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HEALTH PLANNING AND MANAGEMENT - REQUIREMENTS FOR HFA2000 DEVELOPMENT

Report on a Working Group

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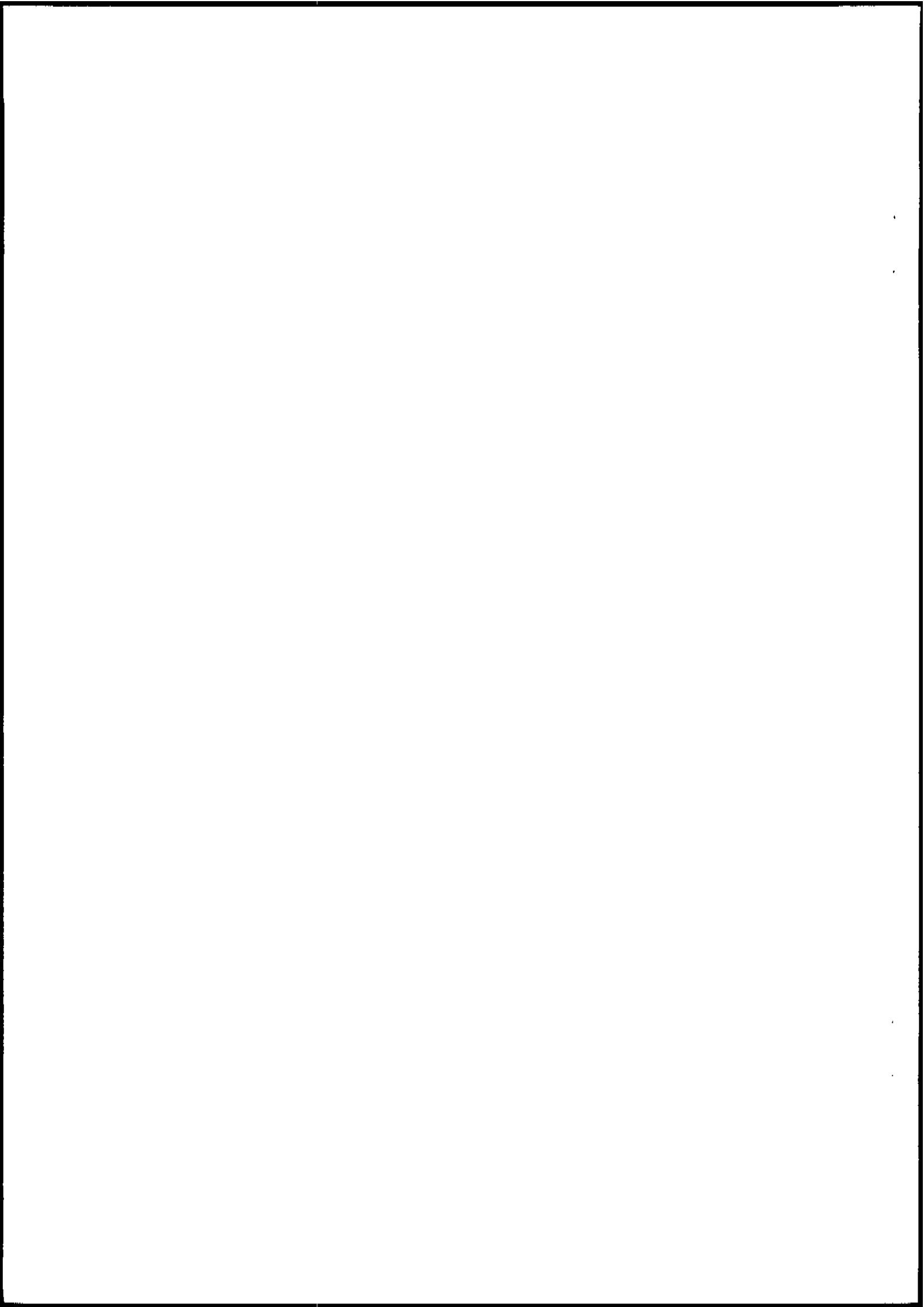
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## 1. Introduction

Over the last three or four decades all European countries have made practical attempts at planning, steering and controlling the health sector or components of it. The early 1970s brought an explosion of literature on the conceptual framework of health planning and management. The actual practice of health planning and management, and particularly comparative studies of its application under the different political, cultural and socioeconomic conditions obtaining in Member States of the European Region, have received far less attention than the enlargement and steady revision of planning and management theory.

The studies carried out under the auspices of the WHO Regional Office for Europe on the planning of health services in eight European countries between 1972 and 1977<sup>a</sup> are one of the very few attempts that have been made to balance knowledge and discussion of concepts with a description of the state of the art in practice. Mention should also be made of the report of the 1978 International Workshop organized by FAHO/WHO and the United States Department of Health, Education and Welfare,<sup>b</sup> reflecting health planning and methodology in 26 countries represented at the Workshop. These regional studies date back to a time when there was, for the most part, a favourable attitude towards planning and management. Whether this generally conducive climate still exists in the countries of the European Region has not been the subject of any extensive study, nor have the practical effects of formally developed planning and management in terms of real achievements in health protection and health care delivery been well documented.

For these reasons, and to seek a better insight into the existing practice and experience of health planning and management, the Regional Office for Europe convened a special Working Group in Athens from 26 to 29 September 1983. It was hoped that the invited experts would provide a broad empirical review of these issues in preparation for the European Conference on Planning and Management for Health in 1984.

An additional impetus came from the challenge to existing health planning and management presented by WHO's global strategy for health for all by the year 2000 (HFA2000), adopted by the World Health Assembly in 1981. Adequate steering, managing, planning and controlling mechanisms are seen to play a major role as supportive measures in the gradual adoption and implementation of this strategy at the global and regional levels.

The purposes of the Working Group, composed of temporary advisers and consultants from 12 Member States of the European Region were, therefore:

- (1) to examine how the existing health management and planning systems in the European Member States comply with the requirements of HFA2000; and
- (2) to identify critical areas in the development of health systems and ways of promoting change.

In this context, the Group was asked to discuss:

- (a) existing health planning structures and processes in European Member States specifically with a view to long-term outcome and strategic planning;
- (b) levels of decision-making in planning, and the balance between centralization and decentralization;
- (c) the involvement of providers and consumers in the decision-making process of health planning;
- (d) mechanisms for intersectoral involvement and leadership in health development issues;
- (e) how existing financial mechanisms and budget availability meet the needs of problem-oriented issues and programme budgeting;

<sup>a</sup> McLachlan, G., ed. The planning of health services: studies in eight European countries. Copenhagen, WHO Regional Office for Europe, 1980.

<sup>b</sup> Blum, H.L. Health planning methods: an international perspective; report of the 1978 International Workshop. U.S. Department of Health, Education and Welfare, 1979 (DHEW publication no. (HRA)79-14042).

(f) the consequences of management and planning for health, taking the present economic situation into consideration.

