REPORT OF THE MEETING

POLITICAL AND ECONOMIC ISSUES IN HEALTH PLANNING AND MANAGEMENT

Commonwealth countries have accepted the WHO goal of health for all by the year 2000 and seek this achievement through special emphasis on primary health care.

2. The commitment to primary health care requires an emphasis on:

   (a) community participation in health care;

   (b) preventive and promotive health care;

   (c) the contribution of diverse sectors to health care;

   (d) health education;

   (e) the equality of provision and access to health care;

   (f) rehabilitation.

3. This represents a profound challenge to existing professional and political structures and values, and to prevailing practices and procedures in the delivery of health care.

Institutions and infrastructure

4. "Primary health care reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country."* Consequently its achievement involves several sectors of government and society.

5. Health Ministers identified a number of economic and institutional constraints to the effective implementation of health policy and planning, particularly in the area of primary health care. Traditional political structures should have greater flexibility in order to promote effective institutional collaboration. Because it is incorrectly perceived as a non-productive sector of the economy, health planning is often isolated from the mainstream of national development. Failure to

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*All quotations from the Declaration of Alma-Ata

take health into account in cross-sectoral planning often leads to unforeseen and even negative developmental results. It also has an adverse effect on the administrative co-ordination needed to deliver programmes at all levels.

6. To help to ameliorate these problems, the Meeting proposed the following guidelines.

(a) Overall development strategy should reflect health needs. Such strategy should be based on accurate assessment of health needs in order to identify under-served areas and to direct services towards them.

(b) Intersectoral influences on, and inputs in, health programmes should be thoroughly understood and evaluated.

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

(d) Multisectoral activity focused on health should be co-ordinated at the national level by a co-ordinating body, possible mechanisms being a national health council or a committee of cabinet. Such a body would examine the overall use of national resources for their effect on health, consider the impact on health of the plans of different sectors, and evolve consistent criteria for decision-making affecting health.

(e) Collaboration needs to extend through the administrative machinery. Governments should seek out the collaborative mechanisms most appropriate to their countries to break down isolation between different decision-making agencies bearing on health.

Allocation of resources

7. "Primary health care is essential health care... at a cost the community and country can afford to maintain, at every stage of their development."

8. Health Ministers acknowledged the competing legitimate claims on limited budgetary resources in the national planning process. Nevertheless, the inadequacy of resources for health was recognised; so was the inequitable distribution of resources between components of the health sector.

9. The Meeting proposed the following guidelines.

(a) 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.

(b) Resources should be concentrated on a selected number of primary

health care activities, the choice being determined by the following criteria:

(i) epidemiologically significant problems;

(ii) problems for which effective interventions are available;

(iii) interventions which are affordable and technically manageable.

(c) 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.

(d) 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 vary.

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

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

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

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

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

Mobilisation of support

10. "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

11. Health Ministers considered that the acceptance of primary health care is inhibited by a lack of understanding of its real impact on development and on personal well-being. Mobilisation of support for primary health care is essential at all levels.

12. The meeting proposed the following guidelines.

(a) 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.

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

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

(d) 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.

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

(f) 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.

Co-operation

13. "The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life."

14. Recognising the political and economic constraints, and the challenge to values and structures implicit in the development of the primary health care system, it will be necessary to maximise co-operation within the Commonwealth at all levels. Policies of development co-operation require that donor countries respect the national and regional priorities of the recipient countries, and that recipients understand the constraints on donor agencies.

15. Health Ministries considered that co-operative programmes and projects have frequently had limited effectiveness due to inadequate recognition of these priorities. Undue emphasis on economic development alone has been an impediment to support for needed health activities. Primary health care has suffered in particular. Furthermore, industrial and agricultural development projects may have unanticipated negative consequences for the health status of populations.

16. To maximise the effectiveness of Commonwealth co-operation, the Meeting proposed the following guidelines.

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

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

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

(d) Targeted health projects should be framed on the basis of perceived 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.

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

17. Many Commonwealth governments are concerned about the time-consuming and complex processes involved in obtaining international assistance. The offer of the Government of Canada to undertake in collaboration with the Commonwealth Secretariat a study on technical co-operation and development assistance among Commonwealth countries was warmly welcomed by Health Ministers. As further developed by the Meeting, it is proposed that this study 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 clear indication of the time frame for the implementation of the project.

18. 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 Ministers to convince cabinet colleagues of the value of the investment.

19. It is proposed that 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.

20. The Commonwealth 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

21. In striving towards the goal of health for all by the year 2000, many Commonwealth governments are planning, or are in the process of restructuring, administrative systems for the provision of health care. This reflects an increasing emphasis on the delivery of primary health care services designed to improve the health of populations in the rural and peri-urban areas. It also reflects a growing recognition that

decentralised systems of administration, including those designed to deliver primary health care, encourage more responsible attitudes towards the development and use of health care services, leading to more effective and efficient use of resources. Such changes in the emphasis of health care systems place different and frequently greater demands on administrative and management processes than systems based on a more curative approach to health care.

