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NATIONAL HEALTH PLANNING WITH SOME OBSERVATIONS
ON THE RELATION TO ECONOMIC DEVELOPMENT

(Presented by the World Health Organization)

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SUPPLEMENT: Presented by the World Health Organization.

NATIONAL HEALTH PLANNING WITH SOME OBSERVATIONS
ON THE RELATION TO ECONOMIC DEVELOPMENT 1/

I. INTRODUCTION - PLANNING - THE PRESENT SITUATION AND HISTORICAL BACKGROUND

1. "Planning" in the sense of the preparation of a blue-print for the social, cultural and economic development of a country is no longer merely a word, suggesting future potentialities, but has become in its own right the description of a dynamic process. That process has as its objectives the conception and implementation of policies and strategies which will at least influence, if they do not actually determine, the rate, direction and ultimate success of the development. Planning should include both within its review of the existing circumstances and its projections into the future every aspect of the country's resources, human and material, its activities, agricultural, industrial and commercial, its health situation and its educational facilities.

2. Hardly any developed country in the modern world has been able to escape the necessity of planning, and each has proceeded in accordance with its own particular political and economic philosophy. Even within those particular political philosophies the methods may have varied. The systems of the USSR and Czechoslovakia are not identical in every respect; France, India and the United Kingdom similarly differ in their approach to the problem of their economic future.

3. It is not surprising therefore that the peoples of the emerging countries in Africa, Asia and America also seek to plan their development on lines which are equally forward-looking. They are not likely to be satisfied with the "laissez-faire" outlook of the nineteenth century which, in all probability, they have already experienced. At times under such a regime it is possible that they would have found that at best their economic progress marched pari passu with their population increase, and at worst lagged far behind. This intense interest in the possibilities of planning and its benefits is

1/ Prepared by WHO Consultant, Sir John A. Charles, K.C.B., M.D., F.R.C.P., D.P.H.

both an expression of a desire to keep in step with the other members of the emerging family of nations, and evidence of that dynamism which their accession to independence and political equality in world affairs has already engendered. They are aware that the great scientific and technical advantages of the last two decades, and modern economic thinking have provided them with facilities for the organization of effort which will enable them to enjoy the optimum benefit from their human and natural resources. Nevertheless it would be wrong to suggest that the motivation is largely the acquisition of wealth. There is implicit in what has sometimes been called "African Socialism" a desire not only to see that man shall "have" more, but that he shall "be" more - healthier, better educated and more capable of adjustment to the further changes which may yet occur.

4. The planned development of a country's economy as a whole is a relatively recent development, but the organization of health and similar services on a national basis has a much longer history. It is only necessary to mention the monumental work of the Bavarian Johann Peter Frank on the organization of medical policy written between 1779 and 1819, and in a similar field the endeavours of the Englishman, Edwin Chadwick - an effort based on a careful and detailed survey of existing housing and working conditions - to rectify the sanitary evils of the early Victorian epoch. And in another field altogether there were the far-sighted policies of Bismark which led to the institution of a system of insurance against the economic consequences of illness in the working population. Amongst the first real efforts to produce comprehensive plans in the health field were those of the USSR, India, the United Arab Republic and Czechoslovakia. They had the added virtue of being integral portions of the over-all national planning. Since their appearance, there have been many others, emanating from such countries as Ceylon, Iran, Indonesia, Finland, Rhodesia, Mauritania - some dealing with the whole problem of health planning and others concerned with only one portion of the health sector, for example hospitals or the eradication of a specific disease or diseases.

5. In the broader territories of planning for economic, cultural and social development, the main "task-force" has been provided by the economists. In some instances elaborate mathematical coefficients have been formulated, the science of econometrics has come into being, macro-economic models have been created, and much material has been fed to computers. All this has given rise to ideas very different from those about "the inevitability of gradualness" and has fostered in some quarters the impression that there is, however, a certain inevitability about the favourable outcome of planning procedures.

But like all human activities "planning" can be fallible, and must run the gauntlet of catastrophe of nature such as floods and earthquakes, financial crises, obstruction based on tradition, inadequacy of equipment, apathy and the expediency of politicians.

