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PLANNING METHODS FOR THE HOSPITAL SECTOR

Report on a WHO Working Group

Kiel, Federal Republic of Germany
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1. Introduction

The World Health Organization, Regional Office for Europe, in collaboration with the Government of the Federal Republic of Germany, convened a Working Group on Planning Methods for the Hospital Sector, Kiel, from 25-29 November 1985. The meeting was attended by 22 participants from 19 countries (the list of participants is given in Annex 1.). The meeting was opened by Dr W. Hubrich, Regional Officer Hospitals and Primary Health Care on behalf of Dr J. Asvall, Regional Director. Dr K. Treml welcomed the participants on behalf of the Regional Government of Schleswig-Holstein, Mr H. Harsdorf on behalf of the Central Government of the Federal Republic of Germany and Dr E. Tsokos-Seifert on behalf of the Municipality of Kiel. Professor F. Beske welcomed the participants on behalf of the hosting institute, Institut für Gesundheits-System-Forschung, Kiel, a Collaborating Centre of the World Health Organization. Professor F. Beske was elected Chairman of the meeting, Professor I.V. Poustovoi served as Vice-Chairman and Dr D. van der Meer acted as Rapporteur.

2. Scope and Purpose

In 1977 the Thirtieth World Health Assembly resolved that "the main social target of governments and WHO in the coming decades should be attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". This means that better approaches should be used to promote health, to prevent diseases and to reduce disabilities and incapacities.

One of the main principles of WHO's regional strategy for attaining Health for All is "the orientation of the health care system to cover the whole population". This could mean a shift in health care focus from a delivery structure dominated by hospital-based curative care, to one driven by preventive primary care concerns. Therefore within EURO's newly-established programme, "Hospitals and other health institutions" the present Working Group was convened with the following objective: to review planning methods for the hospital sector applicable to a situation of slow or zero economic growth with emphasis on establishing closer cooperation between hospitals and primary health care services (PHC) in the context of overall health service planning. It was noted that a situation of slow or zero economic growth is not relevant to all countries, so it was decided to concentrate on optimal use of available resources. In any situation priorities should be set as the needs are always so numerous and the resources available to meet them so few that a choice must be made.

3. A description of hospital planning in the participating countries - some general trends

Prior to the meeting the participants prepared country statements, consisting of two parts, A and B. In part A, a description was given on the overall situation of hospital planning in the participating countries. In part B, the impact of hospital planning was described from the viewpoint of acceptability, accessibility, efficiency and effectiveness, together with an evaluation of the planning methods used. The discussion concentrated on part B, the impact of planning considered from several viewpoints and will be described in section 4.

In this section is a very short summary of the descriptions of hospital planning in the participating countries. The statements prepared by the participants described a broad variety of planning methods and a very heterogenous way in which the health care systems are organized. There are many differences between the participating countries with regard to:

- the involvement of the Government in health care matters,
- the responsibility of the hospital management,
- the way health care is financed and the population's attitude to medical care.

This of course influences the planning methods used.

A very rough division of countries according to similar health care systems can be made:

- In the socialistic countries a central planning system is used with a high form of integration, organized by the administrative sector. There are, however, possibilities to decentralize responsibilities to lower levels, also in an integrated way. Those lower levels may have a responsibility not just for health care, but they are allowed to reallocate money from health care to other sectors. The lower levels are expected to execute goals set on the central level. It shows that an integrated system provides the opportunity for making allocations within a budget to those sectors that are most in need of money.
- National Health System (Scandinavian countries and England). Though there are some differences between several National Health Systems, there are a lot of similarities, especially concerning regionalization and responsibilities on lower levels. In general a National Health System gives a good opportunity to develop a comprehensive health care system. This means that there is an Authority who has the formal responsibility for the whole health care in a certain region (sometimes with constraints, as financial limits and so on) To exert this responsibility this Authority has the power to (re)allocate the money between the different areas of the health care system (hospitals, nursing homes, primary health care and so on). Problems may arise in the (re)allocation of money between the health care services and the social and welfare services. For example, home care for the (mentally) handicapped is often taken care of by social or welfare services, whereas the institutionalized care for those patients is covered by the health care, so there is a need for cooperation between the health services and the social and welfare services. This cooperation is often more difficult to realise if the responsibility for the health care (in England the Regional Health Authority and in Sweden the county level) is on a different level compared with the responsibility for the social and welfare services (municipality level).
- In Central European countries there is a complex system which consists of a combination of public and private-owned hospitals and where the Government is not much involved in the decision-making process, except general provisions by Law. Governments may also decide which hospitals

are included in the hospital plan and accordingly, eligible for financial support (e.g. Federal Republic of Germany). The financing bodies have an important role in the negotiations with the hospital representatives on number of admissions, functions and expensive medical equipment. In general this system responds very quickly on innovation, especially with regard to new medical technological possibilities, but they are very expensive.

