Public Health Practice

Morris Schaefer

New needs in health management

National health development policies demand the building of operational and management capacities. A WHO study has identified key requirements in these areas and has found that few countries are in a position to meet them.

Over the last quarter of a century, health leaders have become increasingly aware that inadequate management capacity in many developing countries dims their prospects for health development.

In the 1960s, WHO and other agencies began to make serious efforts to improve national health planning. The primary objective was to raise the abilities of countries to define policies and programmes. More recently, projects have been designed with a view to building segments of basic managerial infrastructure. But an effective comprehensive approach to managing health development is still lacking at the national and international levels.

Management implications of health for all

Following the Declaration of Alma-Ata, most countries adopted health policies consonant with the goals of primary health care and the global strategy for health for all by the year 2000. The implementation of these policies requires health management able to guide established health services and create and operate more extensive systems that can favourably influence health status. These systems, in contrast to ones based on hospitals or health centres, should be open in the sense of interacting with their environments. The systems are required to operate extensive networks of properly supported services, to link units throughout the health sector, to organize and support voluntary community action, and to work with other sectors to strengthen impacts on health and enable health development to contribute to socioeconomic development.

WHO has provided countries with technical guidance and field support in such areas of health infrastructure development as manpower, evaluation, technology assessment, information, systems research, and planning. The centrepiece of these efforts has been the managerial process for national health development (1). For some years only patchy information was available on progress towards the implementation of

The author is Emeritus Professor of Health Policy and Administration, University of North Carolina School of Public Health, 717 Caswell Road, Chapel Hill, NC 27514, USA.
the policies in question, and the adequacy of national health management was doubtful. The 1985 global evaluation of progress towards health for all made the picture clearer. Most Member States reported severe problems in managing the implementation of their health development policies (2). Some countries had neither programmed their policies nor obtained basic resources; in some countries, programmes had been defined but there were no operational systems to deliver them; and in some other countries, progress was frustrated by fragmented health structures.

These reported problems, together with WHO’s need to evaluate its technical cooperation in management development, led the Organization to undertake a detailed study of the situation in developed and developing countries during 1987-88. Because of the many differences between countries, the study had to be comprehensive, it had to involve key national personnel and all levels of WHO, and it had to employ a broad concept of management. The essential premises of the study were as follows.

- Management is not a separate function but is integral to the health system it serves.
- The full range of management involves formulating policies, programming, funding, developing the health system and its human and material resources, and guiding operations.
- The adequacy of management ultimately has to be measured not by its resources or by managers’ performance but by the effectiveness and efficiency with which services and other health-promoting interventions are delivered (3).

The study was conducted through the analysis of documentation supplemented by observation and discussion with national personnel ranging from village health workers to ministers of health in developing countries in four WHO Regions. In the two WHO Regions that were not visited, staff produced special reports in accordance with the design of the study. Information was obtained on problems, the capacities required for health development, and possible actions. It was found that whereas few countries have a management capacity matching the requirements of national health development, many have made progress, sometimes in developing capacity, sometimes in gaining an understanding of their needs.

Several developing countries have built the foundations for strong health development systems, guided by health-for-all policies. They have extended service coverage, improved resources, elicited community action, and strengthened health service structures. A few countries have even made advances in intersectoral action, which has proved to be the most difficult element in primary health care, by linking health programmes with community development efforts in agriculture and education.

A larger number of countries have made little progress in policy implementation,

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although some are developing certain basic elements. In many countries, objectives for health development have been crystallized, and shortcomings and constraints are now better understood. Among these countries
are the poorest ones with the least-developed health systems and others with extensive, highly institutionalized health sectors. In both rich and poor countries, health development advocates are seeking ways to make their health systems more effective.

Integrationist ideas meet strong opposition because of specialized interests and popular and professional preference for medical intervention.

