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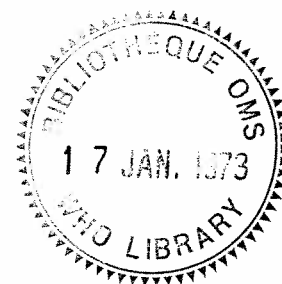
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ORGANIZATIONAL STUDY ON "METHODS OF PROMOTING  
THE DEVELOPMENT OF BASIC HEALTH SERVICES"

Report of the Working Group

The Twenty-fourth World Health Assembly, acting on the recommendation of the Executive Board, selected as the subject for an Organizational Study "Methods of Promoting the Development of Basic Health Services" and called on the Executive Board to present its report on this study at the Twenty-sixth World Health Assembly (see resolution WHA24.38).<sup>1</sup>

At its forty-ninth session the Executive Board established a Working Group of five members to develop the organizational study on the topic selected. The report of the Working Group is now submitted to the Executive Board for its consideration.



<sup>1</sup> Off. Rec. Wld Hlth Org., No. 193, p. 20.

CONTENTS

	<u>Page</u>
1. Introduction and summary . . . . .	3
1.1 Origin of the study . . . . .	3
1.2 Its methods and orientation . . . . .	3
2. General statement . . . . .	4
3. An appreciation of the present position . . . . .	6
3.1 What is done . . . . .	7
3.2 How it is done . . . . .	7
3.3 By whom . . . . .	8
4. Suggestions upon the role of WHO programmes in future developments . . . . .	9
4.1 World health conscience . . . . .	9
4.2 Modes of action . . . . .	9
4.3 WHO's programmes for promotion . . . . .	10
4.3.1 Programme development and the search for new solutions . . . . .	11
4.3.2 Allocation of resources and health planning . . . . .	11
4.3.3 Information systems and evaluation . . . . .	11
4.3.4 Steps indicated . . . . .	12
5. Conclusions . . . . .	13
ANNEX	
Clarification and working definition of health service functions and terminology . . . . .	14

## 1. INTRODUCTION AND SUMMARY

### 1.1 Origin of the study

The Twenty-fourth World Health Assembly<sup>1</sup> decided, on the recommendation of the Executive Board, that the subject of the next organizational study should be "Methods of promoting the development of basic health services" and requested the Executive Board to report to the Twenty-sixth World Health Assembly on the progress of the study.

At the forty-ninth session of the Executive Board in January 1972 a working paper (EB49/WP/6) was submitted for use in discussions on this subject and, subsequently, the Board appointed a Working Group composed of Dr E. Ammundsen, Dr C. Hemachudha, Dr M. U. Henry, Dr Z. Onyango and Dr M. N. Ramzi, to make a further study.

### 1.2 Its methods and orientation

The Working Group met on several occasions, during the forty-ninth session of the Executive Board, during the Twenty-fifth World Health Assembly and again before the fifty-first session of the Executive Board. In the course of these meetings the Working Group reviewed the evolution of the concept of basic health services and the definition of terms; it agreed on the need for a better definition of the basic functions and structure of health services; it reviewed documents produced by the Secretariat and added its own comments and amendments; finally it endorsed two working documents, one of which proposes some alternative strategies for the promotion of basic health services and suggests WHO's possible role in these developments, taking into account the Fifth General Programme of Work and complementing it, while the other describes the conflict which exists in the terminology of health services and suggests some usable terms and definitions.

At its final meeting the Working Group examined the drafts for these two documents and prepared them as the final text of the report for submission to the Board, and as its Annex.

The Working Group's consideration of the methods of promoting the development of basic health services comprised three phases beginning with the very useful general statement of the problem that was presented to the Board at its forty-ninth session in document EB49/WP/6 and now reprinted as the Appendix to this document, through a clarification of terminology (see Annex) to a statement of possible strategies (section 4 of this report). The recognition and consideration of the multiple factors involved in the question and the complexities of the different dysfunctions within the health services of many countries has led the group to some general conclusions, which are presented in three sections, as follows:

- a general statement
- an appreciation of the present position
- suggestions upon the role of WHO programmes  
in future developments.

In all three of these sections an attempt has been made to make general statements of principle rather than specific indications for immediate action. This has been done because it was considered that the questions of this Organizational Study are core questions which must influence all other questions related to health in national administrations, and within WHO. They relate to philosophic principle, political and economic structure, and to national priorities, and while failures and partial failures can be identified, the description of a complete success is impossible at this time. Despite this difficulty it was felt that what is already known does suggest some qualities for change which could accelerate improvements in many countries and which could make WHO's role a more meaningful and effective one.

<sup>1</sup> WHA24.38, Off. Rec. Wld Hlth Org., No. 193, p. 20.

## 2. GENERAL STATEMENT

While the title of this Organizational Study refers to "Basic Health Services" the conclusion drawn from the Annex (Clarification and working definition of health services functions and terminology) was that it deals with the development of "health services". It was found difficult to make any useful distinction between health services designed to provide for the "essential health needs" of a population, and other levels of health services. Health services development is in practice a continuous and continuing process and objective definitions describing where one phase of development ends and another begins cannot be made. Moreover, the concept of "basic health services" has grown in time until it hardly excludes any form of service. However, this does not conflict with the concept of basic health care as a fundamental right of every individual and the corresponding development of the health services according to the principles stated in resolution WHA23.61.

The Board considers that there are five major principles which dominated its discussions and conclusions.

(a) While health services in countries have international significance (as disease can be an international threat) their primary purpose is national. It may be considered that health decisions are an individual or personal matter, but in practice the complexities and expense of health service actions cannot be carried out effectively and efficiently except by groups pooling their resources. For the most part these groups must be national even though in order to ease administration or to increase adaptation to local needs and wishes, the executive actions of a health service may be regional, provincial or local.