- In the Southern European countries a reorganization takes place. There is a strong tendency for Governmental influence. The Government tries to promote PHC and there are examples that promoting PHC cannot be done without directly involving the hospital care. In general there are some shortages and one looks for ways to allocate the scarce resources in an optimal way.
- The French system has a tendency towards central guidance, but in contrast with the centrally guided systems, the imperative planning, the French system is that of an indicative planning. In general this system shows tendencies of centralization, for example the separate planning of hospitals may result in a less pronounced cooperation between hospitals and primary health care as it is not a comprehensive health care planning.

Some general trends

It is of course difficult to find common elements in the planning methods for the hospital sector used in the participating countries. The governmental structures and the way a government is involved in health care matters differ considerably. However, we can see some general trends:

- In all countries there is a strong need for a flexible health care system which adapts itself rapidly to the fast technological innovations, the changing morbidity and the changing demography. This fast response can no longer be reached just by placing more money into the health care system, so there is a need to get those adaptations within (nearly) fixed financial limits.
- Health care systems which have centrally guided structures try to get more flexibility by strengthening intermediate structures, so we see a tendency for decentralization and deregulation to give more responsibility to the intermediate levels.
- In systems with less governmental guidance, the main concern is to keep the health costs within certain limits without disturbing the flexibility of the whole system too much. The emphasis in increasing efficiency is very dominant and one hopes that more efficiency will make enough money available for innovations. On the one hand, one tries to increase efficiency by introducing new financing systems (mostly some kind of prospective budget systems) and sometimes allowing for profit hospitals.

On the other hand, one tries to regulate the supply side by putting limits to the number of hospital beds, to the capacity of facilities, to the introduction of new functions, to the number of health professionals and so on. It is interesting to see that there is often a discrepancy between the planning methods with detailed regulations and the change

to more global ways of financing. There is a danger that the increase in efficiency (and flexibility) caused by the more global ways of financing is taken away by the planning methods used.

- In all systems, there is a tendency for a closer cooperation between hospitals. In more centrally guided systems this closer cooperation is used for structuring the hospitals (as for example district/local, regional and central hospitals).

In less centrally guided systems, the closer cooperation and coordination between hospitals is stimulated by considering a hospital or a group of hospitals responsible for the most cost-effective way they should provide the hospital care for the population within a certain area or region. There is sometimes a tendency for merging of hospitals within a certain region. The insurance companies sometimes play an important role to stimulate this cooperation and coordination between hospitals.

In more free-market systems, the insurance companies tend to shop around for the best bargain. The hospitals come into a more competitive surrounding and develop all strategies which are well-known in the normal free-market industrial activities.

In all systems, one of the fast growing sectors in the health care system is the ambulatory care (out-patient clinics, day-care centres, either independent or coupled to hospitals).

This kind of care often asks not only for a close cooperation between out-patient and in-patient care, but also for a closer cooperation of the hospital (and ambulatory) care with the primary health care system, but in all countries one is looking for ways to improve this cooperation.

4. Discussion: The assessment of the impact of planning for the hospital sector

As mentioned before, the impact of planning for the hospital sector was approached from different angles: the impact on acceptability, on accessibility, on efficiency and effectiveness, together with an evaluation of the planning methods used.

The discussions on the different subjects commenced in plenary session, where the specific subjects were introduced by some of the participants (Miss P. Winterton, Dr A.B. Pereira, Dr G. Lamnevik, Dr H. Schmidl and Professor A. Keck respectively). The Rapporteur then presented the questions which were to be discussed. After a short plenary discussion on the clarity of the questions put to the participants, the whole group split into three sub-groups in which the actual discussions took place under the guidance of a chairman. In plenary session the viewpoints of the groups were presented by a rapporteur. The report below on the sub-group discussions is structured by the questions that were put to them.

4.1. The impact of planning on acceptability of hospital care

In what way is (or should be) the community able to influence the hospital care delivery systems?

