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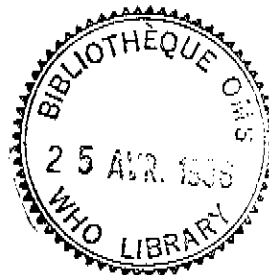
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PLANNING AND MANAGEMENT FOR HEALTH  
IN PERIODS OF  
ECONOMIC STRINGENCY AND INSTABILITY

by

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## INTRODUCTION

The mid 1970's mark the end of history's longest period of uninterrupted economic growth and initiated in Europe a period of economic stagnation and instability. Along with the prosperity explosion in the past the pattern of health problems has been changed. Moreover the demand for care kept on rising without much improvement of health status in general. Thus, there is a critical need to rethink how to ensure that the necessary changes occur within the limits of shrinking resources and the allotted time span. This change of priorities envisaged by the Health for All - 2000-strategies will need to take place against the background of an aging population, social instability, further development of new lifestyles and continuing economic scarcity

The purpose of this paper is to analyse the changed planning conditions in periods of economic stringency and instability and on this basis to make recommendations as to whether and what type of health planning and management might successfully cope with the policy reorientation on the basis of the HFA 2000-strategy. In its core, this document is not devoted to an evaluation of cost containment policies.

The plan of the paper is as follows:

First an overview will be given of health development in relation to the past, present and to expected future economic trends (sections 1 - 10).

Then an analysis will be made of cost-effectiveness in health, special attention being given to experiences across countries. In addition the basic issues have been mentioned which need to be solved to make planning and management in health effective (sections 11 - 23).

The changing planning conditions will be reviewed on the basis of a framework for analyses defined as the ' planning environment '. Following this framework the changed conditions for planning and management will be discussed in a period of economic stringency and instability. Also the requirements will be mentioned needed for improvement of the effectiveness and efficiency of planning (sections 24 - 50).

Finally, a limited number concepts of planning will be listed. The point of view will be elucidated that the selection of a particular concept of planning and management will depend on the objectives of the decision maker and on the determinants of the planning environment.

The document will be completed by a list of recommendations with respect to research and training.

The paper is written on request of WHO and put forward as a discussion document for the European Conference on Planning and Management to be held in The Hague from August 27 - September 1, 1984.

1-10 GROWTH WITH SCARCITY

1-4 The Economic Perspectives of Europe

1 From 1945 to 1975: The thirty glorious years

As expressed by the title, in his book "Les trente glorieuses, ou la révolution invisible de 1946 à 1975", the French economist Jean Fourastié (1979) has called the great economic and cultural boom after the Second World War "The thirty glorious years". In this period prosperity grew probably like never before in the history of Europe. Purchase power went up by jumps for the majority of the people, while working-hours were reduced. Within a few decades the concern for one's existence which had weighed so heavily on previous generations has been taken off the shoulders of the present one. And young people suddenly and unexpectedly achieved what their parents had hardly dreamed of. However, round 1975 the explosive progress of the thirty glorious years became to an end. Particularly after the oil crisis real growth of the world economy sharply slowed down.

2 The Economic Recession of the Mid 1970's

This economic recession struck not only the traditional industrialized countries of Europe and North America, but also the new industrialized power of Japan, where real growth went down from 10% before the oil crisis to less than 5 %. And not only the "open-market" economics suffered from the economic contraction but also the growth of the "planned" economics of the socialist countries seemed to slow down. And because of their relatively low level of economic development in particular the countries of the "third world" were most badly hit by the recession. At the same time a process of drastic change of the international economic structure had taken place. The increasing significance of Japan, the rise of the so-called New Industrialized Countries (N.I.C.'s), the developments around

the OPEC-countries, the ever growing gap between "developed" and "developing" countries and the process of stagnation in important market sectors in USA and Europe have changed the international pattern of industry and trade. Within this picture the position of Europe in general is considered to be relatively weak. Reasons for the unfavourable development in Europe are: the fragmented market structure, absence of dynamic competitive relationships and defensive, conservative industrial policies.

3 The Economic Development to the Year 2000

The slump we are experiencing now seems to be quite different from the previous short economic fluctuations of the general upward trend. The impression exists that the recession which started in the mid 1970's initiated a long term downward wave which may cut deeply into the economies of various nations. The causes of stagnation in Europe are structural by nature, and therefore difficult to remedy in the short term. For this reason the European industry may not be fully able to meet the competition of enterprises operating from the USA, Japan and the New Industrialized Countries. In the period 1975 - 1983 these countries were able to create tens of millions of "new" labour posts, whereas the member states of the European Community (E.C.) for instance, were not able to create half a million new posts. Also the level of total investments decreased, and even the balance of trade of high technology products with the rest of the world is showing deficits from time to time. On the basis of these facts most experts tend to expect that the future of Europe will remain relatively unfavourable for many years to come, with restricted economic growth and continuing unemployment in a great number of countries.

4 Economic Stringency and Instability

During the years of economic expansion most European countries could afford to solve health problems by increase of resources.

The present situation and economic outlook have abruptly and completely changed the scene. When the money to be spent is rather limited and the resources are scarce, as is the case to-day, choices have to be made, also in health, and additional means have to be required by substitution of services and reallocation of resources. Moreover the volume of economic support to the health sector may not only be restricted, but also fluctuating in the short term. Governments confronted with economic set-backs and unforeseen budgetary deficits are enforced to find compensations for the shortages a.o. by cutting the health budgets. These interim budgetary corrections may cause uncertainty, frustrate long term planning and contribute to political unrest.

5-7 Trends in Expenditure on Health

5 The Relationship of Economic Growth and Health Expenditure

The size and strength of the national economy is an important background influence on health systems. Differences in human welfare between nations are expressed in differences in the level of development of health resources. Great differences in this respect can be observed between "developing" countries, and "developed" countries. Also within Europe there are still differences between national health systems because of differences in national income. In centrally organized economies "health planning" is an integrated part of the overall socio-economic planning and health resources are in principle allocated in accordance with the changing economic circumstances. But in states where health services are predominantly in the private sector and the reach of planning is limited and fragmented, this relationship between the economic circumstances and the development of health services can be demonstrated as well. It has also been shown that if the national income rises one tends to find a higher share going to health care. However, when economies stagnate, as is the case now, to push down that share of Gross

Domestic Product proves to be very difficult, if not impossible.

6 Cost-Containment: a Principle Issue of Health Policy

During the thirty glorious years expenditure on health care has been rising substantially faster than the gross national product. This trend caused little concern in most countries during the 1950's and 1960's, when rapid economic growth made it possible for real disposable income to increase, despite the parallel growth of public expenditure, including health. In many countries, the coverage of national health insurance was being expanded and a widening range of services was being provided. The extension of health care was seen as part of the results of growing affluence and the right to health care was increasingly accepted, as an integral part of socio-economic development. Although it had been recognized before, that health care spending could not go on rising continuously as a proportion of national resources and remain unchecked, it was the changed economic outlook which forced countries to try and come to grips with the problem. In some countries there were signs of tax resistance which brought political response. Also security schemes have been faced with a crisis of financing. The number of contributors fell or ceased to rise as a result of growing unemployment. Income has no longer growing in real terms. At the same time, provision has to be made for the growing number of unemployed on top of the rising number of pensioners. It is in this wider context that health expenditures has become a matter of major concern and of utmost political priority in nearly every government in Europe.

7 Reasons for the Increase in Health Expenditures

The reasons for the continuing increase in health expenditures differ between countries. There is no doubt that some or all of the following factors constitute sufficient explanation of what has occurred in the majority of the European countries:

One of the most powerful determinants of rising health expenditures in the past three decades has been the relationship of spending on health care to how well, or poorly, a country's economy is doing.