II. THE COMMON PRINCIPLES OF PLANNING FOR ECONOMIC DEVELOPMENT AND IN THE HEALTH FIELD

6. In one respect the economist is perhaps a little open to criticism. There is a tendency - most marked in regard to the health services, to a less extent with the nutritional state of the population, but also with education at many of its levels - to regard them all as matters which in these days can be taken for granted. Some attention has been given recently to the question of the economic value of a man - first raised nearly 400 years ago - and there is a more clear understanding of the benefit that accrues to a community by the saving of young lives, with the consequential addition in later years to the available labour force, and from the reduction in the amount of communicable disease, preventable disability and absence from work. But even now there are economists who, without any suggestion of inhumanity, complain that the successful achievements of the health services make the task of the planner more difficult. They have in mind the resultant population increase, and the consequential questions of finding employment and food which can arise.

7. However, there is a basic resemblance in the methods whereby the economist and the health planner approach their respective problems. The economist first demands what he describes as an "inventory" for the country which he

is studying and from which ultimately he and his expert colleagues in agriculture, industrial development, transport, mining, etc. will evolve a complex but co-ordinated plan. They ask for the establishment of a continuing mechanism for the collection of facts of every kind, and one which will provide a steady flow of data. They promote the development of new techniques for the acquisition of this information, and the appetite for facts steadily grows on what it is fed.

8. These assembled data must be made available to all those who are interested in the planning process, not only to the experts already mentioned, but to government officials, politicians and the informed general public. In brief, they must be "communicated" or made common so that fresh minds can be brought to bear upon them. The facts must be assessed as regards their reliability, and where necessary appropriate approximations and reservations made to render them more trustworthy. From the facts so modified it is possible to make projections, to arrive at some strategic conception of the development campaign as a whole, and to draft the plan.

But the draft and the plan itself must provide for flexibility in operation, and for the possibility of continuous adjustment. Planning has been aptly described by Dr. S.R. Sen of the Indian Planning Commission as "An exercise in successive approximation".

9. It is important that a government, before proceeding to the actual process of planning, should have a broad conspectus of its ultimate objectives as regards economic and social development. It should consider, if it does not immediately resolve, such questions as centralization as against decentralization of administration. It should also determine to what part of the machinery of government, planning and the execution of the plan are to be allocated. There are, of course, many possibilities including, amongst others, a separate ministry for the purpose, a high-level committee of ministers, civil servants and experts with executive or co-ordinating powers, an ad hoc planning commission, somewhat remote from, but subject to, the governmental machine. The recommendations of these bodies would form the basis for the final decision which would be taken at the highest level.

Finally there come the moments of truth when the plan is applied and becomes as it were "an order of battle". After a period its results begin to accrue, or its deficiencies are revealed. One fact of importance may become obvious at a comparatively early date, namely that the undue stressing of a timetable - made without taking into account the delays, inherent in all human activities - may create its own difficulties.

10. Planning should be regarded much as an experiment in a laboratory; it is in essence applied research. As such, it has many of the characteristics of all scientific thought and action. These are the careful and accurate collection and classification of facts and observations and of their inter-relationship, the testing of these facts, the formulation of a hypothesis or a plan based upon them, the testing of the hypothesis by experiment or other action, the readjustment where necessary of the hypothesis, its communication and discussion, its application and finally its assessment and evaluation.

These are principles which the health planner also follows. But if they are common to both the economist planner and the health planner and their aim and purpose are the same, what then is the difference between them?

III. THE APPLICATION OF THESE PRINCIPLES IN HEALTH PLANNING

11. It probably lies in the fact that the health planner's approach to his problem is more pragmatic and rather less academic. By virtue of his training he is accustomed both to consider a gradual approach, step by step, to the solution of a situation, and yet at the same time he has been trained to act positively and urgently in an emergency. It is not that he is necessarily any more humanitarian in his outlook than the economist. But in his combined role as practical man and philosophic scientist, the first characteristic predominates. The application to public health administration of the broad principles briefly outlined in paragraph 10 as being the common working rules of health planner and economist alike have been recently discussed in the

