NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF HEALTH SCIENCES

COURSE CODE: PHS 212

COURSE TITLE: HEALTH MANAGEMENT I

PHS 212 HEALTH MANAGEMENT I

COURSE GUIDE

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PHS 212 HEALTH MANAGEMENT I

Introduction

PHS 212: Health Management I is a first semester course work of two credit hours to be taken by all students, in the BSc. Community Health programme in the School of Science & Technology. The course consists of 12 units embracing introductory lectures to health management and related service deliveries.

The course guide tells you what the course is all about this course. It also contains other information such as Tutor-marked Assignments / Questions. In the course of your studies, you will be exposed to some tutorial classes.

Course Content

The course content consists of:

Overview of Management

Concept of Planning – meaning, objectives, rationale, types,

steps

Health Planning- what is? Nature, need for? Types,

stakeholders, deliverable

Health Planning Process

Critical success factors in Health Planning

Strategic and Operational Planning

Health Policy

Historical Development of Formalized Health Planning in

Nigeria

Nigeria Health Care System

Challenges of Health Care in Nigeria

Health Records & Documentation

Health Care Executives Competencies & Vocabulary

Course Aims

The aim of this course is to expose you to the principles of planning and policy in health care as a prerequisite for effective utilization of resources to achieving desired result in health care delivery system.

The aims will be achieved by:

- Explaining the principles, features, objectives and importance of management
- Describing the planning function, meaning, purpose and steps
- Explain the concept, purpose and types of health planning
- Identifying and describing the critical factors for success in health planning
- Explain the difference between strategic and operational planning and how they relate to health care.
- Describing the meaning of policy and also examine the historical development of health care policy in Nigeria
- Examining the challenges of health care in Nigeria
- Identifying the core competencies and vocabulary of a professional health care executive.

Objectives

At the end of this course, you should be able to:

- Explain the definition and scope of management.
- Identify the meaning, purpose and basic steps in planning.
- Appreciate the importance planning in health care
- Apply the principles of planning in Community Health care
- Identify the critical factors for success in health planning
- Clearly distinguish between strategic and operational planning and apply concept to health care
- Define public policy and apply to health care
- Identify the core competencies of a health care professional

- Describe the Historical Development of Formalized Health Planning in Nigeria.
- Discuss the Health Care System in relation to the National Health Policy and the challenges of health care in Nigeria
- Understand the health records & documentation
- Increase Your Vocabulary – Definition of terms

Course Materials

Course Guide
Study Units
Text Books
Assignment Guide

Study Units

There are 12 units in this course, which should be studied carefully.

Unit 1: Overview of Management

Unit 2: Concept of Planning – meaning, objectives, rationale, types, steps

Unit 3: Health Planning- what is? Nature, need for? Types, stakeholders, deliverables

Unit 4: Health Planning Process

Unit 5: Critical success factors in Health Planning

Unit 6: Strategic and Operational Planning

Unit 7: Health Policy

Unit 8: Historical Development of Formalized Health Planning in Nigeria

Unit 9 : Nigeria Health Care System

Unit 10: Challenges of Health Care in Nigeria

Unit 11: Health Records & Documentation

Unit 12: Health Care Executives Competencies & Vocabulary

Each study unit will take at least three hours and consists of the introduction, objectives, main content, exercise, conclusion, summary and references as well as tutor-marked question.

Working through this Course

To complete this course you are required to read each unit, read the textbooks and other materials which may be provided by the National Open University of Nigeria.

Each unit contains a Tutor Marked Assignment which you must attempt to answer on your own and which you will be required at certain point in this course to submit for purposes of assessment. At the end of the course there will be a final examination. The course should take you about a total of 16 weeks to complete. Also, stated below is the list of the all things you need to do in this course and how to allocate your time as you study each unit.

The nature of study of the Open University requires that you spend a lot of time studying alone. You are therefore advised to spend between 2 – 3 hours studying each unit, in addition to availing yourself of the tutorial classes to be facilitated in order to be able to get explanations from your facilitator and compare notes with your classmates.

The Course Material

The main components of this course material include:

1. The Course Guide
2. Study Unit
3. Tutor Marked Assignment
4. Reference/Further Readings
5. Presentation Schedule

Each unit is made up of about one to two weeks work and it includes an Introduction, Objective, the main Content, Conclusion, Summary, Tutor Marked Assignment (TMA) and Reference/Further Reading. The unit helps you to work on your Tutor Marked Assignments which will enable you determine the progress you are making and also help you achieve the learning objectives stated in each unit, and the course as a whole.

Presentation Schedule

Your course materials have some important date to ensure early and timely completion and submission of your TMAs and attendance of tutorial classes. You should endeavour to submit all your TMAs by the stipulated time and date. You should not lack behind in any of your work.

Assessment

There are two aspects to the assessment in this course. The first consist of the Tutor Marked Assignment and the second is the written examination at the end of the course. The Tutor Marked Assignment which you will submit to your tutor for marking will count for 30% of your total course scores, while the final examination you shall write at the end of the course which shall last for three hours counts for 70% of your total course scores.

Tutor Marked Assignment

The TMA is a continuous assessment component of your course. It accounts for 30% of the total score. You will be given four (4) TMAs to answer. Three of these must be answered before you are allowed to sit for the end of course examination. The TMAs would be given to you by your facilitator and returned after you have done the assignment. You should be able to answer your assignment from the information and material contained in your further reading, reference and study units. However, it is desirable in all degree level of education to demonstrate that you have read and researched more into your reference, which will give you a wider view point and may provide you with a deeper understanding of the subject.

Also make sure that each TMA reaches your facilitator on or before the last date stipulated in the presentation schedule and assignment file. If for any reason you are unable to complete your work on time, contact your facilitator before the assignment is due to discuss the possibility of an extension. Extension may not be granted after the due date except for exceptional circumstances.

Final Examination and Grading

The end of course examination for professional ethics will be for about 3 hours and it has a value of 70% of the total course work. The examination will consist of questions, which will reflect the type of self-testing, practice exercise and

tutor marked assignment problems you have previously encountered. All areas of the course will be examined,

Endeavour to use the period between finishing the last unit and sitting for examination to revise the whole course. You might find it useful to review your TMAs and comments on them before the examination. This is because the end of course examination covers all aspects of the course.

Course Marking Scheme

Assignment	**Marks**
Assignment 1 - 4	Four TMAs, best three marks of the four count at 10% each – 30% of course marks.
End of course examination	70% of overall course marks.
Total	100%

Facilitators/Tutors and Tutorials

There shall be 16 hours of tutorial provided in support of this course. You will be informed of the times, dates and location for these tutorials. You will also be given the name and phone number(s) of your facilitators, as soon as you are allocated a tutorial group.

The facilitator will mark and comment on your assignment, keep a close watch on your progress and in case of any difficulty you might encounter during the course he will provide you with assistance. You are expected to mail your Tutor Marked Assignment to your facilitator before the stipulated date (at least two working days are required). These would be marked and returned to you as soon as possible.

Please do not hesitate to contact your facilitator by telephone or e-mail whenever you need assistance.

The following might be circumstances in which you would find assistance necessary, hence you would have to contact your facilitator if:

You do not understand any part of the study material or the assigned readings.
You have difficulty with the Tutor Marked Assignment

You have a question or problem with an assignment or with the grading of an assignment,

You should endeavour to attend the tutorial classes. This is the only chance to have face to face contact with your course facilitator and to ask questions which are answered instantly. You can raise any problem encountered in the course of your study.

To gain much benefit from the tutorial classes prepare a list of questions before attending them. You will learn a lot from participating actively in discussions.

Summary

Course PHS 212 – Health Management I will introduce you to the principles and practice of Health Care. It is important to state that the questions you should be able to answer are not limited to the one listed above. And in order to have maximum gain from this course you should endeavour to apply the principles you have learnt to your understanding of professional ethics.

While wishing you success in this course. I hope will you find it both interesting and useful in your study and work

PHS 212 HEALTH MANAGEMENT I

Unit 1: Overview of Management

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1.0 Introduction

This unit introduces the subject management. It discusses the various definitions of management. The unit further explains the features and levels of management. Finally, it discusses the objectives and importance of management and concludes by differentiating between management and administration.

2.0 Objectives

At the end of this unit, learners will:

Define management
Identify the features of management
Enumerate and discuss the various levels of management
Appreciate the importance and the objectives of management
Distinguish between management and administration.

3.0 Main Content

3.1 What is Management?

Management is a universal phenomenon. It is a very popular and widely used term. All organizations - business, political, cultural or social are involved in management because it is the management which helps and directs the various efforts towards a definite purpose. According to *Harold Koontz*, "Management is an art of getting things done through and with the people in formally organized groups. It is an art of creating an environment in which people can perform and individuals and can co-operate towards attainment of group goals". According to *F.W. Taylor*, "Management is an art of knowing what to do, when to do and see that it is done in the best and cheapest way".

Management is a purposive activity. It is something that directs group efforts towards the attainment of certain pre – determined goals. It is the process of working with and through others to effectively achieve the goals of the organization, by efficiently using limited resources in the changing world. Of course, these goals may vary from one enterprise to another. E.g.: For one enterprise it may be launching of new products by conducting market surveys and for other it may be profit maximization by minimizing cost.

Management involves creating an internal environment: - It is the management which puts into use the various factors of production. Therefore, it is the responsibility of management to create such conditions which are conducive to maximum efforts so that people are able to perform their task efficiently and

effectively. It includes ensuring availability of raw materials, determination of wages and salaries, formulation of rules and regulations etc.

Therefore, we can say that good management includes both being effective and efficient. Being effective means doing the appropriate task i.e., fitting the square pegs in square holes and round pegs in round holes. Being efficient means doing the task correctly, at least possible cost with minimum wastage of resources.

Management can be defined in detail in following categories:

1. Management as a Process
2. Management as an Activity
3. Management as a Discipline
4. Management as a Group

3.1.1 Management as a Process

As a process, management refers to a series of inter – related functions. It is the process by which management creates, operates and directs purposive organization through systematic, coordinated and co-operated human efforts, according to George R. Terry, "Management is a distinct process consisting of planning, organizing, actuating and controlling, performed to determine and accomplish stated objective by the use of human beings and other resources". As a process, management consists of three aspects:

1. Management is a social process – Since human factor is most important among the other factors, therefore management is concerned with developing relationship among people. It is the duty of management to make interaction between people – productive and useful for obtaining organizational goals.
2. Management is an integrating process – Management undertakes the job of bringing together human physical and financial resources so as to achieve organizational purpose. Therefore, is an important function to bring harmony between various factors.
3. Management is a continuous process – It is a never ending process. It is concerned with constantly identifying the problem and solving them by taking adequate steps. It is an on-going process.

3.1.2 Management as an Activity

Like various other activities performed by human beings such as writing, playing, eating, cooking etc, management is also an activity because a manager is one who accomplishes the objectives by directing the efforts of others. According to Koontz, "Management is what a manager does". Management as an activity includes –

1. Informational activities – In the functioning of business enterprise, the manager constantly has to receive and give information orally or in written. A communication link has to be maintained with subordinates as well as superiors for effective functioning of an enterprise.
2. Decisional activities – Practically all types of managerial activities are based on one or the other types of decisions. Therefore, managers are continuously involved in decisions of different kinds since the decision made by one manager becomes the basis of action to be taken by other managers. (E.g. Sales Manager is deciding the media and content of advertising).
3. Inter-personal activities – Management involves achieving goals through people. Therefore, managers have to interact with superiors as well as the sub-ordinates. They must maintain good relations with them. The inter-personal activities include with the sub-ordinates and taking care of the problem. (E.g. Bonuses to be given to the sub-ordinates).

3.1.3 Management as a Discipline

Management as a discipline refers to that branch of knowledge which is connected to study of principles and practices of basic administration. It specifies certain code of conduct to be followed by the manager and also various methods for managing resources efficiently.

