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STRENGTHENING MINISTRIES OF HEALTH FOR PRIMARY HEALTH CARE

— PROGRAMME STATEMENT —

Division of Strengthening of Health Services
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Introduction

Since its origin, the World Health Organization and its Member States have worked to develop strong Ministries of Health in all countries. Such public authorities are recognized as the major organized bodies for directing and coordinating all activities within national health systems – not only within the central government but in all settings throughout a country.

What is the problem?

Why is WHO so much concerned about *strengthening* Ministries of Health?

What is the problem?

It was realized soon after the International Conference on Primary Health Care in Alma-Ata that the implementation and extension of primary health care in many countries were being hampered by organizational constraints in the national health system, particularly in the Ministries of Health. Translating primary health care into actions and results implies rethinking the health system and hence reorganizing and restructuring Ministries of Health, revising and expanding functions at all levels, and changing priorities, activities and procedures.

The reality in most countries is that Ministries of Health (MoH) play only a relatively small part in the affairs of overall national health systems. Such systems have become more and more complex, with advances in science and countless developments in society to apply technology for health promotion and protection, in the treatment of disease and in rehabilitation. But MoHs often play only secondary roles in harnessing these developments.

In virtually all national health systems there is a significant private sector – a commercial market in which health services are bought and sold for various prices. The distribution of health services through market mechanisms leads to enormous inequities in populations, related both to household location (rural/urban) and to social class. In addition, religious and other voluntary/charitable organizations provide health services in many places. Industrial enterprises and social security bodies serve or finance care for employed wage-earners and sometimes their families. Independent cooperatives and welfare societies may establish special health care programmes for their members.

Aside from the direct provision of health services, every national health system includes relatively complex arrangements for the production of qualified human resources or health manpower. Universities are involved

in the preparation of physicians, nurses and pharmacists; various training institutions prepare nurses, technicians, physiotherapists and others. Private enterprises manufacture most drug products and medical equipment. Water supplies and facilities for waste disposal are often the responsibility of numerous public and private agencies outside the MoH.

Even within the framework of government, the MoH often occupies a rather weak position. In the national cabinet, the Ministry of Health seldom has a strong voice. The Ministry of Health is regarded as a "consumer" Ministry and in most cases is given a low priority in the government's development policies. Thus, MoHs always fare poorly in national budgets. In many countries, the percentage of total government expenditure allocated to health has actually declined in recent years.

With countless independent health care providers, health organizations and health programmes – each going its own way – most national health systems are extremely fragmented, even chaotic. Scarce resources are misused, in accordance with the dictates of money and power, not in response to human need. Countries speak of having "a surplus of doctors" in spite of tragic shortages in rural areas and urban slums, because market criteria rather than social needs are used for judgement. A directing and coordinating authority for the protection of human health is lacking at all levels of society in nearly all countries.

This is the problem. This is why Ministries of Health need to be strengthened – so that they will be in a position and will have the capability to direct and coordinate the many component parts of national health systems, so essential for primary health care.

What has WHO been doing?

In 1982, WHO and DANIDA jointly sponsored a workshop on "Alternative ways of organizing Ministries of Health for primary health care", held in Fredensborg (Denmark), where an international group of experts was brought together to explore in depth the tasks to be faced in bringing about changes in complex organizations, such as Ministries of Health, and to discuss the conceptual framework for the analysis of Ministries of Health. The proceedings of this workshop were published in 1984 as WHO Offset Publication No. 82, Strengthening Ministries of Health for Primary Health Care.

As a result of the interest generated by the Fredensborg workshop, WHO received a number of requests from countries for further support in this area. To facilitate this process of change in the Ministries of Health, WHO in collaboration with the Danish International Development Agency (DANIDA) agreed to jointly support a programme which was called "Strengthening Ministries of Health for Primary Health Care".

Objectives of the WHO Programme on Strengthening Ministries of Health for Primary Health Care

Broad objective

To increase the effectiveness and efficiency of Ministries of Health at all levels in moving towards the goal of "Health for All" through primary health care.