The distinction between, on the one hand, the national responsibilities in stating national goals, evolving a standard health technology, a resource allocation within the national scene, and the common use of research, training and specialized institutions, and, on the other hand, the control, configuration and administration of the services at the periphery by the consumers themselves, is a source of major confusion and error. In the Board's view the differences between urban and rural societies, between different regional and ethnic groups, and between persons with different ways of living and values make it essential that the interface between the consumer and the health service be influenced by the consumer and that the accepted pattern serve the needs of both the health services and the consumer. This has no disadvantage in terms of national policies and has enormous advantages as it can result in the tapping of local resources for health service purposes, make medicine "belong" to those to whom it should serve, and encourage innovation and experiment in a place within the health services which matters. The dividing line between national and local responsibility has never been adequately described. The assignment of these different responsibilities can result in insecurity and questions of control. However, the Board considers that a structuring of responsibilities within the health services which gives greater emphasis to consumer preferences need not detract in any way from the primary principle that health services must be thought of and planned as a coherent whole. Yet it seems an essential core question which must be faced and goes many steps further than the support of a decentralized federal structure in a large country.

(b) While the reasons for developing a health service on a national basis may include economic and other factors, most successful examples have been put forward and administered to express a population's demand for social welfare and justice. For this need to be met effectively it should be expressed in terms which can be called "outputs" and which will indicate the final return to the individual in health status and in service. The protection and rights of personnel within the health service need to be removed from the consideration of this national will, and dealt with quite independently as a separate question.

(c) Most health services authorities appear to give only token recognition to those segments of the services not under their financial or direct executive control. National health administrations often "plan" for that part of the national budget which is said to be their responsibility; provincial or regional administrations frequently act similarly. This is often done even though a large or a major part of health expenditures may be made directly by the individual, and not through prepayment or taxation. The same comment could be made about assistance from bilateral or multi-lateral agencies, including WHO to countries. The actions are based upon what this or that body considers that it has the authority, resources or mandate to do, rather than the needs of the health services taken as a whole. This fragmentation "appears" justifiable as it is difficult to make decisions upon matters not directly under executive control, and it may appear a harmless and innocent distortion to support one or other action in a way unrelated to the whole. However, the Board considers it unjustifiable and harmful and that some of the present health service dysfunctions are the result of such thinking. The health service must be taken as a whole, public and private; national and international; curative and preventive; peripheral, intermediate and central.

(d) There has been a long and unsuccessful research endeavour over the years for an overall indicator, or a series of objective quantitative measurements, which could be used to judge the development and performance of health services. No such measurement is at present available and usable on a wide scale. Despite this difficulty it is considered that health service goals, plans, and performance should be thought of under the following criteria:

**Health Status.** The ultimate judgement must be the health of the population. Health in these terms includes fertility, the opportunity for proper growth and development, morbidity, disability and mortality.

**Operational Factors.** Many changes in health status occur slowly and a population requires a visible indication that the immediate and long-term health needs are being adequately dealt with. Therefore a health service must work towards, and use for its own management, a series of operational measures, in addition to health status, which should include the coverage and utilization of the health service facilities as well as other measures of internal functioning.

**Accepted Technology.** For many health conditions which can be influenced either directly or indirectly, there are a finite number of possible methods of intervention. These vary in their cost, their effectiveness, their acceptability, and their usefulness in different societies and in different health service structures. A health service can be partly evaluated by the way a national set of such methods is applied to the relevant populations at risk.

**Cost.** No health service is likely to have sufficient resources to undertake all actions needed. The use of scarce resources for doing "a bit of everything" is also a waste of national treasure. The cost of undertaking health actions is therefore a proper basis for self-examination.

**Consumer Approval.** Both the operation of a health service and the statement of goals and priorities requires consumer approval. There is no single measure of such approval, but underutilization, the development of parallel health service structures (privately or within special groups) and other measures do signify disapproval or criticism and should point to a re-examination of existing solutions.

(e) It seems improbable that any international model or "standard" for health services will be developed. It is also unlikely that within any one country a health service will be evolved in a final form which will not require further change as the result of new knowledge or changed conditions. Therefore although many techniques, approaches and general lines of development may be transferable from country to country, each country will have to possess the national ability to consider its own position (problems and resources), assess the alternatives available to it, decide upon its resource allocation and priorities, and implement its own decisions. The resources needed to undertake these functions at the country level must vary with the size of the country but it appears unlikely that they can be carried out intuitively or without some specialized resources and institutions.

### 3. AN APPRECIATION OF THE PRESENT POSITION

The present world level of health services has never been adequately assessed. However, the experience of the members of the Working Group and the statements made in the Executive Board and the World Health Assembly all point to a situation which should be the basis of real concern. The Board is of the opinion that in many countries the health services are not keeping pace with the changing populations either in quantity or quality. It is likely that they are getting worse. Even if this is looked at optimistically and it is said that the health services are improving, the Board considers that we are on the edge of a major crisis which we must face at once as it could result in a reaction which could be both destructive and costly. There appears to be widespread dissatisfaction of populations about their health services for varying reasons. These dissatisfactions occur in the developed as well as in the third world. They can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness by the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professions but which is not what is most wanted by the consumer.