New planning and management systems

22. Experience in restructuring the administration of health services has shown that the processes of change are complex, far-reaching, time-consuming and sometimes incur unanticipated costs. In particular, their installation necessarily calls for the development of new planning and management systems including changed patterns and processes of decision-making; redistribution in allocation of responsibilities among staff; reorientation of personnel; new procedures for budgeting, disbursement and accounting; new communication styles, patterns and linkages; and new reporting, monitoring and evaluation. It is therefore essential that the introduction of change is carefully planned, with a phased and targeted approach to the installation of the necessary new procedures. It is particularly advisable to pay close attention to the development and reorientation of staff who will operate the new system at central, regional and peripheral levels. It is vital that the plans and proposals for change are fully discussed and that consultation occurs at all levels.

Upgrading status of health

23. While decentralisation of health care provision delegates some responsibilities - notably those of identifying priorities and developing and administering local services - from the ministry of health to regional, district and local levels, it is evident that a decentralised system cannot operate effectively without the support of a strong central administration sustained by a strong political commitment to health.

24. Individual and community health are fundamental requirements for ensuring a productive population. It is vital that the significance of health care programmes for the growth and development of the nation should be acknowledged by member governments. Health Ministers themselves have an important part to play in heightening the political and administrative awareness of their colleagues, both on the importance of the nation's health and on the means of achieving it. Some Ministers have organised workshops for their cabinet and other parliamentary colleagues to this end.

National health policy

25. An essential factor in developing an efficient health care system, particularly along decentralised and intersectoral lines, must be the establishment of a national health policy. This should be based on full consultation at all levels, agreed to at the highest level of government, and adopted by parliament where necessary. It should incorporate key indicators for health and a time frame for the achievement of its goals. Through the adoption of such a policy, many

of the problems associated with the acquisition of funds and other resources, and also with intersectoral co-operation, can be minimised.

Intersectoral linkage

26. Implementation of an effective policy will require action involving a number of different sectors - such as agriculture, education, housing, industry, and water supply. This interdependence should be reaffirmed through the institutionalisation of mechanisms to establish effective intersectoral linkages at both national and local levels. In some cases new mechanisms may be required, such as central and local health advisory councils. In other cases it may be possible to use existing statutory bodies, even the cabinet itself. Where there are incompatibilities between ministries arising from different degrees of decentralisation, it is important to develop special mechanisms to overcome potential conflicts.

Community linkages

27. If health services are truly to reflect the needs and expectations of the people, links with the community are essential. People must be encouraged to take a greater interest and become actively involved in providing their own health care. Members of the community should participate in the design and provision of their health care delivery systems. This helps to generate enthusiasm for health care, to release community-based resources and to overcome the resistance that can be associated with programmes that are proposed from above. In determining local priorities, local health boards can draw on the experience of a variety of different disciplines, including public health officers, agriculture extension workers, public health nurses, local leaders and politicians.

Planning system for health care

28. Effective development and operation of health care delivery at community level requires the establishment of a planning system that uses all levels of the administrative structure. On the one hand this will take account of national priorities, while on the other it will respond to local concerns and needs. At the central level there is a clear role for a planning unit in the ministry of health comprising a multidisciplinary team of specialists such as economists, manpower planners, demographers, statisticians, and various health care personnel, including university, medical school and training staff. The unit should assemble and analyse relevant health data, give direction on current and future health care needs, and monitor and evaluate programmes and project implementation. As far as possible, people in the planning cell should be actively involved in the implementation process.

29. To be effective, planning requires effective information flow and information gathering and processing systems. Health service planners require data on mortality, morbidity, health profiles in different sectors of the population and in different parts of the country. They need information on project proposals, resource requirements and resource availability, and they require feedback on problems and progress in project implementation. Such systems must effectively

process information in both directions between the central and peripheral levels.

Financial adjustments

30. A fundamental factor in decentralised health care provision is delegation of financial responsibility and authority, both for locally-initiated and for national projects. In some countries traditional civil service practices for financing ministry of health operations often lack the necessary flexibility and may be a severe constraint on the success of decentralisation. Coupled with this, traditional management practices and associated management attitudes may impede the introduction of new systems. Yet there is considerable evidence to suggest that the success of decentralised decision-making rests with the introduction of suitable project or programme-based budgetary systems. It is therefore essential that changes in financing and accounting procedures be instituted.

New management skills

31. New systems of administration of health care require new and specialised managerial skills and techniques. Those with administrative responsibilities at all levels should be properly trained to carry out their managerial responsibilities. Care should be taken to avoid misuse of human resources, especially specialised health personnel whose training has prepared them to perform other specialised functions but not necessarily administration. It is important that executive positions in the health ministry and at other levels in the health service should be held by persons who have been appropriately trained for that task.