Specific objectives

1. To develop greater awareness and understanding among health managers of organizational options in the pursuit of primary health care and of means for reorienting and changing organizational behaviour to achieve primary health care.
2. To expand existing knowledge and experience about organizational behaviour and methods of organizational change in health institutions in different political, economic and cultural settings through a "learning-by-doing" process.
3. To develop a critical mass of skills at national, regional and global levels in the analysis of health organizations and in inducing planned change in support of health-for-all goals.
4. To support countries in implementing programmes at national, provincial and district levels to reorient and strengthen their health systems by application of the knowledge and skills generated above.
5. To facilitate the exchange of experience between countries and ensure the documentation and dissemination of relevant knowledge gained.

Programme activities

Since 1982, Programme activities have taken place at three levels: country, intercountry and global. At the *country level*, workshops, seminars and other activities were carried out at both national and subnational levels. The activities included joint reviews of the primary health care system and other activities such as training, logistical support and in-depth studies of specific areas. Although the type of support varied from country to country, a major component in all cases was to promote and support the development of multidisciplinary skills to continue the process which has been initiated. Support was also given to improve linkages among multidisciplinary

institutes to enable individuals and groups in them to carry out the required analysis and identify appropriate interventions. At the *intercountry level,* activities concentrated on facilitating the exchange of experiences among the countries and individuals and development and sharing of technical skills. At the *global level,* the main activities were the analysis, synthesis and documentation of ongoing experiences and overall support to the Programme.

In July/August 1985, an intercountry workshop on strengthening Ministries of Health for primary health care was held in Gaborone, Botswana, which launched the Programme by providing a forum for the exchange of ideas between a consultant network of organizational development people, health consultants and country managers to try and find appropriate areas for further joint action, both in the countries and at the global/regional levels.

From its inception, it was recognized that the term "Ministries of Health" did not apply only to the central organization and authority. Hence, the Programme has supported a wide range of activities designed to strengthen and improve the organization and management of the Ministry of Health at all levels.

For the initial phases of the Programme, support was limited to certain Anglophone African countries* and some countries in the South-East Asia Region;** representing a variety of socioeconomic conditions and political conditions, resulting in a wide range of issues using different approaches to the problem of strengthening Ministries of Health being addressed by the Programme.

The issues addressed by the countries and supported by the Programme included:

- Ministry of Health structure;
- decentralization;
- strengthening district health systems;
- management training;
- PHC orientation and training;
- training in PHC planning for regional and district health staff;
- production of guidelines and training materials;
- urban primary health care;
- health manpower planning, management and information systems;
- financial management of health services.

**Botswana, Ethiopa, Gambia, Kenya, Lesotho, Malawi, Swaziland, Tanzania, Zambia, Zimbabwe.*

***Burma, Maldives, Sri Lanka.*

The global activities include organizing:

- consultancies;
- intercountry and interregional workshops;
- preparation of guidelines;
- conducting case studies;
- publications;
- producing a Newsletter;
- supporting country activities.

Some of the activities addressing these issues are highlighted in the next section.

Highlights of the activities

In an effort to develop a critical mass of personnel at the national, regional and global levels with skills in the analysis of health organizations and in inducing planned change in support of health-for-all goals, training courses for health managers at various levels have been conducted in Botswana, Ethiopia, Gambia, Kenya, Malawi, Tanzania, Zambia and Zimbabwe in the African Region and in Sri Lanka in the South-East Asia Region.

To expand existing knowledge and experience about organizational behaviour and methods of organizational change in health institutions in different political, economic and cultural settings, action research and developmental activities on strengthening health management at the district level, and a comparative study of health personnel management have been carried out in a number of countries.

A number of countries in the African and South-East Asia Regions have been supported for implementing programmes to restructure their Ministries of Health (Botswana); decentralizing the health systems (Botswana, Ethiopia, Kenya, Sri Lanka); integration of training for vertical projects (Tanzania); and health manpower planning and information systems (Burma, Maldives, Tanzania).

