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PRIORITY SETTING

AND

THE INTEGRATED DELIVERY OF HEALTH CARE

REPORT OF
AN INFORMAL MEETING ON
HEALTH INTERVENTION PACKAGES

Geneva, 29-31 August 1994

World Health Organization
District Health Systems
Division of Strengthening of Health Services

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1. INTRODUCTION

The International Conference on Primary Health Care (PHC) at Alma-Ata[1] resulted in an internationally agreed declaration containing five principles that should underlie any approach to improving health and eight essential elements of care that any country's health system should include. The kind of health care defined in the declaration is known as comprehensive primary health care and is distinct from the concept of selective primary health care, which emerged soon afterwards.

Advocates of selective PHC argued that comprehensive PHC was an impossible and unaffordable ideal and that choices had to be made. They made their choices using a combination of epidemiological and cost-effectiveness criteria. The argument was persuasive in the context of a global economic recession, and certain diseases became selected as priorities for intervention, with considerable donor support. There was difficulty in implementing these priorities in countries with poorly functioning health services, and vertical programmes with strong central control were created.

The consequences of these programmes have been much discussed. One of them has been the development of fragmented health systems, with uncoordinated organization and management of staff, supplies, and programmes. There is debate about whether the successes achieved in decreased disease-specific mortality from strategies such as the expanded programme of immunization (EPI) can be sustained when external support is withdrawn. There is also concern that while disease-specific mortality may have fallen dramatically in areas in which EPI has been applied, overall child mortality has not shown the same level of decline because of a rise in deaths from other causes.

The fundamental philosophical differences underlying comprehensive and selective PHC remain. An approach to health that recognizes the multiple determinants of disease and the multiple outcomes of interventions and therefore emphasizes the importance of intersectoral collaboration, community participation, and appropriate technology does not fit well with standardized, centrally run, disease-focused programmes that rely on specialist health workers. While this debate is going on, however, we continue to be faced with the problems of high mortality and morbidity from preventable and treatable diseases, a rising demand for health care, constrained resources, and weak health systems.

In considering how to make the most rational use of available resources, a variety of strategies are being discussed, such as the following.

- The development of standard tools to assist priority setting. One much publicized recent tool which combines epidemiological and economic information is the "disability adjusted life year", used by the World Bank as the basis for the selection of priority interventions published in its World development report 1993[2].

- The concept of "packages" of health care, i.e., a standardized collection of essential and affordable health care interventions that should be guaranteed to a country's population. However, some people doubt whether such packages could be agreed and implemented.

- The development of district health systems, in accordance with World Health Assembly resolution in 1986, as a means of improving the appropriateness and responsiveness of care delivered to communities and promoting the original concept of PHC. Much attention has been paid to improving district health systems but considerable problems remain. Emphasis is being put on the integrated delivery of care, which includes the development of a health infrastructure that can deliver multipurpose programmes.

These issues formed the basis of an informal meeting on priority setting (see Annex A) held at the World Health Organization, Geneva, in August 1994 with the following objectives.

1. To develop a better understanding of current priority-setting processes for clinical and public health interventions.

2. To determine what is needed to ensure that priority setting in districts reflects local needs and circumstances.

3. To consider whether priority setting can be done in a way that encourages the integrated delivery of care.

4. To contribute to the future debate both within countries and at WHO meetings on integrated service delivery and primary health care.

5. To clarify the definitions of various terms.

6. To consider how to improve understanding of the original meaning of primary health care at all levels, not just at grass-roots level.

The meeting was not a comprehensive overview of the subject of priority setting but focused on areas in which participants had particular interest or experience. There was discussion about what the actual priorities are in different countries and how they are chosen and implemented.

It is acknowledged that improved health is achieved as a result of many more influences than just health care and that an intersectoral approach is essential, but the principal mandate of the government health service is health care delivery. Priorities were discussed within the framework of that mandate.

The discussion concentrated mainly on priority setting in government health care, but there was also some exploration of the opportunities created by the rise in private care. The programme of work is given in Annex B.

2. THE CURRENT SITUATION

Priority setting is a process of ranking options so as to make the best use of limited resources. A broad interpretation of the word "priority" was used at the meeting to include organizational and managerial priorities and not just health care

intervention priorities. This emphasis on organization and management reflected the view that the main challenge to government health services is to improve their current performance.

Among the factors that affect the context within which priority setting occurs are the following.

- A continually changing national policy environment.