In many countries little explicit attention is paid to the acceptability for the population in the formulation of plans for the hospital services. In planning the hospital services there is a strong emphasis on the accessibility of care as one of the important factors which influences the acceptability (see part 4.2.).

Sometimes one tries to start the planning process with the wishes of the population, but those wishes have to be translated by professionals to see how one can respond to them and they have to be confronted with the economical constraints. So it is clear that the wishes of the population (or the needs of the community) can be the starting point only for the planning process. Too much reliance on patient expectations, which are influenced by, for example, technological development, can lead to a substantial increase in the health care costs. Therefore the population needs to be informed not only about the medical and technological possibilities, but about the cost-aspects, the limitations in the possibilities and the need for priority setting as well.

How should the hospital sector respond to an increasing shift from in-patient to out-patient care?

In many of the participating countries there has been a growth in out-patient care. The change in the delivery of hospital services is especially influenced by changes in technology and medical behaviour. These kind of changes can be supported by the planning process. However, in some countries planning of the out-patient care and the shift from in-patient to out-patient care presents a problem because of the inflexibility between in-patient and out-patient components, due to the organizational structure and/or differences in financing mechanisms. The shift in hospital care from in-patient to out-patient care has a direct effect on the acceptability of the hospital care. It is important that the hospital planning takes into account the resources that are available for care in the community. Arrangements for reduced length of stay, early discharge or day surgery will only be acceptable if resources are available in the community to support patients when they return to their home.

In what way can hospitals support PHC?

Hospitals, being a part of the total health care system, should be planned in combination with other health care institutions, specialized ambulatory care and PHC. Closer cooperation between hospitals and PHC should concentrate on continuity of care. Such cooperation requires a development of PHC. Often prestige is associated with hospital work and this could be an impediment to cooperation and coordination. This might mean that incentives have to be provided to encourage the hospital sector to cooperate. If patients are to be encouraged to go to doctors in the PHC-sector, these doctors may need further training, perhaps under guidance of the hospital sector to ensure that they have adequate knowledge of modern techniques. Unless patients are satisfied with the quality of care provided by PHC-doctors, they may go direct to the hospital (for example the emergency department) for treatment, even if this incurs more costs for the patient.

4.2. The impact of planning on accessibility of hospital care

What is the impact of planning on accessibility in relation to the structure of hospitals?

One of the relevant objectives of any health care system is to ensure a good accessibility of health care resources to the population. Another one of the basic principles of any health care planning system is to meet the patients' needs for care in the most adequate way. This means a distinction of different types of health care adequate to the real needs, to guarantee that patients who are no longer in need of highly qualified care can have access and be transferred to less sophisticated levels of care. So planning of health care requires some kind of stratification of hospital structure, which should include public and private institutions. A structure can be defined in terms of bed-capacity, number and types of specialisms, affiliation with a teaching institution.

Some countries have structured their hospitals in three categories: university, general and rural (or central regional and district/local). In such a structure a problem might be the quality of care in rural or basic hospitals. If the distances are not too large, it is often seen that a basic hospital works in close cooperation with a larger hospital. If the distances are larger, basic hospitals often need special attention to guarantee certain quality standards.

What is the impact of planning on accessibility and the relation with the geographical distribution of hospitals?

A good proximity to health care has a high priority, localization of hospital beds for basic specialisms close to the population is therefore important. Ideally, the supply of hospital care should be connected to the need of care which is in turn determined by the morbidity and by the size and structure of the population itself. For instance, we see that the chronic diseases with need for long-term care increase with age. If we do not foresee beds for this kind of care acute beds will be occupied by these kinds of patients. Therefore, proximity decisions should take into account the local circumstances, the type of pathology, the conditions of patients, means and availability of transport, etc.

What is the impact of planning on the cooperation between the hospital sector and PHC and how should the referral system function?

In many countries the general practitioner is the one who sees the patient first and he makes the decision about referring the patient to the hospital and if so to the appropriate hospital level. A good accessibility to the hospitals requires a well-developed primary health care. If the general practitioner is the one who first sees the patient, PHC should also be well accessible; that means not only from 8.00 am - 5.00 pm., but 24 hours x 7 days per week. If no resources are available for PHC to be opened 7 x 24 hours each week, the hospital should take over during nights and weekends e.g. the emergency wards (under the responsibility of PHC?).

What is the impact of planning on the accessibility in relation to the ratio of beds/population in total and per different medical disciplines?