The discussions, results and conclusions of the Working Group form the background material for this paper, which is limited to discussing the situation in those countries that were represented at the meeting. The participants were selected on a geographical basis to ensure a balanced representation of various parts of Europe, various political systems and different patterns of health service organization. The views expressed during the meeting were the personal views of the participants and did not necessarily reflect the official standpoint of governments.

Dr Philalithis was elected Chairman of the Working Group, and Professor A. van der Werff Vice-Chairman. Mr D. Affeld and Dr S.E. Ekeid were the Co-Rapporteurs. A list of participants is attached as Annex 1.

## 2. HFA2000 - challenges for national health policy and national health planning and management

In the opinion of the Working Group, the broad policy basis, the strategic goals and the majority of targets of the HFA2000 strategy for the European Region are widely accepted. However, this general agreement does not exclude marked differences in the emphasis placed on various aspects of the HFA2000 message in the countries represented at the meeting. For some European countries whose health care systems are largely centred around hospitals, the primary health care concept seems to be the major challenge to their present health policy orientation, with implicit challenges to the existing health planning and management mechanisms. In other countries, the concept of equity, both social and regional, seems to be the prevalent strategic challenge to their present health policies. Other European countries are primarily challenged by the health promotion and disease prevention aspects of the HFA2000 strategy, with the inherent consequence of reorientations in health management and planning.

The HFA2000 European regional strategy assigns to health management and planning an important role in launching, implementing and monitoring the processes towards achieving the HFA2000 goals. This may mean an important challenge to the existing health policy steering mechanisms and, especially, to existing concepts of health management and planning as practised in many European countries at present. The HFA2000 management approach advocated by the WHO Regional Office for Europe seemed to many participants to be much better suited to political systems with a planned economy than to countries with a market economy. For some countries, especially those with largely autonomous non-state and insurance-based health service sectors, the concept of management, and especially the planning approach presented in the HFA2000 documents, seems rather rigid. Some of these countries are reluctant to formulate analytically based, explicit, detailed state health strategies, plans and objectives. Health policy development in these countries is largely left to societal forces and dependent upon self-regulating processes. This will have consequences for steering, managing, planning and controlling systems that are very different from those in countries with a central or regionalized governmental authority.

The existing and well-established national health planning and management patterns seem to depend on broad structural organization principles and on the cultural values of given societies much more than on the technical or medical requirements of the health sector. In a given country, the health sector's social and economic importance may vary, as may its political importance. Concepts like decentralization, consumer participation and community involvement, for example, can hardly be adopted in the health sector alone, but must be part of the general framework of society, as must the concept of the integration of the health sector with other sectors of society.

In the European context it is necessary, therefore, to define planning and management for health as a large variety of mechanisms aimed at modifying future developments, and not to concentrate solely on formalized health planning and management systems. Some European countries with little or no formalized planning machinery have achieved at least the same degree of success in health status improvement and health care delivery as other countries with well-developed mechanisms more commonly associated with "planning". The Working Group expressed doubt about the possibility of constructing a single set of "optimal rules/arrangements" for planning and management for health that would be applicable to all Member States of the Region. It is important to examine further the background, the implications and the achievements of alternative processes and mechanisms.

### 3. Existing European health planning and management mechanisms

A wide variety of steering, planning and management approaches to the health sector exists in the European Region. Actual management practice varies according to the different balances between formal planning mechanisms and more informal steering and negotiating mechanisms.

Some countries (e.g., France, the Federal Republic of Germany and the Netherlands) have only minimum formalized planning and management systems with regard to the health services. In these countries, "planning", and especially governmental planning in the classical sense of the word, is seen as just one of a number of possible and useful management and steering processes. State and government agencies in these countries exert direct control functions in the health sector only to a limited extent. Policy and innovation are largely achieved through negotiations and consensus-building processes, with the close and direct involvement of statutory insurance systems, users, professions, associations of trade unions and employers, etc. As equity of health care delivery is not the predominant guiding issue for governmental health policy in these countries, this is, therefore, also not a central impetus for planning and management. As a general result, health policy, planning and management are seldom organized according to governmental "programmes" in these countries.

In the Federal Republic of Germany, for example, even parts of existing sectoral planning procedures are left to non-state, autonomous agencies of the physicians and the sickness insurance funds. Such sectoral health planning and management carried out by different agencies usually causes significant institutional problems of coordination. In countries with limited formalized and little governmental health planning and management, little overall socioeconomic planning for the whole country exists.

Other countries have a clear legal or constitutional basis for the government's mandate in health planning, management and controlling processes. This is the case in such greatly differing countries as Finland, Norway, Portugal, Turkey, the United Kingdom and the USSR. The formalized health policy and management procedures and systems that have developed from such governmental mandate show, in practice, a large variety in accordance with the country's general political, cultural and socioeconomic background.

There are those countries that have fully developed, many-staged, hierarchically organized and comprehensive health planning systems within an overall national socioeconomic planning system as, for example, in the USSR.

The planning systems in Finland, Norway and the United Kingdom are less hierarchically organized and place a strong emphasis on regional or local community planning and management responsibilities. However, even in these countries there may exist a relatively substantial and increasing private health care sector under little governmental control alongside the national health services, with an implicit problem of coordination.

The planning system in Norway is characterized by the central Government having general legislative powers and steering mainly taking place by means of guidelines and advice, whereas local authorities have responsibility for planning and running services, these powers being linked with the right to levy local taxes. In Finland, there is also central influence on local authority planning and management through strict budgetary and manpower limits set by the central Government and through the use or size of the state subsidy as a central means of control.

Several European countries are currently experimenting with their approach to health planning and management, attempting to find solutions that are adequate both in the sense of degree and strength of direct political control, as well as in the sense of finding the most suitable institutional setting for health planning and management within their political and societal framework. Among these are the Netherlands and several countries in the Mediterranean region. In the Netherlands, discussions have recently been initiated on the advantages and disadvantages of either strengthening state regulation in health, with subsequent reinforcement in health planning and management, or strengthening deregulation in the health sector by minimizing state interference and reinforcing non-state autonomous agencies.

Some Mediterranean countries such as Greece and Italy have recently changed fundamentally their health policy orientation and reorganize their health care delivery systems, with concomitant changes in health planning. The new legislation and management structures are, in part, explicitly related to the strategic goals of HFA2000. Together with the introduction of a national health service type of health care delivery, formalized systems of health planning and management are being promoted. The introduction of new management procedures, the recruitment and education of the necessary health planning and management staff and, simultaneously, the decentralization of

decision-making and management to the regional or local level, all require time and effort. An evaluation of such examples of fundamental health policy reorientation will, however, need to be postponed until the changes have been fully implemented.

The consequences of HFA2000 strategy implementation, largely by negotiations and bargaining among non-state autonomous agencies in countries with no explicitly formulated health policy and little "classical" health planning and management, would seem to call for further investigation. Even a very sophisticated adaptation of "classical" planning and management approaches might not be applicable in the conditions existing in these countries.

