PC-SPIRS 3.30 MEDLINE (R) 1/94-1/95

1 of 26
Marked Record

TI: Educational programs in US medical schools, 1993-1994.
AU: Jonas-HS; Etzel-SI; Barzansky-B
AD: Division of Undergraduate Medical Education, American Medical Association, Chicago, Ill 60610.
SO: JAMA, 1994 Sep 7; 272(9): 694-701
LA: ENGLISH
AB: From the data on faculty, students, and curriculum, is it possible to identify any responses to actual or anticipated health system changes? While one could foresee medical school downsizing in response to a potentially more competitive environment in which income from faculty practice would be reduced, what has occurred, on average, is steady growth in the number of faculty members across departments, with a large increase in the past year. However, expansion is not consistent across states. Between 1992-1993 and 1993-1994, the number of full-time faculty members decreased 1.5% in California medical schools, increased 3% in Minnesota medical schools, increased 6% in North Carolina medical schools, and increased 10% in New York and Pennsylvania medical schools. These differences may reflect the fiscal situation at the state level as well as differences in the practice environment in different areas. For example, managed care has not had a major effect in many markets. It will be important to monitor trends in faculty at both the national and regional levels to understand the full impact of health system changes. There is considerable diversity among US medical schools in goals, in student profiles, and in curriculum structure. A number of schools have goals or objectives that contain a reference to the training of primary care physicians. The majority of these are public institutions, but a number of private schools have chosen to address the issue as well. Many schools, both public and private, are under external scrutiny related to the performance and specialty and practice location choices of their graduates.(ABSTRACT TRUNCATED AT 250 WORDS)

2 of 26
Marked Record

TI: Communication of the monitoring and evaluation process through the use of storyboards and story notebooks.
AU: Lewis-LC; Honea-SH; Kanter-DF; Haney-PE
SO: Semin-Perioper-Nurs, 1993 Oct; 2(4): 269-76
LA: ENGLISH
AB: In preparation for the 1993 Joint Commission on Accreditation of Health Care Organizations (JCAHO) survey, Audie L. Murphy Memorial Veterans Hospital Nursing Service was faced with determining the best approach to presenting their Total Quality Improvement/Total Quality Management (TQI/TQM) process. Nursing Service management and staff, Quality Improvement Clinicians, and medical staff used the Storyboard concept and the accompanying Story Notebooks to organize and to communicate their TQI/TQM process and findings. This concept was extremely beneficial, enabling staff to successfully present the multidisciplinary TQI/TQM data to the JCAHO surveyors.

3 of 26
Marked Record

TI: A review of methods used for medical quality assurance in hospitals: advantages and disadvantages.

AU: Wolff-AM
AD: Wimmera Base Hospital, Horsham, Victoria.
SO: J-Qual-Clin-Pract. 1994 Jun; 14(2): 85-97
LA: ENGLISH
AB: This paper reviews the advantages and disadvantages of medical quality assurance methods commonly used in hospitals. A computer-based literature search up to April 1993 was done using the terms quality assurance, quality control, audit, utilization review, accreditation, occurrence screening and total quality management. In addition, a manual search was undertaken of references of papers obtained by the computer search and of the contents of the following journals: Quality Review Bulletin, Australian Clinical Review and the British Medical Journal. An assessment of the advantages and disadvantages of 15 quality assurance methods used in hospitals was made. Many quality assurance methods used in hospitals have significant disadvantages. A systematic method that provides meaningful and useful information to clinicians and improves patient care is urgently required. New methods such as occurrence screening and total quality management are slowly emerging and have much potential.

4 of 26
Marked Record

TI: The future of healthcare ethics committees.
AU: Smith-ML
SO: Trends-Health-Care-Law-Ethics. 1994 Spring; 9(2): 7-10
LA: ENGLISH
AB: Ethics committees are fairly common in healthcare institutions in the United States. Comprised of a multidisciplinary membership, including physicians, their functions within institutions are generally threefold: policy recommendation, ethics education and case consultation. The number of such committees will grow as a result of "Patient Rights" standards established by the Joint Commission on Accreditation of Healthcare Organizations (1992 Manual). The author projects and discusses five areas of development and change in the future of healthcare ethics committees. These five areas are: 1) renewed efforts to educate healthcare professionals, 2) cooperation and collaboration among ethics committees, 3) networking with community-based ethics groups, 4) clearer delineation of responsibilities and limitations, and 5) continuous quality improvement. The ability of ethics committees to address successfully these areas of change will determine their future usefulness.

5 of 26
Marked Record

TI: Impact of increased intensive care on residents' education [letter]
AU: Carracio-CL; Berman-MA
SO: Acad-Med. 1994 Jul; 69(7): 563-4
LA: ENGLISH

6 of 26
Marked Record

TI: Quality assurance.
AU: Kunkel-MJ
AD: Yale University School of Medicine, New Haven.
SO: Hosp-Pract-Off-Ed. 1993 Jun; 28 Suppl 1: 33-8; discussion 63-4
LA: ENGLISH
AB: At present, there are no accepted guidelines for quality assurance in the outpatient setting, although they are being developed. Greater emphasis is being placed on ongoing rather than retrospective improvement of quality, as measured by the care-giving process and outcome. Thus, programs need to incorporate sound methods for teamwork, communication, and documentation of services.

7 of 26
Marked Record

TI: The measurement mandate: report card day is coming.
AU: O'Leary-DS
AD: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL 60181.
SO: Am-J-Hosp-Pharm. 1994 Mar 15; 51(6): 757-61
LA: ENGLISH

8 of 26
Marked Record

TI: Patient-centered outcome measures of accreditation.
AU: Barr-JT
AD: Bouve College of Pharmacy and Health Science (NERCOA), Northeastern University, Boston, MA 02115.
SO: J-Allied-Health. 1994 Winter; 23(1): 47-50
LA: ENGLISH

9 of 26
Marked Record

TI: A futurist's view of health care and education: impact on specialized accreditation.
AU: Bezold-C
AD: Institute for Alternative Futures, Alexandria, VA 22314.
SO: J-Allied-Health. 1994 Winter; 23(1): 3-9
LA: ENGLISH

10 of 26
Marked Record

TI: Critical challenges facing allied health accreditation: Pew Health Professions Commission's recommendations.
AU: O'Neil-EH
AD: University of California at San Francisco 94109.
SO: J-Allied-Health. 1994 Winter; 23(1): 15-7
LA: ENGLISH

11 of 26
Marked Record

TI: Measuring the quality of health care.
AU: Loegering-L; Reiter-RC; Gambone-JC
AD: Scripps Clinic, San Diego, CA.
SO: Clin-Obstet-Gynecol. 1994 Mar; 37(1): 122-36
LA: ENGLISH

12 of 26
Marked Record

TI: Quality improvement: then and now.
AU: Meeker-CI
AD: Maine Medical Center, Portland 04102.
SO: Clin-Obstet-Gynecol. 1994 Mar; 37(1): 115-21
LA: ENGLISH

13 of 26
Marked Record

TI: Enhancing faculty participation and interest in quality improvement in academic centers.
AU: Akpunonu-BE; Mutgi-AB; Federman-DJ; Wasielewski-N; White-P; Donabedian-H
AD: Department of Medicine, Medical College of Ohio, Toledo 43699-0008.
SO: Am-J-Med-Qual. 1994 Spring; 9(1): 18-23
LA: ENGLISH
AB: Continuous quality improvement (CQI) is necessary in maintaining and improving the quality of medical care delivered. However, quality assurance (QA) in the past was performed superficially to meet requirements of the Joint

Commission on Accreditation of Health Care Organizations and other regulatory agencies. Academic faculty participation in QA activity was also limited. Faculty often assume that meaningful quality process demands excessive efforts and time unrewarded with career advancement, promotion, or monetary compensation. In addition, unstructured QA leads to duplication of data and loss of educational opportunity. We reorganized the QA process in internal medicine using the CQI concept to: (a) improve academic faculty participation, (b) incorporate educational concepts, (c) stimulate interest in outcome research and CQI, and (d) integrate cost containment. A reorganized CQI format has stimulated enthusiastic participation of faculty and residents, and has generated conferences and grand rounds pertinent to medical care, outcome research, and cost containment. We conclude that academic faculty should play leadership roles in the CQI process and include teaching models. Improved and increased academic faculty participation could be realized, when educational values, research activities, and cost analysis are incorporated into the CQI process.

14 of 26
Marked Record

TI: Quality in hospital care.
AU: Novaes-H-de-M
AD: Health Services Development Program, Pan American Health Organization, Washington, DC 20037.
SO: World-Health-Forum. 1993; 14(4): 367-75
LA: ENGLISH

15 of 26
Marked Record

TI: [Accreditation is proof of good quality]
SO: Vardfacket. 1993 May 13; 17(9): 21
LA: SWEDISH; NON-ENGLISH

16 of 26
Marked Record

TI: The measurement mandate: report card day is coming.
AU: O'Leary-DS
AD: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.
SO: Jt-Comm-J-Qual-Improv. 1993 Nov; 19(11): 487-91
LA: ENGLISH

17 of 26
Marked Record

TI: The transition to continuous quality improvement: a home care model.
AU: Ruden-JC
AD: Community Health Accreditation Program, National League for Nursing, New York, NY.
SO: J-Nurs-Care-Qual. 1994 Jan; 8(2): 9-15
LA: ENGLISH
AB: Managers of home care organizations in the 1990s are faced with serious challenges. The magnitude of change occurring makes it difficult to distinguish a reasonable course of action. Quality improvement techniques offer an exciting opportunity for organizations to regain control of their strengths by identifying and improving their weaknesses. This article presents a transitional model for quality improvement involving structure, process, and outcome variables adapted to home care organizations. It encompasses unique committee structures mandated by licensure and certification requirements, which can be adapted to quality improvement focus. Finally, it identifies customer service trends that provide managers with information to fine-tune good business practice.

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Marked Record

TI: Bringing quality to the customer: a new paradigm for quality managers.
AU: Largen-CW
AD: Department of Veterans Affairs Medical Center, Seattle, WA.
SO: J-Nurs-Care-Qual. 1994 Jan; 8(2): 81-4
LA: ENGLISH
AB: The transition of health care organizations to total quality improvement (TQI) models has significant consequences for quality manager roles and quality systems. Changing paradigms regarding one's quality role and programs requires critical self-awareness, new knowledge, and a fresh approach to employee-customer relations. The quality manager's challenges are to discover one's own learning needs, integrate new philosophies into one's behavior, and successfully model and mentor TQI to fellow health care providers. Quality managers have an opportunity to develop a vital and powerful leadership role vis-a-vis TQI and the point of contact between health care provider and patient.

19 of 26
Marked Record

TI: Transition to quality improvement: adapting the quality management plan.
AU: Johnson-T
AD: Division of Surgery, Brookdale Hospital Medical Center, Brooklyn, NY.
SO: J-Nurs-Care-Qual. 1994 Jan; 8(2): 16-21
LA: ENGLISH
AB: Health care organizations across the country are in different phases of transition from quality assurance to quality improvement. A plan is essential to ensure quality assessment and improvement requirements are met while the organization is in transition. Based on the hospital's commitment to quality improvement, the Division of Nursing at The New York Hospital has built on the strengths of the QA program and begun transition to QI by incorporating the principles of QI and developing quality improvement teams with other disciplines and within nursing.

20 of 26
Marked Record

TI: Total quality management in the hospital setting.
AU: Ernst-DF
AD: Department of Nursing, Georgia Southern University, Statesboro.
SO: J-Nurs-Care-Qual. 1994 Jan; 8(2): 1-8
LA: ENGLISH
AB: With the increasing demands on hospitals for improved quality and lower costs, hospitals have been forced to reevaluate their manner of operation and quality assurance (QA) programs. Hospitals have been faced with customer dissatisfaction with services, escalating costs, intense competition, and reduced reimbursement for services. As a result, many hospitals have incorporated total quality management (TQM), also known as continuous quality improvement (CQI) and quality improvement (QI), to improve quality care and decrease costs. This article examines the concept of TQM, its rationale, and how it can be implemented in a hospital. A comparison of TQM and QA is made. Examples of hospital implementation of TQM and problems and issues associated with TQM in the hospital setting are explored.

21 of 26
Marked Record

TI: Preparation for hospital accreditation: an efficient and practical approach.
AU: O'Connor-PT; Wolff-AM
AD: Wimmera Base Hospital, Horsham, Victoria.
SO: Aust-Clin-Rev. 1993; 13(4): 157-63
LA: ENGLISH

AB: Hospital accreditation has been criticized for its emphasis on structure and documentation. Less attention is given to the clinical process and outcomes of care. How can the accreditation process become a meaningful part of day-to-day hospital management? Four approaches are discussed. (1) The development of industrial type quality assurance programmes that detect negative patient outcomes and improve patient care. (2) The appointment of a Quality Assurance/Accreditation Coordinator with appropriate authority. (3) The establishment of an effective Quality Assurance/Accreditation Committee. (4) The continuous review of accreditation standards through normal committee function and department review, and trial surveys. Such strategies will enable hospital accreditation to develop beyond a paper exercise and to provide the foundation for excellence in health care delivery.

22 of 26
Marked Record

TI: Minimally invasive surgery. Implications for hospitals, health workers, and patients.
AU: Banta-HD
AD: TNO Health Research, Center for Medical Technology, Leiden, Netherlands.
SO: BMJ. 1993 Dec 11; 307(6918): 1546-9
LA: ENGLISH
AB: Minimally invasive surgery is one of the great innovations of health care in the 20th century. It promises to revolutionise surgery by allowing many more operations to be performed with minimal hospitalisation. Pressure from patients has caused many techniques to spread rapidly before they have been adequately assessed. This must be resisted, and policy makers must pay more attention to minimally invasive surgery to ensure that good assessments are made. The widespread use of minimally invasive techniques has important implications for hospitals and health workers. As more patients are treated on an outpatient basis, fewer hospital beds will be needed, and traditional operating rooms will have to adapt to a greater turnover of patients. Surgeons will have to acquire new operating skills, possibly requiring formal training and accreditation, and, as different specialties fight for control of new technologies, surgery may eventually be merged with internal medicine so that specialists will deal with organ systems. Postoperative care will have to be carried out in the community rather than in hospitals, and policy makers will need to reorganise their health systems to cope with these developments.

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Marked Record

TI: As it was in the beginning.
AU: Wilson-LL
AD: Qual-med Pty Ltd., Connell's Point, NSW, Australia.
SO: Aust-Clin-Rev. 1993; 13(3): 101-9
LA: ENGLISH
AB: A brief account of the obstacles faced during the introduction of hospital accreditation in Australia is provided, with some insight into the politics of change in health care. Some observations are made concerning critical elements of the accreditation program and the implications for the future of the Australian Council on Healthcare Standards.

24 of 26
Marked Record

TI: The peer review organization process revisited.
AU: Harris-MD
SO: Home-Healthc-Nurse. 1993 Sep-Oct; 11(5): 67-8
LA: ENGLISH
AB: The outcomes of patient care are of increasing importance in the 1990s from a quality of patient care perspective. Most of the review processes that HHAs are subjected to, including the Medicare certification survey, the accreditation process by the Joint Commission on the Accreditation of

Healthcare Organizations and the Community Health Accreditation Program, are focused toward patient outcomes. Also included is the PRO process that addresses the quality of care issue when home care was provided as one of the intervening care services if a patient is readmitted to an acute care facility within 31 days of discharge, HHA standards as well as professional nursing standards. There is no question that the care rendered and the complete and accurate documentation by home healthcare nurses contribute to the minimal number of confirmed quality of care problems that have been identified in HHAs. We would appreciate findings reported in other states. Please share published information on the PRO activities in your state in care of Home Healthcare Nurse. We look forward to hearing from you.

25 of 26
Marked Record

TI: Planning to meet the JCAHO standard: consideration of scientific findings.
AU: Mayhew-PA
SO: Medsurg-Nurs. 1993 Oct; 2(5): 426-8
LA: ENGLISH
AB: Bringing research findings into practice does take some thought and planning, but most health care institutions already have committees, departments, and positions that can facilitate research utilization. It may just take some assessment of the roles and functions of these components to more carefully plan for systematic use of research findings in practice. This planning will pay off by enhancing the quality of nursing care and providing documentation that review of policies and procedures includes consideration of current scientific and nursing research findings.

26 of 26
Marked Record

TI: Introduction of total quality management (TQM) into an internal medicine residency.
AU: Ellrodt-AG
AD: Internal Medicine Training Program, Cedars-Sinai Medical Center, Los Angeles, CA 90048.
SO: Acad-Med. 1993 Nov; 68(11): 817-23
LA: ENGLISH
AB: In spite of significant enthusiasm for the principles and methods of total quality management (TQM) in health care organizations, there have been only a few creative programs applying TQM to medical education. In addition, teaching programs are under significant pressure to teach and practice cost-effective medicine and to produce more sophisticated general internists. In July 1992, the governance and operation of the internal medicine training program at Cedars-Sinai Medical Center was restructured to integrate a TQM program with a health services research section and a resource management department. This restructured program transfers significant programmatic responsibility and power to houseofficers. Within the playing field defined through a housestaff values statement and requirements of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine, the housestaff have brought about substantial change. The first housestaff survey after the new program was operational for six months revealed that 68% of the 77 respondents felt the housestaff had greater programmatic influence, 68% felt that the rate of program change was "better," and 63% felt the overall training program had improved, while 3% felt it had worsened after the restructuring. Fifty-six percent of the housestaff felt the new program should be continued unchanged, and 29% felt it should be continued with changes. Housestaff teams have approached educational issues, quality-of-care problems, and resource management challenges through formal scientific problem-solving techniques. This article discusses the lessons learned in the first six months and the program improvements that will be attempted in the future.(ABSTRACT TRUNCATED AT 250 WORDS)

1 of 27
Marked Record

TI: Quality oversight: how much is too much?
AU: Kraft-JL; Dunham-Taylor-J
SO: Nurs-Econ. 1995 Sep-Oct; 13(5): 272-5
LA: ENGLISH
AB: Concern for quality, which has created $1 billion/year quality oversight businesses, has affected health care organizations financially in different degrees. The most costly is the JCAHO accreditation process. Health care organizations have the power to control these businesses and expenditures.

2 of 27
Marked Record

TI: How best to utilize limited resources.
AU: Forder-AA
AD: Department of Medical Microbiology, University of Cape Town, Medical School, Observatory, South Africa.
SO: J-Hosp-Infect. 1995 Jun; 30 Suppl: 15-25
LA: ENGLISH
AB: South Africa's new health policy embraces the primary health care (PHC) approach for all its peoples and will include good primary, secondary and tertiary care. The policy will hope to provide the highest possible standards of care, yet be of a scale and complexity that the country can sustain into the future. There will almost certainly be rationalization of many of the tertiary teaching hospitals, with inevitable cut-backs in their budgets. This in turn could carry the risk of damage to the fabric of these institutions, which might be impossible to repair. Medicines offer a simple, cost-effective answer to many health problems in Africa, provided they are available, accessible, affordable and properly used. A looming problem in African drug markets is inefficiency and waste. The use of counterfeit medicines has reached unparalleled heights. It is vital that there should be a competent, honest, accountable and independent national drug regulatory authority, secured in law, to provide the necessary infrastructure for the acquisition of sound medicines. Medicines are central to a sound national health policy, but there is great public concern about their costs. Anti-infective drugs are amongst the most widely used class of drugs in the world. Inappropriate use of these agents is widespread and guidelines need to be established for their correct use. The control of all medicines in South Africa is governed by the Medicines & Related Substance Act of 1965. The Medicines Control Council is mandated to ensure that all medicines (including antibiotics) available to the public are efficacious, safe and of high quality. An informally-constituted Antibiotic Study Group has been established in order to monitor aspects of antibiotic therapy that impinge on more general issues of public health, country-wide. The Antibiotic Study Group has instituted an Antibiotic Surveillance Programme to monitor the development of antibiotic resistance nationally. In addition the majority of the tertiary teaching hospitals have comparable in-house antibiotic control policies to help prevent such resistance and to cut costs. These issues need to be debated and resolved. Once in place and working effectively, they will in the long-term supply the most cost-effective means of providing health care for all.

3 of 27
Marked Record

TI: Quality with a human face? The Samuels Planetree model hospital unit.
AU: Blank-AE; Horowitz-S; Matza-D
AD: Grants Management and Research Support, Beth Israel Medical Center, New York, NY 10003, USA.
SO: Jt-Comm-J-Qual-Improv. 1995 Jun; 21(6): 289-99
LA: ENGLISH
AB: BACKGROUND: Hospitals across the country are seeking to restructure the delivery of care. Planetree, an international consumer health care organization, works with hospitals to cultivate educated health care consumers and to create caring inpatient environments. This article gives an overview of Planetree's philosophy, examines staff and patient satisfaction, and contrasts Planetree with total quality management (TQM)/continuous quality improvement (CQI) as practiced at one hospital. PLANETREE'S PHILOSOPHY: Planetree's model differs from other patient-centered or patient-focused care models because of its emphasis on educating patients and making them active partners in the care process. To help make the hospital environment less forbidding, more homelike, and more conducive to social interaction, Planetree physically redesigns the hospital space. STUDY RESULTS: Planetree hopes to achieve many goals with its restructuring of patient care, two of which are staff and patient satisfaction. Preliminary surveys indicate that nurses and nursing assistants on Planetree are more satisfied than are staff on comparable units. The results of patient surveys, however, are more ambiguous. Planetree patients are no more, or no less, satisfied with their care than patients on comparable units. DISCUSSION: Both Planetree and TQM/CQI have goals of improving the delivery of patient care, and there are times when these approaches work in concert. There are times, however, when the different vantage points of TQM/CQI and Planetree may raise different questions and foster different solutions. Questions are also raised regarding whether Planetree benefits all patients in the same way. Furthermore, since it is not clear if Planetree's vision of humanizing patient care brings the results it hopes for, a long-term multifaceted research program is called for.

4 of 27
Marked Record

TI: Sleep in hospitals at night: are patients' needs being met?
AU: Southwell-MT; Wistow-G
AD: Nuffield Institute for Health, Community Care Division, Leeds, England.
SO: J-Adv-Nurs. 1995 Jun; 21(6): 1101-9
LA: ENGLISH
AB: Although the functions of sleep are not clearly understood, it is generally accepted that it is necessary for the maintenance of good health, and that the need for sleep increases with illness. The findings of a study on the hospital in-patient night show that many patients do not consider that they have sufficient sleep in hospital at night; that discomfort, worries and pain may contribute to their wakefulness; that the sleep of many is disrupted by a variety of sources of disturbances; that ward lights are dimmed for the night for no longer than required by the average, healthy person; and that patients continue to be woken early in the morning. A variety of ways of tackling these problems is proposed. Differences in the perceptions of nurses and patients about certain aspects of in-patient care at night demonstrate the importance of systematically asking patients about their experiences. Once viewed through patients' eyes, the everyday procedures, routines and environments of the hospital become visible and tangible influences on patient care, rather than part of the taken-for-granted context in which patients receive that care.

5 of 27
Marked Record

TI: Is quality in the eye of the beholder?
AU: Sales-A; Lurie-N; Moscovice-I; Goes-J
AD: University of Minnesota, Institute for Health Services Research, School of Public Health, Minneapolis 55455-0381, USA.

SO: Jt-Comm-J-Qual-Improv. 1995 May; 21(5): 219-25
LA: ENGLISH
AB: BACKGROUND: Relatively ignored in the literature on quality improvement (QI) in health care is the question of who defines the issues in quality of care and decides how those issues will be addressed. METHODS: In late 1992, 669 hospital administrators, quality assurance (QA) coordinators, physicians, and nurses in 72 hospitals in six states were surveyed by telephone. Respondents were asked to identify the most serious issue related to quality of care in their hospital. RESULTS: Of all the respondents, hospital administrators were most likely to identify quality issues related to organizational/institutional issues. QA coordinators, most of whom had nursing backgrounds, were most likely to identify organizational and patient care issues. Physician responses were distributed approximately evenly across issues related to physicians, to the organization, and to patient care. Nurses were most likely to identify issues related to patient care and patient satisfaction. DISCUSSION: The findings validate the viewpoint that "quality is in the eye of the beholder" and that the eye is conditioned by the discipline in which hospital staff have been trained and socialized. As total quality management and continuous quality improvement approaches are implemented, and participants from many disciplines are involved in QI, a wide range of issues that have both a direct and indirect effect on patient care are likely to be addressed. CONCLUSION: The findings of this study suggest that surveys that specifically target certain disciplinary groups may yield important information about issues related to quality of care.

6 of 27
Marked Record

TI: The role of total quality management in patient-centered restructuring.
AU: Auton-GM
AD: Sunhealth Alliance, Marietta, GA, USA.
SO: J-Soc-Health-Syst. 1995; 5(1): 63-71
LA: ENGLISH
AB: The fundamental structure and organization of the American hospital has changed little in the past fifty years. The current and future environment requires hospitals to reconsider how basic patient care delivery systems are organized and managed. Organizations are discovering how the traditional structure limits a hospital's ability to achieve sustainable improvements in clinical and service quality. A number of pioneering hospitals have initiated efforts during the past several years to completely redesign their organizations to create systems that are patient-centered and customer responsive. This paper discusses the opportunities and obstacles of operational restructuring and how total quality management principles can assist in achieving an effective transition to a new system.

7 of 27
Marked Record

TI: Shared governance: first year experience.
AU: Travis-S
SO: Nebr-Nurse. 1995 May; 28(2): 22
LA: ENGLISH

8 of 27
Marked Record

TI: From development to evaluation. Making a competency plan work.
AU: Britton-BP; Raper-JT; Walden-CM
SO: J-Nurs-Staff-Dev. 1995 Jul-Aug; 11(4): 210-4
LA: ENGLISH
AB: Staff development educators face numerous challenges because of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, continuous quality improvement, and economic constraints. For many, the most difficult challenge is complying with the JCAHO requirement for initial and ongoing competency, which must be validated for all nursing personnel. In this

article, the authors describe how the educational nurse specialists of a tertiary care, regional referral medical center facilitated the development, implementation, and evaluation of a competency plan to validate initial and ongoing competency for all personnel within Nursing Services.

9 of 27
Marked Record

TI: Determinants of compliance with a national smoke-free hospital standard.
AU: Joseph-AM; Knapp-JM; Nichol-KL; Pirie-PL
AD: Department of Medicine, Veterans Affairs Medical Center, Minneapolis, MN 55417, USA.
SO: JAMA. 1995 Aug 9; 274(6): 491-4
LA: ENGLISH
AB: OBJECTIVE--To determine the extent of compliance with the new Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standard requiring acute care hospitals to be smoke-free, and to identify predictors of adoption of smoke-free hospital policies. DESIGN--We conducted a survey of a national sample of acute care hospitals and developed a predictive model for implementation of smoke-free policies during multiple logistic regression. We examined numerous factors that might predict adoption of smoke-free policies, such as hospital characteristics, patient care services, and experience with smoke-free initiatives. SETTING AND PARTICIPANTS--A systematic 20% sample of JCAHO-accredited hospitals in the United States (n = 1278). Military, Department of Veterans Affairs, Indian Health Service, psychiatric, substance abuse treatment, and children's hospitals were excluded. MAIN OUTCOME MEASURE--Compliance with the JCAHO standard. RESULTS--The response rate was 85%. Six-five percent of hospitals were in compliance with the standard 16 months after it was introduced. Factors that were independently and positively associated with implementation of smoke-free policies were administrative support (odds ratio [OR], 7.82; 95% confidence interval [CI], 2.05 to 29.65) and inpatient smoking cessation services (OR, 1.24; 95% CI, 1.02 to 1.52). Factors negatively associated with implementation of smoke-free policy were the number of psychiatric treatment beds (OR, 0.57; 95% CI, 0.14 to 0.81), number of substance abuse treatment beds (OR, 0.17; 95% CI, 0.11 to 0.26), and presence of an active task force to address smoking policy (OR, 0.56; 95% CI, 0.40 to 0.77). CONCLUSIONS--The majority of acute care hospitals are in compliance with the JCAHO national smoke-free policy initiative. The standard is well accepted by most patients and employees. It is critical to address the challenges presented by special populations, such as psychiatry patients, to accomplish the goal of completely smoke-free hospitals.

10 of 27
Marked Record

TI: Smoking bans in US hospitals. Results of a national survey.
AU: Longo-DR; Brownson-RC; Kruse-RL
AD: Department of Family and Community Medicine, University of Missouri-Columbia School of Medicine, USA.
SO: JAMA. 1995 Aug 9; 274(6): 488-91
LA: ENGLISH
AB: OBJECTIVE--To examine compliance and characteristics of hospitals with tobacco control standards enacted by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). DESIGN AND SETTING--On-site national survey of hospitals as part of routine JCAHO accreditation visits. PARTICIPANTS--A total of 3327 US hospitals received site visits in 1992 and 1993 and were matched with American Hospital Association Annual Survey of Hospitals data. MAIN OUTCOME MEASURES--Compliance or noncompliance with tobacco control standards; location in a tobacco-producing state; and organizational characteristics, including provision of psychiatric/alcohol-chemical dependency services. RESULTS--Two years after implementation, 95.6% of hospitals met the new JCAHO smoking ban standard; 90.9% of hospitals were in compliance with a second smoking standard requiring development and use of medical criteria for

physician-ordered exceptions to the ban. Hospitals in tobacco-producing states had higher-than-average rates of compliance when compared with hospitals in other states. Hospitals providing psychiatric and/or substance abuse services had lower-than-average rates of compliance. CONCLUSION--This first industry-wide smoking ban has been successful. However, hospitals should consider evaluating the use of medical exceptions to this policy.

11 of 27
Marked Record

TI: The future of the hospital epidemiologist in the 1990s.
AU: Gross-PA
AD: Department of Internal Medicine, Hackensack Medical Center, NJ 07601, USA.
SO: Infect-Control-Hosp-Epidemiol. 1995 Mar; 16(3): 179-82
LA: ENGLISH

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Marked Record

TI: Accreditation aches and pains [editorial]
AU: Alspach-G
SO: Crit-Care-Nurse. 1995 Jun; 15(3): 13-5
LA: ENGLISH

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Marked Record

TI: Alternate site testing in hospitals--place in the future? [editorial]
AU: Barlow-JF
SO: S-D-J-Med. 1995 Mar; 48(3): 77-8
LA: ENGLISH

14 of 27
Marked Record

TI: From the Joint Commission on Accreditation of Healthcare Organizations.
AU: Loeb-JM; O'Leary-DS
AD: Joint Comission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, USA.
SO: JAMA. 1995 May 10; 273(18): 1405
LA: ENGLISH

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Marked Record

TI: Essential components of growth and development.
AU: Frederick-C; Reining-KM
SO: J-Post-Anesth-Nurs. 1995 Feb; 10(1): 12-7
LA: ENGLISH
AB: The Joint Commission on Accreditation of Healthcare Organizations' standards require that documentation of age-appropriate care be done when a child or adolescent is treated, with particular attention given to growth and development, socialization, and other issues. The principles of growth and development from infancy to adolescence are discussed, including physical, psychological, and psychosocial needs. Nursing implications are presented to improve understanding of growth and developmental stages as well as provision of nursing care.

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Marked Record

TI: Joint Commission on Accreditation of Healthcare Organizations.
AU: Patterson-CH
AD: Department of Performance Measure Development, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL 60181-4813.
SO: Infect-Control-Hosp-Epidemiol. 1995 Jan; 16(1): 36-42
LA: ENGLISH

AB: The Joint Commission on Accreditation of Healthcare Organizations was founded in 1951 as a private, not-for-profit organization that evaluates and accredits hospitals and other healthcare organizations. In 1987, the JCAHO launched its Agenda for Change to create a more modern and sophisticated accreditation process to place primary emphasis on actual performance. Coincident with this new emphasis, a number of task forces were established, including two for infection control standards.

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Marked Record

TI: The Project to Monitor Indicators: a collaborative effort between the Joint Commission on Accreditation of Healthcare Organizations and the Society for Healthcare Epidemiology of America [see comments]
AU: Kritchevsky-SB; Simmons-BP; Braun-BI
AD: Department of Preventive Medicine, University of Tennessee, Memphis.
SO: Infect-Control-Hosp-Epidemiol. 1995 Jan; 16(1): 33-5
LA: ENGLISH

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Marked Record

TI: Quality measurement in nursing: where are we now?
AU: Rantz-MJ
AD: School of Nursing, University Hospital, University of Missouri, Columbia.
SO: J-Nurs-Care-Qual. 1995 Jan; 9(2): 1-7
LA: ENGLISH
AB: The American Nurses' Association commissioned a review of the nursing quality measurement literature to understand the state of the art of nursing quality measurement and to influence policy makers to include nurse-sensitive quality measures in health care reform legislation. Using both computer and hand searching methods, 158 articles that described measuring nursing care quality were abstracted. Recommendations based on the analysis of literature include implementing the Nursing Minimum Data Set (NMDS), documenting nursing hours per patient and the education level of nurse providers in large data sets, implementing a system for determining appropriate outcomes for patients that is sensitive to each individual's potential for self-care or recovery, and continued research directed toward nurse-sensitive outcomes.

19 of 27
Marked Record

TI: Debate on the methods to improve health care.
AU: Cairns-J
AD: St Francis' Hospital, Katete, Zambia.
SO: Trop-Doct. 1995; 25 Suppl 1: 9-12
LA: ENGLISH

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Marked Record

TI: Advance directives in the medical intensive care unit of a community teaching hospital.
AU: Johnson-RF Jr; Baranowski-Birkmeier-T; O'Donnell-JB
AD: Medical Intensive Care Unit, Blodgett Memorial Medical Center, Grand Rapids, MI.
SO: Chest. 1995 Mar; 107(3): 752-6
LA: ENGLISH
AB: STUDY OBJECTIVE: To evaluate the frequency with which advance directives (ADs) are available at the time of admission and their impact on subsequent care in a medical intensive care unit (MICU) setting before and 9 months after the implementation of the Patient Self-Determination Act (PSDA). DESIGN: Prospective nonrandomized cohort data collection and analysis. SETTING: Thirteen-bed MICU of community teaching hospital providing primary and referred care. PATIENTS: Consecutive admissions during 2-month periods separated by 1

year: August-September 1991 (91) and August-September 1992 (92). MEASUREMENTS: The following were assessed: the presence and type or absence of AD at the time of admission; the presence or absence of a written order to limit resuscitation (WO-R) during the MICU stay; duration of MICU stay in hours; outcome; and combined duration of use or administration of seven selected interventions. MAIN RESULTS: Fifteen of 133 patients (11.3%) in the 91 group and 15 of 171 patients (8.8%) in the 92 group presented with an AD. This difference was not significant (p = 0.578). Most patients in both groups (75.9% in 91 and 80.1% in 92) presented without an AD and did not have a WO-R during their MICU course. In addition, most patients who did present with an AD, 11 of 15 (73.3%) in the 91 group and 14 of 15 (93.3%) in the 92 group, did not have a WO-R. A subgroup of older and more severely ill patients in both cohorts was identified; they did not present with an AD but subsequently a WO-R was established. These patients had the highest mortality, about 40%, when compared with the overall mortality of 8.2%. CONCLUSION: Advanced directives were infrequently available and had little impact on the pattern of care.

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TI: From the Joint Commission on Accreditation of Healthcare Organizations.
AU: Seidenfeld-J; Hanold-LS; Loeb-JM
AD: Joint Commission on Accreditation of Healthcare Organizations.
SO: JAMA. 1995 Mar 1; 273(9): 691
LA: ENGLISH

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Marked Record

TI: Why has 'historic' public disclosure of hospital performance data attracted so little attention? [news]
AU: Voelker-R
SO: JAMA. 1995 Mar 1; 273(9): 689-90
LA: ENGLISH

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Marked Record

TI: Rural primary care. American College of Physicians.
SO: Ann-Intern-Med. 1995 Mar 1; 122(5): 380-90
LA: ENGLISH
AB: This overview of rural health care today shows the role that internal medicine can and should play in delivering primary care to rural populations. The American College of Physicians recommends changes to improve access to and delivery of primary care in rural areas. There are six specific recommendations. 1. Implementing universal health care coverage through a system that makes primary care equally affordable to rural populations. 2. Increasing the supply of primary care providers in rural areas by lessening specialty and geographic differentials in physician income. 3. Increasing the supply of primary care providers in rural areas by changing medical education to emphasize training enough rural physicians. 4. Decreasing professional isolation in rural areas through accessible continuing medical education and through telecommunications technology. 5. Identifying tertiary care needs at the community level and using state and federal funds to assist rural hospitals where access to care would be threatened by hospital closure. 6. Using innovative delivery systems that emphasize coordination and cooperation among providers, institutions, and communities.