The picture of national managerial needs can be most easily understood by placing countries in groups according to stage of health system development. Three clusters have emerged, comprising countries with early-stage developing, middle-stage developing, and mature health systems. The latter group includes both developed and developing countries. In addition to the needs specific in each group, those common to all groups have been identified.

Countries with early-stage developing systems

These are countries in which only limited progress has been made in some or all of the following phases of health development: establishing viable health-for-all policies, obtaining basic resource allocations, formulating strategies and programmes, and implementing programmes. In some countries, health development is constrained by “uncontrollable” factors, such as poverty, war, famine, natural disasters, and underdeveloped physical, social and technical infrastructures.

The countries in this category all lack human and material resources to carry out the health development process: public health is only partly organized; staffing for planning and management is minimal and available only at the central level; information support is poor; political links with governmental and other power centres are weak; and the official health structure competes with other health sector organizations more often than it leads them.

It is tempting to generalize by saying that these countries require “everything”, but many of them lack the capacity to absorb substantial resource inputs because of weak structuring and staffing of the management function. The experience of countries with middle-stage systems suggests that countries with early-stage systems have yet to develop the basic management capabilities required for large-scale system and resource development.

Countries with middle-stage developing systems

Although the countries in this group suffer many of the “uncontrollable” constraints facing early-stage countries, they have been able to establish policies and strategies for health development and have made substantial progress in implementation. Their major needs are to develop supplementary resources, further rationalize their health systems, raise the level of intersectoral action, and strengthen supporting institutions. In other words, they urgently need to strengthen their operating systems.

An examination of how these countries reached their present stage of health development sheds light on the problems of the other groups. One critical factor has been the proper specification of a health development strategy to provide a comprehensive framework for planning and budgeting decisions, setting priorities for
resource development and service coverage, defining targets and approaches for community participation and intersectoral cooperation, and selecting and directing the use of external assistance. What constitutes the proper specification of a health strategy depends on not only the adequacy of the product but also the process by which it is formulated. National strategies that merely collate elements of existing categorical health programmes into a separate primary health care programme are less powerful than those produced by a more organic process of assessing health needs and constraints before deciding on programme structures and developmental tactics. Countries that have followed the latter route have been more successful in integrating vertical programmes, linking health work to actual needs of populations and potentials for community action, and providing criteria for decisions on financial and other developmental issues.

Countries with mature systems

Complex and highly institutionalized health sectors in these countries usually give primacy to curative medical care, with the support of organized bodies of providers and users. Services are usually strong in central urban areas but coverage of economically disadvantaged populations varies greatly among the more developed countries and is usually poor in developing countries.

Some developed countries have undertaken to reorientate public policy around health development concepts, and have adopted objectives meant to influence the decisions and activities of autonomous health agencies. The health resource situation in these countries is comparatively favourable but management capacity is usually better within health service agencies than at the level of the community, where staffs are often meagre and the local information base is too weak to support small-area analysis. In most sectors, as in health, institutions and disciplines are so self-contained that comprehensive attacks on social problems are difficult to mount.

Institutionalization in the developing countries resembles that of their industrialized counterparts. Reform is impeded by professional traditions, sectoral divisions, and bureaucratic inertia. In addition to having to overcome fragmentation, leaders are under immense pressure to develop health resources and strengthen management in agencies and in the field of community health. Economic stringencies, added to political and managerial weaknesses, limit the ability to meet these needs.

Shared problems

Some problems, among them those outlined below, cut across all three country clusters.

- Inadequate diffusion of planning orientations and skills among health managers; the required qualities are sometimes altogether lacking or they may be limited to staff at national level.
- Fragmented efforts to meet health development needs; lack of comprehensive approaches and plans for developing operating systems and their management.
- Meagre resource development in relation to the requirements of health development.
- Policies and strategies that do not address environmental determinants of health, treatment taking precedence over prevention.
- Promotion and development of intersectoral action inadequate either for
relating health to socioeconomic development or for effecting improvements in the socioeconomic determinants of health.