Examples of such expressions can be found within the borders of most countries but it is suspected that the countries that apparently show least dissatisfaction are probably the ones where the causal factors are most prevalent and where their effects have the greatest disadvantages in terms of health. It is possible to list likely reasons for some of these occurrences. There are insufficient health service funds in many countries although the proportion of the national income spent on health services may often be similar in the wealthy and in the less fortunate. Many countries have an inadequate coverage of the population by State supported health services. But even where "coverage" is high it may be insufficient as the dominating goal must be the use of the proper services. People should be able to afford to use the services, and the services should provide a level of health care which people consider proper to use. A pattern is emerging of less or least utilization of health services in areas which have the least sufficient services. There is a shortage of trained staff at all levels but countries which have insufficient staff show the greatest maldistributions within the country, and appear to have the highest emigration rate. It would appear to be economic and sensible to invest more money in preventive services when this could show a higher return to more people, in terms of health. However, the immediate needs in terms of health care are more important to the parent of a sick child than a long-term possible risk, and a service geared to the long-term needs, and not to emergency care, may be looked upon as an irrelevance and even with anger.

Many other reasons for the present position could be listed. It is not considered that any one predominates or that it can explain most of what is happening. Most are correctable and all deserve detailed attention. Rather it is appropriate to state that these are possibly symptoms of a wide and deepseated error in the way health services are provided. The Board must be aware of this and examine it carefully. It must be prepared to state it widely and publicly knowing that it is a criticism which could find a target in most Member countries. The Board must also be prepared to find solutions which can be widely introduced before the proper reactions of populations, and the national administrations which are responsible to them, force health services into abrupt and destructive changes which may be wasteful and bad.

There are three issues:

What is done (by the health services).  
How it is done.  
By whom.

### 3.1 What is done

It would be fine if a list could be produced stating minimal requirements for health service actions, and for their quality: this would then be the immediate goal of all health services. It is not considered that such a list exists for the world, or should exist. As physicians we cannot say that persons with this or that condition, for which a health intervention is possible, should be given first priority and another disease should be left alone to be dealt with later. Not only collective, epidemiological criteria should be used to decide priorities: there are priorities of individuals, families, and groups, as well as national priorities, and while they may not be described as rational (in a collective sense) they must be not only respected, but taken into account.

If such a listing was made for a country it should include the likely effectiveness of medical measures in correcting these risks or diseases, and the costs. From this national listing, priorities should be made, publicly, and knowing the likely outcomes. The core idea must be that health services should not just grow by minor additions and adaptations but they should be designed and built. There are major expectations that existing techniques of planning, operations research and the management sciences, when applied to the health services, will be able to present optimal choices within the health service resource allocation and priority problems. This is misplaced optimism. These techniques may help present the question in a way in which it may be easier to choose, but health service questions should be expressions of national will rather than of mathematical functions.

The assessment of the resources available, the possibilities for action, and the decision upon resource allocation are the primary questions within the health services.

### 3.2 How it is done

A decision is meaningless unless it can be carried out. Within this task there appear to be three main qualities. Firstly there needs to be a health service structure having the capability of taking action. Many actions do require direct contact between the services and certain selected or all parts of the population. If the health service structure does not have this "coverage" then many actions, whether they be directed to preventive or curative action or to specific programmes such as fertility regulation, will be difficult or impossible. Within this structure there is also a need for varying degrees of competence which can be accessible to certain persons with special needs. This coverage and the manner in which special needs can be catered for selectively, is open to enormous degrees of variation and originality. The Board does not consider that a single or "best" pattern exists.

Secondly, there needs to be proper management. Lip service is given to this idea but there are few indications that the health services are progressing fast in a direction which would result in the introduction of a health management system which could give confidence that health decisions are being carried out in the most efficient way possible. It is said that health services are run by doctors, and doctors are not taught to be managers. If this is true, a different solution will need to be found.

Thirdly, the health services must really be accepted by the persons they serve. It is not difficult to understand why health services have developed as an imposed system upon populations - something from outside which comes into a town or a village from the outside. Medical literature and project proposals are filled with terms such as "acceptors", "refusal rates", "problem families", "underutilization", which show clearly that the problem is seen as a failure on the part of people, rather than a failure of the health services. What is necessary now is to solicit community identification with, and participation in, the development of health services. This will require innovative approaches.

### 3.3 By whom

Section 2 referred to the fact that the decision makers, both nationally and internationally, mainly concern themselves with the segment of the health services under their financial or executive control. In all segments of the health services the same error is apparent. A health worker is only concerned with the part of the picture within his mandate and his professional future and income is dependent upon this alone. If it is possible (and the Board considers it possible) to identify actions, interventions, duties, or tasks which should be carried out at different levels of the health services by individuals or groups of health service workers, then these personnel should be trained to undertake these tasks, singly or collectively, and they should carry them out. The pressure groups to protect professional rights of health service workers must be understood for what they are. This clear protectionist activity is within the health services and is therefore harder to face. It does not appear that it can be attacked purely by changing the health service educational structure. It goes deeper than this and the logical point of change would appear to be an initial structural change of the health services themselves even though this would necessarily involve a major retraining task at many different levels and consequent changes in the educational and training systems.

The interaction between the public (largely Government or tax supported) segment of the health services and the remainder of the health care system (supported by special groups or by individual payment) is not properly understood in most countries. The non-public sector includes persons and institutions of different levels of skills ranging from the specialized hospital to the private general practitioner, the pharmacist, the village midwife, or even the local healer. It also includes persons who are supported completely by individual payments, part-time workers who may be also employed by the public sector or even persons who have only a fringe or occasional involvement in health. All these services are part of the health care system even though the role that some of these individuals play may not be accepted as important or essential within the present view of health service practice.

Two main points about these "private" parts of the health services should be made clear.