Factors at work in this respect are: an expansion in coverage of health insurance and/or in the scope of services provided, higher relative remuneration for persons working in the health sector, partly due to equal pay for women, the expansion of physicians (and dentists) per 1000 population leading to a large number of authorised services and an increase in hospital beds and the rebuilding of hospitals.

A second determinant is demographic change.

The impact of aging on health expenditures is one of the single-most powerful factors in past cost increases and in future ones. The elderly in any health care system use resources in a ratio 3 - 1 compared to other age groups, and most European countries have already reached the 'greying' stage, with rising dependency ratios.

Thirdly: The advancements in technology have been dramatic. Technology has proved to be expensive and since health care is labour intensive new technologies have raised both the capital expenditure and running costs.

The fourth determinant of rising health expenditure is the inefficiency of organization of delivery systems. As a consequence of medico-technical developments together with the major elements making up costs including remuneration and financing, the hospital sector has become subject to a disproportionately large part of the strain. Hospital-centrism has dominated health care systems in many countries, whereas preventive care and ambulatory health services have not developed as greatly as they might.

Finally also inefficiencies in finance systems, and in particular the inefficiency of incentives for use on providers and consumers

has contributed to the problem of disproportionate increase of health expenditure.

8-10 Socio-Economic Development and Health

8 Economic Development: a Major Factor in Improving Health

Economic development has not only determined the size and quality of health services systems and the level of health resources, but it has also, and almost independent of this, improved 'health'. It has been demonstrated that the historical role of health care in the reduction of disease levels and death rates has been limited and less important than economic development, expressed in improvements in nutrition, water supply, and sewerage. From analyses of one country's mortality experience since the beginning of industrialization, (Great Britain, for instance), it has been shown that improvement in nutrition has been by far the most important factor in reducing mortality, particularly from infectious diseases, which previously caused the majority of deaths. Improvements in hygiene, housing, and working conditions made a substantial contribution to reducing water-, food-, and vector borne diseases. It has also been shown that these improvements were protected and enhanced by a fundamental behavioural change, namely the reduction in the birth rate. Finally, preventive and therapeutic personal medical services, which arrived comparatively recently in the development sequence, have (with some exceptions) made comparatively little difference to mortality and life expectancy overall, but have helped maintain or accelerate pre-existing trends.

9 The Paradox: Prosperity as the Main Cause of Disease

So much for the past. What of the present and the future? On the basis of above historical trend analyses we should have been able to predict our health problems from the socio-economic characteristics of our advanced mostly industrialized societies.

In 1974, in his opening address of the first European Conference on National Health Planning in Bucharest, Dr. Leo A. Kaprio placed health in the general context of development and stressed the paradoxical situation that prosperity is not longer contributing to further improvement of health, but seem to turn into the main cause of illhealth and disease.

Indeed the health problems in the prosperity explosion of the thirty glorious years are different from those in the period before. Ironically nutrition is still a major factor, but now overnutrition and alcohol consumption, made possible by high income, have become fundamental causes of disease and death. It is clearly factors related to socio-economic development that again are affecting health. However the emphasis has largely shifted from areas dependent on social action, like basic nutrition and environmental protection, to areas of personal behaviour concerning nutrition, alcohol and smoking. At the same time cultural patterns in the field of personal lifestyle, marriage and living together, upbringing and education, church and work are changing at a tremendous rate. Instead of the pre-dominant uniform models in all these areas of life, a fundamentally wider variety of lifestyles and social institutions is going to develop.

As pointed out in the Regional Strategy for attaining HFA by the year 2000 (EVR/RC30/8, Rev. 2 1982) most of the health problems in Europe are caused by new lifestyles and physical and social environmental factors, albeit that in the poorer parts socio-economic development still is essential from the viewpoint of health improvement.

10 Rising Cost and Low Effectiveness on Health

The unfavourable economic perspective, and within this context, concern about the rising cost of health care, has led to a re-examination of what is being obtained for the money spent in terms of improved health. Abel Smith (1984) has summarized the findings as follows:

- the rapid increase in spending in real terms has not led to a commensurate improvement in standardised mortality rates;
- there are no clear correlations between standardised mortality rates and the proportion of GDP spent on health care, i.e. spending more does not necessarily buy you better health;
- in countries which have data, there has not been a narrowing of relative differences in mortality rates between different social classes.

Naturally at the present level of health which has been achieved in Europe, mortality rates have become less relevant indicators. Measures of disability, discomfort and dissatisfaction are more important. Data using such measures are, however, not yet available for most countries, and such data as are available are based on varying definitions. The only complete and comparable information covers mortality. The significance of abovementioned findings can be criticised, therefore, on the basis that mortality rates are seriously incomplete measures of health status. On the other hand, in so far as they do have a validity, these findings can be explained by the fact that the main determinants of the health of the populations of advanced societies lie outside the field of health care in the economic and social environment and in the lifestyles of individuals and families.

11-23 IMPROVING COST-EFFECTIVENESS IN HEALTH

11-18 Planning and Cost-Effectiveness in Health

11 The Similarity of Problems Across Countries

Health planning seems a logical way to restrain cost and to improve health effectiveness. And in periods of economic stringency and instability as we are experiencing to-day, and have to anticipate for the future, planning becomes even more important. Actually this has been recognized by the majority of the countries in Europe and in the recent past action has been taken almost everywhere to extend the functions of health planning and to improve the related planning organization. However there exists also considerable doubt whether health planning is effective as an instrument to contain cost and to improve health effectiveness. This question seems to be justified since the problems of rising cost and low effectiveness are not confirmed to a particular political administrative environment, but are more or less the same for all European countries. This suggests that the problems are universal and independent of the characteristics of national health systems and the scope and reach of health planning.

12 The International Experience

International studies of global indicators over the period 1960 - 1982 show indeed that the trend is comparable throughout Europe. Recent OECD-figures prove that as a proportion of Gross Domestic Product (GDP) total expenditure on health care nearly doubled in this timespan, at least in the non-socialist countries. As mentioned earlier the growth of real incomes, demographic change, the advancements in technology, and inefficiencies in the delivery of services and financing have found to be the main determinants.

But in the year 1982 the share of total health expenditure in

GDP still varies considerably between countries. Up to 1975 this country variation could be explained to a large extent by differences in rates of economic growth. To-day however other factors may also become of importance to explain the differences in the share of total expenditure in GDP, in particular between those countries which have reached approximately the same level of wealth and health. Outside Europe it may be instructive to look at Canada in comparison with the USA. Canadian health care expenditure in total, per capita, and as percentage of GDP over three decades contrast the very different US-experience. While the Canadian percentage has fluctuated between 7 per cent and 8 per cent since 1970, the USA has risen to far over 10 per cent. This divergence between Canadian and US experience dates from 1971, when Canada's national health insurance programme became nationwide. Earlier, when Canada's funding system was broadly similar to that of USA, so was the cost experience. But the two delivery systems have remained similar, with medical services provided primarily by private practitioners reimbursed fee for service, and acute care hospitals owned by voluntary societies and run by boards of trustees. Evans concludes that it is the funding system which is critical. The universal public insurance programmes in each province which reimburse all hospital and medical costs through direct budgetary allocation and fee schedule negotiation, respectively, make expenditure control not easy, but possible in Canada. The fragmentation of funding sources between private out-of-pocket payment, private for-profit and non-profit, adjusted by public programmes, which characterizes USA now, and Canada prior to the public plans, does not. Both countries prefer minimal government involvement and practice little planning, but in spite of great efforts planning in USA seems not to be effective whereas in Canada it is. Comparisons of the same global indicators in Europe may lead to similar conclusions.

