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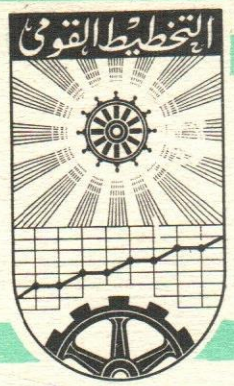

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TRAINING IN HEALTH PLANNING: SOME PRACTICAL GUIDELINES FOR A PLAN OF ACTION

BY

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INTRODUCTION

"No man is an island" John Donne said long ago and no man stands alone. This metaphysical truth which philosophers and poets are so apt at articulating is one which has profound implications in the social sciences and, more especially, in the social sciences as they relate to socio-economic planning.

At this point in time of the twentieth century those of us concerned with economic development have given intellectual assent to the fact that "no man is an island". We also assent to the fact that no organization can survive for long as an island but that individuals and organizations must band together within any nation that seeks to induce major societal change in its self-process of development.

Again, we have given intellectual assent to the fact that it is no longer the "rugged individual" who is the moving force in any of our socio-economic sectors. Rather, it is the team (a group of persons comprising various and diffuse contributions who work toward the achievement of a desired outcome) that is the significant decision making unit in the organizations of modernity. Also, equally true is the fact that no one organization within a particular sector can survive without establishing linkages with other organizations working toward the achievement of the specific goals of that sector.

We have given these concepts intellectual assent but the path to application of these concepts in the planning process is a rather more difficult matter since application often requires fundamental behavioural changes which call into question some cherished cultural values.

A case in point is that of the health sector. As socio-economic development specialists we are aware of the fact that the decline in the death rate of a nation in the past represents an expression in summary of that nations total economic growth and of the increase in the material well being of the population and that "medicine" (i.e., the doctor in contact with patients) had little or no role to play in this decline. Rather the decline in death rates of the past was due to the efforts of the public health officers and it was they who made the contribution to development. Yet, it is often the case that organizations and entire nations (see for example the USA Medicare fiasco) ignore the multi-disciplinary nature of the approach necessary to the solutions of the health problems and instead allocate their meager resources to personal curative services provided generally in acute care facilities to the immense detriment of preventive services with attending incalcuable social costs to the community.

Why does this situation prevail in so large a part of the world we live in? Simply because there is a serious cultural lag between what we accept intellectually and what we implement in actuality. In the health field for many centuries -- and indeed even in the present century -- health was defined in the minds of most people as being cured of a specific physical symptom and in some cultures of being freed from the presence of an evil spirit which had supposedly caused the affliction in the first place. Before Pasteur and the development of the germ theory of disease "health" and the responsibility for it was entirely in the hands of the all powerful physician who was looked upon as a quasi sacred individual. All due honour and at times almost adoration was paid to those who practiced their mysterious craft for the alleged well-being of man thus catering to his deepest instinct - that of self preservation.

Though the knowledge of the causes of ill health, personal, social and environmental ill health, has grown immensely since the 1900's the cultural lag in the re-definition of the role of the physician as but one contributor to the complex process of reaching the objective of "the realization and enjoyment by every human being of his and her full physiological and psychological potential" (WHO Formulation) remains to be solved.

Every nation has poured millions of units of its currency into its health sector only to find that such expenditures seem to serve only to arouse heightened expectations for more, and more costly, personal medical services. So powerful are the members of the medical profession that in their refusal to recognize their contribution as only one aspect of "health", they induce national expenditure in areas of least priority thus contributing to rather than reducing the awful problems of the vicious circle of poverty and disease.

Again we ask why is this so? Surely we know it is not through ill will on the part of the physicians some of whom recognize the problem. Again, the answer is cultural lag - an implicit often unconscious refusal to change outmoded behavioural patterns which so deeply affect the cultural values of the physician and hence his self image. Coupled with this is the problem that if the lag is to be taken up physicians of the future must be educated in the direction of the desired modes of behaviour. Hence no matter how great the quantity of material resources poured into the health sector it is reasonable to assume that unless and until there is a fundamental behavioural change in the direction of an integrated multi-disciplinary team approach to improvement in the health of a community little will be achieved.

If considerable numbers of the worlds physicians still maintain their traditional "master-slave" (with themselves as master) attitude toward all those professionals involved in health sector plan formulation and implementation very little fruitful work can be done in national health plan formulation and, what is more problematic, in national health plan implementation.

Once it is recognized by each member of the health team that each member has a unique contribution to make toward the achievement of a specific objective there is a greater probability that the emphasis in the health sector allocations will be in areas of priority in terms elucidated by sound cost benefit analyses.

But how can individual health professionals come to this recognition? One of the ways in which WHO is seeking to create improvements in this area is by sponsoring short-term courses for health professionals.

This paper is devoted primarily to offering some guidelines in the development of such short-term courses in health planning, specifically to the development of short term courses which embody actual planning experience for the participants involved.

