RECOMMENDATIONS OF THE MEETING

Action

POLITICAL AND ECONOMIC ISSUES IN HEALTH PLANNING AND MANAGEMENT

Governments

1. Overall development strategy should reflect health needs, and should be based on accurate assessment of these needs in order to identify under-served areas and to direct services towards them.

2. Intersectoral influences on, and inputs in, health programmes should be thoroughly understood and evaluated.

3. Intersectoral collaboration should take place at all levels of decision-making to overcome the frequently isolated nature of health planning.

4. Multisectoral activity focused on health should be co-ordinated at the national level by a co-ordinating body (such as a national health council or a committee of cabinet) which would:

   (a) examine the overall use of national resources for their effect on health;

   (b) consider the impact on health of the plans of various sectors;

   (c) evolve consistent criteria for decision-making affecting health.

5. Governments should seek out the collaborative mechanisms most appropriate to their countries, to break down isolation between different decision-making agencies bearing on health.

6. The allocation of resources to health should be regarded as an investment in economic development. This can be buttressed by showing the true economic return of expenditure on health, demonstrating the economic value of a healthier population and the reduced need for curative medicine.

7. Resources should be concentrated on a selected number of primary health care activities, the choice being determined by the following criteria:

   (a) epidemiologically significant problems;

(b) problems for which effective interventions are available;

(c) interventions which are affordable and technically manageable.

8. The commitment to equity in the allocation of resources in primary health care requires a comparative assessment of health needs as between different populations or areas, and of health care services to them.

9. It should be recognised that the development of primary health care calls for the redistribution of resources. This will involve difficult political and professional choices. The priorities, and balance of needs, for each government differ.

10. In so far as non-governmental organisations and private health professionals are encouraged to participate in the primary health care area, such participation should:

(a) be within the national goals of the primary health care system;

(b) complement, not compete with, the public system;

(c) be capable of easy integration with the public system.

11. Costs can be reduced by concentrating on community-based training programmes which would enable health workers to perform defined tasks at the periphery.

12. Health Ministers, should ensure that all national decision-makers, as partners in the development process, are aware of the economic benefit of primary health care, its cost-effectiveness and positive impact on other sectors.

13. High priority should be given to ensuring a collaborative partnership with existing health professionals in the referral aspect of primary health care.

14. Primary health care practitioners should be accorded status commensurate with their critical role in the health delivery system.

15. As important promotional and delivery agents of the primary health care system, non-governmental organisations should be involved in the mobilisation of support for primary health care.

16. Training programmes should aim at producing health workers who are advocates for the primary health care system.

17. As local community participation is an essential element in the success of the primary health care system, public

education on its merits should be a high priority. This popular understanding is a necessary precondition for such mobilisation.

18. National planners should incorporate health aspects as a component of all social and economic development and project proposals, and donors should respond similarly.

19. In so far as donor countries place conditions on health projects, they should give priority to primary health care.

20. Through pilot projects, countries should seek to demonstrate the development potential of primary health care - a healthy society is a productive one.

21. Targeted health projects should be framed on the basis of perceived health needs, which may be unrelated to the stage reached in national development - health has an economic impact but cannot be judged solely by economic criteria.

22. Due account should be given in formulating project proposals to recurrent operational costs and their impact on the distribution of resources.

Regional

23. Regional health organisations should conduct workshops for senior health planning officials to enable them to exchange experience on identification of realistic objectives and the monitoring of changes effected by primary health care programmes.

Canada and Secretariat

24. The study on technical co-operation and development assistance among Commonwealth countries in the health field, which the Government of Canada has offered to undertake in collaboration with the Commonwealth Secretariat, should:

(a) document the terms of reference of donor agencies and provide an inventory of sources and types of assistance;

(b) identify the process, source, amount and types of funding which apply to technical assistance projects and the conditions associated with their award;

(c) list and compare the amounts and types of assistance available from multilateral, bilateral and non-governmental sources;

(d) include national as well as international bodies, within and beyond the Commonwealth;

(e) give a clear indication of the time frame for the implementation of the project.

Secretariat

25. The Commonwealth Secretariat should survey cost-benefit analyses based on published and solicited data from Commonwealth countries, and if necessary supplement such analyses, of key or critical primary health care projects, to assist health ministries in their planning and to help Health Ministers to convince cabinet colleagues of the value of the investment.

26. The Secretariat should prepare an indicative inventory of proven mechanisms for cross-sectoral collaboration on health issues at all levels of decision-making.