report of the Expert Committee on Public Health Administration - Planning of Public Health Services^{1/} - a document which has been made available to the conference. Inasmuch as the report follows these principles, it is not proposed to review in detail the various procedural stages in the preparation of a plan. They can be recapitulated as follows: surveys for information, priorities, targets and objectives, consultation and co-ordination, drafting, implementation and assessment or evaluation. However, some observations and comments setting out more recent and additional views on certain of these procedures may be of interest. Information is also available as to the increasing use of planning in the preparation of national health programmes, and to a limited extent on the benefits to the country's economy which can be reasonably claimed. Finally, some indication will be given as to the opportunities which can be provided for the institution of national health plans in such of the developing countries, as may wish to avail themselves of this form of guidance.

IV. SURVEYS - THEIR IMMEDIATE USE AND POSSIBLE DEVELOPMENT

12. The careful and accurate collection of the main relevant facts and data is only feasible in a very limited number of countries - perhaps in not more than 15 per cent of those appearing in the United Nations Statistical Year Book. For this small group there exists an organized and developed service at all administrative levels for the collection, correlation and analysis of vital and health statistics, and for the maintenance of records, and the promulgation of synoptic reports. Elsewhere simpler and more restricted forms of recording may operate but in many instances the only means of collecting data upon which planning can be based is through surveys. Attention should be directed to two modern techniques in this field. The first consists of long-term retrospective inquiries in which interviewers inquire into certain of the events that have occurred in the lives of individuals and which are not likely to have been forgotten, for example the number of children born to women over the age of 15. The second

^{1/} Wld Hlth Org. techn. Rep. Ser. 215.

comprises a short-term retrospective survey in which the questioning is concentrated on such matters as the occasions and nature of illnesses during a period of a few months; memories for such recent minor and transient events, however, are often vague and fallible.

13. It is becoming apparent that from such procedures there can gradually be built up a rudimentary but yet continuing machine for the collection of demographic data and vital statistics. The machine in the first instance will become more efficient if, in effect, it is a one-man business. It should be located on premises such as a health centre, with its activities and interests covering a fairly stationary local population largely through the personal visitation of families by the same individual investigator. A more comprehensive machine would be obtained by placing the collector of information on the premises of the local hospital where he could supplement his locally collected information by that available in the hospital records. In this connexion it is interesting to note that from a simple system of parish recording of the facts of life, death, marriage and literacy in Finland, it has been possible to envisage some aspects of the demographic and health situation of local communities over a period of nearly 300 years.

Other questions which will arise are the use of such a survey machine for the multiple purposes of obtaining information on a collective basis on health, educational activities, agricultural productivity, the economic situation of families, etc.

For certain general purposes, e.g. in the field of community development, such an arrangement has its advantages, but from the narrower point of view of acquiring knowledge about, and keeping in touch with the health situation and the problems arising from it, ad hoc surveys are probably to be preferred, particularly if they are carried out in a number of areas of a country. A synthesis of such surveys over a period of years, during which the deficiencies of the interviewing and recording procedures can be ironed out, will not only provide a fairly continuous record of events but constitute the basis from which a national system for the collection and study of vital and health statistics could evolve.

V. DETERMINATION OF PRIORITIES

14. After the collection of the basic information, some decision must be taken both as to the immediate and prospective needs of the community as regards health services. This involves a policy decision which can only be taken by governments, and involves consideration of priorities not only amongst the possible health service activities but amongst the other claimants upon the country's resources. Decisions as to the relative priority of health services, education, agricultural and industrial development, and transportation are of a major order, and it is outside the scope of this paper to discuss them, but it is possible to indicate in broad terms some of the considerations which must be taken into account in determining the priority of attention which the various health problems should respectively receive.

15. Certain general considerations are briefly indicated in the report of the Expert Committee on Public Health Administration - Planning of Public Health Services - already mentioned. They are, with some additional comments:

(a) that emphasis be placed on prevention (though this should not prevent the concurrent introduction or development of both curative and preventive health services);

(b) that provision be made for services to people engaged in productive work - and that there may even be a differentiation between the claims of various types of productive labour - e.g. heavy as contrasted with light industry. It is desirable that whenever industrial or agricultural organizations are providing or proposing to plan health services, they should consider and consult about the relation of these to the general health services, and should provide for any special hazards to which their employees may be exposed^{1/};

(c) that provision be made for services to vulnerable groups (e.g. mothers and children);

^{1/} Wld Hlth Org. techn. Rep. Ser. 246.