Management as a discipline specifies certain code of conduct for managers and indicates various methods of managing an enterprise. Management is a course of study which is now formally being taught in the institutes and universities after completing a prescribed course or by obtaining degree or diploma in management, a person can get employment as a manager.

Any branch of knowledge that fulfils following two requirements is known as discipline:

1. There must be scholars and thinkers who communicate relevant knowledge through research and publications.
2. The knowledge should be formally imparted by education and training programmes.

Since management satisfies both these problems, therefore it qualifies to be a discipline. Though it is comparatively a new discipline but it is growing at a faster pace.

3.1.4 Management as a Group

Management as a group refers to all those persons who perform the task of managing an enterprise. When we say that management of ABC and Co. is good, we are referring to a group of people those who are managing. Thus as a

group technically speaking, management will include all managers from chief executive to the first – line managers (lower-level managers). But in common practice management includes only top management i.e. Chief Executive, Chairman, General Manager, Board of Directors etc. In other words, those who are concerned with making important decisions, these persons enjoy the authorities to use resources to accomplish organizational objectives and also responsibility to for their efficient utilization.

Management as a group may be looked upon in 2 different ways:

1. All managers taken together.
2. Only the top management

The interpretation depends upon the context in which these terms are used. Broadly speaking, there are 3 types of managers -

1. Patrimonial / Family Manager: Those who have become managers by virtue of their being owners or relatives of the owners of company.
2. Professional Managers: Those who have been appointed on account of their specialized knowledge and degree.
3. Political Managers / Civil Servants: Those who manage public sector undertakings.

Managers have become a part of elite group of society as they enjoy higher standard of living in the society.

3.2 Features of Management

Management is an activity concerned with guiding human and physical resources such that organizational goals can be achieved. Nature of management can be highlighted as: -

1. Management is Goal-Oriented: The success of any management activity is accessed by its achievement of the predetermined goals or objective. Management is a purposeful activity. It is a tool which helps use of human and physical resources to fulfill the pre-determined goals. For example, the goal of an enterprise is maximum consumer satisfaction by producing quality goods and at reasonable prices. This can be achieved by employing efficient persons and making better use of scarce resources.
2. Management integrates Human, Physical and Financial Resources: In an organization, human beings work with non-human resources like machines. Materials, financial assets, buildings etc. Management integrates human efforts to those resources. It brings harmony among the human, physical and financial resources.
3. Management is Continuous: Management is an ongoing process. It involves continuous handling of problems and issues. It is concerned with identifying

the problem and taking appropriate steps to solve it. E.g. the target of a company is maximum production. For achieving this target various policies have to be framed but this is not the end. Marketing and Advertising is also to be done. For this policies have to be again framed. Hence this is an ongoing process.

4. Management is all Pervasive: Management is required in all types of organizations whether it is political, social, cultural or business because it helps and directs various efforts towards a definite purpose. Thus clubs, hospitals, political parties, colleges, hospitals, business firms all require management. Whenever more than one person is engaged in working for a common goal, management is necessary. Whether it is a small business firm which may be engaged in trading or a large firm like Tata Iron and Steel, management is required everywhere irrespective of size or type of activity.
5. Management is a Group Activity: Management is very much less concerned with individual's efforts. It is more concerned with groups. It involves the use of group effort to achieve predetermined goal of management of XYZ and Co. is good refers to a group of persons managing the enterprise.

3.3 Levels of Management

The term "Levels of Management' refers to a line of demarcation between various managerial positions in an organization. The number of levels in management increases when the size of the business and work force increases and vice versa. The level of management determines a chain of command, the amount of authority and status enjoyed by any managerial position. The levels of management can be classified in three broad categories: -

1. Top level / Administrative level
2. Middle level / Executory
3. Low level / Supervisory / Operative / First-line managers

Managers at all these levels perform different functions. The role of managers at all the three levels is discussed below:

LEVELS OF MANAGEMENT

1.Top Level of Management

It consists of board of directors, chief executive or managing director. The top management is the ultimate source of authority and it manages goals and policies for an enterprise. It devotes more time on planning and coordinating functions.

The role of the top management can be summarized as follows –

a. Top management lays down the objectives and broad policies of the enterprise.
b. It issues necessary instructions for preparation of department budgets, procedures, schedules etc.
c. It prepares strategic plans and policies for the enterprise.
d. It appoints the executive for middle level i.e. departmental managers.
e. It controls and coordinates the activities of all the departments.
f. It is also responsible for maintaining a contact with the outside world.
g. It provides guidance and direction.
h. The top management is also responsible towards the shareholders for the performance of the enterprise.

1. Middle Level of Management

The branch managers and departmental managers constitute middle level. They are responsible to the top management for the functioning of their department. They devote more time to organizational and directional functions. In small organization, there is only one layer of middle level of management but in big enterprises, there may be senior and junior middle level management. Their role can be emphasized as –

a. They execute the plans of the organization in accordance with the policies and directives of the top management.
b. They make plans for the sub-units of the organization.
c. They participate in employment and training of lower level management.
d. They interpret and explain policies from top level management to lower level.
e. They are responsible for coordinating the activities within the division or department.
f. It also sends important reports and other important data to top level management.
g. They evaluate performance of junior managers.

h. They are also responsible for inspiring lower level managers towards better performance.

2. Lower Level of Management

Lower level is also known as supervisory / operative level of management. It consists of supervisors, foreman, section officers, superintendent etc. According to *R.C. Davis*, "Supervisory management refers to those executives whose work has to be largely with personal oversight and direction of operative employees". In other words, they are concerned with direction and controlling function of management. Their activities include –

a. Assigning of jobs and tasks to various workers.
b. They guide and instruct workers for day to day activities.
c. They are responsible for the quality as well as quantity of production.
d. They are also entrusted with the responsibility of maintaining good relation in the organization.
e. They communicate workers problems, suggestions, and recommendatory appeals etc to the higher level and higher level goals and objectives to the workers.
f. They help to solve the grievances of the workers.
g. They supervise and guide the sub-ordinates.
h. They are responsible for providing training to the workers.
i. They arrange necessary materials, machines, tools etc for getting the things done.
j. They prepare periodical reports about the performance of the workers.
k. They ensure discipline in the enterprise.
l. They motivate workers.
m. They are the image builders of the enterprise because they are in direct contact with the workers.

3.4 Objectives of Management

The main objectives of management are:

1. Getting Maximum Results with Minimum Efforts – The main objective of management is to secure maximum outputs with minimum efforts and resources. Management is basically concerned with thinking and utilizing human, material and financial resources in such a manner that would result in best combination. This combination results in reduction of various costs.
2. Increasing the Efficiency of factors of Production – Through proper utilization of various factors of production, their efficiency can be increased to a great extent which can be obtained by reducing spoilage, wastages and breakage of all kinds, this in turn leads to saving of time, effort and money which is essential for the growth and prosperity of the enterprise.

3. Maximum Prosperity for Employer and Employees – Management ensures smooth and coordinated functioning of the enterprise. This in turn helps in providing maximum benefits to the employee in the shape of good working condition, suitable wage system, incentive plans on the one hand and higher profits to the employer on the other hand.
4. Human betterment and Social Justice – Management serves as a tool for the upliftment as well as betterment of the society. Through increased productivity and employment, management ensures better standards of living for the society. It provides justice through its uniform policies.

3.5 Importance of Management

1. It helps in Achieving Group Goals – It arranges the factors of production, assembles and organizes the resources, integrates the resources in effective manner to achieve goals. It directs group efforts towards achievement of pre-determined goals. By defining objective of organization clearly there would be no wastage of time, money and effort. Management converts disorganized resources of men, machines, money etc. into useful enterprise. These resources are coordinated, directed and controlled in such a manner that enterprise work towards attainment of goals.
2. Optimum Utilization of Resources – Management utilizes all the physical and human resources productively. This leads to efficacy in management. Management provides maximum utilization of scarce resources by selecting its best possible alternate use in industry from out of various uses. It makes use of experts, professional and these services leads to use of their skills, knowledge, and proper utilization and avoids wastage. If employees and machines are producing its maximum there is no under employment of any resources.
3. Reduces Costs – It gets maximum results through minimum input by proper planning and by using minimum input and getting maximum output. Management uses physical, human and financial resources in such a manner which results in best combination. This helps in cost reduction.
4. Establishes Sound Organization – No overlapping of efforts (smooth and coordinated functions). To establish sound organizational structure is one of the objective of management which is in tune with objective of organization and for fulfillment of this, it establishes effective authority and responsibility relationship i.e. who is accountable to whom, who can give instructions to whom, who are superiors and who are subordinates. Management fills up various positions with right persons, having right skills, training and qualification. All jobs should be cleared to everyone.
5. Establishes Equilibrium – It enables the organization to survive in changing environment. It keeps in touch with the changing environment. With the change is external environment, the initial co-ordination of organization must be changed. So it adapts organization to changing demand of market /

changing needs of societies. It is responsible for growth and survival of organization.

6. Essentials for Prosperity of Society – Efficient management leads to better economical production which helps in turn to increase the welfare of people. Good management makes a difficult task easier by avoiding wastage of scarce resource. It improves standard of living. It increases the profit which is beneficial to business and society will get maximum output at minimum cost by creating employment opportunities which generate income in hands. Organization comes with new products and researches beneficial for society.

3.6 Management and Administration

According to *Theo Haimann*, "Administration means overall determination of policies, setting of major objectives, the identification of general purposes and laying down of broad programmes and projects". It refers to the activities of higher level. It lays down basic principles of the enterprise. According to Newman, "Administration means guidance, leadership and control of the efforts of the groups towards some common goals".

Whereas, management involves conceiving, initiating and bringing together the various elements; coordinating, actuating, integrating the diverse organizational components while sustaining the viability of the organization towards some pre-determined goals. In other words, it is an art of getting things done through and with the people in formally organized groups.

The difference between Management and Administration can be summarized under 2 categories:

1. Functions
2. Usage / Applicability

On the Basis of Functions: -

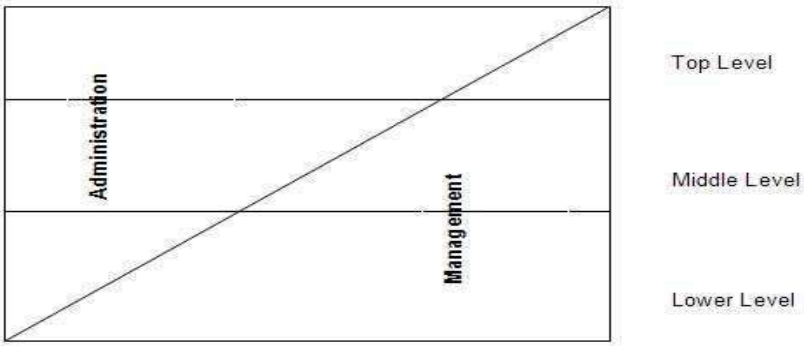
Basis	Management	Administration
Meaning	Management is an art of getting things done through others by directing their efforts towards achievement of pre-determined goals.	It is concerned with formulation of broad objectives, plans and policies.
Nature	Management is an executing function.	Administration is a decision-making function.
Process	Management decides who should	Administration decides what

	as it and how should he dot it.	is to be done and when it is to be done.
Function	Management is a doing function because managers get work done under their supervision.	Administration is a thinking function because plans and policies are determined under it.
Skills	Technical and Human skills	Conceptual and Human skills
Level	Middle and lower level function	Top level function

On the Basis of Usage: -

Basis	Management	Administration
Applicability	It is applicable to business concerns i.e. profit-making organization.	It is applicable to non-business concerns i.e. clubs, schools, hospitals etc.
Influence	The management decisions are influenced by the values, opinions, beliefs and decisions of the managers.	The administration is influenced by public opinion, govt. policies, religious organizations, customs etc.
Status	Management constitutes the employees of the organization who are paid remuneration (in the form of salaries and wages).	Administration represents owners of the enterprise who earn return on their capital invested and profits in the form of dividend.