Firstly, it is not widely appreciated that in many countries the "private" sector is the dominant one judged both by the expenditures involved and by utilization. This may apply especially to the developing world. This could be thought of as an advantage as the government need not face the direct expenditure, and persons who have the money have an alternative service available to them. The dangers inherent in this state of affairs are not fully appreciated. The principle that essential life-and-death services depend upon the wealth of the individual or family is a bad one, unacceptable in all countries. The growth of private services to a dominant role is not quickly reversible, and inevitably will create major difficulties now and in the future (the grossly disproportionate concentration of private doctors in big cities is one). The placing of the "public" health services in a

subsidiary or supporting role will influence the use of these services and what they can do even now. If trained health workers perform in both public and private capacities, the private role is likely to dominate. These threats in the present and the future may seem to be inevitable and necessary evils while public services are built up. The Board considers them of real moment and requiring public and active attention by health service administration now, because they require urgent action.

Secondly the Board considers that the health services are missing real opportunities by not taking advantage of the resources in money, manpower and local organization which already exist and which could be channelled to further proper national health service goals. Their strengths are in their present acceptance by the populations, their local control, and the proportion of family and community income already assigned to health by individual decisions. Their weakness lies in confused goals and poor expression in terms of health technology and in the lack of contact or relationship with the official health service structure. These weaknesses can be resolved.

The present position is bad but it is not unchangeable. It does not appear to be getting better and without change it is likely to become worse. Minor changes in detail will not bring about correction. Coverage can be increased or doubled, but if the present coverage rate is one per cent., a doubling is meaningless. Administrative change of "vertical services" to "horizontal ones" will not attack the important defects. A decrease of the numbers of hours spent upon anatomy and the replacement by the equivalent number of hours of community medicine in the field, may not be sufficient to change a doctor's thinking and actions radically enough in later life to change the system. Rather than dealing with important but circumscribed reforms, we should deal with the key features of the wider picture.

#### 4. SUGGESTIONS UPON THE ROLE OF WHO PROGRAMMES IN FUTURE DEVELOPMENTS

In this complex and difficult series of problems it is proper to ask what part WHO can or should realistically play.

The Board considers that WHO has an important role in promoting the development of basic health care and the corresponding health services. The role is of three types:

##### 4.1 World health conscience

WHO has no responsibility for any population, but it could be said to have certain responsibilities to everyone in all the Member States. While WHO as an international body must be under proper constraints in order that it does not offend countries or their administrations, these constraints are different ones from those we faced in a national setting. It is possible to use WHO not only as a forum to express ideas or dissatisfactions but also as a mechanism which can point to directions in which Member States should go; a body which can show the constraints in a different perspective; and a catalytic mechanism in which those who agree to follow a new path can be assisted. It is more than useful to have a conscience; it is essential. This organizational study of the Executive Board may give Member States the opportunity to express this conscience in a clear and simple way on this crucial subject, and thence assist the Secretariat to keep it in front of all of us until it results in action. This report, by its nature, must be incomplete and possibly should be further built upon, so that the ideas expressed are put in detail with proper examples, and thus have a greater impact.

##### 4.2 Modes of action

If health service development is one of the dominating medical questions of our time and if the principal forms of action can be identified in the manner expressed in the previous section, then WHO should be advised to adapt its programme to take cognizance of it. By this it is not necessarily meant that WHO's resources should be so markedly enlarged that it can massively deal with the multiple problems in the many countries requiring assistance in this respect.

However, the Board suggests that this question be given a proper recognition within WHO's priorities, so that it reflects its importance. Within this programme there would appear to be some qualities which should be reconsidered once again and which the Board would like to emphasize.

WHO has responded vigorously in the past to major and difficult challenges (smallpox eradication is a good example). There are other examples where it has failed or where progress has been slower or less effective than would have been hoped. The development of health services has been one of these disappointments. The reasons for this are complex but it seems probable that one of them is that the problem has not been phrased in such a way that WHO's role is clear both to the Secretariat and to the countries requiring assistance.

WHO has grown and developed in prestige and experience and has now come of age. The time has come when it can face this priority problem even though both the manner of dealing with it and the implications for national administrations may be different from the past. The Board is convinced that WHO could properly respond to a clear mandate and it is part of the Board's function to supply it.

Health services are essentially a national or country concern but within a country they should be taken as a whole. It would seem therefore essential that assistance by WHO to countries should be integrated so that a health service country programme can be viewed as a whole. Those parts given priority should clearly lead to a series of changes which would pass to a known result in a stated period of time. This country programme for the health services should take into account national developments and actions taken or planned by the national administration as well as by other agencies, whether they be bilateral or multilateral. By this it is meant more than consultation and collaboration. Many present WHO programmes appear to be designed as if WHO was attempting to assist a country alone. This does not seem to be reasonable and may result in WHO attempting to help mainly small subsegments of a country's health service system rather than tackling the major problems which really confront it. This fragmentary policy may appear reasonable considering the amount of resources WHO has available, but the Board suggests that if WHO directed its resources for health services development towards these major basic questions, and accepted the place of other agencies as joint partners for some of the segments, it could be more effective. WHO should assist agencies to play their roles within an overall strategy and accepted priorities (of the country and not the agency).

Every WHO project should be part of a clear and explicit chain of events which will lead to health service action. This does not mean that all of WHO projects should be in direct and intimate contact with the population, but rather that the success of the project should be judged by such actions occurring within the chain in an identifiable manner, and within a reasonable period of time.