Using the bed/population ratio as the only planning parameter is no longer of great value. In addition to these other indicators, especially services such as the number of operations, the number of specialists and specialisms, the admission figures, occupancy rates, the available in- and out-patient facilities must also be considered. The allocation of resources should also take into account demographical, geographical and cultural factors, which differ from one country to another; even within a country the differences can be considerable. So planning of beds as well as planning of other facilities should be guided by estimates of needs in a certain area. However, data about the needs is typically poor and high priority should be attached to obtain such information.

4.3. The impact of planning on efficiency of hospital care

In what way can regulation (or deregulation) stimulate, so that patients are helped in the most cost-effective way (also with regard to the cooperation between hospitals and PHC)?

Aprerequisite for efficient care is doing the right things in the right way. Health care can be considered efficient if the resources expended on it are as good as possible in relation to the objectives that have to be met. The changing needs of citizens and patients for medical and social care have to be met with resources growing less rapidly than in the past. Yet, even with limited resources, the focus is on a high degree of patient satisfaction, improved health status through disease prevention, etc. Long-term care strategies, disease control, prevention programmes as well as the location and differentiation of hospitals and out-patient institutes in connection with the macro-economic development may help to save funds. They enable optimum cost-benefit relations both in the construction and the running of health institutions.

Different types of regulation can be distinguished to raise the efficiency: the entry to the system (admission), the payment, education, performance standards, etc. It was concluded that some kind of referral system is necessary. Connected to the cooperation between hospitals and PHC, this gives the general practitioner the role of a "screener" or "gatewatcher". On the other hand when a closer cooperation between hospitals and PHC has been established, efficiency asks for mutual acceptance of diagnostic findings. The same goes for a closer cooperation between out-patient and in-patient services. This asks for mutual acceptance of treatment schedules (protocols).

At the same time there should be incentives for the cooperation between hospitals and PHC in such a way that it offers an incentive for both hospitals and PHC to treat patients in the most cost-effective way. By offering patients alternatives for treatment (for example a shortening of hospital stay and better support in home care) together with certain financial incentives, they will become more involved in thinking about the most efficient kind of health care. Shortening the length of stay in hospitals asks for a well organized use of available resources, good equipment and well-developed social services. Extension of standard procedures may help to raise efficiency, but then some kind of quality assurance is needed.

What level of financing mechanism stimulates efficient behaviour?

As far as payment is concerned, it was noted that a general shift should be made from reimbursement to global prospective budgets. In most countries which know a system of budget financing, it is more the financing system than the planning system which makes the hospitals much more responsible for their expenditure and much more aware to work in the most efficient way. The budget has to be global to prevent inflexibility and prospective to give the hospital an opportunity to steer and control. Ideally, such a budget should give the hospital incentives to work in the most efficient way, which means that exceeding the budget means a financial penalty for the hospital. On the other hand, when a hospital is allowed to keep part of the money which it is able to "save", this may give the hospital incentives to work in the most efficient way.

In some countries there are different systems for financing the investments on one hand and exploitation decisions on the other. This could mean an inefficiency because investments that could lead to a cheaper exploitation cannot be carried out because no approval for it is given. In those cases efficiency could be improved by deregulation.

Regarding the expensive medical equipment, it was concluded that special norms for installing are needed to prevent more hospitals than necessary installing this kind of equipment. This requires a close cooperation between hospitals, private as well as public ones, on the joint use of this equipment. Patients with a certain disease for which this equipment is required should be treated in the hospital that has this equipment at its disposal. These kinds of decisions should be placed against an overall strategic long-term plan for the hospital care of those hospitals that work together. This is especially the case if one has to deal with a non-growth situation. More expenses in one hospital have to be compensated by less expenses in others.

If new equipment has been purchased to replace older, outdated equipment, one has to be sure that when this is installed, the equipment it is replacing is removed, otherwise the costs of using the new equipment will be additional to the costs being incurred on the old, thus there will be no savings at all.

Combined diagnostic departments could be useful to raise the efficiency of hospitals, though especially in areas with a large number of small hospitals working together one has to balance the advantages of bringing all diagnostics into one department, against the disadvantages of the difficulties in coordinating this kind of system and a possible tendency towards bureaucracy.

What are the main tasks for improving management in order to increase efficiency?