Practically, there is no difference between management and administration. Every manager is concerned with both – administrative management function and operative management function as shown in the figure. However, the managers who are higher up in the hierarchy denote more time on administrative function and the lower level denote more time on directing and controlling worker's performance i.e. management.



The Figure above clearly shows the degree of administration and management performed by the different levels of management

4.0 Summary

The subject management was introduced in this unit. Consequently, various definitions such as management being a process, an activity, a discipline among others were given. The features of management such as: goal orientation and being continuous were considered. Three levels of management were identified and discussed. The unit highlighted the objectives and significance of management. It concluded by distinguishing between management and administration using meaning, nature, process, function, skills and levels as basis of comparison.

5.0 Conclusion

The following conclusions are drawn from the unit:

Management is a universal phenomenon applicable in every facet of human endeavour – business, politics, culture, social among others. Management is also a purposeful activity because it directs group efforts toward achieving pre-determined goals. Furthermore that management exits at all levels – top, middle and lower levels. It is also concerned with harnessing human and physical resources to facilitate achievement of organizational goals. Therefore, management is a skill that all managers must acquire to be efficient and effective.

6.0 Tutor Marked Assignment

Discuss the features, objectives and significance of management.

Management and administration mean the same thing – True or False? Justify your stand.

7.0 References

Drucker, P. F. (1974): *Management Tasks, Responsibilities, and Practices*, Harper & Row, New York (1974)

Hill, C. W. L., McShane, S. (2006): *Principles of Management*, McGraw-Hill/Irwin (2006)

Katz, R. L. (1974): *Skills of an effective Administrator*," Harvard Business Review, September – October 1974, 90 – 102

Koontz, H. & Weihrich, H. (2001): Management: A Global Perspective. First Edition. New Delhi: Tata Mc. Graw Hill Publishers; 2001.

Koontz, H., Weihrich, H. (2004): *Essentials of Management: An International Perspective (6th Edition)*, Tata McGraw-Hill Publishing Company Limited, New Delhi, (2004)

Ogunbiyi, I. K. (2010): Health Management II – CHS 313, National Open University of Nigeria, Lagos (2010)

Prasad, M. (1983): *Principles and Practice of Management(4th Edition)*, Sultan Chand & Sons, New Delhi(1983)

Provitera, M. J. (2003): *'What Management Is: How It Works and Why It's Everyone's Business*, Academy of Management Executive 17 (August 2003), 152 – 154

Rue, L. W., Byars, L. L. (2008) : *Management*, McGraw-Hill/Irwin, United States (2008)

Unit 2: Concept of Planning

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4.0 Summary

5.0 Conclusions

6.0 Tutor Marked Assignment

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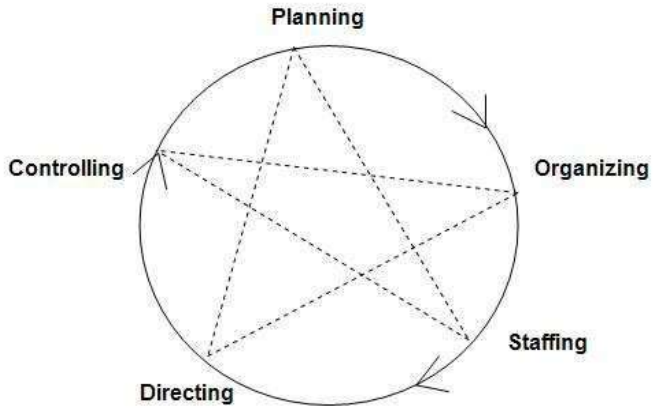
1.0 Introduction

Management has been described as a social process involving responsibility for economical and effective planning and regulation of operation of an enterprise in the fulfillment of given purposes. It is a dynamic process consisting of various elements and activities. These activities are different from operative functions like marketing, finance, purchase etc. Rather these activities are common to each and every manger irrespective of his level or status.

Different experts have classified functions of management. According to *George and Jerry*, "There are four fundamental functions of management i.e. planning, organizing, actuating and controlling". According to Henry Fayol,

"To manage is to forecast and plan, to organize, to command, and to control". Whereas Luther Gullick has given a keyword 'POSDCORB' where P stands for Planning, O for Organizing, S for Staffing, D for Directing, Co for Co-ordination, R for reporting and B for Budgeting. But the most widely accepted are functions of management given by KOONTZ and O'DONNEL i.e. Planning, Organizing, Staffing, Directing and Controlling.

For theoretical purposes, it may be convenient to separate the function of management but practically these functions are overlapping in nature i.e. they are highly inseparable. Each function blends into the other and each affects the performance of others.



This unit will focus on Planning Function of Management

2.0 Objectives

At this end of this unit, learners will be able to:

Define and appreciate the ingredients of of planning
Identify the steps involved in effective planning
Define the characteristics of Planning
Enumerate the advantages and disadvantages of planning
External factors that hinder effective planning

3.0 Main content

3.1 What is planning?

It is the basic function of management. It deals with charting out a future course of action and deciding in advance the most appropriate course of actions for achievement of pre-determined goals. It is a preparatory step. It is a systematic activity which determines when, how and who is going to perform a specific job. Planning is a detailed programme regarding future courses of action. According to Koontz and O'Donnell, "Planning is deciding in advance – what to do, when to do and how to do. It bridges the gap from where we are and

where we want to be. It makes possible things to occur which would not otherwise occur It makes possible things to occur which would not otherwise occur". According to Urwick, "Planning is a mental predisposition to do things in orderly way, to think before acting and to act in the light of facts rather than guesses". Planning is deciding best alternative among others to perform different managerial functions in order to achieve predetermined goals. A plan is a future course of actions. It is an exercise in problem solving and decision making. Planning is determination of courses of action to achieve desired goals. Thus, planning is a systematic thinking about ways and means for accomplishment of pre-determined goals. Planning is necessary to ensure proper utilization of human and non-human resources. It is all pervasive, it is an intellectual activity and it also helps in avoiding confusion, uncertainties, risks, wastages etc. Therefore planning takes into consideration available and prospective human and physical resources of the organization so as to get effective co-ordination, contribution and perfect adjustment. It is the basic management function which includes formulation of one or more detailed plans to achieve optimum balance of needs or demands with the available resources.

3.2 Steps in Planning Function

Planning function of management involves following steps:-

1. Establishment of objectives

a. Planning requires a systematic approach.
b. Planning starts with the setting of goals and objectives to be achieved.
c. Objectives provide a rationale for undertaking various activities as well as indicate direction of efforts.
d. Moreover objectives focus the attention of managers on the end results to be achieved.
e. As a matter of fact, objectives provide nucleus to the planning process. Therefore, objectives should be stated in a clear, precise and unambiguous language. Otherwise the activities undertaken are bound to be ineffective.
f. As far as possible, objectives should be stated in quantitative terms. For example, Number of men working, wages given, units produced, etc. But such an objective cannot be stated in quantitative terms like performance of quality control manager, effectiveness of personnel manager.
g. Such goals should be specified in qualitative terms.
h. Hence objectives should be practical, acceptable, workable and achievable.

2. Establishment of Planning Premises

a. Planning premises are the assumptions about the lively shape of events in future.
b. They serve as a basis of planning.
c. Establishment of planning premises is concerned with determining where one tends to deviate from the actual plans and causes of such deviations.
d. It is to find out what obstacles are there in the way of business during the course of operations.
e. Establishment of planning premises is concerned to take such steps that avoids these obstacles to a great extent.
f. Planning premises may be internal or external. Internal includes capital investment policy, management labour relations, philosophy of management, etc. Whereas external includes socio- economic, political and economical changes.
g. Internal premises are controllable whereas external are non- controllable.

3. Choice of alternative course of action

a. When forecast are available and premises are established, a number of alternative course of actions have to be considered.
b. For this purpose, each and every alternative will be evaluated by weighing its pros and cons in the light of resources available and requirements of the organization.
c. The merits, demerits as well as the consequences of each alternative must be examined before the choice is being made.
d. After objective and scientific evaluation, the best alternative is chosen.
e. The planners should take help of various quantitative techniques to judge the stability of an alternative.

4. Formulation of derivative plans

a. Derivative plans are the sub plans or secondary plans which help in the achievement of main plan.
b. Secondary plans will flow from the basic plan. These are meant to support and expedite the achievement of basic plans.
c. These detail plans include policies, procedures, rules, programmes, budgets, schedules, etc. For example, if profit maximization is the main aim of the enterprise, derivative plans will include sales maximization, production maximization, and cost minimization.
d. Derivative plans indicate time schedule and sequence of accomplishing various tasks.

5. Securing Co-operation

a. After the plans have been determined, it is necessary rather advisable to take subordinates or those who have to implement these plans into confidence.
b. The purposes behind taking them into confidence are :-

i. Subordinates may feel motivated since they are involved in decision making process.
ii. The organization may be able to get valuable suggestions and improvement in formulation as well as implementation of plans.
iii. Also the employees will be more interested in the execution of these plans.

6. Follow up/Appraisal of plans

a. After choosing a particular course of action, it is put into action.
b. After the selected plan is implemented, it is important to appraise its effectiveness.
c. This is done on the basis of feedback or information received from departments or persons concerned.
d. This enables the management to correct deviations or modify the plan.
e. This step establishes a link between planning and controlling function.
f. The follow up must go side by side the implementation of plans so that in the light of observations made, future plans can be made more realistic.

3.3 Characteristics of Planning

1. Planning is goal-oriented.
    a. Planning is made to achieve desired objective of business.
    b. The goals established should general acceptance otherwise individual efforts and energies will go misguided and misdirected.
    c. Planning identifies the action that would lead to desired goals quickly and economically.
    d. It provides sense of direction to various activities. E.g. Elizade is trying to capture once again Nigerian Car Market by launching diesel models.
2. Planning is looking ahead.
    a. Planning is done for future.
    b. It requires peeping in future, analyzing it and predicting it.
    c. Thus planning is based on forecasting.
    d. A plan is a synthesis of forecast.
    e. It is a mental predisposition for things to happen in future.
3. Planning is an intellectual process.
    a. Planning is a mental exercise involving creative thinking, sound judgment and imagination.
    b. It is not a mere guesswork but a rotational thinking.

c. A manager can prepare sound plans only if he has sound judgment, foresight and imagination.
d. Planning is always based on goals, facts and considered estimates.

4. Planning involves choice and decision making.
    a. Planning essentially involves choice among various alternatives.
    b. Therefore, if there is only one possible course of action, there is no need planning because there is no choice.
    c. Thus, decision making is an integral part of planning.
    d. A manager is surrounded by no. of alternatives. He has to pick the best depending upon requirements and resources of the enterprises.
5. Planning is the primary function of management / Primacy of Planning.
    a. Planning lays foundation for other functions of management.
    b. It serves as a guide for organizing, staffing, directing and controlling.
    c. All the functions of management are performed within the framework of plans laid out.
    d. Therefore planning is the basic or fundamental function of management.
6. Planning is a Continuous Process.
    a. Planning is a never ending function due to the dynamic business environment.
    b. Plans are also prepared for specific period f time and at the end of that period, plans are subjected to revaluation and review in the light of new requirements and changing conditions.
    c. Planning never comes into end till the enterprise exists issues, problems may keep cropping up and they have to be tackled by planning effectively.
7. Planning is all Pervasive.
    a. It is required at all levels of management and in all departments of enterprise.
    b. Of course, the scope of planning may differ from one level to another.
    c. The top level may be more concerned about planning the organization as a whole whereas the middle level may be more specific in departmental plans and the lower level plans implementation of the same.
8. Planning is designed for efficiency.
    a. Planning leads to accomplishment of objectives at the minimum possible cost.
    b. It avoids wastage of resources and ensures adequate and optimum utilization of resources.
    c. A plan is worthless or useless if it does not value the cost incurred on it.
    d. Therefore planning must lead to saving of time, effort and money.

e. Planning leads to proper utilization of men, money, materials, methods and machines.