It does not seem reasonable for WHO to grade its endeavours to countries strictly in accordance with a "fair share" principle. The promotion of health service development will require major clearly structured programmes over long periods of time. These should be selective and encouraged in countries ready for change and especially in situations where replication is most likely and easy. A priority should be given to major WHO endeavours to countries where the application of intensive programmes is likely to show major returns and where these collaborative endeavours are likely to result in a long-term national capability for dealing with primary problems.

#### 4.3 WHO's programmes for promotion

The Board considers that there are major opportunities for WHO to give important assistance to specific countries, in addition to its wider endeavours, which would be of general significance.

These fall under three main headings.

4.3.1 Programme development and the search for new solutions. The Board does not consider that all likely configurations for health services have been fully explored. There have been few large scale attempts to find, introduce and supervise a health service, staffed mainly by health auxiliaries responsible for primary care. For example, the barefoot doctor idea is an interesting one deserving greater attention. If the peripheral services have clearly stated technical functions consistent with national goals, proper supervision, and a referral system related to the more specialized health service resources and the needs and demands of the community, it would appear probable that coverage and utilization would be improved and a greater return would result from the use of similar resources. It could be said that the way in which such a service could be run is already known and that what is lacking is a national will and a manner of overcoming the entrenched opposition of organized medicine. While these reasons for lack of change may be valid, there are few or no examples where a change in emphasis of the type and degree required has been introduced within an existing health service without a preceding change in social policies. This link between health service and political structure is not so intimate that the health services cannot change separately and independently within most socio-political systems. However, the manner in which health services change in different systems and under different circumstances, the process of change, and the dominating constraints making change difficult, are largely unknown. The Board would consider useful the collection of a body of knowledge relating to this question, but WHO should give an even higher priority to participating in and documenting such changes as they occur in order that these experiences can be made widely available and the lessons learned can be used by others.

A change in resource allocation and structure of the health services is unlikely to be effective by itself. Management of the system at all levels is essential and it is felt that such management can be meaningful and effective and at the same time be simple. WHO appears to have given far too little attention to this subject in the past and should reconsider its place among its priorities.

4.3.2 Allocation of resources and health planning. There are many well-documented difficulties presently being experienced by many health services, including a vertical programme structure, urban-rural maldistribution, major gaps in the health delivery systems, health manpower - health services dysfunctions, consumer dissatisfactions, etc. These difficulties and wasteful abuses appear to be symptoms of a wider core question rather than distorting actions which would settle the problems when they have been solved individually. While many have distinct relationships with lack of resources (monetary and manpower), the core question has been referred to in the general section where it was suggested that the health services need to be thought of as a whole, as an expression of a national decision of social priorities, coupled with a national will to implement, in spite of the vested interests of the health professions if necessary. For effective action there must be a clear expression of these priorities, and a firm and powerful decision-making and implementation structure including the national availability of the minimal competencies able to present alternatives and implement decisions made. Past WHO programmes attempting to assist Ministries of Health to have this capability have taken place in a fragmentary and piecemeal fashion and appear to have been largely ineffective. The Board thinks that this has not been because the principles behind past programmes have been wrong but rather that a different sort of assistance is required. WHO will need to concentrate upon large-scale and long-term (but intensive) assistance involving high calibre experts with both research and practical experience, working on the spot. This help should be participatory rather than advisory and should be directed towards a visible and objectively defined improvement in the health services, coupled with a legacy of the proper national skills and structure able to function permanently.

4.3.3 Information systems and evaluation. Health service information systems as they now exist are often ineffective and inefficient despite their clear need within the activities mentioned above.

There are historical and other reasons for this failure. Some of these reasons are an expression of the difficulties in defining criteria for health service success and have been referred to elsewhere in the text. Health information systems need to be designed once again starting from basic principles.

An information system must come from the needs of the health service programme itself. Can the information needed be identified whether this be for planning, evaluation, decision-making or management and supervision? If it can, then can the place and person requiring the information also be identified and can he state how he is going to use it and in what form? If these questions can be answered work can start upon judging the practicability, cost and workings of the information system through the difficulties and many compromises associated with such a decision. Few examples are known of such a process taking place within a country and this is remarkable or shocking when one remembers that the information systems are for the most part a segment of the health services themselves, are financed by them, and are under their executive control.

4.3.4 Steps indicated. The steps that must be taken to further the development of health services through WHO assistance appear to be clear. They are:

- (1) The Executive Board and the World Health Assembly must renew their mandate to put this problem at the top of WHO's priorities during the next decade. This mandate should include a statement that each Member country should have a health service accessible and acceptable to the total population at the level of health technology considered necessary to meet the problems of that country at a given time; this mandate must emphasize those parts of the problem which are primary to progressive health service development;
- (2) WHO should concentrate upon coherent programmes which will assist countries in providing health care to all of the population; special emphasis should be given to those populations which have insufficient or no access to health services;
- (3) WHO should develop guidelines for national health services systems expressed in their component parts, which can be adapted and developed according to national needs;
- (4) WHO should develop a capability for assisting national administrations in health service development on a country basis;
- (5) WHO programmes should be designed to encourage Member States to develop a strong national will to undertake action in an intensive manner and its resources should be made available to and concentrated in such Member countries as request it;
- (6) WHO should assist such countries to express their health service structure in operational terms with resource allocation, systems analysis and management methods capable of implementing the decision taken; and to assist in the development of national capabilities in these skills within the shortest period of time;
- (7) WHO should concentrate upon adapting and putting in operational terms both the health technology already available and the health delivery system components already known to be essential;
- (8) WHO should encourage and participate in the gathering and relating together of resources (local, national, international, bilateral) able to further these national health service goals;
- (9) these steps should be implemented as quickly and widely as possible.