A global prospective budget gives, as stated previously, a means of steering and control to the hospital management. As neither managers nor the medical specialists are familiar with this kind of system they both need to be trained to handle this responsibility. Apart from the task of the management to perform a more difficult task within the hospital organization (see also 4.4.), the hospital manager also has to improve the cooperation between the

other health care facilities. More emphasis has to be put on the strategic capacities (for example the necessity to make strategic hospital plans) of the hospital manager to combine the external changes and constraints with the internal possibilities. In most countries hospital managers have either an administrative or medical background. Those with an administrative background need more medical knowledge for management development. Those with a medical background need more management training.

4.4. The impact of planning on effectiveness of hospital care

What is effectiveness and can it be measured (or controlled, described, oriented)?

Speaking about effectiveness first, a distinction has to be made between effectiveness and efficiency. Efficiency always concerns the relation between means and objectives, between input and output. It refers to processes and less to objectives. A procedure is effective if the results obtained are in accordance with the objectives for reducing the dimensions of a problem or improving an unsatisfactory situation. So effectiveness should always be coupled to goals, which in health care means to the needs of the population. Goal-setting is often coupled to overall health care, which makes it necessary to define the tasks, mission and function of the hospital as part of the health care system within a region, which in turn is dependent upon the tasks of other facilities. The hospital functions have to be (re)defined (for example, development of an acute geriatric service, rehabilitation unit, support of PHC, open-heart surgery etc.) and these functions have to be agreed upon by the management, the physicians and a higher authority (on central level in small countries, on lower levels in larger ones).

The defining of the hospital functions asks for insight in functions or tasks of other health care and social institutions and a definition of the responsibility of a hospital to serve the population in a certain area, which could include the cooperation between hospitals. Each hospital has to make decisions about the resources that are necessary to fulfill the agreed functions. This means that the hospital translates its functions in facilities, equipment, personnel, beds, and so on, and in objectives (the number of patients that can be treated, the number of diagnostic tests, the number of operations, and so on). Decisions have to be made about the allocation of the resources according to the agreed functions, then the effectiveness can be measured in the way the hospital meets its objectives.

The discussion about allocating money for the hospital sector concentrated more on the way it affects the functions and facilities than how it influences the way in which health problems can be solved. The whole insight in the way hospitals actually help to solve health problems is only very limited. In the first instance the medical specialists orient themselves to help individual patients in the best way they can and hospitals try to support this process as far as possible. This implies a much stronger orientation to individual problems of illness than an orientation to health problems of the population. It is not even certain that solving an individual problem of illness means decreasing the health problems of the individual.

In what way can the hospital cope with the changes in technology, morbidity and demography in a situation of tight (or sometimes even diminishing) budgets for the hospital sector?

It was noted that any financing system in a non-growth situation may have a tendency towards conservativeness with respect to innovations. Innovations of one service or establishing new services means diminishing resources of already existing ones. Ways should be found to prevent this inflexibility. Flexibility can be gained by increasing the time basis, so hospital management should be stimulated to develop global long-term strategic plans, whereas the financing system has to provide the possibility to guarantee under certain conditions the financial funds for the next four years. This offers the possibility internally to scrutinize existing treatments, discuss the possible alternatives and try to find the most cost-effective way for those treatments. This kind of discussion will only be successful if it takes into account the behavioural aspects of the health professionals. Moreover, other health care providers (for example health professionals from PHC) should be involved in the discussions (before decisions have been taken), if the changes in treatment will also influence their work. Discussions with the patient interest group may also be wise and fruitful.

How can "the appropriate use of available technology" be stimulated?

Medical intervention should always weigh the possibilities of health care against the necessities. Health care may be able to lengthen a person's life, but always the quality of this life has to be taken into account. Within medicine more attention has to be paid to ethical questions.

Though the planner is the one who deals with the broad structural changes, there is a link with quality assurance. Planning and quality assurance are not exactly the same. The quality assurance comes much more from the medical standpoint where the planning is seen as an activity from outside the hospital. If the planning is going to be effective, it needs a cooperation with the clinical issues and the planner needs some knowledge about the clinical issues. Planning should always be based on an adequate information system and on some system of quality assurance. Methods should be developed to analyse the effectiveness and efficiency of planning decisions.