9. Planning is Flexible.
    a. Planning is done for the future.
    b. Since future is unpredictable, planning must provide enough room to cope with the changes in customer's demand, competition, and govt. policies etc.
    c. Under changed circumstances, the original plan of action must be revised and updated to make it more practical.

3.4 Advantages of Planning

1. Planning facilitates management by objectives.

    a. Planning begins with determination of objectives.
    b. It highlights the purposes for which various activities are to be undertaken.
    c. In fact, it makes objectives more clear and specific.
    d. Planning helps in focusing the attention of employees on the objectives or goals of enterprise.
    e. Without planning an organization has no guide.
    f. Planning compels manager to prepare a Blue-print of the courses of action to be followed for accomplishment of objectives.
    g. Therefore, planning brings order and rationality into the organization.

2. Planning minimizes uncertainties.
    a. Business is full of uncertainties.
    b. There are risks of various types due to uncertainties.
    c. Planning helps in reducing uncertainties of future as it involves anticipation of future events.
    d. Although future cannot be predicted with cent percent accuracy but planning helps management to anticipate future and prepare for risks by necessary provisions to meet unexpected turn of events.
    e. Therefore with the help of planning, uncertainties can be forecasted which helps in preparing standbys as a result, uncertainties are minimized to a great extent.

3. Planning facilitates co-ordination.
    a. Planning revolves around organizational goals.
    b. All activities are directed towards common goals.
    c. There is an integrated effort throughout the enterprise in various departments and groups.
    d. It avoids duplication of efforts. In other words, it leads to better co-ordination.
    e. It helps in finding out problems of work performance and aims at rectifying the same.
    f.

4. Planning improves employee's moral.
    a. Planning creates an atmosphere of order and discipline in organization.
    b. Employees know in advance what is expected of them and therefore conformity can be achieved easily.
    c. This encourages employees to show their best and also earn reward for the same.
    d. Planning creates a healthy attitude towards work environment which helps in boosting employees moral and efficiency.
5. Planning helps in achieving economies.
    a. Effective planning secures economy since it leads to orderly allocation of resources to various operations.
    b. It also facilitates optimum utilization of resources which brings economy in operations.
    c. It also avoids wastage of resources by selecting most appropriate use that will contribute to the objective of enterprise. For example, raw materials can be purchased in bulk and transportation cost can be minimized. At the same time it ensures regular supply for the production department, that is, overall efficiency.
6. Planning facilitates controlling.
    a. Planning facilitates existence of certain planned goals and standard of performance.
    b. It provides basis of controlling.
    c. We cannot think of an effective system of controlling without existence of well thought out plans.
    d. Planning provides pre-determined goals against which actual performance is compared.
    e. In fact, planning and controlling are the two sides of a same coin. If planning is root, controlling is the fruit.
7. Planning provides competitive edge.
    a. Planning provides competitive edge to the enterprise over the others which do not have effective planning. This is because of the fact that planning may involve changing in work methods, quality, quantity designs, extension of work, redefining of goals, etc.
    b. With the help of forecasting not only the enterprise secures its future but at the same time it is able to estimate the future motives of its competitor which helps in facing future challenges.
    c. Therefore, planning leads to best utilization of possible resources, improves quality of production and thus the competitive strength of the enterprise is improved.
8. Planning encourages innovations.
    a. In the process of planning, managers have the opportunities of suggesting ways and means of improving performance.
    b. Planning is basically a decision making function which involves creative thinking and imagination that ultimately leads to

innovation of methods and operations for growth and prosperity of the enterprise.

3.5 Disadvantages of Planning

3.5.1 *Internal Limitations*

There are several limitations of planning. Some of them are inherit in the process of planning like rigidity and other arise due to shortcoming of the techniques of planning and in the planners themselves.

1. Rigidity
    a. Planning has tendency to make administration inflexible.
    b. Planning implies prior determination of policies, procedures and programmes and a strict adherence to them in all circumstances.
    c. There is no scope for individual freedom.
    d. The development of employees is highly doubted because of which management might have faced lot of difficulties in future.
    e. Planning therefore introduces inelasticity and discourages individual initiative and experimentation.
2. Misdirected Planning
    a. Planning may be used to serve individual interests rather than the interest of the enterprise.
    b. Attempts can be made to influence setting of objectives, formulation of plans and programmes to suit one's own requirement rather than that of whole organization.
    c. Machinery of planning can never be freed of bias. Every planner has his own likes, dislikes, preferences, attitudes and interests which is reflected in planning.
3. Time consuming
    a. Planning is a time consuming process because it involves collection of information, its analysis and interpretation thereof. This entire process takes a lot of time specially where there are a number of alternatives available.
    b. Therefore planning is not suitable during emergency or crisis when quick decisions are required.
4. Probability in planning
    a. Planning is based on forecasts which are mere estimates about future.
    b. These estimates may prove to be inexact due to the uncertainty of future.
    c. Any change in the anticipated situation may render plans ineffective.
    d. Plans do not always reflect real situations inspite of the sophisticated techniques of forecasting because future is unpredictable.

e. Thus, excessive reliance on plans may prove to be fatal.

5. False sense of security
    a. Elaborate planning may create a false sense of security to the effect that everything is taken for granted.
    b. Managers assume that as long as they work as per plans, it is satisfactory.
    c. Therefore they fail to take up timely actions and an opportunity is lost.
    d. Employees are more concerned about fulfillment of plan performance rather than any kind of change.
6. Expensive
    a. Collection, analysis and evaluation of different information, facts and alternatives involves a lot of expense in terms of time, effort and money
    b. According to Koontz and O'Donnell,' Expenses on planning should never exceed the estimated benefits from planning. '

3.5.2 *External Limitations of Planning*

1. Political Climate- Change of government from Congress to some other political party, etc.
2. Labour Union- Strikes, lockouts, agitations.
3. Technological changes- Modern techniques and equipments, computerization.
4. Policies of competitors- e.g. Policies of Coca Cola and Pepsi.
5. Natural Calamities- Earthquakes and floods.
6. Changes in demand and prices- Change in fashion, change in tastes, change in income level, demand falls, price falls, etc.

4.0 Summary

We were able to understand the meaning and essence of planning so far in this unit. It dwelt on the on the meaning of planning and the steps that facilitate effective planning such as establishment of objectives, planning premises, choice of alternative course of action, formulation of derivative plans, securing cooperation and follow up/appraisal plans. It also reviewed the characteristics of planning, advantages and limitations.

5.0 Conclusions

From this unit it can be concluded that planning is the basic function of management that focuses on carting a future course of action and deciding the most appropriate course of action needed to achieve pre-determined goals. It is therefore requires a systematic thinking about ways and means for accomplishing pre-determined goals. It is key to ensuring proper utilization of

human and non human resources to avoiding confusion, unnecessary risks and wastages.

6.0 Tutor Marked Assignment

i. Discuss the planning function of management based on meaning, steps and characteristics.
ii. State the benefits of effective planning and limitations (if any).

7.0 References

Koontz, H., Weihrich, H., Aryasri, A. R. (2004): *Principles of Management*, Tata McGraw-Hill Publishing Company Limited, New Delhi, 2004.

Ogunbiyi, I. K. (2010): Health Management II – CHS 313, National Open University of Nigeria, Lagos (2010)

Prasad, M. (1983): *Principles and Practice of Management (4th Edition)*, Sultan Chand & Sons, New Delhi, 1983.

Stoner, J. A. F.,Freeman, R. E., Daniel R. Gilbert, D. R.,Jr, (2000): *Management (6th Edition)*, Prentice Hall of India, New Delhi, 2000.

http://www.mindtools.com/plintro.html - An Introduction to Planning Skills

www.webanswers.com/.../luther-gullick-coined-a-new-term-posdcorb-in-the-acronym-what-doesthe-b-stands-for-fff76a

Unit 3: Health Planning

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1.0 Introduction

Health planning comprises a range of activities that share the goal of improving health outcomes, or improving the efficiency of health services provision, or both.

Health planning occurs within the pressured environment of political direction, changing public expectation, new information and evidence about outcomes, and on occasion, media headlines. A solid and well-designed health planning process should be resilient enough to accommodate these pressures and to use them as levers to go forward to dialogue and find solutions for improved health care provision and health outcomes in the population.

2.0 Objectives

At the end of this unit, learners will:

Define health planning
Identify who conducts health planning and main deliverable
Enumerate planning steps and translate Plans Into Actions
Identify the types of health planning
Distinguish between types of health planning.

3.0 Main Content

3.1 What Is Health Planning?

Health planning is a process to produce health. It does this by creating an actionable link between needs and resources. Its nature and scope will depend upon:

• the **time allowable**

• the **number of answerable questions** to be addressed within the process "answerable questions" comprise questions that are worth asking and for which there is evidence to allow them to be answered

• the **resources available** to support the process

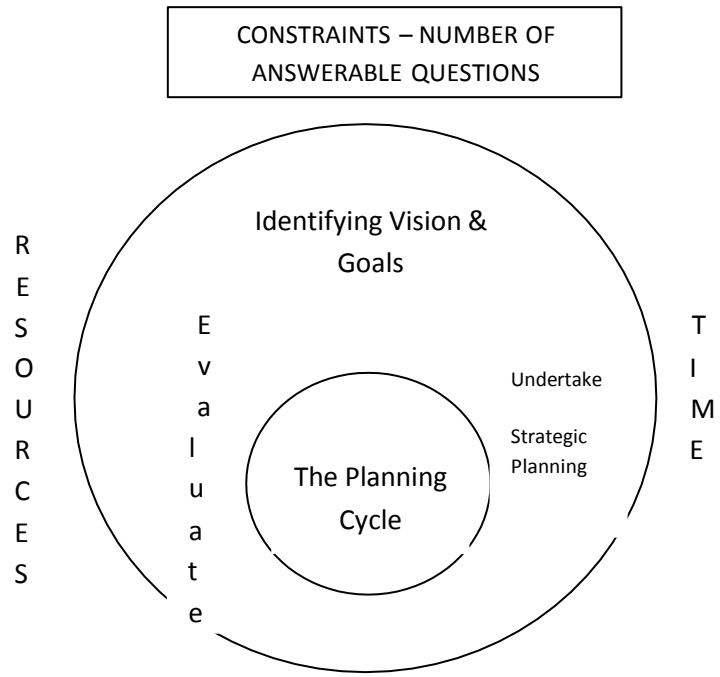
• the **broader political and social environmen**t.

There are three broad elements in a planning process:

identifying the vision and goals,
undertaking the strategic plan, and
evaluation.

Planning occurs within four potential constraints, creating a tension in many planning processes – a tension between what **ought to be** done and what **can be** done.

Figure 1: Constraints and Opportunities in Planning`



Source: The Health Planner's Toolkit, 2006

3.2 Who Conducts Health Planning?

The health planning process occurs within the health service sector, usually initiated by government or bodies delegated by government to manage health resources in an area, such as the Ministry of Health.

A health planning process may also be led by service providers such as mental health agencies, hospitals, public health agencies and other service providers to help them define future roles or immediate service goals. A teaching hospital for example may undertake planning on key delivery areas such as neurosurgery and vascular surgery.

Professional associations such as nurses' or physicians' organizations may also establish planning processes to address areas of interest to them. Consumers as well, through advocacy groups, forums or other processes, promote their needs to the government and thereby seek to increase or influence allocation of health resources.

3.3 Health Planning's Main Deliverables

The outcome of an effective health planning process should be an actionable link between needs and resources. The health planning process itself can be a deliverable.

A good planning process reflects necessary perspectives and engages key stakeholders in the development of strategies. Through that process, some of the initial marketing of the changes required can be accomplished.