(d) that the services provided affect the health of the maximum number of the people; and,

(e) that provision be made for improvement of the nutritional standard of the population.

16. In the questionnaire for the recently published Second World Health Situation Report^{1/}, countries were invited to state the nature of their unresolved health problems. In their replies, they broadly fell into three groups:

1. Those with virtually no residual problems.
2. Those with a relatively small number of problems, which however differed materially between the developed and developing countries.
3. Those with a large number of problems, a list of 10 or 12 such problems being frequently given.

The first group consisted entirely of developed countries, and certain of the residual problems quoted seemed almost trivial, though no doubt locally they were both troublesome and potentially dangerous as, for example, hydatidosis in dogs.

The third group included amongst its members many of the developing countries, for whom the health situation might seem complex and almost overwhelming.

The second group included both developed and emerging countries, many of the latter having partially organized services, particularly in the statistical field, which enabled them to give a considered judgement on their needs.

A comparison of the priorities typically assigned by those two types of countries is interesting.

Taking a typical country of the "developed" group, its health problems in descending order of importance were stated to be cancer, the care of the aged, chronic and degenerative disease, mental illness and accidents.

1/ Off. Rec. Wld Hlth Org. 122.

For the majority of the emerging countries (admittedly mostly in the tropical zone), the outstanding problems were, again in order of descending importance, malaria, tuberculosis, bilharziasis, nutritional deficiencies and environmental defects. These were followed by leprosy, yaws and certain other endemic diseases, maternal and child health, and - remarkable in its relative infrequency as a stated problem - shortage of personnel and material.

17. It is not entirely a digression to mention here that the proposals of the World Health Organization for priorities during the Development Decade of 1960-1970, expressed in the broadest possible terms, are:

- (1) the formulation of national health plans;
- (2) education and training;
- (3) the setting-up of health targets, based on indices of the current health situation in the country;
- (4) the appropriation of additional national resources (e.g. finance and personnel).

The indices and targets which have been suggested are:

- (a) the ascertainment and establishment of the present level of infant mortality, followed by an attempt to reduce it to an appropriate level;
- (b) the ascertainment of the incidence of important infectious diseases and attempts to control or eradicate them;
- (c) the ascertainment of nutritional levels, and efforts to raise them where necessary; and
- (d) the provision of the basic requirements for the health environment - potable water, sewage disposal, etc. - to predetermined percentages of the population.

This is the projection of the world's needs in respect of health and mutatis mutandis with all the necessary adjustment required by local circumstances, lower base-lines from which to commence operations, and the conditions which the environment of the tropical zone imposes upon its inhabitants; it summarizes the desiderata for healthy living in the developing countries although the specific and detailed listing of priorities will inevitably vary.

VI. LONG - AND SHORT-TERM PLAN - THE FINANCIAL IMPLICATIONS

18. When the priorities have been defined with such clarity as may be possible, it is necessary to set up targets and objectives for achievement. This will determine to some extent the actual mode of planning, whether it shall be on a long-term or a short-term basis. There is a tendency to think both prospectively over a period of a decade or even 20 years, and comprehensively, so as to envisage the full picture of aims and objectives for the future. This is sometimes called perspective planning. Its adoption, however, postulates more realistic planning over a shorter period commonly of five years, and this in its turn is subject to a review at the time when the annual budget is under consideration. Furthermore, it is customary for each forthcoming five-year plan to be modified in the light of the success or possible partial failure of its predecessor.

19. Among the targets which may be set up are such long-range proposals as the provision of free medical care for all citizens (which incidentally in the United Kingdom stemming from the National Health Insurance Act of 1912 took 36 years to accomplish), the control or eradication of communicable diseases, of which malaria is the outstanding example, the provision of water-supplies and sewerage for communities of 2000 inhabitants or more, and above all for the training of personnel. The timing for the attainment of the last-named target is likely to be exceedingly complicated for it must take into account primary, secondary, technical and professional education.