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Marked Record

TI: What information do consumers want and how will they use it?
AU: Ware-JE Jr
AD: Health Institute, New England Medical Center Hospitals, Boston, MA 02111.
SO: Med-Care. 1995 Jan; 33(1 Suppl): JS25-30

LA: ENGLISH

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Marked Record

TI: Performance measures. How are they developed, validated, and used?
AU: O'Leary-DS
AD: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL 60181.
SO: Med-Care. 1995 Jan; 33(1 Suppl): JS13-7
LA: ENGLISH

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Marked Record

TI: From the Joint Commission on Accreditation of Healthcare Organizations.
AU: Koss-R; Nadzam-D; Loeb-JM
AD: Joint Commission on Accreditation of Healthcare Organizations.
SO: JAMA. 1995 Jan 11; 273(2): 99
LA: ENGLISH

27 of 27
Marked Record

TI: Continuous quality improvement in inpatient clinical nutrition services.
AU: Flanel-DF; Fairchild-MM
AD: Department of Food and Nutrition Services, Yale-New Haven Hospital, CT 06504.
SO: J-Am-Diet-Assoc. 1995 Jan; 95(1): 65-74; quiz 75-6
LA: ENGLISH
AB: Defining quality patient care is a complex and often confusing issue. This article describes one hospital's experience in applying quality improvement theories to inpatient clinical nutrition practice. The key to measuring quality was the use of standardized practice guidelines. In this article, terms such as continuous quality improvement are clarified and fundamental assumptions such as "quality is defined as conformance to requirements" are discussed. We review a working model for the 10-step plan of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and its application in practice, including the indicators and measurement tools used. Actual results from ongoing quality improvement efforts are addressed and compared to the JCAHO nine components of quality patient care. Because of preexisting nutrition practice guidelines at the Yale-New Haven Hospital, improvements in the delivery of patient nutrition care could be demonstrated; these included enhanced efficiencies in screening and intervention. Continuous quality improvement initiatives do work, and practitioners can use the practice experience presented here as a conceptual framework to justify or validate the quality of patient nutrition care in their own institutions.

1 of 16
Marked Record

TI: Seven functions for network accreditation.
SO: Nurs-Qual-Connect. 1995 Sep-Oct; 5(2): 16
LA: ENGLISH

2 of 16
Marked Record

TI: Quality Q & A. Visual quality models.
AU: Green-E
SO: Nurs-Qual-Connect. 1995 Sep-Oct; 5(2): 14
LA: ENGLISH

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Marked Record

TI: Ethics consultation quality: is evaluation feasible? [news]
AU: Phillips-DF
SO: JAMA. 1996 Jun 26; 275(24): 1866-7
LA: ENGLISH

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Marked Record

TI: The best system in the world.
AU: Brody-H
AD: Center for Ethics and Humanities in the Life Sciences, Michigan State University, East Lansing, USA.
SO: Hastings-Cent-Rep. 1995 Nov-Dec; 25(6): S18-21
LA: ENGLISH

5 of 16
Marked Record

TI: How we lie.
AU: Annas-GJ
AD: Law, Medicine and Ethics Program, Boston University School of Medicine, USA.
SO: Hastings-Cent-Rep. 1995 Nov-Dec; 25(6): S12-14
LA: ENGLISH

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Marked Record

TI: Lessons in cooperation: four hospital consortia relate their quality improvement experiences.
AU: Kabcenell-AI; Wakefield-D; Kaiden-SA; Thraen-I; Holland-M; Helms-C; Jordan-C
AD: Program for Improving the Quality of Hospital Care, Cornell University, Ithaca, NY, USA.
SO: Jt-Comm-J-Qual-Improv. 1995 Nov; 21(11): 579-92
LA: ENGLISH
AB: BACKGROUND: In 1989, The Robert Wood Johnson Foundation launched a demonstration project to test a consortium approach to quality improvement. As part of this project, four hospital consortia in various parts of the United States are currently sharing quality resources (for example, training) and collaborating on various improvement efforts. The purpose of the project is to

demonstrate that hospitals can take on more difficult problems and accomplish more in cooperation with each other than on their own. CASE STUDIES: The Institute for Quality Healthcare (Iowa City, Iowa) has built a comparative database so that 40 member hospitals can make meaningful comparisons on various aspects of performance; The Vermont Program for Quality in Health Care has lowered the postoperative infection rate in Vermont by monitoring compliance with consensus guidelines; Interwest Quality of Care, Inc, which has member organizations in Utah, Wyoming, and Idaho, has adapted and disseminated guidelines for diabetic care; and The Public Hospital Institute, in Berkeley, California, has worked with the Joint Commission on Accreditation of Healthcare Organizations to develop a written guide to help surveyors understand the unique operational traits of public hospitals. LESSONS LEARNED: Projects such as those with champions in several member organizations and comparative data analysis lend themselves more easily to cooperative work than others. They also provide some strategies for collaboration, such as continually reinforcing the principles of collaboration, obtaining a fully informed commitment, beginning with initiatives that are likely successes, and being serious and vocal about the commitment to confidentiality. CONCLUSIONS: Collaborators in quality improvement gain important resources, such as better information, more relevant reference databases, colleagues and support for quality improvement specialists, and economies of scale in education programs, training materials, and interaction with vendors. However, the difficulties in collaboration are great. Hospitals must continually consider not only "What's in this for me," but also "What can we accomplish as a group that is greater than what each of us can do alone?"

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Marked Record

TI: From the Joint Commission on Accreditation of Healthcare Organizations.
AU: Loeb-JM; Buck-AS
AD: Joint Commission on Accreditation of Healthcare Organizations.
SO: JAMA. 1996 Feb 21; 275(7): 508
LA: ENGLISH

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Marked Record

TI: Joint Commission on Accreditation of Healthcare Organizations requirements for sedation.
AU: Sklar-DP
AD: Department of Emergency Medicine, University of New Mexico School of Medicine, Albuquerque, USA.
SO: Ann-Emerg-Med. 1996 Apr; 27(4): 412-3
LA: ENGLISH

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Marked Record

TI: Strategies to Prevent and Control the Emergence and Spread of Antimicrobial-Resistant Microorganisms in Hospitals. A challenge to hospital leadership.
AU: Goldmann-DA; Weinstein-RA; Wenzel-RP; Tablan-OC; Duma-RJ; Gaynes-RP; Schlosser-J; Martone-WJ
AD: Department of Medicine, Children's Hospital, Boston, Mass 02115, USA.
SO: JAMA. 1996 Jan 17; 275(3): 234-40
LA: ENGLISH
AB: OBJECTIVE--To provide hospital leaders with strategic goals or actions likely to have a significant impact on antimicrobial resistance, outline outcome and process measures for evaluating progress toward each goal, describe potential barriers to success, and suggest countermeasures and novel improvement strategies. PARTICIPANTS--A multidisciplinary group of experts was drawn from the following areas: hospital epidemiology and infection control, infectious diseases (including graduate training programs), clinical practice

(including nursing, surgery, internal medicine, and pediatrics), pharmacy, administration, quality improvement, appropriateness evaluation, behavior modification, practice guideline development, medical informatics, and outcomes research. Representatives from appropriate federal agencies, the Joint Commission on Accreditation of Healthcare Organizations, and the pharmaceutical industry also participated. EVIDENCE--Published literature, guidelines, expert opinion, and practical experience regarding efforts to improve antibiotic utilization and prevent and control the emergence and dissemination of antimicrobial-resistant microorganisms in hospitals. CONSENSUS PROCESS--Participants were divided into two quality improvement teams: one focusing on improving antimicrobial usage and the other on preventing and controlling transmission of resistant microorganisms. The teams modeled the process a hospital might use to develop and implement a strategic plan to combat antimicrobial resistance. CONCLUSIONS--Ten strategic goals and related process and outcome measures were agreed on. The five strategic goals to optimize antimicrobial use were as follows: optimizing antimicrobial prophylaxis for operative procedures; optimizing choice and duration of empiric therapy; improving antimicrobial prescribing by educational and administrative means; monitoring and providing feedback regarding antibiotic resistance; and defining and implementing health care delivery system guidelines for important types of antimicrobial use. The five strategic goals to detect, report, and prevent transmission of antimicrobial resistant organisms were as follows: to develop a system to recognize and report trends in antimicrobial resistance within the institution; develop a system to rapidly detect and report resistant microorganisms in individual patients and ensure a rapid response by caregivers; increase adherence to basic infection control policies and procedures; incorporate the detection, prevention, and control of antimicrobial resistance into institutional strategic goals and provide the required resources; and develop a plan for identifying, transferring, discharging, and readmitting patients colonized with specific antimicrobial-resistant pathogens.

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Marked Record

TI: TeamWorks: a model for continuous quality improvement in the health care industry.
AU: Hunter-DL; Kernan-MT; Grubbs-MR
AD: Baptist Health Systems, Birmingham, AL, USA.
SO: Am-J-Med-Qual. 1995 Winter; 10(4): 199-205
LA: ENGLISH
AB: Total quality management (TQM) or continuous quality improvement (CQI) are terms no longer being used exclusively within the manufacturing industry sector. Health care facilities, such as hospitals and nursing homes, are beginning to actively compete with each other for patients as well as face new regulations from the government. Hence, it is imperative that these facilities reevaluate their services and correct any production problems in order to be cost-effective and efficient in providing quality. Therefore, the objective of this article is to describe a model developed for improvement of hospital-wide services provided by the Baptist Health Systems' Montclair facility, a private, community hospital located in Birmingham, Alabama. The TeamWorks for Quality model, used to charter over 40 teams, illustrates how managers and employees can build a multifaceted process that delivers services in excess of customer expectations.

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Marked Record

TI: The focused review process: a utilization management firm's experience with length of stay guidelines.
AU: Nelson-MF; Christenson-RH
AD: Meridian Resource Corporation, Milwaukee, WI 53203, USA.
SO: Jt-Comm-J-Qual-Improv. 1995 Sep; 21(9): 477-87
LA: ENGLISH

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Marked Record

TI: Hospital accreditation programmes: some international perspectives [Editorial]
AU: Duggan-JM
SO: J-Qual-Clin-Pract. 1995 Sep; 15(3): 129-31
LA: ENGLISH

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Marked Record

TI: Increasing the impact of quality improvement on health: an expert panel method for setting institutional priorities.
AU: Rubenstein-LV; Fink-A; Yano-EM; Simon-B; Chernoff-B; Robbins-AS
AD: Center for the Study of Healthcare Provider Behavior, Sepulveda Veterans Affairs Medical Center (VAMC), CA, USA.
SO: Jt-Comm-J-Qual-Improv. 1995 Aug; 21(8): 420-32
LA: ENGLISH
AB: BACKGROUND: Successful implementation of modern ongoing quality improvement (QI) methods requires investment of institutional resources, but can produce significant improvements in medical care. A health care organization's goals and objectives for improving care are expressed in strategic plan documents, which could provide a framework for planning quality improvement initiatives. However, institutional strategic planning processes are often not well linked to QI staff and resources. We developed the Quality Action Program (QAP) to connect QI to strategic planning. HISTORY: In 1991, Sepulveda VHAMC implemented a major primary care initiative, documented in a comprehensive strategic plan. The QAP was developed to enable the initiative to be evaluated within a QI context. THREE-ROUND EXPERT PANEL PROCESS: To carry out the QAP, members of an institution's quality council engage in a structured consensus process. The first round involves reading educational materials and filling out a quality action survey the second round includes participation in an expert panel meeting, and the third round involves making final priority rankings. EIGHT-STEP QAP IMPLEMENTATION PLAN: QI staff carry out activities to prepare for and carry out the three-round expert panel process. RESULTS: QAP induced significant institutional QI activity directed toward achieving the top-ranked QI criterion--ensuring continuity of care. Continuity of care improved significantly over time between the pre- and post-QAP periods. CONCLUSIONS: Expert panel methods can be used to link strategic plan goals and objectives to QI efforts.

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TI: The Australian Council on Healthcare Standards care Evaluation Program.
AU: Collopy-BT; Ansari-MZ; Booth-JL; Brosi-JA
AD: Australian Council on Healthcare Standards Care Evaluation Program, Melbourne, VIC.
SO: Med-J-Aust. 1995 Nov 6; 163(9): 477-80
LA: ENGLISH
AB: With the assistance of the medical colleges, the Australian Council on Healthcare Standards (ACHS), through its Care Evaluation Program, has established clinical performance measures which will assist both internal and external review of care and enable hospitals to compare their quality of patient care with that of other hospitals.

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Marked Record

TI: From the Joint Commission on Accreditation of Healthcare Organizations.
AU: Schyve-PM; Loeb-JM; Simmons-BP
AD: Department of Research and Evaluation, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, USA.

SO: JAMA. 1995 Nov 15; 274(19): 1497
LA: ENGLISH

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Marked Record

TI: The availability of health care information for consumer use.
AU: Mowll-CA
AD: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois, USA.
SO: J-Health-Care-Finance. 1995 Summer; 21(4): 31-44
LA: ENGLISH
AB: This study assesses the current availability of health care cost and quality information at both the state and national levels. More than 130 sources were contacted, including all state commissioners of health and state hospital associations. Eighty-one percent of the responding states report provider-specific information to the public, 73% require providers to submit data to the state, and the department of health or a state health care commission is the data collection entity of 69% of the states. However ambitious or mature some state health care data initiatives have become, the comparative measures of provider performance are generally primitive, the data sources are unreliable in many cases, and the data sources and measures are widely variant across states.

1 of 2
Marked Record

TI: What (if anything) is wrong with residency overwork?
AU: Green-MJ
AD: University of Wisconsin-Madison Medical School, USA.
SO: Ann-Intern-Med. 1995 Oct 1; 123(7): 512-7
LA: ENGLISH
AB: Long work hours during residency are a time-honored tradition. Efforts have recently been made to shorten work hours. This paper examines the main arguments supporting reform: that sleep deprivation is harmful to patients and residents and that it is exploitative. Because the data on the harms and benefits are mixed and because exploitation is difficult to prove, a stronger argument for reducing work hours is an ethical one: that overwork interferes with the development of professional values and attitudes that are an essential part of the moral curriculum of residency. Providing a climate that promotes moral growth during training is an important curricular objective that may be better achieved by shortening work hours, providing better resident supervision, and using substitute workers for some of the noneducational tasks of residency.

2 of 2
Marked Record

TI: Diffusion of standards of care for cancer pain [see comments]
AU: Hagen-N; Young-J; MacDonald-N
AD: Department of Clinical Neurosciences, University of Calgary, Alta.
SO: Can-Med-Assoc-J. 1995 Apr 15; 152(8): 1205-9
LA: ENGLISH
AB: The authors report the results of a symposium on improving the standards of care for patients with cancer pain. The symposium was sponsored by the Advisory Committee on Cancer Control of the National Cancer Institute of Canada and was held Apr. 8 to 10, 1994, in Toronto. Participants included experts on control of cancer pain and on diffusion techniques, patients with cancer and representatives of regulatory agencies. They suggested the following strategies to improve outcomes in patients with cancer pain. Processes for accreditation of health care institutions should require documentation of cancer pain, its treatment and its outcome. Tertiary care facilities that provide cancer treatment should have expert, subspecialty, multidisciplinary programs for pain control and should provide adequate psychosocial support to patients suffering cancer pain. The Canadian Cancer Society should conduct a public-education campaign to encourage patients to report pain to health care providers. The National Cancer Institute of Canada should foster research on cancer pain by restructuring its process for review of pain-research protocols. Examinations for professionals who care for patients with cancer should include a defined number of questions concerning pain and symptom control. Provincial programs to monitor prescribing through the use of triplicate prescription pads should have an educational as well as regulatory purpose.

1 of 42
Marked Record

TI: NHS league tables: does a 5-star rating indicate 5-star care? [editorial]
AU: MacAlister-L
SO: Br-J-Nurs. 1994 Jul 14-27; 3(13): 647-8
LA: ENGLISH
AB: The Hospital and Ambulance Services: Comparative Performance Guide 1993-1994 rates all major hospitals in England according to criteria drawn from The Patient's Charter. It is important to interpret the performance ratings carefully as the data do not speak for themselves. Crude data about waiting times may be misleading. An improvement in the waiting times for some treatments may mask increased waiting times for others, perhaps painful, treatments. More informative measures relating to the quality of care are necessary to make meaningful distinctions between the hospitals.

2 of 42
Marked Record

TI: Economic issues in managed care.
AU: Dobbins-R
AD: United American Healthcare Corporation, Detroit, MI 48207.
SO: J-Health-Care-Poor-Underserved. 1994; 5(3): 214-8; discussion 237-9
LA: ENGLISH
AB: Economic issues abound in managed care. The advent of health insurance in the United States, which was created to ensure payment to hospitals, diminished an early emphasis on charity care. Escalating health care costs have ensued. Today, economic considerations dictate the need to control health care expenditures while guaranteeing responsible care. Managed care organizations can achieve both goals by establishing financial partnerships with physicians while instituting quality-control audits, management review teams, and home-care arrangements.

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Marked Record

TI: The quality improvement strategy.
AU: Burns-LR; Beach-LR
AD: Department of Management and Policy, College of Business and Public Administration, University of Arizona, Tucson.
SO: Health-Care-Manage-Rev. 1994 Spring; 19(2): 21-31
LA: ENGLISH
AB: To prepare for managed competition, many hospitals now focus on service quality as a means to improve their competitive position. To aid in decisions about where best to direct limited resources, managers need physician feedback about how the hospital's services compare with its competitors' services (competitive advantage), and about the degree to which the hospital's services fall short of, meet, or exceed physicians' expectations (customer satisfaction). This article describes a strategy for acquiring information about competitive advantage and customer satisfaction and for using the information to identify optimal service improvement opportunities. It then presents a step-by-step application of the Quality Improvement Strategy (QIS) for a large urban hospital.

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Marked Record

TI: Cost containment: the Americas. Argentina.
AU: Palizas-F; Gallesio-A; Wainsztein-N; Ceraso-D; Apezteguia-C; Pacin-J
AD: Intensive Care Unit, Clinica Bazterrica, Buenos Aires, Argentina.
SO: New-Horiz. 1994 Aug; 2(3): 336-40
LA: ENGLISH
AB: For many years, the evolution of Argentina's healthcare system has been influenced by political and economic instability. Inflation and hyperinflation have led to anarchic development of both health administration systems and hospitals. Critical care grew in a similar manner, resulting in a mix of > 500 critical care units with very different levels of technology and trained personnel. Cost-containment policies have been implemented mainly by health administration systems. Public institutions (university and large provincial and county hospitals) have suffered hard budget cuts that have resulted in a decrease in the quality of care and the loss of trained human resources. Union organizations, which cover the healthcare costs of > 60% of the population, implemented a low reimbursement policy that resulted in low standards of care for critically ill patients. The country's private hospital system is extremely heterogenous, ranging from little, simple institutions with a 20- to 30-bed capacity to great private institutions with international standards of care. Cost-containment efforts have been sporadic and isolated, and statistical data to analyze the results are lacking. In order to formulate a strategy of cost-containment in the near future, accreditation and categorization of critical care units and human resources training are being implemented by health authorities and the Argentine Society of Critical Care Medicine.

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Marked Record

TI: GUIDe (Guidelines for the Use of Intensive Care in Denver): a community effort to define futile and inappropriate care.
AU: Murphy-DJ; Barbour-E
AD: Senior Citizen's Health Center, Presbyterian/St. Luke's Medical Center, Denver, CO 80218.
SO: New-Horiz. 1994 Aug; 2(3): 326-31
LA: ENGLISH
AB: Several issues force us to critically evaluate futile or inappropriate intensive care. These issues include cost control, quality of care, and professional and family integrity. The debate has progressed along three avenues: ethical discourse, prognostic scoring systems, and debate in the courts. Despite these arenas of discussion, a consensus about futile or inappropriate care has not been reached. The healthcare profession and the public need to work together to forge a consensus. We describe one model that facilitates this political process. Guidelines for the Use of Intensive Care in Denver (GUIDe) is a consortium of metropolitan Denver hospitals and other healthcare institutions whose goal is to develop guidelines for the use of futile or inappropriate intensive care. The building of consensus starts with subcommittees (adult intensive care, neonatal intensive care, and long-term care) that present proposals at plenary sessions. Other subcommittees (public liaison and legal subcommittees) facilitate dialogue with the public. Feedback from the plenary sessions, the greater medical community, and the public lead to proposal revisions. We expect to present hospitals with actual guidelines in approximately 3 yrs.

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Marked Record

TI: Care of dying patients in hospital.
AU: Mills-M; Davies-HT; Macrae-WA
AD: Department of Epidemiology and Public Health, University of Dundee, Ninewells Hospital and Medical School.
SO: BMJ. 1994 Sep 3; 309(6954): 583-6
LA: ENGLISH
AB: OBJECTIVE--To study the process of care of dying patients in general

hospitals. DESIGN--Non-participant observer (MM) carried out regular periods of continuous comprehensive observation in wards where there were dying patients, recording the quantity and quality of care given. Observations were made in 1983. SETTING--13 wards (six surgical, six medical, and one specialist unit) in four large teaching hospitals (bed capacity 504-796) in west of Scotland. SUBJECTS--50 dying patients (29 female, 21 male) with mean age of 66 (range 40-89); 29 were dying from cancer and 21 from non-malignant disease. RESULTS--Final period of hospitalisation ranged from 6 hours to 24 weeks. More than half of all patients retained consciousness until shortly before death. Basic interventions to maintain patients' comfort were often not provided: oral hygiene was often poor, thirst remained unquenched, and little assistance was given to encourage eating. Contact between nurses and the dying patients was minimal; distancing and isolation of patients by most medical and nursing staff were evident; this isolation increased as death approached. CONCLUSIONS--Care of many of the dying patients observed in these hospitals was poor. We need to identify and implement practical steps to facilitate high quality care of the dying. Much can be learned from the hospice movement, but such knowledge and skills must be replicated in all settings.

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Marked Record

TI: Impact of quality-of-care factors on pediatric intensive care unit mortality.
AU: Pollack-MM; Cuerdon-TT; Patel-KM; Ruttimann-UE; Getson-PR; Levetown-M
AD: Department of Pediatrics, George Washington University School of Medicine, Washington, DC.
SO: JAMA. 1994 Sep 28; 272(12): 941-6
LA: ENGLISH
AB: OBJECTIVE--To determine the importance of the following care factors previously associated with hospital quality on survival from pediatric intensive care: size of the intensive care unit (ICU), medical school teaching status of the hospital housing the ICU, specialist status (pediatric intensivist), and unit coordination. DESIGN--After a national survey, consecutive case series were collected at 16 sites randomly selected to represent unique combinations of quality-of-care factors. SETTING--Pediatric ICUs. PATIENTS--Consecutive admissions to each site. MAIN OUTCOME MEASURE--Patient mortality adjusted for physiologic status, diagnosis, and other mortality risk factors. RESULTS--There were 5415 pediatric ICU admissions and 248 ICU deaths. The ICUs differed significantly with respect to descriptive variables, including mortality (range, 2.2% to 16.4%). Analysis of risk-adjusted mortality indicated that the hospital teaching status and the presence of a pediatric intensivist were significantly associated with a patient's chance of survival. The probability of patient survival after hospitalization in an ICU located in a teaching hospital was decreased (relative odds of dying, 1.79; 95% confidence interval [CI], 1.23 to 2.61; P = .002). In contrast, the probability of patient survival after hospitalization in an ICU with a pediatric intensivist was improved (relative odds of dying, 0.65; 95% CI, 0.44 to 0.95; P = .027). Post hoc analysis indicated that the higher severity-adjusted mortality in teaching hospitals may be explained by the presence of residents caring for ICU patients. CONCLUSION--Characteristics indicative of the best overall hospital quality may not be associated, or may be negatively associated, with quality of care in specialized care areas, including the pediatric ICU.

8 of 42
Marked Record

TI: Individualized developmental care for the very low-birth-weight preterm infant. Medical and neurofunctional effects [see comments]
AU: Als-H; Lawhon-G; Duffy-FH; McAnulty-GB; Gibes-Grossman-R; Blickman-JG
AD: Department of Psychiatry, Harvard Medical School, Boston, MA.
SO: JAMA. 1994 Sep 21; 272(11): 853-8

LA: ENGLISH
AB: OBJECTIVE--To investigate the effectiveness of individualized developmental care in reducing medical and neurodevelopmental sequelae for very low-birth-weight infants. DESIGN--Randomized controlled trial. SETTING--Newborn intensive care unit. PATIENTS--Thirty-eight singleton preterm infants, free of known congenital abnormalities, weighing less than 1250 g, born before 30 weeks' gestation, mechanically ventilated within 3 hours of delivery and for more than 24 hours in the first 48 hours, randomly assigned to a control or an experimental group. INTERVENTION--Caregiving by nurses specifically trained in individualized developmental care; observation and documentation of the infants' behavior within 12 hours of admission, and subsequently every 10th day; developmental care recommendations and ongoing clinical support for the nurses and parents based on regular observation of the infant by developmental specialists; and the availability of special caregiving accessories. MAIN OUTCOME MEASURES--Medical outcome, including average daily weight gain; number of days the infant required mechanical ventilation, oxygen, gavage tube feeding, and hospitalization; severity of retinopathy of prematurity, bronchopulmonary dysplasia, pneumothorax, and intraventricular hemorrhage; pediatric complications; age at discharge; and hospital charges. Neurodevelopmental outcome, including Assessment of Preterm Infants' Behavior scale and quantified electroencephalography (2 weeks after due date); and Bayley Scales of Infant Development and Kangaroo Box Paradigm (9 months after due date). RESULTS--The infants in the experimental group had a significantly shorter duration of mechanical ventilation and supplemental oxygen support; earlier oral feeding; reduced incidence of intraventricular hemorrhage, pneumothorax, and severe bronchopulmonary dysplasia; improved daily weight gain; shorter hospital stays; younger ages at hospital discharge; and reduced hospital charges compared with the infants in the control group. At 2 weeks after their due dates, these infants also showed improved autonomic regulation, motor system functioning, self-regulatory abilities, and visual evoked potential measures; and at 9 months, they had improved Bayley Mental and Psychomotor Developmental Index scores, as well as Kangaroo Box Paradigm scores. CONCLUSION--Very low-birth-weight preterm infants may benefit from individualized developmental care in the neonatal intensive care unit in terms of medical and neurodevelopmental outcome.

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Marked Record

TI: Evaluating risk adjustment by partitioning variation in hospital mortality rates.
AU: Smith-DW
AD: Biostatistics and Epidemiology Department, College of Public Health, University of Oklahoma, Oklahoma City 73190.
SO: Stat-Med. 1994 May 30; 13(10): 1001-13
LA: ENGLISH
AB: The variation in mortality rates among hospitals has often been described informally as having three major components: patient severity, quality of care and random variation. These informal concepts are characterized formally by partitioning sums of squares and finding their expected values. The partition relates to commonly used tests for whether individual hospitals have unusual mortality rates. Application of the partition to the hospital mortality reports by the Health Care Financing Administration shows that their models for patient risk account for about one-half the variation among hospital mortality rates. An example using clinical measures of severity accounts for about two-thirds of mortality variation among hospitals.

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TI: Interim report of the Quality Indicator Study Group.
AU: Scheckler-WE
AD: University of Wisconsin Medical School, Department of Family Medicine,

Madison 53715.
SO: Am-J-Infect-Control. 1994 Apr; 22(2): 30A-36A
LA: ENGLISH

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Marked Record

TI: Can we set futile care policies? Institutional and systemic challenges.
AU: Murphy-DJ
AD: St. Luke's Hospital, Denver, CO 80218.
SO: J-Am-Geriatr-Soc. 1994 Aug; 42(8): 890-3
LA: ENGLISH

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Marked Record

TI: Standardizing the language for nursing treatments: an overview of the issues.
AU: McCloskey-JC; Bulechek-GM
AD: College of Nursing, University of Iowa Hospitals and Clinics, Iowa City.
SO: Nurs-Outlook. 1994 Mar-Apr; 42(2): 56-63
LA: ENGLISH
AB: The development and use of standardized language in nursing marks the development of a new era of nursing science. It will assist the professional nurse to communicate with colleagues in her or his own facility and across the world. Being able to clearly articulate what it is we do makes visible what previously has been invisible about nursing. When we use standardized language to document the care we give, then we can build large databases, which will articulate with those of other health providers, that can be used to demonstrate the effectiveness of nursing care. As we move into the 21st century, the use of standardized nursing language will become one of the hallmarks of the profession.

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TI: CEO summit. The new delivery & financing realities. Part II of III.
AU: Becker-BF; Cramer-H; Easley-D; Nathanson-P; Neeson-R; Raney-J; Samuelson-C; Ummel-S
SO: Hosp-Health-Netw. 1994 Aug 5; 68(15): 86-8
LA: ENGLISH
AB: In cooperation with McManis Associates Inc., Hospitals & Health Networks recently convened a summit on the integration of financing and delivery in health care. This is the second of a three-part series on lessons learned by those on the front lines of integration activity. The session was designed and facilitated by senior associates at McManis. Among the issues discussed in this second segment. What level of understanding do purchasers have of quality differentiators in health care services? Can provider-driven integrated delivery systems compete with insurer-driven ones? And what happens when, as in the Philadelphia market, a large integrated delivery system merges with a dominant insurer? Can that model be replicated in other markets?

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TI: Understanding patient-centered care in the context of total quality management and continuous quality improvement.
AU: Wakefield-DS; Cyphert-ST; Murray-JF; Uden-Holman-T; Hendryx-MS; Wakefield-BJ; Helms-CM
AD: Graduate Program in Hospital and Health Administration, University of Iowa, Iowa City 52242.
SO: Jt-Comm-J-Qual-Improv. 1994 Mar; 20(3): 152-61
LA: ENGLISH
AB: BACKGROUND: Implementing patient-centered care (PCC) requires a fundamental shift in thinking-from how to best provide a wide variety of independent

services to how to effectively combine individual service components into an integrated health care experience that meets patient needs and preferences. DISCUSSION: PCC attempts to improve patient care by organizationally and physically moving selected service functions such as basic laboratory, pharmacy, admitting/discharge, medical records, housekeeping, and material support services to patient care areas, thus effecting an organizational restructuring. PCC creates teams composed of multiskilled or cross-trained individuals capable of providing more of the services directly on the patient care unit. Extensive redesign of the basic work processes as proposed by PCC advocates may result in significant changes in employee job scope, task responsibilities, professional autonomy, and reporting relationships. From the employee's perspective such changes may be neither warranted nor welcomed. Therefore, critical PCC implementation issues include obtaining employee buy-in and establishing appropriate incentive structures to facilitate the desired changes. How does PCC fit in with the popular improvement philosophies of total quality management (TQM) and continuous quality improvement (CQI)? Inherent within TQM and CQI is the belief that it is wiser to maximize efforts to design a product or process to be right the first time and to minimize resources devoted to inspection and repair caused by poor processes. PCC builds upon previous TQM/CQI health care efforts by focusing on ways to reduce the white space handoff problem by examining what, if any, changes in underlying structures and processes may be required. In the PCC hospital, TQM/CQI can function as intended, as a methodology for examining and improving the process of care and patient-care outcomes, regardless of internal departmental or profession-based organizational boundaries. CONCLUSION: For hospitals to remain competitive in today's rapidly changing environment, it is becoming necessary to reevaluate both how they are organized and how their work processes have been designed and controlled. The groundwork already laid by TQM/CQI initiatives will facilitate the more fundamental and long-lasting improvements derived from the redesign of the patient-care unit as prescribed by the goals of PCC.

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TI: Equity in the NHS. Monitoring and promoting equity in primary and secondary care.
AU: Majeed-FA; Chaturvedi-N; Reading-R; Ben-Shlomo-Y
AD: Department of Public Health Sciences, St George's Hospital Medical School, London.
SO: BMJ. 1994 May 28; 308(6941): 1426-9
LA: ENGLISH
AB: Although need is often assumed to be the most important factor in determining the use of health services, there are many inequities in the provision and use of NHS services in both primary and secondary care. For example, existing data from district child health information services have been combined with census data for small areas to show wide variations in immunisation rates between affluent and deprived areas. Purchasers of health care are already responsible for assessing health needs and evaluating services, and the process of monitoring equity is a logical extension of these activities. Routine data sources used to collect activity data in both primary and secondary care can be used to assess needs for care and monitor how well these needs are met. Purchasers and providers should collaborate to improve the usefulness of these routine data and to develop a framework for monitoring and promoting equity more systematically.

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TI: A quality improvement focus for patient rights: advance directives.
AU: Oleson-KJ; Jones-Schenk-J; Tuohig-GM
AD: Nursing Practice Department, University of Utah Hospital, Salt Lake City.
SO: J-Nurs-Care-Qual. 1994 Apr; 8(3): 52-67

LA: ENGLISH
AB: This article highlights the implementation and evaluation phases of specific mechanisms developed in a university hospital setting to comply with the Patient Self-Determination Act (PSDA) of 1991. The article describes the program within the context of a continuous quality improvement cycle beginning with a philosophy about patient involvement in health care decision making. The article takes the reader through each phase of the process, culminating in the development of a revised quality improvement plan.

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Marked Record

TI: Interim report of the Quality Indicator Study Group.
AU: Scheckler-WE
AD: University of Wisconsin Medical School, Department of Family Medicine, Madison 53715.
SO: Infect-Control-Hosp-Epidemiol. 1994 Apr; 15(4 Pt 1): 265-8
LA: ENGLISH

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Marked Record

TI: Financial and clinical performance: bridging the gap.
AU: Fleming-ST; Boles-KE
AD: University of Missouri-Columbia.
SO: Health-Care-Manage-Rev. 1994 Winter; 19(1): 11-7
LA: ENGLISH
AB: The article explores the relationship between the cost and the quality of hospital care by elaborating a conceptual model of hospital performance. The model relates the financial health status of an organization (financial integrity) to the quality of care provided by that organization (clinical integrity) within an environment that is characterized by various forms of risk. The model suggests that both concepts determine the corporate destiny (success, bankruptcy, or merger) of the organization. If this model proves valid empirically, the results could be used as an early warning system to identify hospitals that might experience financial or clinical distress.

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TI: What is interface audit?
AU: Baker-R
AD: Eli Lilly National Clinical Audit Centre, Department of General Practice, University of Leicester, Leicester General Hospital, UK.
SO: J-R-Soc-Med. 1994 Apr; 87(4): 228-31
LA: ENGLISH

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Marked Record

TI: Closing the gap between research and practice.
AU: Bostrom-J; Wise-L
AD: Stanford University Hospital, California.
SO: J-Nurs-Adm. 1994 May; 24(5): 22-7
LA: ENGLISH
AB: Currently, a 10- to 15-year gap exists between discovery of potential innovations and implementation of these innovations into nursing practice. The Retrieval and Application of Research in Nursing (RARIN) project is helping to reduce this gap in one western hospital. The goal of RARIN is to improve the quality of nursing care by facilitating the transfer of new and clinically relevant nursing information to current practice. This is accomplished by providing nurses with both the tools and training for rapid retrieval of scientific information. Their work areas have been electronically linked with local, national, and international scientific information systems.

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TI: Managed care plan performance since 1980. A literature analysis.
AU: Miller-RH; Luft-HS
AD: University of California-San Francisco, Institute for Health & Aging 94143.
SO: JAMA. 1994 May 18; 271(19): 1512-9
LA: ENGLISH
AB: OBJECTIVE--To compare the health care utilization, expenditure, quality of care, and satisfaction since 1980 of enrollees in managed care and indemnity plans. DATA SOURCES AND STUDY SELECTION--Studies selected met the following criteria: data from 1980 forward, private insurance or Medicare enrollees, a comparison group, a reasonable attempt at statistical adjustment for noncomparable managed care and indemnity plan enrollees, and peer-reviewed findings (with two exceptions). Few studies on preferred provider organization plan performance met the selection criteria. DATA SYNTHESIS--Compared with indemnity plans, health maintenance organization plans had somewhat lower hospital admission rates, 1% to 20% shorter hospital length of stay, the same or more physician office visits per enrollee, less use of expensive procedures and tests, greater use of preventive services, mixed results on outcomes, and somewhat lower enrollee satisfaction with services but higher satisfaction with costs. The evidence does not support the hypothesis that prepaid group practice or staff model health maintenance organizations are more effective than individual practice association or network model health maintenance organizations. CONCLUSIONS--Although this literature analysis found several clear patterns of results, several factors, including unmeasured selection bias, diverse and rapidly changing health plans and local market conditions, and relatively few research results, suggest that generalizations must be made with caution.

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TI: Variation in practice for discretionary admissions. Impact on estimates of quality of hospital care.
AU: Miller-MG; Miller-LS; Fireman-B; Black-SB
AD: Department of Quality and Utilization, Kaiser Permanente Medical Care Program, Oakland, CA 94612.
SO: JAMA. 1994 May 18; 271(19): 1493-8
LA: ENGLISH
AB: OBJECTIVE--To demonstrate theoretically and empirically the existence of systematic bias in commonly reported standardized hospital mortality ratios when variation in hospital admission practice is not adjusted for in the analysis. The underlying analytic model used in hospital mortality analyses is specified and the confounding effect of selection bias arising from variation in admission practice is shown. DATA SOURCES--An empirical example is presented using state-level data from the Health Care Financing Administration's Medicare Hospital Information Report for 1988 to 1990. STUDY SELECTION--The Medicare Hospital Information data are used to demonstrate the effects of the bias because they contain population-based admission rates and mortality rates. DATA SYNTHESIS--Selection bias arising from variation in admission practice causes the expected mortality rate to be overestimated for all hospitals, but especially for hospitals with more lenient admission practices. Using the Medicare Hospital Information Report, the resulting standardized hospital mortality ratios are shown to be significantly inversely correlated with higher relative risks of hospitalization ($P < .01$). CONCLUSION--Standardized hospital mortality ratios based on analyses that do not account for variation in admission practice among hospitals are biased. Variation in admission practice will cause any outcome measure based solely on hospitalized patients to be similarly biased. Correction for selection bias is required to produce valid measures of hospital quality.

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TI: Targeting ambulatory care cases for risk management and quality management.
AU: Macnee-CL; Penchansky-R
AD: College of Nursing, Department of Family and Community Health, East Tennessee State University, Johnson City 37614-0676.
SO: Inquiry. 1994 Spring; 31(1): 66-75
LA: ENGLISH
AB: Means are needed to identify "highly productive" areas for quality review and risk management in ambulatory care; untargeted medical record reviews have too low a yield and too high a cost to be useful. Highly productive areas are those with important medical and economic consequences, large numbers of cases, and a reasonable potential that problems exist. This paper describes untoward event screens to identify highly productive areas for review based on hospital discharge diagnosis, procedure codes, and parameters such as length of stay and cancer staging. The approach proposed has been evaluated in six ambulatory care organizations and appears effective and efficient.