5. CONCLUSIONS

There are no obvious solutions to the promotion of the development of health services that can be mentioned which have been omitted by WHO endeavours over the past years. The realities behind the lack of effective change would appear to rest upon the low priority they have been given within country programmes and the consequences at the international level; the fragmentary manner in which they have been applied; the lack of appreciation that has been given to the proper judgement that success or failure needs to be evaluated at the periphery by services delivered and health status improved; the failure to look at health services as a whole; and the absence of a clear understanding that WHO can do some things at the request of Ministries of Health which no other organization is able to do. WHO should identify and concentrate upon these aspects rather than attempt to give assistance across the Board which it has neither the resources to do, nor the need. If it can be stated that the starting point in health service promotion and development in a national administration is a national will, it could be said equally to WHO that there is the need for an international will.

ANNEX

CLARIFICATION AND WORKING DEFINITION OF HEALTH SERVICES  
FUNCTIONS AND TERMINOLOGY

1. Introduction

1.1 The first WHO Expert Committee on Public Health Administration (Technical Report Series No. 55, November 1952) remarked that modern public health has been developed during the last hundred years from primarily a legislative and police function to an applied science, which constitutes an important and integral part of social and economic evolution. The techniques used in health administration have consequently been changed to emphasize positive measures in planning and organizing the modern health services on a community basis, in order to create a health environment for the people, and in educating the public for active participation in health work. In general, most governments are following this trend of development particularly where there are few traditions to overcome.

The same Committee consequently added that in view of numerous definitions of public health and of the use of this term occasionally in place of that of preventive medicine, and vice versa, it was necessary to refer to an early (1920) definition by Winslow,<sup>1</sup> already amended in order to include mental as well as physical health. The definition is as follows:

"Public health is the science and art of preventing disease, prolonging life, and promoting mental and physical health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery to ensure to every individual a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity."

In fact this definition outflanked preventive medicine merely through the words "early diagnosis and preventive treatment of disease", in other words the very preliminary phase of medical care or curative medicine. It was considered that development in public health already made it essential to coordinate all measures of prevention, care and restoration into one health service system, which would, thus, be more effective and less expensive through the pooling of resources to achieve a common objective. Therefore, all types of health services rendered in a country by public or private agencies should be integrated into the health programme. Finally, the Committee agreed to adopt the four following terms: health administration - health services (to include medical service) - health care (to include medical care) and health policy. Incidentally, the Committee did not amplify the definition of these terms.

1.2 However, reading through the literature of the past 20 years shows that in WHO and Member State documents, specialized or technical publications, and health leaders' statements, different kinds of health services are denominated as follows:

Health Services  
National Health Services  
Public Health Services  
General Health Services  
Integrated Health Services  
Comprehensive Health Services

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<sup>1</sup> Winslow, C.-E. A. (1923) The evolution and significance of the modern public health campaign, New Haven, p. 1.

Basic Health Services  
Community Health Services  
Personal Health Services  
Family Health Services  
Environmental Health Services  
Rural Health Services  
Urban Health Services  
Regionalized Health Services  
Specialized Health Services  
Specific Health Services  
Categorized Health Services  
Preventive Health Services  
Curative Health Services  
Health Care Services  
Medical Care Services  
Health Infrastructure

This list is not exhaustive and gives an idea of the complexity degree of the subject matter; also the degree of confusion because usually no clear definition is given of the terms or expressions and they are often substituted haphazardly one for another. Possible criteria for classifying these terms could include the public or private character of the services, their single or multipurpose objective, degree of comprehensiveness, coordination or integration, structure, function, organization, geographical location, and individual or group consumer orientation, etc.

1.3 Present health service practice uses terms which can be used in different ways and may be misunderstood. A glossary of some of these terms is given in section 4.

## 2. Levels of objectives

2.1 The ultimate goal is the improvement of the health status as part of individual and community development in order to make the WHO Constitution definition of Health a reality. This goes beyond the responsibilities of the health services alone and involves economic and social development issues as a whole.

2.2 In practice, national health authorities are concerned with the impact of health services on health.

2.2.1 At best, the objective is to provide the population with health services that can cope with health needs and demands in a comprehensive quantitative and qualitative manner by best utilizing the resources available (financial, human, material) within given constraints. This means that the value and justification of the health services system is, or should be, gauged from the following criteria: the appropriateness of the services in terms of their impact on the health status of the population; the adequacy of the services in terms of allocated means to achieve the stated objectives; their effectiveness, defined in technical and operational terms, which characterize their productivity and worthiness, in other words the measurable contribution to the stated objectives made by the accomplishment of the operational activities; their efficiency, taking into consideration both effectiveness and the financial/economic aspects of these services, in other words the search for optimal use of resources in achieving the operational aim.

2.2.2 In many countries, not only developing countries, the general development stage assigns to health services a much more limited objective: to cope with the essential demands (i.e. felt and expressed needs) of the people, and with the essential needs (unfelt but detected by relatively simple measures) of the community - an additional difficulty being that demands may, or may not, always correspond to needs.

Annex

3. Health services systems

3.1 There exist everywhere three main ways of delivering services. In the first the services are brought to the individual; this lends itself to the management of community problems, as well as to community surveys; it also serves the purpose of follow-up of a problem into the community, and may serve for selective search for individuals, groups or ecological situations at greater-than-normal risk for intensive attention or management. In the second, the individual takes the initiative and visits the service; this is the pathway for a "passive" service, and should serve the bulk of the diagnosis and therapy that can be managed without continuous or prolonged observation or surveillance. The third is residential or institutional and temporarily or permanently removes the individual from his environment or community; this should take care only of that part of the load which is unsuited to the other two - by reasons of specialized diagnostic or therapeutic requirements, or where custodial care is unavoidable.