3.4: Health Planning Steps

The basic steps in health planning is fully discussed in unit 4, however, the steps include:

Step One – Surveying the Environment

Step Two – Setting Directions

Step Three – Problems and Challenges:

Step Four – Range of Solutions

Step Five – Best Solution(s)

Step Six – Implementation

Step Seven – Evaluation

3.5 How to translate Plans into Actions

It is often argued that planners are only involved in the first five steps namely:

1. Surveying the environment

2. Setting directions

3. Identifying problems and challenges

4. Identifying the range of solutions to problems and challenges

5. Identifying the preferred solution(s).

The reality however is that planners have a stake in understanding and helping to shape implementation and evaluation, and they may even be called upon to lend a hand in both of these activities.

In the view of Henry Mintzberg an organizational analyst, planning especially strategic planning often fails because it is not allied with or embedded within the strategic centre of an organisation (he argued that planning is about analysis, while strategy is about synthesis).

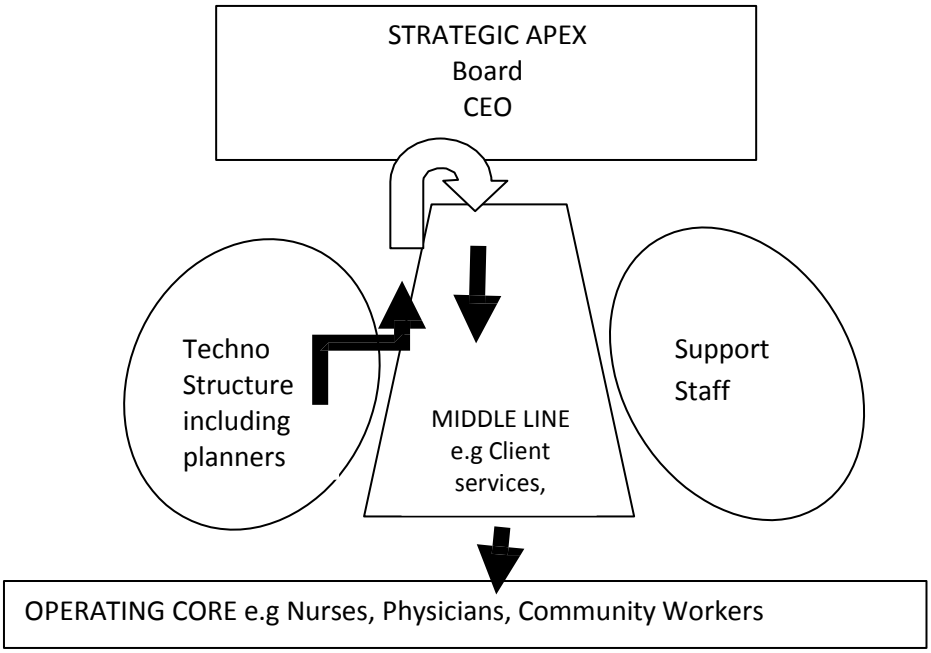
At the very least the planner should be aware that within his/her organisation or system, planners are often off to the side and that:

• decisions made on the basis of planning will be made not by planners but by what Mintzberg calls the strategic apex of the organisation or system.

• the results of the planning will need to be embedded within the operating core of the organisation or system.

Mintzberg's schematic depicting organisational subunits can be used to show the usual relationship between planners and decision-makers in terms of making planning effective. This schematic is organisation focused but a similar schematic could be created for system-level activity.

Figure 3: The Plan-to-Action Path



It is important to note the following:

The arrows show the typical flow of findings and advice from planners, through the middle line, board and management, to the organization's operating core

If the findings and advice are not embedded as action in the core, then planning has been largely ineffective.

In most instances the findings and advice must also be embedded in all other subunits (strategic apex, middle line, techno structure and support staff subunits)

If the planning project has worked well, then representatives from the strategic apex, the techno-structure, the support staff and the operating core have all been involved in the planning and 'own' its outcome.

3.6 Types of Health Planning

Health planning includes several specific, often connected, types of planning. Basically, the common types are:

Dispersed health planning
Focused health planning
Central health planning

Types of Planning in the Health Care System

Health planning in this unit is considered as a developmental process in which different types of planning appear at different times.

In a modern economy, there is a highly complex set of professional practitioners, organizations, and consumers which provide, pay for, and use health care services. From a phenomenological point of view there are simply a very large number of people acting individually and collectively according to their needs, wants, interests, and capacities.

From a theoretical point of view, however, it is possible to analyze the individual and collective behaviours of people and abstract from these certain patterns of structure and process related to a purposive definition of health care.

One may then interpret such patterns in terms of a health care system-a complex network of selected activities generally related within a framework of cultural values and a social structure of role-status relationships. This network is a dynamic mechanism, constantly changing, yet subject to no single set of controls.

From the perspective of the health care system, health planning always occurs. The relevant issues concern that does the planning, to what ends, how it occurs, what social structures support it, and what are its cumulative effects on the health care system.

From an historical perspective, health care planning may be viewed as a developmental process encompassing three categories of planning activities. Each successive "category" of health planning has developed as a result of specific limitations in the capacity of the previous category to respond fully to forces impinging on the health care system.

Each new category of planning has not, however, replaced the previous ones. It has, instead, acted to support previous types of planning while limiting their negative effects on the health care system.

3.6.1 Dispersed Health Planning

The earliest developed, most pervasive, and continuing form of health planning is that undertaken by each provider, consumer, and financing organization which make up the health care system. This form of health planning consists of the many decisions made by all individuals and organizations in the health care system as they attempt to provide, finance, and use health care services. Such health planning decisions may be divided into four groups:

1) the definition and selection of health problems, goals, and standards which are considered relevant and worthy of consideration;

2) the establishment of priorities among valued problems, goals, and standards and the acquisition or allocation of resources in accord with such priorities;

3) the establishment of coordinative and integrative activities with other health system personnel and organizations; and

4) the choices of day-to-day activities in the performance, use, or financing of health care services.

For example, each physician selects the problems and goals of his professional practice in the process of selecting a specialty within medicine. He also decides where he will locate his office and with which hospitals he will affiliate.

In doing so, he is choosing the socioeconomic class of consumers he will accept as patients. In his daily activities, he repeatedly makes choices concerning the severity and complexity of illness and disability which he will attempt to treat. He also decides on the standards of performance he will use in providing medical services. Since he must frequently supplement his own services with those of other health care workers, he must also plan relationships with personnel in hospitals, nursing homes, health departments, and other independent professional practitioners.

Each health care consumer does his own health care planning in a similar fashion. He defines his own health problems and goals in accordance with the values of his family and subculture. He decides which health problems and goals are most important and worth the investment of time and money in seeking their alleviation. He fits his health care activities into his daily schedule, weekly budget, and family and work relationships. He ties together the services of one or more physicians, dentists, optometrists, and relates to these the acquisition of drugs, eyeglasses, and other products necessary to receiving reasonably adequate health care.

Each financing organization also makes planning decisions which follow the same pattern seen in the decisions of providers and consumers. Types of diseases, disabilities, health services, and health facilities are identified and ranked in priority for the distribution of available capital or operating funds. Detailed plans are set up for their allocation. Since health care funds are supplied through many different voluntary and governmental programs, plans must be developed for their coordination in the interests of comprehensive care and efficient use of resources.

The planning activities of providers, consumers, and financing organizations are expressed in a series of sequential interactions among these groups. Each

individual and organization balances his own self-interest with the self-interests of other individuals and organizations whose help and cooperation are required. Transfers and exchanges of goals, problems, resources, and services occur continuously as plans are translated into health care behaviours. The cumulative effect of the planning decisions of the multitude of providers, consumers, and financing organizations is reflected in the nature of the health care system. In other words, the health care system represents the net result of the dispersed planning decisions of each and all of its units.

In advanced economies like the U S A, this form of health planning was the only kind which occurred in 1900. Even today, a large share of planning in the health care system is dispersed among the individuals and organizations which provide, finance, and use health services. Some people believe that dispersed planning by a multitude of persons and organizations, each pursuing his own ends in a shared interacting context, results in a cumulative selection of important problems, goals, and standards, and an optimal balance in the distribution of human and material resources. However, between 1900 and the present, dispersed health planning has become less and less adequate as an exclusive basis for planning the health care system. Scientific, economic, and health value changes in the society have increased the complexity of the health care system. Specialization, population expansion, centralization of industry, social mobility, and rising expectations of health care as a social right, have contributed to an increase in the difficulty with which each provider, consumer, and financing organization can carry out his own planning without some kind of external help.

In addition, it has become increasingly apparent that total reliance on dispersed health planning has resulted in a variety of problems caused, or not amenable to solution, by this form of planning. The cumulative results of dispersed planning have been found to be less than the sum of its constituent elements. This has become more and more evident in the duplications, gaps, and inconsistencies in the distribution of health care personnel and facilities. The dispersed planning decisions of some providers, consumers, and financing organizations have resulted in negative consequences for others who have not been involved in making these decisions. Thus, vocational decisions by physicians and hospitals have resulted, in part, in the lack of access to adequate health care by minority and disadvantaged groups in the population. Finally, it has been recognized that some problems and goals, some priorities and resource allocations, and similar planning issues cannot be resolved through the dispersed planning of many separate, independent, individuals and organizations.

These limitations in dispersed planning have resulted in the gradual development of two additional kinds of health care planning during the past fifty years. These new types of planning have been superimposed on dispersed planning. They have been designed partly to supplement dispersed planning,

partly to guide it, and partly to limit its negative consequences for the health care system.

3.6.2 Focused Health Planning

Focused health planning refers to the voluntary association of persons and organizations in an attempt to solve problems which they have in common (although the effects may be felt differently) or to attain goals which they cannot achieve on an individual basis. Focused planning brings together simultaneously the attention and efforts of a relatively large number of persons and organizations. In contrast, dispersed planning involves a multitude of concurrent and sequential relationships; each, however, involving only a few persons and organizations at a time.

Early efforts at focused planning occurred on an ad hoc and informal basis. Professional practitioners, health agency administrators, and consumers met together, frequently through the stimulation of a charismatic leader, to analyze and plan for the solution of specific problems in the health care system. However, the increasing complexity of society gradually undermined the capacity of ad hoc and informal processes to bring people together to engage in focused planning. As a result, several kinds of organizations have been created during the past fifty years so that focused planning could be facilitated by a formal structure. These organizations have been variously known as councils of social agencies, health and welfare councils, health facility planning councils, and comprehensive health planning councils. Despite their varying labels, these organizations have shared certain features which also set them apart from other types of organizations. For example, focused planning organizations are established solely for the purpose of organizing the voluntary efforts of persons interested in planning together to solve problems in the organization and financing of health care. These organizations do not, themselves, offer health services. Nor do they control and allocate funds for construction of health facilities or payment for health services. Neither do they exclusively represent any specific group interested in a single disease, disability, or type of health care.

Almost all focused planning agencies are voluntary, non-profit organizations incorporated under the relevant laws of the state in which they are located. The entire structure of these organizations is expressly designed to facilitate the focused planning process. Boards of directors and project and advisory committees are all designed to encourage a broad pattern of representation of professional health personnel, health service and financing organizations, and consumers.

All of the funds available to these agencies are directed to the performance of focused planning activities, as are the efforts of the staff employed in these agencies.

Focused health planning makes several kinds of contributions to the continuing development of community health care systems. It provides a framework to which the dispersed planning of individual providers and consumers of health services can relate. It offers a way to balance the self-interests of individuals and organizations making decisions with the interests of others who are indirectly affected by those decisions. It also offers an opportunity to analyze the cumulative effect of many individual planning decisions on the health care system as a whole. Focused planning offers a way to analyze health care problems which have not been amenable to solution through the dispersed planning by individuals and organizations. Finally, focused planning offers an opportunity for providers and consumers to voluntarily pool their respective interests and resources towards goals that could not be met by independent individual efforts.