There are numerous differences between health systems in Europe, and planning and management approaches to the health sector show a wide variety. No country is the same. Nevertheless it may be permitted to cluster countries into 5 different groups which share common features: Central and Western Europe, United Kingdom, Nordic countries, Mediterranean countries and the Socialist countries of Eastern Europe.

13 Central and Western Europe

The countries clustered within this group, i.e.: Austria, Belgium, France, Federal Republic of Germany, Netherlands and Switzerland apply only minimum government controlled planning with regard to the health sector and are generally characterized by social insurance systems in which compulsory contributions to sickness funds are used to pay health expenses on a 'fee for service' basis. The volume and quality of services, tariffs of prices and rates of remuneration are in principle established by a process of negotiations between parties. Broadly speaking the degree of territorial decentralization in the health sector is still limited in most countries within this group. For the year 1982 the economic situation in health expenditures as a percentage of GDP has been calculated by OECD to be in the range of 7 - 9 percent. Belgium seems to be an exception (6.4 per cent of GDP). As from 1975 onwards the indicators in these countries kept on rising with exception however of the Federal Republic of Germany.

14 United Kingdom

Contrary to the predominantly insurance based national health systems of Central and Western Europe, in the UK health care is completely nationalized and almost fully (88%) paid for out of the general tax revenue. Cash limits are set for current and capital expenditure on health services, and the available funds are allocated by the Department of Health and Social Services to

the administratively deconcentrated Regional and District Health Authorities. An extensive, formalized planning, programming and budgetting system has been in operation nation wide for almost 10 years now. In the period 1975 - 1982 the share of total health expenditures in GDP in this country have been in the range of 5.5 - 5.9 per cent of GDP.

15 Nordic Countries

Also in Denmark, Norway, Sweden and Finland the health services are run by government, in particular by health authorities at the intermediate level (counties) or the local level (municipalities) or by both authorities on the basis of a predetermined division of tasks between these echelons. County- and municipality councils are elected bodies, and entitled to levy taxes which revenues are supplemented by the State. In all of these countries formal planning and budgetting has been practiced for many years now. In 1982 the shares of total health expenditures in GDP of Denmark (6.9 per cent), Norway (6.8 per cent), and Finland (6.8 per cent) were ranking higher than in the UK, but remained below the figures calculated for the countries of Central and Western Europe. In contrast to the lastmentioned group the increase of the indicators have been between narrower limits i.e. between 6.5 - 6.9 per cent of GDP for the whole period 1975 - 1982. However Sweden is the exception. In 1970 this country was already at the same level as Canada and the USA, and the share of total health expenditures in GDP went further up from 8.0 per cent in 1975 to 9.8 per cent in 1982. Obvious reasons for the differences are the lack of strict budget control at the national level in Sweden and the strongly deviating organization of the health services.

16 The Mediterranean Countries

The Mediterranean countries are in a transitional phase, and

are moving towards national health systems fully controlled by the State, and based on territorial decentralization. In principle financing is or will be effectuated in this group of countries out of general tax revenues. In addition government controlled and decentralized planning and budget systems covering the whole of the health services have been or are going to be introduced. Italy was the first which fully changed the administrative framework of its health system by the establishment of the Servizio Sanitario Nazionale (1978). Portugal established its National Health Service in 1979, and is available to the whole population. But the organization of the services is still in a process of reorientation and integration. In 1982 Greece has taken the first steps for a fundamental reform of administration and financing. And just now (1984) Spain is discussing the legislation for a complete reform as well. Turkey decided in 1961 to establish a NHS, which was initiated in the Eastern provinces first and from there expanded to the other provinces. This process has not yet been completed. Total health expenditures both per capita and in percentage of GDP still reflect the differences in economic growth rates. In the period 1975 - 1982 the second mentioned indicator fluctuated in Italy around 7 per cent, in Portugal around 6 per cent, in Spain between 5 - 6 per cent, and in Greece between 4.0 - 4.4 per cent. No figures were published with respect to Turkey.

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#### The Socialist Countries

In the socialist countries health planning is part of the nationwide socio-economic planning system, run by the State. Traditionally health planning has a multi-sectoral scope, and is effected by a territorially decentralized framework. Also for this group of countries global indicators have been estimated, showing that the share of total health expenditure in GDP is in the range of 5 - 6 per cent.

18 Differences in Efficiency of Health Systems and Health Planning Across Countries at the Aggregate Level

Naturally the results of international comparisons at the aggregate level should be considered with caution. First it is important not to overemphasize the relationship between health expenditures and GDP. The scope and range of health activities may be different in different countries because of various restrictions of rights of patients and health professionals and the existence of public and private co-payments. Also the definitions of cost and GDP may be different. Thirdly the percentages may reflect fluctuations in growth rates of GDP rather than improvements of cost effectiveness. And finally as from 1975 onwards planning has partly been replaced or adjusted by different cost controls so that the effects of planning cannot be isolated from other cost containment policies. Thus no wholly valid conclusions can be derived from comparing the data. Taking these limitations into consideration, the differences in the extent of government regulation and intervention and financing are sufficiently significant across nations to conclude that countries which apply state planning models are in a better position to keep costs at the required level. In particular, the system of financing is of importance in this respect and the linkage between financing and planning. Countries which combine government controlled planning and tax based financing have proven to be better equipped to control growth under conditions of scarcity. There are exceptions, but these are few.

19-21 Planning and Cost Containment in Health

19 Effects of Cost Containment Policies in Different Countries

Recently published studies show that most countries under the pressure of scarcity have been able to produce a marked dece-

leration in the growth of health costs in relation to GDP. It is noticeable in this respect that the Federal Republic of Germany, where the average annual growth rate over the period 1966 - 1975 of approximately 7 per cent was brought down to 1 per cent over the period 1977 - 1982. In this country Federal Government has no formal controls over any of the costs of health care. By law the health insurance funds have been entrusted with cost control. This result has probably been achieved by the 'concerted action for health' a legally based forum, in which all parties concerned -both private and governmental- are represented. This forum established the ceilings for the increase of tariffs, rates of remuneration and various cost categories, including hospital costs, in a process of negotiating. As health insurance covers 90 per cent of the population, controlling the cost of health insurance controls the vast bulk of health expenditure. This 'annual decision making process on the basis of bargaining between interest groups' is not considered as planning in Germany. The aim of the concerted action to fix targets which keep the total growth of health expenditure in line with the growth of national resources has also been achieved in quite different political, administrative settings and on the basis of 'formalized' planning.

20

#### Measuring Effects of Cost Containment Policies

Comprehensive health planning comprises a complete package of controls to restrain cost and to improve health effectiveness both in the short and the long term. However in a number of countries the application of planning is much more restricted and is considered as one instrument amongst others. With respect to cost containment many different mutually complementary and substitutive measures may be chosen in addition to planning. For most countries the practical problem has been, and still is, how to find politically realistic ways of moving towards greater economic efficiency in the very short run.

If the existing planning methods have to be found inappropriate for these purposes, or the planning organization is considered inadequate or is still lacking, policymakers tend to prefer pragmatic solutions which can be initiated without involving the planning agencies. The choices made in particular countries are inevitable strongly influenced by political considerations. And what is politically feasible in one country may not be in another. Thus the mixes of cost containment measures are showing great variations between countries. In addition the share of planning may be different from country to country. Consequently the effectiveness of health planning as an instrument to contain cost cannot always be verified without more detailed analysis. Important in this respect is that in particular cost containment policies are monitored in the national situation to determine what effects these measures are actually having after they have been implemented. .