All planning and management for HFA2000, regardless of the political and institutional setting, requires a long-term and outcome-oriented approach, an integrated health care planning concept and a comprehensive view of planning for health that reaches far beyond the health sector. The existing planning practice in all European Member States needs considerable, albeit varying, development to come up to these ambitious goals.

### 3.1 Integrated health care planning

A deliberate movement towards integrated health care planning may be seen in all countries favouring formalized health planning systems. Other countries, such as the France, the Federal Republic of Germany and the Netherlands, seek some substitutive steering processes able to compensate for over-hospitalization in the health care services and to develop a more balanced service structure. In the Federal Republic of Germany, the "Concerted Action for Health", a legally-based forum of the highest representatives of all health-related agencies, is meant to achieve this on a voluntary, regular bargaining basis.

The mechanisms chosen to achieve integrated health care planning and the results already obtained vary considerably. Finland seems to be a good example of a country where a more balanced service structure has been successfully achieved by means of continuous and competent planning activities coupled with relatively extensive decentralization of executive powers.

### 3.2 Comprehensive health planning

Comprehensive health planning, conceived as covering both planning for health protection and planning for health care services in an integrated manner, seems to be in the stage of general discussion and conceptual clarification in most European countries. The members of the Working Group could report no substantial movement towards this goal. There is extremely little practical experience in this field. It appears that countries which have already achieved some successful integration in health care planning are most likely to extend planning activities into health-related neighbouring fields like social services or environmental policy. Finland, Norway, the United Kingdom and the USSR demonstrate different ways of attempting to achieve this.

A strong regional or local community element in health planning and management appears to be another aspect favourable to more comprehensive approaches. Finland and Norway, but also Yugoslavia and especially Italy, provide various examples of this. Italy is one of the very few countries in the European Region where fundamental institutional reorientations in health planning and management have led to the local health authorities being jointly responsible for the whole range of health care and large segments of social services, and for occupational and environmental health. It is too early, as yet, to evaluate the practical impact of such approaches on health conditions, health care, health expenditure, and health status of the population.

In their attempts to achieve greater comprehensiveness in health planning and management, the European countries have different starting-points and orientations. Some attempts are directed towards better coordination and joint efforts of health (care) and social (care) services, with the middle- and long-term goal of comprehensive care planning and management to cover both the health and the social field. Other attempts are more concerned with combining health and environment approaches and thus strive for a comprehensive "planning for health" and prevention concept. The degree to which health planning is integrated into comprehensive socioeconomic planning for the whole country varies considerably.

### 3.3 Long-term health planning

As already indicated, long-term health planning is under serious doubt in many European Member States, as is long-term socioeconomic planning in general. This is due to queries as to the validity and usefulness of long-term commitments.

Economic stringency and instability have added considerably to a tendency, observed in many European countries, to leave long-term planning (in health and other sectors) to continuous policy discussion and formulation, often of the central strategic elements. This is particularly noticeable in those countries with traditionally weak affiliations to planning.

Only very few countries in the European Region report formalized long-term planning as an established health management activity. In the USSR, for example, long-term (10-15 years) health planning, middle-range prospective (5 years) planning and annual plans are complementary within the overall planning process for health care resources. In Finland and Norway, long-term strategic planning is part of health policy development.

Some countries, e.g., Finland and the Netherlands, have just entered experimental stages in studying alternative tools for health policy formulation, for example, scenario techniques. Any valuable assessment of the consequences for health policy and health planning and management is still lacking.

The Group generally displayed a certain scepticism as to the utility of excessively sophisticated, detailed and data-demanding tools for modelling and prognoses in future health developments. There is a growing demand for the use of simpler techniques which might more easily be brought into line with political decision-making.

#### 3.4 Outcome planning and programming

In almost all European countries, health planning and management in practice is input/resources- and output/delivery-oriented. Some Member States are making serious attempts to move towards outcome planning and programming. So far, experience seems to indicate that, with regard to special "single-issue" planning, e.g. for child health care or for cardiology or emergency services, a number of countries have had positive results with outcome-oriented planning approaches. However, serious doubts remain as to the practical value of attempting this kind of planning on a more global health-planning scale, and it remains to be seen whether it will be introduced into routine planning within a reasonable time. No country reported the complete integration of outcome programmes into a national health plan.

#### 3.5 Prescriptive planning and indicative planning

In some countries with formalized health planning systems, where proposals of plans originate and the planning process starts at the local level, e.g., the USSR, the outcome of the process is national prescriptive planning, in that plans once approved take the form and force of law. Countries with formalized health planning systems, but with regionalized or decentralized governmental systems and/or deconcentration of executive power (e.g., Finland, Italy, Norway, the United Kingdom), tend to have indicative planning at the national level. In these countries, planning becomes prescriptive to a certain extent at the peripheral levels only.

Some countries represented in the Working Group stressed the importance of not confusing "health planning and management" (only a supportive measure of the HFA2000 strategy) with the accomplishment of HFA2000 as such. The challenge of the HFA2000 regional strategy vis-à-vis national health policy and national health planning and management will largely depend upon:

- (a) a country's given situation as regards health conditions, health status and health care delivery systems;
- (b) a country's present facilities and socioeconomic potential for change and improvement;
- (c) the sensitivity, flexibility and competence of a country's established health planning and management system;
- (d) a country's national special emphasis on the strategy's main components.

In the Working Group, the participants from Portugal and Turkey underlined the overriding importance of (a) and (b) whenever discussing the contribution of planning and management mechanisms. The major issue in health planning and management for some countries is not one of refining the planning machinery but of achieving success in bridging the gap between plans and implementation, goals and facilities. Participants from other European countries, such as the Federal Republic of Germany, Greece and the United Kingdom, underlined the necessity of not overestimating the role of structural changes in health planning and management. In some countries, major reorientations may primarily concentrate on institutional, financial and organizational changes. There is considerable doubt about the degree to which effective changes in health protection and health delivery are connected to such institutional changes.

#### 4. Balance between centralization and decentralization in health planning and management

The issues of centralization and decentralization play an important role in the majority of health planning and management mechanisms and systems in the European Region. These issues contain an essential dilemma of value conflicts that are receiving growing attention. Basic need orientation, innovative capacity, sufficient flexibility and community as well as user and provider participation in health development call for health planning and management to be closely related to the expressed needs of the population in local communities, in regions or other "peripheral" levels. Simultaneously, equally well accepted goals, like equity in health development for all (social and geographical) parts of society, and the maintenance of a desired level of quality and effectiveness and of common efficiency standards, call for more centrally structured planning and management.

Given this dilemma, also inherent in the HFA2000 strategy, various solutions - both for the structure and the process aspects of it - have been developed in the European countries and were described by members of the Working Group, who underlined the need not to concentrate on either centralization or decentralization but to seek the right balance between these two concepts. There was general doubt as to the possibility of identifying the optimum point of this balance. The existing experience in the various European settings provides some evidence that each country's cultural, historical and political background might be the most important factor in reaching the "right" balance for that country. The existing administrative structure is also essential in this respect.