• Ineffective mobilization of university resources in support of health development.

• Weak information support for policy, management, and clinical work.

• Ambiguous policies and practices on decentralization, limiting responsiveness to local conditions and needs.

Management and health development

Erroneous views of management often lead to inappropriate structures, responsibility assignments, and training. Many health workers consider management to be annoying, mysterious, confusing and frustrating, something to be avoided if possible. Some management specialists surround their work with mystique fortified by jargon, thus further discouraging colleagues who are primarily concerned with clinical work. Underlying this situation there are widely shared misconceptions about management. One is that management is separable from the work and programmes being managed, which is roughly equivalent to believing that the central nervous system can function outside the body. This leads to the mistaken notion that only management specialists do management work, and that most health workers need not, therefore, be prepared for it. A further misconception is that it is useful to develop the several elements of management (human resources, information, planning, finance) separately from one another, even though they are highly interdependent. Yet another erroneous view is that management depends primarily on good managers, irrespective of the organizational background and despite much evidence that a poorly structured management system will defeat the best efforts of able people. The correction of such misconceptions is essential if management capacity in the health field is to be increased.

Management functions

Management involves the guidance of activities, programmes, organizations and systems. “Guidance” is the key word, meaning that management both aims enterprises in particular directions and conducts their work. This holds for enterprises ranging from the treatment of patients to directing a national health system. In general, defining the aims — what is to be accomplished, when, how, at what standard — is done through planning based on analysis of problems and needs. Conducting the effort is the task of operational management, which has to guide the performance of the service mechanism and its various supports, including supplies, transport and records.

Most managers are called on both to aim and conduct: to plan, monitor and correct activities. A manager’s planning differs according to his or her role: the content of policy planning by a national programme director is different from that of a nurse’s monthly planning of health centre activities, but planning skills are required in each case. Likewise, provincial-level monitoring is more general than monitoring by a hospital pharmacy aide or by a supervisor of community health workers, but all monitoring should be done within the respective areas of responsibility of the people concerned. The community health worker should plan how best to use resources to respond to people’s needs and should assess what he or she is able to accomplish.

From another perspective, management is integral to health work because effective
health development requires that decisions and programmes be based on an understanding of health dynamics, i.e., community health problems and solutions, appropriate medical and related technologies, optimal use of resources, indicators of service performance and health impact, and institutional settings.

Moreover, all managers are dependent on the work of other managers in the system. Viable linkages must operate between the political and technical levels, between administrative levels, and between units and facilities at the same level. The centre needs timely and accurate information from the field so that suitable policies and programmes can be formulated, resources properly budgeted for and allocated, and objectives and targets adjusted. Service units depend on the higher levels for guidance and extra-community supports such as drugs, transport and staff replacements. The intermediate levels require information from both the centre and the periphery in order to mobilize resources, support operations, and foster improved system capabilities. Management cannot be effective if duties are not specified and understood, staff are not trained, linkages are faulty, standards and procedures are not laid down, and support needs are ignored.

**Health development capacity**

Analysis of country experiences has made it possible to produce a composite picture of the capacity required in a health system, which should offer:

- overall guidance of health development policies, embodied in proper public policy documents;
- strategic guidance that realistically identifies programme objectives and priorities, responsibilities of sectoral and other agencies, the use of appropriate technology, and the phasing of implementation and operations—all backed by enabling legislation;

- mobilization and rational allocation of resources, funded through public and private participation, and monitoring of their use;

- national, local and community objectives and action plans, systematically updated, which people can understand;

- specification of actions to be taken by organized health services, by community groups, and through intersectoral collaboration;

- standards governing health work and its management, together with practical procedures to guide clinical, informational and managerial processes;

- a clear understanding by all workers of their responsibilities and how they fit into the service and the system;

- active community participation, supported by health units, in accordance with explicit policies and procedures;