21 Health Planning: a Comprehensive Cost Containment Strategy

This paper is not devoted to an evaluation of different cost containment policies. Nevertheless, three broad conclusions may be in place.

In general cost containment policies are concerned with the limitation of increases in expenditures, and tend to neglect the effects of these policies on volume and quality of health care delivered. Also cash limits which have proved effective in controlling aggregate health expenditure, in both national budget systems, such as in Finland, and in the UK, and in the Bismarckian model of health insurance schemes, such as in the Federal Republic of Germany, leave unresolved the problems of resource allocation in accordance with the quantity and quality of health needs.

Present approaches to restrain cost tend to neglect the relationships and interdependencies within health systems, and may

cause unforeseen side-effects and confirm existing inequalities.

Cost containment policies which are being carried out in the present years of economic scarcity are generally confirmed to the short term without much consideration to eventual long term effects.

Health planning carried out as a comprehensive cost containment strategy could, at least in principle, reduce most of these failures. It may be permitted to refer in this respect again to Finland. This country succeeded to keep control over cost development, relying on strict budget limits and long term planning. In the 1960's the expansion of hospital construction has been regulated on the basis of planning. And in 1972 these efforts have been extended to primary health care with the result that the intended network of primary health care centres has been completed now (1984), with full coverage of the country. In this way the Finnish authorities were able to organize a shift of patients from specialized hospitals to lower cost neighbourhood health centres. Shifts in preventive/curative-mixes of health policies in accordance with the changing needs, reorientations of health systems towards a more economical balance of services and consistent reallocation of resources are probably more efficient measures to proportionate reduction of health expenditure. A long term view, as has been demonstrated by Finland, is essential. In this respect planning as a comprehensive cost containment strategy may be superior in the end to different controls and steering mechanisms which are not related to each other and only effective in the short and medium long term.

22-23 Planning and Cost Effectiveness Analysis

22 The Need for Incentives to Induce Efficiency

Planning by itself does not remove the fundamental defects of health systems. The first fundamental problem faced by all countries is the

absence of incentives which induce decision makers to strive after the efficient use of resources. The design of health systems, both national budget systems or private insurance systems have removed the price barrier to consumption to the patient. Care is provided almost free at a highly subsidized price, and has ensured that the cost constraints on physicians are minimal. In both types of systems the costs are borne by the taxpayer, respectively by the sickness funds. Thus all types of health systems encourage patients to maximize consumptions regardless of costs. Patients have no incentive to economize. The main decision makers on the supply side, the doctors have no incentive to economize either, especially as they have no idea of the cost of their decisions. Because of the ethic to provide the best care for the patient in charge, quite naturally doctors seek to maximize the benefits of health care regardless of costs. Thus whether it is believed that the patient or his doctor is the demander on his behalf, both demanders and suppliers have no incentives to be careful in their use of society's scarce resources. Not only are the incentives inadequate but also, as Maynard and others have pointed out, perverse. Some elements of payment, in particular remuneration of doctors and pricing of services are inducing less than efficient responses. For these reasons health planning will not improve cost-effectiveness, unless appropriate incentive systems are designed and implemented.

23

The Need for Information about Cost-Effectiveness

One of the more intractable issues preventing an evaluation of health systems is the absence of comprehensive information at the macro level about inputs and outputs and of the processes between these two elements. Also at the operational level this problem exists, as the majority of health care therapies in use to-day have not been evaluated in a scientific fashion and hence may lack efficacy despite their high cost (Cochrane). There is no agreed means of placing a value on the outcome of a parti-

cular treatment or, at the margin, on the extent to which it should be pursued, and at what cost in return for diminishing incremental benefits to the patients. Again the context is one in which resources used in one direction must be assessed against the benefits of their alternative use elsewhere. This problem is further complicated by the wide differences in the type, cost and duration of treatment applied to similar disorders. It is difficult therefore for policy makers (and planners and managers) to oppose the introduction of new therapies or to make choices between competing technologies without evidence of relative advantage of outcomes and costs. The need to acquire better information about cost-effectiveness is essential. Therefore, health planning will not improve cost-effectiveness, unless the appropriate information is being made available at the key levels of decision-making.

24-50 THE CHANGING ENVIRONMENT OF HEALTH PLANNING AND MANAGEMENT

24-26 The Concept of the Planning Environment

24 Determinants of the Planning Environment

Changing consecutive periods of economic scarcity and differences in economic circumstances across nations influence the 'context', in which a health planning agency is operating. Not only the economic conditions are of importance. Changing health problems and the preventive-curative health policy mix or set of output functions determine largely the scope of planning for health. Also the characteristics of the health services system is influencing the planning environment next to the resources (or inputs) which the system need to carry out its functions. This whole complex has to be regulated (a.o. by planning and management). The health system in any country is part of its social and political setting. This factor in particular is colouring the environment of planning and management.

Other background factors which have impact are: the extent of government intervention and regulation, the institutional framework of health administration, the existence of multi-sectoral co-ordination, the balance between centralization and decentralization, the characteristics of decision-making processes in health, the degree of legalization of processes of decision-making and the role and power of the actors involved, styles of management and financing systems. In case the economic situation is changing most of these factors, if not all, will react, and in different fashions. In addition some of these factors are influencing each other. This set of different, mutually dependent and interrelated factors are determining the 'planning environment'.

25 Different Concepts of Health Planning and Management

Usually a different environment requires a different concept of planning and a different concept of management, which have to be adapted in the course of time. In periods of 'economic expansion' the style of planning and management may differ from the 'style' needed in periods of 'economic contraction and instability'. This line of reasoning is of practical value, in particular from the political and administrative point of view. Decision makers are selecting certain approaches of planning to achieve their objectives. But the feasibility of the selected approach has also to be taken into account. This means that before a particular concept of planning can be selected the characteristics of the planning environment has to be considered. To express this differently: decision makers may accept a particular planning approach, or parts of it, but refuse others on the basis of their judgement that - under the circumstances - the changes of purposeful application of one particular concept of planning, or parts of it will be estimated as 'high' and of other concepts 'low'. The basic idea is that there is no single solution which is 'best' under all circumstances. Whether a concept of planning is the best one,

can therefore in general not be decided on beforehand, but is largely dependent on the objectives which have to be achieved and on the situation in a certain place and at a certain point in time.

26 The Need for International Contingency Research

The identification and testing of the relationships between the characteristics of environment of planning and (parts of) concepts of planning would allow to formulate empirically founded planning methods. The same would be true for management styles. At this moment in the health sector this information on situational determinants of different approaches is largely unknown. It is impossible to recognize the characteristics of the planning environment and to relate these to the situational determinants of different concepts of planning, and make choices. Therefore international contingency research should be undertaken to fill this gap in our knowledge.

27- 31 Improving Health in spite of Scarcity

27 Conflicts in the Health Sector

The planning environment has altered by the change of health problems and by the recognition that fundamental changes are needed as envisaged by the strategy for HFA 2000. Implementation of this strategy requires decision making on priorities in terms of health, a major shift in the preventive-curative health policy mix, a multi-sectoral approach, and reorientation of health services systems. In periods of economic stringency and instability conflicts may arise with respect to these issues.