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Marked Record
TI: Corporate relations. Business ethics.
AU: Keane-MM
AD: Nova Care, Inc., Fairfax, Virginia.
SO: ASHA. 1994 Feb; 36(2): 47-8
LA: ENGLISH

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Marked Record
TI: [The evaluation of outpatient nursing care according to the client's perception]
AU: Sanna-MC
SO: Rev-Esc-Enferm-USP. 1993 Apr; 27(1): 133-49
LA: PORTUGUESE; NON-ENGLISH
AB: This study reveals the clients perception of a pediatric ambulatory in a great University Hospital, about the quality of the offered nursing assistance. An investigation was oriented by the phenomenologic approach which propitiated the reveling of reality investigated from the analysis of the interviewed clients discourses. The studied answers were grouped in three categories: the Nursing Work, the Nursing Attitude and the Evaluation of the Received Assistance. Upon these topics the interviewed clients formed a not very clear concept of nursing as science and as a profession. The related aspects and the commentaries about the expected and the meeted behaviours by the nursing professionals merited a larger part of attention by the interviewed clients. The evaluation of the received attendance was centered on absence of complaints. The interviewed clients expectancy is directed towards the satisfaction of the security and acceptance needs from which the mothers of children are deprived. The attendance of this necessities give mothers conditions for establishment of a professional-client link to a therapeutic relationship. Which the devolution of the findings to the nurses responsible for the ambulatory assistance, we pretended to contribute to the improvement of the offered assistential quality.

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Marked Record
TI: Nursing quality management in The Netherlands.
AU: Giebing-H
AD: Nursing Quality Assurance Programme, Utrecht, The Netherlands.
SO: Int-Nurs-Rev. 1994 Jan-Feb; 41(1): 17-22
LA: ENGLISH
AB: Since 1979 the National Organization for Quality Assurance in Health Care (CBO) in the Netherlands has been offering support and training to healthcare professionals in the application of structural and systematic quality assurance

activities in hospitals. Below, CBO's framework to develop nursing quality management at institutional and national level, with the ultimate goal of ongoing quality improvement of nursing care.

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Marked Record

TI: Withdrawing care. Experience in a medical intensive care unit.
AU: Lee-DK; Swinburne-AJ; Fedullo-AJ; Wahl-GW
AD: Rochester General Hospital, NY 14621.
SO: JAMA. 1994 May 4; 271(17): 1358-61
LA: ENGLISH
AB: OBJECTIVE--To describe the process and outcomes of withdrawing life-sustaining interventions in a medical intensive care unit (MICU). DESIGN--Retrospective case series. SETTING---Medical intensive care unit in a community teaching hospital. PATIENTS--Consecutive series of 28 patients in whom mechanical ventilation, dialysis, and/or vasopressors were withdrawn. We distinguished physiological, neurological, and functional rationales for care withdrawal. MAIN OUTCOME MEASURES--Duration of discussions, MICU length of stay, and hospital survival. RESULTS--Mean +/- SD Acute Physiology and Chronic Health Evaluation (APACHE II) score was 27.1 +/- 7.3 on MICU admission, and average +/- SD predicted hospital mortality was 61% +/- 22%. Discussions leading to withdrawal of care occurred over an average +/- SD of 5.2 +/- 5.5 days, with decisions achieved soonest in cases with poor neurological prognosis. Average +/- SD MICU length of stay was 1.4 +/- 1.8 days following a decision to withdraw MICU care, and only four patients received more than 48 hours of additional MICU care. Four patients were discharged alive from the hospital. CONCLUSIONS--Patients and their surrogates willingly considered outcomes in addition to mortality when considering withdrawal of life-sustaining interventions. Finding an accommodation between physician judgments and patient preferences took time and effort but was an effective means of limiting ineffective life-sustaining efforts. Withdrawing futile or unwanted care was not always fatal.

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Marked Record

TI: Quality of health services in Papua New Guinea: what do we know?
AU: Thomason-JA
AD: Department of Community Medicine, University of Papua New Guinea, Port Moresby.
SO: P-N-G-Med-J. 1993 Jun; 36(2): 90-8
LA: ENGLISH
AB: The discussion of quality issues in Papua New Guinea requires that attention be focused on what is known about the actual quality of the health care provided in Papua New Guinea. Since 1987 there has been increasing evidence that there are serious deficits in the quality of care in rural areas and that there are similar problems in the country's hospitals. This paper summarizes what is known and discusses the implications for the development of quality assurance activities in Papua New Guinea. The paper concludes that many of the deficiencies observed are amenable to improvement through simple and inexpensive means and that with sustained commitment, improvements are achievable.

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TI: Consensus statement on the triage of critically ill patients. Society of Critical Care Medicine Ethics Committee.
SO: JAMA. 1994 Apr 20; 271(15): 1200-3
LA: ENGLISH
AB: The demand for medical services such as critical care is likely to often exceed supply. In the setting of these constraining conditions, institutions and individual providers of critical care must use some moral framework for

distributing the available resources efficiently and equitably. Guidelines are therefore provided for triage of critically ill patients. There are several general principles that should guide decision making: providers should advocate for patients; members of the provider team should collaborate; care must be restricted in an equitable system; decisions to give care should be based on expected benefit; mechanisms for alternative care should be planned; explicit policies should be written; prior public notification is necessary. Patients who are not expected to benefit from intensive care, such as those with imminently fatal illnesses or permanent unconsciousness, should not be placed in the intensive care unit. Hospitals should assign individuals the responsibility of intensive care triage, and a committee should oversee the performance of this responsibility to facilitate the most efficient and equitable use of intensive care.

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TI: Does the patient come first?
AU: Ausman-JI
SO: Surg-Neurol. 1994 Mar; 41(3): 253
LA: ENGLISH

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TI: Computers, quality, and the clinical laboratory: a look at critical value reporting.
AU: Tate-KE; Gardner-RM
AD: LDS Hospital/Brigham Young University, Salt Lake City, UT.
SO: Proc-Annu-Symp-Comput-Appl-Med-Care. 1993: 193-7
LA: ENGLISH
AB: The reporting of critical values is an important function of the clinical laboratory. The success of critical value reporting depends on laboratory personnel recognizing critical values and effectively communicating them to clinicians, and on clinicians correctly interpreting and using the critical values to provide appropriate patient care. At LDS Hospital, we have conducted a study of the critical value reporting process. Results of the study indicate that few critical values are actually reported by the clinical laboratory (only 28 of 294 critical values during November 24-30, 1992). Data on the quality of critical value documentation showed that 19 of 124 (15%) patient charts audited during January-February, 1993 contained no documentation that clinicians were ever aware of the critical value, or that corrective actions were taken. Other data on the quality of critical value reporting were also collected and analyzed. Study results have been used to design and implement a computerized critical value reporting system to improve the quality of critical value reporting at our hospital.

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TI: Evaluation of a treatment limitation policy with a specific treatment-limiting order page.
AU: O'Toole-EE; Youngner-SJ; Juknialis-BW; Daly-B; Bartlett-ET; Landefeld-CS
AD: Department of Medicine, University Hospitals of Cleveland, OH.
SO: Arch-Intern-Med. 1994 Feb 28; 154(4): 425-32
LA: ENGLISH
AB: BACKGROUND: Concerns about misinterpretation, misunderstanding, poor communication, and lack of documentation prompted a revision of our hospital's treatment limitation policy. The revised policy was designed to explicate do-not-resuscitate (DNR) orders, structure the use of DNR and other treatment-limiting orders in a logical and standard way, and improve communication. Use of a Specific Treatment-Limiting Order Page (STOP) was required. METHODS: To evaluate the policy's effects, we conducted (1) a prospective cohort study (involving 2733 patients) of treatment limitation

practices before and after the new policy and (2) cross-sectional surveys of 58 nurses and 62 physicians. Outcome measures included documented treatment-limiting orders, documented discussions of these decisions, and deaths. Staff opinions about effects on communication and patient care were elicited. RESULTS: Rates of death (5.4% before and 5.6% after the policy; P = .80) and rates of DNR orders (9.3% vs 9.2%, P = .9) did not change. The use of the STOP enhanced the clarity of DNR orders and, among DNR patients, greatly increased the frequency of orders limiting 12 other specific treatments for conditions short of arrest. For example, before the policy, orders prohibited mechanical ventilation in 2% of DNR patients, compared with 66% after the policy (P < .001). Staff reported that the policy improved communication among health professionals, patients, and families. CONCLUSIONS: The treatment limitation policy with the STOP improved documentation and communication of treatment-limiting decisions. On the basis of our results, we offer a STOP for use and evaluation by others.

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Marked Record

TI: Provision of postoperative care in UK hospitals.
AU: Crosby-DL; Rees-GA
AD: University Hospital of Wales, Cardiff.
SO: Ann-R-Coll-Surg-Engl. 1994 Jan; 76(1): 14-8
LA: ENGLISH
AB: Surveys have been undertaken of the clinical dependency of surgical patients in eight United Kingdom acute general hospitals. The findings indicate that patients' needs are not always matched by appropriate levels of clinical care. In particular, it appears that a significant number of surgical patients need high-dependency care. Currently most of these patients are admitted to ITU beds, or are at risk on surgical wards.

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TI: Relating outcomes to processes of care: the Maryland Hospital Association's Quality Indicator Project (QI Project).
AU: Kazandjian-VA; Lawthers-J; Cernak-CM; Pipesh-FC
AD: Maryland Hospital Association, Lutherville 21093-6087.
SO: Jt-Comm-J-Qual-Improv. 1993 Nov; 19(11): 530-8
LA: ENGLISH
AB: BACKGROUND: The Maryland Hospital Association's Quality Indicator Project (QI Project) is a program of indicator development and application that has grown from 7 hospitals in 1987 to more than 700 hospitals today. METHODOLOGY: Expert panels help to create sets of indicators that describe events involved in a specific sequence of patient care. Each hospital collects data elements for the 21 indicators on a quarterly basis using specifically designed data-collection software. Indicator data are adjusted for case complexity, risk of adverse outcomes, and patient group characteristics. A report is developed that states the rate of occurrence of each indicator and how the hospital's indicator rate compares to other hospitals in the database. Hospitals then use this information to determine if specific processes in their delivery of care yield results that deviate from those of other hospitals. The QI Project promotes regional sharing of information about specific hospital initiatives that might benefit other participants. It also provides a model to use in interpreting what the indicator data reveal about hospital performance. OPERATIONAL ISSUES: QI Project is testing process indicators for patient-level and service-level data to supplement current aggregate-level trend and profile analysis. Indicator data are shared solely with participating systems, but changes in the confidentiality policy are being studied. Reliability assessment surveys are periodically conducted. EXAMPLES: Case studies portray improvement of processes prompted by indicator data for unscheduled admission following ambulatory surgery, for surgical wound infections, and for reducing emergency room waiting times. CONCLUSIONS: The chief contribution of the QI Project and

similar projects may not be that they identify all issues of quality, but rather that they may help develop a generation of hospital professionals who will be better able to quantify, evaluate, and improve health care quality.

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TI: Data-driven performance improvement in health care: the Joint Commission's Indicator Measurement System (IMSystem).
AU: Nadzam-DM; Turpin-R; Hanold-LS; White-RE
AD: Department of Indicator Measurement, Joint Commission, Oakbrook Terrace, IL 60181.
SO: Jt-Comm-J-Qual-Improv. 1993 Nov; 19(11): 492-500
LA: ENGLISH
AB: BACKGROUND: Since 1986, the Joint Commission has worked to create an evaluation system that would remain standards based but would accent an organization's performance as well as its capability to provide care. One component is the Indicator Measurement System (IMSystem), which involves continuous data collection and periodic feedback about specific performance measures, or indicators. An indicator is a quantitative measure of an aspect of patient care. It is not a direct measure of quality; rather it is a screen or flag which indicates areas for more detailed analysis. METHODOLOGY: Sets of indicators, each set related to specific important health care functions such as perioperative care, are established by expert task forces and are then subject to two phases of testing. Alpha testing addresses face validity and feasibility of data collection and may result in indicator revision. In the beta phase, a large group of organizations test the indicators for validity, reliability, and usefulness in improving performance. OPERATIONAL ISSUES: In 1994, the IMSystem will contain ten indicators and participation by hospitals will be voluntary. Once the value of these data in the accreditation process has been demonstrated--possibly as early as 1996--participation will become an integral component of accreditation. Hospitals will transmit indicator data to the Joint Commission but no patient or physician identifiers will leave the hospital. The system will provide organizations with information they can use to monitor and improve their performance, while helping meet external needs for performance measurement.

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TI: Planning for patient care redesign: success through continuous quality improvement.
AU: Smith-P; Adams-D; Bersante-S; Kalma-S
AD: Cardiopulmonary Department, St. Clare Hospital, Tacoma, WA.
SO: J-Nurs-Care-Qual. 1994 Jan; 8(2): 73-80
LA: ENGLISH
AB: A key to improving patient care in hospitals is the use of staff nurses on a continuous quality improvement team to redesign the patient care delivery model. This article describes the planning process and strategies for patient care delivery redesign on a medical-surgical unit in a small community hospital. A team of 12 staff nurses working with trained facilitators and a team leader began the seven-month project. The article describes how the team assessed the needs of the customers, developed a plan for a pilot, and drafted evaluation criteria.

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TI: Quality improvement in discharge planning: an evaluation of factors in communication between health care providers.
AU: Anderson-MA; Helms-LB
AD: University of Illinois at Chicago, College of Nursing, Rock Island.
SO: J-Nurs-Care-Qual. 1994 Jan; 8(2): 62-72
LA: ENGLISH

AB: Extending quality improvement principles to coordinating patient care among multiple levels of health care service providers has received only limited attention. Referrals function by communicating information about patients' continuing care needs between health care organizations as they transfer responsibility for providing different levels of care. Our evidence suggests several procedural improvements with immediate benefit for improving the quality of referrals. These include employing standardized, written referral forms; assigning responsibility for communication by requiring a signature on each referral; and instituting an information feedback system between sending and receiving health care providers.

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Marked Record

TI: Equity and efficiency in Italian health care.
AU: Paci-P; Wagstaff-A
AD: Department of Social Sciences, City University, London, UK.
SO: Health-Econ. 1993 Apr; 2(1): 15-29
LA: ENGLISH
AB: Health care finance and provision in Italy is unusual by international standards: public financing relies heavily on both general taxation and social insurance, and although the vast majority of expenditure is publicly financed, the majority of care is provided by the private sector. The system suffers, however, from a chronic failure to control expenditures and its record on perinatal and infant mortality is poor. Hospitals in Italy have a low bed-occupancy rate by international standards and the per diem system of reimbursing private hospitals encourages unduly long stays. Costs per inpatient day are high by international standards, but costs per admission are close to the OECD average. Ambulatory care costs are extremely low, but this appears to be due to the fact that GPs see so many patients that their role is inevitably mainly administrative. Consumption of medicines is extremely high, but because the cost per item is low, expenditure per capita is not unduly high. Despite the emphasis on social insurance, the financing system appears to be progressive. There is evidence of inequalities in health in Italy, and some evidence that health care is not provided equally to those in the same degree of need.

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TI: Physician-Directed Diagnostic and Therapeutic Plans: a quality cure for America's health-care crisis.
AU: Musfeldt-C; Hart-RI
AD: Ernst and Young, Chicago, IL.
SO: J-Soc-Health-Syst. 1993; 4(1): 80-8
LA: ENGLISH
AB: The most effective way to improve quality is to reduce variation in the processes of providing a service. Physician-Directed Diagnostic and Therapeutic (PDDT) Plans are a proven methodology for reducing variation in clinical processes and improving the quality of care. A major part of the PDDT Plan process is the development of a critical pathway. Critical pathways are an application of Total Quality Management (TQM) principles to clinical care which have provided clear, tangible results in those hospitals committed to this process. These pathways define the processes, timelines and responsibilities associated with the patient's clinical needs from preadmission to post discharge. Representatives of the various health-care professions involved in treating the specified patient populations work together, led by a physician, to define the processes of care. When completed, everyone involved in treating the patient understands what is to be done, by whom, and when. The pathways allow clinicians to plan ahead and let the patient and family know what to expect. Through establishing standards of care, these critical pathways also reduce the uncertainty of treatment decisions and free physicians from having to practice defensive medicine, and thus reduce cost. While the most visible

outcome of this process is the actual PDDT Plan, it is not necessarily the most important. The very process of designing the pathway improves intra- and interdisciplinary communication, and fosters teamwork.

40 of 42
Marked Record

TI: Prioritization and organ distribution for liver transplantation.
AU: Bronsther-O; Fung-JJ; Izakis-A; Van-Thiel-D; Starzl-TE
AD: Pittsburgh Transplant Institute, University of Pittsburgh (Pa) Medical Center.
SO: JAMA. 1994 Jan 12; 271(2): 140-3
LA: ENGLISH

41 of 42
Marked Record

TI: Inpatient standards of care and the suicidal patient. Part I: General clinical formulations and legal considerations.
AU: Bongar-B; Maris-RW; Berman-AL; Litman-RE; Silverman-MM
AD: Clinical Psychology Program, Pacific Graduate School of Psychology, Palo Alto, CA 94303.
SO: Suicide-Life-Threat-Behav. 1993 Fall; 23(3): 245-56
LA: ENGLISH
AB: The most common legal action involving psychiatric care is the failure to reasonably protect patients from harming themselves. In this regard it is critical to understand that courts have tended to impose much stricter standards on inpatient than on outpatient care; that at the present time, most malpractice actions involve clinical activities related to inpatient care (negligent admission, treatment, supervision, discharge, etc.). This article reviews the current climate in the legal and clinical formulation of standards of care for hospitalized adult suicidal patients. It suggests general guidelines for effective assessment, management, and treatment procedures that balance the need for high-quality care by a reasonable and prudent practitioner with the requirements of court-determined and statutory standards. The authors specifically discuss court cases that show common failure situations in inpatient care, discharge planning, and follow-up (e.g., problems in pharmacotherapy, the decision to hospitalize, the assessment of imminence and lethality, etc.). The paper also emphasizes the crucial element of clinical judgment in developing any inpatient standard of care.

42 of 42
Marked Record

TI: Enabling more dying people to remain at home.
AU: Thorpe-G
AD: Moorgreen Hospital, Southampton.
SO: BMJ. 1993 Oct 9; 307(6909): 915-8
LA: ENGLISH
AB: When it comes to dying there is no place like home. Since earliest times most cultures have accepted that dying people should remain at home. But this was never possible for all. Some were destined to die in accidents, on battlefields, by execution, and from catastrophic illness, maybe many miles away. Nevertheless, with few exceptions people could expect to die in their own beds and in the bosom of their families. In Europe from the Middle Ages until a century ago there was a simplicity about dying. Aware that the end was approaching, people would take to their sickbeds and preside over the ritual. The family, including children, friends, and neighbours would congregate. The ceremony was public and doctors often complained about overcrowding. Death was not regarded as a frightening event and was accepted as an inevitable and integral part of life. Dramatic changes in attitudes to death have taken place since the mid-nineteenth century. The natural acceptance of a biological reality has been lost and people are now unable to come to terms with their own mortality. One consequence is that death has become institutionalised. This

paper seeks to answer five questions. These refer to where people die, where they would choose to die, where they spend their last year of life, the reasons for admission for terminal care, and whether more dying people could remain at home. Discussion is restricted to adults in the United Kingdom. References are mostly from the past decade.

NATIONAL WORKSHOP
ON
"ROLE OF VOLUNTARY ORGANISATIONS IN HEALTH CARE DELIVERY"

VIGYAN BHAVAN
NEW DELHI

JANUARY 4-5, 1988

PROGRAMME

DIRECTORATE GENERAL OF HEALTH SERVICES
NIRMAN BHAVAN, NEW DELHI-110011

Objectives of the Workshop

1. To review the roles of various voluntary organisations working in the health sector engaging in alleviating human suffering and promoting health and quality of life.

2. To identify the priority areas of voluntary participants in the context of health for all by 2000 A.D.

3. To work out a tentative programme of voluntary participation indicating its nature, thrust areas, role of government agencies in supporting such participation etc.

Organising Secretary :

Dr. S. C. Sharma,
Asst. Director General (HA),
Directorate General of Health Services,
Nirman Bhavan,
New Delhi-110011
Phones : 301-9366 (Off)
693291 (Res)

PROGRAMME

National Workshop on "Role of Voluntary Organisations In Health Care Delivery" at Vigyan Bhavan JANUARY 4-5, 1988

Monday, the 4th January, 1988

0930 hrs.	Registration	
	Inaugural Session	
1000 hrs.	Welcome address	: Dr. G.K. Vishwakarma, Director General of Health Services
1010 hrs.	Key-note address	: Shri S.S. Dhanoa, Secretary, Ministry of Health and Family Welfare
1025 hrs.	Inaugural address	: Shri P.V. Narasimha Rao, Union Minister of Human Resource Development and Health & Family Welfare
1040 hrs.	Vote of thanks	: Dr. A,K. Mukherjee, Addl. Director General of Health Services
	TEA	

Plenary Session-I
Chair Person
Mr. Ashish Bose,
President,
Indian Association for
the Study of Population
C/o Institute of Economic Growth
Delhi University

	Speaker/Discussant	**Topic**
1100 hrs.	Dr. Harcharan Singh Adviser (Health) Planning Commission	National Health Care Policy : Voluntary Participation, National Plan, Achievements and Failures.

	Speaker/Discussant	Topic
1115 hrs.	Dr. N.H. Antia, Director, Foundation Research & Community Medicine, Bombay.	Health for All by 2000 A.D. Role of Voluntary Organisations —issue and prospects.
1130 hrs.	Dr. A.K. Mukherjee, Additional Director General of Health Services (PH)	Dimensions of Primary Health Care Programme in the country —Status Report
1145 hrs.	Dr. D. Banerjee, Prof. of Community Medicine, Jawaharlal Nehru University New Delhi-110067	Health Care Delivery in India —A critical analysis.

Plenary Session-II

Chair Person
Mr. Bunkar Roy,
Consultant, (Voluntry
Agency Rural Development).
Planning Commission

	Speaker Discussant	Topic
1230 hrs.	Shri P.K. Umashankar, Special Secretary, Ministry of Health & Family Welfare	Family Welfare Programme in India: Situtation Analysis Problems encountered ard prospec.s.
1245 hrs.	Smt. Ababhai Wadia, President, Family Planning Association of India, Bombay.	Non-Governmental Organisatians: Family Welfare & Child Survival Services —Participation and Contribution.
1300 hrs.	Shri Alok Mukhopadhyay, Executive Director Voluntary Health Association of India, New Delhi	Partnership between Voluntary Organisations and the Government : Challenges and Issues

1315 hrs. Discussion

1345 hrs. Lunch

1445 hrs Formation of Groups,
Election of Chair-person,
Rapporteurs
and Rapporteur General
for Groups

1500 hrs. Group Discussion

1615 hrs. Tea

1630-1800hrs. Group discussion continue

Tuesday, the 5th January, 1988

Plenary Session-III

Chair Person
Dr. A K. Mukherjee,
Addl. Director General of
Health Services (PH)

	Speaker/Discussant	**Topic**
0900 hrs.	Dr. Indra Bhargava, Dy. Commissioner(MCH) Family Welfare	M C.H. and Immunization Programme.
0915 hrs.	Dr.(Mrs) Shanti Ghosh Consultant in Paediatrics	Child Survival : Issues and role of Voluntary Organisations.
0930 hrs.	Prof. B.N. Tandon Deptt. of Gastroenterology, AIIMS New Delhi	Integrated Child Development Services : Achievements and Failures.
0945 hrs.	Mr. Bunkar Roy, Consultant (Voluntary Agency Rural Development) Planning Commission	Integrated Rural Health Care

	Speaker/Discussant	Topic
1000 hrs.	Dr. Almas Ali, Director, CRESEDA, Bhubaneshwar	Health care programme for tribals.
1015 hrs.	Dr. M.I.D Sharma, Former Commissioner Family Welfare	Control of communicable diseases
1030 hrs.	Mrs. Rami Chhabra Adviser (MM & C) Min. of Health & F.W.	Community awareness and involvement.
1045 hrs.	Discussion	
1115 hrs.	Tea	
1130 hrs.	Group discussion continue	
1245 hrs.	Finalisation of Group Reports	
1345 hrs.	Lunch	
1445 hrs.	Presentation of the Group Report.	
1545 hrs.	Finalization of Report	
1630 hrs.	Tea	

Valedictory Session

Chair Person
Mr. Mira Seth,
Addl. Secretary
Ministry of Health & F.W.

1645 hrs. Valedictory Address

Kumari Saroj Khaparde,
Union Minister of State for
Health & Family Welfare

TERMS OF REFERENCE

GROUP-I

1500 to 1800 hrs. Working Group for drafting plan of action and modalities of co-operation between the Voluntary Organisations and the Government of India

1. To identify priority areas of co-operation for Family Welfare & Primary Health Care Programmes.
2. To identify inputs - material, manpower etc.
3. To formulate plan of action indicating guidelines, format of proposals, periodic reporting, nature of feed back etc.

GROUP-II

1500 to 1800 hrs. Working Group on training requirements.

1. To identify the topics and areas of training.
2. To identify trainers/core-faculty from Voluntary Organisations for various topics.
3. To specify provisions of Scholarship/Fellowship for training of personnel of Government and Non-Government organisations.
4. To explore the possibilities of financial assistance to training institutions for imparting training in specific courses.
5. To suggest ways and means of procuring and preparing publications, technical reference material, books, manuals etc.

GROUP-III

1500 to 1800 hrs. Working Group on administrative matters.

1. To identify and consider administrative problems and make suggestions for remedial measures.
2. To indicate norms of grant-in-aid to the voluntary organisations.
3. To work-out a uniform service pattern in voluntary organisations with regard to Primary Health Care Programme.

NATIONAL WORKSHOP ON "ROLE OF VOLUNTARY ORGANISATIONS IN HEALTH CARE DELIVERY" AT VIGYAN BHAVAN ON 4-5 JANUARY, 1988.

List of documents/working papers and mimeographed papers and others.

Government of India Publication

1. Statement on National Health Policy, New Delhi, 1983

W.H.O. Publications

1. Strengthening of Referral System for Primary Health Care - SEA/HSD/97.
2. Primary Health Care Networks - SEA/HSD/112.
3. Primary Health Care Information Network - SEA/HSD/95.
4. Intersectoral Actions for Health - SEA/HSD/106.
5. Report of the intercountry conference on Primary Heallh Care Networks, New Delhi - SEA/HSD/74.

UNICEF Publication

1. The Status of World Children 1988.

Other Publications

1. Chapter 5. Population and Family Planning Management of Primary Health Care : O.P. Ghai
2. Elements of National Health Policy : Voluntary Health Association of India, 1987.
3. Position Paper on National Health Policy, Amla Rama Rao Voluntary Health Association of India, 1987.
4. Summary of Problems in Primary Health Care United Nations Development Programme Evaluation Study No 9 p. 29-37
5. Recommendations for Strengthening Human Resource Development for Primary Health Care through External Support. United Nations Development Programme Evaluation Study No. 9 p. 38-46.

NATIONAL WORKSHOP ON ROLE OF VOLUNTARY ORGANISATIONS IN HEALTH CARE DELIVERY
VIGYAN BHAVAN

4 - 5 JANUARY, 1988

P R O G R A M M E

DIRECTORATE GENERAL OF HEALTH SERVICES
NIRMAN BHAVAN, NEW DELHI-110011

Objectives of the Workshop

1. To review the roles of various voluntary organisations working in the health sector engaging in alleviating human suffering and promoting health and quality of life.

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3. To work out a tentative programme of voluntary participation indicating its nature, thrust areas, role of government agencies in supporting such participation etc.

Organising Secretary,
Dr. S.C. Sharma,
Asst. Director General
of Health Services,
Nirman Bhavan,
New Delhi - 110 011.

P R O G R A M M E

NATIONAL WORKSHOP ON ROLE OF VOLUNTARY ORGANISATION IN HEALTH CARE DELIVERY AT VIGYAN BHAVAN ON 4-5 JANUARY, 1988

Monday, the 4th January, 1988

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1040 hrs.	Vote of Thanks	Dr. A.K. Mukherjee, Addl. Director General of Health Services (PH)
	Tea	

Plenary Session-I

Chair Person

Mr. Ashish Bose,
President,
Indian Association for the Study of Population,
C/o Instt. of Economic Growth, Delhi University
Delhi-7.

	Speaker/Discussant	Topic
1100 hrs.	Dr. Harcharan Singh, Adviser, Health & Family Welfare, Planning Commission, New Delhi.	National Health Care Policy: Voluntary Participation, National Plan, Achievements and Failures.

	Speaker/Discussant	Topic
1115 hrs.	Dr. N.H. Antia, Director Foundation Research & Community Medicine, Bombay.	Health for All by 2000 A.D.: Role of Voluntary Organisations - Issues and Prospects.
1130 hrs.	Dr. A.K. Mukherjee, Additional Director General of Health Services (PH).	Dimensions of Primary Health Care Programme in the country - Status Report.
1145 hrs.	Dr. D. Banerjee, Prof. of Community Medicine, Centre of Social Medicine and Community Health, Jawahar Lal Nehru University, New Delhi-67.	Health Care Delivery in India - A critical analysis.
	Plenary Session - II	
	Chair Person Mr. Bunkar Roy, Consultant, (Voluntary Agency Rural Development), Planning Commission, Sansad Marg, New Delhi - 110 001.	
1230 hrs.	Shri P.K. Umashankar, Special Secretary to Govt. of India, Ministry of Health and Family Welfare.	Family Welfare Programme in India: Situation analysis, Problems encountered and Prospects.
1245 hrs.	Smt. Ababhai Wadia President, Family Planning Association of India, Bombay.	Non-Governmental Organisations: Family Welfare and Child Survival Services - Participation and Contribution.
1300 hrs.	Shri Alok Mukhopadhyay, Executive Director, Voluntary Health Association of India, New Delhi.	Partnership between Voluntary Organisations and the Government: Challenges and Issues.

1315 hrs.	Discussion
1345 hrs.	Lunch
1445 hrs.	Formation of Groups, Election of Chair-person Rapporteurs and Rapporteur General for Groups.
1500 hrs.	Group Discussion
1615 hrs.	Tea
1630 hrs. § to § 1800 hrs. §	Group discussion continue

Tuesday, the 5th January, 1988

Plenary Session-III

Chair Person

Dr. A.K. Mukherjee,
Addl. Director General
of Health Services (PH)

	Speaker/Discussant	Topic
0900 hrs.	Dr. Indra Bhargava, Dy. Commissioner(MCH)	M.C.H. and Immunization Programme.
0915 hrs.	Dr.(Mrs) Shanti Ghosh Consultant in Paediatrics.	Child Survival: Issues and role of Voluntary Organisations.
0930 hrs.	Prof. B.N. Tandon Deptt. of Gastroentrology, All India Instt. of Medical Sciences, New Delhi.	Integrated Child Development Services: Achievements and Failures
0945 hrs.	Mr. Bunkar Roy, Consultant, (Voluntary Agency Rural Development), Planning Commission, Sansad Marg, New Delhi - 110 001.	Integrated Rural Health Care.

1000 hrs.	Dr. Almas Ali, Director, CRESEDA, Bhubaneshwar, Orissa.	Health Care Programme for Tribals.
1015 hrs.	Dr. M.I.D. Sharma, Former Commissioner, Family Welfare, Govt. of India.	Control of Communicable Diseases.
1030 hrs.	Mrs. Rami Chabra, Adviser (M.M&C) Min. of Health and Family Welfare, New Delhi - 110 011.	Community Awareness and Involvement.
1045 hrs.	Discussion	
1115 hrs.	Tea	
1130 hrs.	Group discussion continue	
1245 hrs.	Finalisation of Group Reports	
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1630 hrs.	Tea	

Valedictory Session

Chair Person

Ms. Mira Seth,
Addl. Secretary (Health),
Ministry of Health and,
Family Welfare,
New Delhi.

1645 hrs. Valedictory Address

Kumari Saroj Khaparde,
Minister of State for
Health and Family Welfare,
Nirman Bhavan,
New Delhi - 110 011.

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2. To identify inputs - material, manpower etc.
3. To formulate plan of action indicating guidelines, format of proposals, periodic reporting, nature of feed back etc.
4. Any other matter relevant to the topic with the permission of the Chair.

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1500 hrs. to 1800 hrs. Working Group on training requirements.

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1. To identify and consider administrative problems and make suggestions for remedial measures.
2. To indicate norms of grant-in-aid to the voluntary organisations.
3. To work out a uniform service pattern in voluntary organisations with regard to Primary Health Care Programme.
4. Any other matter relevant to the topic with the permission of the Chair.

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4. Intersectoral Actions for Health - SEA/HSD/106.
5. Report of the intercountry conference on Primary Health Care Networks, New Delhi - SEA/HSD/74.

UNICEF Publications

1. The Stautus of World Children 1988.

Other Publications

1. Chapter 5, Population and Family Planning Management of Primary Health Care: O.P. Ghai
   First Published in India in 1985.
2. Elements of National Health Policy
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3. Position Paper on National Health Policy,
   Amla Rama Rao
   Voluntary Health Association of India, 1987.
4. VI. Summary of Problems in Primary Health Care
   p.29-37 (1 set)
   United Nations Development Programme
   Evaluation Study No.9
   Human resource development for Primary Health Care.
5. Recommendations for Strengthening Human Resource Development for Primary Health Care through External Support. p.38-46.
   United Nations Development Programme Evaluation Study No.9
   Human resource development for Primary Health Care.
   United Nations Development Programme
   New York - December, 1983.

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WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

SOUTH-EAST ASIA REGION

SEA/HSD/74
21 May 1985
RESTRICTED

REPORT OF THE INTERCOUNTRY CONFERENCE ON PRIMARY HEALTH CARE NETWORKS, NEW DELHI, 28 JANUARY - 1 FEBRUARY 1985

WHO Project: ICP PHC 006
UNDP Project: RAS/81/027

SEA/HSD/74

CONTENTS

1. INTRODUCTION

The International Conference on Primary Health Care in Alma Ata in 1978 affirmed that primary health care was the key approach to achieve an acceptable level of health throughout the world. It also affirmed that the primary health care approach connoted health as an integral part of social development and implied a spirit of social justice.

Following upon the Declaration of Alma Ata, governments formulated strategies for health for all, adopted plans of action, and started orienting national health systems based upon primary health care. The orientation of national health systems has made varied progress; such progress is dependent upon political will with all the political, social, economic and other realities which often are in conflicting arrangement. In most countries of the Asia and Pacific Regions, the national health infrastructure and services are still not able to undertake comprehensive delivery of essential health care to all the people. Also, the health infrastructure is not fully capable of absorbing and delivering the available health technologies. Sometimes the technology that is available is not the appropriate one for delivery through the infrastructure using the primary health care approach.

Specifically, the orientation process in health infrastructure is facing difficulties in regard to a credible and effective referral system for primary health care. Intersectoral collaboration is an essential component of primary health care. Here too, there is much agreement on principles but little evidence of action.

Though health services research has drawn so much debate and emphasis during recent years, much remains to be done by way of simple, practical and problem-solving research likely to be of immediate use. Much of the health services research already conducted remains on the shelves of academic circles. Careful selection of research subjects and mechanisms for involving the health administrators and academicians in the design and use of research results is urgently needed.

Mutual technical cooperation among countries has been unexceptional in principle. But the great potential for such cooperation in health development remains largely unexploited. The Ministers of Health of South-East Asia Region, in successive meetings commencing in 1981, have provided strong support to the selection of specific areas and modalities for mutual cooperation. This augurs well for a functional network in which interested countries can cooperate bilaterally or multilaterally to their mutual advantage.

This Intercountry Conference on Primary Health Care Networks was a follow-up of the previous meeting on the same subject held in New Delhi from 16 to 20 August 1983 (see SEA/HSD/65). The Conference addressed some of the problems related to the restructuring of health infrastructure, use of health systems research, development of middle-level managers and functions of a regional network of primary health care.

2. OBJECTIVE OF THE CONFERENCE

The objective of the Conference was to develop a plan of action for a functional network of primary health care in the Region. Within this objective, types of activities in three broad subject areas were to be identified for the plan of action for the period of 1985 and 1986. The three broad subject areas were:

(a) Restructuring of health infrastructure towards health systems based on primary health care;

(b) Development of middle-level health managers, and

(c) Development and use of health systems research.

3. PARTICIPANTS

There were seventeen participants from nine Member Countries of WHO/SEAR, and two from Afghanistan in WHO/EMR. One representative each from UNDP and US AID in India participated. The WHO secretariat supporting the Conference consisted of ten staff members including one from WHO Headquarters and one from the WHO country office, Bangladesh. The full list of participants is at Annex 1.

4. CONDUCT OF THE CONFERENCE

The Conference was inaugurated by Dr M.A. Rahman, Director Programme Management, on behalf of the Regional Director of South-East Asia.

In his inaugural address, Dr Rahman drew attention to the facts that primary health care could be established by activities of the health sector alone, and that there was considerable similarity in the socio-cultural and economic conditions amongst the countries participating, which should enable them to share the knowledge and experience gained in primary health care. Thus there was need for close coordination and collaboration, both intersectoral and within the health sector itself. He added that a regional network of primary health care could be a good mechanism for cooperative activities by the countries. There was good prospect of bringing the health administrators and research workers together to solve problems and procedures. Finally, Dr Rahman suggested that the regional network could function at a number of levels - national, institutional, intersectoral and international.