The European governmental systems vary from highly centralized structures to highly decentralized structures with a large degree of deconcentration of executive powers. The Working Group noted that, for a planning and management system to be truly decentralized, the peripheral levels should have their own authority and competence, together with either independent or delegated responsibility and corresponding facilities for raising financial revenue. Highly centralized systems, in these terms, are not incompatible with decision-making processes at peripheral levels and regionalization. In this respect, the issuing of norms and standards at republic level and the two-way flow of information and decisions in building up plans in the USSR were quoted. On the other hand, decentralized systems, in order to maintain the system's basic components, may need to leave key decisions to the central level.

In some countries, authority and responsibility for large parts of health care are left to a system of self-management built around special trade and interest organizations, as for example, in the Federal Republic of Germany and in Yugoslavia. This type of decentralization in decision-making, planning and management does not merely mean regionalization in the sense of delegation of governmental executive power from the central to the peripheral levels. It means, instead, division of power between the central and the peripheral levels and at the same time between state and non-state self-managing organizations. Starting-points in the search for a correct balance between centralization and decentralization are different in the various Member States of the European Region.

In Finland and Norway there is a strong historical and cultural tradition of local-authority autonomy in the organization of services, coupled with a strong political will to achieve social and geographical equity. Although all the countries in this part of Europe have chosen slightly different patterns of organization of health and social services, the common denominator is that the responsibility of the State is limited to legislation, guidance and financial subsidization, whereas the local authorities are responsible for planning, management, administration and financing through local taxation.

In the United Kingdom, the central Government is responsible for policy formulation and financing. Practical planning and management are, however, decentralized through the delegation of responsibilities and resources to fairly autonomous regional and district health authorities.

In Finland, Norway and the United Kingdom, it is felt that the balance between centralization and decentralization has already been adequately achieved. These countries are, therefore, less concerned with restructuring the responsibilities at the central, regional and local levels than with developing the procedural mechanism intended to make the given structure work adequately. Central government mechanisms in these countries include refined methods of influencing through constraints like political exhortation, control of capital investments, control of senior medical manpower establishment, budgetary limits for peripheral levels and balancing influences, such as subsidizing weak regions or providing financial incentives for cooperation among regions and local communities - all designed to ensure national social and geographical equity.

Some countries, such as the Netherlands, are at present experiencing a strong movement for a basic restructuring of health planning and management towards a decentralized system. In some cases, the major reason for these recent developments is the growing difficulty of central

governments in successfully coping with cost-development and, consequently, their wish to introduce cost-containment mechanisms. But if decentralization only serves as an alibi for shifting cost-containment responsibilities in times of economic stringency, hardly any positive results will emerge in the long run.

In some Mediterranean countries which have recently implemented new national health service systems, concomitant decentralization has been successfully achieved already (as in Italy) or decentralization is in progress but will take some time for practical reasons (as in Greece). Turkey is planning an experimental stage of decentralization, with some of the provincial health directorates moving towards more autonomous health management with a much more independent health budget than has hitherto been the case. Decentralization in these countries may face practical problems, partly because of a lack of local authorities that can take on the responsibilities of running a decentralized system, partly because of the felt need for centralized power during the critical implementation stage in order to influence key strategic elements. To introduce local-need orientation and innovative flexibility into a hitherto centralized health planning and management system will require the training and motivation of local authorities as well as the reorientation of central institutions, and this can only take place over a period of time.

Some countries with highly decentralized or fragmented mechanisms for steering and controlling the health sector's development are less concerned with issues and mechanisms of decentralization as such. A much more evident development in countries like France and the Federal Republic of Germany is the introduction of complementary centripetal forces into a basically centrifugal health system. Such reorientations are particularly difficult in countries with a constitutionally based tradition of strict federalism and extensive professional and insurance-based self-government in the health service sector. The most powerful issue in favour of bringing in such, albeit restricted, new concepts of health planning and management has been the need for overall budgeting and budget planning for health within a balanced intersectoral socioeconomic development. Bringing in such centripetal mechanisms has been the urgent answer to problems caused almost exclusively by cost-development and cost-containment needs. Thus, the above-mentioned "concerted action" has been the most demonstrable innovation in health management in the Federal Republic of Germany.

A closer look at the basic features of centralization or decentralization in health planning and management reveals major and important differences within the systems of European countries. Health planning and management at the national level, largely concentrating on the hospital sector (in France and Portugal, for example), has left considerable room for regionalized planning and management in primary health care. Fragmented health management (as in the Federal Republic of Germany) is complemented by more centralized planning and management with regard to the delivery of specialized health services, e.g., cardiology services and the care of seriously burnt or intoxicated persons.

In a number of countries, the problem of optimal decentralization also raises the question of establishing adequate criteria for the identification and practical demarcation of regional and local units. Such questions are even more difficult in countries where there are extreme differences in the geographical distribution and density of the population. Cultural entity, political or administrative boundaries, and critical size of population in relation to economic and financial capacity are all important criteria, but there are no optimal solutions. The Working Group expressed serious doubt whether decentralization in health planning and management alone would be viable in any country without a general tendency towards decentralization in the society of that country as a whole.

Whereas empirical evidence concerning the right balance between centralization and decentralization in the European Region varies, it is almost exclusively related to the narrower concept of health care planning. HFA2000 requires a major step towards "planning for health" which goes far beyond health care or health resource planning that may induce a re-examination of decentralization concepts. Planning for health must necessarily involve some responsibility, management and regulation at the central level, for example in water supply and sanitation, air pollution, soil protection, housing and agriculture. Recently an increasing number of authors have expressed doubt whether local, regional or even national initiatives alone are sufficient in these fields. A number of topical health problems call for national or transboundary solutions.

5. Involvement of users, providers and decision-makers: community participation in health planning and management

The involvement of users, providers and decision-makers as well as community participation can contribute considerably to the responsiveness of health planning and management to local needs. It will induce the flexibility needed to accept new approaches and will strengthen the community's,

the users' and the providers' contributions to health protection and health development. This is why HFA2000 calls for direct and active involvement and participation in the planning and management processes, not only for reaction to plans already implemented.

Active involvement and participation will thus entail a dialogue among planners, users and providers on priority-setting and evaluation in order to achieve consensus and collaboration in health planning. It will further mean the deliberate development of the community's own motivation and capacity to implement health-related activities. For these reasons, there was general agreement within the Working Group that participation and involvement will to a large extent go together with decentralization. Both aspects in health planning and management share the same dilemmas and value conflicts. If unbalanced, involvement and participation can lead to increasing inequities between regions or local communities. They may lead to unlimited or unrealistic local health demands or to technically, as well as economically, inefficient solutions if not balanced with the planners' professional, though perhaps sometimes technocratic, knowledge. The present difficulties in many European countries with regard to hospital planning (both in planning and in building new hospitals, and especially in closing down hospitals that are no longer necessary) were attributed at least in part to such negative aspects of local or regional alliances of community decision-makers, users, providers and pressure groups. According to the type of decision-making and planning levels in a given system, various forms of participation by communities, users and providers exist in all countries in the European Region. In countries such as France, the Federal Republic of Germany and Yugoslavia, a strong direct user/provider component is a basic feature of the systems of health service self-government. The same applies to community participation in countries with very marked regional and local decentralization of health service systems, such as Finland, Italy and Norway. In Finland and Norway there is a statutory obligation for continuous consultation at all stages of planning with representatives of the professions, health workers and representatives of the community and voluntary organizations before political decisions are made by the relevant local or regional elected bodies on approving and implementing the planning documents.

