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GENERAL REMARKS ON CONTEMPORARY HEALTH PLANNING  
IN REPRESENTATIVE COUNTRIES<sup>1</sup>

by

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<sup>1</sup>Background document for reference use at the technical discussions on "Health Planning as an Administrative Tool".

At the Technical Discussions on Health Planning held in connexion with the Eighteenth World Health Assembly, Dr. Evang called planning "a relatively new venture started in the Soviet Union after the Russian Revolution as part of the overall economic and social planning". Evang pointed out how this new procedure was met with ridicule and laughed at in the Western world at the time.

Since then the situation has changed considerably and today "planning", including national health planning, is almost taken for granted.

There had not been, of course, as pointed out in Dr. Angara's paper (document WPR/RC19/TD1 Rev.1), even before the Soviet planning a total haphazard development of health services. Evang's main point was that in the not strictly economic production sectors the economist was missing from the picture. What was new - and what came in with Soviet planning - was that health became part, and an integral part, of the general economic and social planning for the country.

For discussing planning and the different methodological approaches it is may be useful first to establish the extent to which there are similarities between these approaches. I believe it would be found that practically all approaches - ranging from the most complex, like the Santiago methodology, with which Dr. Duran will be dealing in some detail, to the purely pragmatic approach which was used in five recent cases of planning the health sector in African countries - contain certain basic elements essential in planning:

- (1) the orientation is towards output;
- (2) alternatives are established and discussed;
- (3) an attempt is made at maximization of benefits and minimization of cost.

The main difference in the approaches is in the varying complexities of manipulation of data.

/It is, however, ...

It is, however, possible to divide the approaches to health planning into different categories. The Johns Hopkins group has conceptualized the demand for health care in four different ways:<sup>1</sup> (1) what do people want; (2) what do the professionals think they need; (3) what will people pay for; (4) what do the professionals (technical and administrative) consider feasible.

It will readily be seen that the established demand will differ very much according to which of these approaches is utilized. There is no reason to believe that what people need technically to keep them healthy is necessarily the same as their "popular" desire or what they can afford. Administratively and technically it is also unlikely that the "scientific need" can be fully met. Much methodological work has been concerned with the relationships between these four concepts!

It has been customary to make a distinction between the approach to planning in the market and the non-market economy countries. In a study of economic planning in the Union of Soviet Socialist Republics (USSR), M.Z. Bor<sup>2,3</sup> describes national economic planning as a system for directing the development of the country's economy and culture based on the deliberate use of "the objective laws of socialism" to satisfy the needs of society as fully as possible. The economic basis of USSR national economic planning is public ownership of the means of production.

The Soviet approach to health planning is what the Hopkins workers have called the "normative approach" - which involves setting standards and norms. It has, however, also strong elements of what the Hopkins workers call the "biological" approach - that is the establishment of the actual scientific need for health care. Recently the Soviet workers have also become increasingly interested in the cost, utilizing the techniques of cost/benefit analysis. However, the basic approach is the setting of norms for health services and medical care requirements and evaluation of the extent to which medical care requirements are being met.

/Until recently the ...

Until recently, the Soviet workers were more or less satisfied that with the very considerable prophylactic and medical care services they had developed - morbidity more or less equalled demand. Recently, the "Moscow Institute of Social Hygiene and Public Health Administration" has carried out a survey of general morbidity in five cities situated in different economic areas of the country with a total population of 1.5 million.<sup>4</sup> This survey showed that the health services' primary records gave satisfactory information on acute diseases requiring immediate out-patient or in-patient care and on those chronic diseases with clinical symptoms so marked as to force the patient to apply for medical care. However, it was found that there are a fairly large number of illnesses which do not seriously inconvenience the patient or disturb the tenor of his life and work. Thus, current attendance on personal initiative (or popular demand) does not reflect the real prevalence of the milder and early forms of disease. It is likely that the Soviet approach will come to contain more and more of the elements of the largely "biological" Santiago approach.

While as mentioned above the USSR workers have become interested in the cost aspects, Aleksandrov and Sahgel'djanc in a paper for a Moscow Seminar in 1968 write:<sup>5</sup>

"However, it should be fully realized that economic considerations must now be uppermost where health problems are concerned. The main deciding factor in any measure taken must be its medical benefit. Whatever is advisable in the interests of personal and social health should be carried out by all possible means regardless of the economic consequences. It is essential to know what these are and to analyze them but a fetish may not be made of them."

/Most of the ...

