
- are "long" on data and "short" on illuminating analysis
- fail to feed back analysed information to the community and to health care workers.

Approaches to solutions

Practical experience from a number of countries that have developed effective information systems indicate the importance of:

- designing a system that starts with simple home-based information that can be obtained by appropriately trained CHW's working under professional supervision in defined geographical 'patches' of 100-500 households

- aggregating this information at different levels in the district and combining it with more detailed and sophisticated data relevant to health posts and centres and first referral level hospitals

- organizing the system so that at each level the data-gathering and reporting mechanisms focus on what should be shared with people, what is needed at each health care level and what needs to be passed on to other relevant decision-making levels.

- presenting the results in comparative format that will facilitate decisions on adjustments and changes in content and emphasis of current programmes and on the need for new programmes and re-allocation of resources.

The hospital at the first referral level can be encouraged to help in promoting a community-oriented information system by enlisting its assistance in:

- devising survey procedures
- designing forms, questionnaires and report-sheets
- training CHWs and other field staff
- orientation of doctors, nurses and other health professionals
- logistical support (e.g. duplicating facilities, provision of forms, etc.)
- analysis, evaluation and feed-back of data.

Benefits to Hospitals at the First Referral Level

The benefits of a community-based information system for the FRLH can include:

- helping the hospital to identify more accurately the true needs of the population it serves,
- helping it to make decisions on what services need to be expanded or reduced (or added or discontinued) and on what kinds of assistance to give to health posts/centres linked to it,
- helping it to define community needs that could benefit from intersectoral collaboration,
- helping it to develop a more effective referral system, which in itself might lead to reduction of hospital workload by screening out patients who could be satisfactorily treated at health posts or health centres.

5.4.2 FINANCING MECHANISMS

The process of involving hospitals in more active participation in PHC means that the issue of financial support for that participation will inevitably arise. The deteriorating economic situation of many countries has caused severe financial difficulties for health services as a whole. Efforts to increase hospital participation in PHC should therefore take into account how to generate the resources needed to make this a reality, and how to overcome the barriers that block attempts to utilize resources for this purpose.

Nature of problems

Some of the main problems in this field include:

1. The establishment of national priorities

At national (macro) level one of the main problems is often in deciding what is a more appropriate and more equitable allocation of national resources to health. Decision-makers have difficult choices to make in balancing the distribution of resources among priorities in different sectors such as health, education, housing, transport, water supply and sanitation, security and defence. As the WHO Executive Board has stated, "countries will need to examine all feasible ways of financing the health sector ... the search for alternative financing must be intensified for the immediate future." "Political commitment to equity will remain a fundamental prerequisite to achieving the goal of Health For All ..." ²³ How can the health sector obtain a greater share of national resources which will permit effective implementation of Health for All?

2. Resource allocation within the health sector

It is recognized that there are limited resources overall to meet extensive health needs. A further problem is that there is often inequitable distribution of resources between hospitals and other parts of the health care system. Perhaps as much as 80% of the country's health budget can be consumed by hospitals which serve only a small proportion of the total health needs of the population.

The question is: what distribution of resources would do most to satisfy prevailing health needs? how can hospitals contribute most effectively to this end?

Inward-looking solutions will continue to yield unbalanced approaches and appropriations. If basic health preventive and activities at the community level can prevent more deaths and disability at a much lower cost, how can these activities be supported more adequately from health sector funds? What are the unique elements of care that can only be provided adequately by the hospital in its supportive back-up to PHC?

3. Financial and management information

The lack of appropriate and reliable financial and management information can easily result in unbalanced decisions in the allocation and management of resources. How can the proper kind of practical financial and management information system for a local PHC complex be designed and implemented? Who should be responsible for it? To whom can a hospital or a local PHC complex turn for help in designing such a system? How can the managerial and financial staff be trained to design, implement, and use the system? What kinds of financial and management reports should be shared with medical and health professionals, and how can those who receive them be oriented to understand and use the information found in the reports to promote change?

4. Cost control and cost effectiveness

The need for cost control and cost effectiveness is well known to hospital and health service managers, but are not as well known to health professionals. Yet health professionals have a key role in achieving cost control and cost effective procedures, if they are made aware of their importance and can participate effectively in decision-making on these subjects. How can this be done? One barrier is the lack of cost consciousness among health professionals, and even the existence of disincentives for cost control and cost effectiveness. There is also frequently an absence of skilled managers. The primary interest of health professionals is in doing the best for individual patients, which is often weighted towards saving and prolonging life almost at any cost. Costs become of secondary importance, when compared with alleviating serious pain or handicap or saving lives. How can health professionals be encouraged and trained to balance priorities and maximize benefits from existing resources? And how can health services management be strengthened?

5. Obtaining other resources

When the question of financial and material resources for hospital involvement in PHC comes up, the question frequently raised is: are there unused potential resources that can be tapped, either inside or outside the community? How flexible can hospitals be with their existing budgets to enable them to participate more actively in PHC? One problem in finding resources for hospital/PHC involvement is that most hospitals do not have any budget provision for that involvement. Are there creative ways of overcoming this problem?

Approaches to solutions

Recognition of the problem and its roots is obviously the first step towards solving it. Identification of the components and roots of the problem can lead to suggestions for solutions within the local PHC complex. But where does one start to solve the problem and how does one go about it?

1. A dialogue among key actors

One way is to develop a dialogue among administrators of hospitals and other local health services, health professionals, third party payers and government policy makers. They can discuss how various parts of the local health system administration can pursue the resources that are needed to participate and be effective in PHC in a cohesive way. They can explore unused or underused potential resources that can possibly be tapped inside and outside the district. They can make each other understand the perspectives and priorities of each group, and how they can make their often seemingly disparate interests into a cohesive force to help respond to unmet needs, especially among deprived population groups. Together, they can often make decisions on how to obtain the resources needed to meet priority needs.

2. Flexibility in financing

As a result of such meetings, and changes in policy health may allow hospitals under their jurisdiction to have flexibility in their current budgets to enable them to start participating more actively in PHC. They may even insist on incentives being given to stimulate them to do so, such as insisting that a proportion of the budget be spent on PHC programmes, or being more generous to hospitals that have strong PHC activities. They could decide to providing funding to a PHC complex rather than to hospitals and other services separately. In some countries, they may explore ways of involving people and communities in contributing toward the cost of care, considering not only finance but often non-financial support. One option is the use of civic groups, volunteer health workers and health assistants for specific PHC activities. Another may be the participation of families in caring for or even providing food for their hospitalized relatives.

3. Appropriate financial and management information system

A task force, with representation from various components of the local PHC complex, could design, test and refine a comprehensive financial and management information system that would help decision-makers in relation to

financial allocation and reallocation to address specific needs and priorities. The system could include performance indicators for comparison with the costs of care. The task force could invite people from within the system, or outside it, to help in the design of the system. It could decide how to obtain the understanding and acceptance needed to make the system work, and how to train the people who could implement and use it. The task force could formulate basic and continuing education and training for managerial and financial staff, and could also consider how to orient health professionals towards cost-control and cost-effectiveness in their daily procedures.

4. Making the system work

Making proper use of the results of financial and management reporting systems is ultimately as important as developing and implementing the systems. Mechanisms need to be instituted that will bring together key people within the local PHC complex, to review and discuss the reports, these being complemented by their own observations and perceptions of needs and problems. These discussions could include representatives from different levels of providers, consumers, and politicians and other key figures. Their objective would be to agree on (1) issues or priority needs that demand changes or adjustments (2) what those changes should be, and (3) who should implement them.

5.4.3 REFERRAL SYSTEMS

Within our concept of referral, we include not only the two-way referral of individual patients, but also other forms of two-way consultation and support.

Nature of Problems

An earlier section of the report (section 3.2) introduces the important subject of patient referral and identifies some of the key problems such as:

- overloading of hospital with inappropriate self-referrals, or poorly-judged referrals
- barriers of distance, transport or payment
- lack of confidence in health care at the health post/health centre levels, leading to by-passing of those levels
- inadequate information-flow in both directions

Other problems may also be mentioned here:

- inappropriate hospital use because of lack of support for people who find it difficult to live independently and a lack of appropriate facilities in the community
- lack of trust between hospital and community levels of the health system, often due to the absence of organizational or personal linkages
- lack of a well-designed referral system with written procedures, management support and appropriate forms
- lack of information and knowledge, at each of the four PHC levels, on the the available facilities, specialties or capabilities within the local or regional health systems
- lack of logistic support
- inadequate training or guidance at each level on referral criteria, and on what conditions should be referred to which components in the system
- the 'dumping' of patients and simply passing them to the hospital, because of overload at community level, or lack of adequate knowledge or training of health workers at that level.

Approaches to solutions

1. General considerations

Practical experience from a number of countries that have developed successful referral systems indicates the general importance of:

- recognizing that the whole referral system, from family to health posts/centres and the first referral level hospital, should be viewed as an integral part of the whole district complex
- developing the system in consultation with potential users (providers and consumers), pre-testing it and providing mechanisms for review and introduction of refinements until the sytem is working well;
- ensuring that contacts between hospital and health centre are frequent and close, so that staff know and have confidence in one another;
- avoiding over-rigid systems, so that alternative choices can be made.

2. Patient referral

These points apply to referral generally. Turning more specifically to patient referral, experience suggests the importance of:

- ensuring that the hospital is careful to concentrate on its referral role for the whole area, not doing work that can equally well be done at the health centres;
- recognizing that in some cases this may require the establishment of a "health centre within the hospital", so that patients from the immediate neighbourhood do not use the hospital's referral resources as a preferred source of first contact care;
- treating patients from health posts/centres as referred patients, not subject to additional delays or costs, and avoiding duplication of investigations;
- referring patients back as soon as possible to the source of referral, and with full information;
- introducing financial incentives/disincentives (e.g. charging a fee to hospital patients who have self-referred themselves when they could and should have gone to a health post/centre);
- developing manuals of procedures and protocols for referrals
- making referral easy and convenient by having well-designed forms readily available, with some facts already completed by clerical staff so that the referring person only needs to fill in the critical parts of the forms;
- considering local cultural requirements, especially in matters of privacy, such as who can examine women, and in what circumstances;

3. Administrative and management referral

Within this very broad heading, the evidence available to the Expert Committee highlighted the importance of:

- enabling the hospital to provide logistic support, giving at least equal (and possibly preferential) treatment to the health centres in doing so;
- developing intersectoral collaboration to help overcome communication and transport barriers and other obstacles to progress;
- obtaining, publicising and disseminating information on health care resources and capabilities in the area, making it available to the community, as well as to the providers of care;

- developing appropriate training and supervisory mechanisms for community health workers and field staff, including traditional birth attendants and local healers;
- ensuring that the hospital itself plays an essential role in education of community health workers and other staff based at health posts/centres, and in health promotion - but without ever being patronising;
- developing mechanisms for evaluation of the main aspects of performance, including access, technical effectiveness and efficiency, acceptability and outcome, which is an essential component of local health care management: it must include hospital and other services together, and the accent should be on quality assurance, not on measurement for its own sake;
- recognizing the role of traditional medicine in the local health system.