Some countries with a strong central governmental role in health planning and management, but with a largely decentralized health planning process (the United Kingdom, for example), have developed mechanisms of structured participation, involvement and expert advice at all levels. Special committees are established to provide a balance between technical expertise and unfiltered lay opinion. A general tradition of compromising and consensus-seeking is seen to be the major prerequisite for the practical use of such difficult and time-consuming mechanisms.

Countries with basically centralized health planning and management systems have developed different mechanisms to incorporate community participation and involvement of users and providers. In the USSR, for example, the direct local expression of satisfaction or dissatisfaction with services and planning outcomes, special committees to deal with such complaints and representation by people's deputies are seen as effective means of participation and involvement.

Special attention to the minimum prerequisites for meaningful participation seems to be necessary in countries like Portugal and Turkey, which have a traditionally centralized system and concomitant large social and geographical differences. If the size of the respective areas, the educational standards of the local population and their readiness to express needs and preferences do not favour adequate participation, the danger of an unwanted takeover of the process by pressure groups must be kept in mind and may need to be counterbalanced.

As with decentralization, changes leading to more participation and involvement in health planning and management may need considerable time if initial conditions are unfavourable. Thus, the time and energy spent on achieving participation must be carefully balanced with the effort expended to meet the urgent need for a rapid improvement of health, particularly in some less developed rural areas.

A number of European countries have long-standing experience with health councils as a type of participation forum, especially at the national level. In many cases it seems doubtful whether the usually high-ranking representatives chosen for or elected to such councils really can be regarded as advocates of the needs and interests of local communities, users and practising providers.

Participation and involvement in health planning and management are given a legal basis in some countries or are in the process of being introduced in the regulations. All countries report a strong tendency for such formalized participation mechanisms as the above-mentioned health councils either explicitly or implicitly to strengthen the existing powerful position of the providers and the medical professions.

In most European countries, the providers are traditionally well organized and exert significant pressure on health policy, planning and management up to the highest governmental levels. On the other hand, organized and powerful user groups acting as a counterbalance through participation and involvement are largely lacking in many countries. The insurance-based systems are to some extent an exception, since the insurance agencies are often owned by the users.

Until now, only very few European countries have a strong consumer movement with access to governmental health policy-making, Finland perhaps being an exception. In that country, and in the Netherlands, the process of preparing a special patients' rights bill has been initiated.

In some countries, e.g., Finland, the Federal Republic of Germany, the Netherlands, Norway, the United Kingdom and the USSR, the trade unions play an important role in mediating the users', and sometimes also the providers', interests vis-à-vis the local, regional and national health policy and planning processes. In addition, some countries, such as the Federal Republic of Germany and the Netherlands, have traditionally had a very strong component of important and powerful non-state welfare organizations, especially in the health sector, as was formerly the case in Finland and Norway; in these two countries the role of such organizations was diminished greatly with the introduction of the Scandinavian welfare-state model. Among the characteristic features of these welfare organizations is the participation and involvement of the churches; in general, they exert a remarkable influence, especially in the fields of hospital planning, the ambulant health services and home nursing services for the handicapped and the elderly.

The notion of the participation and involvement of users, providers and communities as constituting an important element in the HFA2000 strategy is basically accepted in the European context. It inevitably means the introduction of an even greater complexity and difficulty into bargaining, negotiation and consensus formulation than that already inherent in health planning and management. The ambitious goals of the HFA2000 strategy require that the time and resources needed for active user, provider and community involvement should be made available, and precautions should be taken against the tendency, already experienced in some Member States, for participation to end up as yet another set of bureaucratic mechanisms.

#### 6. The multisectoral approach to planning for health

Health protection and health development are major objectives in all countries of the European Region. The health sector represents the structural form given to that function within a country's overall socioeconomic organization. Thus, the health sector may be perceived as one of various sectors which are working towards different objectives aimed generally at the welfare of society as a whole. Besides the health sector, various other sectors play an important role in fostering better conditions for health, although they are usually not explicitly centred around health development goals and values. The different sectors have, in all European countries, a considerable degree of autonomy. They have their own guiding principles and their respective mechanisms of steering, financing, planning and management. Thus, multisectorality is a key issue of the HFA2000 strategy, in the sense of making the relevant sectors give their best possible contribution to improving health conditions and health status.

In the Member States of the European Region, the health sector itself covers a wide variety of health-related activities. There are marked differences in the range and extent of activities conceived to belong to this sector and in its organizational design. Environmental and occupational health, domestic hygiene and accident prevention, food safety and the care of the elderly are common examples. Experience throughout the region shows that the actual design of the health sector depends on general policy and on persons rather than on rational planning and management principles. Last but not least, the environment, labour and social security, although viewed in many countries as sectors of equal importance to health, seem to be regarded by many as fields that lend themselves more successfully to policy implementation and organization.

European countries provide evidence that a wide range of health-related responsibilities are deliberately included in, or excluded from, the functions of health ministries. In addition, the field of health seems to offer itself readily to organizational combinations with numerous other fields as, for example, social welfare and security, youth and family affairs, culture, education and sports, internal affairs, environmental protection, labour, etc. In a number of European countries, continuity in the organizational background of the health sector and health policy is lacking. Health responsibilities seem to shift easily from one ministry to another. This widespread experience casts some doubt on the capacity of the health sector to compete successfully with other sectors when it comes to expressing organizational power. In the Federal Republic of Germany, Greece, the Netherlands, Norway and Yugoslavia, for example, national health ministries have faced a gradual erosion of responsibilities, especially with regard to occupational and environmental health, during the last couple of decades.

The fact that in several European countries health is linked under the same ministry with environmental protection, welfare or social services should not necessarily be interpreted as proof of attempts at integrated planning for health, or of political acceptance of the advantages of such integration. Such examples, instead, demonstrate the necessity of an approach going beyond simple organizational techniques to overcome the obstacles to integrated multisectoral planning and management for health.

Furthermore, in a number of Member States the organizational design of the health sector can vary considerably at the different governmental and administrative levels. Thus, environmental protection may not be linked with the health sector at national level, but it may be part of the health administration at the regional or local level. On the other hand, certain social services, for example, may be part of health policy at the central level, but may be part of a largely independent social administration at the regional or local level.

This variety in the actual organization of the health sector and other health-related activities explains some of the differences in the scope of health planning and management in the European Region, and it is one important starting-point for a description and evaluation of ongoing attempts to attain a multisectoral approach in planning for health. Such attempts seem to range from "integrated planning" and "coordinated planning" to "cooperative planning" for health.