The expansion in the number and type of focused health planning organizations during the past two generations is a clear indication of their functional utility. Focused planning agencies have:

1) facilitated the dispersed planning by individuals and organizations;

2) identified residual problems in the operation of the health care system;

3) produced a partial re-allocation of resources available for health care; and

4) produced a partial re-alignment of the activities and relationships of health care practitioners and organizations.

Focused planning organizations also have had their limitations. Their attention to residual problems in the health care system has sometimes resulted in the creation of new organizations, thereby adding to the -complexity of the system. In addition, remedial action concerning residual problems may have obscured the need for more basic changes in the structure or operation of the health care system, or in the structure or operation of other parts of the society.

The lack of control of resources by focused planning agencies has limited their ability to implement planning recommendations arising out of the focused planning process.

Voluntary action by other individuals and organizations is necessary to carry out such recommendations. Disagreement with planning agency proposals by those who control resources necessary for implementation has resulted in inaction.

Conversely, recommendations which require large amounts of resources often cannot be implemented through the voluntary action of many independent units. Finally, some focused planning agencies have been dominated by selected

interest groups, or have developed their own self interests which have interfered with their performance of the functions they were intended to serve.

The limitations of focused planning and dispersed planning to deal with certain kinds of issues in the health care system have resulted in the development of another, type of planning which may be called central planning.

3.6.3 Central Health Planning

Central health planning refers to the planned use of power controlled by an individual or organization to force other individuals and organizations to use their own resources in accordance with its plans. It differs from dispersed planning in which the scope of power available covers a narrow segment of health care activity. It differs from focused planning in which the planning agency has no power to implement its plans.

Central health planning power may be based on the legal responsibility of one profession for all health care services provided to an individual patient. For example, in the clinical practice of medicine, a physician uses his legal (and professional) authority to direct the actions of other health personnel in accordance with his plan for meeting the health needs of a patient.

Central health planning power may also be based on funds controlled by a health care financing organization.

3.6.4 Three Types of Health Planning as an Integrated Process

Dispersed, focused, and central health planning are considered to operate as differentiated aspects of an integrated health planning process. Through this process, the society defines problems, establishes goals, norms, and standards, ranks priorities, allocates and translates resources into actions, and integrates the operation of the many different units in the health care system. Dispersed planning expresses the individualistic values of our culture and continues to be the dominant approach to health planning at the present time. Focused planning reflects that segment of our value system which emphasizes voluntary cooperation.

Its rapid expansion in recent years may be attributed both to its basic acceptability and its compatibility with the individualism of dispersed planning. Central planning expresses the concern of our culture for rationality and efficiency in the organization and use of resources. However, the use of power particularly that based on governmental authority is perceived as directly antithetical to the individualistic values of the culture. Thus, central planning has had limited expression in the health care system.

Planning efforts shift from one type of planning to another as decisions made in one planning context create a need for other types of planning. For example, dispersed planning decisions by individuals and organizations leave gaps and duplications in the allocation of health care resources. These set in motion focused planning efforts to solve such problems by voluntary cooperative efforts. However, focused planning may uncover the need for governmental authority or control of substantial financial resources to solve part of the problem. This may result in the creation of an authoritative unit to carry on a limited amount of central planning.

In the future, it appears that the three types of health planning will continue to be important processes in the operation of the increasingly complex health care system. Health planning will continue to facilitate the decisions of providers, consumers, and financing organizations.

Simultaneously, these health planning processes will bring about changes in the structure and operation of the health care system which will extend and improve the health care available and accessible to the population.

Imagination, creativity, and leadership will be required in the analysis of health care system problems and in the development of proposals for change in the system. With extended participation and broadened perspective, the appropriate application of health planning in all of its forms will be a force for improving the level of health for all of the population.

4.0 Summary

This unit explores the meaning of health planning. The challenge of who conducts health planning was resolved. The unit further highlights the steps in health planning in addition to discussing what actions to take to translate plans into action. Three types of health planning namely dispersed, focused and central planning were listed and discussed.

5.0 Conclusion

From this unit it can be concluded that types of health planning can be said to be in line with development i.e., a new type of planning evolved as a result of the shortfall of the earlier. Hence, the newly adopted type of planning builds on the earlier and suggests some new idea. It can also be concluded that to the get the best from any health planning effort, adopting a disciplined approach is essential.

6.0 Tutor Marked Assignment

(i) Explain the term: health planning.

(ii) Identify and discuss the three types of health planning you know.

7.0 References

Darley, M. (2002); Managing Communication In Health Care
Six Steps To Effective Management: Elsevier Health Sciences Publishers, 2002

Health System Intelligence Project (2006): The Planning Process, Ontario 2006.
McKenzie, J. F., Pinger, R. R., Kotecki, J. E. (2001): An Introduction to Community Health Edition 7, Jones & Bartlett Publishers, 2011

Wilcock, P., Campion-Smith, C., Elston, S., (2003): Practice Professional Development Planning: A Guide for Primary Care
Radcliffe Primary Care Series, Radcliffe Publishing, 2003

Wolper, L. F (2004): Health Care Administration: Planning, Implementing, and Managing Organized Delivery Systems Edition 4, Publisher Jones & Bartlett Learning, 2004

Unit 4: Health Planning Process

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3.2 The Seven Steps to Health Planning

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1.0 Introduction

This unit discusses the steps in health planning which basically follows the same logical steps that any planning process follows. These steps constitute a cycle that is normally repeated in terms of planning for programs, systems, populations or health goals.

2.0 Objectives

At the end of this unit, learners will:

Appreciate the importance of a disciplined process in conducting health planning
List the steps required for a successful health planning process
Discuss the seven basic steps in health planning

3.0 Main Content

3.1 Steps in a Health Planning Process

Planning is the process which involves defining a problem, assessing the extent to which the problem affects the society, formulating goals with a view to solving the problem, assessing the various intervention measures based on their advantages and disadvantages, selecting the best mode of action, taking steps to implement it, monitoring the progress of the implemented system and evaluation of the results.

At its core, health planning follows the same basic steps that any planning process follows. In health planning these steps constitute a cycle that is normally repeated in terms of planning for programs, systems, populations or health goals. Repetition of the cycle is usually necessary because any or all of the following conditions prevail:

• Definitions of what constitutes "health" will change, necessitating planning to take into account the effect of the new definition on society's health goals.

• New techniques and technologies to create, restore or support health emerge continually, so planning must be cyclical to integrate these emerging innovations into the planning process.

• Unforeseen health conditions emerge (a rapidly spreading infectious disease for example), requiring a new planning cycle to factor in these conditions.

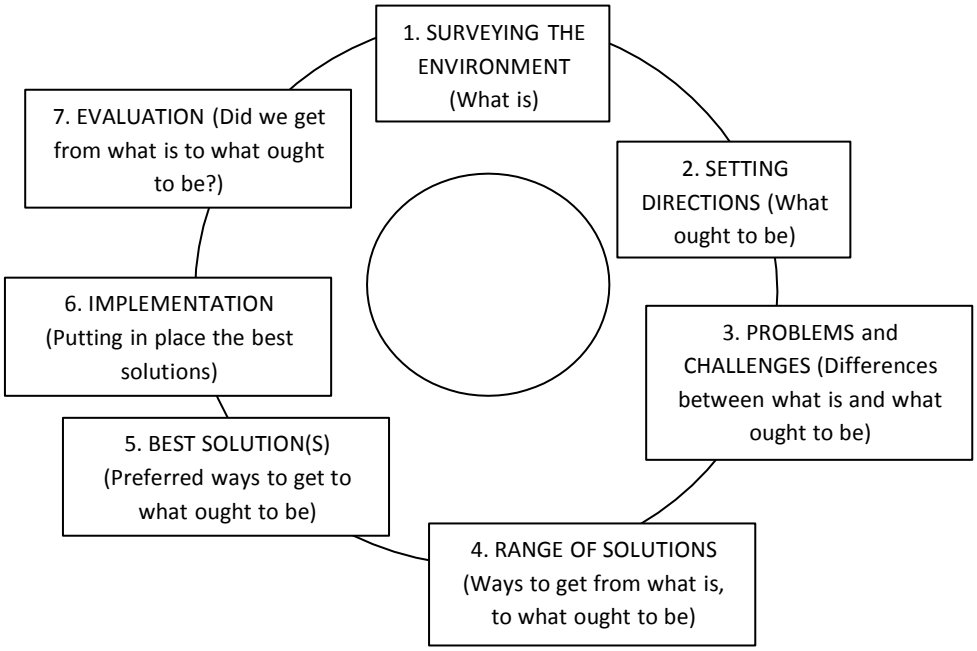
Similarly, emerging social conditions (an increase in child poverty for example) can have implications that require a new planning cycle to deal with the health effects of the change.

• Changed economic conditions may necessitate a new cycle of planning. If a major economic downturn occurs, for instance, a population's health may decline at the same time as governments constrain their spending on health – making a new "lean times" planning cycle necessary.

• Evaluation of the results of a planning cycle will often show weak spots in the initial planning, necessitating new cycles to correct for past oversights and miscalculations.

Most planning cycles (health or non-health) comprise seven basic steps that can be shown graphically.

Figure 2: The Planning Cycle



3.2 The Seven Steps to Health Planning

There are seven steps in a typical planning cycle as shown above. Below is a brief explanation of each step:

Step One – Surveying the Environment:

The first step in health planning is the analysis of the current situation. This often involves extensive information gathering to determine the health or illness profiles and experiences of the population of interest. It is meant to identify the **current state** of the issue under consideration. The different aspects to be studied are:

Population – age and sex structure
Morbidity and mortality values
Epidemiology and geographic distribution of the disease under consideration
Existing healthcare facilities
Technical manpower available
Facilities for training healthcare staff
Awareness of the community regarding the disease

Step Two – Setting Directions:

This involves setting goals and objectives, and it also involves establishing the standards against which current health/illness profiles, or current organisational or system performance, will be compared. This step is meant to identify the **desirable future state** (expressed as outcomes if possible) for the issue under consideration. In this step: List out the objectives and goals.

If there are no clear objectives and goals, a plan cannot be implemented efficiently
At the central level, the objectives would be more general and with each successive level, the objectives will become more specific

Step Three – Problems and Challenges:

This involves identifying and quantifying the shortfalls (if any) between what is and what ought to be.

Step Four – Range of Solutions:

This involves identifying the range of solutions to each identified problem or challenge. This step should also include assessing each possible solution in terms of its feasibility, cost and effectiveness so alternate solutions can be compared with each other.

This step often requires significant creativity, since no off-the-shelf solutions may be available for some problems and challenges.

Step Five – Best Solution(s):

This step involves a choice of the solution, or set of solutions, that should be implemented to address the problems or challenges identified in step three. The choice may need to take into account fiscal, political and other limitations.

Step Six – Implementation:

This step involves implementation of the chosen solutions, and often begins with development of an implementation plan.

Write up formulated plan

Once priorities are laid out, a systematic plan should be made to attain them
All the major steps should be included with the resources required for each step and the expected outcome

Programming and implementation

Once the plan has been approved, it has to be implemented
If not properly implemented, even a good plan will fail
Implementation requires proper administrative support

Step Seven – Evaluation:

This step involves evaluation of the results of implementation to determine whether the implemented solutions are effective in achieving their goals. It also involves evaluating the environment to see if it has changed, thereby rendering the solutions less effective, more effective or irrelevant. This step may begin with development of an evaluation plan well before evaluation actually takes place. It may also involve development of ongoing monitoring methods to be used to continuously identify and assess the intended and unintended consequences of implementation actions.

Monitoring -

Monitoring refers to the assessment of the day to day functioning of the program
Any suggestions for improvement should be implemented

Evaluation

Evaluation refers to the assessment of the final outcome of the plan
A good plan should have an in built evaluation system

These steps are listed as if they were purely linear steps, but feedback loops must be created between and among them; the complexities of the real world mean that what seems to make sense at one step may make less sense when seen from the perspective of a later step.