6. SUMMARY OF ISSUES

From the Expert Committee's consideration of the sequence of problems, a cluster of critical issues has emerged.

We begin with the IMPERATIVES derived from HFA:

The guiding principles of HFA require that health services address the needs of entire populations

PHC is the key to doing so, achieved through bringing effective and affordable services to bear on defined populations, with the full involvement of the individuals and communities concerned.

The COMPONENTS OF THE LOCAL HEALTH SYSTEM based on PHC have been presented:

The LEVELS of PHC...home, community, first health facility, hospital

The elements of PHC PROGRAMMES... nutritional improvement, immunization
oral rehydration, safe water, etc..

The FUNCTIONAL INFRASTRUCTURE...information systems, management, etc.

The EXPERIENCES of different countries in implementing these concepts and programmes show how widespread is the interest and how strong the trends are toward the greater involvement of hospitals in local PHC systems.

As the Expert Committee explored the problems and obstacles that stand in the way of progress toward greater integration of hospitals with local PHC systems it has become clear that a small number of fundamental issues must be addressed. These problem areas are interactive, and all must be addressed if any one is to be effective:

6.1 ORGANIZATIONAL AND FUNCTIONAL INTEGRATION OF HOSPITAL AND OTHER PHC COMPONENTS

Currently, in most settings around the world, hospitals and local health systems are not integrated. They are managed separately and their work is generally not well coordinated.

This problem has several origins. It may be that the hospitals are under different authorities than the local health systems - for example, they are under different departments of government, or one is governmental and the other is nongovernmental. There are numerous variations on these organizational arrangements.

Another contributing factor is that the traditions and technology of hospital ownership and management have simply kept them separated from surrounding community health services. In such situations, there are few models of integration, and little reason has been put forward for it to be otherwise.

Now, however, compelling reasons for integration are emerging. The tasks of reaching entire populations with effective health services cannot be achieved by either hospitals or local health systems acting independently of one another, and certainly the special resources of hospitals cannot be put to optimum use when functioning in isolation from the surrounding PHC efforts.

Given the traditions, varieties and rigidities of current arrangements, significant movement toward integration will require strong commitment and intense efforts.

From the analysis of the Expert Committee and from other work of WHO, it is clear that the conceptual focal point for organizational and functional integration should be THE DISTRICT PHC COMPLEX. That is, the District PHC Complex should be seen as encompassing the HOSPITAL and the other COMPONENTS OF THE LOCAL HEALTH SYSTEM together.

In view of past and current separations of function, and consideration of the various parameters that might be involved in integration - planning, management, information systems, patient referral, staffing, financing, logistics, etc. - it is apparent that the possibilities will have to be explored very carefully. Where hospitals and local health systems are under different authorities, the mode of integration will be different than when they are under the same ultimate authority.

These difficulties notwithstanding, the Expert Committee is convinced that organizational and functional interaction around the District PHC Complex, or its local equivalent, is imperative if full and effective use is to be made of the resources of hospitals at the first referral level and if the health needs of populations are to be met.

Given the diversity of parties involved in hospitals and PHC systems - WHO, Governments, NGOs, hospital-related agencies, etc. - it is incumbent on these various parties to engage themselves seriously in combined efforts to support, promote and encourage the development of practical field-level examples of integration or full participation of hospitals in the District PHC Complex.

6.2 ATTITUDES, EDUCATION AND TRAINING, AND BEHAVIOURAL CHANGE

Very substantial change will be required for movement from current separations of PHC systems and hospitals from one another toward greater interaction, so much so that it is necessary to consider the underlying attitudes and resistance to change that will have to be addressed.

The resistance to change has its roots in differing values, traditions and technologies: the hospital concerned with individual patients, with technological requirements for caring for their needs, and for the immediate provision of acute care; community health with populations, low cost and appropriate technologies, and with the long term requirements for community development.

Changes will have to be brought about in attitudes through promoting better understanding of the rationale for increased PHC participation by hospitals, and through improved insights into the benefits to both hospitals and other parts of the local health system.

The roles of educational and training institutions are very important in shaping attitudes and capabilities of health personnel. Inclusion of substantial amounts of time in the curriculum for community-related and community-based instruction, and selection and appointment of faculty so as to ensure concern for community-oriented educational programmes, will be important. For example, appointments of faculty could specify assignment to a District PHC Complex rather than, or in addition to, assignment to a university hospital. Professional and academic incentives could include rewards for community-based work.

Here we see the need for change, that can be promoted through the work of WHO, the NGOs and other parties, who contribute to restructuring of educational programmes, realignment of professional roles and rewards, and the development of new career options.

6.3 DEVELOPMENT OF MANAGERIAL AND TECHNOLOGICAL SUPPORT CAPABILITIES

A number of managerial technologies - information systems, financial and resource allocation systems, for example - have traditionally been used for either hospitals or PHC systems separately, each without regard for the other; indeed they have been adapted for almost exclusive use in those settings.

But those technologies are vital to decision-making in both settings, and any consideration of integration of the two parts of the system demands integration of the technologies.

An information system, for example, should provide the data base for defining the needs of the population, specifying resources available for dealing with those needs, for formulating health programmes in the light of available resources, and for tracking the impact of those programmes. Currently, most health information systems fall far short of delineating the problems, and when they describe resources and programmes, it is seldom in terms that might make it possible to specify impact on the health of the population. Interactions between information systems of hospital and local health services are weak to nonexistent.

Financing and resource allocation methods are intended to support decisions that should represent best use of resources, yet the methods in use are totally inadequate. Health-related resources, scarce and inequitably spread as they are, are nonetheless not reliably documented. The systems used for managing those resources in either hospitals or local health services rigidly exclude interaction with the other. Thus, each loses the possibility of considering what wider or better impact its resources might have.

Another critical issue has to do with clinical referral. The movement of patients within a system, or between components of a system, is the touch-stone of that aspect of the system that deals most directly with the perceived needs of the population. Whatever preventive or promotive goals the system may have, it must deal with the problems the patients judge of immediate and personal importance.

Referral systems are illusory in the ease with which they can be designed, and the extreme difficulty of achieving effective functioning. The referral problems cut across all aspects of a health system: the confidence of the patients in the different levels of the health system; the trust they have in the personnel; the effectiveness of the information system; the ease or difficulty of transport; the costs of care at different levels, and so on. The point is that ineffective referral, that by-passes the peripheral units to reach the hospital, or that returns a patient to the periphery without useful information, actually sabotages the effectiveness of all parts of the system, the hospital no less than the others.

5.4 HOSPITAL MANAGEMENT ISSUES IN THE CONTEMPORARY SCENE

The main thrust of this Expert Committee report is towards extending the responsibilities of hospitals into the communities which they were built to serve, and towards adding a very important extra dimension to their traditional curative roles. It has been stated already in this report that many hospitals recognize and welcome these developments and are eager to play their part in making the vision of Health For All 2000 a reality.

But it needs to be recognized too that most hospitals are facing the most severe difficulties that they have encountered for decades. For many, the question is not how they can expand their roles, but rather how they can survive their present financial crisis.

These difficulties are causing a whole catalogue of practical problems: overcrowding; long queues; long waiting lists; closing of wards and departments; shortages of staff, supplies and equipment; cut-backs in maintenance and renewal of buildings and equipment; insufficient funding for essential education and training programmes, and so on. The picture is not a happy one.

Added to these have to be the problems of management: insufficient numbers of appropriately trained managers at every level of the health system, including hospitals; and the consequent failure to make the best use of available resources of manpower, money and technology.

These are all critical issues that need to be faced by politicians and Ministries, as well as by hospital managers. Politicians need to ensure that the health sector does get a fair slice of the national economic cake. Ministries of health need to ensure that hospitals get an equitable (but not excessive) share of the health sector budget, in line with their changing responsibilities. Hospital managers need to make sure that their own house is in order and that the resources they do have are managed well and spent wisely.

In this context the potential of hospital associations in relation to these issues is important. Many countries have national hospital associations and/or associations of hospital and health services managers. Such associations can have a major role in:

- helping to improve standards of management and management training;
- offering a natural forum for contact and collaboration between managers of government and non-governmental hospitals and health services;
- providing a mechanism for discussion, planning and action on matters concerning hospitals, including PHC;
- providing a channel for two-way communication and dialogue between the hospital sector and government, professional associations (doctors, nurses, etc.) and other NGOs.

Moreover it may seem paradoxical, but part of the answer to overstretched hospital services is stronger PHC and better links between the hospitals and first contact care.

Several steps are called for to bring all these systems into more effective support of the interaction of the hospital and other parts of the PHC complex. First, the technologies themselves - methods, concepts, materials - need to be re-examined in terms of their uses for this integrative purpose, and steps of further development or adaptation need to be undertaken. Second, greater awareness of these developments has to be created among those working in the field, through workshops, educational programmes, and other means of sharing ideas. Third, practical applications of these ideas need to be pursued in field settings, particularly in specific district health settings.

7. RECOMMENDATIONS FOR ACTION

In considering the roles of various agencies, including WHO, in addressing this set of problems, some special characteristics of this field should be borne in mind.

Hospitals at the first referral level represent a diverse and evolving population of institutions. They are highly pluralistic in their affiliations and ownership, and, as such, are not easily addressed by, or represented through, simple channels of communications and affiliation.

The local PHC initiatives are also diverse, sometimes under government, sometimes dependent on NGO sponsorship, and are often informal and unstructured. They too are evolving, with a sense of direction set by the principles of HFA.