20. Long-term objectives and the successive plans designed to achieve them make important demands upon the country's capital investment programme. Such items as hospitals, medical and other training schools, the building of dams to accumulate and regulate water-supply, environmental sanitation and housing are all expensive. They will have to compete with the country's needs in other fields - industrial development, agricultural extension, the provision of power, the exploitation of natural resources, harbours, transport, and education. The orientation of development through capital allocation is of crucial importance. This was realized in post-war Europe, where in one country concerned greatly about its economic reconstruction the order of approach was housing, industrial restoration and extension, schools and colleges, health installations and roads.

For developing countries the pattern of long-term planning will be determined by considerations specific to each territory, but in every case it will be concerned with the construction apparatus, which will facilitate growth and create conditions for its continuance. In such countries the investment programme has to concentrate on those sectors of the economy which can promote that growth, and in such circumstances it is not surprising that the costly modern hospital receives a relatively low priority. Acceptance of this point of view by the health planner might be reciprocated by the economist agreeing that some more modest allocation of capital to public health purposes can be quickly productive. The simpler and even the more elaborate type of health centre strategically placed can provide centres from which, in addition to their curative functions, maternal and child care services and health education can radiate and upon which the pioneer form of statistical collection can be based. In so far as regular recurrent maintenance budgeting is concerned, and having in mind expenditure upon such routine functions as communicable disease control, mass campaigns against such diseases as leprosy, tuberculosis and smallpox, maternal and child care, health education, the operation of health centres, etc., the situation is probably easier. Once the relative priorities have been determined and evidence becomes available of the contribution these services can make to the health of the community, their demands are more likely to be approved.

VII. CONSULTATION - DECISION-MAKING - CENTRALIZATION AND
DECENTRALIZATION - DRAFTING

21. All this again implies policy decisions as to the division of the national financial "cake". A careful study of such information as may become available from government sources may in its turn shed some light upon the way in which the distribution is effected, but this is a field in which the outsider has more opportunity for speculating than for obtaining precise knowledge. Decisions may depend upon quite unpredictable factors, often political, and dictated by conditions of which the citizen is entirely unaware.

22. Nevertheless, while the knowledge of the motivation of decisions may not be available to the citizen, there is no reason why, to an increasing extent, he should not be brought more frequently into touch with policy-making. The collaboration of the "consumer" in the formulation of policy and particularly in the introduction and development of health services, has for many years been a feature in socialist countries. Its merits, both from the point of view of meeting public requirements most adequately and as an educational process, are being more generally recognized elsewhere. Collaboration in planning within appropriate technical limits, and above all communication of the proposals, should be an article of policy wherever possible in the developing countries. Obviously the range of consultations and the method of conducting them will have to be determined in the light of local circumstances. Apart from consultation with other government departments, certain groups, notably the medical and health personnel, the non-governmental organizations, and members of local communities, must be brought into the discussions. It is in choosing the method of approach to the last group and in the recognition of its appropriate representatives that difficulties will be encountered. But they must be overcome because the success of any service, and success can be measured by the extent to which it is used, depends upon the active, interested and enthusiastic participation of the public for which it is provided. One practical point to be borne in mind is that consultation means the taking of counsel or advice. It does not imply unequivocal acceptance of the advice and it should not be regarded as the equivalent of negotiation.

Finally, proper consultation is in a sense communication, the exchange of ideas, which will advance both the understanding of the purpose of the plan as drafted and will facilitate its operation when implemented.

23. The drafting of the plan when all the data have been assembled, possible hypothetical methods of working have been explored, and the necessary consultations have taken place, is a task requiring technical, presentational and even legal skills. Drafting can only take place after governmental decisions on major administrative possibilities have been given. One of the most important of these is the relative emphasis to be placed on a centralized or decentralized regional form of administration. In the making of this decision the data collected from a wide range of sources will be of assistance. Such data might include inter alia the use made of local health centres and hospitals, the comparative incidence of communicable disease, the size of the towns and villages, and their use as social centres - the lines of transportation and the focal points for the movements of the population.

