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COUNTRY HEALTH PROGRAMMING EXPERIENCE

IN SPAIN AND PORTUGAL

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1. Introduction

During the past few years Spain and Portugal requested assistance from the WHO Regional Office for Europe in health planning. In both cases it was decided to undertake country health programming (CHP) in limited areas, i.e. the province of Vizcaya in Spain (Basque Region) with 1.2 million population and the two districts of Vila Real and Bragança in Portugal with a combined population of 500 000.

In Spain little comprehensive planning has been undertaken within the health administrative structure, and national development plans frequently have not had sufficient impact on the health sector. Thus in 1977 the Government responded to a spontaneous movement of young professionals and students to improve health conditions in the province of Vizcaya, and a request by the provincial Medical College, by seeking assistance from the Regional Office.

WHO responded by sending a consultant to Vizcaya to work with the local health planning team and advise on methodology and organization of the planning process. A WHO-assisted CHP training workshop was organized and the team then formulated a provisional health plan, keeping to the time limit of 31 December 1978 set for this purpose. However, due to general political developments in Spain in 1978, this proposal has so far not been incorporated in a development plan for the Vizcaya region.

Portugal has conducted national planning for many years. Health sectoral planning is a routine process aimed at providing an objective framework for the allocation of resources in the annual budgets.

The request for WHO cooperation in health planning originated in the Bureau of Studies and Planning of the Ministry of Social Affairs. Following an initial assessment by a team from the Regional Office for Europe, a proposal was made to undertake a multisectoral integrated planning of the CHP type in one of the most needy areas of the country and this activity started with a CHP training workshop in March 1979.

In Spain and Portugal the methodology used was that of CHP as described in the WHO guidelines. In this paper comparative results are summarized by the writer, who was a WHO consultant in both projects.

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2. Background

2.1 Sociopolitical factors

Portugal and Spain are at present undergoing changes in their political structures. The historical background and nature of the changes must be considered since they constitute terms of reference for the planning process.

The changes in social trends in both countries fit into a well-known political framework. Awareness of needs and criticism of public functions leads to increasing community involvement, and decentralization is therefore seen as a logical measure. Implicitly or explicitly, a proposal for integration at all levels is a plea for a more rational approach in order to provide better services to the population.

In this respect the trend under Spain's recent Constitution is towards increasing regional autonomy, i.e. decentralization of government functions.

With the development of social security in the country, a health care system has emerged in which large hospitals of a thousand or more beds are the major health facilities in communities, with consequent weakness of baseline services (primary care), particularly in the preventive field. The great cost of this system is a major reason for the changes now being undertaken.

The unequal distribution of needs and facilities in Portugal underlines the importance of regionalization of public and private functions, already reflected in the existence of Regional Planning Boards. In this context, suggestions for the creation of a National Health Service are being discussed.

2.2 Regional determinants

The size of the planning areas selected in both countries is significant. An entire province of over a million people in Spain may seem rather large for clear definition of all basic health needs of the population. However, the recent creation of provincial health administration units (by a Royal Decree in 1978) would facilitate adoption of the strategies.

In Portugal, the smaller size of the planning area and better definition of the health problems will compensate for the administrative complexity of the coordination needed, in that the planning is for only two districts of one region.

The planning areas selected in both Portugal and Spain fulfil two main requirements: the existence of health services covering the essential needs of the population (maternal and child health, internal medicine, surgery and preventive measures), and the existence of a basic organizational and administrative structure in which to develop the decision-making process needed for running the health programmes. Both elements, however, need to be perfected.

The need for an intersectoral approach is already felt in the health care in both countries. The Regional Planning Boards will facilitate the formulation of an integrated health plan in Portugal, although Spain still has to create an adequate structure at regional level.

Community participation at local level is considered a fundamental requirement in both cases. In Portugal, the necessary support will be given by a "political group" consisting of representatives of the Municipal Chambers and the Municipal Assemblies and Councils. Since the health planning effort in Vizcaya so far has been less of an official initiative, the constitution of community advisory groups will be subject to formal adoption of the plan.

3. Preparatory activities

The following action was taken in the two countries:

3.1 Health planning bodies

An ad hoc Health Planning Board was nominated prior to the initiation of planning activities in Vizcaya. It was composed of representatives of the health and health-related institutions to be involved. Its main function has been the approval of all the steps leading to the formulation of the health plan. The subsequent health policy decisions can only be made by the authorities once the plan has been formally adopted.

Portugal has already a regional planning structure. However, a National Committee on the Integrated Health Plan for Vila Real and Bragança was formed as a focal point for the planning process. Initial steps were approved by this Committee. Regional political, technical and professional support groups were also constituted in Vila Real and Bragança at the start of CHP.

3.2 Advisory services

A health planning team of 12 members was nominated in Vizcaya, including a director (on behalf of the Medical College), two technical advisers and nine health planners. A large number of other collaborators participated in the process.

About forty persons will make up the health planning group in the Vila Real and Bragança districts in Portugal, with representatives of both districts forming coordinating groups.

3.3 Terms of reference for CHP

As a matter of principle, government health policies should constitute the basis for setting terms of reference for the CHP process. However, under the special conditions which prevailed in Spain no official statements of health policy were made to guide the health planning team for CHP. A framework for the planning was established, in the light of current health policies and problems. Detailed guidelines on the team's activities were prepared, as well as a schedule which was approved by the Health Planning Board. A PERT diagram was found very useful in developing schedules.