28 Conflicting Aims between Actors

Growing health problems in contrast to shrinking resources can only be solved by explicit priority-setting. Variations in economic

circumstances may cause, sometimes with a time-lag, undesired variations in overall morbidity and mortality rates. Thus in periods of severe economic pressure governments may decide to give even higher priority to health in general and enlarge the budgetary room for the health sector (as in Poland). Most countries however have put on the brakes. The challenge here is to improve health in spite of tightening budgets. It would be recommendable under the circumstances to start off the planning process by formulating priorities in terms of levels of improvement required in health (as stated in the WHO-document on targets, 1983). This approach introduces a substantial change in planning which has been noticeably weak in the specification of targets in health terms. In the past periods of growth in planning the emphasis has been on resource inputs allocation and on financing. And most planning of to-day still is highly resource oriented. The government bodies and other institutions in charge of socio-economic policy and finance will prefer resource inputs planning because this type of planning is easier to monitor and to keep under control. Hence a conflict situation may come into being between the actors in the planning process. The health authorities will defend the need for health improvement and assurance of quality standards. The group of socio-economic and finance authorities will stress the importance of cost containment. In periods of economic stringency the health authorities, usually will receive little room to concentrate on health improvement unless they can prove that the consequences on cost of the proposed policy changes will not outrange the ceiling which is set on growth.

29

#### Conflicts between Short-Range and Long-Range Aims

One of the attractive claims made for prevention is that it can help slow the relentless growth in medical care expenditures. This is possibly the case in the long term, but in the short term effects of this type cannot be expected. Consequently, there is a

conflict situation between short-range and long-range aims. In periods of scarcity it is unlikely that increased health promotion and disease prevention may be seen as a reason for cutting down on the health services. In contrast, it is quite possible that traditional curative health services will get the highest priority. Referring to technological advancement, clinical hospital specialists will make attempts to attract a disproportionate share of diminishing resources. These requests are justified to a certain extent and coincide with the expectations of the consumers. Politically these actions are very difficult to resist. Budgets of health promotion and disease prevention belong to the responsibilities of governments, also in countries where financing predominantly is based on insurance. In general health promotion and disease prevention are easier targets for short term savings than specialized curative care. In addition to this comes that it is difficult to prove the cost effectiveness of preventive care in comparison with curative care.

30

#### Conflicts between Sectors

The promotion of lifestyles conducive to health and the reduction of preventable conditions cannot be effected without intersectoral approaches. With respect to health actually all sectors are involved. Basically there is always an underlying conflict situation with respect to responsibilities and budgetary obligations. Under economic pressure and instability these conflicts between sectors may worsen, as they all are confronted with budgetary deficits. Quite naturally each sector tries to solve its own problems, if necessary even at the expense of other sectors. These mechanisms prevent effective multi-sectoral collaboration. The experience learns that other sectors refuse to accept increases in their budgets for sharing new responsibilities in health activities with the health sector without budgetary compensation.

31 Conflicts between Services

The reorientation of health services which is part of the HFA 2000-strategy comprises strengthening of primary health care services and a reduction of the bed capacity of specialized hospital services. Budgetary neutral substitution of specialized institutional services at the secondary care level by general ambulatory services at the primary care level will ultimately result into a more economic balance of services within the health system, as has been shown in the case of Finland. Budgetary neutral shifts between services are in accordance with the overall goal of cost containment. However in the majority of cases it has not been feasible to realize the intended substitution between services so that total health expenditures went up because of the extension of primary health care. Budgetary neutral shifts between services are not possible unless strict cash limits on current expenditure and investments are applied. Application of strict limits may cause conflicts between services, in particular when these ceilings are lowered along with the need for additional structural savings. The same 'passing the buck-mechanism', to which is referred earlier, will cause discrepancies within the system. The strongest group of actors within the system i.e. the clinical specialists operating in short-stay general hospitals will succeed in attracting a disproportionate share of the limited resources. As a consequence, health policies directed to a strict control of health expenditures will be implemented at the expense of the weaker services sectors, such as primary health care, mental health care, care of the elderly and care of the handicapped

32-34 The Socio-Political Context of Planning

Ideologies, Norms and Values

The health system in any country is part of its social and political setting. In respect to health planning principal features are ideolo-

gies, norms and values. Different ideologies, norms and values are at the roots of the value placed in society on health, the choices made with respect to the balance between collectivism and individualism and the decisions taken concerning the degree of equity in the distribution of services and resources. These socio-political foundations of health systems are deeply rooted in society and are not changing rapidly.

33 The Political Context

The political situation at a particular point in time has a great impact on the planning environment. Changes in the socio-political foundations of health systems usually require changes in the power structure. Major changes in health policy need political will and the support of a group which is politically large and strong enough to carry out the designed plans in spite of the resistance. Generally speaking, health is not an important political issue. Although the HFA 2000-strategy is based on certain preferences with respect to the main political choices, it never provoked a major political debate. The economic recession changed the pictures in a great number of countries, as the health sector has been found to be one of the main causes of the disproportionate increase of public expenditure and budgetary deficits. For the first time now political pressure is there, but it is coming from forces outside the health service. Under these circumstances it may happen that short term savings are demanded and also acquired without sufficient attention being paid to existing health priorities. Long-term structural developments are threatened to be interrupted, postponed or discontinued, and cause instability. Besides these negative effects there are also positive effects, as political interest has come into being with respect to the cost effectiveness of health interventions. By tackling this question the political debate is moving towards the most central issues, such as the 'limits of care', which draw the boundaries between what is technically feasible and what is socially and ethically permissible.

34 Attitudes towards Planning

The differences in attitudes towards planning are reflected in the 'classic' discussions on the relations between 'planning' and 'freedom'. Even to-day these discussions about the possibilities or impossibilities of planning as an instrument for promoting freedom are colouring the literature. 'Orthodox' or 'classical' planning for instance has been rejected by some authors because it limits freedom, leads to rigidity and requires technical methods. 'Modern' planning is considered to be better because it is more open, flexible and takes the political aspects into account. Differences in attitude are also reflected in the debates on 'planning' and 'rationalism'. Ten years ago, at the first European Conference on National Health Planning, Brotherton referred not without reason to this discussion by distinguishing 'rational planning' in contrast to 'anti-planning'. And this argument of 'reason' versus 'faith' is still a topic to-day. Although there is not much proof of their validity, these beliefs still have great influence on the acceptance and application of planning. In periods of economic stringency and instability these conflicts between these opinions, or beliefs, are becoming more explicit. Whereas in some political groups in society the main trust remains in planning, in other parts the opinions are dominated by the conviction that the extent and reach of planning should be more restricted.

35-39 The Political-Administrative Setting of Planning and Management

35 The Main Characteristics

The political administrative context in which national health systems have to be built and are functioning is an important background factor influencing the environment of planning and management. Main issues are the extent of government regulation and intervention, the institutional framework of the health ad-

ministration, multi-sectoral co-ordination, and the balance between centralization and decentralization.