Given this diversity and pluralism, the key strategic issue is the necessity for addressing these institutions and settings through a communion of interests rather than mainly through traditional WHO-government channels

Thus, each of the interest groups will need to see its role in the context of the collective action that is called for by all.

7.1 THE WORLD HEALTH ORGANIZATION

WHO has the critical role to play - an organizing and catalyzing role that will enlist the interests, commitment and resources of governments, other agencies, universities and other training institutions, funding agencies, hospitals and the media in these efforts.

Recognizing the pivotal role of WHO, the Expert Committee RECOMMENDS that the Organization:

1. continue and strengthen ongoing programmes that promote the role of the hospital at the first referral level in support of primary health care at both Headquarters and Regional levels
2. develop a mechanism for consultative discussions with governments, agencies, nongovernmental organizations, universities and other training institutions, hospitals and individuals, in order to ensure effective communication and sharing of ideas, concerns, progress and problems among interested parties, including the development and pursuit of an agenda of "unfinished business", i.e. further steps to be taken to advance this field. The report of the Expert Committee could be used as a basis for discussion at the first meeting
3. establish a collaborative network, possibly organized on regional basis, that could
 - promote, reorient, support, monitor and evaluate efforts of both hospitals and District Health Systems to integrate their efforts in implementing Health For All Strategies:

study and develop appropriate methods and materials relating to:

- organization of PHC programmes
 - selection and appropriate use of technologies at various levels of the district health system
 - information systems
 - allocation of financial resources
 - referral systems
 - characterizing defined populations
 - indicators of performance for hospitals involved in PHC
 - facilities planning and maintenance
- establish orientation and training programmes for staff at various levels of the district health system, emphasizing on action orientation and participation, organizational development approach

4. promote the dissemination of ideas and descriptions of constructive actions in this field in a continuing manner through the media, professional journals, workshops, seminars and word of mouth and through widespread distribution of the Report of this Expert Committee to hospitals and other interested parties
5. invite multilateral and bilateral agencies, including UNICEF and the World Bank, to review their programmes in relation to PHC with due consideration of the issues discussed in this report, and reorient their funding policies accordingly
6. encourage and promote the provision of funds from extrabudgetary resources to support initiatives in this field
7. Promote still further regional and national training programmes in hospital management and finance, recognizing the financial and other difficulties facing hospitals.

7.2 GOVERNMENTS

National governments carry the primary responsibility for the health of their populations. The vast majority of health services systems fall under the authority of or are greatly influenced by governments, although there are many examples of NGOs and other parties that contribute to health services, and with whom governments have opportunities for collaborative programmes.

WHO has well established relationships and modes of cooperative programme development with governments. In addressing the roles of hospitals at the first referral level in support of PHC, government-WHO interaction promises to be especially fruitful.

In view of their central responsibilities for the health of their populations, the authority they have over governmentally managed health systems, and the influence they have over nongovernmental health activities, the Expert Committee RECOMMENDS that governments:

1. identify the specific roles to be played by hospitals at the first referral level in support of PHC as a matter of priority for the further development of their health services;

2. seek to adjust organizational and functional arrangements of health services so as to facilitate the integration of hospitals with other PHC components, particularly at the district and local levels;
3. establish integrated district health systems for more effective provision of health services to defined populations or geographical areas of which hospitals in those communities are an integral part;
4. pay specific attention to the multi-hospital situation of large urban areas, where the PHC Complex may need adaptation in the form of consortia, so as to avoid the creation of artificial districts;
5. cooperate with NGOs and other parties interested in this field, and promote collaborative approaches to enhancing the roles of hospitals at the first referral level in support of PHC;
6. pay specific attention to considering non-governmental hospitals as part of the district PHC complex and involving them as appropriate;
7. identify institutions to participate with WHO, NGOs and other interested parties in networks, possibly organized on a regional basis, that will contribute to further practical developments in this field;
8. give sympathetic consideration to the financial crisis that faces many hospitals at this time and seek to ensure that the health sector as a whole receives an equitable share of the national budget;
9. develop further planning, monitoring and review mechanisms to ensure that financial, human and physical resources of hospitals are efficiently developed and well managed;
10. develop still further appropriate policies and programmes for training in hospital management and finance.

7.3 NONGOVERNMENTAL ORGANIZATIONS

A number of the NGOs that are intimately related to hospitals have potential roles to play in support of PHC systems.

The NGOs have advantages that contribute to their capacity for innovative developments in this field. One is that collectively they are affiliated with a variety of organizations and institutions and thus bring a diversity of influences to bear on this field. A second is that they can be flexible in terms of local initiative without the necessity of recourse to large bureaucracies.

In view of these characteristics, the Expert Committee RECOMMENDS that the NGOs give consideration to the supportive and innovative role they can play in promoting the roles of hospitals at the first referral level in support of PHC, including:

1. participate with WHO in consultative discussions that would explore the possibilities for constructive actions undertaken jointly with other interested parties in promoting the roles of hospitals at the first referral level in support of PHC
2. identify, encourage and support institutions that could participate in a network of institutions in order to:
 - encourage increased (hospital) involvement in PHC
 - establish examples of District PHC Complexes
 - develop methods and materials
 - carry out field trials
 - pursue a learning-while-doing agenda of questions, actions, programmes
 - establish orientation and training programmes
3. promote the diffusion of ideas in this field
4. encourage and promote provision of funds to support initiatives in this field
5. strengthen existing standards of management and management training, and exploit still further the opportunities that NGO status provides for innovative approaches in hospital management and in financial control and incentives.

7.4 HOSPITALS

The Expert Committee appreciates that hospitals in virtually every country of the world are committed to the health of their surrounding populations and have contributed innovative ways of relating to those populations through PHC. As understanding of the PHC approach deepens and the possibilities of bringing effective health services to entire populations are improved, the critical role of hospitals at the first referral level becomes all the more apparent.

The Expert Committee RECOMMENDS that hospitals at the first referral level:

1. re-examine their own role in the local health system, with particular relevance to the questions appended to these Recommendations, including:
 - does the hospital identify a specific population defined in terms of numbers and geographical boundaries or other characteristics, to which it relates as the hospital at the first referral level in support of PHC activities?
 - does the hospital view its responsibilities as extending to that population, outside as well as inside the hospital walls?
 - in evaluating its own performance, does the hospital consider its contributions to surrounding PHC activities as important components of its programmes? For example, would it use a rising or falling infant mortality rate, or the extent of coverage of the population, as indicators of its performance?
2. consider and explore how they can be optimally effective in support of local PHC initiatives, including:
 - how the hospital at the first referral level might become more integrally linked with other partners in the local health system;
 - how the hospital might contribute to better understanding of the attitudes, roles, incentives and needs of hospital personnel who can contribute to health services more generally, and develop approaches involving them whenever possible in PHC programmes outside the hospital, particularly in relation to their specialties, and to orientation and training that could strengthen their interests and roles;

- how the hospital might assist in the development of a district-wide health information system that could serve to define the problems of the population and support decision-making at all levels of the health services, including the hospital;
 - how financing and resource allocation methods might be developed so as to promote the best use of resources in relation to the needs of the entire population, and to support appropriate decisions in the hospital and other components of the local health system;
 - how clinical referral systems can be made to function more effectively, including ways in which the hospital can support the more peripheral health units, thus increasing the confidence of the community in them and strengthening the health system as a whole including the role of the hospital;
3. consider how they might participate with WHO in a network of institutions collaboratively working toward the enhancement of the roles of hospitals at the first referral level in support of PHC.
 4. use this Report of the Expert Committee as a starting point for discussions within and among hospitals, asking for their response to the Report, and for indications of the next steps they propose in contributing to progress in this field.
 5. hospitals in countries that do not already have hospital associations or associations of hospitals and health service managers, should consider establishing such associations.

* * *

"A health system based on PHC cannot, I repeat, cannot be realised, cannot be developed, cannot function and simply cannot exist without a network of hospitals with responsibilities for supporting primary health care; promoting community health development action; basic and continuing education of all categories of health personnel; and research."¹

Dr H. Mahler
Director-General, WHO

APPENDIX

QUESTIONS TO ASK HOSPITALS
WITH RESPECT TO THE FIRST REFERRAL LEVEL IN PHC SYSTEMS

- 1 Does the hospital identify a specific population defined in terms of numbers and geographical boundaries or other characteristics, to which it related as the HFRL in support of PHC activities?
- 2 Does the hospital view its responsibilities as extending to that population, outside as well as inside the hospital walls?
- 3 Does the hospital consider its role to include developing relationships with all health agencies in the area, health practitioners of various types, community representatives and authorities from other sectors, in order to plan how the problems and needs of the population are to be handled?
- 4 Does the hospital consider its role in PHC to include participating in the characterization of the population - its problems, resources and needs - including differential needs and coverage - and in planning how those problems and needs should be addressed?
- 5 With respect to specific health problems, such as malnutrition, diarrhoeal diseases, complications of pregnancy and childbirth injuries, etc., does the hospital participate in defining the prevalence and distribution of those problems and helping to plan who should be cared for outside the hospital and who should be cared for within it?
- 6 Does the hospital see its role as participating in the development and maintenance of an information system that would allow continuous and periodic assessment of the status of major problems affecting the population, monitoring of programmes directed at those problems, and evaluation of their effectiveness.?
- 7 Does the hospital see its role as participating in health manpower development throughout the area, including helping in recruitment, training, supervision and evaluation of health workers?
- 8 Does the hospital consider its responsibilities to include responding to selected needs of the surrounding local health system for logistical support such as bulk purchasing and storage of supplies, equipment maintenance, communication, transport, etc?
- 9 With respect to referral of patients, does the hospital consider its role to include the development of criteria for referral from peripheral health workers, delineation of information that should accompany patients in both referral to the hospital and return from the hospital, and training of various personnel to ensure effectiveness of such referral arrangements?
- 10 In viewing the overall costs of PHC for the area, does the hospital consider it reasonable that resources should be allocated and reallocated across institutional boundaries? In other words is it prepared to see "its" budget in wider terms?
- 11 Does the hospital consider quality of care assessment an important approach to evaluating hospital functions, and would the hospital consider it appropriate to extend that approach to assessing the quality of area-wide PHC services?