- The decentralization taking place within government health systems in many countries, which involves political, organizational, and managerial changes. For example, information collection and the monitoring of standards have become more fragmented during decentralization in the Philippines.

- Rapid changes in the pattern of financing or the provision of care. These changes sometimes occur in advance of amendments to official policy documents. For example, in the United Republic of Tanzania the 1990 policy document stated that government health services should be free at the point of use, but since then user fees have been introduced in government hospitals. In Zambia, doctors are now allowed to undertake some private practice in public hospitals.

- The changing needs and demands of the population.

- Underfunding of the health service, which is all too common. For example, government health expenditure per capita in 1990 was $2.7 for the United Republic of Tanzania, $2.8 for Uganda, $7 for the Philippines, $9.9 for Kenya, and $10.9 for the Central African Republic[2]. These figures may be compared with the cost of the combined package of interventions recommended by the World Bank, which works out at $12.

- The lack of explicitness in traditional methods of making choices in health care. The merits of more explicit decision-making are that trade-offs between choices are more apparent and it is easier to anticipate the consequences. There is currently considerable international interest in making resource allocation both more efficient and more explicit and in designing standard tools for doing this.

These changing factors mean that priorities themselves constantly need to be reviewed. Priority setting should not be regarded as a single event but as a continuous cycle involving several overlapping stages: situation analysis, priority selection, implementation, and evaluation.

The Current priorities - what are they?

Priority setting is helped by having a clear vision of the type of health system a country wants to develop and by setting the priorities within the framework of PHC.

Priorities for health care interventions

To make a distinction between clinical and public health interventions is unhelpful because it is artificial and can lead to the uncoordinated provision of care. The term "health care intervention" should be used to cover both. The essential health care interventions that should be provided in low-income countries are well established and the problem is rather how to deliver them.

The eight elements of primary health care are the foundation for selecting health service activities, and in some countries mental health, rehabilitation, and dental care have been added.

Priorities in organization

Organizational priorities should have the following aims.

- To improve the coverage of services.
- To maintain levels of service delivery after decentralization.
- To improve coordination between authorities with different or overlapping responsibilities (e.g., the health service, local government, and the private sector). To do this it may be necessary to simplify complex reporting structures, coordinate vertical programmes, improve the collection of relevant information, and improve the organization of supplies.

Priorities in management

Management priorities should have the following aims.

- To find ways of decreasing the tension between national plans and local autonomy in a decentralized system.
- To improve management capacity at district level.
- To resolve human resource management issues such as salaries, training, performance, and morale.
- To reconcile the priorities of the health service with the expectations of users. For example, in the United Republic of Tanzania the village health workers have a preventive emphasis in their training, but users demand curative care.

In the discussions no clear distinction was made between short- and long-term priorities.

Criteria that are used to guide the selection of priorities

There is no single correct way to do priority setting, but there are approaches that can improve the equity and efficiency of health care delivery. The types of criteria used to set priorities affect these outcomes.

There are two types of criteria to be considered - those concerned with the type of information to be collected that will help in decision-making and those concerned with the process of decision-making itself. The former might include parameters such as need, the cost of interventions, the effectiveness of those interventions, and resource availability. The latter might include, for example, a requirement for the involvement of the public in the decision-making.

The way a particular type of information is presented affects the way criteria are selected, and this in turn affects the way priorities are defined. For example, the needs of a population can be described in terms that may be epidemiological (e.g., disease prevalence), economic (e.g., income) or sociological (e.g., the user's perception of need). One approach that can be used to allocate scarce resources is to provide care only to specific groups of people in particular need. Priorities based on disease prevalence may select certain conditions for treatment, e.g., tuberculosis. Another criterion could be location, with priority given to those living in remote rural areas. A third criterion could be age, such as providing care only to the under fives.

Selecting certain groups to receive care automatically excludes other groups from access to health care. It was felt that this approach should be avoided, for both practical and ethical reasons. Firstly, if the criterion for access to health care is based on a specific disease, people may not know whether their ailment entitles them to care or not, and, even if it does not, some type of care can frequently be offered, even if it is only advice. Secondly, it may be politically sensitive to deny care to specific groups, such as the urban poor while providing it to others such as the rural poor. Lastly, whatever criteria are used in selection, if access to care is restricted to a particular group, it will lead to a system that is inherently inequitable.