In his brief statement, Mr Michael E. Smith, Deputy Resident Representative, UNDP, India, speaking on behalf of the UNDP, drew attention to the meeting that took place in August 1983 on the subject of primary health care network, and in particular, to the report of the evaluation of the UNDP-funded intercountry project "Promotion and Development of Primary Health Care". He hoped that the findings and recommendations of this evaluation report would be reflected upon by the participants at this Conference.

Dr M.D. Saigal (India) was elected Chairman, while Dr C.D. Herath (Sri Lanka) and Dr Abdul Sattar Yoosuf (Maldives) were elected as Vice-Chairman and Rapporteur respectively.

The objectives of the Conference (Annex 2) were adopted while the provisional agenda (Annex 3) and programme (Annex 4) were adopted with minor changes. Each agenda item in the programme was discussed both in the plenary and group sessions. The participants were divided into two groups for in-depth discussions on each agenda item and asked to produce group reports with recommendations for the plan of action. Each group elected a chairman and a rapporteur and used suggested guidelines for discussion.

5. DISCUSSIONS

One participant from each country presented an overview of the existing state of development of primary health care institutional network. From these presentations, it was evident that the structural and functional networks for primary health care were in different stages of development. However, there was similarity in problems and opportunities for further development in specific areas such as integrated disease control, referral system, intersectoral collaboration, and management and supervision in health services. Frequent reference was made to the need for action-research, sharing of information and technology within various levels of national health systems and amongst countries.

Dr B.C. Ghosal, WHO Consultant, presented a brief background of the activities of the Project ICP PHC 006 and some thoughts on the possible future activities required of the project in the light of the recommendations of the tripartite review held in July 1984. He also presented a summary of the country situation reports made by the participants earlier.

5.1 Restructuring of Health Infrastructure for Health Systems Based on Primary Health Care

An introductory paper on this agenda item was presented by Dr Uton M. Rafei, Director, Health Promotion and Protection, which was followed by another discussion paper presented by Dr Zakir Husain, Senior Public Health Administrator (PHC), dealing with the referral system development and intersectoral collaboration for primary health care. Besides the conceptual framework of restructuring, referral system and intersectoral actions, the possible strategy framework and suggested lines of action were presented.

Restructuring with particular reference to the referral system should encompass much more than mere referral of patients to hospitals. In the context of health systems orientation, logistics support, supervision-cum-training, and good communications were essential pillars of a sound referral system. The strategic framework of a referral system consisted of coverage of the entire population, health and health-related services and strengthening of two-way support links throughout different levels. Some of the essential steps for the design of a good referral system would be the (i) quick analysis of the existing situation and potential in manpower, institutions, and other facilities; (ii) selection/adaptation of health technologies and services at different levels; (iii) combination of supervision and training in problem-solving; (iv) monitoring of materials supply and utilization; and (v) coordinated service and support with health-related sectors. Some of the early points of action would include the first referral institution, balancing the health facilities at various levels of the health system, appropriate linkages amongst service, training and research facilities, and training

and motivation of health and other workers for the referral system's functions. Finally, the referral system should be viewed as a broad supportive system for enhancing the credibility of primary health care.

The subjects of referral system and intersectoral actions were discussed in both the plenary session and in groups. Practical recommendations on the types of activities to be supported through the regional primary health care network were formulated (see Section 6).

Several important issues came up in group discussions. Reference was made to the various action points inherent in the strengthening of referral systems. There was need for developing the required technical expertise in systems design; standards or norms for referral institutions were needed; flexibility in operating a standard referral design was essential; action-research was more relevant than model-building; manuals were helpful and would have to be prepared; country studies on alternative systems for supplies, logistics and maintenance were suggested. Based on these, a few types of activities were selected for inclusion in the regional plan of action for the years 1985 and 1986.

On intersectoral actions for health, discussions in the groups identified several major problems and recommended the increased use of existing bodies and avenues for collaboration amongst the various sectors rather than creating new mechanisms exclusively for this purpose. The groups also pointed to the need for careful selection of a few relevant indicators for intersectoral collaborative actions to enable periodic assessment of the progress, problems and prospects. A suggestion was also made for some localised studies with a view to formulating some basic guiding principles based on local experience.

A few approaches to the subject of intersectoral collaboration were mentioned. One was to align the health goal with the broader development goal. Another approach was to start from the end of community level organizations as opposed to the official sectors' end. The initiative of this approach was in the hands of the community moving towards self-reliance with technical support, where needed, of the official agencies. Yet another approach was to start and continue a systematic review of health components of development activities at all levels with a view to maximizing the internal linkages and complementarity. A few recommendations on the types of activities were made for inclusion in the regional plan of action.

5.2 Development of Middle-Level Managers

An introductory paper on this agenda item was presented in a plenary session by Dr K.N. Seneviratne, bringing out the expected outcome of the discussion on this subject, namely, to provide guidelines for work plan for middle-level management training. The current assessment of health management situation in countries appeared to point to the priority need for developing middle-level managers. Training of middle-level managers would be one major contributor to this development. Management was essential for the optimum use of available resources in the context of primary health care. The management needs for primary health care related chiefly to self-reliance of communities for their health, decentralization

of resources and responsibilities, progressively to peripheral levels and greater involvement of community organizations in the planning and management of local health care. In the context of middle-level management, much of the training would need to be stressed to improve problem-solving skills and the performance of programmes. It was felt that relatively more attention would be needed for programmes/project planning, implementation, management and monitoring programme performance. The training content might also include leadership skills and management of staff, human relationships and skills in the resolution of conflicts. Additional skills of financial management and effective communication were required. The specific contents and the preferred types of management training will be different in the countries depending on their particular needs and priorities. Experience during the past two decades in health management training in the Region seemed to confirm that in order to make training highly relevant and effective it should focus more upon practical management competence and less on generalized concepts and principles. Middle-level management training had limited objectives and it should be seen within the broader perspective of overall improvements in health management. It would deal with developing skills as well as the appropriate attitudes. It would also have to be linked with the process and progress of decentralization of authority and responsibility.

During discussions in the plenary following the presentation and in-depth discussion in the groups on this subject, further elaboration of the contents of such training was made. There was a suggestion to include training in basic epidemiological discipline while other suggestions were for more personnel management, budget and financing control. The idea of including management as a subject in basic educational curriculum did not receive wide support. At the end of these discussions the groups agreed on a few types of activities for the regional plan of action for 1985-1986. Three major types of activities identified were:

(1) A clearer identification of actual management training needs;

(2) Strengthening of training capabilities of institutions and trainers, and

(3) Development of a basic module at the regional level for adaptation in countries.

5.3 Development and Utilization of Health Systems Research

A paper on this subject was presented in a plenary session by Dr Mya Tu, Director, Health Systems Infrastrucutre, WHO/SEARO. Two alternative approaches to health systems research were explained. One was problem-oriented research-seeking information (PORIS) approach and the second, research information display/utilization promotion (RIDUP) approach. Between these two, the PORIS approach was based on marketing techniques and, therefore, was likely to assure better utilization of research results. This approach relied on information-seeking behaviour of the decision-makers and tried to stimulate that behaviour in decision-making situations. The basic premise in this approach was that managers faced with problems had to make decisions. If motivated to seek essential additional information and if research attempted to generate that information, it had a better chance of being accepted and used. On the other hand, the RIDUP approach relied heavily on the initiatives of researchers who, having obtained the findings, tried to sell their products

to the user, i.e., managers and decision-makers. Naturally, in this approach the subject of research and the results might not be the ones that the consumer wanted or needed. Thus, it was necessary to promote the PORIS approach, which was more appropriate and gave some possibilities of being accepted and utilized by decision-makers and managers. The present situation in the field of health systems research was rather discouraging although, by definition, health systems research was directly concerned with the problems of organization, logistics, financing, etc. of the health services and these appeared to be highly relevant for use by planners and administrators, this had not in fact occurred to any large extent. More often, problems continued to be chosen by the individual researcher in academic institutions with or without the involvement of the health services personnel. It was assumed that the results thus obtained by the researchers and subsequently published in reputed or other journals would be used. This did not happen. The subject of utilization of research results had, in the past few years, been discussed in various forums. Many suggestions had been made in this regard including the joint selection of problems by service agencies and research agencies, and dissemination of results in easily assimilable form. Suggestions were also made for a dialogue between the users and producers at all stages. But the fact remained that much of the research findings still remained unutilized.

The subject was discussed in the two groups with a view to identifying a few specific types of activities for regional network to support. The groups identified seven areas for health systems research in the context of primary health care. These included supplies and procurement, personnel management, behavioural research, financial management, service delivery, appropriate health technology and training of health workers. Specifically, three broad areas for research emerged. First, operational research in the management of primary health care with a built-in mechanism for the immediate use of findings. Second, development of models in respect of urban primary health care with special attention to slum population. Third, alternative and new approaches to implement primary health care.

A major recommendation was made after discussions in groups and in the plenary to support national efforts in health systems research (see Section 6).

5.4 Regional PHC Network

Dr Mya Tu introduced this subject from an operational point of view.

The necessary preconditions of a successful network were reaffirmed. It was essential that areas or problems amenable to network collaboration were clearly defined and firmly agreed upon. A functional network was felt to be more practicable than a structural network. In fact, a structural network might be difficult to sustain. On the other hand, the proposed functional network could benefit from linkages and sharing of information with already established formal networks, e.g., ASEAN Training Centre for primary health care, the Asian Pacific Academic Consortium of Public Health, and the South-Asian Regional Cooperation.

Following in-depth discussions in the two groups and presentation of their reports to the plenary session, a few recommendations on the functioning of a regional PHC network were proposed (see Section 6). It was the consensus of the Conference that some level of formal national networks of designated institutions or individuals was a prerequisite for a functional regional network. In this regard, WHO/SEARO was expected to take some initiatives. The Conference also endorsed the view that functional linkages with established mechanisms under geopolitical grouping, e.g., ASEAN, SARC, and other bi-regional networks were necessary.

6. RECOMMENDATIONS FOR PLAN OF ACTION

As stated earlier, the discussions on the subject agenda items in the two groups followed by review in plenary sessions crystallized selected recommendations related to the plan of action for the regional primary health care network during 1985 and 1986. The recommendations were in the nature of broad indications of relevant types of activities that the Conference suggested to be of high relevance to the needs of national networks for primary health care. These recommendations constituted the guidance for drawing up a detailed plan of action with budgets related to the proposed activities under the intercountry project ICP PHC 006. The recommendations are presented for each agenda item as follows:

(1) Item 1 - Restructuring of PHC infrastructure

A. Referral system

1. Carry out rapid analysis of the existing situation in health infrastructure - staff, facilities, equipment, institutions.

2. Design and develop an action programme/pilot project and implement measures to improve the referral system based in particular on the following types of activities:

   (a) Reorientation, reorganization and strengthening of referral institutions.

   (b) Orientation and training of health personnel at different levels about the referral system.

   (c) Information and education of communities in the functions of the system.

3. Monitor, evaluate and reformulate a referral system.

4. Produce guidelines and/or guiding principles for wide application in the health system.

B. Intersectoral action

1. Carry out a qualitative analysis of the existing situation in intersectoral collaboration at the implementation levels.

2. Design and develop an action programme/pilot project and implement measures to improve functional linkage within the framework of existing mechanisms for intersectoral collaboration.

3. Monitor, evaluate and formulate a mechanism for intersectoral collaboration.

4. Produce guidelines and or guiding principles for wider application.

(2) Item 2 - Development of middle-level health managers

Collaboration with national institutions/focal points in developing middle-level management training programmes as follows:

1. Identify management training needs of middle-level health managers through different approaches such as job analysis, interviews of health personnel, particularly observations, and organization of workshops.

2. Select and strengthen training capabilities of institutions and trainers through:

   a) trainers' training;
   b) development and exchange of training materials;
   c) curriculum development and adaptation, where relevant, and
   d) exchange of trainers, guest speakers, and other relevant resources.

3. Development of management training module at the regional level which could be adapted by countries. This module should include aspects such as community organization, community mobilization and other contents relevant to primary health care management.

Item 3 - Development and use of health systems research

Promote the development and use of health systems research by supporting, through national and regional network mechanisms, national efforts in the:

1. Identification of problem areas in primary health care management amenable to health systems research for solution.

2. Review of available relevant studies or information for practical application.

3. Design and conduct of operations research with the overall objective of improvement in planning, management and implementation of primary health care.

4. Design and implementation of innovative approches to primary health care.

5. Development of urban or semi-urban primary health care models in pilot areas in selected countries, with particular reference to slum areas.

Development of Regional PHC Network

1. National networks should be formed in countries consisting of relevant individuals or institutions designated as national focal points for primary health care. These focal points should be able to communicate with each other, with the focal points of Member Countries, other existing networks directly or through SEARO acting as a coordinator. WHO/SEARO should initiate action.

2. Relevant activities being carried out through other network mechanisms like ASEAN Training Centre for PHC Development (ATC/PHC), Asian Pacific Consortium of schools of Public Health (APCSPH), South Asia Regional Cooperation (SARC) should be taken into consideration, and functional linkages established, for sharing resources, experience and information and avoiding duplication.

These recommendations were adopted in the concluding plenary session.

7. CLOSING SESSION

Dr U Ko Ko, Regional Director, addressed the concluding session of the Conference. In his address, he reiterated the importance of the subject of the Conference and thanked all the participants for having provided useful and practical guidance for activities in countries that were highly relevant, and their assistance in the formulation of a plan of action for regional support.

In this context, Dr U Ko Ko invited particular attention of the participants to the need for mobilizing resources through mutual technical cooperation by countries to support the regional network. He also highlighted the recognition of the fact that the training of "Health for All" leaders in countries was a subject of very high priority that the WHO Executive Board endorsed for the coming years. Dr U Ko Ko further asserted that the real action must take place in the countries and that WHO was ready to support actions that countries themselves took to implement the recommendations.

Annex 1

LIST OF PARTICIPANTS AND SECRETARIAT*

1. Participants

Afghanistan

Dr Ainuddin Malyar
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Ministry of Public Health
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Dr Abdul Saboor
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*Originally issued as document SEA/PHC/Meet. 10/2.

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Ministry of Public Health
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2. United Nations and Other Agencies

Mr Michael E. Smith
Deputy Resident
Representative
United Nations Development
Programme
New Delhi

Dr P. Diesh
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United States Agency for
International Development
New Delhi

3. WHO Secretariat

Dr Mya Tu
Director, Health System
Infrastructure

Dr B.A. Jayaweera
Director, Research and
Family Health

Dr Uton M. Rafei
Director, Health Protection
and Promotion

Dr Zakir Husain
Senior Public Health
Administrator (PHC)

Dr S. Moday
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WHO Headquarters

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Regional Adviser on
Community Health Services

Dr K.N. Seneviratne
Regional Adviser on
Health Manpower Development

Mrs Saiyud Nyomviphat
Regional Adviser on
Nursing

Dr M. Otgon
Health Manpower
Development Officer

Mr George Jamieson
WHO Management Officer
Bangladesh

Dr B.C. Ghoshal
WHO Consultant
Project ICP PHC 006
SEARO

Annex 2

OBJECTIVES*

1. As a follow up of the recommendations of the Meeting on development of Primary Health Care Networks in the Member countries, WHO/SEARO, New Delhi, 16-20 August 1983, to develop a plan of action for the development and functioning of regional primary health care networks with special reference to the following network activities:

   1.1 Restructuring of health infrastructure towards national health systems based on primary health care;

   1.2 Development of middle-level health managers, and

   1.3 Development and use of health systems research.

*Originally issued as document SEA/PHC/Meet 1.1

Annex 3

AGENDA*

1. Review of the implementation of the PHC network and its activities in the countries of the Region and to identify problems and constraints.

2. Development of a plan of action for the development and functioning of regional primary health care networks with special reference to the:

   2.1 Review of the functioning of the restructured health infrastructure towards national health system based on primary health care;

   2.2 Development of middle-level health managers, and

   2.3 Development and use of health systems research.

*Originally issued as document SEA/PHC/Meet. 10/1

Annex 4

PROGRAMME*

MONDAY, 28 January 1985

0900 - 1030	Registration
1030 - 1115	Inaugural session
1115 - 1200	Plenary session

- Adoption of Agenda
- Objective of the Meeting
- Procedures of the meeting and administrative arrangements

1300 - 1500 and 1515 - 1630 — AGENDA ITEM 1

Review of the implementation of the PHC network and its activities in the countries of the Region

Presentation by Member countries

TUESDAY, 29 January 1985

0900 - 1030 — Summary of the country presentation and the future framework of the primary health care networking activities under the project ICP PHC 006

Presentation by Dr B.C. Ghoshal

1045 - 1200 — AGENDA ITEM 2

Development of a plan of action for the functioning of regional primary health care networks

2.1 Review of the functioning of the restructured health infrastructure by the Member Countries towards national health system based on primary health care

*Originally issued as document SEA/PHC/Meet. 10/1.3

- Referral support for primary health care
- Intersectoral action on primary health care
- Presentations by Dr Uton M. Rafei and Dr Zakir Husain

1300 - 1530 and 1545 - 1630 — Group discussion on Agenda item 2.1

WEDNESDAY, 30 January 1985

0900 - 1030 — Plenary discussion on Agenda item 2.1

1045 - 1200 — 2.2 Development of middle-level health managers - Plenary session

- Presentation by Dr K.N. Seneviratne

1300 - 1530 — Group discussion on Agenda item 2.2

1545 - 1630 — 2.3 Development and use of health systems research

- Presentation by Dr Mya Tu

THURSDAY, 31 January 1985

0900 - 1000 — Plenary session on Agenda item 2.2

1000 - 1030 — Presentation by Dr Mya Tu: Regional PHC Network

1045 - 1200 and 1300 - 1530 — Group discussion on Agenda items 2.3 and 2.3.1

1545 - 1630 — Plenary session on Agenda items 2.3 and 2.3.1

FRIDAY, 1 February 1985

0900 - 1030 and 1045 - 1200 — Preparation of and discussion on the draft plan of action prepared jointly by groups and adoption of final recommendations of the Conference

1230 - 1300 — Concluding session

- Concluding remarks by the Chairman
- RD's closing address

ComH 5A – 3

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

SOUTH-EAST ASIA REGION

SEA/HSD/74
21 May 1985
RESTRICTED

REPORT OF THE INTERCOUNTRY CONFERENCE ON PRIMARY HEALTH CARE NETWORKS, NEW DELHI, 28 JANUARY - 1 FEBRUARY 1985

WHO Project: ICP PHC 006
UNDP Project: RAS/81/027

1. INTRODUCTION

The International Conference on Primary Health Care in Alma Ata in 1978 affirmed that primary health care was the key approach to achieve an acceptable level of health throughout the world. It also affirmed that the primary health care approach connoted health as an integral part of social development and implied a spirit of social justice.

Following upon the Declaration of Alma Ata, governments formulated strategies for health for all, adopted plans of action, and started orienting national health systems based upon primary health care. The orientation of national health systems has made varied progress; such progress is dependent upon political will with all the political, social, economic and other realities which often are in conflicting arrangement. In most countries of the Asia and Pacific Regions, the national health infrastructure and services are still not able to undertake comprehensive delivery of essential health care to all the people. Also, the health infrastructure is not fully capable of absorbing and delivering the available health technologies. Sometimes the technology that is available is not the appropriate one for delivery through the infrastructure using the primary health care approach.

Specifically, the orientation process in health infrastructure is facing difficulties in regard to a credible and effective referral system for primary health care. Intersectoral collaboration is an essential component of primary health care. Here too, there is much agreement on principles but little evidence of action.

Though health services research has drawn so much debate and emphasis during recent years, much remains to be done by way of simple, practical and problem-solving research likely to be of immediate use. Much of the health services research already conducted remains on the shelves of academic circles. Careful selection of research subjects and mechanisms for involving the health administrators and academicians in the design and use of research results is urgently needed.

Mutual technical cooperation among countries has been unexceptional in principle. But the great potential for such cooperation in health development remains largely unexploited. The Ministers of Health of South-East Asia Region, in successive meetings commencing in 1981, have provided strong support to the selection of specific areas and modalities for mutual cooperation. This augurs well for a functional network in which interested countries can cooperate bilaterally or multilaterally to their mutual advantage.

This Intercountry Conference on Primary Health Care Networks was a follow-up of the previous meeting on the same subject held in New Delhi from 16 to 20 August 1983 (see SEA/HSD/65). The Conference addressed some of the problems related to the restructuring of health infrastructure, use of health systems research, development of middle-level managers and functions of a regional network of primary health care.

2. OBJECTIVE OF THE CONFERENCE

The objective of the Conference was to develop a plan of action for a functional network of primary health care in the Region. Within this objective, types of activities in three broad subject areas were to be identified for the plan of action for the period of 1985 and 1986. The three broad subject areas were:

(a) Restructuring of health infrastructure towards health systems based on primary health care;

(b) Development of middle-level health managers, and

(c) Development and use of health systems research.

3. PARTICIPANTS

There were seventeen participants from nine Member Countries of WHO/SEAR, and two from Afghanistan in WHO/EMR. One representative each from UNDP and US AID in India participated. The WHO secretariat supporting the Conference consisted of ten staff members including one from WHO Headquarters and one from the WHO country office, Bangladesh. The full list of participants is at Annex 1.

4. CONDUCT OF THE CONFERENCE

The Conference was inaugurated by Dr M.A. Rahman, Director Programme Management, on behalf of the Regional Director of South-East Asia.

In his inaugural address, Dr Rahman drew attention to the facts that primary health care could be established by activities of the health sector alone, and that there was considerable similarity in the socio-cultural and economic conditions amongst the countries participating, which should enable them to share the knowledge and experience gained in primary health care. Thus there was need for close coordination and collaboration, both intersectoral and within the health sector itself. He added that a regional network of primary health care could be a good mechanism for cooperative activities by the countries. There was good prospect of bringing the health administrators and research workers together to solve problems and procedures. Finally, Dr Rahman suggested that the regional network could function at a number of levels - national, institutional, intersectoral and international.

In his brief statement, Mr Michael E. Smith, Deputy Resident Representative, UNDP, India, speaking on behalf of the UNDP, drew attention to the meeting that took place in August 1983 on the subject of primary health care network, and in particular, to the report of the evaluation of the UNDP-funded intercountry project "Promotion and Development of Primary Health Care". He hoped that the findings and recommendations of this evaluation report would be reflected upon by the participants at this Conference.

Dr M.D. Saigal (India) was elected Chairman, while Dr C.D. Herath (Sri Lanka) and Dr Abdul Sattar Yoosuf (Maldives) were elected as Vice-Chairman and Rapporteur respectively.

The objectives of the Conference (Annex 2) were adopted while t provisional agenda (Annex 3) and programme (Annex 4) were adopted wi minor changes. Each agenda item in the programme was discussed both in t plenary and group sessions. The participants were divided into two grou for in-depth discussions on each agenda item and as ed to produce gro reports with recommendations for the plan of action. Each group elected chairman and a rapporteur and used suggested guidelines for discussion.

5. DISCUSSIONS

One participant from each country presented an overview of t existing state of development of primary health care institutional networ From these presentations, it was evident that the structural and function networks for primary health care were in different stages of developmen However, there was similarity in problems and opportunities for furth development in specific areas such as integrated disease control, referr system, intersectoral collaboration, and management and supervision health services. Frequent reference was made to the need f action-research, sharing of information and technology within vario levels of national health systems and amongst countries.

Dr B.C. Ghosal, WHO Consultant, presented a brief background of t activities of the Project ICP PHC 006 and some thoughts on the possib future activities required of the project in the light of t recommendations of the tripartite review held in July 1984. He al presented a summary of the country situation reports made by t participants earlier.

5.1 Restructuring of Health Infrastructure for Health Systems Based on Primary Health Care

An introductory paper on this agenda item was presented by Dr Ut M. Rafei, Director, Health Promotion and Protection, which was followed another discussion paper presented by Dr Zakir Husain, Senior Public Heal Administrator (PHC), dealing with the referral system development a intersectoral collaboration for primary health care. Besides the conceptu framework of restructuring, referral system and intersectoral actions, t possible strategy framework and suggested lines of action were presented.

Restructuring with particular reference to the referral syst should encompass much more than mere referral of patients to hospitals. the context of health systems orientation, logistics suppor supervision-cum-training, and good communications were essential pillars a sound referral system. The strategic framework of a referral syst consisted of coverage of the entire population, health and health-relat services and strengthening of two-way support links throughout differe levels. Some of the essential steps for the design of a good refer system would be the (i) quick analysis of the existing situation a potential in manpower, institutions, and other facilities; (i selection/adaptation of health technologies and services at differe levels; (iii) combination of supervision and training in problem-solvir (iv) monitoring of materials supply and utilization; and (v) coordinat service and support with health-related sectors. Some of the early poir of action would include the first referral institution, balancing t health facilities at various levels of the health system, appropria linkages amongst service, training and research facilities, and traini

and motivation of health and other workers for the referral system's functions. Finally, the referral system should be viewed as a broad supportive system for enhancing the credibility of primary health care.

The subjects of referral system and intersectoral actions were discussed in both the plenary session and in groups. Practical recommendations on the types of activities to be supported through the regional primary health care network were formulated (see Section 6).

Several important issues came up in group discussions. Reference was made to the various action points inherent in the strengthening of referral systems. There was need for developing the required technical expertise in systems design; standards or norms for referral institutions were needed; flexibility in operating a standard referral design was essential; action-research was more relevant than model-building; manuals were helpful and would have to be prepared; country studies on alternative systems for supplies, logistics and maintenance were suggested. Based on these, a few types of activities were selected for inclusion in the regional plan of action for the years 1985 and 1986.

On intersectoral actions for health, discussions in the groups identified several major problems and recommended the increased use of existing bodies and avenues for collaboration amongst the various sectors rather than creating new mechanisms exclusively for this purpose. The groups also pointed to the need for careful selection of a few relevant indicators for intersectoral collaborative actions to enable periodic assessment of the progress, problems and prospects. A suggestion was also made for some localised studies with a view to formulating some basic guiding principles based on local experience.

A few approaches to the subject of intersectoral collaboration were mentioned. One was to align the health goal with the broader development goal. Another approach was to start from the end of community level organizations as opposed to the official sectors' end. The initiative of this approach was in the hands of the community moving towards self-reliance with technical support, where needed, of the official agencies. Yet another approach was to start and continue a systematic review of health components of development activities at all levels with a view to maximizing the internal linkages and complementarity. A few recommendations on the types of activities were made for inclusion in the regional plan of action.

5.2 Development of Middle-Level Managers

An introductory paper on this agenda item was presented in a plenary session by Dr K.N. Seneviratne, bringing out the expected outcome of the discussion on this subject, namely, to provide guidelines for work plan for middle-level management training. The current assessment of health management situation in countries appeared to point to the priority need for developing middle-level managers. Training of middle-level managers would be one major contributor to this development. Management was essential for the optimum use of available resources in the context of primary health care. The management needs for primary health care related chiefly to self-reliance of communities for their health, decentralizatior

of resources and responsibilities, progressively to peripheral levels a greater involvement of community organizations in the planning a management of local health care. In the context of mi[illegible]e-level management much of the training would need to be stressed to improve problem-solvi skills and the performance of programmes. It was felt that relatively mo attention would be needed for programme/project planning, implementatio management and monitoring programme performance. The training content migl also include leadership skills and management of staff, human relationshi and skills in the resolution of conflicts. Additional skills of financi management and effective communication were required. The specific conten and the preferred types of management training will be different in t countries depending on their particular needs and priorities. Experien during the past two decades in health management training in the Regi seemed to confirm that in order to make training highly relevant a effective it should focus more upon practical management competence a less on generalized concepts and principles. Middle-level manageme training had limited objectives and it should be seen within the broad perspective of overall improvements in health management. It would de with developing skills as well as the appropriate attitudes. It would al have to be linked with the process and progress of decentralization authority and responsibility.

During discussions in the plenary following the presentation a in-depth discussion in the groups on this subject, further elaboration the contents of such training was made. There was a suggestion to inclu training in basic epidemiological discipline while other suggestions we for more personnel management, budget and financing control. The idea including management as a subject in basic educational curriculum did n receive wide support. At the end of these discussions the groups agreed a few types of activities for the regional plan of action for 1985-198 Three major types of activities identified were:

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(2) Strengthening of training capabilities of institutions a trainers, and

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A paper on this subject was presented in a plenary session Dr Mya Tu, Director, Health Systems Infrastrucutre, WHO/SEARO. T alternative approaches to health systems research were explained. One problem-oriented research-seeking information (PORIS) approach and t second, research information display/utilization promotion (RIDU approach. Between these two, the PORIS approach was based on marketi techniques and, therefore, was likely to assure better utilization research results. This approach relied on information-seeking behaviour the decision-makers and tried to stimulate that behaviour decision-making situations. The basic premise in this approach was th managers faced with problems had to make decisions. If motivated to se essential additional information and if research attempted to generate th information, it had a better chance of being accepted and used. On other hand, the RIDUP approach relied heavily on the initiatives researchers who, having obtained the findings, tried to sell their produ

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The subject was discussed in the two groups with a view to identifying a few specific types of activities for regional network to support. The groups identified seven areas for health systems research in the context of primary health care. These included supplies and procurement, personnel management, behavioural research, financial management, service delivery, appropriate health technology and training of health workers. Specifically, three broad areas for research emerged. First, operational research in the management of primary health care with a built-in mechanism for the immediate use of findings. Second, development of models in respect of urban primary health care with special attention to slum population. Third, alternative and new approaches to implement primary health care.

A major recommendation was made after discussions in groups and in the plenary to support national efforts in health systems research (see Section 6).

5.4 Regional PHC Network

Dr Mya Tu introduced this subject from an operational point of view.

The necessary preconditions of a successful network were reaffirmed. It was essential that areas or problems amenable to network collaboration were clearly defined and firmly agreed upon. A functional network was felt to be more practicable than a structural network. In fact, a structural network might be difficult to sustain. On the other hand, the proposed functional network could benefit from linkages and sharing of information with already established formal networks, e.g., ASEAN Training Centre for primary health care, the Asian Pacific Academic Consortium of Public Health, and the South-Asian Regional Cooperation.

Following in-depth discussions in the two groups and presentation o their reports to the plenary session, a few recommendations on th functioning of a regional PHC network were proposed (se ection 6). It wa the consensus of the Conference that some level of formal national network of designated institutions or individuals was a prerequisite for functional regional network. In this regard, WHO/SEARO was expected to tak some initiatives. The Conference also endorsed the view that functiona linkages with established mechanisms under geopolitical grouping, e.g. ASEAN, SARC, and other bi-regional networks were necessary.

6. RECOMMENDATIONS FOR PLAN OF ACTION

As stated earlier, the discussions on the subject agenda items i the two groups followed by review in plenary sessions crystallized selecte recommendations related to the plan of action for the regional primar health care network during 1985 and 1986. The recommendations were in th nature of broad indications of relevant types of activities that th Conference suggested to be of high relevance to the needs of nationa networks for primary health care. These recommendations constituted th guidance for drawing up a detailed plan of action with budgets related t the propcsed activities under the intercountry project ICP PHC 006. Th recommendations are presented for each agenda item as follows:

(1) Item 1 - Restructuring of PHC infrastructure

A. Referral system

1. Carry out rapid analysis of the existing situation in healt infrastructure - staff, facilities, equipment, institutions.

2. Design and develop an action programme/pilot project an implement measures to improve the referra system based i particular on the following types of activities:

   (a) Reorientation, reorganization and strengthening o referral institutions.

   (b) Orientation and training of health personnel at differen levels about the referral system.

   (c) Information and education of communities in the function of the system.

3. Monitor, evaluate and reformulate a referral system.

4. Produce guidelines and/or guiding principles for wid application in the health system.

B. Intersectoral action

1. Carry out a qualitative analysis of the existing situation i intersectoral collaboration at the implementation levels.

2. Design and develop an action programme/pilot project an implement measures to improve functional linkage within th framework of existing mechanisms for intersectora collaboration.

3. Monitor, evaluate and formulate a mechanism for intersectoral collaboration.

4. Produce guidelines and operating principles for wider application.

(2) Item 2 - Development of middle-level health managers

Collaboration with national institutions/focal points in developing middle-level management training programmes as follows:

1. Identify management training needs of middle-level health managers through different approaches such as job analysis, interviews of health personnel, particularly observations, and organization of workshops.

2. Select and strengthen training capabilities of institutions and trainers through:

   a) trainers' training;
   b) development and exchange of training materials;
   c) curriculum development and adaptation, where relevant, and
   d) exchange of trainers, guest speakers, and other relevant resources.

3. Development of management training module at the regional level which could be adapted by countries. This module should include aspects such as community organization, community mobilization and other contents relevant to primary health care management.

Item 3 - Development and use of health systems research

Promote the development and use of health systems research by supporting, through national and regional network mechanisms, national efforts in the:

1. Identification of problem areas in primary health care management amenable to health systems research for solution.

2. Review of available relevant studies or information for practical application.

3. Design and conduct of operations research with the overall objective of improvement in planning, management and implementation of primary health care.

4. Design and implementation of innovative approches to primary health care.

5. Development of urban or semi-urban primary health care models in pilot areas in selected countries, with particular reference to slum areas.

Development of Regional PHC Network

1. National networks should be formed in countries consisting o relevant individuals or institutions designated as nationa focal points for primary health care. These focal points shoul be able to communicate with each other, with the focal point of Member Countries, other existing networks directly o through SEARO acting as a coordinator. WHO/SEARO shoul initiate action.

2. Relevant activities being carried out through other networ mechanisms like ASEAN Training Centre for PHC Developmen (ATC/PHC), Asian Pacific Consortium of schools of Public Healt (APCSPH), South Asia Regional Cooperation (SARC) should b taken into consideration, and functional linkages established for sharing resources, experience and information and avoidin duplication.

These recommendations were adopted in the concluding plenar session.

7. CLOSING SESSION

Dr U Ko Ko, Regional Director, addressed the concluding session o the Conference. In his address, he reiterated the importance of the subjec of the Conference and thanked all the participants for having provide useful and practical guidance for activities in countries that were highl relevant, and their assistance in the formulation of a plan of action fo regional support.

In this context, Dr U Ko Ko invited particular attention of th participants to the need for mobilizing resources through mutual technica cooperation by countries to support the regional network. He als highlighted the recognition of the fact that the training of "Health fo All" leaders in countries was a subject of very high priority that the WH Executive Board endorsed for the coming years. Dr U Ko Ko further asserte that the real action must take place in the countries and that WHO wa ready to support actions that countries themselves took to implement th recommendations.

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WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTE

SOUTH-EAST ASIA REGION

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INTERSECTORAL ACTIONS FOR HEALTH - SOME ISSUES AND OPTIONS

WHO Project: ICP PHC 006
UNDP Project: RAS/81/027

CONTENTS

1. INTRODUCTION

An overview of the health and socio-economic situation in the South-East Region of WHO shows close and complex links between health and socio-economic development. Health is an investment in the development of human resources. Improvement of the state of people's health results from socio-economic development with distributive justice and not from mere economic growth, as evident from contemporary experience with development strategies throughout the world.

The global strategy for health for all,[1] adopted by the Member States in the World Health Assembly in 1981, calls for the mutual reinforcement of health and economic development policies. Achievement of health goals is, to a considerable extent, determined by the policies, strategies and programmes of other sectors of development. There are health hazards associated with economic under-development as there are with unbalanced economic development. Economic planners and political decision-makers need to be aware of the health implications of alternative development strategies and programmes which either promote or threaten health. National policies on poverty alleviation, agriculture and food, water and sanitation, education and adult literacy, housing and environment have significant effects on the health of the people.

Intersectoral actions for health through close coordination and cooperation between the health and other social and economic development sectors are essential for health development. Yet the first evaluation of national health-for-all strategies points inter alia to weaknesses in the mechanisms and processes of international actions for health.

In order to promote an understanding of the conceptual basis and the adoption of a simple analytical framework to examine the intersectoral dimensions of health development, an intercountry consultation was convened in the WHO Regional Office, New Delhi, from 28 October to 1 November 1985. The main objectives of the consultation were:

(1) to promote clear conceptual understanding of intersectoral actions for health;

(2) to develop a general framework for critical analysis of sectoral strategies in relation to their effects on health, and

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[1] HFA Series No. 1, WHO, Geneva, 1981

(3) to stimulate the awareness of options for intersectoral actions for health using the existing mechanisms of intersectoral coordination in countries.

2. THE CONCEPTUAL FRAMEWORK

2.1 Health, Economic and Human Development

Experience confirms that improvement of the state of health results from socio-economic development reflected in higher levels of literacy, employment and income, housing and sanitation, and standard of living. Conversely, the process of agricultural and industrial development and changes in life-style and food habits create new health hazards. Within the overall socio-political structure and environment, peoples' participation in decision-making influences the development process and distribution of resources, and thereby the health and welfare of the people.

Health is not the concern of the health sector alone. It also requires actions by other social and economic sectors. Health for all, as a social goal, has to be integrated into social and economic goals, and health strategies into the overall social development strategies.

2.2 The Health-Related Sectors

Some of the sectors closely related to health development are education, culture and life pattern; agriculture and food; environment and sanitation; general economic development and growth; industries, and housing. Much of the health problems and their manifestations are traceable to the development activities in these sectors through dynamic processes and linkages (Figure 1). There may be very few health problems that are entirely amenable to actions by the health sector alone. More often, the health-related sectors have a greater potential to contribute to overall health development.