36

The Extent of Government Control: the Market versus the Collective Model

The extent of government regulation and intervention is largely determined by the socio-political foundations of national health systems, and may range from 'maximal', when society takes full financial and organizational responsibility for the provision of health services, through 'moderate', when financial and organizational responsibility is shared between society and the individual to 'low' when society assumes little financial and organizational responsibility. This 'public/private mix', may also depend on what is considered the 'collective optimum' and the extent of individual tolerance of government regulation and intervention. In the past the public has come to demand access to health care as an inviolable human right. Political acceptance of this demand has enforced throughout Europe a shift from private to public financing, which resulted in increasing government control. However, under the pressure of the economic circumstances the 'market model' has been advocated again, which may lead to rebalancing the collective optimum. If the state fails in its efforts to regulate the public sector's provision and finance of health care, it can divest itself of these functions i.e. they can be 'privatized'. However whilst such policies may reduce public expenditure, the overall effect on total (social) expenditures on health care is unlikely to lead to economy, as the fundamental problems involved in the delivery of health care remain. The private financiers and providers will ultimately face the same pressures that are generated in a public system, as can be seen in the United States. They will respond to these pressures by self-regulation i.e. the private insurers will seek to control the prices, quantities and quality of health care (Maynard and Ludbrook). Both the market and the collective model have limitations and the achievement of the objectives of liberal freedom and socialist equality is obstructed by similar forces: monopoly power, lack of

incentives to induce efficiency and lack of information about cost-effectiveness

37 Challenges of Health Administrations

The scope and range of tasks and responsibilities of the health authorities has been broadened over the years, along with the increasing role of government. The acceptance of the HFA 2000-strategy has considerably widened the field of activities, as it requires multi-sectorality of approaches. Within this context in Europe attention has been given to the linkages between health and social services. And in the last decade a great number of countries has taken legal and organizational measures to enforce the co-ordination of these two types of services. Closely connected with these developments is the decentralization of administrative tasks and responsibilities to the intermediate and local levels. Thus the institutional frameworks of the health administration care in a process of organizational change because of three reasons: the emphasis on primary health care, the growing importance of multi-sectoral co-ordination and the shift towards decentralization. In particular the ministries of health are facing these challenges. In accordance with this development health planning has gained in comprehensiveness. The planning activities have been extended to other sectors and have to be carried out over more levels of administration. This has aggravated the tasks of planning and management. At the same time the number of duties and the workload of planning has been increased on account of the economic problems. The daily struggle to find compensations for ad-hoc budgetary corrections has put great pressure on the planning agencies too. But in spite of the increasing workload most governments have to curtail their administrations. And what may be even worse, little budgetary room is left for innovation in planning, experiments and improvement of information systems. Under these conditions utmost efficiency is needed in planning.

38

Multi-Sectoral Co-ordination

There are marked differences between countries in the scope and range of tasks and responsibilities which are conceived as to belong to the health sector. Besides this, health policy seems to offer itself readily for a wide variety of organizational combinations with other sectors. From the viewpoint of health protection and health development, it is important to secure co-operation and co-ordination with other sectors, and mechanisms have to be developed for achieving this. But, the health sector is not free in the organization of multi-sectoral co-ordination. The political-administrative context in a country is usually settling the matter. Also there seems to be a low level of continuity in the organizational criteria for the health sector. Health responsibilities seem to shift easily from one government design to the other. Thus the possibilities of multi-sectoral co-ordination may fluctuate in the course of time. International experiences has also shown that new artificial structures which neglect existing mechanisms do not function. The establishment of multi-sectoral bodies may even weaken the position of the health sector than strengthen it, as other sectors tend to front the health sector in case of argument. In section 31 reference has already been made to the conflict situation which may rise between sectors in periods of economic stringency. This experience shows that it is probably more effective to apply more flexible approaches and to restrict the multi-sectoral initiatives to those subjects of which the expected cost-effectiveness can be demonstrated in advance.

39

The Balance between Centralization and Decentralization

The next issue which is setting the scene for planning is the balance between centralization and decentralization. In general also this matter is largely determined by the political -administrative structure in a country. In Europe three models exist: 'decentralization', 'deconcentration' and 'shared authority'.

The degree of decentralization in the health sector differs greatly amongst countries, and is continuously under debate, as the balance has to be struck between social and geographical equity on the one hand and responsiveness to local needs on the other. In the recent past in a majority of countries decentralization has been fostered by extending local autonomy. This general trend in Europe supports the implementation of the HFA 2000-strategy, as it promotes local decision-making and encourages community participation. The speed with which the change is envisaged can be more or less ambitious. While there are many cases of decentralization proceeding at a snail's pace, examples also exist of timetables that try to do too much too fast, which may result in a loss of control over the process, or in failure at the lower levels to deliver the services. Decentralization implies a new division of labour between the health authorities, new definitions of staff responsibilities, increasing managerial competence and probably an increase in staffing levels away from the centre. It has proven to be difficult to effect an increasing degree of decentralization without rising costs. Where pressures for political devolution are strong, there will be concurrent pressures to minimize interference from central ministries in the running of local services. This could lead to problems in the implementation of nationally agreed cost containment policies, mainly because of the 'upward push' towards increasingly sophisticated service and equipment. Moreover the local authorities are reluctant to share responsibilities with the central government to economize, as they are afraid, and not without reason - that by decentralization the burden of curtailment are shifted off to them. These are difficult and delicate issues, because local politicians can play a forceful role. Therefore the authorities in charge with cost containment and financing are usually in favour of centralization, and will urge to redress existing balances.

40-43 Decision-Making Processes in Health

40 The Main Characteristics

Next to the political administrative context which has been dealt with in sections 36-40, decision-making processes are influencing the planning environment. The main features are: the complexity of decision-making, the degree of legalization, the role and power of the actors involved.

41 The Complexity of Decision-Making in Health

Heterogeneity

A distinguishing mark of the health planning environment is the complexity of health problems and decision-making processes. The first characteristic of complexity is the existence of a great number of different actors with heterogeneous interests.

Variety

The second feature of complexity can be found in the nature of health problems. In solving health problems a great variety of factors has to be taken into account. Moreover between these variables exist interrelationships and interdependencies which have to be considered as well.

Quantity

Not only health problems are complex by themselves, but also decision-making processes in health are quite complicated. Health systems are social systems by which and within which decisions are taken, and these decisions have to be connected to each other. The more decisions there are to be made, the more complex these systems will become.

The socio-political development, the shift towards government control, the extension of the scope and range of tasks and responsibilities of health authorities, multi-sectoral coordination, decentralization, increasing democratization in a 'multi-actor' society, and last but not least the rationalization of decision-making processes, are factors which have driven up the number of decisions.

#### Uncertainty

The fourth element of complexity can be described as 'uncertainty'. This means that usually the information, or knowledge, is lacking to be certain about the outcome of decisions and the results of subsequent activities. Political changes, demographic trends, shifts in morbidity patterns, rapid development of technology and economic circumstances are the main causes of uncertainty in health matters. The possibilities of eliminating uncertainties are limited. Besides, reduction of uncertainty, not to speak of elimination of uncertainty, may easily exceed available budgets.

#### Complexity: in spite of or on account of Planning?

Heterogeneity, variety, quantity and uncertainty are inherent features of decision-making in health. The purpose of planning is to simplify this complexity by regulating these features. But along with development, planning itself has gradually become almost as complex as the decision-making processes, it has to simplify. Planning seems to have contributed more to the existence of complexity, and hence of bureaucracy than to its prevention. State-planning is suffering more from this failure, than non-state planning. However, as the problems are the same, the complexity, respectively the amount of bureaucracy and level of expenditures of non-state steering mechanisms should not be underestimated either. Economic constraints and economic instability are complicating this issue in a paradoxical way.

By limiting the room to maneuver economic factors contribute to a large extent to further increase of complexity of decision-making, but planning and management will be blamed as the cost of their activities rise accordingly. Under the circumstances it is unavoidable to simplify planning and to improve efficiency of managerial processes and mechanisms in health. Obvious areas of improvement are: the quality and quantity of staffmembers, the organization of planning agencies, the planning regulation, the procedures in use, the extent of participation in planning, the applied methods, supply of information and in general the amount of paperwork.