- 12 Does the hospital consider it necessary to develop specific functional, organizational and physical changes within the hospital in order to accommodate or facilitate its role in support of area-wide PHC activities?
- 13 In evaluating its own performance, does the hospital consider its contributions to surrounding PHC activities as important components of its programmes? How would the hospital assess its contributions? For example, would it use a rising or falling infant mortality rate, or the extent of coverage of the population, as indicators of its performance?
- 14 Does the hospital consider it part of its role to join with community representatives and other interested parties in generating social and political support for the overall PHC effort?

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UNISANTE, GENEVA.

FOR MRS BRUGGEMANN. PLEASED TO RESPOND TO YOUR MAY 28 LETTER REGARDING AGENDA FOR SEPTEMBER MEETING. PROPOSED AGENDA LOOKS EXCELLENT. SUGGEST WE SUBSUME ITEMS UNDER FIVE OR MAXIMUM SIX TOPICS TO FACILITATE DESIGNATING LEAD DISCUSSANTS ON BOTH SIDES AND ENSURE SUFFICIENT TIME FOR DISCUSSION EACH TOPIC. DETAILED COMMENTS AND SUGGESTIONS FOLLOW. AAA) DISTRICT HEALTH SYSTEMS TOPIC WOULD PROVIDE USEFUL OPPORTUNITY TO SHARE EXPERIENCE AND VIEWS, INCLUDING IMPORTANCE BANK ATTACHES TO SYSTEMS APPROACH TO INVESTMENT OF WHICH HARDWARE ONLY PART. BBB) WE WELCOME OPPORTUNITY TO SHARE VIEWS ON CRITICAL ISSUE OF FINANCING HEALTH FOR ALL. DRAFT OF PHN HEALTH FINANCING PAPER MIGHT PROVIDE VEHICLE FOR DISCUSSION. WILL MAIL COPY. CCC) ELEMENTS OF YOUR ITEMS 3, 4 AND 6 MIGHT BE COMBINED TO ADDRESS CRITICAL QUESTION OF HOW TO EVALUATE IMPACT OF HEALTH PROJECTS AND PROGRAMS, DEVELOPMENT OF NECESSARY DATABASE, AND FUTURE ACTION OF WHO AND BANK IN ENSURING PROGRESS IN THIS NEGLECTED AREA. DDD) WE AGREE REGARDING IMPORTANCE OF DISCUSSING RESEARCH AGENDAS OF BOTH ORGANIZATIONS AND WILL SEND COPY OF POLICY AND RESEARCH WORK PROGRAM AS ONE INPUT. EEE) BANK FINANCING OF INTERNATIONAL HEALTH EFFORTS MIGHT USEFULLY FOCUS ON RESEARCH SUPPORT, E.G. TDR,

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CLASS OF SERVICE: Telex	TELE NO	DATE: 7/24/86
SUBJECT: WHO Strategy Meeting	APPROVED BY: <i>[Signature]</i>	EXTENSION: 61573
CLEARANCES AND COPY DISTRIBUTION	AUTHORIZED BY (Name and Signature): John D. North	
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PROSPECTS FOR OTHER SIMILAR EFFORTS, E.G. SUPPORT FOR HRP, AND WHO
ROLE IN FACILITATING SUCH ASSISTANCE. FFF) A SIXTH TOPIC MIGHT
DEAL WITH THE COLLABORATION AND COMMUNICATION PROCESS AND HOW WHO
AND THE BANK MIGHT WORK CLOSER IN THE FUTURE ON SECTOR ANALYSIS,
PROJECT PREPARATION AND PROJECT IMPLEMENTATION. GGG) WE SUGGEST
INFORMALITY BE STRESSED TO FACILITATE OPEN COMMUNICATION AND
WONDER WHETHER POSSIBLE TO MEET OUTSIDE WHO HQ AS DISCUSSED
PREVIOUSLY. WE BELIEVE TWO DAYS SHOULD BE SUFFICIENT TO COVER
AGENDA AND WOULD APPRECIATE YOUR SUGGESTIONS ON TIMING WITHIN
AGREED SEPTEMBER 3-5 TIMEFRAME. HHH) MY COLLEAGUES NANCY BIRDSALL,
STEPHEN DENNING, ISHRAT HUSAIN, ANTHONY MEASHAM, EMMERICH SCHEBECK
AND EYE ARE LOOKING FORWARD TO PRODUCTIVE MEETING. REGARDS NORTH,
INTBAFRAD, WASHINGTON.

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TELEX SERVICE Telex

7/24/86

WHO Strategy Meeting

ARMeasham, CJM

61573

cc: Bak, Birdsall, Denning, Husain,
McDonald, Measham, Sai, Schebeck

John D. North

DEPARTMENT
PHN

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OFFICE MEMORANDUM

WHO - GENEVA STRATEGY F

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DATE: August 12, 1986

TO: Distribution

FROM: Gloria Davis, Acting Chief, AEAIN

EXTENSION: 72509

SUBJECT: INDONESIA - Health Planning and Budgeting Study
Initiating Memorandum Review

Please find attached a copy of the Initiating Memorandum for the proposed Health Planning and Budgeting Study in Indonesia. Because of time constraints we are not able to schedule a formal meeting at this time. However, I would be grateful if you could forward your comments directly to Nicholas Prescott (ext. 61600) or Dennis Mahar (ext. 61598).

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INDONESIA: HEALTH PLANNING AND BUDGETING

INITIATING MEMORANDUM

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INDONESIA: HEALTH PLANNING AND BUDGETING

INITIATING MEMORANDUM

I. BACKGROUND AND OBJECTIVES

1.01 The Indonesian health sector is characterized by poor performance relative not only to other countries in the region, but also to the average for all low and middle income countries (Annex 1, Table 1). Bank estimates indicate that life expectancy at birth had reached about 55 years in 1984 while the infant mortality rate was 97 per 1,000 live births. These indicators reflect progress over previous levels, but they lag far behind the achievements of other comparable countries. By contrast, life expectancy in both the low and middle-income countries averages 61 years, and the infant mortality rate averages 72 per 1,000. These unfavorable inter-country differences are associated with wide performance differentials within the country. Estimates from the 1980 census show much higher infant mortality in rural than urban areas (113 per 1,000 compared to 86 per 1,000), with provincial averages ranging up to 187 per 1,000 in West Nusa Tenggara (Annex 1, Table 2).

1.02 Sectoral objectives set out in REPELITA IV include a reduction in the infant mortality rate to 71 per 1,000 and an increase in life expectancy at birth to 59 years by 1988/89. To achieve these objectives the GOI proposed a public investment program for the health sector estimated to cost Rp 3,086 million (at current prices) over the five-year plan period ^{1/} Unanticipated resource constraints associated with the oil price decline have, however, led to major and increasing shortfalls in the resources available for implementation of the investment program. Central government development expenditure (DIP plus INPRES) allocated to Ministry of Health (MOH) programs during the first three years of REPELITA IV totals Rp 622 million (Annex 1, Table 2), or only about 40 percent of the estimated resource requirement for this period (Annex 1, Table 4). The resource constraint has become particularly severe with the 1986/87 austerity budget, which proposes a 25 percent nominal reduction compared to total development expenditure budgeted for health in the previous year (reflecting a 46 percent cut in the DIP, with no change in INPRES). In real terms, development expenditure for health has been declining since 1983/84, and is now back to the level achieved in 1979/80 (Annex 1, Table 5). And the prospects for any rapid recovery for this deteriorating trend are clearly

^{1/} Bank staff estimates prepared for the Public Investment Review. These estimates include all Ministry of Health programs, of which a subset are included in the BAPPENAS classification of the health sector (code 10.0).

weak in view of the substantial further decline in world oil prices which has occurred since the latest budget announcement. It is now certain, therefore, that the physical targets proposed in REPELITA IV will not be achieved, and this appears likely to compromise attainment of the sector's ambitious targets for health status improvement.

1.03 These circumstances necessitate a careful review of options for efficient and equitable sectoral adjustment to the tight resource situation. The objective of this study is to assess selected options, focusing on three broad areas: expenditure priorities (including both development and recurrent expenditure), resource mobilization (particularly for recurrent cost finance) and related improvements in planning and budgeting procedures. As such the study is designed to follow up previous work undertaken by PHN as part of the Public Investment Review, and to be fully consistent with the scope and objectives of the programs-managed Public Resource Management Study. The work program for the proposed Health Planning & Budgeting Study will require 35 SW from the PHND2 sector work budget.

II. ISSUES AND APPROACH

Expenditure Priorities

2.01 The immediate burden of sectoral adjustment to budgetary stringency will inevitably fall on changes in expenditure priorities, in terms both of the scale and composition of the expenditure program. This part of the study will focus on these short-term implications, focusing on priorities for the balance of REPELITA IV (1987/88 - 1988/89). The assessment of appropriate expenditure priorities will be based on a review of: (i) the affordability of the expenditure program given realistic budgetary prospects for the sector, and (ii) the adequacy of the expenditure program in light of sectoral objectives.

2.02 Affordability. The assessment of affordability will cover both the investment and recurrent cost sides of the expenditure program. In each case the basic approach will involve three steps: (i) specification in physical units of past and planned expansion in public sector facilities, programs and manpower, (ii) simulation of the total cost implications of these changes in physical units, based on detailed estimates of unit costs for investment and recurrent expenditure (O & M) requirements, (iii) projection of the overall magnitude and sources of budgetary finance likely to be available for these expenditure requirements. The analysis will be based on the quantitative accounting framework set out in the microcomputer-based Health Finance Planning Model developed recently in PHN (Annex 2).

2.03 The first step will involve an update of the work undertaken previously for the Public Investment Review, which developed a relatively complete matrix of planned physical targets (by program area) for investment in expansion of facilities, programs and manpower during REPELITA IV. On the investment side, this update will consist of a review of progress made in implementing these targets by the middle of the plan period, and what

revised targets appear likely to be retained for the remainder of the plan. The review of past and planned changes will then be extended to the recurrent cost side, by projecting changes in the stock of physical units requiring recurrent expenditure on wages and salaries, other operating costs and maintenance.