The rationale for intersectoral actions for health is also derived from a new and more meaningful development approach which puts human development at the centre of economic growth and social development. Achievement of sectoral goals cannot but be interlinked with the central goal of human development in such a development approach. The health effects of development strategies and programmes in all sectors become an important concern for development planners and coordinators, health being an inseparable component of human development (Figure 2).

Coordination and collaboration are conceptually dependent upon some preconditions. Those who are expected to coordinate and collaborate among themselves must perceive mutual problems, mutual benefits, and mutual contributions. Mutualities of needs and interest are fundamental to a state of active collaboration and willingness to submit to a mechanism and process of coordination. These mutualities are also essential pre-requisites for willing and sustained cooperative actions amongst partners. These pre-conditions may not be spontaneous, and may have to be consciously generated. Efforts to sustain the mutuality of perceptions are essential. Intersectoral actions for health cannot be left merely to ad hoc decisions.

A permanent mechanism to generate valid information on the health effects of sectoral activities and provide this information and options for

action to the decision-makers is an important constituent of the conceptua framework.

3. INTERSECTORAL ACTION FOR HEALTH IN COUNTRIES OF THE SOUTH-EAST ASIA REGION

3.1 Situation in the Countries

Generally speaking, in most of the countries, plans for developmen and the allocation of resources are sector dominated and do not reflect t a great extent either a policy commitment or programme support relate specifically to intersectoral actions for health.

All Member Countries of the South-East Asia Region of WHO are imple menting their strategies for health for all through the primary health car approach. Intersectoral action for health is recognized as an importan component of the strategies. Even though its importance is appreciated, an mechanisms for coordination exist, intersectoral action for health remain a weak area in the implementation of health-for-all strategies.

There is inadequate analysis and projection of the mutual benefit which may accrue to the participating sectors through mutual collaboration A review of the situation in the countries revealed that there seems to b a lack of concrete knowledge of the scope and nature of mutually supportiv actions among the different sectors, particularly in relation to health The health ministry does not play a leading role in mobilizing th cooperation of other sectors in the reduction of health-related problem which are amenable to activities by these sectors. There is no mechanism t generate information of a convincing nature to make other sectors perceiv the importance of their role and the specific health components that may b incorporated in their goals and objectives. In-depth studies of th programmes and activities of other sectors which have a bearing on healt are seldom undertaken. There is no permanent mechanism such as a task forc or technical group in the ministry of health or outside it to undertake th task.

3.2 Existing Mechanisms

In all countries, mechanisms exist at the central level to assum the responsibility for bringing about coordination and intersectoral actio for national development. These mechanisms are usually in the form of a cabinet-level committee, an inter-ministerial committee of secretaries, th national socio-economic development board or council, the ministry of planning or economic developments, or the national planning commission. However, most of these mechanisms address coordination amongst sectors for economic growth and development, and not for health development as such.

Political commitment to the health-for-all goal led to the creatio of national-level bodies in some countries, e.g., Health For All Steerin Committee (Napal), Primary Health Care Coordination Committee and National Health For All Council (Bangladesh), and the National Health Council an National Health Development Networks (Sri Lanka). These national leve mechanisms vary in their composition, terms of reference, and level of activities.

At the intermediate level, mechanisms for coordination among sector vary even more widely in form, functions and operational efficacy. Recent

efforts by governments to decentralize development activities to the provinces and districts have only met with partial success. These remain, by and large, weak with few exceptions, because of lack of institutional or material resources. Occasionally, lack of clear directives and monitoring procedures keeps the mechanisms dormant.

At the peripheral level, the participation of communities is being encouraged through various types of representative local government bodies in community development, notably integrated rural development programmes. Workshops, seminars, distribution of education materials, and consultative decision-making by community agencies are some methods employed in countries to promote intersectoral actions for community development.

Occasionally, village councils are supported by executive bodies and sector-specific technical personnel with advice and material assistance in programme implementation. This process developed into a high degree of functional decentralization when real resources and responsibilities were delegated to representative local government bodies and when the people themselves were involved in deciding on activities to meet their own needs and implementing these activities themselves.

On some occasions intersectoral action has been achieved by integrating health care with programmes such as rural development, nutrition, family planning, the basic minimum needs programme or even with education as, for example, in Thailand, Nepal, Bangladesh and India.

As stated before, the various mechanisms at different levels are still evolving. These have met with various degrees of success. Their method of work also differs. In countries where the higher echelons such as the inter-ministerial coordination committee, the planning commission or the national development council have strongly articulated intersectoral actions in their health policies and supported them by clear operational directives at all levels, there has been greater success. Orientation seminars on health-for-all and the primary health care approach have also been helpful in mobilizing the commitment of political leaders, such as in Sri Lanka.

3.3 Operational Constraint

The mechanisms established for promoting intersectoral coordination have not necessarily resulted in coordinated actions for health. There could be many reasons for this, an important one being the lack of a common understanding of a framework of intersectoral actions for health.

Actions for health by cooperating sectors resulted more often from ad hoc perceptions and sporadic decisions. Besides, lack of skills to translate policy decisions into specific operational activities rendered agreements in principle and the mechanisms ineffective. Poor communication between the central and other levels, lack of motivation and inadequate manpower skills in the health and often other ministries were additional constraints.

3.4 Financial Constraints

The countries in the Region were implementing their development plans under severe financial constraints. Financial allocations and resource adjustments were difficult exercises, especially in times of econoic crisis

when different sectors compete with each other for higher allocations. In such a situation, adjustments and compromises more often affected the resources of the health and other social sectors. Owing to lack of information and knowledge of viable options, resources of other sectors were not used for bringing about the reduction of health problems or the promotion of health. Analytical presentations of the inter-relationships between economic and social development expenditures with health were scarcely found.

3.5 Critical Issues

Some of the critical issues in intersectoral actions for health which require priority attention were identified at the consultation. These have often been reported to affect adversely the efforts to foster intersectoral action for health.

(1) Problems of translating political commitment into specific operational means for intersectoral actions for health.

(2) Lack of multi-level mechanisms for policy formulation, planning and implementation of intersectoral actions for health in a systematic manner.

(3) Inadequacy of analytical and action-oriented information and associated problems of evolving clear directives for actions and feed-back.

(4) Insufficient criteria and indicators to monitor and measure the impact of intersectoral actions for health.

(5) Absence of simple and quick methods to analyse systematically the positive and negative impact of development on health, especially on the weaker sections of society.

4. METHODOLOGICAL FRAMEWORK FOR ANALYSIS OF HEALTH PROBLEMS WITH IMPLICATIONS FOR INTERSECTORAL ACTION

4.1 Methods of Analysing Health Problems

Sound policy decisions require adequate and appropriate information. In most countries, the system of epidemiological intelligence did not provide the type of information derived from careful analysis of health problems resulting from activities in other sectors. Health ministries usually publish progress reports of activities in various health programmes. These reports give statistical information on health activities but do not report on health problems in the perspective of developments outside the health sector.

Health systems research was needed to generate information of this nature. It should address specific health problems, and particularly intersectoral actions for health. Research into priority health problems should highlight concrete evidence of how the activities of various sectors either reduce or aggravate particular health problems in field situations. New health hazards should be promptly reported and viable options for actions should be discussed in such reports.

Different types of health problems can be traced back to a single originating source. On the other hand, several sectors may contribute to a specific health problem, for example, a highly endemic disease such as malaria.

4.2 Suggested Steps for Analysis

A methodological framework for the systematic analysis of a health problem requiring intersectoral actions can be broken down into a series of sequential steps:

(1) Selection of a critical health problem should be the first step. Specific criteria for selection should be agreed. The amenability of a particular problem to intersectoral actions should be an important criterion.

(2) The direct and indirect causes of the selected health problem or health hazard should be investigated. Side by side, environmental factors which have a reducing effect on the problem should be identified. It may be necessary to commission short-term or on-going field studies to generate this information. In most cases, this will require a multidisciplinary team approach and possibly multi-centre studies.

(3) Considering the findings of the analysis and available means, a number of options supported by a feasibility/ constraint analysis should be proposed.

(4) A summary and a position paper containing information and options to the policy-making bodies or sector administrators should be prepared.

(5) Policy decisions and directives emanating from the coordinating bodies should be fully explained, and specified methods of implementation widely disseminated.

(6) The results of implementation should be reported to the coordinating mechanism, and to the concerned sectors.

5. BASIC CONDITIONS NECESSARY FOR INTERSECTORAL ACTIONS FOR HEALTH

Meaningful intersectoral actions for health may be sustained if certain basic conditions are fulfilled.

(1) Recognition and acceptance at all levels that health is basic to human development, and intersectoral action for health is a core strategy for development as a whole.

(2) An agreed and accepted conceptual framework of intersectoral actions for health and its adoption as an instrument of national development policy.

(3) A permanent and adequate mechanism to analyse health problems and identify sector-specific health effects and to provide viable options for intersectoral actions for health.

(4) Mechanisms to translate stated policies and priorities for intersectoral action into operative guidance.

(5) Mechanism to monitor implementation.

Options for Promoting Intersectoral Action

The following options could be considered for promoting intersectoral actions for health. A detailed annotation of options is provided in the Annex.

(1) Strengthening the ministry of health by creating a mechanism, cell or nucleus, with the required technical capability and some executive responsibility. This could be the focal point for promoting and sustaining activities for coordinated intersectoral actions. Some of the important functions of this cell or nucleus could be:

(a) to carry out specific situation analyses for the health-related programmes in health and other sectors;

(b) to identify priority economic and infrastructure development programmes most amenable for incorporation into a health component;

(c) to provide factual information and options to the decision-makers, and

(d) to train and orient health staff towards improving their analytical skills and attitudes.

(2) Strengthening the existing health planning units and health information sections to assist in some of the functions as listed above.

(3) Designating a section or a wing in the planning commission to generate and maintain an up-to-date database for intersectoral planning and programme development.

(4) Integrating health components into high priority social and economic development programmes early in the planning stage.

(5) Involving the core administrative sectors, such as the ministry of interior and the ministry of home, to institutionalize the process of intersectoral actions for health in the intermediate and local government institutions.

6. CONCLUSIONS AND RECOMMENDATIONS

All countries in the Region recognize the importance of intersectoral actions for health to attain the goal of 'Health for All by

the Year 2000'. In all countries, mechanisms exist, starting with the national decision-making bodies at the apex, to formulate policies, and sometimes directives, for intersectoral actions. Alternative methods are being evolved and applied in several countries. Owing to some inherent constraints, the existing mechanisms are, however, not fully effective.

The participants in the intercountry meeting reviewed the current situation and the conceptual framework, and suggested a few short-term actions to further promote intersectoral actions for health. Basically these relate to the concept and critical issues: options for intersectoral action; methodological framework for systematic analysis; and the creation of a focal point/mechanism in the ministry of health. The recommendations of the meeting are summarized below.

6.1 Creation of a Cell within the Ministry of Health for Intersectoral Action for Health

Sound policy decisions pre-suppose the availability of accurate, adequate and appropriate information. For the collection, analysis and interpretation of relevant data, creation of a cell within the ministry of health was recommended by the participants. Its primary function could be to compile relevant information from several sources and identify areas for action. More specifically, its functions could be:

(1) to classify and index information for locating problem areas, their different dimensions and their short and long-term implications;

(2) to assess trends, the overt and latent health consequences of the development progammes, and projections of the future impact on health;

(3) to identify specific sectoral actions and the agencies whose collaboration will be required;

(4) to monitor the progress of implementation and provide feedback to decision-making bodies, and

(5) to prepare scientific reports, position papers, other special documents, etc., for the use of different sectors and their respective decision-making apparatuses.

The proposed cell will have to perform multiple functions, and therefore will need to organize the right mixture of skills and methods of work.

Its functions will include the exploration of basic information on a given problem, diagnosis of the cause-effect complex of factors, monitoring of the progress of actions, projections of effects and impacts, and acting as a technical arm of the ministry of health.

6.2 Plan of Action

Participants from the countries drew up tentative short-term (for 1986) country plans of action for intersectoral action for health, starting with a few activities.

Some of the areas identified as part of country-level follow-up action in the immediate future could be as follows:

(1) Relevant and timely information on health effects due to sectoral activities.

(2) Orientation of staff of different sectors at all levels, to improve the conceptual understanding of intersectoral action for health.

(3) The need to sensitize high-level decision-makers in the social and economic development sectors to the rationale of intersectoral actions for health for human resources development.

(4) Seminars for political and public representatives on the health-for-all goal.

(5) Timely and regular channels of communication between sectors as also within the ministry of health on the intersectoral aspects of health problems and health effects.

(6) Studies and publications of reports on priority health problems and intersectoral actions to encourage joint sectoral programme development.

(7) Short-term action-research at the district and peripheral levels to test practical methods of field assessment and actions for health.

(8) Prompt dissemination of research results and inculcation of research information-seeking behaviour in administrators.

(9) Use of simple indicators to monitor intersectoral actions for health by the communities and local government bodies.

Annex

OPTIONS FOR THE USE OF EXISTING MECHANISMS AND METHODOLOGIES FOR IMPLEMENTING INTERSECTORAL ACTION FOR HEALTH

1. All roles must emanate from programmes

2. Mechanisms required by health sector to:

   (a) analyse sub-activities
   (b) identify action point
   (c) ensure coordination

3. Need for focal point for intersectoral action for health (IAH) with responsibility and accountability

4. 'Cell' or section or wing within the planning commission

5. Need for qualitative improvement in the capability of personnel

6. Network

7. Planning units to be strengthened - multisectoral vision

8. Sensitize top decision-makers and provide information (cell)

9. Cell to deal with sector-specific analysis and recommendations

10. Involve core administrative sector, i.e., ministry of interior/ ministry of home

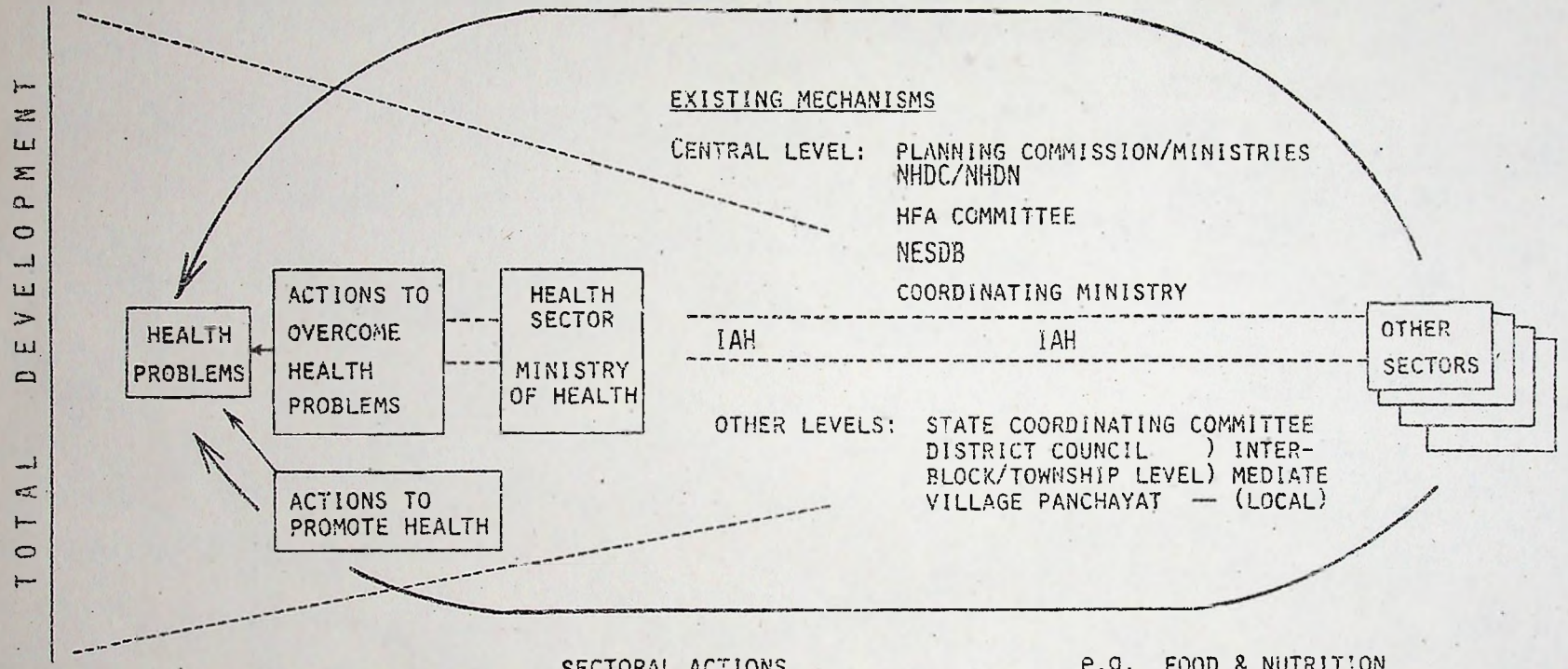
11. Change in attitudes of ministry of health personnel

12. Training of health staff in development programmes

13. Tag health to other priority development/economic programmes.

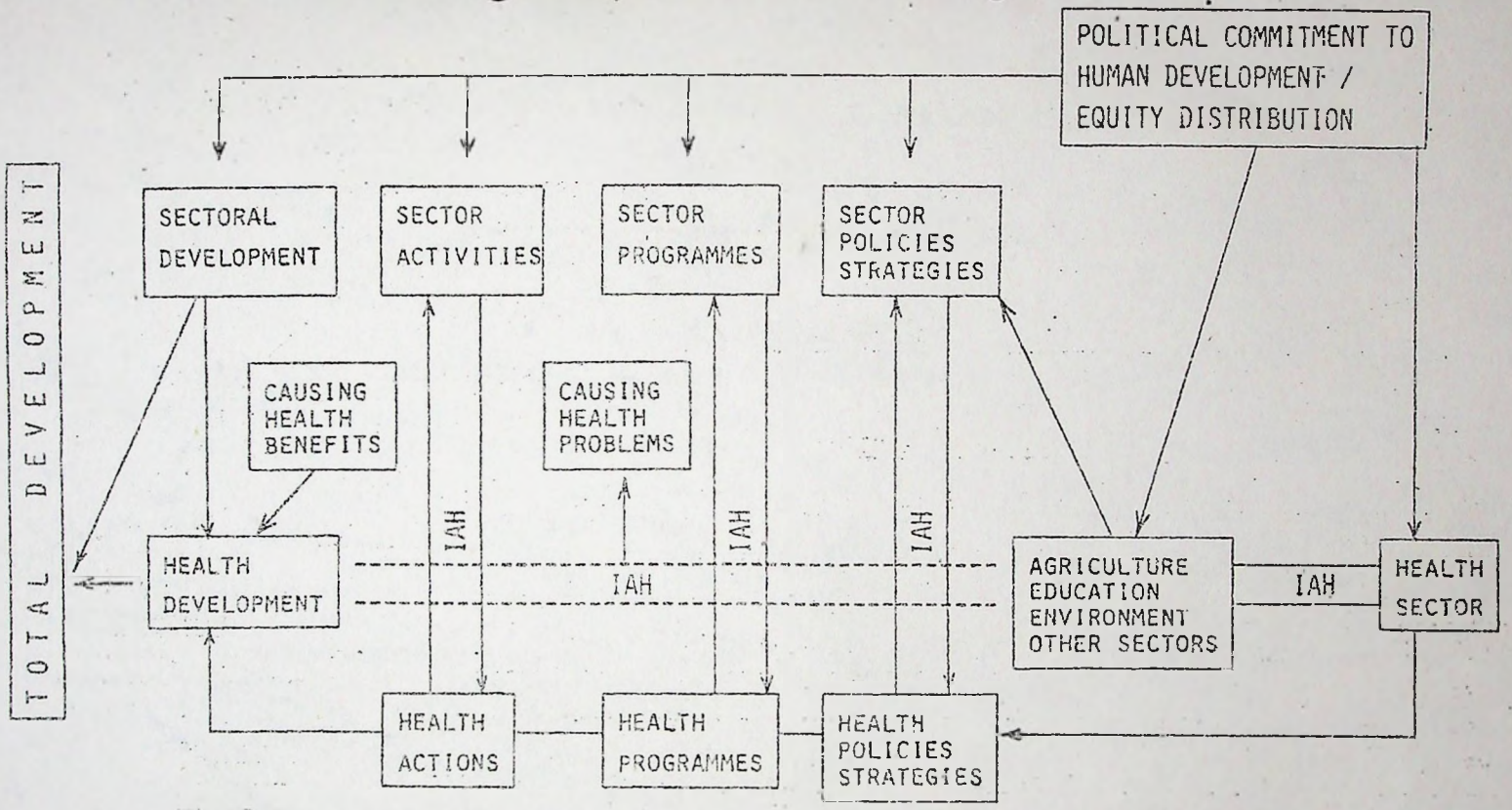
SECTORAL ACTION CAUSING
HEALTH PROBLEMS/HEALTH HAZARDS

e.g. IRRIGATION/DAMS
FACTORIES/INDUSTRIES
PESTICIDES
FISHERIES



SECTORAL ACTIONS
REDUCING HEALTH PROBLEMS
AND HEALTH HAZARDS

e.g. FOOD & NUTRITION
OCCUPATIONAL HEALTH
DRUG CONTROL
HEALTH PROMOTION
WATER AND SANITATION
HOUSING



IAH - INTERSECTORAL ACTION FOR HEALTH

PROBLEMS IN PRIMARY HEALTH CARE

Based on the analyses of human resource development for primary health care offered in previous chapters, we may now attempt to summarize the major problems found in six study-countries and the desk review. Not every problem, of course, is found in every country, but if a problem or issue has been identified in two or more countries it has been considered worth reporting. These observations will be presented in three groupings: health human resources development, primary health care delivery, and underlying issues. It should be clear that all problems are inter-related.

6.1 Development of Human Resources for Health

To avoid repetition and to sharpen this presentation, the problems of human resource development for health will be presented mainly under generalized concepts, rather than separately for each personnel category:

(1) Inadequate Numbers and Ratios of Conventional Personnel. Most developing countries have inadequate supplies of physicians, professional nurses, sanitarians, dentists, pharmacists, some types of technicians and other conventional categories of personnel to meet their health needs. While various adjustments - such as training many assistant nurses or community health workers (see below) - are necessary, a minimal supply of fully-trained physicians, sanitarians, and others is still essential for the effective operation of a health care system providing primary health care. In some countries, where the supply of doctors is adequate, relative shortages of nurses and other personnel result in the inefficient use of medical time.

(2) Inappropriate Training of Conventional Personnel. The education and training of physicians, nurses and other conventional personnel in developing countries are based largely on teaching models drawn from industrialized countries. The emphasis is on laboratory sciences, clinical specialization and high technology. It is weak on the basic requirements of primary health care such as prevention - personal and environmental - and the psycho-social aspects of family health problems, so important in PHC. Some use may be made of field training in a community setting, but seldom enough and often none. Some medical schools are greatly overcrowded, reducing the quality of teaching, and teachers are technologically, rather than socially, oriented; this applies to the education of nurses and sanitarians as much as to physicians. Little if any use is made of social scientists in the educational programmes.

(3) Lack of Health Human Resource Planning. For health personnel trained in universities there is seldom communication with health authorities or national planning bodies on the needs. Even for personnel categories trained in a Ministry of Health, there may be poor communication between the branches responsible for training and those using the personnel. The lack of planning applies to both the numbers turned out and the content of their education. Nurses or assistant nurses trained in hospitals, for example, may be quite unprepared for functions they are later expected to perform in community health centres.

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(4) Lack of Community Health Workers. In response to many health human resource problems, new types of multi-purpose community health workers (CHW) have been produced, with varying levels of training. Some highly developed countries have also done this to meet health needs in rural areas, where doctors were lacking. In most developing countries, however, the numbers of these CHWs trained have to date been below the needs. There have been difficulties in finding suitable teachers, in developing appropriate teaching materials, and in recruiting qualified students. Moreover, the educational content in these programmes has sometimes been highly technical and clinical, rather than social and preventive. As a result, the later performance of CHWs may be largely confined to treating the sick rather than promoting community health and welfare.

(5) Inadequate Teamwork and Supervision. All of the countries reviewed in this study, and most developing countries generally, provide primary health care through teams of personnel working in organized frameworks. The effective functioning of such systems, however, requires an understanding of the meaning and practice of teamwork. It also requires that team leaders are capable of leadership and effective (not dictatorial) supervision. Such qualifications seem to be rare in the countries studied.

Basic education in medicine, nursing, pharmacy, etc. seldom has the time or resources to teach the requirements for teamwork and supervision. As a result this ordinarily becomes a task for in-service training and continuing education. Even such education, however, appears to be lacking or unsuccessful in the countries studied. Teamwork requires sensitivity to personal relationships and supervision requires organizational knowledge and skills; such matters are not easily taught in a classroom but are learned best in a field practice setting.

(6) Lack of Continuing Education. Effective teamwork and leadership are not the only subjects for which continuing education can be useful. For good performance of all health care functions, clinical as well as social, education should be a lifetime process. Systematic arrangements for periodic continuing education are important but seldom found in developing countries. Its lack may also help to explain the poor morale among many health workers.

(7) Lack of Job Descriptions. Problems in teamwork and general work performance are often due to lack of any clear explicit statement of the tasks expected from each member of the health team. Absence of job descriptions leads to confusion and uncertainty in the relationships among personnel in a health facility. It also contributes to inappropriate training. Both the teacher and the student require a clear understanding of future job functions. Such job descriptions should be prepared by health authorities responsible for programmes, and they should be updated periodically with experience.

(8) Absence of Relations with Traditional Healers. In most of the developing countries studied, traditional practitioners and traditional birth attendants (TBAs) play a large part in the primary health care of the people. Yet - with some exceptions for TBAs and in one country for general

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healers - the policy in the countries reviewed is to ignore these personnel and hope that provision of modern health services will lead eventually to their disappearance. The soundest policy toward traditional healers may be subject to debate, but Ministries of Health that simply ignore their existence are missing an opportunity to exert influence on the nature of health services used by millions of people.

(9) Low Motivation of Personnel. Permeating many of the health manpower problems reviewed above are the attitudes and motivation of health personnel. These attributes may be initially acquired during basic training, but they are shaped by many subsequent experiences. All too often one encounters health professionals, particularly physicians, who rush to complete their tasks in a health centre in order to maximize the time they have for private practice. Others undertake post-graduate studies abroad and do not return to their home country; this "brain drain" means a serious loss of health manpower investment by many developing countries.

The issue of personnel motivation is, of course, complicated, and it is caused by many economic, social and psychological factors that are not easily influenced. No simple course of training can impart a socially responsible motivation in any doctor, pharmacist or nurse. But many policies may have an influence on motivation, as will be explored in the next chapter.

6.2 Problems in the Functioning of Primary Health Care

It is recognized that it is somewhat artificial to separate the considerations of health human resource development in the last section from the overall primary care system; however, this section will attempt to address the problems in the functioning of programmes on a somewhat broader basis.

(1) Poor Working and Living Conditions. The greatest need for primary health care programmes in developing countries is in rural areas, and life there offers few of the amenities to which staff trained in urban centres are accustomed. While most countries are devising strategies to make rural health work and rural life more attractive to such personnel, work in many rural health centres remains difficult; the physical structure is often deteriorated, and may lack properly functioning heat, water and electricity. When personal housing is provided for staff, it may be modest and in poor condition; schools for dependents of personnel from urban areas are usually below the standards to which they are accustomed. A particular need in most countries is housing for young unmarried female staff such as nurse-midwives whose posting to areas other than the home village may be culturally unacceptable without appropriate housing. These are, of course, problems inherent in rurality, but they must be recognized as requiring various compensatory measures.

(2) Inadequate Salaries and Incentives. Among the greatest obstacles to organizing adequate PHC programmes is the low level of salaries paid to all levels of staff. The typically low public service salaries are undoubtedly responsible for short periods of public employment and high turnover.

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Physician salaries are a particular problem, insofar as - unlike most other personnel - doctors have an alternative option to engage in private practice. There may sometimes be financial awards for meritorious service, but they are not very large.

Remuneration for community health workers presents special problems. Ordinarily, countries do not want to pay CHWs official salaries. They are sometimes regarded as "volunteers", and may receive only compensation for their work expenses. In reality, these small amounts may be the only monetary income of the CHW, and therefore are significant for their stability in the PHC work. Governments differ on this policy question and international agencies tend to be reluctant to finance such personnel expenditures, but experience has shown that reliance on "volunteerism" is unrealistic for sustained health activities (as against one-time compaigns in village clean-up, immunization, etc.).

(3) Weak Health System Management. The above problems concern the management of a health care system, but there are other more fundamental difficulties. In all the study countries, responsibilities in the Ministries of Health (and other ministries) are highly centralized. Even when MOH officials function at a provincial or district level, they have usually been appointed by central authorities and often must get approval from the top for almost anything involving the expenditure of money. This policy causes delays, inefficiencies and irritations. Proper management also requires a flow of information on the operation of health programmes - information on patients seen, services provided, problems encountered, etc. Seldom do such information systems function efficiently. Sometimes there are printed forms to be used, but they are not filled out. In some higher-level offices receiving such forms, they pile up and are not analysed.

Official personnel policies, another aspect of management, may be counter-productive. In one of the study-countries, any physician doing clinical work is paid more than a physician whose main duties are administrative. Thus a Provincial Health Officer receives a lower salary than a fresh young medical graduate treating patients. The problems of inadequate training in teamwork and supervision are further obstacles to good management, discussed above. Another impediment to supervision is simply the frequent inadequacy of communication (if telephones do not work) and transportation (if vehicles are not available). The isolated health worker is often left with little or no supervision or consultation.

(4) Problems with Equipment and Supplies. Operational equipment and adequate supplies can be crucial in a PHC programme, and yet they are often lacking in health facilities. The supply of drugs and vaccines is particularly important, but - depending often on imports from abroad - they may simply be unavailable. Even when available in a central depot, the logistical process of getting them out to rural units may break down, causing serious delays. Recurrent costs of drugs are a chronic problem. Vehicles may be available, but without fuel. Refrigerators, important for storing vaccines, may not work for lack of spare parts; personnel with the necessary skills may not be available to maintain equipment in working order.

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(5) Meagre Community Participation. One of the weakest aspects of the PHC programmes in the six study-countries relates to the involvement of the community. While a village or municipality may contribute land or money for establishing a health centre and even labour for its construction, local people rarely are involved in deciding priorities for health unit operation. In some countries local Health Councils are established to represent community people in programme administration, but - sometimes after initial enthusiasm - they seldom meet and do not function. Co-operative work by local people is essential in improvement of water supplies and sanitation, but this usually requires mobilization and guidance by sanitarians, which is often lacking. Campaigns against snails or other disease vectors can be carried out by community groups, with proper technical leadership and inter-sectoral co-operation, but this has not been observed in the country studies.

(6) Weak Intersectoral Co-operation. While it is widely recognized that health depends on far more than health services, implementation of this concept has proven difficult. At the local, provincial and central levels, health personnel are often overburdened with their own work. Opportunities to improve environmental sanitation through association with agricultural and public works personnel are not exploited. Seldom does the PHC nurse have the authority to gain access to children in the schools. Even within a Ministry of Health, theoretically committed to primary health care integration at the local level, local operation of specialized vertical programmes in such fields as malaria control or family planning often continues.

(7) Weak Preventive Orientation. While curative health services are an essential responsibility of health personnel, much too often preventive and health promotive activities are overlooked both in training personnel and in the functioning of the health post. Overworked staff, under pressure from the community to provide curative services, may have little time or energy to devote to prevention activities, even where their training has included it. Moreover, prevention is an overall orientation rather than a discrete set of activities which is needed at all levels, from CHWs to doctors.

(8) Low Utilization of Services. As a result of the many problems summarized above, both in health manpower development and in the functioning of PHC programmes, it is not surprising that many community people seem to have relatively low regard for the PHC services of health centres or other local health units. Analysis of utilization rates in countries studied shows them to be very low, by comparison with other programmes in the same country (such as health insurance schemes), with health care utilization rates in other countries, with the capacities of the health facility staffs, or with obvious evidence of health needs.

In spite of (or perhaps because of) the low rates of utilization of PHC services, the data suggest that hospital out-patient departments are heavily used and overcrowded. Clients with ailments which could be handled at the health post, by-pass it and go to a hospital where they are aware that they will see a Specialist rather than a general medical practitioner, non-medical community health worker (or perhaps neither of these types of personnel) at

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the health post. In some countries there is evidence that physicians are offering private medical services, even in rural areas, for which individuals and families are paying personally. Alternatively, patients consult a traditional healer or a private physician.

(9) Disease and Waste. The ultimate cost of all the inefficiencies and other problems reviewed is persistent disease and death, excessive birth rates and unnecessary waste in the use of resources. Children and adults do not receive preventive and/or treatment services that could avert disease or cure it; instead they get seriously sick and may die. We see the evidence of this in the high infant mortality rates and the relatively low life expectancies of all six of the study-countries.

Waste is easy to demonstrate. The low utilization of PHC resources means that those resources are not fully utilized. In countries with serious shortages of personnel - according to widely accepted standards - one sees doctors, nurses, and others sitting around and waiting for patients who do not come. The money paid for their salaries is wasted and, more important, the capability of these personnel to serve people is squandered.

6.3 Underlying Issues

All of the problems in health manpower development and primary health care functions may, in a deeper sense, be regarded as symptoms of certain underlying issues. Exploration of these basic social issues in depth is impossible here, but they may be identified briefly.

(1) Inadequate Health Funds in the National Budget. Where total figures were available in the study countries, the funds allocated to the Ministry of Health have been only a very small percentage of the national government budget. They usually amount to less than 5 percent for both recurrent and capital costs, and in at least two of the six study-countries this figure has been declining in recent years. This reflects, of course, low government priorities.

(2) Low Regard for Primary Health Care. Comprehensive health services include a wide range of technical activities for the diagnosis, treatment, and rehabilitation of diseased persons, as well as for prevention and health promotion. The complex technologies found in hospitals have a dramatic quality not seen in the day-to-day tasks of health maintenance. Primary health care, therefore, tends to be appreciated by many people at much less than its true value. These attitudes are unfortunately reflected in the budgetary allotments of Ministries of Health.

There are, of course, health expenditures by ministries other than the Ministry of Health, but the MOH is the major source of public support for PHC furnished to the general population. Yet, analysis of MOH expenditures nearly always shows the lion's share of funds - usually over 50 percent - to go to the support of hospitals and reflect an urban emphasis rather than a rural one. Primary health care tends to occupy a very important place in the declared priorities of health authorities, but not in the way that the available funds are actually allocated and spent.

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(3) The Private Health Care Market. Private household expenditures for health services have not been quantified in many developing countries, but where they have been, they have usually been found to be large - larger indeed than overall government health expenditure. In one of the study countries where this question has been investigated, private health expenditures were found to account for some 60 percent of the total. A large share of these personal expenditures goes for primary health care, including private physicians, traditional healers and self-prescribed drugs. These expenditures result not only in serious inequities, but also in serious inefficiencies. They mean inequities because the services go to those with most money to spend, rather than to those in greatest need. They mean inefficiencies, because the lack of planning and organization in the private medical market is inevitably wasteful. Private incentives even mean that patients may be given services that are unjustified and unnecessary because they yield a fee to the provider.

(4) External Support for Health. In the next Chapter we will examine in more detail the process of external support for health. One fundamental question involved is the level of resources which developed countries are prepared to make available to developing countries; on a global level this is less than 0.5 percent and health expenditures are only a very small percentage of this. Even if the inefficiencies noted previously did not exist, the impact of external health support on the developing countries would be small. Inefficiencies and lack of co-ordination unfortunately make the impact even smaller.

(5) Political Commitment. Probably most fundamental of all the issues that lie beneath problems in HRD/PHC is the political will of each nation for the advancement of its people's health. Since WHO was founded in 1948 and especially since the Alma Ata Conference of 1978, declarations about health as a "basic human right" and about the goal of "health for all" have been made by health leaders in every country. But there is a vast difference between declarations and actions taken to implement them. The gap between these two is determined by the degree of political commitment to health in a country. This, in turn, is influenced by countless different forces in each national society.

6.4 Health Project Evaluation

The evaluation of projects in primary health care, as in any other cross-sectoral, multi-disciplinary field, is inherently difficult. As regards the problems outlined in this study, each problem has its explanations, and pointing a finger of blame at any one international or national organization does not usually serve to right the situation. By its nature, national development in health and every other sector is a complicated process, bound to involve delays. Perhaps the most important lesson is that, with very limited resources, goals must not be too ambitious, and time-schedules should anticipate the probability of delays. Otherwise both national and international staff can become frustrated and demoralized.

The ultimate evaluation of a health project must depend on its impacts on the health of the people. Is there evidence that the activities of the project have made them healthier? Is there a reduction of

morbidity or an improvement in the capability of people to work and function in society? Is there evidence of improved nutritional status in children? Are there lower rates of parasitic infestation? These are, of course, very difficult to measure - even so straightforward an index as the infant mortality rate in a defined geographic area. Even if an objective improvement in some such measure can be demonstrated, it can seldom be concluded that the change has been due solely to the project under study, and not also to other related social and environmental circumstances. Moreover, the slightest real change in the health status of a population usually takes years to demonstrate.

Evaluation of activities in the field of human resource development is particularly difficult. One may assess what students have learned in a course, through examinations. But the crucial question is what effect does the course have on the graduates' subsequent performance. Determining this, in relation to other influences on performance, is not so easy.