Existing mechanisms for health planning and management in the European countries are faced with a different kind of experience that goes beyond organizational power structures when trying to indulge in multisectoral approaches. In a number of European countries, the medical paradigm at the very core of classical health policy and health care delivery is under increasing discussion. There is growing scepticism as to the equalization of health and medicine. The HFA2000 strategy of planning for health if wrongly understood may even serve to widen the gap between, on the one hand, health protection and development and, on the other, the contribution of the classical medical field to the goal of improving the health status of the population.

Health policy, health planning and health management have generally stood for a rather narrow, classical cure- and care-orientation. There is growing reluctance to adopt a new multisectoral approach if this means, basically, the medicalization of nonmedical but health-related fields. Such reluctance is heightened when classical health policy and planning seem unable in their own fields of responsibility to cope successfully with their problems and to stop health expenditures from rising beyond the possibilities of balanced economic development. In many European countries, this actually seems to foster a redefinition of the classical health sector's role in society, from a leading to a more advisory role or to a dialogue with nonmedical health-related fields. Thus, multisectorality in planning for health should strive to be at the same time beneficial both to the classical health sector and to the other sectors involved.

Almost all European countries admit value conflicts and basic differences in professional background as important obstacles to successful multisectoral cooperation. Multiprofessionalism is one of the underlying problems of multisectorality. An open debate on professional bias, especially in combination with active public involvement, could overcome excessively medicalized problem-formulation and open the way for multisectoral problem-formulation as well as problem-solution.

In all Member States of the European Region, the problems of restricting health policy to a rather narrowly defined process of care delivery and financing are becoming more and more evident. There is broad general agreement on the need for a multisectoral approach but, with very few exceptions, practical proposals, not to mention experience and general evidence, are largely lacking, if one analyses the multisectoral collaboration aiming specifically at improving health.

Those countries in the Region which have some overall socioeconomic planning, e.g., Finland, Greece, Norway, Portugal and the United Kingdom, appear to have a broad framework for the integration of health policy into general development goals. The integrative aspect seems to be strengthened when national plans contain short- and medium-term financial implications for the health sector. However, except in countries with centralized economic planning (e.g., the USSR), national socioeconomic plans generally contribute little to the achievement of multisectoral planning for health, approached from a policy point of view. Conversely, in most cases the health sector is reported to play a relatively weak role in the national socioeconomic planning processes of countries regardless of management systems.

In Finland, where health has been a priority field during the last ten years, attention is now shifting to the social field. "Hidden health activities", especially in agriculture, traffic and environmental policy, have received special attention. Health policy, health planning and management have largely abandoned over-ambitious aspirations to formal coordination, integration

and leadership. They have, instead, restricted themselves to a more modest advisory role within the given power distribution concerning health-related activities. This, in combination with compelling evidence of cost-effective internal cooperation among the various health care services, has added to the acceptance of advisory capacities in a broader approach to planning for health. Value conflicts between the different sectors are seen to be stimulating and functional, in that they encourage open political debate about the place of health in society.

In Norway, a multisectoral planning approach has brought the health sector together with the agriculture, fishery, trade, finance and other sectors in the formulation of a national nutrition policy which underlines the health aspects of such a policy as its most important objectives.

In countries such as France, the Federal Republic of Germany and the Netherlands, autonomous societal forces and, basically, market principles largely determine developments within and between broad sectors of society. Thus, the governmental mandate and the possibilities it has of steering the health sector in these market economies are much more limited than in countries with a higher degree of formalized governmental health and general socioeconomic planning. Nevertheless, this has to some extent led to well-developed occupational and environmental protection policies besides "classical" health policy. Social services and the health care delivery system are of a comparably high standard in these countries. To relate these developments, however, to a clearly structured planning and management process, to an explicitly formulated health policy and to the deliberate adoption of a multisectoral approach would be misleading. These countries face some difficulties with the concept of an explicit multisectoral approach to planning for health. The (unintentional) multisectoral practice in these countries seems beneficial, in that budgetary disputes are not necessarily restricted to internal disputes within a fixed health budget.

The Working Group formulated a number of proposals regarding practical approaches and improvements in multisectoral planning for health:

- a stronger involvement of the general public in discussing health and general policy issues;
- education and motivation of both health sector personnel and key persons from other sectors in multisectoral management techniques;
- multisectoral research in comprehensive planning for health;
- reinforcement of all types of governmental coordination mechanisms.

Some countries have had positive experiences with multisectoral training and research approaches, sufficient at least to arouse interest in multisectoral collaboration. Apart from information on the costs of this proposal in terms of time and resources, evidence relating to the final results of major changes in approach is very limited.

All countries have different traditional mechanisms and structures for intersectoral collaboration. In most cases, they may even be laid down formally in the governments' or other agencies' standing orders or regulations. Some of these standing orders pay special attention to, and lay down special mechanisms for, overall coordination for certain functions such as safeguarding economic or financial stability or ensuring environmental protection. This means that any activity substantially affecting these functions has to be formally announced to and approved by the ministries for economic affairs, financial affairs or the environment respectively. Most of the Working Group's members reported that their countries did not have similar statutory mechanisms for health protection involving, for instance, approval by the health ministry of activities potentially detrimental to the health of the population.

Normal governmental coordination procedures are not thought to be capable of bringing about the necessary changes leading to multisectoral planning for health. Nevertheless, a better use of existing structures, better identification of "hidden" activities in the different sectors of society and deliberate support for such activities seem more promising ways forward in most Member States than attempts to create new mechanisms for multisectoral involvement that are controlled mainly by health ministries or other health agencies. Recent experiences indicate that many new multisectorally-oriented councils and committees are artificial additions to existing steering mechanisms and therefore have little viability.

In almost all Member States there is growing evidence that a multisectoral approach to planning for health is considerably eased, and in some cases even forced, when the respective agencies are faced with immediate health problems of a very obvious intersectoral nature, for example, malaria eradication, drug abuse, and food or water pollution. This can be an entry-point for more general long-term multisectoral involvement in comprehensive planning for health.

Some countries, however, seem to have had experiences of such urgent single-problem multisectorality being restricted to this kind of problem. Programmes in, for example, children's health or the care of the elderly, designed to improve the health of certain socioeconomic or age groups, might be more suitable fields for combining short-term concrete problem solutions with a longer-term multisectoral approach. The United Kingdom, for example, strengthens this positive effect by granting extra money from higher levels as an incentive to cooperative approaches by the different health and social services sectors.

Other countries face problems with this approach because segmentation at the central level is carried through to the local level. The most common example of this is when cooperative planning for health and social services is complicated by vertical separation of agencies from national to local level. Whereas Finland and Norway have a tradition of avoiding such separation, it has not been a common feature in most other European countries. A similar change has recently occurred in Italy. With the recent introduction of a new decentralized system of health planning and management in that country, the local health authorities are now combining all classical health care responsibilities with responsibilities for occupational and environmental health and also for the social services. Those Italian regions that have already gained practical experience with these new arrangements report a marked increase in multisectoral activities. This development is attributed largely to the coincidence of direct need and problem orientation at the local level, to the necessary broad coverage of political, planning and management responsibilities at the local level, and to autonomous local decision-making.