For instance, during step two (setting directions), planners may set a target for health improvement, only to find in step four (range of solutions) that none of the solutions comes anywhere near achieving the target without a change in provincial policy about how a service can be provided. The planner may therefore need to set a lower target (i.e., a target achievable within current policy), while also recommending that provincial policy be changed and that the target be changed if and when policy change takes place.

4.0 Summary

A disciplined approach to conducting health planning process was suggested in this unit. This involves using seven steps of surveying the environment, setting directions, identifying problems and challenges, proffering a range of solutions, choosing best solution(s), implementation and evaluation.

5.0 Conclusion

In this unit, it can be confidently stated that planning is the process which involves defining a problem, assessing the extent to which the problem affects the society, formulating goals with a view to solving the problem, assessing the various intervention measures based on their advantages and disadvantages, selecting the best mode of action, taking steps to implement it, monitoring the progress of the implemented system and evaluation of the results. Seven steps which are interrelated are therefore necessitated. In health planning these steps constitute a cycle that is normally repeated in terms of planning for programs, systems, populations or health goals. Repetition of the cycle is usually necessary because any or all of the following conditions prevail

6.0 Tutor Marked Assignment

List the seven steps required in carrying out a successful health planning process

7.0 References

Health System Intelligence Project (2006): The Planning Process, Ontario 2006.

McLaughlin, C. P., Kaluzny, A. D. (2004): Continuous Quality Improvement in Health Care: Theory, Implementation, and Applications Edition2, Jones & Bartlett Learning Publisher, 2004

Richard K. (2003): Health Services Planning Thomas, 2nd ed., 2003, 320 p. McGraw-Hill, 2003.

Williams, S. J., Torrens, P. R. (2008): Introduction to Health Services, Thomson Delmar Learning, Clifford, NY 2008

Williams, S. J. (2005): Essentials of Health Services (Thomson Delmar Learning Series in Health Services Administration) Edition3, Cengage Learning Publisher, 2005

Unit 5: Critical success factors in a Health Planning Process

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1.0 Introduction

As in any other endeavor, success depends on certain key variables whose absence may frustrate the achievement of set goals. This unit describes those factors that aid health planning process in achieving results in an effective manner.

2.0 Objectives

At the end of this unit, learners will:

Identify key factors for effective health planning process
Frame the right questions that will be specific to the actual advice required
Select the Process Relevant to the task
Identify and engage relevant stakeholders

3.0 Main Content

3.1 Defining the Right Question

The foremost critical success factor in a health planning process is to ensure that the question being addressed is the "right" question. What is meant by the "right" question?

The planning question should:

• be specific to the actual advice required

• be posed in terms that are easy to understand (e.g. free of unnecessary adjectives and acronyms)

• be at the correct altitude, to ensure the issue is expressed in the way that will elicit the maximum relevant advice.

Consider the following scenario and three potential questions for a health planning body:

• **Question 1:** What would be the impact of this move on the three communities?

• **Question 2:** What are the health needs of persons in the area currently being served by the three hospitals?

• **Question 3:** What would be the optimal configuration of hospital and community services to meet the current and projected future needs?

In this case it is reasonably predictable that access patterns would change and that people in at least two communities would fear loss of service and claim bias related to economic status. Thus the first question, while important, will be

stalled in the politics of the communities and the ethical considerations of any perceived reduction of access to service change. By proactively addressing the larger second question, the planning process would provide a more useful framework for looking at overall resource allocation in that area from a population perspective. Based on answers to the second question, the third question can then be properly answered, leading to identification of gaps and duplications, and helping to create service plans for both hospital and community services.

3.2 Choosing the Process Relevant to the Task

The second critical success factor is to decide what type of process is to be undertaken – usually a decision between strategic and operational planning. The outcome desired will define the planning focus – that is, whether it is a systems level task or service/program level task.

Regardless of which type of planning process is established, the discussions and strategies proposed must be based on best available data, usually a combination of health status, demographic and utilization data used in tandem with qualitative data obtained from activities such as surveys and key informant interviews. These are then aligned with knowledge about best practices as identified in evidenced-based literature or based on successful local initiatives.

The desired outcome will define the planning focus.

3.3 Engaging Stakeholders

The third key success factor is to decide who needs to be engaged in the planning and how the engagement will occur. The stakeholders who participate in the planning process are key to its success. Generally a range of perspectives should be at the table. When engaged in broad system planning at a strategic level, the goal will be to have experienced and recognized leaders and thinkers from the health sector, challenged and augmented by representatives from areas such as consumers, academia and the private sector.

There are several advantages to bringing together a diverse group:

• a broad range and depth of issues are explored

• the intended and unintended consequences of system change are considered

• the broader group will itself represent integrative thinking

• champions will emerge from a successful planning process.

Shorter term planning processes are often necessary when dollars become available toward the end of a fiscal period or when new funding announcements are made, requiring a quick plan for use of these resources.

In these instances it is expeditious to have the issue experts and current service providers (hospital clinical leaders, physicians) help develop the response. The plan will thus be driven primarily by provider realities and existing implementation opportunities.

3.4 Establishing Effective Project Management

The fourth critical success factor for health planning is effective project management. Process design and implementation, a key aspect of project management, should stimulate useful discussion and debate among key participants, who will be persons with knowledge relevant to the issue at hand. These persons may all be within the governmental or funder area, or may be multi-sector stakeholders brought together as part of a local systems process. In either case, dialogue may have to be coaxed out, or strictly managed to a tight time frame. The methods used to facilitate and build consensus within the discussion process will make or break the dynamics of the planning process.

3.5 Planning Within an Ethical Framework

An overlooked but important success factor in any planning project is transparent presentation of the project's ethics. Ethics in health planning is assumed, but not necessarily appropriately so. It is essential that the assumptions underlying decision-making processes be clearly stated. If the right people are involved, the right questions and information are addressed and the outputs are responsibly handled, the process will usually seem to have been done in an honest and ethical manner. Within this consideration, it will be easier to promote the ethics of a broad-based open input planning process than one that is done entirely behind the closed doors of the funder. However, even in the latter case, the results can be seen as sufficient as long as they are accompanied by explanation of data and evidence to support directions that have been determined.

When funding challenges arise, an ethical and consistent decision-making approach will be important. Dealing with resource decisions in a tight health care funding environment implies that some may gain while others may appear to lose from planning outcomes. The integrity of the process will be in question if the process is, or seems to be, poorly balanced in terms of its participants or founded on inadequate information.

3.6 Accessing and Applying Relevant Information

A taxonomy of human service planning information would include the following types of information.

"Hard data":

These data include many kinds of information used in both traditional and newer planning methodologies.

Hard data include:

• **Demographic data** (what are the characteristics of a population?)

• **Epidemiological and social indicator data** (what are the characteristics of social problems and health disorders within a population?)

• **Inventory data** (what are the numbers, types and characteristics of human service resources for a population – including the cost of these resources and the linkages among the resources?)

• **Utilization data** (how does a population use those resources?)

• **Outcome data** (what changes in social and health status do these resources produce for populations?)

Attitudinal and behavioral information:

This is information on the beliefs and attitudes of consumers and of providers concerning human service systems - it is the "sociology of well-being". For instance, a consumer may believe that physicians are better helpers than other human service professionals, and may behave on the basis of this belief by seeking out a physician rather than another professional, even in the face of hard outcome data suggesting that another professional (a nutritionist for example) may yield a better outcome for that consumer.

Ignoring attitudinal and behavioral information may produce a plan that makes logical sense based on hard data, but which is impossible to implement because:

• it flies in the face of what people believe and how they act

• or because it does not build in provisions for changing outmoded attitudes and behaviors.

It is essential that the assumptions about decision-making processes be clearly stated.

Expert opinion:

Both consumers and providers can be experts – a consumer may well be the expert on what it is like to be a consumer – and the provider may be an expert on specific approaches to improving social well-being and health.

Often these kinds of expertise are not easily modifiable as hard data, but they are still valuable sources of information. If one were planning an improvement in respiratory health, for instance, consumers might provide expertise on the emotional burdens of chronic lung disease. Similarly, a renowned environmental specialist might have great expertise in helping disadvantaged populations experiencing high rates of asthma.

Political process information:

Human service issues are often political, in terms of formal electoral politics as well as the politics of powerful stakeholders, particularly in formal human service systems. Knowledge of formal positions taken by political, bureaucratic or other social groupings may make the difference between a plan that will be implemented and a plan that will remain on a shelf.

In short, each of the information types can be characterized as follows:

• Hard data – the **facts** of human services

• Attitudinal and behavioral information – the **sociology** of human services

• Expert opinion – the **wisdom** of human services

• Political process information – the **politics** of human services.

Using Taxonomy:

Whether information taxonomy uses the categories of information outlined above – or any other set of categories – it can prove useful in helping planners make informed decisions about what kind of information to gather at each stage in the planning process.

Information Type / Planning Stage	Hard Data by Type					Attitudinal & Behavioral Information	Expert Opinion	Political Process Information
	Demographic	**Epidemiological**	**Inventory**	**Utilization**	**Outcome**			
1. What out to be?								
2. What is?								
3. Problems/ challenges (1-2)								
4. Range of solutions								
5. Best solution (s)								
6. Implement								
7. Evaluate								

Figure: Relative Volumes of Information Matrix

Often a simple matrix can help a planner or planning group decide what kinds and relative volumes of information should be gathered at each planning stage.

3.7 A Commitment to Monitoring and Evaluation

Planning is often cyclical, in the sense that one cycle of planning leads into the next cycle, so that planning is a continuous and iterative process that takes into account:

• changed circumstances

• the effects of implementation of previous planning.

However, one cycle of planning cannot learn from previous cycles unless monitoring and evaluation processes are put in place to determine the effects of previous planning cycles.

Many planning processes make it part and parcel of the process to identify the monitoring and evaluation processes and tools that are needed and to exert influence to ensure these processes and tools are developed and used.

One interesting variation on the use of monitoring and evaluation is "trajectory planning". This way of thinking assumes that the implementation of any

planning may encounter **turbulence** – much like the headwinds or tailwinds that aircraft experience during their trajectory from take-off point to landing point.

Trajectory planning uses monitoring tools to:

• identify turbulence

• determine whether that turbulence will aid or impede achievement of the plan's goals

• provide the basis for "mid-flight corrections" to help ensure that the plan achieves its goals.

4.0 Summary

The unit examines the major critical success factors for an effective health planning. These factors should be identified timely and addressed accordingly.

5.0 Conclusion

Conducting effective health care planning becomes less stressful if effort is devoted to identifying factors that are critical to the effective implementation of the process and achievement of goals.

6.0 Tutor Marked Assignment

Enumerate the main critical success factors required for an effective health planning process. Discuss any four.

7.0 References

Health System Intelligence Project (2006): The Planning Process, Ontario 2006.

McLaughlin, C. C., Kaluzny, A. D. (2004): Continuous Quality Improvement in Health Care: Theory, Implementation, and Applications Edition2, Jones & Bartlett Learning Publisher, 2004

Porter-O'Grady, T., Malloch, K. (2007): Quantum Leadership: A Resource For Health Care Innovation Edition2, Jones & Bartlett Learning Publisher, 2007

Richard, K (2003). Health Services Planning Thomas, 2nd ed., 2003, 320 p. McGraw-Hill, 2003.

Williams, S. J. (2008): Paul Roger Torrens: Introduction To Health Services, Thomson Delmar Learning, Clifford, NY 2008

Williams, S. J. (2005): Essentials of Health Services (Thomson Delmar Learning Series in Health Services Administration) Edition3, Cengage Learning Publisher, 2005

Unit 6: Strategic and Operational Planning

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1.0 Introduction

This unit explores the meaning of strategic and operational planning. It also distinguishes between the two concepts. The relevance of strategic and operational planning to an effective health planning was further highlighted. Tools that facilitate effective application of these concepts in health planning are also examined.