3.1.1 In developing countries the community way was utilized with priority through the setting-up of specific programmes combating the main diseases and developing their own centrally organized and conducted, mostly mobile, mass campaigns. These campaigns were, and still are, justified in certain circumstances and in some fields remarkable achievements have been reached through this category of health services. The single purpose services they deliver through tight vertical links of technical and administrative authority from the central to the peripheral level cannot, even jointly, cover the whole spectrum of needs and demands. They maintain very few, if any, horizontal relationships with other health services. Last but not least, the law of diminishing returns applies to their activities. When they have reached the maintenance phase, the need for an organized static network, operating their vigilance activities, becomes evident. Thereby, the mobile arm of the static institutions ensures an active approach to the community.

3.1.2 One or more levels of care may be provided within each possibility. A functional approach distinguishes what can be called primary, secondary and tertiary care or service.

Primary care services are general health practice services which are offered to the population at the point of entry into the health service system. Primary contact between the population and the health services occurs at this point. Primary services are concerned with individual patients' care as well as with community health. They are responsible for curative as well as preventive activities involving individuals and the community. Environmental services are implied at this level with various degrees of emphasis and sophistication according to the stage of development of the health services and the technical complexity of the problems to be dealt with.

Problems of water supply, environmental pollution, involving sanitary engineering are usually dealt with in another framework. Such a variety of activities implies the need for a health team including professional and auxiliary workers. The composition of the team varies depending on the nature of the community's health problems as well as on the cultural, economic and political factors surrounding the type of organization in which it is located. Responsibility may be divided among medical staff and other health workers according to categories of functions: specific, which correspond to the particular competence of the team members (e.g. MCH, Environmental Sanitation, etc.); general, which are carried out by all team members (e.g. health education, routine immunizations, record-keeping, etc.).

Annex

Primary care services are provided by health workers alone or in units called either dispensaries or primary care centres, primary health centres with satellite subcentres and/or health posts, peripheral health units, rural health units, basic health units, etc. These institutions or persons are at peripheral or local level.

Secondary care comprises the care provided through specialized services on referral from primary care services. Secondary care is usually delivered at intermediate level, i.e. district, county, province, sometimes regional level. In addition to consultation services this level also harbours inpatient general medical wards for referral from the lower level and an important administrative component responsible for guidance and supervision of the peripheral units.

Effectiveness and efficiency of the two above levels of services may be best found in the organization of regionalized health services.

Tertiary care includes highly specialized services and eventually the super specialities such as plastic surgery, neurosurgery, and heart surgery. It is provided mainly at the teaching hospitals and other teaching medical institutions. According to the size and level of a country's development, these institutions will be at intermediate (province, region) level or at central (national) level.

At this level there is also an appropriate administration within the Ministry of Health, or another central Health Authority, whose main functions are planning, technical guidance, management and evaluation.

3.1.3 Given that there are different channels and levels of care possible, it is important that the people concerned should utilize the most suitable point of entry into the health services system, but at the same time adequate mobility within the system be provided; the principle being that care should be provided at the lowest level that can produce a satisfactory outcome.

In practice, failures and limitations are encountered because: the amount and type of care provided may not be proportional to the need; some elements of need receive more, and more expensive attention than is really warranted, and others may remain unfulfilled; there is often neglect and decay of the peripheral elements of the system, which are short-circuited by the client, although these elements may be perfectly well adapted to meet the majority of needs; by contrast, the more central and more specialized elements are usually grossly overloaded with trivial conditions, with the result that the top of the need pyramid (the part really requiring time and skill) is relatively neglected. Ways and means must then be found to reallocate the load within the service system, i.e. to the most appropriate form and level, either as a result of preliminary screening or through subsequent mobility within the system which must thus keep its "pyramidal" character.

3.2 The above system's criteria are the quality and quantity of the services rendered but they do not prejudge the nature of the service. It may apply to separate preventive and curative services as well as to coordinated or integrated services, and to a limited or extended field of health care. It may include or exclude the activities of former specific programmes. Another dimension of the system is, therefore, the degree of coordination and, furthermore, integration of preventive and curative services, as well as single and multipurpose services, and also personal and environmental services. A step further is the coordination, aiming at the same objectives, of health services and social/welfare services. When the system includes the promotion of health, prevention of disease, early diagnosis and treatment of the ill and rehabilitation of the disabled, the level of comprehensive health services will have been reached.

3.3 Whatever the health service system adopted, it addresses itself to the individual by means of personal health services delivery, and to the community by means of community health

Annex

services delivery. A community has been defined as "a group in face-to-face contact, having a basic harmony of interests and aspirations and bound by common values and objectives".<sup>1</sup> It can be geographical, territorial, socio-economic, professional, etc. It can be small - a village, a factory - it can be large, up to a region. The justification of the denomination of community health services increases with the degree of community involvement in health services delivery. It can be merely the location of health services institutions. It can benefit from the latter to the extent that it utilizes them. It can influence their development through some kind of consumer's association. It can ultimately actively participate through various direct and indirect initiatives, assisting the health team, headed by a community health doctor who is primarily a public health team leader, and thus to some extent providing and organizing health services delivery.