#### 7. Planning for health and financing

In the European Region the variety of financing mechanisms, budgetary processes and pricing procedures reflects the various countries' general governmental features, i.e. state influence or free market principles, centralization/decentralization, etc. Existing regulations frequently have to cover the following basic issues:

- from where do the resources come?
- what resources are available?
- to where do the resources go?
- how many resources are needed?
- what mechanisms are used to mediate between resource demand/need and resource availability?
- what mechanisms are used to steer the processes of resource raising, distributing and spending?
- what mechanisms, if any, are used to regulate the demand for and use of services (i.e. pricing)?

These regulations have the most significant influence on:

- the overall amount of resources available for health development purposes (i.e. the national health quota);
- explicit or implicit priority-setting in the distribution of available resources (i.e. formal national health budgets);
- the relative rigidity or flexibility of resource allocation and consumption patterns (i.e. special health programmes); and
- the complementary mechanisms for steering demand and the use of services (i.e. pricing).

Thus, different financing mechanisms have fundamental implications for the implementation of the HFA2000 strategy. Operational planning and management will either be largely dependent upon these existing regulations or it may influence their future development.

In some countries, health expenditure is financed by the state budget, and in the majority of these countries the source is general taxation, with no special earmarking for health purposes. Whether the budget is a formally integrated health budget or not, health expenditures have to be steadily fought for and justified in the budgetary struggle with all other societal and state sectors. Under these conditions, experienced in many countries of the Region, e.g., Portugal,

Turkey, the United Kingdom and the USSR, the final result of this political process will largely depend on the importance attached to health in a given society and to its organizational standing, and this seems to vary considerably. In some of these countries (Turkey, for example) there are attempts to create extra funding mechanisms in addition to the governmental health budget as a supplementary and more flexible system component.

Other countries traditionally finance the largest part of their health expenditure by means of nongovernmental, autonomous insurance systems that use clearly earmarked contributions for health service programmes only. Financially, the health sector in these countries (e.g. France and the Federal Republic of Germany or, in different terms, in Yugoslavia) is largely independent of state budget developments and competition for funds, and experiences a high degree of budget stability. However, these independent cost-development processes have come under major criticism in the countries concerned because they are becoming increasingly out of balance with the overall socioeconomic development. During the past few years, cost containment has become the overriding health policy issue in these countries. Some types of substitute budgetary ceiling mechanisms have been introduced.

Italy has recently undergone a fundamental change from insurance-based financing of health services to financing principles that are largely taxation- and state-based. Greece is at present facing this same change, with the transformation of the various earmarked contribution funds of insurance systems into one national health budget and a concomitant deliberate increase in health expenditure. However, attention is paid to controlling and rationalizing such expenditure and especially to keeping the state contribution within acceptable limits.

In Finland and Norway, health and social services are financed by state grants from social insurance, together with local authority general taxation. This has led to a decentralized health planning and management system with strong community involvement, backed up by financing principles adequate to the key components of the system. Central-level influence in this system seems to be sufficiently guaranteed by mechanisms for controlling the size of the state contribution, for the control of manpower resources and for the state control of larger-scale investments, e.g. approval of loans from the State for capital investment in hospital buildings.

The geographical allocation of resources plays a crucial role in all Member States with centralized health policy-making and planning mechanisms but with largely decentralized operational planning and management, e.g. the United Kingdom and the Nordic countries. Special "formulae" for the equitable distribution of resources to the various regional units according to objective criteria (without further earmarking) have a long tradition in some countries.

Integrative health budgeting at the national level, especially that covering such classical fields as hospitals and primary health care, but in some cases extending to preventive, occupational and environmental health services as well, exists in some countries, e.g., Finland, Norway, the United Kingdom and the USSR. Experiences with regional integrated health budgets, and sometimes even attempts to standardize the mechanisms and format of such regional budgets, as in the United Kingdom, are rather recent.

Other European Member States are reluctant to integrate health sector budgeting and have different and rather independent sources for financing various branches of the health sector. Such is the case in France, the Federal Republic of Germany and the Netherlands. Up till now there has been little comparative evidence regarding the advantages and disadvantages of an integrated budget or a segmented financing approach as far as the final results of introducing and running the different services connected with "planning for health" are concerned. No member of the Working Group reported the existence of an integrated programme budget for the health sector as a whole, or the existence of a programme budget mechanism spelling out clearly outcomes which are expected to result from the resources allocated.

Countries which place special emphasis on the private delivery of health services within a health insurance system, such as France, the Federal Republic of Germany and the Netherlands, have recently been forced to introduce or strengthen mechanisms for controlling prices, and the overall consumption of medical services. The capacity of such price regulation and control of consumption to serve as major components in health planning and management in a way that is adequate to these countries' basic systems has not been sufficiently explored at the national and international levels.

In the opinion of the Working Group, financing mechanisms will contribute considerably to the implementation of the HFA2000 strategy and make adequate planning for health more easy if they serve the following principles simultaneously:

- (a) they should be in line with the general organization of the State and society, and with the particular features of the health sector;
- (b) they should promote flexible health policy formulation and implementation, setting out a sufficiently stable framework for medium-term health planning and management;
- (c) they should enable consistent priority-setting within the health sector;
- (d) they should include incentives for sectors other than health to contribute to health development to the best of their ability;
- (e) they should contribute to an adequate balance between centralization and decentralization, and between direct community involvement and technical expertise;
- (f) they should strengthen geographical as well as social equity in health development;
- (g) they should guarantee that public and private resources are used in as cost-effective a manner as possible; and
- (h) they should allow health programme outcomes to be linked to resource allocation.

#### 8. Planning for health in a period of economic stringency and instability

The majority of Member States of the European Region are at present passing through a period of economic stringency, with zero or even negative growth tendencies in some cases. There is widespread doubt among economists as to whether this is just a short intermediate phase or the beginning of a longer-lasting basic situation in many national economies. Health expenditures are greatly affected by this situation, as evidenced by cost-containment policies, sharp restrictions on the growth of health budgets, and even cuts in health budgets in a number of countries. This rather restrictive framework makes it impossible to cope with the critical health development referred to in the HFA2000 document by simply increasing health budgets. There are a few exceptions of continuing deliberate health expenditure growth in spite of economic stringency in some Member States, as, for example, the case of Greece quoted above.

Experience in most European countries shows that economic stringency, sometimes coupled with economic instability, exerts serious pressure on meaningful planning approaches. Such pressure may be inversely proportional to a country's general economic strength as, for example, in Portugal and Turkey.

In some countries, conditions of economic stringency have favoured planning and financing models that tend to transfer some of the health expenditure burden from public or semi-public financing to private households. Such a privatization tendency does not usually help to induce a debate on priorities in health care delivery which, in turn, might foster the ideas of HFA2000; rather, it may threaten basic equity goals in the HFA2000 strategy.