- integrated health sector activities and programmes, linking service units and levels, to serve clients efficiently and effectively;

- robust implementation of intersectoral action policies at all levels;

- established networks for resource development, using supporting institutions and in-house capabilities;

- a specified organizational structure, covering every level, unit, and type of position, with delegation of necessary authority to execute assigned functions, and arrangements for communications, supervision, and support to ensure accountability and progressive improvement of the system;
— competent monitoring, replanning, and problem-solving based on health systems research;

— relevant, timely and accurate information to support clinical and managerial decisions, without excessive and wasteful reporting;

— economical and dependable provision of supplies, facilities, maintenance, transportation and other logistics;

— keeping the system and its parts up to date and responsive to changing circumstances.

Such health system capacities result not from luck or accident but from planned efforts under management that guides both the continuing operations and the development and adaptation of the system’s structure, processes and resources.

Possibilities for action

Why is the development of such capabilities so rare? The customary answer is that health system development is limited by environmental factors, such as scarcity.

It is also true that systems for health development are inadequate even in countries where such limiting factors are less pronounced, that health sector behaviours themselves often act as constraints, that health sector actions could modify some constraints, and that, for various reasons, some health leaders are not ready to undertake modifying actions. In other words, more could be achieved if health leaders had clearer ideas of what should be done and acted on them.

WHO’s study of management capacity identified actions that the health sector could take to improve systems and modify internal and external constraints. It also identified ways in which technical cooperation, mobilized by WHO and other development agencies, could give better support to countries. The suggestions made are summarized below.

Integrating specialization

Before a country can have integrated organization and direction of resources, its health leaders must have an organic (or systemic) view of health development. The evolution of such a view is often impeded by specialization in knowledge and social organization. Specialization is valued and rewarded because the division of labour has led to increased scientific, technical and material production. However, this has been obtained at the cost of fragmentation of disciplines, organizations and programmes, and has caused social problems. Specialization endures, even though the effects of tunnel vision, narrow value sets, runaway technology, and barriers between disciplines are often deplored. More and more it is being recognized that the integration of specialization is essential for the well-being of society.

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of funds, exigencies of national politics, weak infrastructures, bureaucratic rigidity, fragmented structures, and the circumstances of war, natural disasters, and so on. This is largely true, especially in developing countries.
Health development is an integrating concept: primary health care defines problems in community terms, and seeks to minimize scientific and programmatic divisions. But as many committed to health for all have learned, integrationist ideas and policies meet strong opposition because of specialized interests and popular and professional preferences for medical intervention. It is not possible to change attitudes and counter opposition solely by stating concepts and mounting pilot projects. Health system strategies should aim at broader and underlying concepts of well-being, which have to be made operational. The progress made in some countries with middle-stage developing systems demonstrates the feasibility of this approach. Similar gains should be possible in relatively poor developing countries, since they are less encumbered by vested interests than countries with mature health systems, where progress towards health for all may be more difficult.

Comprehensive planning of health system development

To avoid the waste of resources which occurs in piecemeal efforts to correct particular deficiencies, each system-building project should be part of a comprehensive developmental design. A national health development strategy should therefore specify how system-building is to be accomplished, perhaps over 5-10 years. A sub-strategy should state the approach to developing the structures and resources needed to attain the policy goals of health development. It should be noted that "resources" means not only manpower, facilities, equipment, supplies and maintenance, but also the less tangible elements of technical methods, communications, information, agreements, mobilizing tactics, standards, procedures and control mechanisms.

This sub-strategy should provide a reasonably detailed picture of the future health system. Component plans should specify: structural relationships in the system; elaborated objectives, standards and procedures; management processes for each system level (macro- and microplanning, supervision, reporting, monitoring, correction and adjustment); logistical supports; and provision for systematic assessment, replanning and redesign. Plans should also identify the resources required for institution-building, financing strategies and priorities, the sequencing and timetable of implementation, and the management of implementation over the short and medium terms.