Human resource requirements

32. The process of restructuring health management systems will require reassessment of manpower requirements. Revised job categories and job descriptions may be needed to reflect the administrative changes, and should be accompanied by the development of manuals outlining responsibilities, relationships and tasks. Manpower surveys will be needed to identify the supply and demand of personnel with appropriate skills, and to assess training needs. It may also be necessary to find ways of upgrading the status of health administrators and of offering incentives to avoid undue losses of skilled managers to the private sector.

33. Health service administrators at all levels, including those from specialised medical backgrounds, require specialised management training to fit them for the demands of providing a modern health care service. All specialised training institutions for health care should include a management component in the curriculum. In addition, special management training programmes should be developed by institutes of management, government training institutions and other in-service training agencies.

Use of the private sector

34. There may be room to reduce the management burden on national health

systems through astute and careful use of private and non-governmental agencies. Privatisation offers opportunities for economies, but may only be feasible where the existing infrastructure contains the facilities required for its implementation. Moreover, although privatisation can reduce the tasks carried out by the health ministry, it does incur some management responsibilities such as preparing contracts and monitoring plan implementation, and may often be open to abuse.

Non-governmental inputs

35. The complementary effect of non-government organisations in an integrated health care system must be recognised. Continuing activities of religious, fraternal and voluntary agencies offer a means to reduce the financial, administrative and programme burden of government services. Increasingly, however, these groups may require financial support, and their programmes need to be reviewed in order to ensure compliance with all details of the national health plan. Another particular source of potential for greater co-operation with non-governmental bodies lies with professional associations. Too often these associations have parochial interests, yet they could significantly contribute more to the health care system.

Drugs, equipment and supplies

36. Adequate supplies of drugs at reasonable cost are imperative for the success of primary health care programmes in developing countries. The availability of drugs brings the patients to the local health worker, creating the opportunity for education and the dissemination of information on basic health principles - hygiene, sanitation, nutrition and the like. The credibility of the local health unit is strengthened when treatment can be obtained, and thus the community is more likely to be receptive to the preventive aspect of health care as espoused by the health worker.

37. The major concerns of the developing Commonwealth countries are the lack of foreign exchange with which to buy drugs or the raw materials to manufacture them, and the failure of distribution systems to transport drugs from the centre to the periphery.

Reducing drug costs

38. Drug costs can be reduced significantly through bulk purchasing arrangements and a procurement system which places due emphasis on factors such as drug price, reliability of the manufacturer, product quality, and delivery time. The establishment of a revolving drug fund (such as is being considered by the Caribbean regional group of countries), to enable those suffering cash flow and foreign currency problems to operate on a bulk purchasing basis and avoid the high cost of sporadic small orders, was considered a useful measure.

Drug distribution

39. The production of a national drug list for use in the public sector and/or the preparation of a drug formulary is considered to be an

important first step in tackling the drug distribution problem. Drugs can be chosen on the basis of proven effectiveness, safety, cost, appropriateness to the health needs of the patients treated in each country's rural health facilities, and according to the level of training of the health workers. The use of internationally recognised generic names for drugs is recommended, particularly in ordering and purchasing, to further reduce costs.

40. To cut misuse and over-use of drugs, some countries have found a rationing system to be effective. Drugs are supplied strictly according to patient work-load and not according to health worker or hospital demands. The use of pre-packaged, sealed boxes of drugs has been instrumental in a number of countries in reducing the loss and wastage due to pilfering, a considerable problem in many countries where drug scarcity means high prices in illicit trade. The boxes contain a one-month supply of drugs and are packed at a central location and delivered to the rural health facilities via district hospitals.

41. Another means of tackling the distribution problem has been to centralise the bulk storage of drugs to the regions in an effort to speed up delivery to the district level. A variation on the rationing principle has been to prepare an authorised list specifying the drugs to be used in each type of health facility, and only those drugs can be used in any particular facility. The list will be reviewed regularly and adjusted as needed.

42. In other schemes, contracting to private companies has been used successfully to overcome management problems associated with the importing and storage of drugs and with their distribution from the centre to the periphery. This has simplified the health ministry's management task by removing the necessity to establish systems for procurement, forecasting and the monitoring of inventory control.

Standard treatment, and quality control

43. Effective drug supply management is also facilitated by the development of standard treatment regimes for each country's most common diseases so that drugs are used properly. Like drug procurement, this is an area amenable to regional co-operation among member countries. Similarly, consideration can be given to the development of regional facilities to monitor the quality control of drugs. The latter is a major problem to many countries: drugs bought by central procurement agencies have sometimes been found to be ineffective, time-expired or otherwise unacceptable, and developing countries seldom possess the necessary quality control facilities to carry out the required checks on the products purchased. Another suggestion is to use the quality control checking programmes offered by UNICEF and the WHO certification scheme to help solve this problem.