It might be more useful if organization and management priorities could be set that would improve the infrastructure, the human resources, and the supply of drugs, and that would rationalize the levels of care at which conditions are treated. A consequence of this would be that final choices about which particular individuals or groups get treatment will occur implicitly, through the judgements of health workers dispensing those resources. This is often what happens at present, and it has the advantage of allowing local health workers to adapt decisions to local conditions.

In practice, priorities are set by using a mix of criteria. For example, in Kenya, where a burden-of-disease analysis has recently been completed, health workers are trying a combination of criteria including prevalence, the availability of effective interventions, feasibility, the geographical coverage required, and provider responsibility. In the Philippines a balance is sought between health ministry policy, locally defined need and demand, available technical resources, and organizational capacity.

Level of decision-making principally involved

In many countries priority-setting decisions have traditionally been made at national level - decisions both on the allocation of resources between sectors and on the deployment of resources at different levels of the health service. What is currently being experimented with is the extent to which the scope of priority setting in districts can be increased, within the framework of national policy objectives. There are naturally great differences between countries in this respect. In Kenya, priority setting is still largely centralized. In Zambia, districts are now being given their own budgets under the strategic health plan. These can be deployed according to locally defined priorities, but within firm central guidelines (e.g., a 40/60 budget split in favour of PHC). In the Philippines, there is a longer history of priorities being chosen by area planning teams based on health centres serving populations of 20 000 - 50 000. Health plans are submitted up through the health system and budgets are allocated once the plans have been approved.

Groups and individuals involved in selecting priorities

In resolving the difficult questions involved in resource allocation, different groups of people are involved at different levels, at different stages of the process, and have varying degrees of influence. There is a view that these questions should be settled by debate involving as many affected groups as possible because of the inevitable trade-offs that occur between groups.

Professionals

Professional planners at central level have considerable influence and have good access to information, though they are subject to the overall control of politicians.

In the district, priority-setting decisions are currently taken principally by technical experts such as the district medical officer, but their freedom of manoeuvre depends on the budgetary and legislative authority they possess, both of which are often limited.

Donors

Donors and externally funded nongovernmental organizations can affect priority setting both directly and indirectly. The indirect effects are due to their large funds and a tradition of supporting vertical programmes, which can distort national or district priorities. To reduce this effect the government in Zambia is encouraging donors to support "baskets" of interventions within districts. That would mean that donor resources would support the priorities in the district health plan rather than fund vertical programmes.

To increase the likelihood that activities in a district reflect government priorities, there is a need to create trust not only between the different levels of the government health service, but also between public and private providers of finance.

The public

Public participation is desirable because it improves the responsiveness of the health services to local needs and demands, but difficulties may arise because of the repercussions it may have beyond the health sector.

In the United Republic of Tanzania PHC committees exist, but not all of them meet regularly. In addition, their legal status is unclear, which limits their potential influence. In Kenya, too, district development committees exist, and provide a clear forum for public participation, but in practice they have little influence.

The potential for conflict between needs as perceived by the public and by the medical profession was not considered to be great.

A way of increasing public participation is being tried in the Central African Republic. In the Dekoa district project, which has been running for 18 months, a system exists in which a community member and a health worker from each of the health posts (representing 3000 inhabitants) and from the three coordinating health centres sit on the district council that meets every six months to decide on district priorities.

Tools currently being used to aid decision-making

Information to guide the selection of priorities can come from a variety of sources but is neither complete nor neutral. It can be presented in many different ways, which will affect the analysis of the situation and therefore the choice of priorities. Technical tools are best seen as an aid to decision-making and not as a means of obtaining objective answers to the complex questions involved in resource allocation. Tools are not interchangeable. Different tools are appropriate at different levels of decision-making.

Demographic and epidemiological data are generally available at central level, though they may be used only randomly in decision-making. They are also subject to certain limitations. They are often of poor quality because of the practical difficulties experienced by district information gatherers, and the data collected are usually irrelevant to the collector's own information needs since most are based on the users of the services.

In Zambia a problem-solving approach that emphasizes the problems encountered in health services has long been used in districts, rather than an approach based on diseases.