STRENGTHENING SYSTEMS OF HEALTH ADMINISTRATION

Governments

27. The Meeting reaffirmed the recommendation of the Sixth Commonwealth Health Ministers Meeting urging each government to establish a national health policy, officially adopted by the national government and not merely by the health ministry, to ensure the commitment of all relevant sectors.

28. Governments should confirm their commitment to "Health for all by the year 2000", and acknowledge the importance of health care programmes for the growth and development of the nation.

29. Governments should review their health care delivery systems to ensure that the necessary mechanisms, statutory or otherwise, exist to facilitate the intersectoral co-operation required to implement a national health policy.

30. Governments should improve the administration of health care through the installation of planning and management systems that are responsive to local needs and circumstances and ensure efficient use of resources for implementation of the national health plan. To this end, ministries of health should:

(a) include a planning unit served by an efficient two-way system of information linked to key government and local agencies;

(b) be staffed by trained administrators at all levels.

Secretariat

31. The Commonwealth Secretariat should establish a clearing house or information depot to assemble details of regional and national needs in health administration, and to provide information on experience, expertise and facilities available in:

(a) health policy formulation;

(b) management systems for health care;

(c) health administration;

(d) drug procurement systems, formularies and equipment inventories;

(e) systems for the repair and maintenance of equipment.

32. The Secretariat should organise seminars and workshops for senior-level administrators of health systems to examine problems and share experience in improving health management practices.

33. The Secretariat or the Commonwealth Pharmaceutical Association should establish an inventory of drug manufacturers and drug packaging plants within the Commonwealth, particularly in the developing countries, in order to assist regional groups making bulk purchase arrangements or planning regional drug manufacturing and packaging programmes where these are desirable.

34. The Secretariat should provide assistance for the establishment of revolving funds for pharmaceuticals to enable regional groups to participate in bulk purchase arrangements. Bulk purchasing significantly reduces the cost of drugs but many developing countries cannot use this tool because of chronic foreign exchange or cash flow problems.

35. The Secretariat should explore practical ways of assisting governments to overcome the impact of serious cash flow and foreign exchange problems on health service operations, and should present proposals to the next regional meetings of Health Ministers.

HEALTH MANPOWER PLANNING AND DEVELOPMENT

Governments

36. The strategic planning of total health care should be a continuous process and a basic prerequisite for health manpower planning and development.

37. Every effort should be made to ensure that the health team for primary health care is multidisciplinary and intersectoral, and includes a representative of the community.

38. Training must respond to service needs and manpower availability within the community. Training programmes should be well-balanced, emphasising promotional and preventive aspects of health and designed to enable health workers to respond to community needs while respecting local customs and traditions.

39. Doctors and other health personnel in supervisory positions should receive management training both at pre-service and in-service levels.

40. Modern practitioners and traditional healers should explore ways of working together to best exploit their collective knowledge and skills in the interest of health promotion and care.

41. To combat internal and external "brain drain":

    (a) training and teaching should be orientated to the national requirements for primary health care;

    (b) adequate incentives should be provided for health workers in rural settings to achieve both personal and professional satisfaction;

    (c) adequate equipment and supplies should be provided;

    (d) more positive mechanisms may be necessary to ensure adequate staffing in rural areas.

42. The Meeting broadly endorsed the recommendations of the Commonwealth workshop on the contribution of medical schools to national health development, held in Sri Lanka in 1982.

43. Nurses should be involved in all aspects of primary health care, from the development of national health strategies to activities at the peripheral level. Curricula and nurses training programmes should be modified to take account of this expanded nursing role.

44. In order to contribute effectively to training personnel for primary health care, medical schools, nursing schools and other health worker training institutions should review their objectives and curricula in consultation with health ministries. Representatives of other ministries interested in community development and primary health care should be involved in these consultations. In general, curricula should emphasise the social and preventive aspects of community care, environmental health, and managerial training.

45. Health services should be strategically planned at all levels, taking into account the relevant priorities and objectives and the available resources.

46. Health manpower planning and development should be an integral part of health planning at all levels within the system, and should be based on the health team. The health manpower pyramid should be built on a base of local community health workers. These may be trained and paid health workers, volunteers and traditional practitioners; in some countries nurses may function at this level.

47. Local community health workers must be adequately supervised and supported by the higher levels within the health system. Support should include the provision of

an appropriate infrastructure (facilities, supplies and transport) and ready access to advice and to an appropriate referral network.

48. The whole system should be adequately planned and managed at all levels to take account of the health requirements and the wishes of the people, and to make most efficient use of the available resources.