A recent review of this matter commented upon the fact that many countries with long experience of centralized organization were now beginning to regionalize or decentralize certain functions and responsibilities, whereas other countries accustomed to less rigorous forms of organization were moving in the opposite direction. There are obviously fashions in this question of centralized or decentralized systems of administration as in other fields of thought and action.

VIII. EVALUATION

24. One other decision which can best be taken at the time of the drafting of the plan is the nature of the provision that is to be made for the assessment and evaluation of the working of the plan as and when it is implemented. Evaluation should be comprehensive covering both the functional efficiency of the schemes in operation and the crucial point of their cost - in brief whether the expected return is being obtained from the money invested.

Evaluation postulates the existence of machinery for the collection of all relevant data including inter alia those which concern vital and health statistics, hospital staffing, records of hospital patient attendances and admissions, waiting lists, and the out-turn of training institutions.

Sophisticated and elaborate organizations which are, in effect, "built-in" statistical systems, have been constructed in some of the developed countries and provide a formidable array of information for the government. Nevertheless, even with evaluation machinery of manifest efficiency it is often difficult to obtain a direct answer to such a forthright question as to the economic value of preventive medicine and organized health services.

Usually all that is possible is to point out in general terms the fall in infant and child mortality, the reduction in communicable disease, the improvement of nutritional status, the reduction in the amount of time lost in the labour field through sickness, the increased expectation of life, and the virtual disappearance of such a disease as diphtheria. From the point of view of the economist all this may appear to be inadequate, but it is reasonable to plead that what we may describe as the science of medical economics is new and lacking in experience. A developing organization, as suggested in paragraph 12, with its improved techniques particularly in sampling, may make it possible to stage controlled investigations. In these it might be feasible to contrast the impact of certain programmes of health care in rural and urban communities, or as between regions of a country. But the time for such investigations has not yet arrived. Nevertheless, in a recent publication of the World Health Organization a study of the costs and sources of finance for providing health services in six selected countries has been described^{1/}.

IX. RECENT ACTIVITIES OF GOVERNMENTS AND WHO AS REGARDS HEALTH PLANS

25. These brief notes on certain aspects of health planning which concern both the health service administrator and the economic planner may serve to indicate the direction in which the mind of the health planner is moving.

^{1/} Wld Hlth Org. Publ. Hlth Pap. 17.

They are not intended to demonstrate the results of his achievements, though some indication can be given of the extent to which health planning has become recognized as an essential feature not only in developed countries but also in those which are on the verge of development.

26. In the First Report on the World Health Situation covering the period 1954-1956^{1/}, long-range planning of health services was described as "a new activity which will ultimately become part of the normal functions of national governments". Examples of countries which had embarked on this form of activity were given and included India, Sudan, Egypt, Ethiopia, Afghanistan, the USSR and Czechoslovakia. It is clear that even at that time the list was not fully comprehensive. The Second Report on the World Health Situation for the period 1957-1960 recorded accessions to this list during these years, and mentioned Rhodesia, Mauritania, Finland, Turkey, Yugoslavia, Ceylon, Cambodia and Korea. But additional evidence as to the planning of health services, either in whole or part, by governments continues to accumulate. Some of this information refers to plans prepared as far back as 1950, some is more recent. Examples of countries which should now be added to the list of those who have accepted health "planning" as a major function of government include Iran, Portugal, Burma and Tanganyika.

27. Nor does the matter end with the voluntary and spontaneous efforts of individual countries to develop national health plans, either as separate entities or as an integral part of a plan for economic, cultural and social development. The Fifteenth World Health Assembly, meeting in Geneva in May 1962, discussed with great interest and at considerable length the question of continued assistance to newly independent States more particularly for developing national health plans, the acceleration of the education and training of their national staff, and for the possible provision of operational assistance to such States. Furthermore, it authorized the Director-General to implement an accelerated programme along these lines^{2/}.

1/ Off. Rec. Wld Hlth Org. 94.

2/ Off. Rec. Wld Hlth Org. 118, resolution WHA 15.22

It was appreciated that these activities will necessitate the acquisition of substantial additional financial resources and that steps should be taken to obtain them, if possible through the General Assembly of the United Nations, the Expanded Programme, the Special Fund and OPEX. Nor has the possibility of national contributions to the Voluntary Fund for Health Promotion been overlooked.