New tools being developed and tested

Management tools

New management tools are being developed in an attempt to achieve a uniform district approach to priority setting, with flexibility in the choice of priorities, and to ensure coordination with national priorities. In the United Republic of

Tanzania, a unified information system is being developed that is designed in such a way that information is usable at all stages of collection. The country has four guidelines to orientate planning towards PHC - the National Health Policy, the 1992 revised PHC strategy, community-based health care guidelines; and the UNICEF Facts for life booklet to devise village strategies. Standard protocols for treatment and an essential drugs programme also exist. In that country, too, district health planning guidelines, have been published to encourage uniform planning in the various districts. By standardizing the approach to planning it is hoped to lessen the continuity problems resulting from the frequent turnover of district medical officers.

In Zambia, budget spreadsheets have been devised to guide district-level decision-making. They contain specified areas for budget deployment and bands of expenditure within which the district can manoeuvre.

Burden-of-disease analysis

Recently a burden-of-disease analysis has been carried out in Kenya and the United Republic of Tanzania with World Bank support. A simplified version of the disability-adjusted life year known as the "discounted life year" was used. The main difference is that morbidity data were omitted and mortality data were presumed to reflect morbidity. It is intended that this analysis (shown in Annex C) will be used to set Kenya's priorities and to persuade the authorities to reallocate resources from curative to preventive care, but the approach has yet to be considered by the government. It is not expected that this tool will be much used in low-income countries because of the complexity of the analysis and the costs involved. It also results in disease-led priorities that are not thought to differ greatly from those established by simpler methods.

3. FACTORS THAT CURRENTLY RESTRICT EFFECTIVE PRIORITY SETTING IN DISTRICTS

While the discussion covered priority setting at all levels, particular was attention was paid to the possibilities of priority setting in districts. A number of obstacles were described by participants:

- lack of information
- autonomy in decision-making
- capacity in decision-making
- vertical programmes
- problems of donor influence
- human resource management issues
- budgets.

Lack of Information

Appropriate information to aid more rational decision-making is often not available at district level. However, recent experience in Zambia suggested that sufficient information was available to allow district planners to make decisions as good as those previously made on their behalf at national level.

Autonomy in decision-making

There is inevitably some tension between central control and district autonomy. This stems from the desire to ensure that districts work within the framework of national priorities and because some decisions have repercussions outside the health service - for example, in the deployment of manpower. However, the tension is greater than it need be because the transfer of responsibilities has not been simultaneously matched by a transfer of power.

There was some discussion about appropriate ways of balancing central and district authority, particularly during the transition period of decentralization when management skills are being developed in the district.

- In Zambia the devolution of power is proceeding slowly, and a variety of instruments are being used to ensure district compliance with government priorities: budget spreadsheets, strict auditing, and financial penalties if districts do not meet agreed targets.

- In the Philippines there is a memorandum of agreement between central and local government that outlines areas of responsibility, and area conferences are held during the planning process to resolve national and local priorities.

Capacity in decision-making

It is sometimes questioned whether the necessary capacity exists at district level to make appropriate decisions on priorities. The apparent failure of many management training courses to develop these skills was considered to be more to do with the lack of power and resources at district level to implement desired changes. Recent experience in Zambia suggests that district managers are well able to take decisions when given the authority.

Vertical programmes

Vertical programmes are centrally managed and therefore affect priority setting at district level in many countries. In the Philippines, for example, there are 36 vertical programmes, and a provincial coordinator has recently been appointed to create links between them. The vertical programmes have to be reconciled with defined needs in the district.

Problems of donor influence

While donors and nongovernmental organizations make considerable contributions to health care in low-income countries, they can adversely affect coordinated priority setting at district level in a number of ways. Their preference for funding programmes in which rapid results can be measured (usually by outputs rather than outcomes) means that money is spent on particular diseases that may not fit with district priorities. Moreover, the way in which programmes are managed, with diverse reporting and accounting structures, makes coordination difficult.

There is clearly a need to develop trust between the different bodies involved, and various strategies were suggested. A useful start is the creation of a forum for consultation like the advisory councils in the Philippines. Increased transparency in the use of donor funds through the use of clear budget spreadsheets and enforcement of strict auditing procedures is helpful, as experience in Zambia shows. Donor agencies may be persuaded to use uniform reporting and accounting systems. Zambia has been successful in this respect, although there have been some problems with implementation.

Human resource management issues

When setting priorities it is vital to consider the practicality of implementating the actions needed to achieve them. In this context, the training and deployment of staff are relevant.

Participants agreed that there is a need to move away from single-speciality health workers to what in Zambia are referred to as "polyvalent health workers", who have a broad training in preventive, promotive, and curative care. The availability of such workers would help the process of priority setting if it became more operational at health centre level and would also help in the implementation of priority activities.