Formulating a sound sub-strategy requires accurate appreciation of the existing situation. The first step is therefore to make a full assessment of health system strengths and weaknesses, including detailed evaluation of management needs. To embrace variation within a country and to examine problems at intermediate and front-line levels, the assessment process requires the collaboration of line managers and staffs throughout the system, working with central planners. In countries with inadequate information the assessment may have to be carried out in several stages.

Redefining the management function

Because of managerial shortfalls, special attention has to be given to the management component of a system-building strategy. Planning the management structure and the preparation of human, informational and procedural resources should be based on how health workers actually participate and ought to participate in management. Too often the functioning of the intermediate management and support levels (province and district) has been overlooked, apparently
on the assumption that their staffs can deduce their responsibilities from general documentation on health strategy. Provision for logistical support, especially supplies, personnel and the maintenance of equipment and facilities, is also frequently inadequate. The reporting function, as part of the management information system, needs to be closely scrutinized to ensure that the right information is recorded and communicated and that it is used. Action is needed to foster attitudes supportive of proper management of the system and its units.

The management of resource development is frequently neglected. Measures should be taken to correct deficiencies such as the following: poor specification of quantities and quality of needed resources, in the light of the strategy and operating system specification; inadequate vesting of responsibilities and staffing of this management function; haphazard mobilization of resources, including schools and universities; and inadequate involvement of field staff in the development of standards and procedures, community participation approaches, and the design of structures.

Developments of operating systems

The need for effective operating systems is now most acute in the countries with middle-stage developing systems which have accomplished the initial steps of planning and implementation. However, health development in all countries could benefit from increased insights and capabilities in system development. Operational factors should be considered even during policy planning and formulation, so as to minimize the occurrence of unexpected problems during implementation.

The weaknesses observed in operating systems in many countries partly reflect inadequate provision of management technology. Support from universities and development assistance agencies has largely concentrated on the planning of programmes and projects, with little attention to the functions of structuring, standardizing, ensuring resource flows, and controlling. National health administrations have had little support in the work of specifying and proving system designs and operational standards.

The basic managerial technology for these tasks rarely exists in a form useful in most health development situations. Much of the technology is found in the literature on organization and management in business and public administration, but the concepts and techniques need to be adapted to the work and environment of health programmes. Furthermore, and this is more difficult, the technology must be recast to fit primary health care settings. Whereas in business there is an underlying assumption that management decisions are made in a formal organization with a single, determinate line of authority, in a primary health care programme working through a network of formal bodies and voluntary participants there are multiple lines of authority and complex social and political connections.

Few developing countries can reformulate operating system technologies on their own,
and resources would be wasted if each country acted alone. Consequently, there is a need for technical cooperation by WHO and allied development agencies, so as to pool expertise and provide coordination and support. This presents a valid demand for international cooperation, because appropriate technology cannot be developed in a laboratory. The management of operating systems is so bound to country conditions that it has to be developed on a basis of health systems research in the field, within and among countries. Textbooks on the subject are unlikely to appear for some years but working papers, case studies and intercountry exchanges could be generated in the relatively near future. Country progress has opened a frontier in the development and programming of health management technology, where WHO could play a valuable role if management development efforts in the various technical programmes were better coordinated.

International cooperation and support

Unfortunately, the situation at the international level parallels that in many of the countries needing support. The potential for technical cooperation is limited by the fragmentation of programmes and actions between and within agencies, which sometimes work at cross purposes. Just as in national health development, the design and implementation of unifying strategies to coordinate intra- and interagency programmes and resources would enhance the prospects for technical cooperation. Since the focal problem is health management, WHO would be the logical leader in such coordinated efforts, while striving to enhance the coherence of its own programmes and its interactions with Member States. Health for all will be achieved only if countries and technical cooperation agencies solve the problem of managing health development.

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References