28. It is thus evident that the ground has been prepared for much further activity in health planning in the emerging countries. In this work, which should be associated with national planning wherever possible, the co-operation of health planners, economists and governments is the essential prerequisite.

SUPPLEMENT TO PAPER ON NATIONAL HEALTH PLANNING
PRESENTED BY THE WORLD HEALTH ORGANIZATION^{1/}

1. The document to which this is provided as a supplement took into account some of the thinking on economic and social planning which characterized the discussions of the United Nations' Conference on Science and Technology which was held in Geneva in February 1963. It was based also on the recommendations of the Fourth Expert Committee on Public Health Administration^{2/} and on the data of the First and Second Reports on the World Health Situation^{3,4/}. It was broad in outlook and the views it expressed were for general application. It was not devoted specifically to Africa and did not, except incidentally, deal with any of the health planning by countries there.

2. Nor does this supplement set out to describe in detail the African situation as regards planning in the health field. The territories of Continental Africa lie within the spheres of three of the regional offices of the World Health Organization: the European which takes in some part of the Mediterranean littoral and the North-West Atlantic coastal area, the Eastern Mediterranean Region which includes the United Arab Republic (Province of Egypt), Sudan, Somalia, and the African Region itself which may be broadly defined as comprising all Africa south of the Sahara. ECA covers the African countries in these three regions and its dynamic approach to planning is beginning to be felt by the great majority of them.

1/ Prepared by WHO Consultant, Sir John A. Charles, K.C.B., M.D., F.R.C.P., D.P.H.

2/ Wld Hlth Org. techn. Rep. Ser. 1961, 215.

3/ Off. Rec. Wld Hlth Org. 94.

4/ Off. Rec. Wld Hlth Org. 122.

3. At a meeting of ECA held at Addis Ababa in October 1962, papers were submitted in respect of comprehensive economic planning for Ghana, Guinea, Upper Volta, Mali, Morocco, Nigeria, Senegal, Sudan, Tunisia and the United Arab Republic. Furthermore, there are a number of other countries - Sierra Leone, Tanganyika, Uganda, Mauritania, Mauritius, Nyasaland and Northern Rhodesia - for which planning material, in the form of reports of Local Commissions, reports of the International Bank, etc., exists and could form the basis for comprehensive planning.

4. This is the general situation. In the health field the picture is less complete. Not all these countries have undertaken any systematic planning for their health services. Actual plans or the material which could be suitably used as the basis for planning are available at least for Ghana, Nigeria, Rhodesia and Nyasaland, Sierra Leone, Sudan, Tanganyika, the United Arab Republic and Uganda. Furthermore, as the result of a resolution of the Fifteenth World Health Assembly (May 1962)^{1/} health planners with appropriate supporting staff will be provided to Gabon, Niger, Mali, Sierra Leone and Liberia with the co-operation of USAID. These planning officials will be at the service of the governments concerned and it is presumed that they will be associated with the work of any existing general planning commission or comparable body in the countries concerned. At present the health planning activities of these teams are limited to a period of approximately one year, but experience in other countries where "planning" has become a well-established function of government, e.g. India, indicates the necessity not only for the drafting of a plan and even of a succession of plans, but also for their periodical review and evaluation.

5. Reference has already been made in the main document to the Second World Health Situation Report (1957-1960), and the lists of its major public health problems which each country was requested to submit. In the case of a number of African States and territories (for replies were not available from all)

^{1/} Document WHA 15.22.

A large amount of statistical and other data were provided, which were relevant to the question of planning. The following paragraphs summarize the main problems as seen through the eyes of the national administrations.

Countries and Territories in the European Region of WHO

Only one country submitted information, namely Morocco. There the six most important problems were stated to be trachoma, tuberculosis, malaria, maternal and infant mortality, nutrition and environmental sanitation.

Countries and Territories in the Eastern Mediterranean Region of WHO

Replies were received from French Somaliland, Sudan and the United Arab Republic. Grouping these three countries together, tuberculosis and malaria were regarded as major health problems by two countries, while bilharziasis, eye infections and the communicable diseases were each assigned a place.