STATEMENT OF PURPOSE

During the last ten years WHO has been active in training different categories of health administrators to encourage and assist governments in developing the necessary personnel for national health planning. Several regional and inter-regional courses and seminars have been conducted in collaboration with national or international institutes in different countries. The last inter-regional course, completed on 27 November 1970, was conducted in collaboration with the National Institute of Health Administration and Education (NIHAE) in New Delhi for which the author was WHO Consultant/Coordinator. The main objective of this course was to encourage the introduction of health planning courses in schools of Public Health as an integral part of public health curricula. Thus WHO added a new dimension to its training activities in health planning which aim at "Institution Building" in the health field to encourage such local institutes to undertake the responsibility of training different categories of health personnel in National Health Planning within the context of their own socio-economic milieu.

As WHO progressed in these training activities several questions were raised and the need for systematic and scientific examination of the subject became necessary. Thus a WHO Expert Committee was given the task of "reviewing different training programmes based on modern concepts of health planning, in order to answer such specific questions as why there is a need to train various types of personnel in this field, which particular categories of personnel are needed, what different types of planning courses and factors should be considered in each category, and what types of medical and non-medical institutions should be used".[1]

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[1] World Health Organization Technical Report Series 1970, No. 456, p.5.

The committee met in Geneva from 24 November to 2 December 1969 and its recently published report reflects the great effort of the committee to deal in depth with this extensive and intricate subject. The Expert Committee identified different categories of personnel required for national health planning and suggested a list of subjects "from which appropriate selection and adaptations can be made for certain other members of the health planning team and for certain categories of implementors".[2] In addition, the Committee included in its report an analysis of the "Levels of knowledge that should be possessed by persons in various roles in health planning".[3]

There is no doubt that the categorization of personnel, the delineation of subject matter and the analysis of levels of knowledge required for different categories of health planners provides very valuable inputs in constructing training programmes in health planning. However, the utilization of these inputs in WHO regional or inter-regional short term courses requires special efforts in adapting the different committee suggestions and recommendations in order to meet the time, resource, and cultural constraints which are the main challenges which these short term courses face more than do the systematic academic courses.

Upon completion of the Inter-regional Course in New Delhi and return to WHO headquarters the author was given the task of reviewing the available material on regional and inter-regional health and manpower planning in the light of the Expert Committee Report on Training in Health Planning, in addition to his own experience as participant, teacher and co-ordinator in such courses. Thus the purpose of this paper is to develop some practical guidelines for conducting courses in health planning designed to develop favourable attitudes towards national health planning and to stimulate the interested participants to pursue further studies.

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[2] Ibid., p. 21.

[3] Ibid., Annex 6

OBJECTIVES OF WHO SHORT-TERM COURSES IN HEALTH PLANNING

As stated above, the clientele of these courses are all drawn from the health field and "health" constitutes a considerable portion of their background in spite of the variation in their professions (e.g., nurses, physicians, sanitary engineers). This fact by itself enables us to set a number of common objectives for these courses. The formulation of the following common objectives is based on the analysis of the available material on WHO regional and inter-regional courses: (Refer to Appendix A for courses reviewed by the author):

(1) To visualize the health system as an integral component of the development ensemble which requires resources from its different systems and provides them with vital inputs necessary for their functioning;

(2) To view planning as an environmental behavioural component necessary to enhance and direct the development process;

(3) To realize the multi-disciplinary nature of the planning process and hence the need for a team approach in planning for the health system within its socio-economic context;

(4) To accept health planning as a means to achieve health objectives which form an integral component of the socio-economic development objectives;

(5) To provide the participants with a chance to apply the principle methods and techniques of planning in a way that clearly shows the utility of the scientific approach to health planning;

(6) To assess the achievement of the course objectives in order to modify future courses.

In addition to these common objectives, some special objectives may also be included, for example:

(1) To develop skills in applying methods and techniques of a special health planning methodology (eg. CENDES);

(2) To develop health planning curricula for certain schools of public health (e.g., the New Delhi inter-regional course).

The above stated objectives clearly show that these courses are by no means intended to produce health planners. The best they can hope to achieve is:

(1) a favourable change of attitude towards health planning;

(2) stimulation of the interest of some of the participants to pursue further studies;

(3) refinement of the individual participant's decisions to use some of the new tools to which he was introduced by seeking the advice of an expert to help him utilize such tools.

In addition to these achievements most important from the authors' point of view is to develop the participants ability to work in teams in which they respect the ideas of other professionals and grow to accept other professionals as partners in the decision making process in the health planning field.

ACTIVITIES INSTRUMENTAL IN ACHIEVEMENT OF OBJECTIVES

A number of activities are necessary to realize some or all of the above objectives. Among these activities the development of a course curriculum is fundamental but not sifficient to realize the objectives. Organizational and administrative activities are very vital to the success of any course. In this paper the author deals with Curriculum Development at length and discusses two other aspects only briefly. These aspects are:

(1) Recruitment of Participants; and

(2) Organizational aspects such as the role of WHO Consultant/Coordinators and the role of the Director and Co-director of the course.

Curriculum Development

The first phase of the course is the time period which serves to:

(1) orient the participants; and

(2) provide them with background information necessary to understand health planning as an integral part of socio-economic development.

This phase usually occupies 25% of the course period. The only course which allocated more time to this phase was the 1969 Inter-regional course held in Iran, UAR apportioning almost 40% of the total course time.