The maldistribution of staff remains a significant problem, often for reasons external to the health service, such as people's preference for jobs in towns. For example, in Zambia the implementation of the strategic plan will require an increase in the number of rural health centre staff from two to eleven.

Budgets

Health services are underfunded, and this fact in itself increases the need for rational and explicit priority setting. However, it also acts as a deterrent to spending scarce money on changing the ways things are done.

In addition, priorities are frequently set as a result of the previously fixed pattern of budgetary allocation, and they ought to be replaced by a new set of priorities based on a negotiated adjustment between budgets and locally determined plans.

4. PRIORITY SETTING AND PACKAGES

The terms "priorities" and "packages" are frequently used interchangeably, but a distinction can be usefully drawn between them. Priorities are interventions that are considered to be important, be they in health care, organization, or management, and they can be ranked from higher to lower. Packages are defined groups of priorities that can be standardized to ensure that equivalent interventions are delivered wherever the package is made operational. Within the package all interventions have equal status, and the package as a whole has been costed.

Different perceptions of the concept of packages

The idea of defining packages of care that a government can afford is a useful management tool that can help improve both resource allocation and resource deployment. It may be seen as an aid to planning, not as a substitute for it.

The possible contents of a package are conceived in different ways by different agencies. Some see a package as containing only clinical and public health interventions, while others see it as including organization and management activities also.

Participants felt that a package should include a mix of health care, management, and organizational interventions. Packages of health care interventions alone were felt to run the risk of being developed into vertical programmes, with the adverse consequences already experienced with that pattern of health care delivery.

The concept of different packages at different levels of health care was discussed. For example, Zambia has developed a strategy in which packages are based on competencies of care from the household through to the tertiary hospital level. These are illustrated in Annex D.

Packages that are level-specific should be defined in a way that ensures that there are clear links between levels and that all packages have a common objective. For example, a district hospital package must be designed to support the activities of the health centres.

This particular concept of packages reflects the practical background of the participants, to whom the problems of health service performance are acute. It is rather different from the World Bank approach, in which a standard package of clinical and public health interventions is suggested, without specifying organizational and management priorities.

Who determines the content of packages?

The final contents of packages for use in a district were thought to be best determined at district level, so that they are responsive to local needs and demands. This raises the question of how one can reconcile standard packages with the desire for local determination of priorities. There were times in the discussion when the term "packages" seemed to be used as a way of summarizing a district's plans and thus as something without uniform content. However, at district level it is possible to define a standard health centre package. The point is that by definition the use of a standard package of care at any level removes the possibility of choice of content from that level.

Unanswered questions about packages

Questions were raised both about the design and implementation of packages, and about their consequences.

- Is it possible to standardize organizational and management priorities?

- Is this damaging to local planning?

- Can packages be implemented?

- Are packages sustainable, bearing in mind the importance of economic development?

- What is the role of the government, donor agencies, and the community in implementing packages?

- Can packages improve indicators such as infant and maternal mortality rates?

While a package of care is principally used to define what the government decides to provide, it is possible that the private sector might provide a package of care in areas not served by the government services - for example, in remote areas served only by missions. The coordination of priorities in sectors with different goals and different sources of funding may give rise to problems and packages may be a way of addressing this issue.

5. HEALTH CENTRES AND THEIR ROLE IN PRIORITY SETTING

The term "health centre" was defined as any facility that provides the first level of contact with the health system for a defined population (from 5 000 to 50 000 people). The importance of health centres in a district health system was agreed, because of their geographical distribution and potential capacity to treat appropriately most of the conditions arising in the local population.

The WHO document, The health centre in district health systems[3], was welcomed as a timely contribution as questions have been raised in some countries about the future role of health centres in health care delivery. This is because many of them are at present functioning below their proper capacity owing to problems of staffing and supplies.

The place of the health centre in priority setting

Participants had had varied experience of involving staff from health centres and members of the local population in priority setting. Daily management involves making operational choices, leaving little opportunity for more formal consideration of priorities. Consequently the incorporation of lower-level priorities into broader district and regional planning is uncommon.

In the area-based planning of the Philippines, representatives of users of the service, the manager, health workers, local nongovernmental organizations, and local government meet and set their own priorities, within the framework of national policy. Plans are submitted to the health service administrators, and, if agreed, budgets are allocated within available finances. If government funding is incomplete, the health centres may try and raise funds from other sources, e.g. nongovernmental organizations.