42 Juridification of Decision-Making in Health

The increasing role of the State in regulating health has led to an increasing intervention of the legislator in the field of health. Originally the legislator entered the health field to fight communicable diseases and to guarantee public order through food hygiene and environmental measures. Also professions have been regulated. From these problem-oriented approaches a change has taken place towards a global approach, covering the entire health field. Such interventions can be illustrated by the legislation on the organization of health systems. Other recent approaches are the appearance of the legislative guarantee of the right to health and the entry of the legislator into the field of promotion of healthier lifestyles. Along with this development a shift has taken place from emphasis on 'codifying' towards 'modifying' legislation. Modifying legislation provides health planning with the necessary regulatory framework. At first the development of legislation was not based on an overall plan. As a result some areas yet remained 'underregulated', as for instance 'patients rights' and 'the limits of care'. Other areas, however, became 'overregulated'. Against this phenomenon objections have been raised. Overregulation is correlated with bureaucracy i.e.: overregulation may cause bureaucracy, and - in reverse - bureaucracy tend to create overregulation.

Over-bureaucracy and over-regulation both are stumbling-blocks for planning, and need to be corrected. However, the present push for 'deregulation', which has been initiated in some countries, may become contra-productive, since it interferes with existing procedures and endangers the progress of developments.

43

The Changing Roles and Power of the Actors Involved in Decision-Making

Over the years the roles and power of the different actors involved in decision-making in health have undergone great changes. In earlier phases of development when the problems were merely of a medical-technical character the 'health professionals' were in a dominant position. Along with development problems of large scale, organization and financing came forward which required different types of factors. 'Public administration and management' became much more important. In this whole spectrum of actors the 'consumers' have been underrepresented for a long time. To-day the need for involving consumers has generally been recognized. In principle the consumers are involved via their (elected) representatives in the different political bodies. Depending on the type of the political-administrative system many European countries are now developing additional organizational structures and mechanisms for consumer participation. This process has been delayed by the economic circumstances, which brought a different group of actors in the centres of power. These persons may be politicians, government officials, service unit managers or financiers, and may have different training, but they all share responsibilities for the control of health expenditure. One will find representatives of this group at all levels of decision-making, and both in the government and in the private sector (e.g. sickness funds). In particular in periods of scarcity, controllers and financiers have better chances to acquire more power and to come into a better

position to defend their interests. And powerful are they, since they make the final decisions on the budgetary limits and determine the size of retrenchments. These changing roles and power of the actors involved in decision-making have contributed to a climate that is in general not auspicious for great changes.

44-46 Styles of Management

44 Differences in Styles of Management

Some individuals are risk takers and some are risk averters; some are cautious and some are daring; some believe in slow adaptation and some in constant change. Similarly, some organizations demonstrate a risk-taking, entrepreneurial, innovation centered orientation, whereas others show a cautiously, adaptive, conservative orientation. While both accept change, the former's tolerance for it is much greater than the latter's. One believes in quantum changes; the other in incremental changes. The differences between the two modes are anchored in different ideologies. The ideology of the conservative management emphasizes stability, evolutionary rather than revolutionary change, a view that the status quo is good unless proven otherwise. Management styles are different combinations of various dimensions, such as risk taking, optimization, flexibility, coercion and participation. Naturally each country, has an unique management style that is, an unique combination of risk taking, optimization, flexibility, coercion and participation. And the same is true for each organization. However, some management styles in general are more in tune with the characteristics of a changing environment, than others.

45 Changes in Health, and the Appropriate Management Style

The adoption of the HFA 2000-strategy implies the realization of major changes in the health sector, and these changes have to be

effected with scarcity of resources. As a result the environment of health management will be marked by change, fluctuation and uncertainty. These characteristics are strongly correlated with entrepreneurial, risk taking decision-making with emphasis on research and innovation. The context in which the health manager has to operate will continue to be rich in technically sophisticated, highly complex contingencies and constraints. These requirements can be met by high optimization orientation, which is generally being marked by preference for planning and cost-effectiveness. Taking into account the perspectives for the future as outlined in this paper, it may be expected that the pressures on health managers will remain to exist. The more intense, diverse and shifting these pressures are, the greater is the need for flexibility. With a view of the expected changes in health in the foreseeable future the appropriate management style will be characterized by entrepreneurial decision-making, optimization and flexibility.

46

#### The Impact of Economic Stringency on Health Management

The changing economic conditions have brought actors in the centres of power who are interested in cost containment in the first place. Representatives of this group tend to remain at the conservative side, prefer cautious, pragmatic, stability-oriented decision-making and show proclivity to low risk. The style of thinking of controllers and financiers differs usually also with respect to the degree of optimization they want. Adaptors characteristically produce ideas on existing agreed definitions of problems and likely solutions. They look at these in detail. Much of their effort in change is in improving and doing better. This satisficing style is not consistent with strategic long-term health planning, but prefers short-term resource input planning. Naturally they are interested in cost estimates and budgeting. Controllers and financiers tend to rely on personnel with experience and common sense in decision-making.

They also tend to use structured channels of communication and restricted flows of information. Essentially, this style of management is marked by conservative, risk-avoidance orientation and satisficing and may conflict with the innovative style needed to implement the HFA 2000-strategy. Probably this conflict situation could become the cause of delays in the introduction of new planning concepts.

47-50 Financing Systems

47 Shifting from Insurance-Based towards Tax-Based Financing

Financing systems have already been discussed in various places in this paper, so that this section can be brief. Over the last 15 years, insurance based systems have increasingly shifted from the private sector, and with few exceptions (the Federal Republic of Germany, for instance) have simultaneously become increasingly dependent on state funds. As indicated in section 16 Italy and Portugal have changed their financing systems completely, and the other Mediterranean countries are also in transition from insurance-based towards tax-based financing.

48 Tax-Based Financing, Territorial Decentralization and Planning

These shifts are making it easier to apply planning, and to restrain cost. Moreover, payment of health care out of general taxation enables 'territorial decentralization'. There are various methods of linking planning and financing in this respect offering different possibilities to ensure that the national health policies are being carried out within the overall financial framework and that the weaker types of services can be protected. It seems important that the authority which does the planning and runs the service, is under separate budgetary control.

49 Insurance-Based Financing, Functional Decentralization and Planning

In those countries where the financing has to be effected by insurance and is handled by private insurers (as sickness funds), planning cannot be linked to financing without limitations. In periods of economic scarcity the position of the sickness funds can deliberately be strengthened by entrusting these financiers with the responsibility to keep cost under control on the basis of regional budgets. Thus also in the model of 'functional decentralization' the health professionals and institutions, which are in fact running the services, can be subjected to separate budget control. This concept as well can contribute to bring health practice in line with local needs and induce sensibility and flexibility. But there are also disadvantages from the viewpoint of equality, as the extent of government regulation and intervention is very restricted. Moreover comprehensiveness in health planning is difficult to achieve.

50 Striking the Balance between Territorial and Functional Decentralization

Some countries belonging to the group of countries which predominantly rely on social insurance systems, are making an attempt to strike the balance between a government controlled planning system at one hand, and the insurance system at the other, like is the case in France and The Netherlands. In the lastmentioned country the provincial and municipal health authorities have been asked to prepare long range plans on the basis of global national guidelines and strict regional cash limits. The sickness funds are placed in an advisory capacity vis-a-vis the governments and they pay the health professionals and institutions on the basis of certificates which are issued on the basis of the approved plans.

