PUBLIC HEALTH PAPERS **67**

HEALTH SERVICES: CONCEPTS AND INFORMATION FOR NATIONAL PLANNING AND MANAGEMENT

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WORLD HEALTH ORGANIZATION
GENEVA

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Experiences Based
on the
WHO/International Collaborative Study of Medical Care Utilization

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WORLD HEALTH ORGANIZATION
GENEVA
1977

ISBN 92 4 130067 1

PRINTED IN FRANCE

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FOREWORD

A large comparative study of health care services in 12 study areas in seven countries was begun in 1964. Known as the World Health Organization/International Collaborative Study of Medical Care Utilization, its report was published in 1976 under the title *Health Care: An International Study*.[1] This presented the results of research on population groups representing more than 15 million people in an attempt to answer questions relating to the health care needs of populations, the organization, resources and use of health services, some factors influencing the patterns of use, and some methodological problems. The study is briefly described in Chapter 3 of this volume.

The World Health Organization felt that the main study report was too detailed and voluminous to be immediately useful to some health policy-makers, administrators and planners and encouraged a subgroup of the study collaborators to prepare the present volume, which attempts to link some of the thinking and findings to the wider national concerns of many countries. Those whose interest it has aroused or who seek further details will refer to the main study.

No two readers of any book see quite the same things in it or put it down with quite the same understanding. What may be highly relevant and interesting to some may be regarded differently by others. However, in this volume there is a consistent thread and a message which appears to be important and which warrants examination and action.

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1 KOHN, R. & WHITE, K. L., ed. *Health care: an international study*, London, New York and Toronto, Oxford University Press, 1976.

There do appear to be a series of health service crises in different countries in the world as health-related needs change; and the acceptable responses to them also change, as judged by our awareness of their usefulness, their applicability and their acceptability. At the same time the social injustice of the maldistribution of health care is becoming unacceptable in many national contexts. While the necessary adaptations of health care systems to these pressures are clearly as much a political as a technical process, the investigators argue in this book that such adaptations can be planned or influenced by "intelligence". They make a distinction between "data", "information", and that blend of information with perceptions of social and political values which they call "intelligence". In making this claim they propose some essential preconditions that affect all levels of this pyramid of knowledge designed to influence the form of a decision, and the primary one is that it should be population-based in addition to using data from users or institutions, so that the two can be related. Their argument seems sound and conceptually links health service thinking with that of epidemiology and health statistics.

If this central idea is accepted, the reader can enjoy himself with the examples. He may well say that the questions asked are not the most relevant questions in his national setting or that this or that indicator or form of presentation is unsuitable for him and another will need to be produced. I am certain that the authors would encourage such an attitude and might even themselves urge that new questions be asked and new indicators used. What they would argue for would be that a continuation or elaboration of such thinking could result now, with our present knowledge and methods, in many forms of meaningful action that could be taken to assist in choosing among a wide range of possible decisions. If their argument proves persuasive, this volume is clearly useful.

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December 1976

CHAPTER 1

CONTEMPORARY PROBLEMS AND ISSUES IN THE HEALTH SERVICES

WORLD-WIDE CONCERN ABOUT HEALTH AND THE HEALTH SERVICES

The need for new ways of thinking about the problems of health and health services stems from world-wide concern for social justice and for improvement in the well-being of all people, but especially of the disadvantaged. This concern is increasingly expressed as dissatisfaction with the uneven distribution, rising costs, and uncertain outcomes of health services. It takes different forms in different countries, regions, and areas, but certain common problems have been identified in recent work of WHO,[1] the United Nations Research Institute for Social Development[2] and the UNICEF-WHO Joint Committee on Health Policy.[3] Four themes recur throughout these and other publications that justify the application of the term "crisis" to the present state of affairs.

First, there is a feeling of helplessness and doubt about whether useful and usable scientific knowledge, or even appropriate care, will ever be brought to bear on the great bulk of health problems that affect most of the people most of the time. Second, this widespread feeling has led local and national communities to take action to fulfil human needs and aspirations and to emphasize self-determina-

1 WHO Official Records No. 206, 1973, Annex 11; WHO Official Records No. 223, 1975, p. 10 (Executive Board resolution EB55.R16).