Countries and Territories in the African Region of WHO

Information was available for 19 countries^{1/} and 14 territories^{2/}. Taking the two groups together, the following tables show the various diseases in the order of importance in which they have been placed by countries, and the number of countries out of the 33 which have nominated them:

Malaria (22), tuberculosis (17), onchocerciasis (16), bilharziasis (12), helminth infestations (12), leprosy (10), yaws (9), venereal diseases (6), gastro-enteritis (4), smallpox (4), trypanosomiasis (4).

Apart from the communicable diseases, four countries mentioned amongst their problems environmental sanitation and shortage of health personnel, and three included population increase in the list.

^{1/} Cameroon, Central African Republic, Chad, Congo (Brazzaville), Dahomey, Gabon, Ghana, Liberia, Madagascar, Mauritania, Niger, Nigeria, Rwanda and Burundi, Sierra Leone, South Africa, Tanganyika, Togo, and Uganda.

^{2/} Angola, Basutoland, Bechuanaland, Cape Verde, Comoro Archipelago, Federation of Rhodesia and Nyasaland, Kenya, Mauritius, Mozambique, Portuguese Guinea, Réunion, St. Helena, Sao Tomé and Príncipe, and Swaziland.

These lists serve to indicate some of the health priorities which are assigned by the countries themselves, and point out one of the directions which health planning must take, namely the control or eradication of communicable disease.

6. The foregoing picture of the health problems for Africa is, of course, very different from the pattern to be found in the European Region where the emphasis is on the disease of the cardiovascular system, cancer, vascular lesion of the central nervous system, the respiratory diseases and accidents. One other difference in Europe is the great variety in the systems of administrative medicine which deal with these diseases. In Africa the position is simpler. Broadly speaking there are two main administrative systems of approach to these diseases, although the purely technical attack may be similar. The systems have been inherited from two of the previous metropolitan powers (France and the United Kingdom) and reflect the respective modes of general administrative practice and thought of those countries. They are still influential, and their usefulness as well as the difficulties they may create were referred to in the Seminar on Urgent Administrative Problems of African Countries which was held at Leopoldville in February/March 1963. The possibility of building on these two systems something which is more intrinsically African, cannot be excluded either in general administration or in the operation of health services.

7. Two other aspects of what may be described as the deficiency situation in Africa remain to be mentioned. They are the low doctor-population ratios in every country except the United Arab Republic and the Republic of South Africa, and the rate of provision of hospital beds (or the equivalent) per 1000 population. With regard to the doctor-population ratio, the United Arab Republic had in 1960 one doctor for every 2568 persons; for the Republic of South Africa the ratio was one to 1880. Elsewhere, however, ratios of the order of one doctor to 20,000 persons were not uncommon, and ratios as low as one to 63,000 and one to 81,000 were recorded. Generally these low doctor-population ratios run parallel with similar low ratios for other health personnel. Hospital bed provision throughout the African countries

is not on a high scale, though countries like French Somaliland and Gabon in 1960 had rates of nine and 6.6 beds per 1000 population respectively. Elsewhere 1.8 per 1000 population appeared to be about the average provision, but many countries had only one bed per 1000 and even less.

8. These then are three of the fields in which African health planning must be active in the formulation of its projects, namely the control of disease, the provision of appropriate health installation (health centres, dispensaries, hospitals) and the creation of a cadre of trained health staff and the provision or extension of the necessary training facilities. There are certain temptations and tendencies which must be resisted in any health planning which is undertaken. They include the preparation of plans which in their demands on the future capital resources of a country are unduly optimistic. There is also the failure to realize that such capital expenditure, even if feasible, will necessitate at a later stage an appropriate increase in the maintenance budget, and make demands for manpower which are in excess of any supply which is likely to be available in the immediate future. It is important to emphasize the need for the realistic and pragmatic approach in planning, and the advisability of seeking nuclear points round which larger and better and more numerous health services can be aggregated. In other words, it is often wiser to proceed slowly and steadily by a succession of approximations and the use of resources known to be available than to embark upon large and comprehensive plans which may not be capable of accomplishment within one or two decades.

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