One of the arrangements under UNICEF's BAMAKO initiative was the creation of health committees, consisting of representatives of the community and the health centre, which meet periodically to discuss key health problems. At times the discussions tend to focus more on financial issues, and it is difficult to ensure broad representation on these committees.

In Zambia the health centre is destined to be the focal point in the strategic health plan, and the intention is that the health centres will set their own priorities within allocated budgets, in a way similar to that initiated at district level. The technical capacity to do this is thought to exist.

6. PRIORITY SETTING AND THE INTEGRATED DELIVERY OF CARE

Many different vertical programmes are implemented by a limited number of local health workers. In the United Republic of Tanzania for instance, 24 vertical programmes are implemented by two or three health workers at dispensaries, who have to adhere to different rules for reporting, accounting, obtaining supplies, and supervision.

This common experience of fragmented service delivery as a result of vertical programmes has raised several issues:

- the need to develop multipurpose programmes,
- the need to have polyvalent health workers with a broad preventive, promotive, and curative training,
- the need to have a common organization for such matters as collecting information, delivering and sharing supplies, accounting, and staff management.

The way in which priorities are set was thought to influence the integrated delivery of care. Disease-based priorities are particularly likely to lead to vertical programmes.

7. CONCLUSIONS AND RECOMMENDATIONS

To provide a national framework for setting priorities a country must have a clear vision of what type of health system it wants to develop.

When considering priorities, the separation of health care activities into clinical and public health interventions is unhelpful because it is frequently artificial in practice. The term "health care intervention" was adopted to cover both.

Priority setting involves organization and management interventions as well as health care interventions. Indeed, they are particularly important at present because of the common problem of poor health service performance.

There is national as well as international experimentation with a variety of technical tools - managerial, epidemiological, and economic - to assist decision-making. There were low expectations of the practical use of complex tools such as the disability-adjusted life year and concern that they might lead to inappropriate priorities.

Currently priorities are frequently set at national level for the whole health service. However there is increasing experimentation with different levels of decision-making, down to the health centre.

To allow effective priority setting in districts, the districts need greater authority over budgets, human resources, and supplies and more relevant and higher-quality information. There is, however, some tension between national priorities and local autonomy; guidelines and agreements may be required to address this problem.

Public participation is recognized as desirable in theory but difficult in practice.

Donors and nongovernmental organizations need to be included in the priority-setting process, so that their activities do not distort government priorities but are complementary.

In general, many changes are too new for there to be a clear idea of their effectiveness in the process of priority setting.

Further analysis of the way in which decisions are reached would be useful.

Packages

The term "package" is being used in a variety of ways. The meeting considered it was most usefully viewed as consisting of a defined and costed mix of health care interventions, and organization and management interventions. Particular care should be taken to avoid lists of disease priorities.

Packages of care can be defined for different levels of the health service, but all such packages should be designed to support care at health centre level. Further discussion is needed on how standard packages can be reconciled with local autonomy in priority setting.

Priority setting at health centres is rare, and the meeting recommended that it should be further explored.

An effort should be made to ensure that priorities are set in a way that fosters the equitable and efficient delivery of care.

Recommendations for future activities

The meeting suggested four areas of activity by WHO and UNICEF:

- a literature review of priority setting;

- guidance on the implementation and evaluation of packages (including the development of indicators for equity);

- the development of a model for defining basic health services;

- further work on communities' perceptions of priorities in health and health care, which would be of help in proposing ways of increasing the role of the community in priority setting.

One area in which countries themselves could do useful work is the evaluation of new methods and tools for setting priorities.

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3 The health centre in district health systems. Geneva, World Health Organization, 1994 (document WHO/SHS/DHS/94.3).

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INFORMAL MEETING ON HEALTH INTERVENTION PACKAGES
Geneva, 29-31 August 1994

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PROGRAMME OF WORK

Monday, 29 August

09.00-09.30	Arrival and registration
09.30-10.00	Introduction (Dr Tarimo)
10.00-10.30	Expectations of the meeting
10.30-10.45	COFFEE BREAK
10.45-12.30	Current priorities - short and long term
12.30-14.00	LUNCH
14.00-15.30	Analysis of the current priority setting process, and ways of minimizing constraints
15.30-15.45	TEA BREAK
15.45-16.30	Discussion continued
16.30-17.00	Summary of the day's discussions