2.04 As part of the second step revised estimates of unit investment costs will be generated based on recent implementation experience, taking into account regional differences where possible. At the same time, emphasis will be placed on estimating a set of unit cost requirements for wage and non-wage components of recurrent expenditure. This work will be approached in two ways: first by reviewing empirical estimates of actual unit costs, and second by constructing estimates based on target requirements. The empirical approach is complicated by the multiplicity of budgetary sources which has, in the past, made it difficult to identify the total costs of operating individual facilities such as hospitals and health centers. A further disadvantage is that actual costs reflect current levels of underfunding. Nevertheless a useful starting point will be provided by two sources: (i) recent work undertaken by the Planning Bureau, MOH, on the costs of a sample of health centers and Class C and D hospitals in five large provinces (West Sumatra, East Java, Bali, South Kalimantan and South Sulawesi), and (ii) a project-financed study on the unit costs of paramedical manpower training, scheduled for completion in July 1986. The alternative requirements approach will be based on, for example, manpower staffing norms established by MOH for different facilities. The degree of current underfunding of recurrent expenditure requirements that is likely to emerge from this analysis is suggested by estimates that: (i) over 80 percent of rural health facilities have less than half the standard complement of required staff; (ii) allocations for maintenance amount to only 2 percent of public expenditure; and (iii) one-third of health facility buildings are in disrepair.

2.05 Finally, projections of budgetary resource availability will be made to estimate the affordability of these projected expenditure requirements. A critical initial step will be to assemble a time-series of consolidated public finance accounts for the health sector in order to assess overall levels and trends in expenditure from the multiplicity of budgetary sources at different levels of government. Projections of future levels of sectoral investment and recurrent expenditure from these sources will then be determined on the basis of budgetary ratios using aggregate development and routine expenditure forecasts for central, provincial and local governments that will be generated by the Public Resource Management Study. The diversity of the relevant funding sources is illustrated with 1982/83 data in Annex 1, Tables 6, 7 and 8. Development expenditure is funded principally by the central government DIP (41 percent) and INPRES (33 percent) budgets. Foreign assistance plays a minor role, while locally-funded expenditure on the development account is negligible. The bulk of routine expenditure is also financed by central government sources. These include direct expenditures from the central MOH routine budget (37 percent) and, more importantly, local government health expenditures indirectly funded from the Subsidi Daerah Otonom (SDO). The SDO is the main central grant paid to local governments on the routine account and is mainly

intended to cover the wages and salaries of local government staff whose appointments are centrally approved. In the health sector the SDO also subsidizes non-salary operating costs of at least 8 provincial teaching hospitals and 22 other local government general hospitals ^{2/}. Overall the SDO plays the dominant role in financing sectoral routine expenditure, accounting for 48 percent of the total in 1982/83.

2.06 Two important features of the public finance picture with implications for the resource projections stand out. First, the historic pattern of overwhelming dependence on central government finance may change in the future, with emerging pressures on central government revenue accompanied by prospective improvements in local resource mobilization associated with the recent property tax reform. Second, the apparent imbalance between recurrent and investment expenditure is distorted by inclusion in the development budgets of substantial funding for recurrent expenditure. Rough estimates for 1982/83 suggest that 42 percent of the central development budgets (DIP plus INPRES) financed recurrent expenditure items (Annex 1, Table 8). An important issue for future budgeting is which of these items, if any, should continue to be funded through the central development account, and whether development budget resources should be explicitly reallocated to the routine budget in order to ensure adequate and sustained levels of recurrent funding [para. 2.16, items (ii) and (iii)].

2.07 Adequacy. Assessment of the affordability of investment and recurrent cost requirements implied by the plan's physical targets is likely to identify significant resource shortfalls, which can only be reduced in the short-term by cutting expenditure for selected programs. The central issue for short-term adjustment therefore consists of identifying an expenditure program which meets sectoral objectives and projected financing constraints. Some of the relevant issues of program priority are:

- (i) What is the appropriate balance of investment between hospitals and lower level health centers or sub-centers? Compared to REPELITA III, the REPELITA IV investment program implies an increase in the share of hospital investment from 33 percent to 39 percent, with a decrease in the health center share from 31 percent to 17 percent. This conflicts with the apparent need to consolidate the health center network in order to support preventive health interventions to reduce infant mortality, and to provide access to basic curative care for poor beneficiaries.
- (ii) What is the appropriate balance between investment in curative and preventive health services, given the likely potential for greater private sector participation in curative service provision, and the stated priority attached to reducing infant mortality?

^{2/} The need for this subsidy is attributed to a failure by the central MOH to consult with local governments about the recurrent expenditure implications of new hospital investment.

- (iii) What level of investment in manpower training capacity is needed to ensure consistency between manpower supply and requirements induced by planned expansion in facilities and programs?
- (iv) Should MOH give up its current role in rural water supply investment given its lack of comparative advantage, particularly in the formulation of appropriate pricing policies for efficient operation and maintenance?
- (v) What improvements in the spatial balance of expenditure are needed to reduce regional disparities in service provision and health status?
- (vi) What should be the balance between recurrent expenditure and new investment?

2.08 These and related issues will be analyzed in terms of their costs and effectiveness in order to formulate an indicative program likely to have the greatest impact on sectoral objectives given what is realistically affordable.

Resource Mobilization

2.09 Longer-run options for sectoral adjustment include reforms in financial policy to mobilize non-budgetary resources for publicly provided services, and privatization of some services to lighten and reorient the burden of public sector provision. These options are, of course, closely linked to the formulation of public expenditure priorities since reforms in these areas will determine the magnitude and composition of budgetary requirements for the public sector. At the same time, however, immediate progress in implementing desirable reforms with any substantial impact is unlikely. This part of the study will therefore take a somewhat longer term view of resource mobilization options to relax the public financing constraint, complementing the earlier focus on inevitable shorter-term adjustments in expenditure priorities. Emphasis will be placed on assessment of current levels and future prospects (magnitude and timing) for cost recovery in the health sector, focusing on pricing policy and closely-related issues of health insurance coverage. Planned work on privatization options will be limited to a review of the present scope of, and trends in, private sector activity, drawing in part upon ongoing work by USAID, with the aim of defining an agenda for follow-up work to be undertaken either as a project-financed study or under the sponsorship of the PHN Policy & Research Division.

2.10 Pricing Policy. User fees are charged for most services provided by public health facilities. Exceptions to this general policy include immunization and treatment for selected communicable diseases. For health center outpatient care there is a standard charge of Rp 150 per first visit (including drugs for 3 days) with a smaller fee for follow-up visits. This fee has remained unchanged since it was adopted as national policy in 1977. Prices for hospital inpatient care are set by the relevant central, provincial or district governments and vary considerably between hospitals.

Typically, hospital inpatient charges per bed-day are differentiated by class of accommodation (grades I to IV). Key issues in reform of this pricing structure include the following:

- (i) The proportion of total recurrent expenditure recovered through user charges is estimated at about 23 percent ^{3/}. Although high compared to cost recovery levels for public expenditure on health in many developing countries, it is much lower than achieved in some others. The polar case is China, where approximately three-quarters of the costs of publicly provided services are recovered directly from users ^{4/}. This high cost recovery rate is achieved by limiting government subsidies principally to salaries while, unlike Indonesia, selling drugs at a 15-25 percent profit. The demonstrable feasibility of this policy in a lower income setting with far superior sectoral performance suggests it as a model for Indonesia to move towards.
- (ii) The distribution of government subsidies for health is regressive. Estimates for 1980 indicate that the upper 30 percent of the household income distribution received 45 percent of recurrent subsidies for health while the lower 40 percent received only 19 percent ^{5/}. This suggests that any increase in cost recovery should be effected through a more progressive fee structure, reducing the unit subsidy paid for higher level hospital services (e.g. higher grades of inpatient accommodation) that are more likely to be used by higher income beneficiaries. What is the likely impact of such a change on utilization and revenues given available evidence of unit costs and price elasticities?
- (iii) Under present policy revenues from user fees are returned to general revenues at the level of government operating the facility. These revenues tend to be treated as an earmarked tax, with health budget allocations at provincial and district levels geared to the volume of revenues collected. In fact at district level where health sector revenues comprise a significant fraction of the total, the net budgetary contribution to the sector is frequently negative. This policy is inequitable, creating in effect an unpredictable tax on illness, and inefficient because of the incentive it creates for health facilities to maximize

^{3/} Estimate for 1982/83. Includes fees from households (15 percent) and ASKES contributions plus fee reimbursements (8 percent).

^{4/} Prescott, N. & Jamison, D. (1984) Health Sector Finance in China, World Bank Reprint Series No. 356.

^{5/} Meesook, O (1973), Financing and Equity in the Social Sectors in Indonesia. SWP #703.

provision of revenue-generating curative services at the expense of preventive health and outreach activities which merely increase operating costs. Alternative mechanisms permitting facilities to retain some or all revenues need to be considered.

2.11 Health Insurance Coverage. Health insurance is an essential complement to cost recovery measures in the health sector. Appropriately designed, risk-sharing schemes could have a major impact on the resource mobilization and efficiency objectives of sectoral policy. Modest coverage charges (prepayments) could, if pooled across a large number of participants, generate substantial revenues from the higher fees implied by increased cost recovery, provided that they lower net prices at point-of-service (copayments) sufficiently to avoid any adverse reduction in demand by insured users. The trade-off on the efficiency side requires copayments to be high enough not to induce demand for inefficient overutilization of services (e.g. unnecessarily long hospital stays). Cost containment incentives can also be built into the supply side by limiting insurance reimbursement to cover standardized costs per insured event, as under the fixed cost per Diagnosis Related Group (DRG) system used in the United States Medicare program.

2.12 The present status of insurance coverage in Indonesia is as follows. The major formal insurance scheme, ASKES, provides compulsory coverage for approximately 3.5 million government employees plus dependents (a total of 12.5 million). The scheme is financed by prepayment of 2 percent of gross salary, and entitles beneficiaries (with some exceptions) to free services at public sector facilities, which are reimbursed directly by ASKES at the subsidized government tariffs. A new scheme, DUKM, has recently been set up by GOI (1985) intended in effect to extend ASKES coverage to private sector employees. The main difference is that DUKM reimbursement to public providers would be on a full cost basis, financed by a much higher prepayment equivalent to 7 percent of earnings. The ultimate objective is to cover all employees (plus dependents) technically eligible for enrollment in the Ministry of Labor's social insurance scheme for the private sector, ASTEK. Potentially this could cover about 14 million employees, or 75 million persons including dependents. Combined with ASKES this would substantially raise formal insurance coverage to nearly 50 percent of the population. However current levels of ASTEK coverage are far below potential, with a 1989 target of only 5 million employees. The pilot phase of DUKM is limited to Jakarta, providing compulsory coverage for only 0.5 million local government enterprise employees plus employees of private firms whose management voluntarily elects to enroll. Elsewhere within the urban sector there is very limited participation in commercial third-party insurance plans or health maintenance organizations (HMOs). And limited evidence for the rural sector suggests a very low level of participation in insurance schemes, although some villages are reported to have established community health funds (Dana Sehat) as part of the village health post (PKMD) program.

