
HEALTH MANPOWER PLANNING

11. The presentation on the subject of health manpower planning, with particular reference to small states, was made by Dr. Richard A. Smith, author of the discussion paper Realistic manpower planning for primary health care: practical considerations (see p61).

12. Dr. Smith noted that the usual approach to health manpower planning was on the basis of individual categories of health worker. There had been too little consideration of the repercussions of introducing new cadres on the other cadres, however, and there was no commonly accepted mix of personnel. For an appropriate and effective mix of health professionals it was necessary to gear planning closely to the actual functions of health workers in the field.

13. Although there was no single planning model suitable for universal application, there were many common factors in the health care problems of various countries and in the approaches adopted to solve them. The problem facing planners in most developing countries included:

- (a) the lack of a clear national health policy;
- (b) low priority given to health in development programmes;
- (c) imbalances within the health sector;
- (d) shortages and maldistribution of manpower, facilities, equipment, supplies and finance;
- (e) inadequate coverage of the population, particularly of isolated or scattered communities;
- (f) under-utilisation of existing services and resources;
- (g) insufficient or ineffective health education;
- (h) insufficient community participation in planning and operating health services;
- (i) inadequate and inappropriate training resources;
- (j) inadequate attention to, and resources for, environmental sanitation.

14. Approaches to the development of manpower for the delivery of primary health care through the hospital-based, capital-intensive model, using increasing numbers of doctors and nurses, were unrealistic. Third world countries had led

the way in developing more appropriate models which relied on widely-deployed mid-level and community health workers, but these had not been wholly successful because of inadequate consideration of the support needed within the health care system, particularly as regards supervision and logistics. Also, training had been on medical school lines, in isolation from the rest of the system, and had not been sufficiently geared to the actual functions of these health workers in the field.

15. For the strengthening and extension of primary health care services, particular attention needed to be given to:

- (a) the analysis and projection of health needs and the demand for services;
- (b) enumeration of all types of existing health workers, including paramedicals and traditional healers;
- (c) estimation of future health manpower requirements;
- (d) detection of present and future imbalances between manpower requirements and supply;
- (e) assessment and strengthening of the existing management structure.

16. An analysis of primary health care programmes which had failed to bring about a significant improvement in health care coverage had been carried out by the MEDEX group in Hawaii. The following eight major problem areas had been identified as basic elements in a productive approach to improved health service coverage.

- (a) A broad base of support is needed to bring together government policy-makers, training institutions, professional associations and others with a particular interest in health care, as part of the planning process.
- (b) A receptive framework, within which new types of health workers could perform satisfactorily, must be developed.
- (c) Improved management capability is the key to successful programme implementation.
- (d) The involvement of doctors in developing the curriculum for the training of health workers and in the teaching of curative care is essential.
- (e) Competency-based training methods, based on task analysis, problem-oriented and omitting irrelevant knowledge, should be used for the appropriate training of mid-level and community health workers at low cost and in the shortest possible time.
- (f) A deployment system needs to be developed for locating health workers in areas of need. Where they will work following training should be determined in advance,

suitable conditions of service and facilities should be provided, and an adequate management structure established.

- (h) Arrangements for continuing education and professional development are required. Routine evaluation and supervision are essential for the improvement of skills.
- (i) A health information feed-back, evaluation and planning system is necessary for obtaining timely and accurate information on all aspects of the primary health care system, and for adjusting and improving training and management.

17. Dr. Smith concluded his presentation by commending the MEDEX approach as a productive way of strengthening primary health care systems and improving health care coverage. It was flexible, it could be quickly adapted to solve local problems and it could be integrated into an existing health care system. It was a system particularly suitable for the health needs of small and disadvantaged countries.

Discussion

18. The meeting agreed that a broad base of support was needed to bring about an improved and more equitable distribution of health resources in small states, and particularly in those with scattered island communities. It was recognised, however, that difficult political decisions at a high level, and also considerable expense, were involved. The extension of health services at the periphery might even involve a weighting of resources towards the periphery and possibly a reduction of resources available for the centre. It was suggested that village communities might have in a sense been subsidising urban health services, and that the problem was how to reverse this weighting.

19. Considerable changes in the health care system might thus be necessary if the needs of the periphery were to be met, and for these sustained political and professional commitment was required. Commitment of the people, especially those at the periphery, was also needed, and community participation in the planning process was essential to bring this about.

20. It was pointed out that, while concentrating on the periphery, the relationship between the periphery and the centre should not be overlooked. People must have the opportunity to avail themselves of more sophisticated health care at the secondary and tertiary levels when this was necessary, so a suitable referral system was required. In some very small countries the sort of primary health care system under discussion might not be required, since the periphery was so close to the centre. Many small countries completely lacked tertiary care facilities, and for these regional cooperation and pooling of resources seemed the only answer. Nor was it possible, participants recognised, to rely completely on labour-intensive low technology for health services; some access to more sophisticated care was essential.

21. The meeting agreed that the basic necessity for each small country was, with the help of community participation, to analyse health care needs, assess local resources, and plan health services and manpower accordingly. Where it was beyond the resources of individual countries to meet certain needs (eg. staff training, tertiary care), groups of countries should endeavour to meet these through regional cooperation. Donor governments, the Commonwealth Secretariat and non-governmental agencies should respond wherever possible to requests for assistance in this connection.