Commonwealth Pharmaceutical Association

44. The services of the Commonwealth Pharmaceutical Association can be used to assist developing countries in meeting problems or developing policies in drug education, standards, procurement, distribution and compiling formularies. Such activities are welcomed and should be strengthened.

Equipment

45. Particular problems are experienced in the acquisition, standardisation, repair and maintenance of medical equipment. In some cases basic equipment and material cannot be obtained because of currency problems. In other cases the diverse origins of equipment supplied by donor agencies and the consequent lack of standardisation exacerbate the repair and maintenance difficulties. As a result, the shortage of technicians qualified to service equipment is severe and the planning and provision of their training programmes is both unwieldly and necessarily complicated.

Technical co-operation

46. The widespread trend in Commonwealth countries towards the introduction of decentralised systems of health care administration, coupled with a growing emphasis on primary health care provision, has both generated new needs and provided new sources of experience, expertise and resources to be shared. There is considerable scope for extending technical co-operation among Commonwealth member states to cover health administration and management. Technical co-operation between developing countries offers particularly useful possibilities for acquisition of expertise, sharing of experience, and co-operation in the development and use of facilities and services.

47. Prerequisites for defining the scope and nature of technical co-operation activities include:

    (a) a highly-focused approach directed at identifying concrete contributions in specific aspects of health administration and management;

    (b) clear and well-documented indications of national priorities and particular requirements arising out of these;

    (c) catalogued information on available experience, skills, facilities and services.

48. A number of areas of priority concern for technical co-operation were identified. These included:

    (a) installation of management systems for decentralised administration of health care services, especially in the fields of planning and information processing;

    (b) development of human resources for health care management;

    (c) procurement and manufacture of drugs, medical supplies and equipment;

    (d) maintenance and repair of equipment;

    (e) exchange of research findings in tropical diseases and disease control.

49. However, problems and needs in health care administration vary from country to country and from region to region. In Africa, for instance,

there is particular concern with systems for procurement and distribution of drugs, with repair and maintenance of equipment, and with training for future health administration. In the Caribbean and South Asia, systems for the identification of regional needs exist and these have identified a number of specific areas requiring regional co-operation and the support of technical assistance agencies.

50. Technical co-operation at regional and sub-regional levels is particularly useful. To facilitate the identification of suitable projects and programmes, regional needs must be identified and prioritised. The Commonwealth Health Ministers Meeting provides an opportunity for assessing regional priorities, discussing ways of responding to these, and identifying specific projects and programmes for regional co-operation and support through the Commonwealth framework.

51. The Commonwealth Secretariat is well placed to provide technical support for regional co-operation. In particular, it should develop a clearing-house service or information depot through which details of regional and national needs are recorded and data on experience, expertise and facilities are available. The establishment of such a service would place additional demands on the already small and committed staff. Additional staff would therefore be required to develop and operate such a service.

52. There is a growing need for health management training to support the introduction of new administrative systems. Courses in the developed countries may be useful but are costly and not always relevant. Suitable courses are in short supply and those that are available can meet only a fraction of the training needs of development in this field. Where possible, bilateral technical assistance agencies should use their training funds for training and development of capabilities at regional and national levels. There is also a need for increased scholarship support for external training opportunities in health management for senior level personnel.

53. At regional and national levels there are serious shortages of suitably qualified and experienced trainers to develop and run health management courses. Training capabilities in health management should therefore be strengthened in medical schools, in institutes of management and in other suitable governmental or academic training institutions. Training courses for trainers at regional and national levels should be developed with external assistance from bilateral and multilateral agencies.

54. As a supplement to specialised training, health management personnel should be developed through study visits, exchanges and attachments, especially at the regional level. Regional and sub-regional workshops and seminars for senior management personnel should also be organised to examine and share experience in resolving health administration problems.

55. Specialised training courses in the repair and maintenance of equipment are a high priority requirement in some countries, particularly in Africa and in small states. Their development should be supported through technical co-operation in the exchange of personnel and curricula and in the provision of expertise.

56. A number of specific projects for technical assistance were identified.

(a) The countries of East, Central and Southern Africa require assistance in establishing a regional drug procurement system.

(b) They also require assistance with the development of a regional approach to training for the repair and maintenance of equipment.

(c) The Caribbean Community Secretariat is seeking technical assistance for the provision of a public health engineer, academic staff and equipment for developing a social medicine course, a public health medical officer, a disease control specialist, a psychiatrist to develop a regional mental health strategy, a public health dentist and a consultant in geriatrics, all for attachment to regional health programmes.

(d) The development of a regional inventory of hospital equipment is also a priority requirement in the Caribbean.

(e) Among the South Asian and Pacific countries, support is required for regional programmes of exchanges and study visits among health personnel. In addition, those countries which have developed expertise in some specific fields offered to share their experience in these fields with other Commonwealth countries.