2.13 Prospects for reform of this insurance structure will be examined in terms of their potential impact on resource mobilization and efficiency. Some of the major issues are:

- (i) Given the limited potential for expanding ASKES coverage, what would be the revenue impact of raising ASKES reimbursement levels from government subsidized prices to the full cost levels intended for DUKM? What implications would this have for prepayment levels?
- (ii) What reimbursement levels have been set for DUKM? Are they likely to yield full cost recovery, now and in the future?
- (iii) What are the realistic prospects for expanding DUKM coverage to private sector employees? What are the implications for the magnitude and timing of resource mobilization from this source?
- (iv) What are the prospects for introducing at least limited insurance coverage (e.g. for catastrophic costs) in rural areas? What is the evidence of demand for risk coverage and mechanisms to supply it?
- (v) What incentives for cost containment should be introduced into the government regulated insurance schemes e.g. on the demand side, copayments (coinsurance and deductibles) instead of the essentially zero prices now paid by insured users and, on the supply side, DRG-based reimbursement limits?
- (vi) What benefits in terms of greater achievement of sectoral objectives might be realized with implementation of the above resource mobilization options?

Planning and Budgeting Procedures

2.14 Sectoral adjustment to the budgetary crisis requires a variety of improvements in planning and budgeting procedures to facilitate efficient allocation of scarce budgetary resources. Many of these are generic to the public sector as a whole and, as such, will be examined as part of the larger Public Resource Management Study. This part of the study will assess options for improvement from a sectoral perspective in the expectation that a sector by sector review will help to define the need for, and sectoral implications of, broader scale reforms.

2.15 Investment Planning. Four important issues in investment planning are:

- (i) Decentralization: Reflecting the pattern of dependence on central government finance, the planning of regionally incurred expenditure is largely carried out by the central authorities, leaving provincial officials little flexibility to allocate resources consistently with local priorities, and perhaps with little incentive to determine those priorities accurately. What mechanisms would ensure more effective decentralization of planning in relation to local needs, including better coordination between the regional BAPPEDAS and the central MOH?

- (ii) Investment criteria: Efficient investment planning requires good project appraisal criteria. While a great deal of formal rigor cannot be attained in the health sector, there is a need for at least rudimentary guidelines on, for example, appropriate hospital bed capacity targets at different referral levels, and appropriate criteria for diffusing expensive items of medical equipment (e.g. CAT scanners and renal dialysis units). What is current practice, and what improvements should be recommended?
- (iii) Updating the investment program: The feasibility of introducing and maintaining an up-to-date inventory of project profiles, with a clear indication of high-priority projects comprising a core program (as proposed in the Public Investment Review) should be examined as a tool to assist regular updating of the health investment program in line with implementation performance and resource shortfalls.
- (iv) Recurrent expenditure implications: Planning for new investment should take into account its incremental recurrent expenditure implications and the projected availability of recurrent funding. What institutional reforms, e.g. improved coordination between BAPPENAS and Ministry of Finance, are needed to ensure this?

2.16 Budgeting Procedures. Improvements in budgeting procedures are closely linked with reforms in the planning process. Some of the major issues are:

- (i) Consolidation of budgets: The fragmentation of funding channels hinders efforts to improve allocative efficiency in the sector by precluding, on any routine basis, a consolidated assessment of existing resource allocation patterns. At the same time it induces excessive administrative costs by multiplying the burden of accounting, reporting, supervision and monitoring associated with individual tasks. What is the scope for consolidating budgetary sources into fewer channels, e.g. absorbing INPRES drug allocations into the MOH routine budget and INPRES health center construction funds into the DIP?
- (ii) Coordination of planning and budgeting: Present budgeting arrangements provide no linkage between investment planning (BAPPENAS) and budgeting for its recurrent cost implications (Ministry of Finance). For example, no apparent effort is made to project the manpower required to operate new health facilities, or to assess the likely availability of finance channelled through the SDO grant for regionally-incurred health manpower expenditure. What mechanisms can be used to improve coordination between the planning and finance functions, e.g. the project profile format?
- (iii) Guidelines for unit costs: Adequate budgeting for recurrent expenditure on operation and maintenance must be based on accurate guidelines on appropriate unit cost requirements, e.g. per health

center or per hospital bed of specified class. How can these be generated, updated and fed into the budgetary process to ensure adequate funding for recurrent expenditure, with clearly defined responsibilities of central and local government?

- (iv) Accounting systems: The accounting systems used in the health sector are diverse and not adequately informative. For example, at central level the MOH routine budget classification by directorate does not conform to the program classifications used in the DIP. At lower levels of government there are no standard budget classifications, and accounting practices in individual facilities vary enormously while uniformly failing to consolidate the fragmented budgetary expenditures on specific programs. What improvements, e.g. a program budgeting framework, could be introduced in order to provide routine, meaningful data on resource allocation patterns and unit costs (to assess efficiency and help set prices)?
- (v) Criteria for central grant distribution: Central government funds finance the bulk of regionally-incurred health expenditure, but their distribution among provinces tends to be extremely unequal, reflecting neither local differences in need nor local differences in ability to finance expenditure from local revenues (Annex I, Table 9). What new approaches to central grant distribution (e.g. the United Kingdom RAWP formula) should be considered and what are their implications for budgetary resource allocation in the sector?

III. WORK PROGRAM

3.01 The detailed work program is shown in Annex III and summarized below. Manpower requirements total 35 weeks (plus 4 weeks allocated to PHND2 project preparation and 22 weeks to the PHN Policy and Research Division). The work program will be executed in two phases. A preliminary mission focusing on data gathering and preparation of expenditure and revenue projections will take place in August-September with relevant background papers completed in October 1986. This will be followed by a second mission focusing on expenditure priorities, resource mobilization and planning and budgeting issues, with background papers completed in December 1986. An outline of the report is shown in Annex IV.

3.02 The work program will be managed by Nicholas Prescott. Howard Barnum will help to coordinate the work on expenditure and revenue projections, and John Akin will coordinate the work on resource mobilization. Nicholas Prescott will be responsible for writing the final report. Preliminary discussions with BAPPENAS and MOH on the objectives and content of this work have been positive. Counterpart working groups have been formed on Unit Costs, Expenditure Priorities and Resource Mobilization and background data collection is in progress under their auspices. The proposed timetable as follows:

Initiating Memorandum	August 1986
First phase mission	August - September 1986
First phase background papers	October 1986
Second phase mission	November 1986
Second phase background papers	December 1986
White cover report	February 1987
Yellow cover report	February 1987
Green cover report	March 1987
GOI discussions	April 1987

SUMMARY WORK PROGRAM

Person	Div.	Task	Staff weeks		
			PHND2 Sector	PHND2 Prep. <u>1/</u>	PHNPR
Prescott	PHND2	Initiating Memorandum	3	-	-
		Management	8	-	-
		Report writing	10	-	-
So	PHND2	Cost projections	-	-	6
Wheeler (Con.)	PHND2	Cost projections: Health centers	3	-	-
Chomitz (Con.)	PHNPR	Cost projections: Manpower	2	-	1
		Resource mobilization	-	-	4
Barnum	PHNPR	Cost projections: Hospitals	1	-	5
Ferster (Con.)	PHND2	Revenue projections	4	-	-
Akin	PHNPR	Resource mobilization	-	-	6
Consultant	PHND2	Expenditure priorities	4	-	-
Consultant	PHND2	Planning and budgeting	-	4	-
		<u>TOTAL</u>	35	4	22

1/ Third Health Project

STATISTICAL TABLES

1. Comparative Health Status Indicators, 1984
2. Health Status Indicators by Province, 1978
3. Health Investment Program for REPELITA IV
4. Central Government Expenditure on Health at Current Prices,
1974-75 - 1986/87
5. Central Government Expenditure on Health at Constant Prices,
1979/80 - 1986/87
6. Sources of Finance for Public Expenditure on Health, 1982/83
7. Public Expenditure on Health by Level of Administration, 1982/83
8. Estimated Investment and Recurrent Components of Public Expenditure on
Health, 1982/83
9. Distribution of Public Expenditure on Health by Province, 1980/81

INDONESIA

COMPARATIVE HEALTH STATUS INDICATORS, 1984

	<u>Life Expectancy</u> <u>(years)</u>	<u>Infant Mortality</u> <u>Rate (per 1000)</u>
INDONESIA	55	97
China	69	36
Korea	69	28
Malaysia	69	28
Philippines	63	49
Thailand	64	70
All Low-income	61	72
All Middle-income	61	72

Source: World Development Report 1986.