4.5. Some suggestions for the improvement of the cooperation between hospitals and PHC

Due to all kinds of technological developments, changes in medical behaviour, changes in political views and so on, there is a strong development of primary health care, specialized and ambulatory care (outpatient clinics, day-care centres either independent or coupled to hospitals). Patients want to stay in their own surroundings as much as possible but patients also want the best professional care that is available. A lot of that professional expertise is concentrated in hospitals, so in a number of discussions the cooperation between PHC and hospitals was raised, problems were analysed and improvements were suggested:

- more attention should be paid to the systematic development of special care programmes for categories of patients (i.e. diabetes, oncology, asthmatic, and so on). For these programmes alternatives could be

developed so that one could obtain the most cost-effective way to treat certain kinds of diseases. For the implementation it is necessary that the hospital doctors and general practitioners (GP's) agree with the programme;

- more medical research should be oriented to the actual type of patients who go to see their GP. At present, most of the medical research is coupled to the (university) hospital which receives only a small number of the total number of patients who go to see their GP. Due to changes in morbidity, to chronic diseases and multipathology, the type of patient changes. Medical research should be oriented in such a way that it generates the best medical assistance to help the population with their health problems;
- some examples were mentioned where a hospital doctor also has a part-time appointment in a health centre. In that way specialists become more acquainted with the kind of diseases the GP treats;
- hospital specialists can act as consultants to the GP. One example was mentioned where a hospital doctor actually supervised a GP on a weekly basis with regard to the referral the GP made to the hospital, the expectation he had, the actual outcome of the treatment and advice about the patient whom the GP could have actually treated himself. (In that hospital the admission figure was of importance for the budget, so the hospital had a strong incentive to keep the admissions as low as possible);
- after a patient's referral to the hospital, the diagnostic procedure should not be started again. The GP should be informed about the specialist's wishes concerning the diagnostic tests;
- a strong incentive for good cooperation between the hospital and PHC is the need of a patient for the best care that is possible with the available resources and also for good continuity of care.

These considerations are a direct appeal on the professional attitudes and should be encouraged by financial and organizational measures.

4.6. Evaluation of planning methods for the hospital sector

Planning is a process of collecting information, retrospective and prospective. At the same time it is a process for preparing decision-making and as such it is an important part of the management task.

The overall health care planning must be such that physicians and other members of the medical staff of hospitals can accept it, so planning should not turn against medicine but form one whole with science and praxis. Health care planning must be distinguished from other planning, for example the industrial planning, for in health care planning, humanitarian, social and cultural aspects should play an important role. Planning of health care should give a general framework and especially the long-term planning has to be flexible to prevent it from being bureaucratic.

In each planning process priorities and objectives have to be set and the actual planning has to be carried out on the basis of a hierarchy of those objectives, independent on the planning level. The methods of planning should not overrule the objectives, they are always of secondary importance. The same goes for the economic objectives of planning. The economic function should serve the medical functions, so planning of the hospital sector has to be in line with the medical and social function of the hospital.

There is a great variety in planning methods for the hospital sector and a sub-division in good, better and best methods cannot be given. There is a need for a better scientific knowledge to improve the planning methods but still the deciding factor in the choice between methods is the one that works the best in practice.

To summarize some important elements for the further development of the planning methods, one could mention the following:

- Further health-oriented and macro-economic guidelines are required from the government for the planning of the hospital sector in its cooperation with other sectors.
- Successful planning requires models, especially the planning of a further integration between the hospital sector and other community services. Only on the basis of models can this objective be reached.
- More research is necessary to introduce system theoretical models. In such models the interdependency of the various processes and services on different levels can be shown. Such a model, which is not only descriptive but also prospective, shows the functional interrelations.
- Methods for long-term planning and forecasting should be further developed, because indicators for planning such as morbidity and mortality can only be seen on a long-term basis and they can be very well related to cost/benefit analyses.
- Next to the economic methods for planning, a development of sociological planning methods is required in health care planning, to get to know the patients' needs and expectations and to know what political health concept is required to meet those needs and expectations.

5. Recommendations

5.1. Hospital Sector

- 5.1.1. Planning for the hospital sector has to be part of the total health planning as well as the overall planning of social and economic developments.
- 5.1.2. Planning for the hospital sector should reflect the changing and expressed needs of the population. It should also ensure that care is provided in the most cost-effective way.