57. Countries offering bilateral assistance should examine ways of overcoming problems of loss of status and career opportunities faced by potential overseas consultants, as this severely limits the pool of experts available to take on technical assistance assignments.

Recommendations

58. Health Ministers made the following recommendations for action.

(a) 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.

(b) 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.

(c) 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.

(d) 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:

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

(ii) be staffed by trained health administrators at all levels.*

(e) 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:

(i) health policy formulation;

(ii) management systems for health care;

(iii) health administration;

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

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

(f) 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.

(g) 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.

(h) 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.

(i) 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

59. Planning and management of health manpower is central to effective delivery of primary health care. Health Ministers discussed a number of areas related to manpower issues and agreed that the strategic planning of total health care should be a continuous process and a basic prerequisite for health manpower planning and development.

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*Suggested components of a health administration system, prepared by the committee which dealt with strengthening systems of health administration, are included in an annex to the report.

Health teams

60. The Meeting accepted the team approach concept to primary health care and pointed out that every effort should be made to ensure that the team is multidisciplinary and intersectoral, and includes a representative of the community.

61. The successful functioning of the team depends on a number of factors, including its ability to respond to the needs identified by the community, the work setting, tasks to be done, and leadership. With regard to leadership, in particular, this should not be determined by discipline but should depend on the tasks in hand, the relevant skills and experience of team members, personal suitability and community acceptance. The Meeting also recognised the value of team members undergoing training together as a team.

Training

62. Training must respond to service needs and manpower availability within the community. It is recognised that the type of training needs given to all categories of health workers directly influences their interest and ability to function effectively in the primary health care setting.

63. 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. Furthermore, the Meeting emphasised the need for doctors and other health personnel in supervisory positions to receive management training both at pre-service and in-service levels.

Traditional practitioners

64. To date, traditional practitioners have not been successfully incorporated into the normal health care system in most member countries. The Meeting noted that a valuable contribution could be made by these traditional practitioners to primary health care. Therefore, modern practitioners and traditional healers should explore ways and means of working together to best exploit their collective knowledge and skills in the interest of health promotion and care.

Recruitment and retention of health care workers

65. It was noted that in many developing countries, health care workers - especially doctors and nurses - are often urban-trained and/or recruited from other countries. Consequently, both locally-trained and expatriate health personnel are generally not suited (in terms of attitudes and knowledge of local conditions) to provide primary health care in rural settings.

66. Concern was expressed about internal and external "brain drain". The following suggestions were made regarding how this could be combated.

    (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.

Medical schools and primary health care

67. Health Ministers recognised the need for medical schools to contribute to national efforts to provide health care for the community, and broadly endorsed the recommendations of the Commonwealth workshop held in Sri Lanka in 1982, which dealt with the contribution of medical schools to national health development.

68. It was noted that medical schools are, in the main, conservative. Curricula often tend to be out of tune with, and not always responsive to, the priority health needs of the community.

69. In keeping with the resolution passed at the Thirty-sixth World Health Assembly in 1983, the Meeting agreed that 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 nurse training programmes should be modified to take account of this expanded nursing role.

70. 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 ministries of health. 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.

Prerequisites for health manpower planning

71. The meeting agreed on the following prerequisites for health manpower planning and development.

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

(b) Health manpower planning and development should be an integral part of health planning at all levels within the system.

(c) Health planning and health manpower planning should be broadly based on the primary health care approach as described by WHO.

(d) Health manpower planning and development should be based on the health team.

(e) 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.

(f) 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.

(g) 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.

72. Given these prerequisites and the fact that the health care systems of most Commonwealth countries are financed largely from public funds, any serious attempt to plan and manage health manpower must start from, and be firmly based in, ministries of health. A realistic prescription for health manpower planning cannot be provided until national health planning priorities and objectives have been identified, the level of available resources defined, and the major strategies are in place for health protection, health promotion and the delivery of health services. Only then is there a basis for negotiating with the health work-force and the education system as to how many health workers, and of what type, will be required, and when and where.

Health manpower planning functions

73. The Meeting identified the following manpower planning functions of the ministries of health:

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

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

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

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

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

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

(h) to monitor implementation of plans;

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

74. Regardless of size, all ministries of health must in some way address these manpower planning functions. It is recommended that each ministry should identify and develop a high-level resource to oversee its manpower planning programme. Where possible, the programme should be built around an information, research and planning unit.

75. The Meeting recommended that the Commonwealth 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.

Community health education

76. Health Ministers broadly endorsed the recommendations of the report of the recent study on community health education in Commonwealth countries. They agreed that health education is the basis of effective primary health care, and must be structured as a continuous process, not a series of separate events, to meet the needs of the community. They recognised that community involvement is the key to the success of primary health care. 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.

77. 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.

78. 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.