At the global level, case studies on a number of issues relating to strengthening Ministries of Health have been prepared. Publications are being prepared on: *"Health care system structures and the implementation of primary health care in developing countries"*, based on case studies in 12 countries; *"Decentralization and Health for All Strategy"*, based on 10 country case studies; *"The role of health legislation in health policy with particular reference to the strengthening of Ministries of Health;* and *"Financial information at district level: experiences from five countries"*.

A number of guidelines are also in the process of preparation for use in the countries:

- "Guidelines for the Rapid Assessment of Urban Community Health Needs";
- "Guidelines on the Cost Analysis of Primary Health Care";
- "Guidelines for Self-Assessment of Ministries of Health Organization and Management".

What strategies lie ahead? – Future actions

In November 1987, a WHO Expert Committee on Strengthening Ministries of Health for Primary Heath Care met in Geneva in order to "identify ... useful approaches to overcome the shortcomings of Ministries of Health ... to assess available country experiences, ... and to make recommendations on how WHO could further cooperate with Member States in their efforts to strengthen Ministries of Health for primary health care". The report of this Expert Committee was appraised and endorsed by the WHO Executive Board, published in 1988 as WHO Technical Report Series No. 766, and was widely distributed.

From the deliberations and recommendations of the Expert Committee, it was apparent that the original objectives of the Programme on Strengthening Ministries of Health for Primary Health Care were still valid. The Expert Committee recommended eight strategies to guide future actions.

1. *Scope of Ministries of Health responsibilities*

The scope of responsibilities for various functions in a national health system should be appropriate. Realistically, this nearly always means that the range of responsibilities should be broadened. Even though for historical reasons many health functions must be vested in other bodies – such as the education of doctors by universities – the Ministry of Health must bear ultimate responsibility for all health system functions. With respect to health planning, standard setting, and evaluation, the MoH should carry regulatory responsibilities throughout both public and private sectors.

WHO will continue to encourage national health authorities in their efforts to achieve the necessary changes in the Ministry of Health to enable them to accept leadership responsibilities in the health sector. WHO will also consider developing a network for providing information of a technical and factual nature on experience in the strengthening of Ministries of Health that has enabled Ministries to function more efficiently.

2. *Coordination of functions within the health sector*

Whatever may be its range of direct responsibilities in a health system, the MoH should have the authority to coordinate the health functions of all public and private bodies. This means that it must be informed at all times about the extent and distribution of health needs in the population and health resources in the country. With such information, it can advise all groups on appropriate directions to follow in their programmes. Wasteful duplication of efforts can be avoided and attention can be drawn to gaps and unmet needs.

WHO will encourage Ministries of Health to sponsor conferences and symposia where all sections of the health sector can meet for exchange of views. WHO will also consider providing technical support to Ministries of Health to facilitate analysis of issues related to the coordination of health programmes, so that policies and procedures can be adopted to overcome the fragmentation now common in the health sector. Such analysis will include questions of manpower development and the use of health care institutions.

3. *Decentralization of Ministry of Health responsibilities*

MoH weakness is often linked to an excessive centralization of authority, so that below the national headquarters there is little initiative and capability. A strategy of decentralizing authority and responsibility, along with resources, to other jurisdictional levels can strengthen the Ministry as a whole. Health personnel at the peripheral levels must be trained for the assumption of wider responsibilities.

Decentralization of functions must be done prudently – with certain functions, such as standard setting and evaluation, retained at the centre.

WHO will continue to study the decentralization process in countries as it occurs, so as to be able to give publicity to successes that may be of value to other countries.

4. *Organizational restructuring of the Ministry of Health*

To be effective, decentralization is bound to require extensive restructuring of the whole framework of a Ministry. The basic concept of primary health care in communities calls for replacement of specialized vertical disease control programmes with comprehensive and integrated horizontal programmes. At the same time, local actions must be supported by sound health district structures. A strong MoH organization depends on principles of health service regionalization, including back-up hospitals.

WHO will promote and facilitate the exchange of experience of structural problems in Ministries of Health in different countries and the strategies utilized to overcome them.