2 United Nations document E/CN.5/519, 5 December 1974 (*Report on a unified approach to development and planning*).

3 DJUKANOVIC, V. & MACH, E. P., ed. *Alternative approaches to meeting basic health needs in developing countries. A joint UNICEF/WHO study*, Geneva, World Health Organization, 1975.

tion as the relevant political mechanism. This in turn stimulates demands from the periphery, generating political forces that push those responsible for planning in all sectors, but especially in the health sector, to reconsider goals, objectives, and priorities in the light of local, regional, and national values and expectations. Fourth and finally, these processes find their dominant contemporary expression in the renaissance of basic or primary health care as the fundamental service in any balanced health care system.

WHO'S CURRENT CONCERN WITH WORLD HEALTH PROBLEMS

WHO and its Member countries are increasingly aware that the health of populations is the result of many influences and involves many sectors concerned with social developments other than health; effective planning for health therefore requires coordination between the health and other sectors. The problems involved have many dimensions that are specific to each individual country and to each local area within a country, but they all fall under three major headings:

(1) The need for improvement in the coverage and content of health services;

(2) The need for improvement in the concepts and processes used in planning health services;

(3) The need for improvement in the form and content of the information available for the planning and evaluation of health services.

MAJOR PROBLEMS AND ISSUES IN THE PROVISION OF HEALTH SERVICES

These shifts in priorities, and the urgency with which they are applied to health care systems, stem only partially from the increase in the cost of services and dissatisfaction with their distribution. They have other causes, some of which, as suggested by the experience in the WHO/International Collaborative Study of Medical Care Utilization[1] on which the present work is based, are amenable to assessment.

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1 The WHO/International Collaborative Study of Medical Care Utilization is described at length and its findings summarized and discussed in chapter 3 et seq. Its report appears as: KOHN. R. & WHITE, K.L., ed. *Health care: an international study,* London, New York and Toronto, Oxford University Press, 1976.

Equity of distribution and adequacy of coverage in relationship to need

The large proportion of the population in many countries lacking any possibility of contact with the health services is a matter of world-wide concern. In all countries the increasing proportion of health care services paid for from public funds, through either general taxes or deductions from pay, justifies according high priority to equity of distribution and adequacy of coverage. In fact, the health care system is being subjected to the same social, economic, and political pressures in relation to distributional equity as already exist for income, social security schemes, housing, and work. No longer are communities prepared to accept the distribution of health services and access to those services as a matter of chance or as an expression of distorted local priorities, pressures, or privileges.

To the extent that efficacious care exists, it is of great importance that all who can benefit should be provided with services that are not only effective, but are also distributed in an appropriate and adequate manner. Services of dubious value should not be continued, and the unwarranted use of expensive services by the few should be severely curtailed or terminated, especially when it is at the expense of useful basic services for the many. The International Collaborative Study has demonstrated how differences in the coverage of services by age, sex, and levels of perceived morbidity can be measured and compared and, to a limited extent, how differences in health care systems and their priorities are reflected in differences in use.

Efficacy of intervention and benefits derived in relationship to resources allocated

Many doubts are being expressed about the intrinsic benefits and relative value of specific forms of preventive, curative, and restorative intervention, and about the efficacy of individual tests and treatments. What exact evidence is there that a particular drug or operation is useful for the purposes for which it is advocated rather than harmful or useless? How does it compare with measures it is designed to replace or even with doing nothing? This is an arena for the objective assessment of benefit and it covers the use of randomized controlled trials and other scientific methods of evaluation. In all countries those responsible for planning and managing health care systems should ask for scientific evidence, instead of pronouncements claiming

authority, on which to approve decisions to pay for new procedures from public funds or even to approve their introduction for use by anyone.

Effectiveness and efficiency of health services in relation to use

Technology may be of benefit in contributing to increases in the gross national product where this has been a societal goal; but where distributional equity, adequacy of coverage, social justice, and improvement of the net economic welfare of all the people are the aim, most new technologies in health have to be regarded critically. Thus, a distinction has to be made between what has been called "half-way" technology and a fundamental technological advance. The former is represented by the "iron lung", a mechanical device for managing afflicted poliomyelitis patients, the latter by the Salk vaccine, a method of prevention based on fundamental research. An assessment also has to be made of the utility of a service. The fact that a new test can be performed by a labour-saving automated machine with a reduction in unit cost is not a sufficient reason for introducing it and thus increasing the number of tests performed unless it can also be shown that useful treatment at reasonable cost can be provided through an effective health care system for the larger number of persons that can be tested. Moreover, the financial and clinical impact of the introduction of half-way technology affecting large numbers, or of fundamental technology affecting a few, must always be weighed against the loss of contact this may involve between people who work in the health care system and those whom they serve. Proximity to a personal source of care or an appropriate entry-point to the health services may be of greater benefit to the population than the availability of sophisticated but remote equipment and care.