79. The Meeting noted that, in general, health education programmes directed at children tend to have more impact than those addressed to adults. Therefore, every effort should be made to ensure that health education features not as a separate school subject but in all areas of the school curriculum. In this connection, it was agreed that the Meeting should recommend to Ministers of Education that health education should be incorporated into the curricula of schools and teacher training institutions.

80. The Meeting considered that health education programmes should be monitored and evaluated to ensure their cost-effectiveness.

81. Health Ministers discussed health education units and agreed that, where possible, such units should be created within ministries of health as focal points for health education activities. The units should provide technical, research and development support for well-organised and on-going health education programmes. The unit should also encourage and co-ordinate input from other ministries, such as those concerned with information and education, and from other health-related organisations.

Technical co-operation

82. Health Ministers noted with appreciation the efforts being made by the Commonwealth Secretariat to promote health co-operation at regional and Commonwealth levels. Specific reference was made to the substantial assistance provided, through the Commonwealth Fund for Technical Co-operation (CFTC), for health programmes of the Caribbean Community Secretariat and for the establishment and programmes of the regional health secretariats for West Africa and for East, Central and Southern Africa. Also commended were the co-operative activities of these regional secretariats, the Commonwealth Nurses Federation and certain individual member countries.

83. The following recommendations for action were made to promote more extensive collaborative activities among member countries.

(a) Member countries should be encouraged to document their research and development experience in planning and implementing health care policies. Where possible, this experience should be documented in publications which can be shared with other countries.

(b) 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.

(c) The Commonwealth Secretariat should collaborate with the Government of Canada in the study on technical co-operation and developmental assistance among Commonwealth countries (see paragraph 17 above).

(d) The Secretariat should set up a mechanism to enable countries to share information collected at the national level - see (a) above.

(e) The Secretariat should revise and update its 1979 publication "Health training: a directory of Commonwealth resources".

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

(g) 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

84. Health Ministers considered the report commissioned by the Commonwealth Secretariat on policies and programmes for disabled people in the Commonwealth. The year 1981 was proclaimed the year of the disabled, and 1983-1992 the decade of the disabled. National plans and programmes for the disabled and for the prevention of disabilities should reflect the magnitude of the problem, different causes of disabilities, and the extent to which preventive programmes should prevail over treatment and rehabilitative services.

National plans

85. Up to this time, few governments have national plans for the disabled or accurate measures of the extent or types of disabilities. Global estimates are that 80 per cent of disability is preventable through such measures as immunisation against debilitating diseases, improved nutrition and particularly maternal nutrition as it impinges on the foetus. Much could be achieved through a changed emphasis in the health field from disease-orientated treatment towards a preventive approach. This poses a challenge to the entire medical community.

Planning and provision of programmes

86. The creation of separate systems for the implementation of programmes for dealing with disability is inadvisable. Instead they should be integrated into existing health care systems. Disabled persons themselves do not want further segregation from society; they should be involved in the planning and implementation of programmes.

87. To ensure the participation of the disabled in the mainstream of society, it is important to recognise that various sectors of society, both governmental and non-governmental, must be involved. While it may be necessary for the ministry of health to take an advocacy position, some problems, such as of access to buildings, public washrooms, and special educational needs, call for an intersectoral approach. In this context, the disabled must be represented in the multisectoral planning process.

88. There is a lack of information on the causes of disabilities. Countries can share in the experience of others through the co-ordinated exchange of information about causes of disabilities. The Commonwealth Secretariat could provide co-ordination of information exchange at Commonwealth and at regional levels. The Commonwealth may also play a role in instituting mechanisms for the provision, care and maintenance of equipment such as wheelchairs.

Recommendations

89. The Meeting endorsed the report and recommendations of the consultant (Mr J K Thompson) and made the following additional recommendations.

(a) 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.

(b) This specialist appointment could also assist medical schools and other health institutions to develop training components on the preventive aspects of disability.

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

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

(e) Governments should provide appropriate support to non-government organisations dealing with the problems of disability.

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

(g) All agencies concerned with the disabled should pay greater attention to the problem of deafness.

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

90. The Thirty-third World Health Assembly, in May 1980, adopted a resolution (WHA 33/32) endorsing the conclusions and recommendations of the joint WHO/UNICEF meeting on infant and young child feeding (Geneva, 1979) emphasising the need for urgent action by governments to promote breast feeding and improve infant and young child nutrition. After extensive consultation, a draft international code was prepared and submitted to the Thirty-fourth World Health Assembly in 1981. This code was adopted by the Assembly as a recommendation to governments.

91. The code has received near-unanimous support by WHO member states and is generally accepted in principle within the Commonwealth. In some member countries, official or legal sanction has been given to the code; in others it has been accepted but is in the consultative process (federal-state, etc). In still other countries, pressure is being brought to bear by manufacturers to discourage the adoption of the code. In certain cases, even though the code itself has not been adopted, measures have been taken to implement some of its features, such as the outright banning of advertising of breast-milk substitutes, the prevention of health institutions from accepting samples, or the requirement that baby bottles be sold on prescription only.