3.4 Health services are difficult to define but can be described as a permanent country-wide system of established institutions, the multipurpose objective of which is to cope with the various health needs and demands of the population, and thereby provide health care to individuals and the community, including a broad spectrum of preventive and curative activities, and utilizing, to a large extent, multipurpose health workers. They rest traditionally upon a three-tier hierarchy of central, intermediate and peripheral levels. All levels are concerned with both decision-making and services implementation. But whilst peripheral level is almost entirely concerned with services delivery and training, intermediate level has a great deal of responsibility in technical guidance and supervision, and at central level, a Health Authority, involving Ministry of Health and other administrations, is entitled to decision-taking in the field of planning, evaluation, training, management systems, etc. According to the country's constitution, organizational and administrative structures, forms of government and levels of socio-economic development, health services are part of the state system, or of another public sector organization, or belong to the private sector, or result from a mix of all. Problems of cooperation and coordination vary accordingly, the aim being to obtain a coherent health system.

The steps in developing health services vary, and few if any countries start from nothing. One intermediate objective in health service development has been the provision of health services able to cope with the essential health needs of a large part of the population. This has been described as basic health services. However, in practice health service development does not occur in a completely balanced way and a country with increasing health resources does not start with satisfying essential health needs and then cope with less essential needs and demands. There are few, if any, objective dividing lines between essential needs and demands and lesser priorities. Health services exist, change, and improve and the point that they reach at one point in time is sometimes less important to development than the national ability to appreciate and understand their functioning, to decide upon national priorities, and to implement national decisions.

4. Glossary

This is a set of working definitions clarifying the meaning of a few terms used in literature relevant to health services and which have appeared in this paper:

Evaluation of health services: the systematic and scientific process of determining the extent to which an action or sets of actions were successful in the achievements of predetermined objectives. It involves measurement of adequacy, effectiveness and efficiency of health services. It renders possible the reallocation of priorities and resources on the basis of changing health needs.

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<sup>1</sup> ACC Working Group on Rural and Community Development, Fifteenth Session 1968. Working Paper No. 2: Policy issues concerning the future evolution of community development.

Annex

System: any recognizable delimited aggregate of dynamic elements that are in some way interconnected and interdependent and that continue to operate together according to certain laws and in such a way as to produce some characteristic total effect. A system, in other words, is something that is concerned with some kind of activity and preserves a kind of integration and unity; and a particular system can be recognized as distinct from other systems to which, however, it may be dynamically related. Systems may be complex; they may be made up of interdependent sub-systems, each of which, though less autonomous than the entire aggregate, is nevertheless fairly distinguishable in operation.<sup>1</sup>

Systems analysis: the examination of various elements of a system with a view to ascertaining whether the proposed solution to a problem or problems will fit into the system and, in turn, effect an overall improvement in the system.

Operational research: the application of scientific methods, by interdisciplinary teams, to problems involving the control of any aspect of an organized system so as to provide solutions.

Objective: a measurable state that is expected to exist at a predetermined place and time as a result of the application of procedures and resources.

Goal: a long-range specified state of accomplishments towards which actions and resources are directed; goals are not constrained by time or existing resources.

Adequacy: the allocation of activities and resources in manner and quantity sufficient to permit the achievement of desired objectives.

Appropriateness: the degree to which one alternative set of activities and resources had the potential for ameliorating health status relative to that inherent in other alternatives.

Effectiveness: the ratio between the achievement of the programme activity and the desired level which, during the planning process, the planners had proposed would result from the programme activity.

Efficiency: the ratio between the result that might be achieved through the expenditure of a specified amount of resources and the result that might be achieved through a minimum of expenditure.

Cost-benefit analysis: the systematic comparison - in monetary terms - of all the costs and benefits of proposed alternative schemes with a view to determining: (a) which scheme or combination of schemes will contribute most to the achievement of predetermined objectives at a fixed investment; or (b) the magnitude of the benefit that can result from schemes requiring the minimum investment. The resources required per unit of benefit must be determined, account being taken of the fact that costs and benefits accrue with time.

Cost-effectiveness analysis: a procedure used when benefits are difficult to measure or when those that are measurable are not commensurable. It is similar to cost-benefit analysis except that benefit, instead of being expressed in monetary terms, is expressed in terms of results achieved, e.g. number of lives saved or number of days free from disease.

<sup>1</sup> Allport, F. H. (1955) Theories of perception and the concept of structure.

Annex

Coverage of the population by health services:

physical or geographical coverage is the ratio between the number of health establishments or institutions per administrative unit and the population and area sizes of the unit. This is a theoretical coverage which corresponds to the institutions' zones of responsibility.

functional coverage is characterized by the "catchment areas" of the health institutions, which in turn are defined in terms of the utilization of health institutions by the population (passive coverage) and of the penetration into the population by mobile elements of the health institution or the radius along which population is contacted (active coverage). This is a practical coverage which corresponds to the zones of effective activity of the institutions.

coverage thus described is quantitative. Qualitative coverage depends upon the level of health technology offered to the population which is defined in terms of equipment and personnel ability.

Integration: means putting different parts together to form a whole; to unify, or complete by addition of parts, to combine parts into a whole. In the field of health, it applies to activities, programmes, plans, services. There may be administrative integration, technical integration, and/or both.

Norms: express the "scientifically" determined requirements in a given sector of health, for instance the percentage of admissions to hospitals out of the number of applications for medical care, the average length of stay of patients in the beds and the subsequent number of beds/days required per year.

Standards: express the material, labour and financial resources required if the norms are to be satisfied; for instance, it can be deducted from the above example related to norms that x beds for medical care per 1000 population are required in the given conditions.

Health needs: may be defined as scientifically (biologically, epidemiologically, etc.) determined deficiencies in health that call for preventive, curative, and eventually control or eradication measures.

Health demands: are usually measured in terms of the actual utilization of health services. Consideration must be given to the fact that all felt needs by a population (most usually in curative medicine) cannot be translated into expressed need or demand for various reasons (absence of accessible health services, lack of information, lack of confidence, low income, etc.).