49. In carrying out health planning functions, ministries of health should:

(a) facilitate the gathering of accurate, timely and comprehensive information about the existing health work-force in the context of service needs;

(b) enable work-force plans to be aligned with the evolving health needs of the population, and with health-related aspects of national planning in other sectors of the economy;

(c) monitor the recruitment, training and development of health workers in the various occupational categories, and promote a national planning cycle for up-dating estimates of requirements and supply for each occupation;

(d) identify and promote, where necessary, new health occupations;

(e) identify emerging work-force shortages and over-supply, and recommend measures, both immediate and long-term, which may include retraining and redeployment, whereby the adverse effects of these imbalances may be minimised;

(f) develop an advisory network to include the relevant education authorities, professional bodies and employer and employee organisations, and establish a structured and on-going planning dialogue with these organisations;

(g) commission research and convene suitably representative working parties to review reports on specific issues;

(h) monitor implementation of plans;

(i) report regularly on the state of the health work-force.

50. Each health ministry should identify and develop a high-level resource to oversee its manpower planning programme. Where possible, the programme should be built round an information, research and planning unit.

51. Member countries should document their research and development experience in planning and implementing

health care policies - where possible, in publications which can be shared with other countries.

Regional

52. Regional health educational institutions should be encouraged, and where possible assisted, to make their facilities available for the training of personnel from countries outside the region.

Secretariat

53. The Commonwealth Secretariat should set up a mechanism to enable countries to share information collected at the national level.

54. The Secretariat should revise and up-date its 1979 publication "Health training: a directory of Commonwealth resources".

55. The Secretariat should set aside resources to consult with and otherwise assist ministries of health wishing to develop new health manpower planning and development capability. In this context, close working relationships should be encouraged between ministries of health, medical schools and other institutions involved in the training of health workers.

56. The Secretariat should investigate the possibility of financial arrangements being made to support technical co-operation between developing countries on a trilateral basis.

COMMUNITY HEALTH EDUCATION

Governments

57. The Meeting broadly endorsed the recommendations of the report, commissioned by the Commonwealth Secretariat, on community health education in member countries.

58. Health education, as the basis of effective primary health care, should be structured as a continuous process, not a series of separate events, to meet the needs of the community.

59. The community, and particularly integral groups such as women's groups, should be involved in the identification, planning, implementation and evaluation of community health education.

60. All health personnel should receive training in health education, including the prevention of diseases and the promotion of health. Such training should emphasise social and communication skills.

61. In view of the multisectoral nature of health education, activities in this connection should involve, in addition to health workers, personnel in social science and health-related areas, such as education, agriculture and the media.

62. As health education programmes directed at children tend to have more impact than those addressed to adults, every effort should be made to ensure that health education features not as a separate subject but in all areas of the school curriculum.

63. The Meeting recommended to Ministers of Education that health education should be incorporated into the curricula of schools and teacher training institutions.

64. Health education programmes should be monitored and evaluated to ensure their cost-effectiveness.

65. Health education units should be created within ministries of health as focal points for health education activities, and should provide technical, research and development support for well-organised and on-going health education programmes. They should also encourage and co-ordinate input from other ministries, such as those concerned with information and education, and from other health-related organisations.

Secretariat

66. The Secretariat should explore ways and means of assisting ministries of health to establish or up-grade their health education units.

POLICIES AND PROGRAMMES FOR DISABLED PEOPLE

Governments

67. The creation of separate systems for the implementation of programmes for dealing with disability is inadvisable. Instead, they should be integrated into existing health systems.

68. Governments should take steps to increase general awareness of the problem of disablement as a multisectoral one.

69. Governments should include greater participation of the disabled in the planning and implementation of preventive care and treatment and other associated programmes and services.

70. Governments should provide appropriate support to non-governmental organisations dealing with the problems of disability.

71. Governments should endorse the objectives of the IMPACT programme initiated by UNDP, WHO and UNICEF against avoidable disablement.

72. All agencies concerned with the disabled should pay greater attention to the problem of deafness.

Secretariat

73. The Commonwealth Secretariat should provide practical assistance, through a specialist appointment, to meet

national and regional needs in the prevention and treatment of disabilities and the rehabilitation and maintenance of the disabled in the mainstream of society. This specialist appointment could also assist medical schools and other health institutions to develop training components on the preventive aspects of disability.

IMPLEMENTATION OF THE CODE ON THE MARKETING OF BREAST-MILK SUBSTITUTES, AND OTHER MEDICAL-LEGAL ISSUES

Governments 74. Those countries which have not yet adopted the international code on the marketing of breast-milk substitutes should speed up their efforts to do so.

Secretariat 75. The Commonwealth Secretariat should commission a report on socio-medical-legal issues and their implications, with a view to establishing a Commonwealth mechanism for monitoring developments in this field, and should report to the 1984 Pre-WHA Meeting.