INDONESIA

HEALTH STATUS INDICATORS BY PROVINCE, 1978

PROVINCE	Urban		Rural		Total	
	IMR	LEB	IMR	LEB	IMR	LEB
<u>Sumatera</u>						
Di Aceh	65	61	93	55	91	56
North Sumatera	70	60	94	55	87	56
West Sumatera	89	56	125	49	121	50
Riau	69	60	126	49	113	51
Jambi	79	50	123	50	118	50
South Sumatera	75	59	104	53	98	54
Bengkulu	65	61	110	52	106	53
Lampung	91	56	98	54	97	54
<u>Java</u>						
DKI Jakarta	79	58	92	55	80	58
West Java	105	53	134	48	129	48
Central Java	78	58	100	54	96	55
DI Yogyakarta	50	65	66	61	62	62
East Java	84	57	102	54	99	54
<u>Nusa Tenggara</u>						
Bali	69	60	90	56	88	56
West Nusa Tenggara	142	46	194	38	187	39
East Nusa Tenggara	56	63	129	49	124	49
<u>Kalimantan</u>						
West Kalimantan	66	61	122	50	116	51
Central Kalimantan	72	60	103	53	100	54
South Kalimantan	101	54	124	49	121	50
East Kalimantan	75	59	110	52	99	54
<u>Sulawesi</u>						
North Sulawesi	80	58	96	55	94	55
Central Sulawesi	85	57	131	48	128	49
South Sulawesi	107	53	109	52	108	52
Southeast Sulawesi	88	56	116	51	114	51
<u>Maluku & Irian Jaya</u>						
Maluku	78	58	128	49	124	49
Irian Jaya	89	56	110	52	106	53
INDONESIA	86	57	113	51	107	52

Note: IMR denotes infant mortality rate (per 1,000), LEB denotes life expectancy at birth (years)

INDONESIA

HEALTH INVESTMENT PROGRAM FOR REPELITA IV
(in Rp billion at current prices) 1/

Program	MOH Investment Program 2/					Total	Plan Allocations	
	FY85	FY86	FY87	FY88	FY89		FY85	Total
<u>Health sector programs</u>	<u>324.4</u>	<u>431.1</u>	<u>491.3</u>	<u>547.9</u>	<u>553.8</u>	<u>2,348.5</u>	<u>253.3</u>	<u>2,051.6</u>
Health education	1.8	2.4	3.1	4.1	5.5	16.9	1.8	13.3
Health services: community health	82.0	92.1	102.9	116.6	132.8	526.4		
Health services: medical care	176.7	237.5	258.9	271.6	237.3	1,182.0	191.2	1,439.1
Communicable disease control	49.1	64.3	86.6	107.7	129.2	436.9	37.9	455.0
Nutrition	8.0	19.8	29.2	35.4	34.7	127.1	5.9	43.7
Food and drug administration	6.7	15.0	10.7	12.5	14.3	59.2	16.4	100.5
<u>Other MOH programs</u>	<u>94.9</u>	<u>130.1</u>	<u>145.4</u>	<u>190.4</u>	<u>176.3</u>	<u>737.1</u>		
Manpower development	65.6	72.2	79.4	87.3	96.0	400.5		
Rural water supply	22.3	44.3	46.1	76.5	56.6	245.8		
Environmental health	1.5	3.5	7.8	13.8	19.7	46.3		
Administrative infrastructure	3.1	7.5	9.1	9.3	--	29.0		
Other 3/	2.4	2.6	3.0	3.5	4.0	15.5		
Total	419.4	561.2	636.7	738.3	729.6	3,085.6		

- 1/ Converted to current prices, assuming an inflation rate of 10% p.a.
 2/ Cost estimates prepared by Bank staff.
 3/ Includes research and development, management, female participation and manpower generation.

INDONESIA

CENTRAL GOVERNMENT EXPENDITURE ON HEALTH AT CURRENT PRICES, 1974/75-1986/87
(in Rp billion)

	<u>Routine</u>	<u>Development</u>			<u>Ratio</u> Routine/Dev.
		<u>DIP</u>	<u>INPRES</u>	<u>TOTAL</u>	
<u>REPELITA II</u>					
74/75	11	9	5	14	0.79
75/76	19	13	15	28	0.68
76/77	17	16	21	37	0.46
77/78	22	21	27	48	0.46
78/79	26	24	27	51	0.51
<u>REPELITA III</u>					
79/80	32	50	30	80	0.40
80/81	49	78	50	128	0.38
81/82	74	98	79	177	0.42
82/83	79	119	99	218	0.36
83/84	82	119	99	218	0.38
<u>REPELITA IV</u>					
84/85	94	119	99	218	0.43
85/86	117	114	115	229	0.51
86/87	139	61	114	175	0.79

INDONESIA

CENTRAL GOVERNMENT EXPENDITURE ON HEALTH AT
CONSTANT PRICES, 1979/80 - 1986/87
(in Rp billion at constant 1987 prices 1/)

	<u>Development 2/</u>			<u>Routine 3/</u>
	<u>DIP</u>	<u>INPRES</u>	<u>Total</u>	<u>MOH</u>
<u>REPELITA III</u>				
1979/80	102	61	163	68
1980/81	146	94	240	93
1981/82	177	143	320	129
1982/83	182	181	363	119
1983/84	167	139	306	115
<u>REPELITA IV</u>				
1984/85	156	130	286	123
1985/86	105	106	211	128
1986/87	61	114	175	139

1/ 1973=100 price indexes rebased to 1987.

2/ Gross domestic investment deflator.

3/ Public consumption deflator.

INDONESIA

SOURCES OF FINANCE FOR PUBLIC 1/ EXPENDITURE ON HEALTH, 1982/83
(in Rp billion)

	<u>Central</u>	<u>Local</u>	<u>Total</u>
<u>Development</u>			
APBN (DIP)	119.5	---	119.5
INPRES	98.5	---	98.5
Crash Program	17.0	---	17.0
Foreign Assistance	51.6	---	51.6
APBD I	---	4.6	4.6
APBD II	---	<u>3.5</u>	<u>3.5</u>
TOTAL	<u>286.6</u>	<u>8.1</u>	<u>294.7</u>
<u>Routine</u>			
APBN (DIK)	78.5	---	78.5
SDO	103.0	---	103.0
APBD I	---	18.8	18.8
APBD II	---	<u>14.0</u>	<u>14.0</u>
TOTAL	<u>181.5</u>	<u>32.8</u>	<u>214.3</u>

1/ Excludes public sector outlays through the Armed Forces, Ministry of Education, Bio Farma, and other departments and state enterprises.

INDONESIA

PUBLIC EXPENDITURE ON HEALTH ^{1/} BY LEVEL OF ADMINISTRATION, 1982/83
(in Rp billion)

	<u>Central</u>	<u>Local</u>	<u>Total</u>
<u>Development</u>			
APBN	30.4	89.1	119.5
INPRES	11.8	86.7	98.5
Crash Program	8.2	8.8	17.0
APBD I	---	4.6	4.6
APBD II	---	3.5	3.5
TOTAL	<u>50.4</u>	<u>192.7</u>	<u>243.1</u>
<u>Routine</u>			
APBN	23.5	55.0	78.5
SDO	---	103.0	103.0
APBD I	---	18.8	18.8
APBD II	---	14.0	14.0
TOTAL	<u>23.5</u>	<u>190.8</u>	<u>214.3</u>

^{1/} Excludes foreign assistance.

INDONESIA

ESTIMATED INVESTMENT AND RECURRENT COMPONENTS OF PUBLIC
EXPENDITURE ON HEALTH, 1982/83
(in Rp billion)

	Central 1/				Local 2/	Total
	Routine		Development			
	APBN	SDO	DIP	INPRES		
<u>Investment</u>						
Equip. & Supplies	17.88	---	15.26	20.12	5.81	59.07
Construction	---	---	49.25	40.39	2.00	91.64
Sub-Total	17.88		64.51	60.51	7.81	150.71
<u>Recurrent</u>						
Personnel	36.91	103.00	10.50	---	20.45	170.86
Drugs	12.56	---	19.52	37.99	10.00	80.07
Maintenance	8.01	---	12.86	---	1.64	22.51
Travel	1.08	---	---	---	0.50	1.58
Other	2.08	---	12.11	---	0.50	14.69
Sub-Total	60.64	103.00	54.99	37.99	33.09	289.71
TOTAL	78.52	103.00	119.50	98.50	40.90	440.42
	=====	=====	=====	=====	=====	=====

1/ Excludes foreign assistance and crash program expenditure.

2/ Includes development plus routine budgets.

INDONESIA

TABLE 9: DISTRIBUTION OF PUBLIC EXPENDITURE ON HEALTH BY PROVINCE, 1980/81
(in Rp per capita)

Provinces	Routine		Development		Total
	Central	Provincial 1/	DIP	INPRES Drugs	
<u>Java and Bali</u>					
1. Jakarta	1962	280	346	110	2698
2. West Java	304	164	215	152	835
3. Central Java	352	333	312	149	1146
4. Yogyakarta	573	442	886	146	2047
5. East Java	136	167	206	147	656
6. Bali	887	877	595	141	2500
<u>Outer Islands I</u>					
1. Aceh	113	358	362	145	978
2. North Sumatra	111	314	239	143	807
3. West Sumatra	701	163	576	143	1583
4. South Sumatra	627	123	387	142	1279
5. Lampung	68	420	181	153	822
6. West Kalimantan	172	482	422	143	1219
7. South Kalimantan	239	454	715	139	1547
8. North Sulawesi	331	625	518	142	1617
9. South Sulawesi	160	200	310	140	810
10. West Nusa Tenggara	73	235	483	143	934
<u>Outer Islands II</u>					
1. Riau	120	157	431	141	849
2. Jambi	130	197	891	147	1365
3. Bengkulu	212	485	1051	156	1883
4. Central Kalimantan	181	354	800	158	1493
5. East Kalimantan	384	1929	1120	175	2608
6. Central Sulawesi	154	589	873	148	1764
7. South E. Sulawesi	194	302	810	142	1448
8. Maluku	221	423	1054	155	1853
9. East Nusa Tenggara	72	271	500	139	982
10. East Timor	-	-	-	-	-
11. Irian Jaya	132	1338	884	153	2507

1/ Includes the central SDO grant.

HEALTH FINANCE PLANNING MODEL: SUMMARY

This model projects the cost and personnel requirements of a planned investment program in the health sector. The inputs required to drive the model are planned expansion in training facilities, number of entering students, and expansion of programs and facilities.

The model is written with the LOTUS 1-2-3 spreadsheet program. It consists of six components detailing the implications over time of a given sectoral investment plan, specified in terms of planned expansion in personnel, programs, and facilities. The six components are: (i) training, (ii) facilities and programs, (iii) personnel, (iv) costs, (v) revenue, and (vi) budget balance. The training component is further divided into student and trainer subcomponents, and the cost, revenue, and budget balance components are further divided into capital, recurrent, and total subcomponents. Each component is nearly self-contained and links with other components using only one or two variables.

Given initial conditions -- existing facilities, students, and training capacity, wages, unit costs, and revenue trends, and parameters -- such as student/teacher ratios, personnel ratios for facilities and programs, and attrition rates -- the number and scale of students, trainers, personnel, facilities, costs and revenues is projected for up to a twenty-year period. In each year the net results of the projection are summarized in three balances that provide a measure of the adequacy of the plan: (i) the number of existing versus required personnel in each personnel category; (ii) the unit capacity of existing facilities or programs compared to the required capacity to provide a target level of services for the population; and (iii) the recurrent, capital, and total budget surplus or deficit.