92. For effective application of the code, it must be adopted by all countries. This will force manufacturers to conform, and to cease making products of lower standards than required by the code or marketing their products in breach of the code. It was felt that since the factors involved in conformity to the code were all under human control, the continued resistance of manufacturers was ill-founded and should not be accepted.

93. To complement these measures, some countries have instituted very positive programmes to aid nursing mothers both through maternity leave provision and in work settings.

94. This issue is but one of a number of socio-medical-legal issues that are emerging. Others include tissue transfer, genetic engineering, and the definition of death. These should be examined before they give rise to wider problems.

Recommendations

95. The Meeting endorsed the recommendations of the Commonwealth workshop held in Harare in January 1983 and made the following additional recommendations for action.

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

(b) 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.

REVIEW OF ACTION TAKEN FOLLOWING THE SIXTH COMMONWEALTH HEALTH MINISTERS MEETING

96. The meeting noted the reports on action taken by governments, regional organisations and the Commonwealth Secretariat following the Sixth Commonwealth Health Ministers Meeting.

NEXT MEETING

97. The Meeting was informed that a provisional offer to host the Eighth Commonwealth Health Ministers Meeting in 1986 had been made by the Government of the Bahamas. This offer was welcomed by Ministers with appreciation.

COMMONWEALTH PHARMACEUTICAL ASSOCIATION

98. The Meeting agreed to accord observer status at future triennial Commonwealth Health Ministers Meetings to the Commonwealth Pharmaceutical Association.

CONCLUSION

99. The Meeting concluded with expressions of thanks to the Government of Canada for the hospitality and facilities it had provided; to the Chairman for her skilful and relaxed conduct of the proceedings; and to the Commonwealth Secretariat and Canadian staff for their work in organising and servicing the Meeting.

SUGGESTED COMPONENTS OF A HEALTH ADMINISTRATION SYSTEM

Ministerial level

(a) Health should be strongly represented at the highest government level. Decisions from other ministries - such as those dealing with finance, agriculture or industry - have an impact on health. Equally, health decisions can affect other sectors. Because of its intersectoral nature, health should be discussed, and action should be agreed, by all departments concerned.

(b) Each country should have a national health policy and plan, prepared, after full consultation, by the health ministry and approved by Cabinet. This ensures that implementation becomes a national responsibility.

(c) To allow full consultation and public accountability, a national health council should be established, consisting of representatives of the health ministries and other ministries, the universities and respected "lay" representatives. The council would report to the Minister of Health.

Central health unit

(a) Line authority from the Minister should pass through professional health administrators, with advice from and co-ordination with technical and professional advisers. To ensure mutual respect between these groups, administrators should be professionally qualified, have proven ability and, in order to attract and retain suitable candidates, have attractive career structures.

(b) To this end, governments should provide training in health administration to develop the necessary skills at all levels.

(c) Where possible, each country should have an institute of management where courses can be developed.

(d) Channels of communication - technical and administrative - should be clearly defined, with lines of advice and supervision following fields of speciality.

(e) At the central ministry of health, the planning cell should include specialist advisers and representatives of universities, professional societies, medical schools and other training units. To ensure a practical orientation, it should have some responsibility for following through on the implementation of its plans.

(f) As a means of simplifying administration, a decentralised managerial approach can be pursued. However, this calls for a strong central unit which has the capability of providing

administrative support and guidance to peripheral units. If decentralisation is to be effective, it is important that decision-making and budgetary regulation, within government guiding principles, should also be delegated.

Intermediate level

(a) As far as possible, administration at the regional and district level should be carried out by professionally-qualified administrators, with technical advice and co-operation from the health professionals.

(b) Public and community co-operation can be much improved by creating or fostering referral or district health advisory committees, consisting of health professionals and also representatives of the public and non-government organisations. Public representation might be through an electoral system.

Peripheral level

(a) At the peripheral level, the responsible administrator will be the most suitable person available in the health team.

(b) There should be a representative advisory committee to advise health staff and to participate in decision-making.

Between levels

(a) There is a need for a management information system to ensure a two-way flow of information on supplies, budget and finance, as well as on disease incidence and health achievements. This two-way flow of data should be regularly monitored and evaluated.

(b) Targets for health achievements should be established at all levels and for all activities.

(c) Terms of reference or job descriptions should be defined for health staff at all levels.

(d) An evaluation system for other staff and activities should be instituted.