- 5.1.3. Planning for the hospital sector and for health care should ensure that necessary care will be provided at the lowest cost-effective level with regard to in-patient care, out-patient care or ambulatory care and community care. Special attention should be given to the development of a well-functioning referral system between the different services and the division of work between hospitals of different kinds.
 - 5.1.4. Hospital planning has to be adapted permanently to the status of health of the population, demography, changes in technology and ethics. This asks for an emphasis on functional flexibility.
- 5.2. World Health Organization/Regional Office for Europe
- 5.2.1. To stimulate studies in different European countries to define the best ways of providing specialized care. These should cover the care given in hospitals as well as outside hospitals, both in polyclinics or in specialized medical practices. These studies should also focus on collaboration between in-patient and out-patient care.
 - 5.2.2. To support national studies demonstrating the implications and consequences for patients transferring from in-patient care to ambulatory care and community care.
 - 5.2.3. To support research for developing planning methods for the hospital sector, which can be applied in different health care systems.
 - 5.2.4. The Regional Office should intensify its efforts to deal with the different aspects of hospital care especially in relation to PHC. This should be regarded as the basic requirement to support PHC in Member States.

Annex I

LIST OF PARTICIPANTS

TEMPORARY ADVISERS:

Dr G. Aadaam

Counsellor to the Minister, Department for Economics, Ministry of Health
of the Hungarian People's Republic, Arany Jaanos U. 6-8, 1361 Budapest V
Hungary

Mr G. Berleen*

Head, Planning Sector, Swedish Planning and Rationalization Institute of
the Health and Social Services, Box 27310, 10254 Stockholm, Sweden

Professor F. Beske

Institut für Gesundheits-System-Forschung Kiel, Beselerallee 41,
2300 Kiel 1, Federal Republic of Germany

Mr H. Clausager*

Director, Ringkobing County Health Administration, St. Blichersvej 10,
6950 Ringkobing, Denmark

Mr J. I. Cuervo

Health Department, Municipality of Barcelona, Barcelona, Spain

Professor S. Eichhorn

German Hospital Institute, Tersteegenstrasse 9, 4000 Düsseldorf, Federal
Republic of Germany

Professor D. Jolly

Professor of Public Health, Public Hospitals of Paris, 3, Avenue Victoria,
75004 Paris, France

Professor A. Keck

Institute of Social Hygiene and Public Health, c/o Ministry of Public
Health of the German Democratic Republic, Rathausstrasse 3, Berlin,
German Democratic Republic

Dr Gunilla Lamnevik

Department of Social Policy, The Federation of Swedish County Councils,
Box 6606, Gävlegatan 16, 113 84 Stockholm, Sweden

Mr R. Leidl*

Gesellschaft für Strahlen- und Umweltforschung, München Neuherberg,
Ingolstädter Landstrasse 1, 8042 Oberschleissheim, Federal Republic
of Germany

Ms Marlies Maarschalkeweerd

Hospital Institute of the Netherlands, Hospital Centre, Oudlaan 4,
GA 3515 Utrecht, The Netherlands

* Participation expenses not paid by WHO

Dr D. van der Meer
Managing Director, Hospital Institute of the Netherlands, Hospital Centre,
Oudlaan 4, CA 3515 Utrecht, The Netherlands

Dr A.B. Pereira
Health Planning Department, Ministry of Health, Avenida Alvares Cabral 25,
1200 Lisbon, Portugal

Professor I.V. Poustovoi
Chair of Health Economics, Central Institute for Advanced Medical Studies,
Pl. Vostania 1, Moscow, USSR

Dr H.-H. Rüschemann
Institut für Gesundheits-System-Forschung Kiel, Beselerallee 41,
2300 Kiel 1, Federal Republic of Germany

Dr H. Schmidl*
Obig Stubenring 6, 1010 Vienna, Austria

Professor M. Shani
Director General, Sheba Medical Centre, Tel Hashomer, Israel

Professor F.A. Sloan
Department of Economics, Institute for Public Policies Studies,
Vanderbilt University, Box 1516 Station B, Nashville, Tennessee 37235
USA

Professor A. Smajkic
Institute for Social Medicine, Mose Pijade 6, 71000 Sarajevo, Yugoslavia

Dr R. Vasama
Director of Hospital Department, Division of Health Services, National
Board of Health, 00531 Helsinki 53, Finland

Ms Oberin Ursula Wiedemann
Bulovstrasse 19, 333 - Helmstedt, Federal Republic of Germany

Ms Pat Winterton
Department for Health and Social Security, Branch HS2, Health Service
Division, Hannibal House, Elephant and Castle, London SE1 6TE, United
Kingdom

WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr W. Hubrich (Secretary)
Medical Officer, Hospitals and Primary Health Care

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