Most of the "planned-economy countries" have approaches to planning based on the USSR experience with local modifications. It would seem that the Czechoslovakian approach to planning is somewhat more flexible than that of the USSR. While indices (norms) are used, they are recommendations, and not as strictly adhered to as is the case with the "norms" of the USSR planning methodology. It would also seem that the Czechoslovakian health service is more decentralized and leaves somewhat larger scope for local initiative than is the case in the USSR planning methodology. Again, we have, apart from the main "normative approach", also a utilization of the "biological need" and the "popular demand" approach. Vacek and Skrobkova write thus in a recent article on "Planning Health Services in Czechoslovakia":<sup>6</sup>

The need for medical treatment and its trend can be estimated by two methods:

- I. The Analytical Method - analyzes the morbidity in a population according to diagnostic information. For any disease entity, an attempt is made to evaluate the type and duration of medical treatment taking into account the stage of disease, age, sex and other factors.
- II. The Experimental Method - On an experimental basis, the demand for health services under conditions similar to those anticipated for the appropriate future period of time is assessed.

A recent description of the Hungarian approach points out that as far as the methodology of planning is concerned, this is conceived as a system of rules and methods brought into accordance and tested practically, Hungary has utilized with benefit the experience of sister countries and, in the first instance, the experiences of the Soviet planners.<sup>7</sup>

/Outside the non-market ...

Outside the non-market economy countries, Indian planning is perhaps one of the earliest. Even before independence, the Congress Party already had a Planning Committee, under Nehru's chairmanship, before the war. The Government of India, under Lord Wavell, was planning in 1944 and the present Planning Commission was set up in 1950. The first Five-Year Plan began in 1951.

In a recent large-scale study of Indian planning<sup>8</sup> Professor Hanson of the University of Leeds emphasizes India's belief that the State should have a leading share in the economy and that some nationalization must take place. In terms of the 1950's Indian planning was relatively sophisticated. India had the tremendous advantage of having a first class Civil Service, something not too common in developing countries. Hanson points out that public co-operation and public opinion constitute the principal force and sanction for planning. However, Union planning and the State planning are, by nature, socially "planning from above". Theoretically, the Indian planners wanted to combine this with "planning from below" in which every unit down to the village and the family plays its individual part at both this formulative and implication stages. In this the planners have to a large extent, failed. Hanson claims that this is due to the characteristics of Indian society. Recently, a large-scale study has been prepared by Gunnar Myrdal<sup>9</sup> which with considerable elaboration comes to the same conclusion and is of prime interest to Asian planners.

The most important aspect of the planning structure that has developed in India since 1950 is that responsibility for planning is shared by the Central and State Governments with the Planning Commission as the co-ordinating authority. The States are charged with the duty of execution of the plan, but do so within a framework and on promises indicated by the Planning Commission with the approval of the Central Cabinet and the National Development Council.

/The actual health ...

The actual health planning in India has been carried out largely through committee work and panels of experts. The approach of these panels has been largely pragmatic and so far no special methodology has been developed in health planning.

In China (Taiwan), a special approach was worked out by Baker and Perlman with the Government,<sup>10</sup> to establish for the private sector - which constitutes the overwhelming part of the health care service - an answer to the question "What health services are people willing to pay for?" The conceptual framework of this study falls in six parts:

- (1) qualitative and quantitative analysis of the supply of health workers;
- (2) projection of this supply to the future;
- (3) analysis of current public and private sector demand for health services;
- (4) projection of these demands;
- (5) trial balance of supply and demand;
- (6) corrective measures for any imbalance.

It will be seen from this that the first part involves measuring the current supply and qualifications of all types of health workers in some detail. The projection of this supply to target dates ten and twenty years, hence, involves analyzing the factors influencing fluctuations in this supply, such as increases by new graduates and losses by retirement, change of profession, migration and death.

This is very much a "status quo" approach. It depends on the utilization of elaborate questionnaire information and is very costly. It is not likely to be useable, at least in its present form, in most developing countries, since China (Taiwan) is rather atypical in the size of its private sector.

/The approach of ...

The approach of the United States of America to health planning is strongly influenced by the planning, programming, budgeting system, the so-called PPBS - best known for its application by Mr. McNamara to the United States Defense Department. Health planning is a new venture in the United States and a Public Law was framed by the 89th Congress in November 1966. On the basis of this law, it has now become necessary for state and local governments in order to obtain federal aid, to provide comprehensive health plans. There has, therefore, been considerable interest in this field during the last two years in the United States. So far, no generally accepted methodology has been produced - the actual approach in planning having been left to the individual states.

Summing up this very sketchy discussion of different approaches to national health planning, I might perhaps repeat what I started by saying: The main differences in the approaches are largely in the varying complexity with which available data are manipulated. If we consider these manipulations the "tools" of health planners, I believe the immediate task in front of us becomes to grade these tools taken from the different approaches in order of their demand on data, personnel and financial resources. We shall then be in a better position to decide on the most efficient and least costly approach for an individual country.

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