Health Systems

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Health programme planning for consolidation and quality

Botswana’s Ministry of Health is implementing a new approach to resource planning and management whereby the work of planners and technical experts is integrated with that of managers of programmes and facilities. The aim is to help the managers to make better use of resources in service delivery.

In Botswana between 1974 and 1987 the numbers of clinics and health posts rose from 50 to 150 and from 23 to 281, respectively. There were comparable increases in the numbers of various categories of health workers. Several primary health care programmes have been established including, for example, the Expanded Programme on Immunization. The increase in service delivery reflected an almost twofold rise in real recurrent expenditure on public health services between 1979/80 and 1987/88.

Decision-makers and planners face new demands as a result of the success of the development programme. During the 1990s the effectiveness of service delivery will have to be improved. A large proportion of the work force is relatively inexperienced. It will be necessary to create appropriate models of individual practice and a management system capable of maintaining a service of high quality on a sustainable basis. Following the implementation of investment plans, increased attention is being paid to the consolidation of services. The funding of public health services is expected to grow more slowly during the 1990s than earlier. None the less, the existing facilities and those already under construction will require additional money. All resources will have to be put to the best possible use. New recurrent expenditure will go preferentially to primary care. This

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means that a full range of referral services may have to be phased in to ensure adequate resources for the districts. Efforts will have to be made to improve management and decrease waste. The expansion of the infrastructure and activities of primary care will be targeted on people who have little access to health services.

Decentralization

The health sector has been transformed from a service based in a few facilities to one with activities dispersed throughout the country. There has been a rapid expansion in its size, the variety of inputs and the number of activities undertaken. Change in the planning and management system, however, has been slow. The highly centralized decision-making that characterized public health services in the past is not appropriate for today’s more complex sector.

A sharp distinction exists between the organization of primary care and that of referral services. Primary care is a responsibility of district councils, while referral services are provided by the Ministry of Health, missions and industrial enterprises. Progress in the devolution of authority for resource planning and management has differed between the two levels of care.

The heads of Ministry of Health hospitals and the small rural health centres have little independence of action in resource management, the major items of expenditure being controlled from head office. A national hospital management congress has agreed on the need to transfer responsibility for resource planning and management to individual facilities. However, a scarcity of skilled hospital administrators means that this will not happen quickly. In the meantime, support with routine planning tasks should be given to heads of hospitals, the training of cadres should be organized, and simple procedural guidelines should be drawn up for running these facilities. The Ministry of Health is implementing this process.

New roles for the centre

The involvement of head office personnel in the direct management of health services decreases as decentralization proceeds. However, these people continue to play an important role in the coordination of the various providers and the provision of management support. The duties of Ministry
of Health officers are being redefined to take account of the changed situation.

At a national meeting of medical officers in 1989 a number of indicators were presented and their relevance to planning was discussed. The participants agreed that useful indicators of resource availability included the shortfall, relative to staffing norms, of nurses at primary care facilities, and per capita expenditure on health services. Indicators of service delivery included the rates of immunization, antenatal visits and outpatient contacts. It was especially useful to discuss reasons for differences between districts. An assessment of progress over time was not possible because of a lack of data.

The indicators for the 1989 district development plans were prepared on an ad hoc basis. Although much information is collected by the Ministry of Health, it is dispersed to a number of units and is often out of date. A considerable effort is needed to make it available to decision-makers. A working group has been formed to review the information system and recommend a small number of key indicators. The planning and statistics units have been made responsible for producing a short review highlighting trends and differences between districts and facilities. In addition, a primary care support unit has been established to monitor the quality of service provision and help the district health teams in the development of effective practices.

Rational planning of resource use has been hampered by a lack of information. There is often no information available on expenditure by both individual hospitals and district health departments. Consequently, the pattern of resource allocation by level of care and by district has not been monitored. A simple methodology has been developed for the planning unit to use in this kind of analysis. However, the eventual aim is to establish an accounting system which can routinely provide the required information.

All Ministry of Health unit heads have been asked to prepare guidelines for use in planning, the aim being to improve communication between head office and the people responsible for service delivery.

The majority of programme managers have prepared planning guidelines which were used by the district health teams in drawing up the 1989 district development plans. They are based on an assessment of recent experience in communication, technical supervision, service delivery, training, and other matters. In addition to technical guidelines, information is provided in a standard format on indicators for monitoring progress, national targets for service delivery, and the resources available for district health services. These data will be regularly updated. Each programme head is encouraged to collaborate with those responsible for service delivery in developing proposals for improving practice, based on an analysis of differences in performance between districts.

Technical experts are also required to prepare guidelines on inputs. These include norms of resource use, e.g., staffing norms based on levels of activity for rural facilities, and suggestions for improving practice, e.g., relating to the relative roles of the various cadres. The development of guidelines on the use of a number of inputs such as drugs,
medical equipment and vehicles will be a high priority in the coming years. The activity targets and input norms are not intended to be seen as directives that have to be applied uncritically. They provide broad guidelines for managers of facilities and programmes.

