WHO and health planning – the past, the present and the future

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The author reviews three decades of WHO involvement in the design and application of health planning methods, and offers some suggestions on how to proceed.

The successive phases of WHO’s activity in the field of health planning reflect the evolution of the Organization’s philosophy concerning health development in general. Drawing on my own involvement in these activities, I would outline these phases as follows:

- pre-1965 – planning as a routine function within overall public health administration;
- 1965–1970 – development of specific planning concepts and methods (such as PAHO-CENDES and National Health Planning);
- 1970–1975 – application of the systems approach, exploration of computer modelling, and advent of health project planning and management (Research in Epidemiology and Communication Science, and Project Systems Analysis);
- 1975–1980 – advent of health sector programming (country health programming) and initiation of the Managerial Process for National Health Development;
- 1980–1985 – Managerial Process for National Health Development in support of health for all through primary health care and specialized programme planning (for instance in immunization and diarrhoeal diseases);
- 1985–1990 – diminishing emphasis on health planning except at district level; increasing prominence of monitoring and evaluation of programme implementation and progress towards health for all;
- 1990–1995 – enhancement of evaluation methods; little attention to health planning except in relation to “health futures”, a methodology for thinking about the long-term future;
- 1995 to present – little practical cooperation in health planning, some support for strategic health planning in countries, interest in defining essential public health functions and in new analysis techniques such as disability-adjusted life years (DALYs).

In the following paragraphs I will take a brief look at each of these periods.

Pre-1970

Before the 1970s the health sector in general and WHO in particular lagged behind other sectors in applying contemporary planning concepts and methods (1–4). It was difficult to encourage
national planners to formulate clear, measurable, time-limited objectives. The concepts and methods of the systems approach, operations research and project management had been in use for some time in other sectors when WHO began to apply them beyond the confines of a few development projects.

An attempt to include economic costs and benefits of health development was first made in a serious way in the PAHO-CENDES health planning methodology. This approach, devised in the Development Studies Centre of the Central University of Venezuela in collaboration with the Pan American Health Organization, was oriented towards the reduction of mortality, using life-years saved as a measurable objective function (5). During the same period, various national health planning methodologies were emerging and being taught in international courses (6–8).

Centrally managed governments tended to employ the more normative approaches for distributing health resources among their populations. The principle of equity was clearly taken into consideration and it was assumed that norms could be established on a technical and epidemiological basis.

In Western countries the emerging health planning philosophy tended to be oriented towards the achievement of specified health improvement objectives using the “rational-analytical” approach. Sometimes resource constraints featured as a major part of the picture and the objective thus became one of optimization. Often, however, current or predicted health resources were not seen as the overriding constraint. Multisectoral cooperation and community participation began to receive attention.

These methods of health planning were taught in WHO-supported regional courses.

1970–1975

WHO began to invest in the development and application of a variety of health planning methods using different approaches. For example, the Division of Research in Epidemiology and Communication Sciences explored analytical and planning methods, applying the latest techniques in the fields of epidemiology, computer modelling and the behavioural sciences. Extensive country-level research and development projects were supported in Colombia, Iran and Malaysia, aimed at using operational research tools and analytical methods for designing new, cost-effective strategies for national health development.

On a much smaller scale, a project approach to health development was devised at WHO headquarters which used some of the concepts of systems analysis within a highly “procedurized” process of project planning and management (9,10). This interregional project supported the application of its methodology in several countries in all the WHO regions. Some regions and programmes worked out their own ways of developing health planning methods (11,12). All the methods normally resulted in the design of national primary health care strategies because the
cost-effectiveness of this approach was obvious although it had not yet been proclaimed as the universal way forward.

1975–1980

A social development vision emerged in WHO during this period, culminating in the International Conference on Primary Health Care held in Alma-Ata in 1978, with its Declaration on equity, community participation, multisectoral cooperation and the eight essential elements of primary health care. WHO would no longer promote and support health planning without being explicit about the values involved. Global goals and a health-for-all strategy became the cornerstone of policy; planning and management methods became a means of promoting policy (13).

In WHO’s health-for-all policy for the 21st century an attempt is made to define the essential functions of health systems and public health work as governments reassess their responsibilities to the population as a whole in the context of downsizing and decentralization.

During this period a largely conceptual planning method emerged from WHO for use in country health programming (14). It was a loosely defined process that attempted to apply some of the principles of rational-analytical planning to strategy development favouring primary health care and health for all. The intended outcome was a national medium-term health development plan covering all government health programmes. The stages and steps of the process were briefly described but there was relatively little procedural and methodological guidance.

In many cases the results were theoretical in nature, taking the form of policies, strategies and plans of action for health for all rather than actual health development plans for countries. Two WHO regions made an effort to support governments in applying the method, with some success. The more successful applications occurred when ministries of health used it in conjunction with project formulation for the preparation of five-year health development plans, as they did in Bangladesh, Indonesia, Maldives, Myanmar and Thailand.