Tuesday, 30 August

09.00-10.30	The contribution of available technical tools to priority setting
10.30-10.45	COFFEE BREAK
10.45-12.30	Further discussion
12.30-14.00	LUNCH
14.00-15.00	The contribution of different decision making methods
15.00-15.15	TEA BREAK
15.15-16.30	The role of the health centre
16.30-17.00	Summary of the day's discussions

Wednesday, 31 August

09.00-10.30	Priority setting and the integrated delivery of health care
10.30-10.45	COFFEE BREAK
10.45-12.30	Areas for research and development
12.30-14.00	LUNCH
14.00-15.30	Open session
15.30-15.45	TEA BREAK
15.45-17.00	Conclusions and future plans

Monday, 29 August

09.00-09.30	Arrival and registration
09.30-10.00	Introduction (Dr Tarimo)
10.00-10.30	Expectations of the meeting
10.30-10.45	COFFEE BREAK
10.45-12.30	Current priorities - short and long term
12.30-14.00	LUNCH
14.00-15.30	Analysis of the current priority setting process, and ways of minimizing constraints
15.30-15.45	TEA BREAK
15.45-16.30	Discussion continued
16.30-17.00	Summary of the day's discussions

Tuesday, 30 August

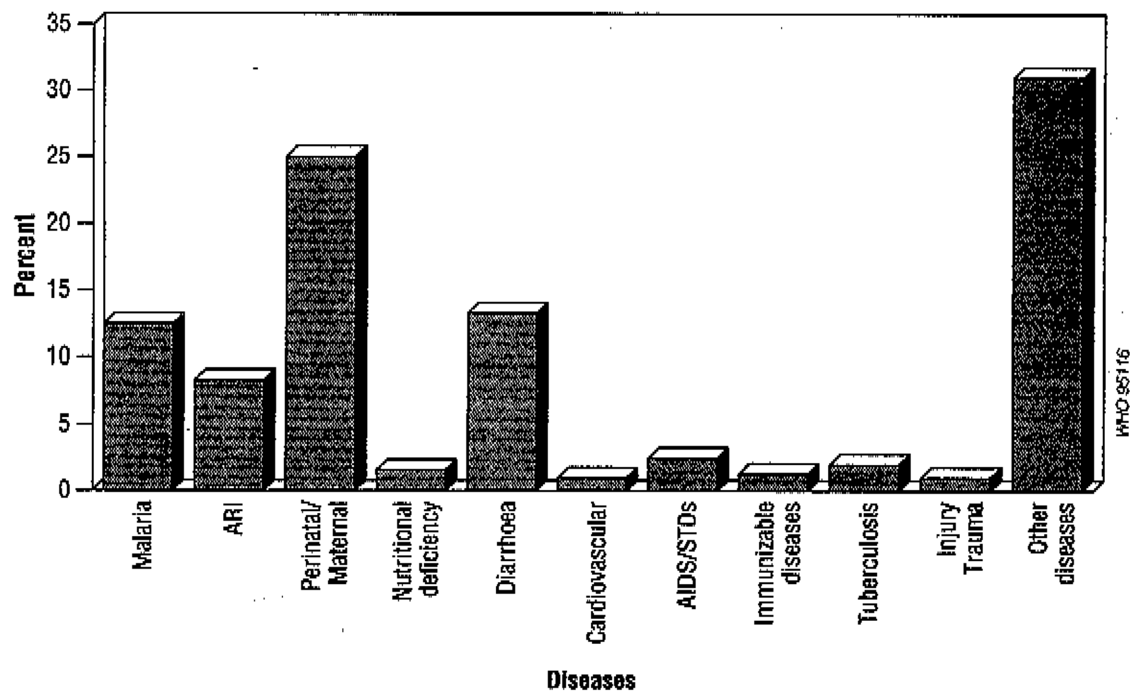
09.00-10.30	The contribution of available technical tools to priority setting
10.30-10.45	COFFEE BREAK
10.45-12.30	Further discussion
12.30-14.00	LUNCH
14.00-15.00	The contribution of different decision making methods
15.00-15.15	TEA BREAK
15.15-16.30	The role of the health centre
16.30-17.00	Summary of the day's discussions

Wednesday, 31 August

09.00-10.30	Priority setting and the integrated delivery of health care
10.30-10.45	COFFEE BREAK
10.45-12.30	Areas for research and development
12.30-14.00	LUNCH
14.00-15.30	Open session
15.30-15.45	TEA BREAK
15.45-17.00	Conclusions and future plans