5. *Management and leadership*

The best laid plans for strengthening a MoH will falter, unless there is proper management in the organization, and effective leadership. In nearly all countries, the highest posts in MoHs are entrusted to clinically-trained and clinically-oriented physicians, who often have little understanding of health in populations and the management of organized health programmes. The principles and strategies of management, however, can be learned. Even leadership – the ability to plan, organize and inspire others – can be developed in nearly everyone. Good management and effective leadership, of course, are not ends in themselves, but important tools for implementation of all the other strategies for strengthening MoHs.

WHO will encourage Ministries of Health to devise methods for the assessment of leadership capabilities among health workers. WHO will also continue to work with Member States in areas of management that have so far received very little attention. WHO will encourage Member States to evaluate existing training programmes for health professionals for their appropriateness.

6. *Intersectoral collaboration*

Collaboration with other sectors is basic to the achievement of health for all, and it can also strengthen the Ministry as the natural leader of the health system. By broadcasting prominently the influence of other sectors on the health of the people, MoH personnel not only benefit the people, but they cast themselves in a favourable light; they are not claiming that the health service is "everything" or even the main determinant of health. National health councils and equivalent intersectoral bodies at other political levels are mechanisms for promoting such interchange, and also for raising the consciousness of leaders from various fields about the social value of healthy people.

WHO will encourage Ministries of Health to use existing mechanisms to the fullest extent to enlist the support for joint action of relevant groups such as intersectoral committees at various levels, single purpose committees (e.g., councils for drug addiction or for population matters), and other pressure groups. WHO will also support action-oriented research on health improvement through intersectoral action and appropriate mechanisms for the stimulation and coordination of such action.

7. *Community involvement*

Related to decentralization and other strategies is the enhanced involvement of community people in policy-making and actual operations of MoH programmes. If local groups and community leaders participate in Ministry affairs, they are more likely to make proper use of MoH services and to support MoH efforts in the larger social scene. Community involvement can also strengthen a MoH, through raising funds and donating supplies or labour to health facility construction efforts. Community people can be helpful in conducting health systems research that leads to strengthening of MoHs.

WHO will encourage Ministries of Health to collaborate with other agencies to strengthen the community and help it achieve a higher degree of self-reliance. Communities should be trained and assisted to identify their problems on the basis of indicators that the Ministry of Health and other sectors have developed and agreed upon along with the people's representatives. They should then be trained in methods of solving the problems. Appropriate manuals should also be developed for the different groups of learners.

WHO will support Member States in conducting research on strategies that Ministries of Health could use to stimulate community involvement and will disseminate the results of such research.

8. *Increased economic support*

Perhaps more fundamental than any other strategy for strengthening MoHs is obtaining greater economic support. Good planning and management, prudent use of manpower and supplies, aggressive policies for disease prevention and health promotion – these may all reduce health expenditures. But weak economic support, especially in developing countries, impedes the development of even the most efficient MoH.

Greater allocation of tax funds from the central government to the MoH depends on the priority assigned to health by the government as a whole. Other financial approaches may marshall inputs from employers, from voluntary health agencies, or from personal payments by the users of MoH services. Various forms of local community financing are being explored in many countries. Most extensive, outside of general tax revenue support, is the strategy of social insurance or social security for the health cadre of employed workers and their families. While programmes so financed are sometimes regarded as competitive with MoHs, the typically abundant insurance funds may also be used for enlarging the support of MoHs.

WHO will encourage Ministries of Health to strengthen their capabilities in the fields of health financing, financial planning and economic evaluation through the recruitment of appropriate staff, training and research. It will also encourage efforts to evaluate the effects of change in sources of financing on patterns of utilization of health services and on health status and will publicize the results of the studies undertaken. WHO will consider producing guidelines on alternative financing sources for the health system, giving due weight to considerations of equity, efficiency and quality of service. WHO will also consider providing training for health financing, financial planning and economic evaluation; as well as information exchange and bibliographic support covering the experience of countries in mobilizing resources for primary health care.