In the face of such difficulties in evaluating health impacts or outcomes, most health and social scientists must be satisfied with more modest criteria for assessment. Is there improved "coverage" of a population, for example, with personnel providing primary health care? Are they accessible more equitably than in the past? Can it be shown that a project has resulted in a higher rate of utilization of certain services by the people? Such measurements of the "process" of health care are easier to make, and yet again there are difficulties. "Baseline data" on conditions before the project must be available, and often they are not. Also, one must still face the question of whether any changes identified can be attributed to the project. Perhaps the mere passage of time in a country brings changes in the health behaviour of people, with or without any specific intervention that an international project may provide. There are comparative research designs that can overcome these difficulties, but it is costly to carry them out and they must be carefully planned in advance.

It is small wonder, therefore, that many attempts at evaluation of health projects, international and national, continue to be too descriptive and impressionistic. One observes events and talks with the personnel involved. Are they satisfied with what has been happening? Is there evidence that people (patients) are pleased with the service? What problems - physical, behavioural, social - have been encountered? Have plans been frustrated and, if so, how much has been due to defects in the planning or to events beyond anyone's control? After a reasonable time has passed, to what extent do the realities of a programme correspond to the original plan?

Despite all the difficulties, evaluation of health projects must be attempted. Primary health care is especially difficult to evaluate, because it encompasses so many activities. In general, if the object of study can be narrowed down, successful evaluation is more likely. The performance of specified immunizations, the childbirths occurring under hygienic conditions, the households accessible to safe water, the proportion of school children with signs of malnutrition, the percentage of women of child-bearing age accepting family planning methods, the rate of malaria parasites detectable in blood smears - such measurements are much more feasible than "primary

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health ıre" as a whole. Yet each of these specific criteria requires the collect ɔn of information ɔnd its recording. The findings must also be interpr ɛd against a background of knowledge about the total health care system ınd, indeed, the overall environment) in which an activity is being evaluat l. In the long run, such efforts have always been necessary for the advance ɛnt of health sciences and health services.

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RECOMMENDATIONS FOR STRENGTHENING HUMAN RESOURCE DEVELOPMENT FOR PRIMARY HEALTH CARE THROUGH EXTERNAL SUPPORT

Solution of the problems or reduction of the difficulties reviewed in the last chapter obviously must depend on national actions and actions suitable to the conditions in each country. Externally-financed technical co-operation is obviously not appropriate for all problems. International agencies may help by supporting such actions or sometimes by suggesting strategies that have been effective in other countries. It must be emphasized that internationally-funded projects or activities are effective only insofar as they support national objectives.

In this chapter some recommendations are made on human resource development for health and the functioning of primary care systems. While they are presented in a roughly logical sequence, the rank order of the proposals, however, should not be interpreted as implying any recommended priorities. Decisions on first-level or second-level priorities will obviously vary in different countries, and at different times in the same country. Priority ratings for the development of primary health care necessarily depend on considerations of resources, deficiencies, historical experiences and political factors in each national health system.

7.1 Development of Human Resource for Health

Actions needed to improve health human resource development should correspond to the problems identified. Recommendations here roughly parallel the problems identified in Chapter VI. However the most appropriate international strategy will vary with the category of health personnel and the country involved.

(1) Increasing the Supply of Health Personnel. In countries with a low supply of doctors, the training of "community health workers" deserves higher priority than the formation or expansion of medical schools. Still a certain minimum number of doctors are needed for the proper operation of a national health care system. Qualified women should be admitted to medical schools on the same basis as men. International agencies can provide consultants, fellowships, equipment, teaching materials, etc. to help establish or enlarge medical schools.

The training of nurses, midwives, pharmacists, sanitarians and other basic types of health personnel can usually be undertaken within the normal resources of hospitals but it is important to develop hospital-based training schools which make use of community settings for teaching students about the social and preventive aspects of PHC. The training of sanitarians in adequate numbers is especially urgent, but it is made difficult by the lack of qualified teachers. Because this work usually pays very low salaries, the most competent sanitarians often leave government for private employment or change to other occupations. External support can provide incentives (including salary supplementation) to teachers, effective teaching materials and housing for students. The schools may be multi-disciplinary institutions, where laboratory technicians, pharmacy assistants and others are taught - with common instruction in basic biology and chemistry.

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(2) Improving the Social Content and Methods of Health Training. The possible role of international agencies for improvement of the social and community content of health training is substantial. In all six study-countries, no deficiency in PHC personnel training is more general than the weak place of community field experience or social science instruction in the preparation of students. Education on the purely technical aspects of medicine, nursing, midwifery and sanitation may be very well provided, but the social, behavioural and environmental aspects of primary health care are almost ignored or, more often, taught only superficially and ineffectively.

In medical education, there are several ways by which the policies might be improved. Departments of Community Medicine (sometimes "preventive and social medicine") are typically small and weak. They require enlargement and further training of their faculties. Secondly, every medical student should have a social exposure to community health work in a rural as well as an urban area - experience at least equivalent in depth and breadth to that received in hospitals on surgery or other clinical subjects. Thirdly, all clinical faculty should be required to teach the social aspects of their subjects - e.g. teaching paediatricians the social aspects of child health, the social aspects of communicable disease, etc. (If faculty members in these clinical departments are incapable of teaching such subjects, they should either learn them or invite others to teach them.)

Teaching methods in most professional health schools have not caught up with modern pedagogical knowledge. Formal lectures are delivered on classical subjects, without regard to their impact on students' learning or understanding. Much education can be made more effective by teaching teachers how to teach, and helping teachers design courses that enable students to solve problems in the real world. (WHO offers a major advisory programme on this matter.)

Equivalent changes should be promoted in schools of nursing, sanitation, etc. In fact, the establishment of field training areas could well serve the training needs of all the PHC health disciplines. In several countries, such field training areas have been established, but they are inadequately staffed or used only by certain schools. The field training areas, in different parts of a country, should be subject to change, but should have the same importance as that now held by hospitals. As part of the field training, students could participate in household surveys on various health problems, which would contribute not only to their education, but also to research on medical/social/environmental problems.

(3) Encouragement of Health Human Resource Planning. Technical co-operation can serve as the catalyst to bring together Ministries of Health, Ministries of Education and universities to adjust training programmes to the needs of the health services. It can also give advice on how to quantify existing health human resources (often quite different from the names on official "registers") and to make reasonable estimates of future needs. Joint councils of health and educational authorities can be very useful for health human resource planning which should, of course, be carried out as part of the planning of overall health systems.

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(4) Effective Training of Community Health Workers. The training of new types of multi-purpose auxiliary health workers has helped to make PHC accessible to rural populations in many countries, but aspects of the concept remain to be clarified. Objective assessment of the situation by national and international experts can lead to sound policies for an effective schedule of training, training of trainers, proper teaching methods, scope of functions, relationships with other health personnel, proper supervision, continuing education, etc. Both women and men should become trained for this work, preferably themselves coming from rural communities; however, even these CHWs may lack community orientation in their work, and need additional training. Finally, very brief training of village "health communicators" or "health promoters" is needed to acquaint people with the availability of PHC units and advise on simple elements of hygiene.

(5) In-service and Continuing Education. The systematic provision of continuing education, according to a practical periodic schedule, is needed by all health personnel. This requires careful planning and administration, physical facilities where teaching can be done and participants housed, as well as proper teachers and teaching materials. The "field training areas" recommended above to enrich the community content of basic health personnel education, can serve also as the sites for continuing education. In-service training, often needed at the beginning of employment in a health post, is a good way for new health workers to learn about teamwork. Acquiring teamwork skills and attitudes can be facilitated by regular meetings of health centre staffs to discuss cases and general problems.

(6) Effective Relations with Traditional Healers. While some traditional healers are highly entrepreneurial and concerned with personal gain, others - probably more frequently among traditional birth attendants - welcome new knowledge about methods of treating and preventing disease. The formal health system, including external technical co-operation, can learn to collaborate with and teach traditional healers, so that they provide beneficial PHC services. Regular but short courses can be given to traditional healers for this purpose, a practice that has been most often done with TBAs.

7.2 Functioning of Primary Health Care

After health personnel are trained, conditions need to be created whereby their work can be well done and effective. Physical settings have an influence on the feelings and attitudes of both patients and health workers and attention should be given to the work setting and the social environment around it.

(1) Improved Working Conditions. To some extent, attractive working conditions are a matter of physical structure and its maintenance. The health post, examining room, laboratory, waiting areas, equipment, pharmacy and its essential drug supply, water and sanitation arrangements should all be as orderly and well maintained as possible. The same applies to personal housing provided for staff members. Technical co-operation can help on such matters, even though physical measures alone are never enough.

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(2) Better Salaries and Incentives. Salary levels in most countries have certain uniformities among different ministries, so that changing them in the Ministry of Health or any other single Ministry is usually difficult. It should be possible, however, within the boundaries of a MOH, to re-arrange the levels payable to different kinds of health personnel. If primary health care is to be truly accorded high priority, this should be reflected in higher salaries paid to its providers. Increments for continuing service and seniority should also be designed to encourage continuity.

Several countries among those studied have mandated periods of public service (usually rural) for all or most new medical graduates. In one country, students with higher scholastic records escape this obligation and may directly enter specialty training - an unfortunate policy since it makes those serving in rural posts feel "punished" and "second class". Mandatory rural service is a way of the student's paying back society for a socially-financed professional education, and it should be required equally of all graduates. In fact, greater rewards and incentives should be built into these programmes, so that young doctors work at optimum levels. A system of periodic reporting and review should be feasible. It is also important to support the young graduate with proper supervision and to provide her or him with opportunities for consultation.

Incentives through rewards for meritorious service are also feasible for all health personnel. Financial increments can be combined with honour, recognition and opportunities for further training. If such rewards go to perhaps 10 per cent of health workers per year, the costs need not be very high. Financial support for such policies might even be explored by international agencies, as has been done by philanthropic foundations in the past, in order to test the value of an idea.

Regarding community health workers, although the prevailing policy in many countries is to pay them no salaries, this policy should be more flexible. When CHWs carry crucial responsibilities for PHC, both national and international agencies should not hesitate to pay them amounts beyond the compensation for their working expenses. Such expenditure would be only minor in the overall health sector budget and would go a long way toward alleviating the sense of disillusionment and high drop-out rate among CHWs.

Other strategies for elevating salaries are being tried. Small charges to patients for drugs can go into a "revolving fund" for purchase of further drugs, and paying small salary increments. Where community participation is mobilized, this can include the organization of a health co-operative, to which all local families contribute small periodic sums for supplementing staff salaries and improvements in the health facility. Where the financial benefit increases the diligence and devotion of health unit staff, the payoff to the community in better service is apparent.

(3) Efficient Health System Management. One of the most concrete and definite ways that PHC programmes can be improved is by strengthening the managerial process in national health care systems. Strengthening is needed at all levels, but especially at provincial and local levels.

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Providing supervision is essential, and this ability does not belong intuitively to every person in a supervisory capacity. For professional personnel, supervision, administration and planning -- the essentials of teamwork -- can be trained at graduate level such as a School of Public Health, as discussed more fully below.

Proper management includes mechanisms for producing, transmitting, organizing, and using information. Information systems are essential to programme evaluation as well as day-to-day management. Without a reliable flow of information on morbidity/mortality, use of human resources, and provision of services to people, evaluation essential for programme planning is very difficult to carry out. Other management essentials include logistics for assuring drugs and other supplies, maintenance of equipment and vehicles, and records on personnel schedules and on all financial matters. At the community level management has an important role to play in achieving effective integration of health programmes . As noted earlier, certain vertical activities (e.g. family planning) may persist in a country for historical reasons, but every effort should be made to integrate these with overall PHC programmes as soon and as efficiently as possible.

To do all these managerial tasks efficiently requires special training. A medical head of a health centre team should not be expected to carry all these responsibilities, in addition to community health and clinical duties. The training of "Health Care Managers" is a realistic solution, for which external support could be highly valuable. An appropriate locale for such training would be a School of Public Health.

(4) Active Community Involvement. Rarely is there a community in a developing country that spontaneously develops the initiative to launch a programme for primary care. A dramatic event, such as an epidemic, may stimulate action, but ordinarily action must be promoted by the health workers themselves. Chapter VI notes the typically limited performance of sanitarians, doctors, and nurses in this regard, and little should be expected unless modifications are made in their training.

In public health affairs, the personnel with training specifically oriented to community organization are "Health Educators". Their skills with posters and talks and audio-visual presentations are generally known, but much more important is their ability - when properly trained - to communicate with the natural leadership and understand the prevailing attitudes of local people, so as to mobilize community action. This concept of health education might be better described as "community health organization". All PHC programmes should have trained Health Educators of this type, not at every local facility, but at a district or provincial level from which every local area can be reached.

The work of the Health Educator should be of two types: first, to orient all health personnel in the PHC programme (especially field workers and their supervisors) on the concepts and methods of health education, and second, to work directly with community leaders and local people in the attempt to demonstrate the value of community participation. The training of Health Educators, like Health Care Managers, should be at a School of Public Health.

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(5) Strong Inter-sectoral Co-operation. Organizing health benefits achievable through schools, agriculture, and other sectors is a task mainly for PHC team leadership. This would include leadership at local health centres, as well as leadership at district and provincial levels. Obviously inter-ministerial health councils at the national level can be most helpful of all, but they are often more difficult to achieve and, if established, to keep active. Proper training and continuing education of PHC leaders is required for this objective.

7.3 Schools of Public Health or Health Development Institutes

References have been made above to the need for a School of Public Health available to each country for training PHC leaders, Health Care Managers, Health Educators, and others. In recent years, some countries have designated such schools as "Health Development Institutes". The terms "School of Public Health" and "Health Development Institute" are treated as synonymous in this section. In three of the six countries studied, some such school or institute existed, but for various historical reasons it was not playing its potential and appropriate role.

Almost every country has a school of medicine, or several of these, not only to train physicians but also to provide leadership role for medical science and service in the country. However schools of medicine, it must be recognized, are inevitably oriented to the treatment of disease in the individual patient. Their educational programmes are built on basic sciences of anatomy, pathology, biochemistry, physiology, etc. and their curricula culminate in internal medicine, surgery, paediatrics, obstetrics, gynecology, ophthalmology, neuro-psychiatry, etc. Aside from the classroom, their places of learning are the laboratory and the hospital ward.

The goals and methods of public health and of primary care, as now understood, are very different. Their orientation is not to individual patients but to communities and populations. Their tasks are mainly preventive, and curative only in an organizational sense. The basic sciences of public health are not anatomy, etc. but sociology, economics, political science, statistics, nutritional science, sanitary engineering, management, ecology, etc. The culmination of their curricula is in disciplines relevant to the population: epidemiology, community health education, public health planning, health care management, applied nutrition, environmental management, health information systems, and so on. Their major places of learning are in communities, rural and urban. In such settings, and in the study of such disciplines, requirements for good primary health care programmes - like teamwork, supervision, motivation, etc. - should be learned naturally without necessarily labelling them as such.

Health Development Institutes must be multi-disciplinary not only in the subjects they teach, but also in the students they admit and the personnel they turn out. The need for training Health Educators and Health Care Managers in such schools has been discussed earlier. In addition, teachers and leaders in nursing, midwifery, environmental sanitation, nutrition, health information (statistics), communicable disease control (epidemiology) and other fields should be trained. Perhaps most important, general Medical

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Officers of Health should study in the School or Institute for at least one year. With such education, one may expect that national, provincial and district leaders in public health and primary care will acquire not only the necessary technical knowledge, but also the motivation and inspiration to provide effective leadership to all other personnel.

Like a school of medicine, every country should have access to a national or regional Health Development Institute, not only to train urgently needed categories of personnel, but also to provide general status and inspiration to the whole field of advancing the health of populations. The average doctor and nurse should, of course, also have some appreciation of public health (or "community medicine", as it may be called, or perhaps "preventive and social medicine"), but departments teaching this field are invariably of very minor importance in medical schools - inevitably dominated by the laboratory sciences and clinical disciplines. Public health is usually regarded by both faculty and students as a diversion from the central purpose of medical education - the diagnosis and treatment of the individual patient. Countless attempts to strengthen departments of public health in medical schools have been unsuccessful. Other attempts to inject a "social point of view" in each of the clinical disciplines have had moderate success in a handful -- perhaps in one per cent -- of the world's medical schools.

The strategy, therefore, should be to develop firmly grounded Health Development Institutes accessible to or in all countries. They should be university-based, but as medical and nursing schools are linked to hospitals, these Institutes should be linked to Ministries of Health or major provincial Departments of Health. Academic degrees might be awarded for certain programmes of study, but not necessarily for all. The Institutes should not only train personnel, but should do research on the problems of the health care system, and provide consultation and leadership. Development of the faculty and resources for such institutions in developing countries would take time, but such development would be an extremely useful objective for external international support.

7.4 Co-ordination of External Technical Co-operation for Health

Co-ordination of international technical co-operation, both multilateral and bilateral, has been discussed in Chapter V. It was clear that co-ordination is necessary, not so much to prevent overlap in particular geographic areas, as to provide technical co-operation that corresponds to the priorities of the recipient country rather than to those of the external agencies. Almost any developing country welcomes financial support for any reasonable purpose; the needs are so great in every sector. But the most effective support is naturally that which co-incides with the overall planning strategy and priorities of the country. To achieve this, co-ordination should be improved on three levels.

(i) Within national governments, general planning units or similar bodies with overall responsibilities should co-ordinate technical co-operation activities for health from all sources. Likewise, Ministries of Health should contain a unit responsible for monitoring, co-ordinating and

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evaluating technical co-operation coming to any part of the Ministry. Every effort should be made to assure the consistency of any externally financed project with the basic policies of the government.

(2) Within the health sector proper, WHO assists the government in co-ordinating technical co-operation activities and its input should be requested early in the planning process for both the health sector and those in other sectors which have implications for health. WHO may also formulate health proposals for support by other international agencies. These roles may be played most effectively when there is a WHO Programme Co-ordinator (WPC) in the country, although governments also have access to the appropriate Regional Office.

(3) Among United Nations agencies, the United Nations Resident Co-ordinator is the designated official responsible for co-ordination. Because of his or her place in the structure of the United Nations and the arrangement whereby the United Nations Resident Co-ordinator is normally the Resident Representative of UNDP, he or she maintains relationships with all U.N. specialized agencies and all ministries of national governments. This endows UNDP with special responsibility with regard to the inter-sectoral aspects of primary health care. For example, the International Drinking Water Supply and Sanitation Decade is one area in which there is need for a high degree of co-ordination across a wide spectrum. Resident Co-ordinators need also to be aware of health activities from non-traditional sources such as multilateral development banks, which may have their own technical as well as financial resources.

Co-ordination of UN system activities with those of other international organizations, such as bilateral and non-governmental ones, is especially difficult since they do not share with UNDP the continuous contact involved in being Executing Agency for UNDP's programme. However, the Resident Co-ordinator should seek to promote communication among them and the U.N. family of organizations and WHO should do the same among the various international agencies concerned with the health sector. Exchange of information can be beneficial for every source of technical co-operation to a country, and can help to avoid duplication or discord on various technical matters.

7.5 Health and Development

This study has focused on primary health care and how it may be strengthened, in particular by human resource development. It has been evident throughout that primary health care is more than a component of the health care system, but is rather a reorientation of that entire system and the personnel in it. Health care systems, it should be explicitly emphasized, are a basic part of development; the attainment and maintenance of good health in populations should not be seen as simply personal and humanitarian goals. They contribute to overall national development in at least two important ways.

The first and more obvious, is that healthy people are better workers, better students, better parents, better citizens and so on. Good health contributes to productivity, community welfare, family life, culture and,

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hopefully, peace. The second and less obvious, is that the health sector is, in fact, one of the most amenable of the many sectors of society requiring change for achieving speedier national development; unlike land ownership, housing, industrial production or foreign policy, it does not touch the deep roots of the basic power structure in a nation. Although some changes in health care may be subject to debate, they are not controversial in the sense of significant changes in other sectors. This is why so many developed countries have benefitted from major reforms in their health care systems, without social upheavals. Important reforms and improvements in health care systems, including PHC, can be made with relative ease politically, for a relatively small price economically, and with large payoffs. The benefit-cost ratio of improved health services is high, especially in developing countries where the main diseases are so readily preventable. The benefits can be high both economically and politically, because every family is concerned with disease and health every year or even every day.

Tackling the "underlying issues" that explain the problems of HRD/PHC, as summarized in Chapter VI, need not, therefore, be so weighty a task as might at first appear. The social forces that can lead to political commitment for health include all sorts of population groupings - farmer's associations, labour unions, women's leagues, religious groups - for whose members health usually has deep personal meaning. If the political commitment to work toward "health for all" can be achieved, the other strategies should be implementable without great difficulty. It is quite feasible to mobilize the large expenditures, already being made in the private sector, for the public sector of health. It has to a significant extent already been done in the many countries - developed and developing - with social security programmes for health service. If this can be done, an increase in the health sector's share of tonal governmental expenditures and in the PHC share of health expenditures, should be implementable in relatively short order.

Thus attainment of "health for all" in a country can demonstrate concretely and dramatically the benefits of planning, community efforts, and social change, for everyone to see. The primary health care orientation of an effective health care system brings benefits even closer to the field of observation of every family. Such achievements in health can encourage equivalent actions for social reform in the many other sectors contributing to national development.

WHO Regional Office For South-East Asia
NEW DELHI

SEA/HSD/112

PRIMARY HEALTH CARE NETWORKS

– Report of an Intercountry Consultative Meeting

WHO Project ICP PHC 006

UNDP Project RAS/81/027

CONTENTS

ANNEXES

1. INTRODUCTION

An Intercountry Consultative Meeting on Primary Health Care Networks was held in SEARO, New Delhi, from 12 to 16 January 1987. Fourteen participants from seven countries attended the meeting, including two participants from Iran. Ms J. Haslett, Assistant Resident Representative, United Nations Development Programme, New Delhi, also attended. Dr D.N. Regmi (Nepal) and Dr N.T. Coorey (Sri Lanka) were elected as Chairman and Rapporteur respectively. The list of participants is given in Annex 1.

The meeting was inaugurated by Dr Chaiyan K. Sanyakorn, Director, Programme Management, on behalf of Dr U Ko Ko, Regional Director. He welcomed the participants from the Member Countries of the Region and also from Iran who responded to the invitation to offer their advice and guidance on the important subject of intensification of primary health care. He said that this meeting would not only review what the countries had achieved through various activities implemented under the intercountry project 'Primary Health Care Promotion and Development' (WHO ICP PHC 006/UNDP RAS/81/027) in the past few years, but also determine what further practical initiatives should be pursued through the successor project, 'Intensification of Action Programmes for Primary Health Care' (WHO ICP PHC 009/UNDP RAS/86/076), in the next few years. In his address, he mentioned that the time was ripe to start building up the health system in defined, manageable units, such as for districts, and to target for health for all starting with the intensification of the priority elements of primary health care, and progressively adding more elements and more districts. He wanted the meeting to draw up a regional plan of implementation for the project, which had country plans of action as a crucial component. While appreciating the complexity of such an action, the Acting Regional Director

felt that the inputs should be made available through the regional project on intensification of PHC and utilized as part of national and external inputs in support of the strategies for health development in selected districts. He hoped that important outputs from this project would not only have a measurable impact on health programme and health care in the district but would also provide useful practical experience in the organization, development and management of district health infrastructure based on the principles of primary health care.

The agenda and the programme of the meeting, as adopted, are given in Annexes 2 and 3 respectively.

2. OBJECTIVES

The objectives of the meeting were:

(1) To review the implementation of the plan of action developed in the intercountry meeting in January/February 1985 with special reference to referral support, intersectoral action, management development and promotion of innovative approaches;

(2) To review the status of national and regional collaborative primary health care networks in and amongst the Member States for sharing information, expertise and resources;

(3) To make recommendations for sustaining and further developing national and regional primary health care networks in the Region, and

(4) To develop a general plan of operation for intensification of the action programme for primary health care, particularly immunization, diarrhoeal diseases, acute respiratory infections and essential drugs and vaccines and other essential elements of primary health care within the overall development structure at district and peripheral levels.

3. ORGANIZATION OF THE CONSULTATION

The consultation was conducted through plenary sessions and group discussions as follows:

3.1 Achievement of the Second Phase (1985-1986) of the Intercountry Project Primary Health Care Promotion and Development (ICP PHC 006)

The project Primary Health Care Promotion and Development (WHO ICP PHC 006/UNDP RAS/81/027), funded by the United Nations Development Programme (UNDP) and executed by the World Health Organization (WHO) commenced as an interregional project in August 1982 with the following development objectives:

- Strengthening primary health care programmes with emphasis on participation and organization, infrastructure development and intersectoral and intrasectoral coordination.
- Strengthening the inputs of existing health manpower in primary health care development and implementation.
- Establishing regional and interregional TCDC networks in primary health care for rural and urban populations.

The project was jointly evaluated by UNDP and WHO in August 1985 and the second phase of the project extended until December 1986. The achievements of the second phase (1985-86) of the project in relation to its seven operational objectives are presented as follows:

Operational Objective 1

To promote and strengthen both national and regional collaborative networks of PHC institutions for sharing resources, information and experiences in primary health care development.

Achievements

An essential ground work for a functional PHC network had been laid with the designation of national focal points, establishment of two regional primary health care information resource centres (PIRCs), compilation of guidelines for PHC networks in the South-East Asia Region and with linkages set up with Health Literature and Information Service (HELLIS) and Health Service Research (HSR) networks and with ESCAP-POPIN. An additional contribution is the lead given by the PHC network in the coordination of the work of the above-mentioned national networks.

Objective 2

To promote intersectoral action level for primary health care development at implementation.

Achievements

A meeting on intersectoral action for health was conducted in SEARO from 28 October to 1 November 1985. Following the recommendations of this meeting, there was development of country plans and initiation of activities in Bangladesh, Burma, Indonesia, Nepal, Sri Lanka and Thailand. Overall, there was deeper understanding of the rationale of intersectoral collaboration in health development in the Region. The progress was reviewed at a Task Force Meeting (sponsored by WHO headquarters) held in SEARO from 13 to 17 October 1986. The results of country activities supported under the project would be of considerable significance.

Objective 3

To strengthen referral support to primary health care

Achievements

A meeting on referral support for primary health care was held in SEARO from 20 to 23 August 1985 and as a follow-up country plans for improving the existing referral system had

been set up and activities initiated in Bangladesh, Bhutan, Burma, India, Mongolia and Sri Lanka for rapid analysis of existing referral systems and identification of gaps in referral services. Following this analysis, a workshop on referral support for PHC was conducted in SEARO from 18 to 22 August 1986 to review past experiences and implement further action.

Objective 4

To develop health manpower at intermediate and peripheral levels for the implementation and monitoring of primary health care.

Achievements

Several activities took place in the Region under the project. Management training and development of middle-level managers were initiated in Bangladesh, Burma, India, Indonesia, Nepal, Sri Lanka and Thailand.

Objective 5

To promote improvement in the management of primary health care programme through operation research studies and utilization of research results.

Achievements

The project led to enhanced awareness of the relevance of health systems research (HSR) in the resolution of problems in health service delivery. Two important concepts were introduced: Problem-Oriented Research Information Seeking Behaviour (PORIS) and Research Information Display Utilization Promotion (RIDUP), and three major problem areas were selected for detailed study in India.

Objective 6

To promote innovations in primary health care implementation.

Achievements

The project helped to sustain interest and further stimulate innovative approaches to PHC in the Region. Studies were initiated in Burma, Indonesia and Thailand.

Objective 7

To promote the development of urban primary health care in selected countries of the Region.

Achievements

Pilot studies were initiated and supported in Indonesia, Thailand, Burma and India for the development of urban PHC models.

Overview of the achievements of the Project ICP PHC 006

The contribution of the project was directed mainly to reinforcing the organizational principles and upgrading of support systems essential in the operation of health systems based on PHC. The project had further strengthened other PHC activities that were taking place in the countries. Referral support to PHC was also being strengthened in Nepal. Activities of the project have thus been [illegible] in the process for HFA/2000 complementing other activities of national governments and WHO. The contributions of the project to national health development in the Member Countries of the Region were directed mainly to reinforcing the organizational principles and upgrading of support systems essential in the operation of health systems based on PHC. The evaluation of national strategies for health for all undertaken by Member Countries during 1984 as part of the global evaluation has shown progress in health development. Health coverage has improved. There have been significant reductions in infant and maternal mortality. Life expectancy at birth has recorded increases. There has been a reallocation of resources to the rural health sector. There is an increase in the deployment of health personnel in rural areas and greater emphasis on their training and orientation. Local production of drugs is being promoted. However, the specific

outputs of activities under each project objective clearly indicate several inter-related developments which have contributed to strengthening national health systems.

The focus of activities in intersectoral action was mainly directed towards ensuring a deeper understanding of the underlying rationale of such collaboration between the health sector and other related sectors and the integration of health development into the mainstream of national socio-economic development. In referral systems support, national activities concentrated on the critical role of referral, especially at the first referral level, and sustaining confidence in the PHC system. National plans of action were directed to the orientation of infrastructure facilities, adoption of referral procedures and guidelines, orientation and training of staff, logistics and communications support. National and regional PHC information networks were significant contributions by the project. Their particular significance related to the specific function of bridging the gap in regard to the non-availability of PHC information, especially in management. The focus of training of middle-level health manager strengthened the system at the operational level as did other activities, such as referral systems support and intersectoral action. This converge to decentralized levels of administration and is in line with decentralization of development administration in the area of health research, activities relating to promotion of research and utilization of research results benefit from information generated by the information networks at national and regional levels. Research information would also reach a wider readership and potential users through the networks. The contributions that health research makes to health development, especially in areas of referral support, health planning and management, urban PHC, and intersectoral action and information, has received greater attention.

Innovations in PHC cover a broad range of activities and are relevant to almost all areas of activity of the project. These are of special significance to PHC development and point to the adaptation of innovative approaches to local conditions and traditions. Emphasis upon socially acceptable and economically affordable technologies calls for innovative approaches. Activities in the application of PHC systems to urban areas have benefited from these endeavours in intersectoral action, information networks, referral support and health research. The studies in progress for [illegible]

information, experiences and expertise available through the networks.

The activities of the project provided catalytic inputs to strengthen the health infrastructure and make it operational in the delivery of the elements of PHC to the community. A well-established infrastructure of manpower, physical facilities, technological and financial resources, rationally organized and efficiently managed is essential for the effective delivery of care and the demonstration of tangible outcomes. A significant pointer that emerges from these activities is the feasibility to directing efforts for the efficient delivery of elements of PHC in a managea[illegible]e and defined unit of administration, such as a district. The infrastructure built up in the countries of the Region as an integral part of the health system would be the vehicle for the delivery of an integrated package of services to the community. This will enable all aspects of the system to be fully tested and lead to the identification of critical factors that make the system effective and efficient in the delivery of services. A district health system with decentralized management is also a vehicle for incorporating the real experience gained through studies and activities in referral systems development, intersectoral action, middle-level management and other areas.

3.2 Country Reports on Present Status of Primary Health Care Development

Presentations were made by participants from India, Indonesia, Maldives Nepal, Sri Lanka and Thailand. A presentation by the participant from Iran was also made.

From the country reports presented, it was apparent that in the last few years, promotion of PHC and its development in the Region has been reoriented to health infrastructure services, increased manpower and larger population coverage. But as HFA enthusiasts, participants were concerned about the pace of progress and its impact on the health status of the people, particularly in the Region's poorer sections of the population.

The presentations also made it clear that though the Member Countries had different national setups, different

socio-economic conditions, different health systems and, in a way, even different levels of health development, they had many common features in PHC development. Health services infrastructure development, training of middle-level managers and the training and appointment of peripheral-level workers, made health services more accessible to the population.

Certain PHC principles, though inadequately developed, had taken firm roots like the need for intersectoral collaboration and a referral mechanism, the need to focus on the underserved and the need to innovate and be more readily acceptable and used by the people.

The achievements of the project ICP PHC 006 were more in some countries than in others. Achievements in some of the project objectives were recognized as being directly attributable to the project's inputs. As concurrent PHC projects operating in the countries - some supported by WHO, some by other agencies, have similar objectives - it became difficult to separate the achievements of the project per se, especially in the broad areas of management, information networks and HSR. There is also this very important fact that while programmes and studies have been launched in the respective countries under the project, many of these are still ongoing and it will be a while before their results are known. The referral systems project, urban PHC, the PORIS studies, and activities to initiate mechanisms for intersectoral action are yet to be assessed.

While achievements of the project may not always be measurable, the project has certainly been a "significant" catalyzing force in the Region through the many activities and programmes funded by the project. A summary of the country presentations, by objective, follows:

(1) PHC Networking. It is agreed that there are networks of PHC in each country in one form or another but their function is yet to be strengthened. The subregional networks (PINIS) have just been established. The identification and strengthening of national focal points need further attention. There is a need to have a close contact among National Focal Points (NFPs) which should be institutions rather than individuals. The channels of

communication and funding must be streamlined. Information networking in countries was working satisfactorily but it needed to include private and nongovernmental organizations. The two PHC information resource centres at NIHFW, New Delhi, and at ATC/PHC, Bangkok needed to have more contact with all national focal points in the network.

(2) Intersectoral Action. The principle of intersectoral action is well accepted at the national level in each country but it remained difficult to operationalize intersectoral actions. At the community level, fewer people closely involved in development can work together and ensure intersectoral coordination. In some countries, micro-level planning and decentralization with delegation of authority to the lower level is showing successful coordination. Examples are in working through the programmes for Quality of Life campaign through NSSDS in Thailand, Basic Minimum Needs in India, and Integrated Family Health Care Package in Indonesia.

(3) Referral System. awareness of referral system has been increased and effort has been made to strengthen the health services infrastructure to provide referral support to PHC. The implementation of the referral system faces many difficulties and the bypassing phenomenon is not uncommon. Small-scale studies on effective referral system are going on in six countries.

(4) Management Training. While the training of middle-level managers received attention in a number of countries, their roles and functions in a decentralized district or intermediate level health system required to be further elaborated. It was doubtful that in all countries districts were immediately ready to move into the decentralized system with additional powers and responsibilities delegated to the District Health Officer. As far as training is concerned, several training programmes had been held for practically all cadres, in health and in some countries for officials of the health-related sectors. Reorientation of approaches and implementation plans as a result of training had occurred in some countries. In intersectoral approaches and management, this was especially visible. In the area of

medical education, however, this had been generally disappointing. Improvement of management training for medical students would remain a challenge although this challenge was being met in some countries.

(5) Operational Research. Operational research is generally weak in the Region but awareness about the benefits of this important back-up for PHC has increased with the studies on situation analysis etc. where priority areas that need research have been identified. Following this awareness, more research proposals have been submitted and supported by the project ICP PHC 006.

(6) Innovations. Most innovations were related to areas where some amount of development had already occurred. For example, in the training and use of peripheral-level workers, and health management, certain countries had also attempted innovations in other areas, such as logistics, resource mobilization and appropriate technology.

(7) Urban PHC. A number of projects are under implementation in Burma, India, Indonesia, and Thailand. In Indonesia, the study seeks to strengthen the development and implementation of the integrated package of services through community participation. The overall objective is the development of a model for urban PHC for the country.

The study in India relates to the city of Bombay and has the objective of developing a community-oriented approach among health personnel. Greater Bombay has 25 health posts and the study is in the nature of a pilot project of these health posts covering 25 000 households. Evaluation will be undertaken before the final stage of expansion to other areas of the city.

The study in Burma seeks to promote and accelerate the development of activities to overcome health problems affecting the urban poor in Rangoon city. Activities include the analysis of the health situation to identify priority health problems, development and implementation of alternative strategies to overcome problems identified with

The reports of the group discussions are given in Annex 4 and the output has been incorporated in the section on conclusions and recommendations.

3.4 Intensification of Action Programmes for Primary Health Care

(1) HFA leadership

As a prelude to the panel discussion on intensification, the HFA leadership concept was introduced. Health for all means striving for equity and social justice and thus narrowing down gaps between the impoverished majority and the privileged minority. It, therefore, cannot be pursued, let alone achieved, without a strong leadership. Such a leadership needs to be in the people of influence and prestige, people who are flexible and creative and those who can choose the place and time of interventions decisively.

A critical mass of HFA leaders is necessary not only in terms of the minimum number of such leaders but more importantly in having such leaders dispersed in strategic and influential sectors of policy making. Thus the critical mass of HFA leaders should be drawn not only from the health sector but also from other sectors: education, agriculture, local development, political parties, interest groups, nongovernmental organizations and many other forms of people's representations.

A commitment to the HFA goal, supported by social, moral and intellectual commitment, is an essential prerequisite.

In reality, the experience has been: (1) There is a lack of continuity of policies and plans due to frequent changes in political and policy making environment (2) There is limited knowledge and experience among health workers of the overall socio-economic development priorities

are inclined to apply conventional technological solutions to major health problems, which, even though technically sound, are not always feasible due to political, cultural, social and financial practice; (5) Health workers have limited capacity to translate key socio-economic policies into health policies; (6) Articulated political will to formulate and implement policies is not always translated into strategies and actions, and (7) Health professionals have little influence in the policy-making process in their countries.

Considering that HFA leadership development is a complex and difficult process, it is also imperative that those with the potential for leadership are brought together to realize their collective strength. It is also necessary to sustain the processes by building networks of individuals and institutions whose resources could be harnessed to develop leaders and sustain the critical mass.

(2) Panel discussions

A panel discussion followed with presentation of five topics related to intensification of primary health care.

Why intensification?. The conceptual model for operational framework for the PHC system, as developed in SEARO, was presented as well as the components of a comprehensive health system based on PHC. Intensification of PHC elements within the district system was emphasized. An integrated approach to deliver selected elements, such as the expanded programme on immunization, control of diarrhoeal diseases, control of acute respiratory infections and provision of essential drugs, was explained. The principles of PHC, such as community involvement, intersectoral actions and orientation of health systems were emphasized.