1980–1985

During the promotion and practice of country health programming the need for concepts and methods covering all phases of management became clear. The management of implementation, including budgeting, monitoring and evaluation, was felt to deserve as much attention as planning. This led to the overall Managerial Process for National Health Development. The concept was defined as a set of guiding principles specifically devised for use in supporting national strategies for health for all. The process contained the following phases:

- formulation of national health policies;
- broad programming (previously country health programming);
- detailed programming (previously project formulation);
- programme budgeting;
- implementation;
- evaluation.
- information system support.

Detailed documents on principles were prepared for each phase and were used in
international and national workshops (15).

This expansion of attention across all stages of management probably led to a diminution of WHO technical cooperation in health planning. Some guidance on general methods of development was provided in the phases of policy formulation, budgeting and evaluation, but direct technical cooperation with countries rarely ensued. Earlier, health planning had been extensively supported in countries through team facilitation in major planning efforts.

The health-for-all movement produced an increase in the need for direct support in planning, implementation, management and evaluation, and consequently it fell to the WHO technical programmes to try and fill the gaps in methodology. Thus, for example, the Expanded Programme on Immunization, supported by the United States Centers for Disease Control, developed a comprehensive series of mid-level management training modules (16).

1985–1990

Use of the Managerial Process for National Health Development declined during this period. Technical programmes continued to produce their own managerial guidelines. The design of methods of evaluation began in most technical programmes and in primary health care as a whole (17). Little effort was made in the area of planning methods, with the exception of an initiative for strengthening health services management at district level (18).

1990–1995

Evaluation methods continued to be improved. Many of them relied on approaches involving sample surveys of village clusters and facilities. Information systems began to receive some of the attention they needed. Little work was done on planning methods (19, 20). The value of health economics in support of policy formulation and planning was recognized and WHO supported numerous studies of health care costs and benefits (21).

Because of the rapidly rising costs of health care, special attention was given to designing and evaluating alternative financing mechanisms. The principle of equity began to receive serious managerial attention, and methods were being developed to measure equity in health (22). The identification of populations most in need of health care and with least access to it was becoming a routine feature of planning. A variety of problem-solving approaches enabled both service staff and communities to define their major prob-

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lems relating to health and services and to design, implement and evaluate solutions (23).

Since 1995

WHO’s efforts in the field of methods are now being concentrated on planning related to specific problems and technologies, and on health system reform. The traditional analytical methods of health planning can no longer support national health reform processes. Health futures research, aimed at giving some indication
of what the situation could be 20 or more years from the present, is beginning to yield material that can support the formulation of health policy and longer-term planning. Futures studies have been carried out in other sectors and in national development planning for some time (24). This approach includes activities such as alternative scenario development, trend analysis and forecasting, and dynamic modelling.

There is a growing recognition in countries and in WHO that new styles of planning are needed to meet the demands of change and reform. New analytical methods are being introduced, such as quantifying health in terms of disability-adjusted life years in order to measure disease burdens. In WHO's health-for-all policy for the 21st century an attempt is made to define the essential functions of health systems and public health work as governments reassess their responsibilities to the population as a whole in the context of downsizing and decentralization. The strategy of focusing on the populations that are in greatest need with interventions that are known to be cost-effective is being widely applied.

I will conclude this brief overview with some views on how WHO should proceed in this field. Many governments and bilateral cooperation agencies think WHO should reduce its direct technical cooperation with countries in favour of more normative and global activities such as developing methodologies, setting standards, mobilizing resources and exchanging information. However, an international agency cannot effectively set standards in matters related to technical programmes unless it is directly involved in those programmes. Direct cooperation with countries is by far the most effective way both to obtain and to share the necessary knowledge and expertise, provided that the decisions are made by the national entities and not by WHO or other external partners. Where WHO's technical cooperation with countries deserves to be criticized is where it fails to foster national self-reliance during the process of sharing expertise. The solution to this problem is not reduced involvement with countries but involvement of a different kind.

I believe it is national working groups that can do the best possible planning, evaluation and management, when the process is facilitated by practical, clearly described methodologies and low-profile technical and procedural support. This style of cooperation by WHO requires methodologies of high quality which are being continually improved and whose effectiveness has been demonstrated through wide application. There is an unfortunate tendency for WHO programmes and regional offices to jettison proven methodologies as soon as the people who developed them go away. Much time and valuable resources are then spent on "reinventing the wheel".

In its technical cooperation, especially within its country programmes, WHO should include more support for national working groups using proven user-friendly methodologies, not only in planning but in all the managerial activities involved. There appears to be sufficient evidence of the effectiveness of methodological support for national group processes to justify expansion in this direction.
References