Terms of reference and a schedule for the activities are being prepared on similar lines in Portugal.

3.4 Preliminary information

Preliminary data on the planning areas are needed for preparing terms of reference and for running the CHP training workshops in both Portugal and Spain.

4. CHP training workshops

To prepare the health planners in applying the necessary concepts and techniques, two-week CHP training workshops were organized in Spain and Portugal.

The number of participants was 36 in Spain and 24 in Portugal; the number should, however, not exceed 28. These planners from Portugal attended the Vizcaya workshop on WHO fellowships, to learn about the experience gained in Spain.

Special editions of the document "A workshop approach to health programming and project management" (WHO-PSA/EC/75.7), produced with local data, in the two languages, were used for guidance of the workshops.

5. Approach to CHP

So far, the practical experience relates to the CHP for Vizcaya only, preparatory work and training have been done in Portugal.

5.1 Data collection and analysis

The need to collect only the most adequate and pertinent data, as indicated in the CHP terms of reference, cannot be overemphasized. There is a natural tendency to collect as much information as possible, with the result that the analysis is often confused by a mass of undigested data. Selectivity is particularly important in developed countries where there is far more information available than is actually needed for CHP. Therefore a basic list of data required should be discussed and approved prior to the start of CHP; additional information can always be provided later if needed.

In Spain it was found practical to divide the health planning team into small groups to collect sets of data from different sources. Situation analysis, on the other hand, always involved full team work.

5.2 Identification of health problems

The definition of health problems and the listing of priorities are among the most difficult tasks in CHP. It was felt by the Vizcaya team that there is no clear guidance or agreement on defining a health problem. Although the abbreviated list of the International Classification of Diseases is useful in assessing health problems, economic and social factors should also be considered in the analysis. More precise indicators would enable better definition and quantification of health problems.

Eventually 10 priority health problems were defined for Vizcaya, as well as 18 diseases were within that framework.

5.3 Estimation of trends and projections

Once a health problem has been defined, past trends and future projections should be established. However, the information on which to assess past trends is often inadequate and the projections may have to be mere estimates, as was often the case in Vizcaya.

The year 1985 was used for projecting health problems and formulating objectives.

In those instances where it was assumed that present activities were not being carried out in the most efficient way, projections were formulated assuming that the activities would be carried out according to the norms. The expected number of cases was thus calculated for the year 1985, and the number to be reduced became the target for the plan.

5.4 Selection of strategies

The next crucial step in CHP, after the definition of health problems and the estimation of projections, is the selection of effective and appropriate strategies.

A preliminary set of general objectives may have to be set prior to the formulation of alternative strategies and thus it was also found useful to analyse the obstacles that would eventually be faced. However it is meaningless to propose new strategies without having clear indications of the health policy lines a government will follow. If these indications are not given, alternative strategies would represent mere proposals - if not speculations - of the health planners. To some extent this was the case for Vizcaya due to the existing political situation as mentioned in the Introduction. Nevertheless, a number of general indications, guidelines and norms were formulated.

The health services in Vizcaya - centered on the specialized hospitals and absorbing most of the health resources of the province - were found to require a new structure, especially in order to improve primary health care.

A proposal for a new structure (one of the possible alternative strategies) was made, together with a definition of the health objectives (expected reduction of cases) to be achieved through the structure by 1985.

The draft health plan for Vizcaya thus concentrated on development of the health infrastructure of the province.

5.5 Design of health programmes and investment projects

The main health programmes and projects under the plan were outlined in order to illustrate the application of the strategy proposed. They specified the technology to be adopted and a proposed administrative structure, but did not give all details necessary for a full-scale implementation.

5.6 Determination of administrative requirements

The strategy for Vizcaya included a design for the creation of a health information system, a description of a new health planning unit and a design for organizing community participation. These three proposals are given in some detail in the plan.

Implementation would represent a further stage in the process, once the plan has been approved and adopted by the health authorities.

6. Conclusions

Country Health Programming is an approach to health planning which so far has been carried out on a full scale in developing countries only. The CHP activities in Spain and in Portugal are the first attempts at introducing these principles in countries with the health problems and health services characteristic of industrialized societies. These efforts are quite recent, and they have by no means been completed. Valuable experience has been obtained in both countries in introducing this approach in societies with powerful professional associations, diversified health services and extensive bureaucratic administrations of long standing. Training workshops on CHP have been successfully organized, although further modifications and refinements should be continuously sought.

Practical planning experience has so far been obtained in the Vizcaya province of Spain only, as Portugal is only on the verge of starting its planning. The limited experience has pointed to certain areas needing further development, which should be ensured through continued cooperation between WHO and national health administrations in real-life conditions.

It seems that the CHP approach, in seeking to improve health care in a broader context than the health services alone has as much potential in Europe as in the less developed parts of the world. The Spanish experience indicates that it is a method which lends itself not only to national health planning at central level, but also to decentralized planning.

As CHP appears to be a versatile tool for health planning in Europe, both WHO and national health planners should continue their efforts towards further methodological refinements of this approach.