Although the model involves approximately 40 to 80 equations, depending on the number of program or project categories, skill categories, and trainer types, it is not complex. The equations are straightforward statements of accounting or technical relationships that are an intrinsic part of the planning process. Economic or behavioral relationships have not been included with the possible exception of the use of depreciation and attrition rates for the stocks of facilities, personnel, and students. This was made in order to have the model viewed by users as a useful tool and not as a black box. The accounting relationships are obvious and transparent in application.

WORK PROGRAM

Task	SW	1986					1987		
		July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.
A. <u>Initiating Memo</u>	Prescott	3	—						
B. <u>Background Papers</u>									
1. Cost Projections:									
- Hospitals	Barnum	6		—					
- Manpower	Chomitz	3		—					
- Health Centers/CDC	Wheeler	3		—					
2. Revenue Projections	Ferster	4	—	—					
	So	6		—					
3. Expenditure Priorities	Consultant	4		—			—		
4. Resource Mobilization	Akin	4		—			—		
	Chomitz	4		—			—		
5. Planning & Budgeting	Consultant	4		—			—		
C. <u>Management</u>	Prescott	8		—			—		
D. <u>Report Writing</u>									
Chapter I	Prescott	6			—		—		
Chapter II	Akin	2			—		—		
Chapter III	Prescott	2						—	
Summary & Conclusions	Prescott	2							—
		<u>61</u>							

HEALTH PLANNING AND BUDGETING: OUTLINE

I. EXPENDITURE PROGRAM: REPELITA IV

1. Mid-Plan Review, 1984/85-1986/87

- Sector priorities, physical targets and achievements
- Levels and allocation of expenditure: investment and recurrent
- Sources of finance: central government (MOH routine, SDO, development, INPRES and project aid), provincial and district governments, and cost recovery (fees, ASKES).

2. Expenditure Program, 1987/88-1988/89

- Physical targets
- Projected investment and recurrent expenditure implications by major subprogram (hospitals, manpower, health centers, communicable disease control and others)
- Projected availability of funds (based on development and routine expenditure forecasts provided by PRMs)
- Resource shortfalls and implications for expenditure priorities (trade-offs between major subprograms, and investment vs. recurrent expenditure).

II. RESOURCE MOBILIZATION

1. Pricing Policy

- Current pricing structure and revenue generation
- Prospects for increased cost recovery (based on evidence of unit costs and price elasticities).

2. Health Insurance Coverage

- Review of current insurance schemes (ASKES, DUKM, other urban and village insurance schemes), coverage and resource flows
- Prospects for expanding coverage and projected resource mobilization impact
- Options for improving efficiency (copayments, and DRG-type reimbursement mechanisms).

III. PLANNING AND BUDGETING

1. Investment Planning

- Decentralization
- Project selection criteria
- Updating the investment program

2. Budgeting procedures

- Consolidation of budgets
- Coordination of planning and budgeting (especially for recurrent expenditure)
- Guidelines for unit costs
- Accounting systems (program budgeting)
- Criteria for central grant distribution.

IV. SUMMARY AND CONCLUSIONS

June 27, 1986

TO: J. North, F. Sai, A. Berg, S. Denning,
~~D. Mahar~~, E. M. Schebeck, ~~N. Birdsall~~ *AL*

IZH

John North asked me to schedule a meeting for us to discuss the draft agenda (attached) for the September 3-5, 1986 "strategy" meeting with WHO/Geneva. Cecilia Mangini will contact your secretary to set up a time.

F 18th 10am JDN office

Thanks,

Loug.

Date: June 16, 1986

To: Mr. John North
Mr. Anthony Measham ✓

From: Bernhard Liese, PHNDR
li

1. District Health Systems. The district health system should be of interest to us, but the software as well as the hardware.
2. National Financing of Strategies for Health for All. WHO has to become more realistic in what it wants to support, in view of limited financial resources.
3. Management of Health Systems. Is obviously an area of mutual interest. I can prepare summary paper on results of our workshop on management issues in tropical disease control programs and put forward some ideas on other management issues.
4. Health Components of Development Projects. I will prepare a background note. Avoiding negative impact of development projects is a major concern in the Bank. WHO often construes this as the "obligation of the Bank to finance some health-related activities."

Attachment

BLiese:shl

WORLD HEALTH ORGANIZATION



ORGANISATION MONDIALE DE LA SANTE

HAND-CARRIED TO WASHINGTON BY
PROF. SAI

Téléphone Central/Exchange: 91 21 11
Direct: 91

In reply please refer to: COR-N55/372/1
Priere de rappeler la référence:

Mr John D. North
Director
Population, Health and Nutrition
Department
The World Bank
1818 H. Street, N.W.
Washington, D.C. 20433
Etats-Unis d'Amérique

28 May 1986

Dear Mr North,

If it were not for the event of the Thirty-ninth World Health Assembly, which took place from 5-16 May 1986, I would find it difficult to apologise for sending you only now, the draft annotated agenda for our meeting planned for 3-5 September 1986.

As agreed with Dr Measham in our short discussion on 24 April 1986, we have prepared a list of issues (that we feel are relevant) for discussion in the September meeting. As we agreed last year in planning for this meeting, we will review matters of a strategic nature which concern us both. We would appreciate your critical review of the subjects, as well as their annotation. You may wish to add other issues or raise particular questions in relation to the subjects mentioned in the agenda.

At this stage, I have not included any particular regional issue of collaboration as we had agreed that these would be more effectively dealt with directly with WHO's regional offices. I am sure you will have the feedback from Professor Sai on the meeting held in WHO headquarters on 26 May 1986 with the Regional Director for Africa, Dr G. L. Monekosso.

Once we have your reaction to the annotated agenda, we will give further thought on how to substantiate the various agenda items.

Looking forward to your response.

With kind regards,

Yours sincerely,

Ingar Brüggemann
Director
Programme for External Coordination

WORLD BANK/WORLD HEALTH ORGANIZATION
MEETING ON HEALTH POLICY AND COLLABORATION

3-5 SEPTEMBER 1986, GENEVA

DRAFT ANNOTATED AGENDA

1. DISTRICT HEALTH SYSTEMS

As a result of the policy to channel major resources into building up health infrastructures, WHO is now concentrating on supporting countries in developing their district health systems based on primary health care. This involves strengthening community health care and the referral system. In addition to planning and organization of the system as a whole, highly specific components are health facilities, such as: health centres; community health posts; hospitals (for both inpatient and outpatient care), and support for community care; and laboratories for clinical and public health support, etc.

Training of health personnel permeates all action. With respect to the health infrastructure, the Bank may support the physical components such as centres and institutions, while WHO could provide support to the "software" such as manpower development, training, training material, etc.

| The relevant roles of the Bank and WHO in the above could be reviewed.

2. NATIONAL FINANCING OF STRATEGIES FOR HEALTH FOR ALL

One of the weaknesses revealed by the recent evaluation of the strategies for health for all is the area of financing. This involves both macro- and micro-economic analysis based on reasonable costing of strategies and their component parts of infrastructure and technology. Also involved are such aspects as programme budgeting, recurrent cost implications of investment, identification of realistic sources of financing, including cost recovery systems. The Bank surely has great experience in this field and could possibly strengthen its involvement. WHO too has produced relevant guidelines based on national experience.

| Closer cooperation between the two organizations could therefore be envisaged and discussed.

3. MANAGEMENT OF HEALTH SYSTEMS

Financing is only one part of the national managerial process and the evaluation of the strategies revealed great weaknesses in management in general. This includes: the planning of strategies based on health policies, the conversion of these strategies into plans of action for building up the health infrastructure, identifying the technology required, and ways of absorbing and using it, implementing health programmes, monitoring and evaluating the strategies and their component programmes and refining them in the light of the findings - all supported by realistic information systems. 'On the job' training is crucial.

This is another area where both Organizations have ample experience, which - if pooled - might lead to the total being greater than the sum of the individual parts.

4. HEALTH SYSTEMS RESEARCH

Optimizing the use of resources is an essential feature of good management. Health Systems Research - if dealt with in a highly practical manner - is a useful tool for making optimal use of resources. For example, it is useful for arriving at the best ways of applying technology under given circumstances and of optimally organizing the health infrastructure to that end. Many endeavours in the field of health management and financing profit from relevant health systems research. An outstanding field for health systems research that is of great social relevance is family planning within the context of delivering mother and child care through primary health care.

Ways of building this research into national health development efforts could therefore be explored jointly by the two Organizations.

5. HEALTH COMPONENTS OF DEVELOPMENT PROJECTS

Some years ago, the Bank adopted a policy including health components in development projects in various sectors, such as agriculture.

It would be useful to consolidate the experience gained with a view to reinforcing national awareness and interest in this field and refining the support that both the Bank and WHO can provide.

6. REVIEW OF THE RESEARCH AGENDAS OF THE TWO ORGANIZATIONS

WHO is constantly expanding the promotion of health research. Recent additions are:

- the development of vaccines through the application of biotechnology, as well as the development of new drugs by similar approach, for example to combat viruses (AIDS!). Social and economic studies on drug use such as prescribing and consumption patterns are envisaged.

Research on tropical diseases and human reproduction continues unabated.

It may be useful to review the collaboration between the two Organizations in the field of health research.

7. INTERNATIONAL FINANCING FOR HEALTH

In addition to the general question of national financing of strategies for Health for All (see item 2 above), the possibility might be explored of increasing the Bank's involvement in international financing for health.

The Bank might consider lending its prestige and expertise to such initiatives as the revolving fund for drug and vaccine procurement sponsored by WHO and UNICEF. Another problem is that of hard currency for procurement of equipment and supplies by developing countries.

8. COMMUNICATION

Ways could be explored of improving the speed and intensity of information exchange between the two Organizations in order to maximize their support to developing countries.

9. OTHER MATTERS

**THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM**

DATE: August 13, 1986

TO: Distribution

FROM: John D. North, Director, PHNDR

EXTENSION: 61571

SUBJECT: Strategy Discussions with WHO, Geneva, September 3-4, 1986:
Terms of Reference

1. You will travel to Geneva for strategy discussions with WHO on September 3-4, 1986. The overall objective of the mission is to strengthen coordination between WHO and PHN. The agenda for the meeting, and individual assignments for leading discussions on individual topics, will be the subject of a separate memo to be issued when the confirmed agenda is received from WHO.

2. Dr. Measham will be responsible for the back-to-office report assisted by other mission members.

Distribution: Messrs. S. Denning, A. Measham, E. Schebeck
Mmes. N. Birdsall, I. Husain

ARMeasham/cjm