SUGGESTED COMPONENTS OF A HEALTH ADMINISTRATION SYSTEM

Level	Responsible executive	Professional adviser	Advisory group	Composition of advisory group
Parliamentary	Minister	Ministry officials	National health council	Health ministry and other ministry officials NGOs University deans Lay representatives
Central	Permanent secretary and administrative specialist heads	Chief medical officer and technical specialist heads	Health ministry planning committee	Administrative and technical specialists Professional bodies, economists, social scientists. Health ministry officials e.g. nursing, paramedics
Regional District	Professional administrator	Senior medical adviser	Regional medical committee	Representatives local health committees and local health staff
Periphery	Most effective administrator available, possibly technical health person	Local health staff	Local health committee	Nominated or elected lay personnel Local heads of government offices

NEWS RELEASE

HEALTH MINISTERS PLAN FOR FUTURE

Planning and management systems for health care in the majority of Commonwealth countries will require urgent restructuring if the new emphasis on preventive, rather than curative, health is to be realised and the goal of health for all by the year 2000 is to be achieved. This was one of the main conclusions reached by Commonwealth Health Ministers at their seventh triennial meeting held in Ottawa, Canada, from 2 to 8 October 1983.

It was the largest gathering of Commonwealth Health Ministers ever; 42 countries were represented, with 36 delegations led by Ministers. The Chairman was Canada's Minister of National Health and Welfare, the Hon Monique Bégin, who was elected by acclamation after the formal opening by Canada's Deputy Prime Minister, the Hon Allan MacEachen.

A special feature of this meeting was the attendance, for the first time, of a representative of Disabled Peoples International as an observer. Other observers represented the World Health Organisation, the Commonwealth Medical Association, the Commonwealth Nurses Federation and the International Planned Parenthood Federation.

Three major addresses dealt with the meeting's theme, "Health Planning and Management". They were by the Commonwealth Secretary-General, Mr Shridath Ramphal, and the two invited lead speakers, Professor O O Akinkugbe, Professor of Medicine at the University of Ibadan, Nigeria, and Dr John Evans, a Canadian and former head of the health department of the World Bank.

Key issues raised by these speakers and discussed at the meeting, in plenary sessions and then in committees, included:

- the political dimension in national health planning;
- the allocation of resources between different sectors in the health field;
- the organisational and a management changes required by ministries of health, both centrally and at local and district levels;
- adequate distribution of health facilities, including personnel, drugs, equipment and supplies; and
- the need to involve a whole range of people, from doctors to lay community groups and non-governmental organisations, in the operation of the new systems envisaged for health care at central and peripheral levels.

In discussing these issues, Ministers recognised that the Commonwealth, containing as it does countries at every level of development, provided a unique forum for the exchange of information on national experience and

priorities. There was general agreement that members shared a commitment to mutual assistance and support which made it possible for them to enlarge technical co-operation within the Commonwealth at all levels, building on existing programmes.

They considered that scarce personnel and material resources could be shared with benefit in such areas as manpower planning; the strengthening of medical and other health training institutions; the sharing of specialist resources; and the development of drug quality control and other technical facilities.

In this context the meeting warmly welcomed the offer of the Government of Canada for a study of technical co-operation and development assistance in the health field to be undertaken by several Canadian agencies - the International Development Research Centre (IRDC), the Canadian International Development Agency (CIDA) and the Department of National Health and Welfare - in association with the Commonwealth Secretariat. This study would document the terms of reference of donor agencies; identify the process, source and type of funding which apply to technical assistance projects; and compare the amounts and types of assistance available from multinational, bilateral and NGO sources. One major benefit would be the identification of gaps in international programmes which the Commonwealth might be able to fill.

A balanced allocation of resources within the health field was seen by Ministers as an investment in economic development. They considered these resources should be channelled towards those health problems which had the highest prevalence in their communities and which would respond most readily to affordable measures.

Ministers also emphasised that medical schools and other institutions for the training of health professionals should review their objectives and curricula to emphasise the social and preventive aspects of community care, and should pay greater attention to the management training that would be required.

The reports of special studies and workshops undertaken during the past three years were reviewed. These included a workshop on the contribution of medical schools to national health development; action on the implementation of the code on the marketing of breast-milk substitutes, and other medical-legal issues; a report on community health education in Commonwealth countries; and a survey of policies and programmes for disabled people in the Commonwealth.

A special recommendation was made that the Commonwealth Secretariat should establish a facility to enable it to respond flexibly and appropriately to national and regional needs in relation to the prevention of disabilities. Special attention was drawn to the need for increased emphasis on prevention in the education of doctors and other health progressionals and for appropriate curricular changes.

Another recommendation was that at the national level multisectoral health planning committees should be established to deal with the complex range of issues which lie outside the normal areas of responsibility of health ministries. These would facilitate the restructuring of administrative and management systems to meet demands for preventive and primary health care initiatives.

At the regional level, it was recommended that health education institutions should be encouraged to share resources and to extend and strengthen their personal training capacities and their research capabilities.

Pan-Commonwealth co-operation was recommended in a request to the Commonwealth Secretariat to set aside resources to enable it to consult with and assist ministries of health wishing to develop new programmes of health manpower planning and development.

Ministers expressed their warm appreciation for the excellent arrangements made for their meeting and the generous hospitality of their Canadian hosts.

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