As a smaller and smaller proportion of many populations seems to be consuming an ever larger proportion of the resources available, there is a need to see that efficacious forms of intervention are provided for all those in the population who could benefit from them or to whom they could be effectively applied. Priority should therefore be accorded to technological and organizational solutions for the important problems that affect large numbers of the population. Sometimes there is no known effective solution, in which case more biomedical or health services research is indicated. More often than not, however, what is required is a change of priorities or the recognition that change of the system is needed in order to make

use of present knowledge. The result achieved by any health care system should be an improvement in the level of health of the whole population. The improvement is a measure of the effectiveness of the entire health care system and must be judged in terms of physical and social dysfunction as well as of satisfaction and comfort. The extent to which beneficial outcomes are distributed equitably among all those in the population who are in need and by means of the optimum allocation and use of resources is a function of how efficient the health care system really is. An efficient system that manages to provide beneficial services equitably is also an effective system.

The conventional medical model in comparison with behavioural and sociopolitical models

The conventional medical approach to the problems of health and disease has tended to emphasize the role of single causal agents, especially microorganisms, and in the past to minimize the role of the environment and of personal or host factors in the genesis of disease. Extended to the use of health services, this approach has again emphasized the role of biologically defined disease and underplayed the role in the genesis of ill health of psychological, social, and cultural factors such as emotional reactions, inadequate housing, and attitudes towards smoking. The implication of this approach when applied to the political and social sphere is that ill health consists of "diseases" whose "cure" or "eradication" will maintain or restore "health".

Contemporary biological and psychological thought, increased interest in systems theory, and mounting evidence from clinical, organizational, and political experience favour the use of much broader conceptual models for understanding the manifestations of health and illness, the use of health services, and the deployment of resources to maintain, restore, and improve levels of health. Each individual possesses psychological and physiological sensing devices and controls which interact with each other and constantly determine how his body will respond to internal awareness and experiences and to external stimuli from other individuals and from the social and physical environment. This psychobiological approach can be extended to a behavioural one which looks at how an individual behaves in the presence of health and sickness, and thus how he uses or does not use the health services. Finally, such an approach can be extended still further to a "societal" or "political" context, in which appropriate sensing devices collect and produce information which is eventually used by decision-makers to assess the utilization by

whole populations of the health services and to control the organization of health care systems and the allocation of resources to or within them.

Information about the perceived health needs of populations is seen to be an essential requirement for the final stages of decision-making. Although these stages are basically political in nature, the decisions can be guided by evidence and logic and should be influenced by the contributions of both the biological and social sciences.

OBJECTIVE OF THIS VOLUME

Our objective in this volume is to present and extend the conceptual, methodological, and empirical findings of the WHO/International Collaborative Study of Medical Care Utilization that are considered to be relevant to health services management and health systems planning. The comparison in that study of human needs with the use of health care resources in 12 diverse study areas in 7 countries was instructive in disclosing important differences and similarities in the organization of health care arrangements. The comparisons resulted in the development of some basic principles that could, in the opinion of the study participants, contribute to a more rational resource allocation and health care organization. The sharing of information based on the use of a common language can accelerate the application of new knowledge about health services, in a manner analogous to that of the international biomedical community, which has flourished by sharing its knowledge through the use of a common scientific language and standards.

It is the purpose of the present small volume to extend the findings of the International Collaborative Study in order

(1) to make widely available a number of practical strategies for incorporating selected information on perceived health needs and on the use of health services as a basis for guiding resource allocation in the context of behavioural and sociopolitical models supported by empirical research;

(2) to describe the elements and indicators of a practical information base for decision-making in the health sector; and

(3) to demonstrate the relative utility of some of the concepts and methods used in the International Collaborative Study in health care organization, in making plans and choosing among competing alternatives for the allocation of resources, and in managing systems in order to improve their structure, functioning, and results.