In some other countries, economic stringency has brought about a strictly budgetary cost-containment model that concentrates exclusively on overall budget ceilings or budget cuts and leaves priority decisions concerning the different branches and services of the health sector to be made through bargaining within the different interest groups of the sector. This will lead to a reinforcement of the classical, medically-based health care services and thus strengthen the existing structure. New developments and investments in health promotion and disease prevention might be postponed as they offer few short-term rewards. Strictly budgetary cost containment could thus be an obstacle to the implementation of HFA2000.

Although economic stringency has basically negative effects on health planning and management, it may afford new opportunities for strengthening the primary health care strategy if deliberately used for this purpose, and may thus at least have positive side effects. Whether it does so or not depends on a country's health policy and the reaction of planning and management bodies to economic pressure.

Under certain conditions, economic stringency tends to underline the urgent need for substantive priority-setting, planning and management for health. Linked with the need to introduce some ceiling on health expenditures, this can lead to a more outcome- and problem-oriented approach in line with the general goals of HFA2000. Such a development could contribute considerably to planning for health by encouraging the optimal use of given resources and even reallocations between different sectors.

Economic instability poses an even greater threat to meaningful long-term planning, especially in the area of resource and service planning. Under these circumstances, countries with well-developed comprehensive planning and financing systems may be obliged to devote special attention to the flexible use of instruments and to shorten the timescales of their planning endeavours.

Those European countries which favour pluralistic bargaining models and little formal planning seem to be still using a comparatively high share of the gross national product for health expenditure than others. In a period of economic stringency and instability, the health sector as a whole must prove that it has done its utmost to contain health expenditures; otherwise, the opportunity to retain its share of the budget and launch new activities in the preventive field will be threatened. In this context, international statistical comparison will play an important role and could be significantly enlarged.

## 9. Conclusions

- (1) Within the various health systems of Member States in the European Region, planning and management carry different weight. If planning is seen as systematic action taken to modify the future, then virtually all countries develop planning, although the timescale may vary; moreover, the mechanisms used and the degree of formalization are extremely diverse.
- (2) All Member States endorse and are ready to develop national health policies or guidance. However, the translation of this guidance into formalized planning documents has not always been productive or feasible in countries organized on free market principles.
- (3) WHO's HFA2000 documents, although setting out a flexible framework, do not seem to answer adequately questions related to managerial aspects of the health system encountered in non-planned market economy systems. It would be timely and relevant for the WHO Regional Office for Europe to fill this gap.
- (4) Comprehensive outcome-oriented planning for health of the type required for the implementation of HFA2000 still needs to be given further conceptual but practically-oriented foundations. This is especially difficult to achieve during periods of economic stringency and instability. Solutions to this problem are not easy, but at least in some countries it would be beneficial to (a) concentrate on strategic elements, (b) increase the responsiveness of the managerial approach, (c) decentralize, and (d) evaluate the process continuously.
- (5) Decentralization, i.e. the delegation of power and resources, is essential for greater responsiveness to needs and for flexibility and innovation. However, intermediate and peripheral levels may lack adequate personnel and training. To be effective, decentralization in the health sector should be in line with decentralization in other administrative sectors. Whatever the degree of decentralization, the central authority must be able to fulfil certain tasks of coordination, facilitate the introduction of health objectives pertaining to the national level, and ensure interregional development towards equity.
- (6) To achieve a more effective response to the demands of the individual and the community, and to make planning mechanisms more acceptable, more attention should be paid to encouraging greater involvement on the part of users, providers and decision-makers. Forms and procedures vary, depending on the administrative level and the societal features. However, the need for more active involvement of this kind is definitely perceived throughout the Region. It is particularly important that direct participation and involvement should not be replaced by artificial mediating mechanisms, i.e., representatives, pressure groups, politicians, etc. By allowing planners to work in isolation one could well assist in the return of technocratic planning which has little influence on decisions and is received with dissatisfaction by consumers.
- (7) Multisectoral collaboration is, in terms of structure and process, a critical issue in HFA2000. In the European context, sectoral development is coordinated through legal, political, financial and administrative channels; none of these mechanisms is specific to the health sector. In some countries, health planning is part of socioeconomic development planning; in others, less structured means of intersectoral marketing negotiation are used. Whatever the system, it is important to reinforce multisectoral coordination and to be careful not to create artificial structures. The variety of organizational patterns for the health sector and related policy fields leaves little room for valid generalized guidance on this issue. A thorough analysis of the existing mechanisms for coordinating the various protagonists and structures in the field of health mechanisms that are sometimes hidden in administrative and political webs characteristic of the European settings, was deemed most appropriate. The WHO Regional Office for Europe should take the initiative in the development and evaluation of practical approaches to multisectorality.

(8) Leadership in multisectoral approaches is difficult; should the present health care system take the lead it is necessary to be aware of society's growing reluctance to accept an overmedicalized view of health. Multisectorality in planning for health should be beneficial both for the classical health sector and for the other sectors involved. It should be seen as a two-way process, with fewer leadership aspirations and an acceptance of competence on all sides. In many cases, the competence of the health sector in planning for health calls for improvement. Research activities, the training of health and other personnel and practical work in multiprofessional teams with a view to solving multisectoral problems seem to be necessary.

(9) The various financing systems and the existence or non-existence of budgetary processes and pricing procedures in the health field reflect the European countries' general governmental features. These differences seem to have major implications for the implementation of HFA2000, when one seeks to link financing to programmes and objectives expressed in terms of improvement of health status.

The variety of sources in health financing and of mechanisms for cost-control are obstacles in formulating valid general guidance in this respect. As a matter of principle, financing should:

- (a) respect the general organization of state and society;
- (b) enable flexible policy formulation and implementation;
- (c) promote decentralized and multisectoral approaches to planning for health;
- (d) guarantee the use of public and private resources in a cost-effective manner; and
- (e) allow health programme outcomes to be linked to resource allocation.

The exchange of experience on the mechanisms and effects of budget-setting procedures in health planning and management should be given special emphasis by the WHO Regional Office for Europe, in collaboration with other international agencies.

(10) Conditions of economic stringency and instability have basically negative effects on health planning and management, but they may have positive side effects in certain cases, favouring higher cost-effectiveness, health promotion and prevention as well as primary health care.

Economic stringency should not merely lead to a transfer of health expenditures to private households or to undifferentiated budget ceilings or budget cuts. It can act as a challenge, paving the way for substantive priority-setting, planning and management in line with the goals of HFA2000. Economic instability makes the long-term planning of resources and services more difficult. Flexible and very responsive mechanisms should be designed by each country so that health goals may be met in the long term. Emphasis on strategic elements in long-term planning may well be a response to the problems caused by instability.

(11) The Working Group considered that, within the framework of general guidance, activities and guidance more specific to the European Region should be developed by the WHO Regional Office for Europe. In particular, country projects should be encouraged, and it would be advisable to intensify the assistance offered to individual Member States when new health policies are designed and implemented, in line with existing settings and taking full advantage of them. Comparative analysis and joint learning in health planning and management are felt to be more stimulating if they are concentrated on countries with similar problems, mechanisms and sociocultural backgrounds.

Annex 1

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