What is a district health system?. The characteristics of a district as an administrative unit and its appropriateness to serve as a natural meeting point for bottom-up planning and organization and top-down planning and support was explained. A framework of a district health system based on

trained health managers at the district level with central planning and technical support was essential for adaptation and implementation of the national health policy. Decentralization may be a political issue and has to be viewed within the constitutional and administrative structures of countries.

What to intensify and how?. Primary health care is defined as essential health care to the entire population. It includes at least eight elements.

Within this operational framework, it is proposed to "intensify" some elements without bandoning the others.

Selection of elements to concentrate upon depends on:

(1) capacity of health infrastructure to deliver the programme element;

(2) epidemiological evidence of magnitude of the health problem relating to the chosen element of PHC;

(3) feasibility of available resources to match needs for intensification; and

(4) cost advantage and possibility of showing significant impact.

Intensification would require that in the process:

(1) full use is made of the health infrastructure to deliver programme elements;

(2) coordination and synergism is maximized with other related programmes, e.g., between EPI and MCH, and between CDD and nutrition;

(3) health facilities are utilized to the fullest extent, and restructured as needed;

(4) realistic targets for programme delivery are set and achieved;

(5) the community is involved and the support of other sectors ensured;

(6) training in clinical and managerial skills is provided to health workers;

(7) adequate material and logistic support is established;

(8) availability of manpower, physical, financial and material resources are to be examined, and reorganized to match what is needed to intensify the chosen elements of PHC. This may call for alternative mixes of manpower, reallocation of tasks and responsibilities, development of skills and work rescheduling;

(9) local level detailed planning (micro-planning) will be an important step for organizing and managing the resources, implementing activities, monitoring and evaluation; and

(10) an appropriate information system that will support both epidemiological intelligence and managerial needs.

District planning. If PHC is to succeed, improvement in district planning activities is crucial. Five processes are important in district planning, namely, analysis of the present situation, establishment of priorities, setting objective and targets, monitoring and control, and evaluation.

Health service research for district health system. Health service/system research (HSR) and its scope towards improving the health of the people was defined and its importance in the understanding of community participation, technological options and alternative interventions within resource constraints. HSR is multidisciplinary, culture- and country-specific. It involves both health and other sectors. HSR mechanisms require institutional base, close involvement of decision makers, utilization of available research

potential and its results in implementation, monitoring and evaluation of programmes. The development of HSR in the South-East Asia Region was referred to. Even though WHA/[illegible] strongly focuses on health systems research, on the whole this has not been too successful. An important reason for this is that it is generally a one-time activity with lack of continuity.

Participants contributed to the panel discussion. Attention was brought to the fact that district-level administrations differ in countries.

(3) Intensification of PHC and Introduction of Project ICP PHC 009

UNDP and WHO agreed in principle to launch the new project ICP PHC 009 Intensification of Primary Health Care. The project will begin in 1987 and last three years for the present. It will be financed by the United Nations Development Programme (UNDP) and executed by WHO/SEARO. The project aims at intensifying and accelerating the PHC action programme, especially immunization, control of diarrheal diseases, acute respiratory infections and essential drugs through the health infrastructure. The project addresses the disadvantaged and vulnerable population groups in well-defined geographical areas and aims at showing a measurable impact.

(4) Plan of Operation of Project ICP PHC 009

The activities necessary for the output of the nine immediate objectives of the project will be started with a comprehensive health system survey followed by a national workshop for developing a detailed country plan of action, including training, management, logistics and supplies, and other activities related to intensification.

The project intends to intensify national action programmes for PHC in selected districts/areas complementing activities and inputs of the ongoing programmes. More districts may be added in future. Practical experience in the setting of comprehensive district health systems under a decentralized management integrating the delivery of health

gramme and health care through health infrastructure and involvement of other sectors will be highly relevant for expanding other districts and other elements of primary health care, thus progressively expanding the coverage. At the national workshop, a country work plan will be prepared detailing the activities. The project will have the following:

(1) Approaches to activities, its objectives, training programmes and health systems research, enhancement of community involvement and intersectoral collaboration through established and innovative mechanisms, determination of specific targets for services and coverage, and establishment of sound epidemiological surveillance and information system for monitoring and management;

(2) Evaluation, in 1989, with a second comprehensive survey. An important content of the evaluation will be the description of managerial processes development and lessons derived for the future development of district health systems, and

(3) Measurement of the performance of the project in terms of achieving outputs for immunization coverage, access to ORS, access to treatment for ARI, and, finally, adequate provision of essential drugs and vaccines.

It will also review the managerial processes, training programmes, physical facilities, logistics, epidemiological and information system. The health status of the district population will be assessed.

(5) Decentralized Management System

The rationale for a decentralized management system for PHC implementation was presented. As one of the objectives of the project ICP PHC 009 was to assist participating countries in developing decentralized managerial processes, the objectives, activities and responsibilities of a district

health management system were spelt out as also the factors influencing its operation, such as political commitment, confidence of the community, support from central administration and motivation and training of district chiefs and district health officers.

It was also stated that decentralized management referred to intermediate levels of administrative unit within national systems which were adequately represented by all other sectors of development to promote intersectoral action for health and referred to as 'district' in the presentation. In order to make it effective, delegation of powers and responsibilities to the District Health Officers to plan, mobilize and utilize manpower, financial, technological and material resources for intensification of the action programmes in coordinated and integrated manner was stressed. Supportive and functional linkages between the District Health Office and central, intermediate and peripheral levels of administration, nongovernmental organizations, community action groups and people were essential and required to be defined.

Decentralization was not an entirely new concept in the Region. It had been tried out successfully in some countries and its value in the areas of community involvement and participation and coordination of health-related sectors in PHC was recognized. It was also pointed out that there could be no uniform decentralized management system to apply for all the countries of the Region as national systems in the different countries differed politically, economically and administratively.

(6) District Health Systems Survey Guidelines

The document on District Health Systems Survey Guidelines (SEA/PHC/Meet.17/5) was presented. The guiding principles for developing a survey protocol to be used at the pre-project phase was circulated and explained. The objective of the survey is to make a comprehensive analysis of the situation, and review existing managerial processes and to review PHC structure in various countries. The conduct of the survey and its expected outcome were also provided along with the survey protocol.

It was clear that the guidelines provided would be used as an outline and full survey protocols developed at the country level after the selection of district(s) for implementing the intensified PHC project.

Group discussions followed these presentations first on decentralized management systems and district health systems survey guidelines, and then on initiating activities to implement the project ICP PHC 009 focusing on two activities: national workshops to develop plans of action for intensification and conduct of pre-project surveys. Group reports are given in Annex 4. With respect to initiating activities for implementing the project, the groups suggested that instead of starting with the baseline surveys as depicted in the flow chart of activities (Annex 5), a national workshop be first convened to plan and select the district(s) for implementation followed by a district workshop where a more detailed plan of action and activities would be set out.

4. CONCLUSIONS

The implementation of the project 'Primary Health Care Promotion and Development (WHO ICP PHC 006/UNDP RAS/81/027) made significant contributions to the promotion and development of primary health care in the Member Countries of the WHO South-East Asia Region (WHO/SEAR). Strategies for intersectoral action on health, establishment of referral mechanisms, strengthening of middle-level managers training, development of Problem Oriented Research Information Seeking Behaviour (PORIS), etc. have provided country experiences to further strengthen both national and regional networks of primary health care. These achievements have led to further initiatives in PHC development through the successor project 'Intensification of Action Programmes for Primary Health Care' (WHO ICP PHC 009/UNDP RAS/86/076) which will be planned and implemented in the Member Countries of WHO/SEAR from 1987. This project aims at intensifying and thus accelerating the progressive expansion of primary health care in the Region to enable the countries to realize the social goal of HFA/2000.

5. RECOMMENDATIONS

5.1 Strengthening of Primary Health Care Networks

(1) Regional and national focal points for primary health care networks existed but did not function satisfactorily. These required to be strengthened chiefly by increasing the awareness of their tasks and functions and establishing functional linkages with satellite nodes in the network. Financial and technical support may be provided to regional and national focal points, if necessary, for manpower development and application of systems approach.

(2) Mechanisms to disseminate information between and among the regional and national focal points may be strengthened. Valid information may be made available to decision-makers, administrators, providers of health services, other related sectors and communities.

(3) Sharing of experience among the different countries and even among the different districts and villages within a country would improve cooperation and strengthen the functioning of the primary health care network. In this context, technical cooperation among developing countries (TCDC) and technical cooperation among developing districts/villages (TCDD/TCDV) may be promoted.

5.2 Intensification of Primary Health Care (Project ICP PHC 009) and Development of District Health System

(1) In the preparatory phase for implementation of the project ICP PHC 009, each country may select a defined geographical area/district(s) for the intensification of national primary health care action programmes. The selected district(s) may neither be the best nor the worst but average in the context of the country's health situation and its health infrastructure. It may be a manageable unit with at least first referral health facilities and with evidence of activities with other sectors that leads to intersectoral collaboration and community participation.

(2) The implementation of the project 'Intensification of Action Programmes for Primary Health Care' (WHO Project ICP PHC 009/UNDP RAS/80/026) may begin with the conduct of a

national workshop with the participation of national focal points for primary health care, expanded programme on immunization, diarrhoeal diseases control, acute respiratory infections control, essential drugs and vaccines and other relevant programmes. This workshop may prepare a detailed country work plan for the intensification of primary health care in the selected district(s). Additionally, it may recommend mechanisms for strengthening and making more effective the national focal points for primary health care and its linkages with the different satellite nodes in the national primary health care network.

(3) Districts selected may have the possibility to experiment with innovative managerial processes, and district health officers may be delegated authority commensurate with their responsibilities in planning, personnel management, budgetary and financial control, all of this in support of intensification and within the framework of a national health policy.

(4) Decentralized management is important and feasible for the intensification of primary health care activities at the intermediate level of the administrative structure, such as districts, in the countries of the Region. Each country may identify its policy guidelines within the framework of its national policies for the decentralization of district health management which may view decentralization in its proper perspective as a management tool for efficient and effective implementation of national health programmes.

(5) A survey protocol may be developed in each country, based on the guidelines discussed at the consultation meeting, and be used as an instrument to make a comprehensive analysis of (a) the health situation, (b) the existing health infrastructure and its managerial processes, and (c) eventually evaluate the progress and impact in the selected district(s). The survey instrument may therefore include both process and impact indicators. It may be used to establish baseline information in the selected district(s) following the national workshop and subsequently to measure the progress and impact of primary health care intensification in the defined area/district(s).

(6) District-level workshops may be conducted by district health organizations with support from the national

level. These workshops may develop district plans and activities and identify requirements for training and other resources.

(7) Training activities, including the training of officials responsible for the intensified primary health care approach at the district level, may be undertaken.

Training modules as developed by WHO/SEARO may be adapted as needed to suit conditions and needs in each country. These may be field-tested by a designated agency or institution and steps to operationalize training modules in close consultation with concerned district officials may also be undertaken.

WHO may provide support for training courses and production of training materials. The organization may also provide support for drugs, medicines, equipment and other supplies necessary for implementation and management of the project ICP PHC 009.

(8) Functional and supportive linkages within the district health office and between the district health office and the ministry of health, district administration, other sectors in the district, more peripheral units and the community are desirable. These linkages may be in the areas of technical support, support for planning resources, logistics, and management, coordination and community involvement.

(9) Each country may periodically review the progress of implementation of the project ICP PHC 009 activities.

6. CLOSING SESSION

Dr Chaiyan K. Sanyakorn, Director, Programme Management, delivered the closing address on behalf of Dr U Ko Ko, Regional Director.

He stated that primary health care intensification should be regarded as a priority programme for achieving HFA/2000 and assured Member Countries that they would receive all possible support from SEARO in the planning and implementation of the project ICP PHC 009.

On behalf of the participants, Dr (Mrs) Suniti Acharya of Nepal, thanked SEARO for organizing the meeting, which, she felt, had helped participants to look at the promotion and development of PHC as a whole and not just as intensification of one element, as in the past. This had far-reaching implications, especially in the understanding of the importance of improved managerial processes and decentralized management, intersectoral collaboration, innovations, etc. The background material provided to the participants and the presentations made at the meeting had been most useful towards enhancing this understanding and thus moving forward towards attaining the health goals in the countries.

The Chairman endorsed Dr Acharya's comments. He closed the meeting after conveying his thanks to the participants, UNDP and WHO/SEARO.

Annex 1

LIST OF PARTICIPANTS

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Regional Adviser in Maternal and Child Health

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Mr D.P. Marwah
Administrative Assistant

Mr R. Rajagopalan
Senior Administrative Secretary

Mr N. Mitroo
Administrative Secretary

Annex 2

AGENDA

1. Evaluate the achievements of the second phase (1985-1986) of the intercountry project 'Primary Health Care Promotion and Development' (ICP PHC 006).

2. Review the present status of development and functioning of national and regional collaborative networks of institutions for primary health care.

3. Recommend ways and means of sustaining and further developing national and regional collaborative networks of institutions for primary health care.

4. Consider the general plan of operation for the intercountry project 'Intensification of Action Programmes for Primary Health Care' (WHO ICP PHC 009/UNDP RAS/86/076).

Annex 3

PROGRAMME

<u>Monday, 12 January 1987</u>

0830-0930 hours	Registration	
0930-1000 hours	Inaugural session	
	- Inauguration by the Ag. Regional Director	
	- Introduction of participants	
	- Nomination of Chairman, Vice-Chairman and Rapporteur	
	- Announcements	
	- Group photograph	
1030-1230 hours	Plenary Session	
	- Objectives and Programme of meeting	
	- Adoption of the Provisional Agenda	
	<u>Agenda Item 1</u>	
	Achievements of the second phase (1985-1986) of the intercountry project 'Primary health care promotion and development' (ICP PHC 006)	
	- Presentation by [illegible]	

Monday, 12 January 1987 (contd)

1400-1700 hours — Agenda item 2

Country reports on present status of development and functioning of national and regional collaborative networks of institutions for primary health care

Tuesday, 13 January 1987

0900-1030 hours — Agenda item 2 (contd)

1100-1230 hours — Agenda item 3

Ways and means of sustaining and further developing national and regional collaborative networks of institutions for primary health care

- Guidelines for discussions - presented by Dr (Ms) Saroj Jha, followed by Groups A and B - discussions

1400-1700 hours — Group discussions (continued) and preparation of reports

Wednesday, 14 January 1987

Agenda item 4

0900-1030 hours — Panel discussions on:

Intensification of action programmes for Primary Health Care

Annex 4

REPORTS OF GROUP DISCUSSIONS

1. Ways and Means of Sustaining and Further Developing National and Regional Collaborative Networks of Institutions for Primary Health Care - Agenda item 3

Group 'A' Chairman : Dr Suyono Yahya
Rapporteur: Dr Prakrom Wutnipongse

(1) The group reviewed the existing PHC networks at national and regional levels. It recognized the need for PHC focal points in the countries to attain the health-for-all goal. It was, however, felt that the national focal points did not function satisfactorily owing to ignorance of their roles (tasks and functions) and lack of awareness of existing secondary nodes. These nodes should be identified and made functional through support resources.

(2) In order to coordinate activities between the regional and national focal points, there is need to identify functions and tasks of both focal points. The functions and tasks of regional focal points should first be identified from the national points of view. The functions and tasks of national focal points should then be identified from the regional point of view. A mechanism of linkages between these two focal points should then be established.

(3) The flow of PHC information within each country between national PHC focal points and secondary nodes has to be established. The role of national focal points and nodes must be clearly defined.

(4) Strengthening of national and regional focal

(a) Member Countries should conduct national workshops for strengthening national focal points and establishing linkages with the regional focal point.

(b) The national workshop will also identify the national focal points, their PHC secondary nodes, regional focal point in terms of institutional structure, function and tasks and the mechanism of linkages among regional and national focal points.

(c) In order to carry out their responsibilities, the national focal points may need training, technology, supplies, experts or fellowships.

(d) The outcome of the workshop should be a national action programme for strengthening national focal points and establishing a mechanism for linkages with the regional focal point. The national action programme should be submitted to WHO/SEARO.

(5) Strengthening linkages with HeLLIS, HSR and POPIN or other information networks should be reviewed in a workshop. This workshop can be conducted at the same time as the national workshop for the strengthening of national focal points or can be done separately.

(6) WHO/SEARO should develop an effective mechanism of communication between SEARO and WRs and between WRs and national PHC focal points with periodic follow-up.

(7) Other ways to strengthen PHC networks within and among Member Countries:

(a) National and regional workshops/meetings to identify tasks and functions of national and regional focal points and develop action programme.

(b) The South Asian Association for Regional Cooperation (SAARC) should be identified as another potential for the regional focal point.

(c) Exchange programmes in the Region.

(d) Country projects.

(e) Technical cooperation among developing villages (TCDV): Expansion of PHC through intercountry training.

(f) Multicentre studies in Member Countries concerning essential elements of PHC, manpower development, appropriate technologies and systems development.

(g) Primary health care information resource centres (PIRCs) should play an active role in the dissemination of relevant information.

(8) The group requests Member Countries to avoid the past experience of sending different persons to attend different meetings of the same project.

(9) Other recommendations:

(a) Countries must recognize the same institutions as the focal point for PHC network.

(b) Follow-up action must be instituted to strengthen national focal points.

(c) Workshops/meetings must be held to share ideas, identify the strengths and weaknesses and to help replicate some innovative developments.

(d) The products of ICP PHC 006 should be used as baseline data to facilitate the implementation of ICP PHC 009.

Group 'B' - Chairman : Prof Somnath Roy
- Rapporteur: Dr Saxena

(1) The discussions of this intercountry meeting have brought up the need to have a fresh look at the national focal points existing in the country and the need to identify

appropriate national focal points (NFP), preferably institutions rather than individuals, who would link with other institutions in PHC operating in the country, e.., training and education institutions, research councils, health service organizations, nongovernmental and voluntary organizations and community organizations at peripheral levels, and also function as an information centre.

(2) The information centre would collect information for use and disseminate it to different levels in the country system: decision makers, administrators, providers of health services not forgetting the community and nongovernmental organizations (NGOs) and to the regional primary health care information resource centres (PIRCs).

(3) Both NFPs and PIRCs will need financial support and guidelines for functioning and for the development of manpower and systems approach through training, if necessary.

(4) Training will relate to all activities in regard to NFP functioning as an information centre - collection, storage, retrieval and dissemination of information, repackaging of information for target groups, and also how to document projects, screen and market information. Training can be arranged at the regional level or at the country level where resources are available.

(5) Type of information to be collected and disseminated includes progress reports of programmes, researches, field and community studies, success and failure stories in the eight elements of PHC and their supportive strategies.

(6) Wherever possible, NFPs for Information, FLLIS and HSR networks must be combined to avoid duplication of efforts and confusion of channels.

(7) The role and function of the PHC networks have to be strengthened and made known to the country in which it is located as also to all the NFPs of the Member Countries.

2. Decentralized Management System and District Health Survey Guidelines - Agenda items 4.3 and 4.4

Group 'A' - Chairman : Dr (Mrs) Suniti Acharya
- Rapporteur: Mrs Aminath Rasheeda

Decentralized Management System

(1) Feasibility of decentralized district health management system:

(a) There is a felt need for the intensification of the existing PHC programme.

(b) New approaches have to be taken to supplement the ongoing national efforts.

(c) A pilot programme of action-cum-research needs to be started.

(d) A district, which is a sizeable, manageable unit with some infrastructure, has to be defined by individual countries.

(e) Since district is the nearest management unit, operation is more feasible.

(2) Characteristics of a district:

(a) It should have enough health facilities - at least up to the first referral unit.

(b) It should not be the best nor the worst, but be average in the national health plan.

(c) There should be enough activities of other sectors in the district to ensure intersectoral collaboration.

(3) Factors which will help to improve district-level management:

(a) Delegate relevant authority and responsibility.

(b) Provide resources and atmosphere:

Technical: Pre-service training
In-service training

(c) Improve competency:

Managerial skills and leadership

(d) Provide information, policy plan and guidance.

(4) Powers and responsibilities that can be delegated to the district health office:

(a) Local-level training

(b) Financial accountability

(c) Personnel management and recruitment

(d) Utilizing the available resources fo the maximum benefit.

(e) Powers and responsibilities have to be country-specific and relevant to the authority to implement the programmes.

(5) Factors that influence district health management:

(a) Political
(b) Economic
(c) Administrative, e.g., degree of autonomy
(d) Level of commitment
(e) Taboos and culture
(f) Geographical topography
(g) Logistics and support
(h) Communication and transport
(i) Leadership, skills and capacity of health team
(j) Inefficiency and red-tapism

(k) Lack of trained manpower

(l) Lack of readily available information, retrospect and prospective

(m) Lack of coordination and cooperation.

(6) Functional and supportive linkages are necessary for decentralized health management within and between the district health office and other related sectors. Efforts should be made to ensure that health development is an integral part of the overall development system at the district level.

District Health Systems Survey

The group did not feel the necessity for the survey protocol as provided in the guidelines. However, it was felt that a general survey is more applicable at present due to time constraints and other factors. A general survey collecting baseline data on the following should be conducted:

(1) Acute respiratory infections (ARI)
(2) Control of diarrhoeal diseases (CDD)
(3) Expanded programme on immunization (EPI)
(4) Essential drugs
(5) Management aspects
(6) Technology used, e.g., ORS, in the control of CDD
(7) Community perception of the programme

This will also help to evaluate the programme.

Group 'B' - Chairman : Prof Somnath Roy
- Rapporteur: Dr Abdul Samad Abdullah

(1) The need for decentralized management was recognized as important and feasible for the identification of PHC implementation at intermediate levels of the administrative structure in the countries of the Region. Intermediate levels refer to those levels away from the centre and which constitute a civil administrative unit with representatives of health and health-related sectors. They need not always refer to districts.

Decentralization is seen in the context of decentralized management of health in a district system within the existing national system and not with decentralized administration which is beyond the purview of this group.

(2) Decentralization should be viewed in its proper perspective, viz., as a managerial tool for efficient and effective implementation of national health programmes. While the concept of decentralization and management is accepted, the degree of its decentralization will vary in different countries according to the strengths of the decentralized units and the existing lines of administration.

Planning and implementation as well as budgeting and financial management at the district level may vary from country to country and from one situation to another, depending on the political set-up, socio-economic situation, managerial capabilities, etc. Decentralization would, therefore, need to be adapted to suit the given situation. There can be no uniform decentralized management system that can apply to the Region as a whole.

(3) Districts or other such integrated units selected for the intensification of PHC programmes should have freedom to experiment with newer concepts in managerial processes, for delegation of authority and responsibilities to the district health offices in planning policies, personnel management, greater control over budget allocations and finances and greater involvement in support of activities, such as guidance in programme matters, drug procurement and equipment usage.

(4) Aspects of decentralization relevant to effective delivery of PHC are in the areas of carrying out situational analysis, problem identification, preparation of sound implementation plans, setting targets, monitoring and evaluation, intersectoral action, resource mobilization, community participation and innovations.

(5) The role of the district health office is critical to the success of the decentralized management system. Motivation, confidence and capabilities in health development are expected from its chief and the health team.

(6) Supportive training activities in management processes will be essential to achieve these

Training activities should also be directed to other officials in the district system who will collaborate in the intensified PHC approach.

(7) Functional and supportive linkages within the district health office and between the district health office and the Ministry of Health, district administration, other sectors in the 'district', more peripheral units and the community will be in the areas of technical support, support for planning, resources, logistics and management, coordination and community involvement.

(8) A situational analysis carried out at the start of the project is an important management tool for planning, programming and monitoring. Also, when carried out at the end of three years when the life of the project is over, it is useful for evaluation. When analysing the health situation, considering the small size of the population and the inaccuracy or non-availability of information, the various indicators suggested (infant mortality rate, maternal mortality rate and life expectancy) may not be appropriate. More importance should be given to process indicators instead.

(9) A survey protocol would be developed at the country level that would serve as an instrument to make a comprehensive analysis of the situation, to review existing managerial processes, and to review the PHC set-up. This instrument may be developed on the basis of the guidelines provided by headquarters and as early as possible. It must necessarily be simple. The survey should be carried out and processed in the shortest possible time for problem identification, target-setting and monitoring. Process indicators must be included, specially in the areas to be intensified, and special attention must be paid to the survey for collecting relevant data from the underserved vulnerable groups.

3. Initiating Implementation of the Project ICP PHC 009 - Agenda items 4.1 and 4.2

Group 'A' - Chairman : Dr Suyono Yayha
- Rapporteur: Dr N.T. Cooray

Country Level Actions

Each country should identify policy guidelines for the decentralization of the district management health system emphasizing on expanded programme on immunization (EPI), control of diarrhoeal diseases (CDD), essential drugs and vaccines (EDV), acute respiratory infections (ARI), etc. This would be followed by a national workshop at which a district will be selected. Project ICP PHC 009 will be introduced with:

(1) planning for collection of baseline data;

(2) preparing a plan of action for implementation, and

(3) strengthening of PHC network and identification of focal points at national and district levels.

This will be followed by the baseline survey. At the same time, the group recommends that a three-day workshop be conducted in the selected district to inform the district level health and health-related sectors about the proposed inputs and activities of the project.

The district-level workshop will identify existing resources and requirements for new or additional resources, including supplies and equipment. Training needs related to activities, such as EPI, ARI, diarrhoeal diseases, drug management, epidemiology, management training, etc., will be identified. The district-level workshop will also develop the district plan and activities. The district health workshop will be conducted by the District Health Officer, with resources from the national level. The district workshop should identify the elements to be included in the

project. This would be based on the baseline survey. The work plan should then be developed in terms of EPI, ARI, CDD, EDV, managerial training needs, development of integrated training modules, supplies and logistics, deployment of manpower, community participation, intersectoral coordination and any other district specific needs. The work plan should identify government inputs and required UNDP inputs The work plan should also include an yearly budget within guidelines and limits set, as stated in the project document.

Action for the WHO Regional Office

(1) The Regional Office should send an official communication to the countries on the following:

- Intercountry consultation of January 1987
- Request commencement of activities as recommended by the meeting
- Request WRs to identify focal points and follow-up action with a responsible person in the WR's Office.

(2) Assistance for training courses

(3) Provision of training modules, when necessary.

(4) Developing, translating and printing of training modules.

1988-1989

(1) Implementation - January 1988

(2) Mid-term review at the district level - July 1988

(3) National workshop to assess results of projects with a view to replication in other districts - January 1989

(4) Regional workshop (before UNDP review) - March 1989.

SCHEDULE OF ACTIVITIES

Activities	1987 J	F	M	A	M	J	J	A	S	O	N	D
1. Preparatory phase including project formulation at country level	———											
2. National workshop				—								
3. Baseline survey				———								
4. Preparation of district workshop						—						
5. District workshop							—					
6. Ordering of supplies and equipment						—						
7. Development of integrated training modules (a) technical (b) management								———				
8. Printing training modules									—			
9. Conducting training												

Group 'B' - Chairman : Prof Somnath Roy
- Rapporteur: Dr Abdul Samad Abdullah

The group discussed activities related to the plan of operation of project ICP PHC 009 after a careful review of the objectives

(1) The plan of operation for the intensification of PHC will be discussed at a national workshop to be convened by the focal points appointed by the governments and participated by key administrators and experts of the intensification areas. At this workshop, what to intensify, how and where will be decided.

(2) The national workshop will be convened as soon as government concurrence to the project is obtained by WHO/SEARO.

(3) Baseline surveys needed for management and monitoring will be conducted as soon as the district or any other manageable area is selected. In the selection of the district it will be remembered that activities will be targeted to the underserved and vulnerable populations. The survey will be conducted using existing manpower and resources in countries and made as simple as possible.

(4) In the plan of operation, focus will be on the implementation of district management in the four areas of intensification and to develop a replicable model in the country for further activities and projects.

(5) The terminology used in the project document, e.g., 'children', 'paediatric group', etc., will be clarified at the country level keeping in mind the vulnerable age groups needing attention.

(6) The training modules to be used will be developed by WHO/SEARO and sent to Member Countries where these will be further developed and adapted to serve the countries' project activities and then field-tested. This will be undertaken by an appropriate institution who will develop steps to operationalize it in consultation with the selected district officials.

(7) Support for supplies will be needed in the following areas:

At the management level -

Word processors and computer
Photocopying and cyclostyling facilities

At the implementation level -

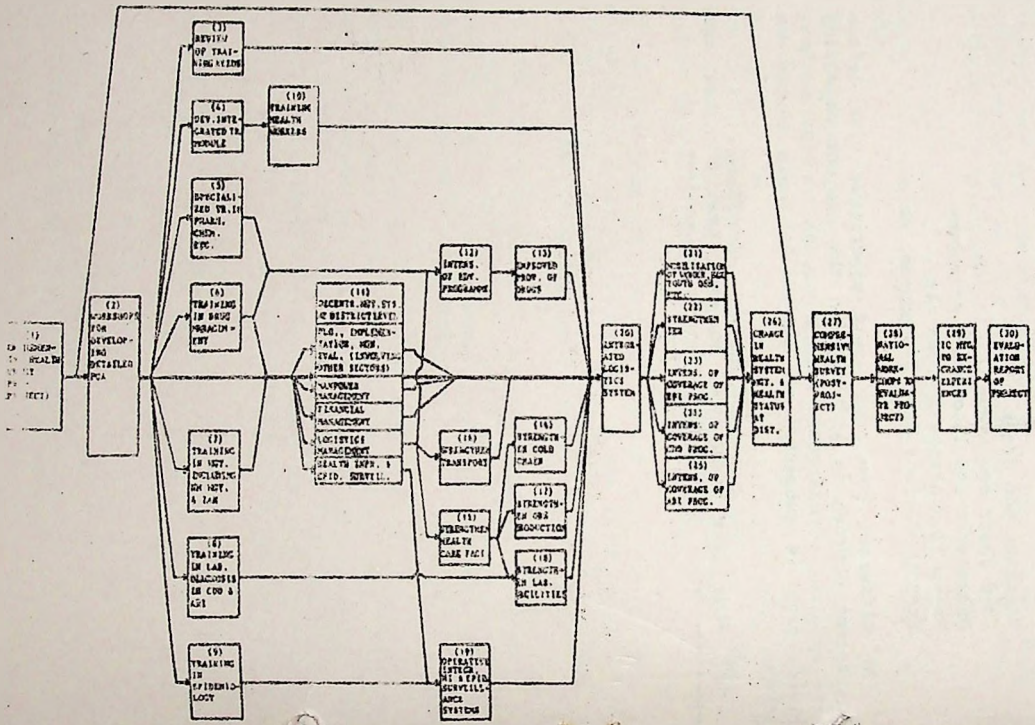
Vaccines and drugs
Cold chain equipment
Diagnostic and laboratory equipment
Production plants for ORS etc.
Transportation: Bicycle, mopeds, etc.

(8) Different countries would experience time delays of different degrees in implementing the project depending on the existing bureaucratic structures. As soon as a clear activity plan is submitted to WHO/SEARO, funds should be released.

(9) Some seed money may be made available for the preparatory stage before the start of the project

Annex 5

FLOW CHART



WHO Regional Office For South-East Asia
NEW DELHI

SEA/HSD/97

12 March 1986

STRENGTHENING OF REFERRAL SYSTEMS FOR PRIMARY HEALTH CARE

Report of a Consultation

WHO Project ICP PHC 006 UNDP Project RAS/81/027

CONTENTS

SUMMARY

The Thirty-seventh session of the Regional Committee held in 1984 had stressed the importance of a sound referral system in providing meaningful support to primary health care. Following this, the subject was again discussed in greater detail at the Intercountry Meeting for Primary Health Care Networks in January/February 1985.

The present consultation was called as a follow-up of the recommendations of the above intercountry meeting and as a first step towards supporting action programmes in the countries with the following objectives:

(1) To discuss and arrive at a consensus on the conceptual framework of a comprehensive referral system in support of primary health care (SEA/PHC/Meet.11/7);

(2) To review the framework for the rapid analysis of referral support to primary health care (SEA/PHC/Meet.11/8);

(3) To exchange information on the existing referral system in individual countries, and

(4) To develop country action research plans on selected aspects of the referral system to support primary health care.

The Director, Health Systems Infrastructure, WHO Regional Office for South-East Asia, welcomed the participants to the Consultation. He explained that since the International Conference on Primary Health Care and the Alma-Ata Declaration, efforts towards primary health care development have taken a quantum leap, but at the same time there have been apprehensions that primary health care would become second-rate health care for the 'have nots'. It has

After thorough informal discussions on the conceptual framework of a comprehensive referral system in support of primary health care, certain terms were redefined in the context of the situation existing in the Member States and some other modifications suggested in the background paper prepared for the Consultation.

On the basis of the framework for the development of an action plan, each of the participating countries developed an action research plan proposal with specific objectives and a tentative calendar of activities. These plans are included in the report.

REFERRAL SYSTEM IN PRIMARY HEALTH CARE
A CONCEPTUAL FRAMEWORK

Definition

In general terms a referral is defined as a process by which reference is made of matters requiring decision or settlement or consideration to some authority, within the scope given to such authority. This definition implies that the level/person to whom the reference is made (i) is higher in level; (ii) is more knowledgeable; and (iii) has the authority. It further implies that the level making the reference has neither the knowledge, competence or facilities, nor the authority to take a decision on the problem referred.

In the background of health for all, when a health problem or a patient requires care which exceeds the capacity or the competence of the home or community or first health facility levels of primary health care, bringing the problem or patient to the attention of more skilled personnel and more adequate facilities to bear on different problems or illness, is called referral (see Report of Informal Planning Meeting, 25-29 June 1984, SHS/HQ).

The 'Glossary of Terms' used in the Health-for-All Series Nos.1-8, defines referral as a turning for support or referring patients to an appropriate facility, institution or specialist at the next more central level in the health system, such as a health centre or hospital. They in turn can refer problems and patients to successive levels in the health organization.

In the light of these definitions, a simplified meaning of referral can be "Referral is a process to seek solution or support to the problem from a person/institution having competence and facilities to do so". However, in a governmental system it also implies that the person to whom the problem is referred has also the authority not only to suggest a solution, but also support its application.

2. NEED FOR REFERRAL SUPPORT SYSTEM

In any organization the available competence and facilities vary at different levels. Similarly, the different levels are vested with varying degrees of authority and responsibilities considered adequate to discharge their functions. However, occasions/problems do arise at each level, where they need the support of persons/institutions who have the required competence and facilities to find a solution to a given problem. The referral system meets the requirements of such situations.

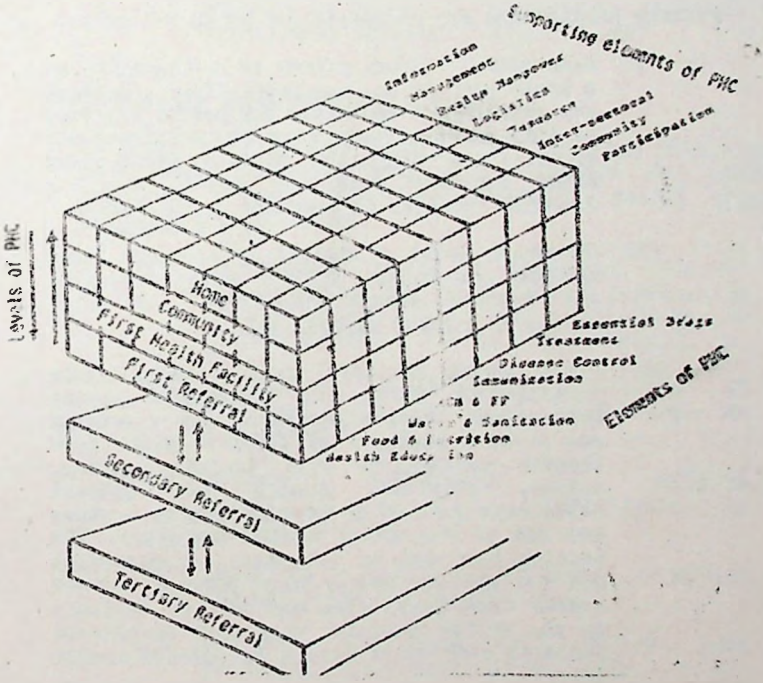
In the field of health, professionals with progressively higher training and competence who can give specialized care or support over a wide range, using more advanced technology that can be offered at peripheral levels, are available at referral-level hospitals. The district health offices similarly are better equipped to solve various types of problems that may arise at home, in the community or at the first health level. Thus the referral system helps in the efficient delivery of primary health care services and in securing people's faith in the primary health care approach.

In the health system at present prevailing in many countries, an individual is free to seek treatment for his/her ailments with any institution at any level. There is also a deep-rooted impression that one gets better advice and treatment at higher-level health institutions. In order to create faith among individuals and the community in the primary health care approach, they have to be assured that in case the services of higher-level institutions are needed, such services would be made available to them on a priority and preferential basis through referrals. A health system based on primary health care cannot be developed and cannot function without support from the first referral level ensured through a well organized system.

3. DIMENSIONS OF A REFERRAL SYSTEM TO SUPPORT PRIMARY HEALTH CARE

A referral system should be able to deal with referrals related to any of the essential elements of primary health care from any level of primary health care in respect of any of the supporting infrastructure (Figure 1).

Figure 1. A CONCEPTUAL MODEL OF A COMPREHENSIVE REFERRAL SYSTEM IN SUPPORT OF PHC



The Essential Elements of PHC

The referral system should be organized to support the essential elements of primary health care, which include at least education concerning prevailing health problems and the method of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child care including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; treatment of common diseases and injuries; and the provision of essential drugs.