Burden of disease analysis
Kenya

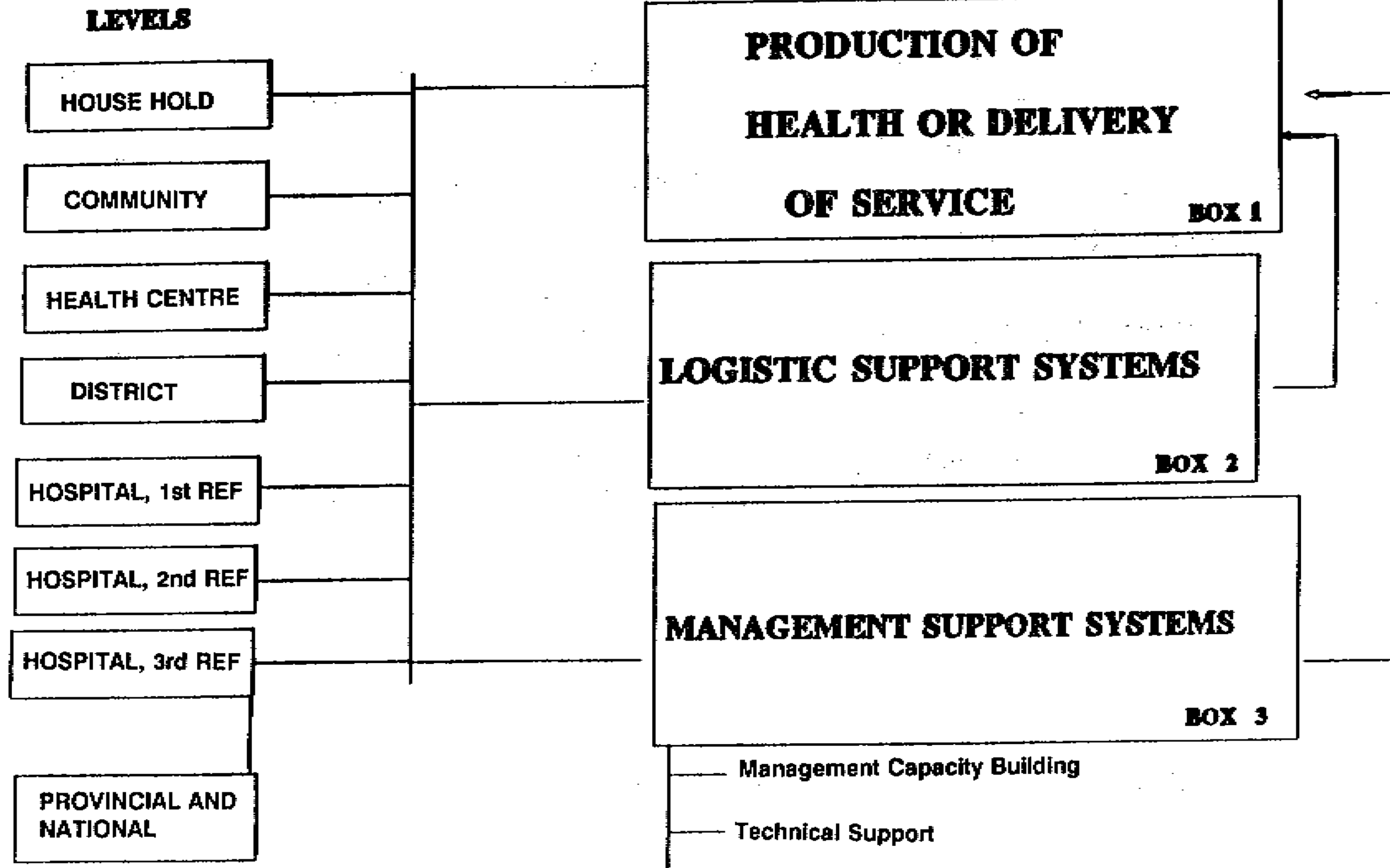
Figure 1. Share of annual life years lost by disease



Source: Ministry of Health Information System Annual Reports, surveys carried by some divisions and various programmes of the Ministry

ZAMBIA

ESSENTIAL "PACKAGE" CONCEPTUAL FRAMEWORK



THE ZAMBIA PACKAGE OF CARE AT THE HEALTH CENTRE LEVEL