There is a shortage of experienced managers. Officers responsible for service delivery require the support of technical experts at national level in the formulation of their plans. This is provided through regular meetings at which national programmes and the use of the various inputs are discussed with head office personnel. For example, district health teams meet regularly with heads of primary care programmes and with officers responsible for manpower planning, drugs, transport, and so on. This personal contact is more effective than a series of Ministry directives and allows an exchange of experience between people working at different levels.

The most important form of training in planning for local managers is for them to be provided with support in carrying out routine work. This also ensures that head office personnel keep in touch with reality in the field. In addition, workshops are held to address specific problems. It is intended that, eventually, heads of hospitals and district health services shall have been fully trained so that they possess all the necessary management skills.

There are few established procedures for the management of hospitals or district health services. The Ministry of Health, avoiding the introduction of new systems from outside, aims to make the existing system work better. Current practices are being translated into procedural guidelines. For example, the ways in which certain planning tasks should be tackled have been summarized (1).

As experience is gained in the integration of planning into day-to-day activities, more information will become available on good and bad performers and it should become possible to develop "best practice" guidelines.

Eight steps to systematic decision-making

Planning officers in Botswana are members of a cadre of economists who are answerable to the Ministry of Development Planning. Their primary responsibility has been the preparation and implementation of public sector investment plans. There is a relatively high turnover of planning officers in the Ministry of Health. In consequence they have not been fully integrated into the health management system. As priority has shifted from expansion to consolidation, the need to develop an interdisciplinary style of work has grown. One aim of health programme planning is to provide a structure in which health professionals, general administrators, finance officers, and planners work together to support those with direct responsibility for service delivery.

Planning takes place in the context of a number of cycles, including the preparation of the annual estimates of expenditure and the formulation of development plans. Experts at national level, including planners, as well as management teams in hospitals and districts, have a role to play in each of these exercises. The following eight steps provide the framework in which the national and peripheral levels participate in a systematic process of decision-making.

- Information is sent to facilities and districts. At the start of the planning cycle, heads of facilities and council
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health departments assess the previous year's performance. They require information on, among other things, health status, service provision and resource use. Some data are collected and analysed at local level. Others are supplied by national units and put together in a statistical report by the health planning unit.

• Guidelines are sent to facilities and districts, so as to provide a means by which policy-makers and technical experts communicate with managers of programmes and facilities. The guidelines include:
  — outlines of national programmes (with national targets);
  — a review of recent experiences, including comparisons between various providers and information on trends in service provision or health status;
  — proposals for improving existing practices;
  — indications of resources that will be available.

• Local providers and users are consulted. The views of health workers and members of the community are solicited. Discussions cover a review of experience, the identification of problems that have arisen, and proposals for new activities, among other subjects.

• Plans are prepared by facilities, programmes and districts. These take into account the information provided in the preceding steps. Local teams will eventually have the capacity to undertake this task with a minimum of technical support. However, for a number of years it will be necessary to combine a programme of training with assistance in the preparation of budgets and plans.

• Draft plans are reviewed at a meeting with technical personnel at national level. The purpose is to:
  — improve the technical quality of the plans;
  — discuss the relative priorities of requests for additional resources;
  — support the improvement of management procedures;
  — provide training in planning and management.

• Senior officers in the Ministries of Health and Local Government integrate the proposals of facilities and programmes into departmental and sectoral plans. Facilities and council health departments are kept informed about decisions made at head office. The completed plans are forwarded to the Ministry of Finance and Development Planning.

• The Ministry of Finance and Development Planning holds negotiations with senior officers in the health sector, who seek to defend their interests in relation to demands made by other ministries. The completed national plan is submitted to the Cabinet and the National Assembly for approval. Individual facilities and programmes are then informed of the resources they will receive.

• The activities of health service providers are monitored for resource use, service provision, coverage of the population, and changes in health status. Less
frequently and in greater detail, evaluations are performed. Monitoring and evaluation are important components of management and should occur at all levels. The results are made available to decision-makers in order to aid replanning.

The eight steps have been translated into guidelines for the various planning exercises. Experience in implementing them will be monitored and the procedures will be revised accordingly. The aim is to develop a management system that integrates the planning approach with day-to-day decision-making.

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**The district role is pivotal in health management**

In determining what can be done in the district to improve health personnel management, one must look at the degree of decentralization in the country, which is a critical factor. While in some countries the district management team may have the authority to take action, in others action will require a central-level decision. In the latter case, the role of the peripheral level is to inform the centre of what is required and justify the proposed action. The responsibility of the central level is to ensure that the system not only allows but also encourages the district level to carry out this role.


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