The levels of PHC

Primary health care may be considered at four levels:

(1) Home level - which refers to a household as a basic unit in any community. Family members are primarily responsible for health activity at this level. People from the neighbourhood as well as community workers of various kinds interact with the family and are directly involved in services at this level.

(2) Community level - activities at this level concern the health of the whole community and require common facilities and joint action by a group of persons.

(3) First health facility level - means state institutions which are permanent, having professional health personnel and providing one or more elements of primary health care (health professions will include doctors, nurses, midwives, health and medical assistants and other trained health workers who are in the state health services). The institutions run by voluntary organizations and the private sector also provide primary health care facilities and can be included in the system provided they have functional linkages with other levels of primary health care.

(4) First referral level = this is the ne higher level in the health organization th the problems arising at any of the fi three levels can be referred for solut The first referral level serves two areas needs, as manifested in clinical programme referrals. The clinical refe system deals with the diagnosis and treatm of patients referred for services at hig levels. The programme referrals deal wi problems involved in planning, manage and support activities. Both sub-syste have science and technology components as well as administrative support functio related to personnel procedures, resources, facilities, equipment, supplies etc.

Supporting Infrastructure for PHC

In order that primary health care functions effectively at all levels, certain supporting elements are considered essential. These supporting elements, called supporting infrastructure, cover:

(1) Information system = including community assessment of the local health problems and health needs, and the monitoring and evaluation of the impact of programmes;

(2) Management functions = including planning, implementation, financing and evaluation of the functions;

(3) Manpower development = including recruitment, training, supervision and continuing education;

(4) Logistics = including supplies, transport communication and maintenance;

(5) Research in identified problem area requiring action-oriented research;

(6) Support for intersectoral coordination; and

(7) Community participation.

Other Levels of the Referral System

These are:

(1) Intermediate or secondary level
(2) Tertiary level

Types of Referral

The types which may be referred from one level of the PHC area to another may be grouped broadly as:

(1) Clinical (patient care, which includes investigation, diagnosis, treatment and after-care) and

(2) Health programme (referrals concerned with problems relating to public health programmes)

Two-way Communication

Referral should not be considered as a one-way traffic from the periphery to more central levels. The dynamics of interaction among various referral levels requires a two-way communication.

- inward flow of problems related to health programmes and treatment of patients;

- outward flow of information with respect to the patients and problems referred, feedback from analyses of reports, policy decisions, new ideas and new technologies, etc.

4. REQUISITES OF A REFERRAL SYSTEM

Procedures

There should be clear-cut procedures in regard to when and where the referral is to be made, indicating clearly, while making the referral, why the referral is being made. Safeguards must be built into the system to ensure that the referral system is not misused for 'passing the buck' and thus overloading the referral level with finding solutions

to problems which can be tackled at the local level itself Steps should be taken to ensure that all persons concerned are well aware of the referral procedures.

Resources

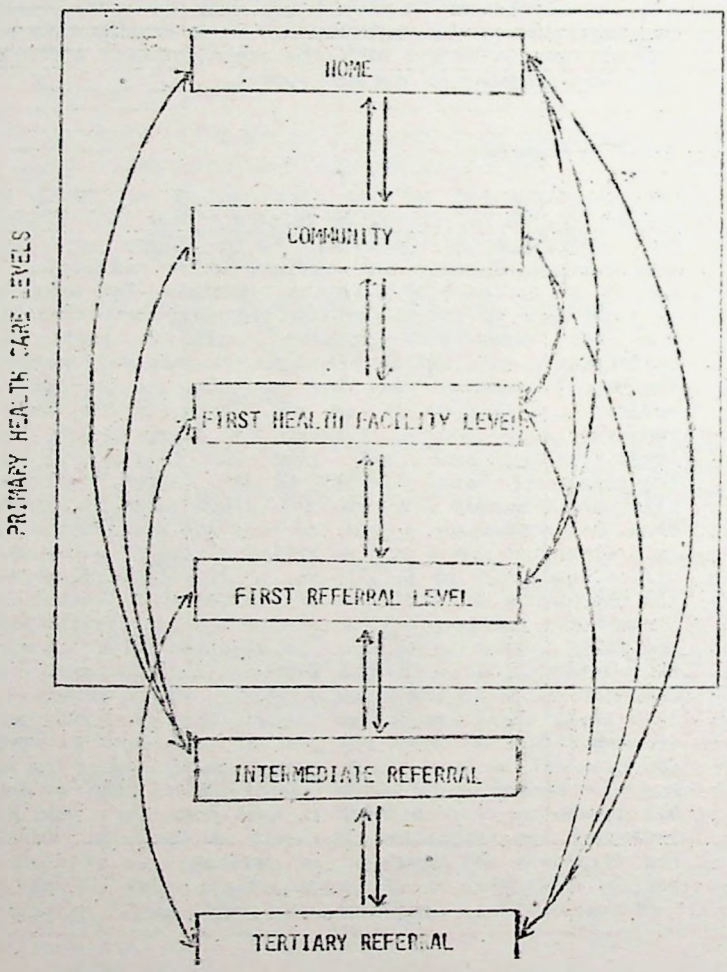
The level referred to should not only have the competence and expertise to find a solution to the problem referred but should also be vested with the administrative authority to implement whatever is decided upon.

Referral Channels

The referrals can be made from and to any level of the system (Figure 2). It may be related either to a clinical or an administrative problem. While there are usually well-defined channels for administrative referrals, it is not so in the case of clinical referrals. The usual method of referrals is to follow the organizational channels. It has its advantages. However, such a rigid system, particularly in clinical referrals is not only unnecessary but may be harmful too. For instance, in the case of a severe head injury it is no use going to the first referral-level hospital through the first health facility level knowing full well that the facilities for its treatment are not available at the latter. As such, in clinical referrals the referral point must be decided in each case according to need and no rigid procedure should be laid down. For the smooth operation of the clinical referral system, each service level must be fully knowledgeable about the competence and facilities available at different levels, so that the referral can be made to the appropriate level in the first instance. Any delay in clinical referrals may lead to discontentment with the services and ultimately people may lose faith in the primary health care approach. At the same time, the pressures and temptations to refer any case on considerations other than actual need must be resisted. The clinical referrals must operate on the principle of "to everyone according to his/her needs and to none on demand". All levels of service delivery must know the competence of personnel and facilities available at different levels for the diagnosis and treatment of patients, so that the case may be referred to the appropriate level in the first instance itself. A "referral slip/card" should be used while making the clinical referrals, giving all details

Figure 2

Figure 2. CHANNELS OF COMMUNICATION BETWEEN DIFFERENT LEVELS OF THE REFERRAL SYSTEM



5. FRAMEWORK FOR RAPID ANALYSIS OF THE REFERRAL SUPPORT FOR PRIMARY HEALTH CARE

Definition of Referral System

The referral system is a formal mechanism to deal with the referrals from any level and consists of a number of sub-systems (organization, persons, equipment, etc.) to achieve the solutions to the problems referred. It is different from the normal organizational or functional linkages that may be existing between the various levels of the delivery of health services.

Nature of Possible Referrals

In the light of the definition of referrals, the areas of referrals will depend on the level from which the referral is made, but broadly cover:

(1) Patient care
(2) Maintenance of Equipment
(3) Training
(4) Evaluation
(5) Research
(6) Inter-sectoral coordination
(7) Community participation

Criteria for Differentiating Between Referral and Management Problems

The referral system is meant to deal with referral problems and not management problems. Referral problems are those which cannot be dealt at the referring level within its composition and functions, while management problems are those which should normally be handled at the particular level, but cannot be tackled on account of the non-availability of the facility at a particular moment, e.g. for example, a patient's referral to a referral hospital for blood examination for malaria parasite because the microscope at the first health facility level (primary health centre, health unit, dispensary, etc.) is not in working order. This is purely a management problem and not a referral problem, and should be taken care of by improved

hospital for X-ray, because X-ray facilities are not planned to be available at the first health facility level, is a referral problem and should be taken care of by the referral system. By their very nature referral problems are permanent, while management problems are temporary.

Framework for Rapid Analysis

The general approach for rapid analysis suggested in the framework is a problem-oriented one. In the first step the present situation is described. In the second step, each country selects a "preferred" item of referral and works out an ideal referral system for the same. In the third step, the ideal referral system worked out is compared with what is existing in the country to identify the gaps for preparing an action plan.

Step 1

Describe the referral system in your country with reference to the following items:

Political and administrative structure in the country

- What are the administrative divisions?
- What are the levels of government?
- What are their relationship to the health sector at different levels?
- What system of decision-making exists at the community level?

Components of the health system

- What important organizations, or groups are there in the country providing health care besides the ministry of health?
- What activities outside the health sector have significant effects on health, either positive or negative?

Organizational structure of the health services

- What is the organizational structure of the ministry of health and its subordinate levels of management?
- What types of health care are provided at each level?
- How are health programmes implemented?

Operational management of the referral system

(Describe separately for clinical referrals and programmes referrals as appropriate)

(i) Procedures

- Does a formal referral system exist at present for patients/health programme problem? Describe.
- Is it a two-way system or only for 'transfer' of cases or problems?
- Are all levels of the referral system aware of the existence of such a system (if it exists?)
- Does the system allow for 'level-jumping' according to the needs of individual patients/problems?
- Are any procedures laid down for making the referrals, e.g., referral slips/referral cards?
- Does the referring level know the information to be provided while making the referrals?
- Are the times and dates fixed known at every level for sending the referrals, so that the services are made available without waiting? Or do facilities exist so that the patient can be attended to at any time?

- Does the system provide for attending to the referrals at the referring levels also (e.g., visit by doctor to the home and community level or by specialists to the PHC level?)

- Is there any organizational or administrative arrangement for referral institutions to attend to referral cases on a priority and preferential basis?

- Has the referral level any accountability for attending to the referrals?

(2) Manpower

- What staff are available at each level for programming technical management tasks?

- Are staffing levels adequate and are job descriptions and responsibilities clear?

- Are mechanisms for handling personnel matters working satisfactorily?

(3) Training

- Are health personnel adequately trained to function appropriately at the level they are posted?

- Are adequate and relevant training materials including manuals and handbooks available?

(4) Supervision

- Are health personnel at various levels being regularly supervised?

- How much on-the-spot training, in-service training or continuing education is given as part of supervisory support?

(5) Supply, logistics and maintenance

- Are transport facilities available and adequate for patients?
- Are communication facilities available between different levels to seek more information and guidance for sending the patients to the referral levels?
- Are storage facilities adequate?
- Is equipment adequate?
- Are facilities and equipment (including transport) adequately maintained?

(6) Intra and inter-sectoral coordination

- Are health activities in general and referral activities in particular being coordinated with other health agencies, other ministries and private and traditional practitioners and other systems?
- Is there any effective coordination?
- Are there structure and mechanisms for coordinating the work of all sectors?

(7) Community participation

- What form of community participation exists for health activities in general and for referral activities in particular?
- Are these activities effective?

(8) Monitoring and Evaluation

- Is there any mechanism to assess the load and type of referral at a particular level?

- Is any assessment being made of the patients' satisfaction with the referral services?

(9) Resources (technical/financial)

- Are the facilities and the competence of personnel at every level standardized to identify the type of services available at each level?

- Are all the levels aware of the facilities and services available to ensure that the referrals are made at the appropriate level?

Step 2

Describe your 'preferred' referral system under the same headings as in Step 1.

(1) Procedures
(2) Manpower
(3) Training
(4) Supervision
(5) Supply, logistics and maintenance
(6) Intra and inter-sectoral coordination
(7) Community participation
(8) Monitoring and evaluation
(9) Resources

Step 3

(1) Identify at least five or more problems relating to the operational management of the existing referral system in your country (as judged by the gap between the present situation and your preferred situation).

(2) List the first five problems in order of priority.

6. PROPOSALS FOR ACTION RESEARCH

BANGLADESH

Action Plan Framework

TOPIC: Scheme for Patients Referral

SITUATION ANALYSIS

Present Situation

- The process of patients referral is not given due importance as a system activity.
- Patient referral is done rather perfunctorily without much sense of responsibility on the part of the referring level.
- No effort is made to find out what happens to the patient once the referral is made.
- Many a time the referral is done verbally.
- The referring level is not aware of the advices given to the patient on disposal.
- There is no scope for monitoring or evaluating the referrals made.
- Referral as a process is not uniform and is not equally familiar to health institutions at each level.
- There is no scope for research.

Needs Identified

- There must be a formal scheme for the referral of patients both at the referring level (FWC) as well as at the UHC, the first referral level.
- Some documentation has to be done both at FWC and UHC levels that can be used for monitoring and epidemiological activities subsequently

- Patients referred must carry some referral documents in the shape of forms/cards which give them a sense of belonging to the system and also of security that they will be looked after at the referral level (UHC).

- Each level (HFWC, UHC, etc.) in the referral system must be clear about its role in the referral process.

PLANNING

- Objective: To develop and field test a patient referral system at HFWC - the first health facility level.

- Area of implementation: 6 HFWCs comprising 2 UHCs of 3 districts.

- Resources: Detailed budgets will be preferred.

- Detailed plan of action: As annexed.

- Indicators of assessment:

  Number of referral requests receiving services
  Number of HFWCs actively participating (first health care facility)

  Number of UHCs participating (first referral level)

  Number of patient follow ups showing satisfaction

IMPLEMENTATION

- Calendar of work: As annexed.

- Staff training and field work: As provided in the action plan.

- Monitoring

  Field visits
  Reporting
  Six-monthly monitoring

- Feedback: Continuing

EVALUATION

- Evaluation plan

  Record analysis
  Sample survey

- Indicators of success: As noted under Planning.

BANGLADESH

PLAN OF ACTION AND CALENDAR OF WORK SEPTEMBER 1985-AUGUST 1986

CALENDAR OF WORK (ACTIVITIES)	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	
1. Preparation of PP and approval													
2. Situation analysis													1 000
3. Selection of UHCs and HFWCs constituting the sample size for field research size for field research and determining the scope of services with ithe referral scheme													
4. Designing of referral cards													
5. Selecting format for basic patient document at HFWC and record and report forms at UHC													
6. Training and orientation of referring level staff on proposed referral scheme jointly with local community leaders (six workshops of 3 days each with about 30 participants)													6 000
7. Trial run of activities Nos.3 and 4 (one day) at five places													

CALENDAR OF WORK (ACTIVITIES)	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	$
8. Finalization and printing of Nos.4 & 5 activities													2 000
9. Implementation of referral systems													
10. Provision of inputs in the development of referral levels													5 000
11. Feed-back consultation between staffs of referring and referral levels													500
12. Selection of indicators for assessment													
13. Evaluation													1 500
14. Publication of reports													2 000
15. Presentation in national meeting													2 000
													TOTAL: 20 000

INDIA

ACTION STEPS TO INTRODUCE A FORMAL REFERRAL SYSTEM FOR PATIENT CARE

Long-term Objective

To introduce a formal referral system for patient care at all levels of medical care

Short-term Objectives

(1) to assess, with the aid of information available, the number and types of referral likely to be made from FWFL (PHC) to the FRL (district hospital);

(2) to study the type of services provided at FWFL (PHC) and FRL (district hospital);

(3) to develop a referral card for use at FWFL (PHC) and FRL (district hospital); and

(4) to assess the referral load at FRL to work out the requirement of manpower, logistic support and trainers required for the referral system to be fully functional (after introduction of referral card)

Area for Implementation

Two primary health centres with possibility of extension to the whole district (about 15PHCs).

Mechanism and Method of Monitoring

Along with the continuous monitoring by FWFL and FRL, a quarterly appraisal would be carried out to assess the progress of the project and suggest modifications if

Evaluations would be done sometime in July 198[illegible]

Indicators would be decided after a detailed study of the existing situation.

Monitoring Mechanism

(a) Continuous

AGENCY

CMO

SMO(H) DHS(F)

MO(FHC) MO

TOOLS

In the month under review

No. of cases attending FPFL
No. of cases referred to FRL
Classification of type of cases

TASK

- Guidance to appropriate referrals
- [illegible] types/responses
- Identification of problems etc
- Making efforts to solve above

(b) Appraisal

AGENCY

PROGRAMME MANAGER

CMO DHS SMS MO MO

TOOLS

- Progress chart of referrals
- No. of problems solved/unsolved
- Any other feed information

TASK

- Extending guidance
- Modification in approach as per need

CALENDAR OF WORK	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
1. Collection of information from FHFL and FRL the number and nature of cases referred and the number of cases and their nature treated at First Referral Level from that particular FHFL (PHC)												
2. Identification of the number of cases from 1 above the number of cases and their nature which would really need referral on the basis of service facilities available at FHFL												
3. Development of procedures for referrals 1. Preparation of guidelines for the use at FHFL and FRL indicating how to make and how to deal with referrals												

CALENDAR OF WORK	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
ii. Study of the service facilities available at FHFL and FRL, standardize them and circulate them for the information of FHFL and FRL												
iii. Preparation and circulation to the public, information material about the functioning and advantages of referral system												
iv. Preparation and pre-testing of the referral card												
v. Introduction of referral cards for use												
4. Monitoring												
i. Study of the services provided to referrals by FRL												
Logistic Support												
i. Identification of the logistic supports needed for dealing with referrals effectively												

CALENDAR OF WORK	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
4. Providing additional logistic support (within the limitation of resources and possibility of recruitment)												
5. Evaluation and preparation of the report												

MONGOLIA

PLAN OF ACTION FRAMEWORK AT KHULD,
SOMON AND AIMAK JOINT HOSPITAL

Main Objective

To improve the OPD and polyclinic aspect of patient care referrals in a selected somon to gain experience in the development of a comprehensive referral system

Indicator for Main Objective

OPD serviced at present and after one year

Indicators for Sub-objectives

(1) A referral system for the somon will have been documented

(2) All health professionals in the brigades/somons/aimak joint hospital will be familiar with the system

(3) The community will also be well-informed of the system

(4) Home care for headsmen will be improved

S.No.	Components	Sub-objectives
1.	Procedures	To improve knowledge of health professionals and community on referral systems
2.	Manpower	To improve competency of health professionals at brigade/somonhospital/aimak joint hospital
3.	Facilities/ equipment	To improve facilities, particularly at the brigade, feldsher station and somon hospital
4.	Logistics including communication	To improve/set up communication facilities: (a) Radio communication (b) Telephone communication (c) Transport
5.	Monitoring and Evaluation	To obtain common understanding by all aimaks on referral systems by reviewing the present project

S.No.	Activities	Responsibility	Time Schedule	Resources (US $)	Remarks
1(a)	Preparation of handbooks on referrals	Dr Rolzodma Ministry of Health	Nov. 1985	4 000	
(b)	Wider distribution to all health professionals	Dr Dulamaureng Aimak Health Director	Dec. 1985		
(c)	Health education in the community		To date		
2(a)	Update and revise job descriptions	Ministry of Health	Nov. 1985	4 000	
(b)	Define required competencies of staff and facilities at each level		Jan. 1986		
(c)	Continuing education courses to staff to update and upgrade their knowledge		Feb-Mar. 1986		
(d)	Study tours		Jan. 1986		

(continued)

(concluded)

S.No.	Activities	Responsibility	Time Schedule	Resources (US $)	Remarks
3	To upgrade Brigade Feldsher stations at Somon hospitals in the project area in accordance with the defined (standard) competency of staff and facilities	MOH/AHD	Feb 1986	10 000	
4(a)	To establish a radio communication network between the Brigade Feldsher Stations/ Somon Hospital/Aimak Joint Hospital	MOH/AHD	Feb-Mar 1986	8 000	
(b)	To strengthen transport facilities at Brigade Feldsher Stations (motorcycles)		Apr-May 1986		
(c)	To provide ambulance service at Somon Hospital for outreach services		Apr-May 1986		
5	To organize National Workshop	MOH	Aug 1986	4 000	

SRI LANKA

A PROJECT TO STRENGTHEN THE EXISTING PROCESS FOR REFERRAL AT THE PRIMARY HEALTH CARE LEVEL IN A SELECTED DIVISION IN SRI LANKA

Situation Analysis

1. The FHW is crucial for the delivery of all PHC services:

   - about 2 500 in the island
   - 18 months' in-service and field training
   - 1 per 3 000 population
   - operate from an Institution: GHC
   - first health facility
   - each has support of 20 volunteers and Gramodaya Mandalas

2. Currently, referral is done by: FHW
   FHM
   PHI
   AMP

   - chiefly MCH
   - informal, optimal

   FHW - no records/documents/registration
   PHN - no feed-back
   - limited scope

   PHI - chiefly communicable diseases control and environmental sanitation
   AMP - ambulatory patient care

Planning

1. Objectives

   Main: Strengthen the quality of existing referral service of PHC worker

   Sub-objectives 1. 1 improve prestige/credibility/utilization of service of PHC worker

1.2 use as a method to upgrade/maintain skills and levels of competence of PHC worker

1.3 provide an additional tool to improve supervision/monitoring of PHC worker

1.4 identify and provide improved priority referral

1.5 increase community acceptance of PHC worker

1.6 make referral more cost effective

1.7 control and screen case load

1.8 improve quality of service provided at referred institution

1.9 provide additional method for monitoring and evaluating health services

1.10 provide design of a referral system for National Health Service

Area of Implementation

AGA Division Beliatta

75 000 population, 50 sq. miles

PHW - 20

PHN - 4

PHI - 6

AMP - 3

20 GHC

4 Central Dispensaries

1 Divisional Health Centre

Bari Hospital

- 1 Provincial Hospital

Major Health Problems

- Nutritional
- Helminths
- EPI coverage
- Gastro-intestinal
- Acute respiratory
- Malaria
- Oral health
- Environmental sanitation
- Food hygiene
- STD
- Alcoholism
- Health education

Plan of Work

1. Get approval of Ministry
2. Arrange meeting with concerned staff to explain project
3. Arrange meeting with Gramodaya Mandalas and other village leaders
4. Assessment to establish base-line workload - sampling
5. Design and prepare required documents
6. Training workshops:
   - indicators
   - use of persons
   - record keeping
   - follow-up
7. Run for three months and review
8. Prepare manual for referral
9. Workshop to discuss and evaluate system
10. Commence modified system and implement for 6/8 months

Evaluation

With respect to:

1. PHC worker
   - work load
   - job satisfaction
   - improved competence
   - improved relationship with community
   - receipt of feed-back

2. Community

- patient satisfaction
- perception of PHC worker by Gramodaya Mandalas

3. Referral Institution

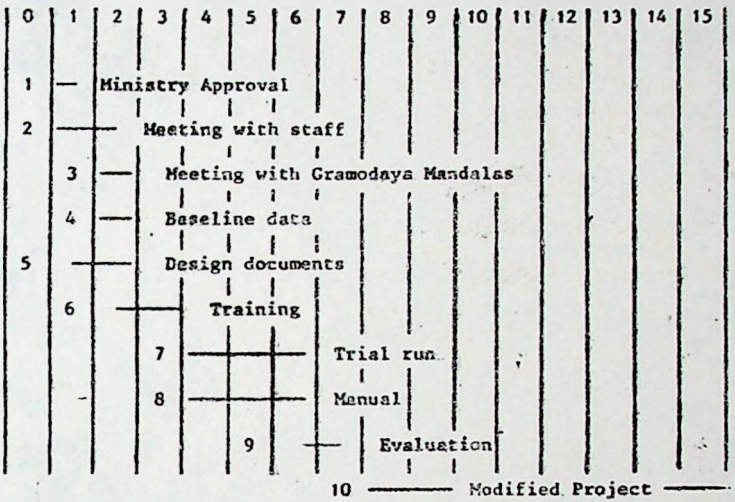
- work load
- appropriateness of referral
- feed-back

4. Supervision

- quality of services rendered
- complaints
- perception of system

TENTATIVE TIME FRAME FOR IMPLEMENTATION

MONTHS



DETAILED PLANNING:

- following approval and discussions
- objectives better defined
- mobilization personnel and material
- review time-frame
- cost
- write up project for submission

ComH-5A — 9

WHO Regional Office For South-East Asia
NEW DELHI

SEA/H[illegible]/95

PRIMARY HEALTH CARE INFORMATION NETWORK

– Report of a Meeting on Clearing-House Activities

WHO Project ICP PHC 005

UNDP Project RAS/81/027

CONTENTS

1. INTRODUCTION

Genesis and Rationale

The primary health care approach has been considered most suitable for achieving the goal of health for all by 2000 A.D. Primary health care requires the coordinated efforts of multi-disciplinary groups in order to ensure intra-sectoral and intersectoral linkages and cooperation for promoting effective health care delivery. There is an urgent need for the proper planning, organization and management of resources available for the activities connected with primary health care. For the successful implementation of these programmes, adequate information is required at different levels of its operation.

In this connection, a review of the existing national and international information services reveals that the subject 'Primary health care' (PHC) has not been given adequate coverage so far. The different components of primary health care and the various supportive activities required for its successful implementation have not been clearly defined or focused earlier. The type of documents/ literature produced on primary health care and the data generated on its activities are in many ways different from the other routine information on health care. Thus, there are currently great gaps in the availability as well as accessibility of information on primary health care and its related areas.

Further, whatever information is available in Member Countries of the Region in various forms such as field experience, success and failure stories, new methodologies and innovative approaches for primary health care, even this is not readily accessible for sharing with one another in the Region. This requires to be consolidated and disseminated for the mutual benefit of policy-makers, health administrators and programme personnel concerned with primary health care activities.

This concern was duly recognised, expressed and shared by representatives of Member Countries of the Region during the recent deliberations of the Intercountry Conference on Primary Health Care held in the WHO South-East Asia Regional Office, New Delhi, in January/February 1985.

The conference recommended the development of network systems with clearing house activities for promoting and sharing information on primary health care.

2. PROPOSED PROJECT

It is proposed to establish a WHO South-East Asia Regional Primary Health Care Information System consisting of a network of primary health care national focal points (NFPs) in the countries of the WHO South-East Asia Region, supported by two primary health care information resource centres (PIRCs).

Scope and Coverage

Geographical scope. The geographical scope of the PHC Information Network System will be the WHO South-East Asia Region covering all the 11 Member countries. For the purpose of collection of information, other countries and international organizations outside this region will also be covered through appropriate linkages.

Subject scope. The overall scope of the subject areas to be covered for this system will include all the essential components of and the relevant supportive activities covered by primary health care. The following eight major areas of primary health care, identified by WHO, will be taken into account for the collection, selection, processing and dissemination of information:

(1) Education of the people concerning prevailing health problems and methods of preventing and controlling them;

(2) Promotion of food supply and proper nutrition;

(3) Adequate supply of safe water and basic sanitation;

(4) Maternal and child health care and family planning;

(5) Immunization against the major infectious diseases;

(6) Prevention and control of locally endemic diseases;

(7) Appropriate treatment of common diseases and injuries; and

(8) Provision of essential drugs.

For the successful implementation of primary health care, various supporting activities are most vital. Therefore, information related to the following supportive activities pertaining to primary health care would also form a part of the scope of coverage.

(1) Involvement of people and community participation;

(2) Involvement of the managerial process;

(3) Development and application of appropriate technology for health care delivery;

(4) Biomedical and health services research, including research on innovative approaches;

(5) Health manpower development;

(6) Development and mobilization of financial resources;

(7) Intra- and inter-sectoral linkages and collaboration; and

(8) Development of an effective referral system.

To facilitate the collection and processing of appropriate information, a detailed list of subject descriptors will be developed by the two PIRCs.

3. OBJECTIVES

Overall

The overall objective of the SEAR PHC Information Network System will be to improve the availability and accessibility of information on primary health care and promote its exchange through systematic and regular collection, storage, retrieval and dissemination at the national and regional levels.

Specific

These will be:

- To improve the availability and accessibility of information on primary health care in the Member Countries for the promotion and strengthening of health care;
- To stimulate exchange of information on primary health care among the Member Countries;
- To identify, collect, process and disseminate information on primary health care generated in Member Countries;
- To make inventories of primary health care information;
- To bring out publications (news bulletins, etc.) for channeling information on primary health care;
- To establish linkages with other information networks such as HSR-HELLES and ESCAP-POPIN (population information); and
- To develop mechanisms for supplying copies of documents to actual users on a regular basis as well as on demand.

4. STRUCTURE AND FUNCTIONS

The South-East Asia Regional PHC Information Network System will consist of a network of national focal points for PHC

-operation of the two PHC Information Resource Centres, which will also have clearing-house functions. The two PIRCs will be located at the National Institute of Health and Family Welfare (NIHFW), New Delhi, India, and at the ASEAN Training Centre for Primary Health Care Development (ATC/PHC), Comrtek, Thailand. The two PIRCs will also function as national focal points for their respective countries. The PIRCs will have close liaison and linkage with the HELLIS national focal points in the respective countries. Linkages with other networks such as ESCAP-POPIN will also be established.

The NFPs in the Member Countries will establish linkages with other network points such as HELLIS and HSR national focal points to form a national PHC information network. This report will provide information to the ultimate users. Information not readily available in the country will be obtained from the PIRCs.

The PIRCs will, in addition to having contact with the NFPs, have linkage with international organizations and information networks within and outside the Region for the monitoring and collection of information. In collaboration with national focal points these resource centres will bring out inventories of holdings of literature. Periodically the PIRCs will disseminate information to national focal points and to other users.

5. NETWORK OPERATIONS

The national PHC information network will be responsible for the identification and collection of relevant information/ documents in the country and will process, store and disseminate them to users.

The PIRCs will:

(1) develop necessary procedures and guidelines to help the national PHC information network to collect documents and information and process them;

(2) identify and collect relevant information and documents

(a) already processed and available in the Member countries particularly in other network systems such as MEDLIS-HSR and POPIN;

(b) in the libraries/documentation centres attached or linked to national focal points of the SEAR PHC Information Network System;

(c) from institutional sources in the Member Countries which are not part of any of the health-related information networks;

(d) from the national and regional networks of other WHO Regions;

(3) process the information and documents thus collected to generate information products such as news bulletins and directories on primary health care;

(4) disseminate information to national PHC information networks through the information products; and

(5) provide information and documents on request.

6. METHODOLOGY

Information Sources

Information on primary health care is being and will be generated from various sources. The PIRCs will identify these sources in each country with the help of the NFP in the countries concerned. The PIRCs will also take into account other national and international sources likely to produce information on primary health care. The individual organizations will fall into the following categories:

(1) Research and training institutions in health related areas;

(2) Management Institutes;

(3) Government departments relevant to health development - both within and outside the health sector;

(4) Relevant departments of Universities;

(5) Voluntary agencies responsible for health and other related activities;

(6) Centres coordinating primary health care programmes; and

(7) Eminent professionals in the area of health.

Document Types

The information on primary health care can be produced in different kinds of documents and in different formats. The PIRCs will mainly concentrate on the collection of the following types of documents containing information relevant to primary health care.

(1) Training manuals;

(2) Educational aids;

(3) Journal articles;

(4) Reports on technical, research, administrative and operational, aspects;

(5) Fugitive literature; and

(6) Other relevant material.

Mechanism for Collection of Information

Role of NFP in collection. Each NFP for primary health care in Member Countries will actively collect information from his/her country in collaboration and coordination with the already established HELLIS-HSR information network.

The NFP/PHC will coordinate with the PIRCs in identifying information sources in the country, providing

information on primary health care activities being organized within the country, arrange for the translation of important documents having information such as case studies, successful experiences etc., which can benefit other countries in the Region, and in providing the PIRCs with information and documents on request.

Role of PIRCs in collection. The PIRCs will collect documents from the Member Countries as well as from other national organizations and international sources outside the WHO South-East Asia Region. The collection will involve the following major activities:

(1) Scanning of literature coming into the PIRC to identify the information relevant to primary health care;

(2) Regular contact with the identified sources for a continuous flow of information;

(3) Monitoring of output generated by international organizations for identifying relevant information;

(4) Monitoring of output generated by other health-related information networks within and outside WHO/SEAR;

(5) Obtaining documents from NFPs for dissemination; and

(6) Preparing a mailing list of producers and consumers of the SEAR PHC Information Network System, in collaboration with NFPs.

Processing and Storing in PIRCs and the National PHC Network Libraries/Documentation Centres

The processing and storing of documents and information on primary health care involves the following important activities. These activities are to be done in the PIRCs and the libraries/documentation centres of the national PHC information network:

Classification. The documents on primary health care will be classified to bring together related items and arranging them in a helpful sequence for retrieval. The documents relating to primary health care will be merged with other documents available in the libraries/documentation centres of the PHC information network. No separate sequence be maintained. Whatever classification scheme is followed by the libraries/documentation centres in the network will be used for the documents on primary health care.

Cataloguing. Documents classified will be catalogued in order to prepare catalogue cards for the main catalogue of the host library/documentation centre. Uniformity in cataloguing practice is essential for cumulating primary health care information at the regional and global levels. Anglo-American cataloguing Rules-II (AACR-II) provide procedures adequately for the type of documents enumerated in Section 6.2. These rules are followed in a majority of the Member Countries as well as for HELLIS network libraries. Therefore, AACR-II rules will be followed.

Indexing. Various thesaurus and subject headings are available for indexing the literature. The most commonly used tools at international level are Medical Subject Headings (MeSH) and POPLN thesaurus. MeSH is already being used in HELLIS network not only for clinical subjects but also in areas such as Health Services Research. Therefore, MeSH will be used for documents on primary health care. Suitable terms will be used for documents on primary health care. Suitable terms will also be used from POPLN thesaurus, if they are not found in MeSH.

Storing. The documents on PHC collected by the PIRC and the libraries/documentation centres of the national PHC information network will be stored along with the documents of the host institute. This would involve storing different documents in different collections such as book collection; report collection; reprint collection. However, the access to these documents will be through the card catalogue or a printed index that may be brought out from time to time. Through indexing, it will be ensured that documents and information on primary health care are accessed from a single source.

The storage of information will be manual initially. In case any of the PIRCs or library/documentation centres of the national PHC information network use computers, the primary health care information will form part of the database.

Dissemination of Information

The National PHC information network will supply whatever documents/information are available with them to users on request. Whatever is not available with them will be requested from PIRCs. The PIRCs will process the PHC information and will disseminate it to all the national focal points and end-users in countries of the Region. The following channels of dissemination will be used:

News bulletin. A quarterly news bulletin on primary health care which will consist of:

(1) Write-ups on important issues;

(2) Listing of documents;

(3) Programme activities and field experiences;

(4) Significant success and failure stories about primary health care activities;

(5) Information on training programmes; and

(6) Relevant research findings.

Information on demand. The PIRCs will provide information on demand to any of the NFPs in the Member Countries. The following types of information will be provided on demand:

(1) Bibliographical
(2) Directory type
(3) Statistical

The PIRCs will provide referral services for information not readily available with them.

Supply of copies of documents. Copies of documents either listed in the newsletter or identified by the NFP and its users will be supplied by the PHCs. They will include copies of journal articles, fugitive literature or technical reports.

7. EVALUATION

It is necessary to envisage and plan in advance about the tools and indicators for evaluating the progress of activities and development of the clearing house. The task of evaluation would be directly linked with the (i) overall objectives of the proposed clearing house, and (ii) with the specified activities in a given time-frame and available resources. The detailed activities listed in Section 5 would facilitate the monitoring and evaluation of the clearing house. However, the following evaluation check-list or simple indicators are suggested for the purpose of evaluation.

Evaluation check-list:

(1) Fulfilment of the general objectives of clearing house:

- Filling up of gaps of PHC information (To a large extent_____to some extent_____)
- Efforts yet to be started in that direction
- Gaps filled for PHC information:
  - only in terms of availability
  - in terms of availability as well as accessibility
  - availability and accessibility (fully adequate _____adequate to some extent_____)
  - still cannot be ascertained

(2) Training/orientation:

- Oriented/trained the people (professionals) who were to manage the clearing house.

- Oriented the institutional representatives of the liaison and managing the information in identified national focal points.

(3) Starting of inventory work:

Type of inventories prepared:

- Manpower inventories
- Health services organization and infrastructure
- Programme inventories
- Researches
- Appropriate technology
- Training aspects

(4) Identification of producers/sources of information:

- List of institutions/individual professionals or addresses available _____

- Institutions contacted and briefed about the objectives or requirements _____

- Information starting coming/flowing in the suggested formats _____

- Type of the information being received from institutions/individual professionals

  - programme reporting _____

  - research findings _____

  - documents/reports _____

(5) Identification of consumers for PHC information:

- Yet to be started _____

- Identified consumers:

  Regional mailing list(s) of consumers of information in collaboration with NFPs primary health care developed: _____

(6) Establishment of linkages with other informati networks:

- Yet to be developed _____
- Partially developed _____
- Fully developed _____

(through meetings and visits) _____

(through correspondence) _____

Status of exchange of information on primary health care:

- (Has) some exchange begun? _____
- Exchange between the clearing-houses _____
- Between and among focal points _____

Status of the news bulletin:

- (Has) the work started _____
- (Is) the PHC information available for bringing out newsletter _____

  - Regularly _____
  - Intermittently _____
  - (How many) news bulletins have been issued _____
  - Any other observation _____

Status of the feedback:

- (Has there been any demand for PHC information from any institution/individual professional?)

  - None so far _____
  - For bibliography alone _____
  - For document reprint _____
  - For data on certain aspects of PHC _____
  - Any other viz., case studies _____
  - Training health personnel _____

Who were/are the users of FHC information:

- Medical doctors and health personnel _____
- Demographers and statisticians _____
- Extension workers _____
- Administrators _____
- Planners _____
- Others _____

So far as the methodology of evaluation of progress of clearing house or its activities are concerned, this can be periodic or at the end of the project. Tools will be simple semi-structured, check-lists and observation.