Various modes to relate financing systems and planning exist. Between the extremes of financing there is as great a variety of mixed systems as there is between territorial and functional decentralization. Recent economic trends may result into an acceleration of development towards government controlled tax-based financing in some countries, whereas in other countries existing insurance-based financing complexes may become more simple and transparent. And the health sector would benefit most if the economic pressure could enforce that its major defects could be removed by the development of more appropriate financial incentives.

51-55 PLANNING AND MANAGEMENT FOR HEALTH: DIFFERENT CONCEPTS

51 Classification of Planning Concepts

A concept or conception of planning usually is understood as an opinion or belief concerning the most desirable, efficient and effective course of a planning process. To be able to select a particular concept of planning it would be useful to have a sound judgement of the various possibilities. In the field of planning in general many different approaches exist. Some authors speak of a jungle of planning concepts. In order to help to find one's way classifications of planning concepts have been developed. Also in the health sector planning and management approaches show a wide variety, and it is not easy to get an overall picture. Therefore it would be useful to design also for health a classification of planning conceptions.

It is not the purpose of this paper to give a synopsis of planning approaches, but it may be useful to consider some of the most common conceptions with view of their suitability of application in periods of economic stringency and instability.

In planning the different approaches may be distinguished as 'options' in a continuum between extreme conceptions. These extreme conceptions are: facilities planning in contrast to comprehensive health planning, blueprint planning versus process planning and rational-comprehensive planning in comparison with incremental, communicative planning.

52

Facilities Planning versus Comprehensive <sup>HEALTH</sup> Planning

On the basis of differences in scope three main concepts of planning in the health sector can be defined: facilities planning, health services planning and health planning. The development which has been from facilities -, i.e. hospital planning to health services planning and from hospital planning to health planning, can be regarded as an application of the general systems approach. Here, health planning means that the traditional 'inner-directed' planning which puts its main emphasis on the development and efficient use of resources is substituted for an 'outer-directed', result oriented approach. If one considers the type of problems as pointed out in sections 28-31 then the conclusion has to be made that health planning based on a systems approach is technically superior to other concepts which have been mentioned. This approach is essential as a tool to show the effects of shifts in health priorities, types of services and resources within the determined boundaries, to protect the weaker sectors within the system and to balance the short term with the long term. Moreover, priority setting in health terms starts from the real problems, and lends itself at the same time to optimization of cost effectiveness. Whether this concept is suitable for application in a country is depending on the characteristics of the planning environment, in particular of the skills of the planning agencies respectively planners. In addition, in most countries great efforts still have to be done to develop this concept further and to perfect it.

53 Blueprint Planning versus Process Planning

Blueprint planning has been distinguished from process planning on the basis of the feasibility of implementation. Blueprint planning can be applied if perfect knowledge is available about the future and in an environment in which sufficient power exists for implementation. In contrast process planning should be applied if imperfect knowledge is available about the future and insufficient power exists. In such an environment stepwise alterations may be needed in the course of time. At least three concepts of process planning have been developed i.e. adaptive planning, planning as a social learning process and planning as a framework for innovation. Adaptive planning suggests that planning must be conceived as a strategy to increase the adaptability of a system. Planning as a social learning process is a later development, which emphasizes the capacity to learn through which individuals and groups develop a sense of direction for coping with unfamiliar problems in an uncertain environment. Finally planning can be considered also as innovative or entrepreneurial planning which is directed on deliberate change of goals, structure and resources. In periods of economic scarcity the resistance to change is increasing as the parties concerned tend to defend their positions. Probably, this situation is true in most planning environments - so that it is justified to conclude in general that the application of a type of process planning will be preferred.

54 Rational-Comprehensive Planning versus Incremental Communicative Planning

A third cluster of planning conceptions has been developed in response to rational-comprehensive planning. This approach can be selected for application in an environment in which decisions can be taken rationally i.e. by comprehensively evaluating all

conceivable alternatives. In contrast, in environments in which rational decision making processes are not feasible nor desirable concepts of incremental planning may be selected. In pluralistic environments, characterized by many conflicting interests, as a rule only marginal changes can be realized. However, also under these circumstances different approaches are possible as means to solve these conflicts. Communicative or participatory conceptions for instance view planning as a framework for deliberation, or even bargaining between interest groups in order to reduce the differences. Naturally a continuum of options exist between rational-comprehensive planning on one hand and incremental planning at the other. Some planning approaches try to compensate the weaknesses of rational-comprehensive planning while leaving intact its overall structure and conceptions. The 'mixed-scanning' approach is such a combination. In this type of planning the decision-maker distinguishes between fundamental issues and incremental issues which have to be solved within the context of the more basic decisions. In particular, the supply of information has to be adapted to this approach by global collection of data and in depth research with respect to the fundamental issues. The strategy of implementation of the mixed-scanning approach is cyclic and iterative. It is difficult to judge the most likely choices in periods of economic stringency. Countries which have the infrastructure at their disposal and have full control over the required information may stick to central control and optimization models. Under such circumstances in other environments policy makers may tend to shift the emphasis towards incremental approaches and bargaining processes. However, the compromise of the mixed-scanning approach could also be selected as an alternative on the basis of its efficiency and relatively low cost.

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In Summary

In the preceding sections the changed planning conditions in periods of economic stringency and instability have been analysed. Also, the requirements needed for improvement of the effectiveness and efficiency of planning have been mentioned. The selection of the most appropriate concept of planning, however, will largely depend on the objectives which have to be achieved and on the situation in a certain place and at a certain point in time. If one accepts this basic idea, than it is more helpful to come to understand the characteristics of planning environments. A planning environment comprises combinations of different dimensions. Countries have different planning environments which are 'unique' and which have to be considered in identifying and selecting approaches of planning (and management). Generalizations are difficult to be made, or what may be even better, should not be made at all. However, it seems that some elements have to be stressed in all types of planning, namely: the orientation towards outcomes and outputs, or problems, the attention for long-term strategic thinking and the application of more efficient, flexible and less bureaucratic approaches.

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PRIORITIES FOR RESEARCH AND TRAINING

Following are the conclusions which can be drawn with respect to the research priorities and training:

Cost containment policies, including planning, or, where appropriate, planning applied as a cost containment strategy, should be monitored in the national situation to determine what effects these measures are actually having after they have been implemented (section 20).

More appropriate incentive systems should be developed to make both demanders and suppliers more careful in their use of resources (sections 22 and 50).

Information systems should be developed about the output-input link in health at the aggregate level and cost-effectiveness of therapies and technologies at the microlevel (section 23).

Contingency research should be undertaken across all European states to identify and test the relationships between the characteristics of 'planning environments' and 'planning' (section 26).

Contingency investigations are equally important with respect to 'management environments' and management or management styles (section 26).

The methods of priority setting in terms of health improvements, and information systems for monitoring and evaluation need further development (sections 27 and 52).

The problems of the 'limits of care' should be studied from ethical, medical, technological, economical, and legal viewpoints (section 32).

The effectiveness and efficiency of the public administration systems should be evaluated by international comparative studies and in-depth analyses where appropriate. Special attention should be given to the functioning and organization of the planning agencies (sections 36-39).

Approaches to simplify planning and to improve the effectiveness and efficiency of managerial processes and mechanisms in health should be developed and tested (section 41).

A classification of concepts of health planning should be developed and the various options be described. Where needed new conceptions should be designed, and tested (sections 52-54).

Longitudinal comparative studies to check the outcome of long-term planning and of related methods should be initiated (section 55).

Health managers are under great pressure in almost all countries. Therefore, the present activities in the field of management development and training, in particular at the international level, should be continued, and extended. Special efforts should be made in Europe to support those countries where great changes are taken place as in the Mediterrean area (sections 12-17, and 48).