22. Examples were discussed of the use of various cadres of health workers to extend primary health care services - nurse practitioners, medical assistants, medex staff, based in local health centres, and community health workers and nutrition aides in the selection of whom the local community took part and whose work was linked with the health centres. This sort of system was regarded as appropriate in particular for self-contained countries such as St. Lucia or Swaziland, and regular visits by a doctor to each centre were considered essential. It was suggested that primary health workers should also be placed in hospitals as the first point of contact with patients, with the object of discouraging patients from by-passing the health centres.

23. Flying doctor services were mentioned as a means of taking health care to isolated communities, but they were regarded as expensive and often an "expatriate" operation which did little to promote greater self-reliance in health care. It was considered that the use of nurse practitioners and similar cadres of primary health care workers reduced the need for such costly expedients.

24. It was noted that where there were status conflicts between different categories of rural health workers, involving questions of who supervised whom - public health nurses and medical assistants were quoted as an example - these indicated a need for health manpower planning decisions to be taken at national level with the object of creating a rational integrated system. The creation of such a system should involve members of the community who should have a say in determining what kind of health workers they wanted.

25. Participants emphasised that each country enjoyed its own sovereignty and that only its own government could decide what health manpower and facilities were required. Where needs were common to several countries but individual national resources were inadequate to meet them, it might be possible to meet them collectively by pooling resources. Political-economic issues might arise in regional groupings, however, and it might be asked why some developing countries should subsidise others.

26. It was pointed out that the Commonwealth Secretariat had been able to help in this connection by providing CFTC funds to enable students from the smaller states to train in more fortunate states in the region which were able to offer suitable training facilities. Assistance for regional

training programmes in West Africa and East, Central and Southern Africa, for example, channelled through Commonwealth regional health agencies, had been used in this way.

27. The meeting agreed that the creation of a satisfactory management capability was crucial to health manpower development, particularly at the middle level. The lack of this capability was seen as serious in many small states. It was noted that after independence, with the departure of expatriates, officers at the middle management level had moved up to the top level, for which they had often lacked the required experience, and the gap they had left at the middle level had been filled by personnel with limited training or expertise. Participants underlined the need for more management training from the top downwards. Small states often lacked the resources to provide this, and here again regional cooperation could be the answer. The regional courses in health management at the Ghana Institute of Management and Public Administration and at the East African Management Institute, which had been conducted successfully for several years with Commonwealth Secretariat support, were commended by the meeting.

28. One suggestion made was that management training might be included in the medical school curriculum, but some participants objected to this on the ground that too much had already been added to the curriculum. Another suggestion was that short-term practical secondments to other appropriate countries to study health management arrangements might be useful. It was pointed out that officers in senior positions often considered that they did not need training in management; the suggestion in this event was that they should be asked to teach management to others so that they would themselves learn in the process.

29. The meeting recognised that the island countries of the South Pacific faced special problems in connection with the training of physicians. In other regions it was already possible to undertake postgraduate training in the university medical schools and produce medical and surgical specialists. In the developing countries of the South Pacific this was not possible, since the University of the South Pacific did not have a faculty of medicine and the Fiji School of Medicine, a national institution, was not a fully-fledged medical school. The result was that almost all the specialists working in Pacific island countries were necessarily expatriates.

30. The meeting considered that this problem merited special attention by the governments of the South Pacific region, and suggested that further consideration might be given to establishing a medical faculty in the University of the South Pacific, possibly by further developing the Fiji School of Medicine for this purpose. It was recognised, however, that this was a matter for the governments themselves to decide, and also that the problem of brain drain might be involved. It was thought that donor countries - in particular, Australia, Britain and New Zealand - and certain non-governmental foundations might be able to assist in this connection.

Conclusions:

31. The meeting reached the following agreed conclusions.

National

(a) For most island developing and other specially disadvantaged countries, there is a need to determine the use of manpower in primary health care programmes in close relation to the locally-defined tasks required for the provision of basic health services for their entire populations.

(b) Where appropriate, a tiered primary health care system should be developed which will use most effectively the professional skills of doctors, maximise the potential of village-level services through community health workers, and deploy mid-level health workers to provide supervisory, curative, referral, preventive and promotional services. Cooperation with other development workers is most important in this connection.

(c) The planning capability of the ministry of health should, where necessary, be strengthened to achieve the most effective use of scarce personnel and material resources, to facilitate the integration of health services with other developmental services, and to allow the health ministry to compete more effectively with other ministries for scarce resources.

(d) For the smaller countries in general, the further development of local programmes for training sub-professional personnel is needed. Competency-based, task-oriented programmes should be developed for the training of new cadres of health workers to produce efficient and cost-effective health care services.

(e) The status relationships of primary health care workers should receive early attention in health planning.

(f) In order that new initiatives in health manpower development should not encounter unnecessary legal obstacles, health legislation should be reviewed.

(g) Generic drug systems and treatment guides should be developed for use by primary health care personnel.

Regional

(h) Where appropriate, small countries with limited resources should cooperate with neighbouring countries on a regional basis in health manpower development, particularly in training programmes, and in the development of generic drug systems and treatment guides.

Commonwealth
Secretariat

(i) Where outside support is required, the Commonwealth Secretariat and other agencies should, on request, provide all possible assistance for efforts by governments and regional groups to develop appropriate systems of health manpower - through providing consultants and training fellowships.