2.0 Objectives

At the end of this unit, learners will:

Define and distinguish between strategic and operational planning
Identify strategic and operational planning process components
Enumerate and discuss tools for effective strategic planning in health care
List and explain tools for effective strategic planning in health care

3.0 Main Content

3.1 Strategic Planning

A strategic planning process is used when there is a broad and open question to be answered, and many paths are on the table - for example, identifying the desired model for delivery of children's mental health services in rural settings and determining how to move to that model.

Usually a strategic planning process assumes a new look at an issue, and an outcome that will take time to put in place but will exist for a period longer than one funding cycle. Generally speaking it is assumed that a strategic plan will need to be revised or redone when the context in which the service exists changes markedly. A change in context could relate to challenges to sustainability, opportunities to expand, or newly identified best practices that should be incorporated into the plan.

A basic guideline for planning is that a vision should be renewed every three to five years and the strategic directions emanating from that vision also re-evaluated, perhaps yearly. A strategic planning exercise will include strategic goals and directions, and in some cases may also include specific implementation or operational planning components. For example in establishing a new local system of children's mental health services, specific budgets, service expectations, timetables and human resource models may be designed by the strategic planning group, for hand-off to providers.

The figure below illustrates a typical strategic planning approach, which calls for initial priority action areas, then yearly establishment of strategic directions within an umbrella framework.

Figure 8: Strategic Plan Model - Adapted from Vancouver Island Health Authority, Integration 2005

The Strategic Plan sets the overall direction for future service delivery to a specified year. It charts the move toward enhanced integration, responsiveness and innovation for all health services across the federation, states or local government.

In particular it outlines:

• priority issues in the health authority

• critical challenges to population health and service delivery in the specified location

• goals and strategic themes that will guide service delivery

• strategic directions by sector and by geographic area.

The Plan advances strategic thinking to include organisational restructuring, new and innovative service delivery models, and future capacity forecasts. It is aligned with the strategic direction of the Ministry of Health, recognizes the significant differences in demographics and health status throughout the health authority, and reflects clinical input and practical experience.

3.1 Strategic Planning Process Components

Within any strategic planning exercise the following activities will occur:

• a visioning exercise

• creating mission and goals

• establishing objectives

• establishing strategic directions

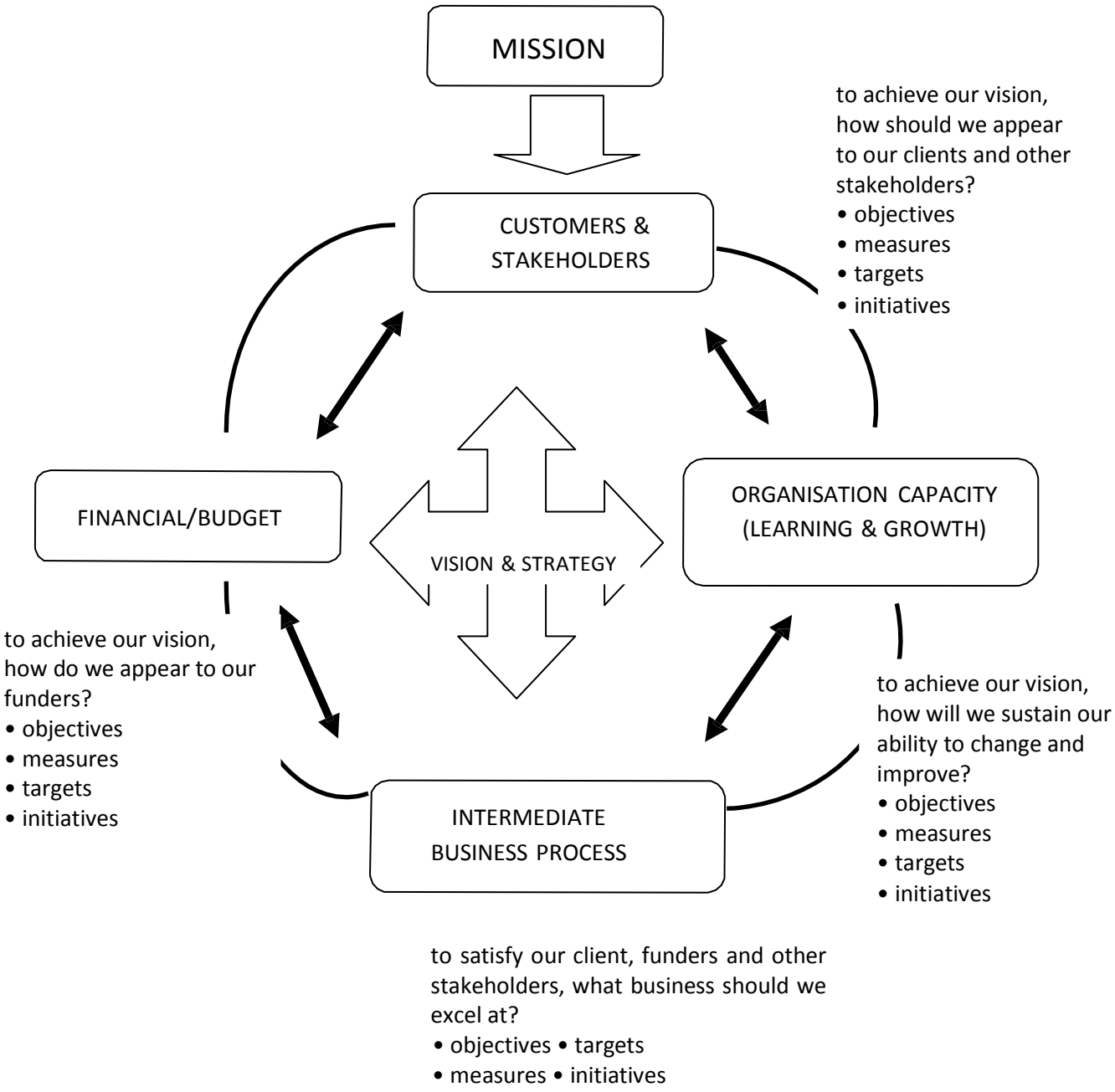
• developing a framework to establish and monitor success – a balanced scorecard approach for instance as shown in the figure below)

• creating an implementation plan/timetable.

Although originally developed for the corporate sector, the balanced scorecard has become popular within the health sector as a tool for both planning and monitoring.

The balanced scorecard suggests that an organization be viewed from four perspectives, and that data collection and analysis be carried out relative to each of these perspectives as in **Figure below**. In some instances it has taken the place of a more formalized and longer-term evaluation exercise.

Figure 9: Public Sector Balanced Scorecard: The Four Perspectives



Adapted from H. Rohm, Balanced Scorecard Institute Strategic planning processes should be supported by:

• use of data, both quantitative and qualitative

• consultation with stakeholders (related to all parts of the process, from visioning to data interpretation and crafting recommendations)

• application of project management and facilitation tools, which may include activities such as SWOT (strengths, weaknesses, opportunities and threats) analysis, mind-mapping and strategic alignment models

• monitoring and evaluation protocols.

3.3 Strategic Planning Tools

The development of a strategic plan for a whole health system is a large and potentially daunting task.

The best tools for strategic planning are often the ones that the person leading the planning is most familiar with and has used successfully in previous initiatives.

However, there are commonly accepted tools that bring rigour and consistency to strategic planning. Some of these are described below.

3.3.1 SWOT Analysis:

This is an outline of strengths, weaknesses, opportunities of, and threats to, the organisation. It is usually done at the start of a strategic planning exercise in a group setting, to identify all factors in each area.

The factors are usually organized in a table of four quadrants so participants in the planning exercise can visually (and easily) see the context for the planning.

• **strengths** include factors like staff capabilities, effective management processes, competitive advantage and unique programs or products.

• **weaknesses** include factors like gaps in staff skills, financial problems and inadequate information systems.

• **opportunities** include factors like global influences, new policy developments, partnerships and research.

• **threats** include factors like market demand, loss of key staff and political effects.

3.3.2 Affinity Diagrams:

An affinity diagram is a creative process used by a group to gather and organise ideas. It can be particularly powerful in a priority setting exercise.

The fundamentals of affinity exercises or diagrams are that:

• a problem or question is stated

• participants write down their thoughts or answers

• all the ideas are posted and then grouped by likeness of ideas or themes. Usually this results in a clear visual demonstration of areas of consensus on issues and responses.

3.3.3 Mind-Mapping:

A new way of visioning and planning, mind-mapping has made its way into both the standard flip chart based discussions, as well as computer based exercises.

It is a way of capturing ideas and organising information. It relies on pictorial representations of the flow and synthesis of ideas.

3.3.4 Mission Statement:

Key to any strategic planning exercise is the development of a vision and a clear mission statement.

The mission statement may be more difficult because it must express to all – employees, clients and other stakeholders – what the organization's current purpose is. It should be expressed at a high level, yet be rich in portraying purpose, values and business.

The mission statement should:

• express an organization's purpose in a way that inspires support and ongoing commitment

• motivate those who are connected to the organisation

• be articulated in a way that is convincing and easy to grasp

• use proactive verbs to describe what the organisation does

• be free of jargon

• be short enough so that anyone connected to the organisation can easily repeat it.

3.3.5. The Balanced Score Card

Strategic planning for some organizations incorporates the balanced scorecard approach. The balanced scorecard was developed in the early 1990s by Robert S. Kaplan and David P. Norton of the Harvard Business School. This new approach to strategic management was named the balanced scorecard to reflect the importance of measuring other factors to balance traditional financial

measurement. The balanced scorecard suggests that an organisation be viewed from four perspectives:

• learning and growth

• business process

• customer

• financial

Under the balanced scorecard approach, metrics, data and analysis should be developed and applied relative to each of these four perspectives.

Howard Rohm, Principal and Director of the Balanced Scorecard Institute, has adapted the balanced scorecard for public sector (See Figure 9 on page 16) in a way which uses slightly different concepts from the private sector approach (e.g. organisational capacity is substituted for learning and growth).

The balanced scorecard is not just a measurement approach. It is also an effective management tool to enable organisations to:

• clarify their vision and strategy

• translate them into action.

It provides feedback around both the internal business processes and the external outcomes in order to continuously improve strategic performance and results.

Kaplan and Norton describe the innovation of the balanced scorecard as follows:

"The balanced scorecard retains traditional financial measures. But financial measures tell the story of past events, an adequate story for industrial age companies for which investments in long term capabilities and customer relationships were not critical for success. Those financial measures are inadequate, however, for guiding and evaluating the journey that information age companies must take to create future value through investment in customers, suppliers, employees, processes, technology, and innovation."

Regardless of which terms are used, the balanced scorecard has been adopted by many health care organizations for planning and monitoring purposes.

3.4 Operational Planning

An operational planning process starts from a point of a specific objective, for example to increase the number of clients served through a primary care clinic at a Community Health Centre, and focuses on the range of opportunities within that delivery framework.

Operational planning will include:

• statement of purpose/deliverables/target to be achieved/success indicators

• use of available and relevant data and information

• stakeholder engagement (who needs to fund, deliver expanded services?)

• selection of priority action approach (new program design)

• developing an implementation timetable and budget.

Operational planning processes may be supported by activities or tools similar to those for strategic planning but with a tighter question applied to these activities.

Included in operational planning could be use of an activity hierarchy model and a program logic model.

Evaluation goals – process or outcome, quantitative or qualitative – must be considered at the front end of any new initiative.

3.5 Operational Planning Tools

3.5.1 Program Logic Model:

This model creates a diagram of the program and allows the effects of a proposed change to be determined. It is very helpful for program planning and implementation monitoring. A logic model depicts action by describing what the program is and what it will do – the sequence of events that links program investments to results. The model has six components:

• **Situation**: Problem or issue that the program is to address sits within a setting or situation from which priorities are set

• **Inputs**: resources, contributions and investments that are made in response to the situation. Inputs lead to

• **Outputs**: activities, services, events, and products that reach people and users. Outputs lead to

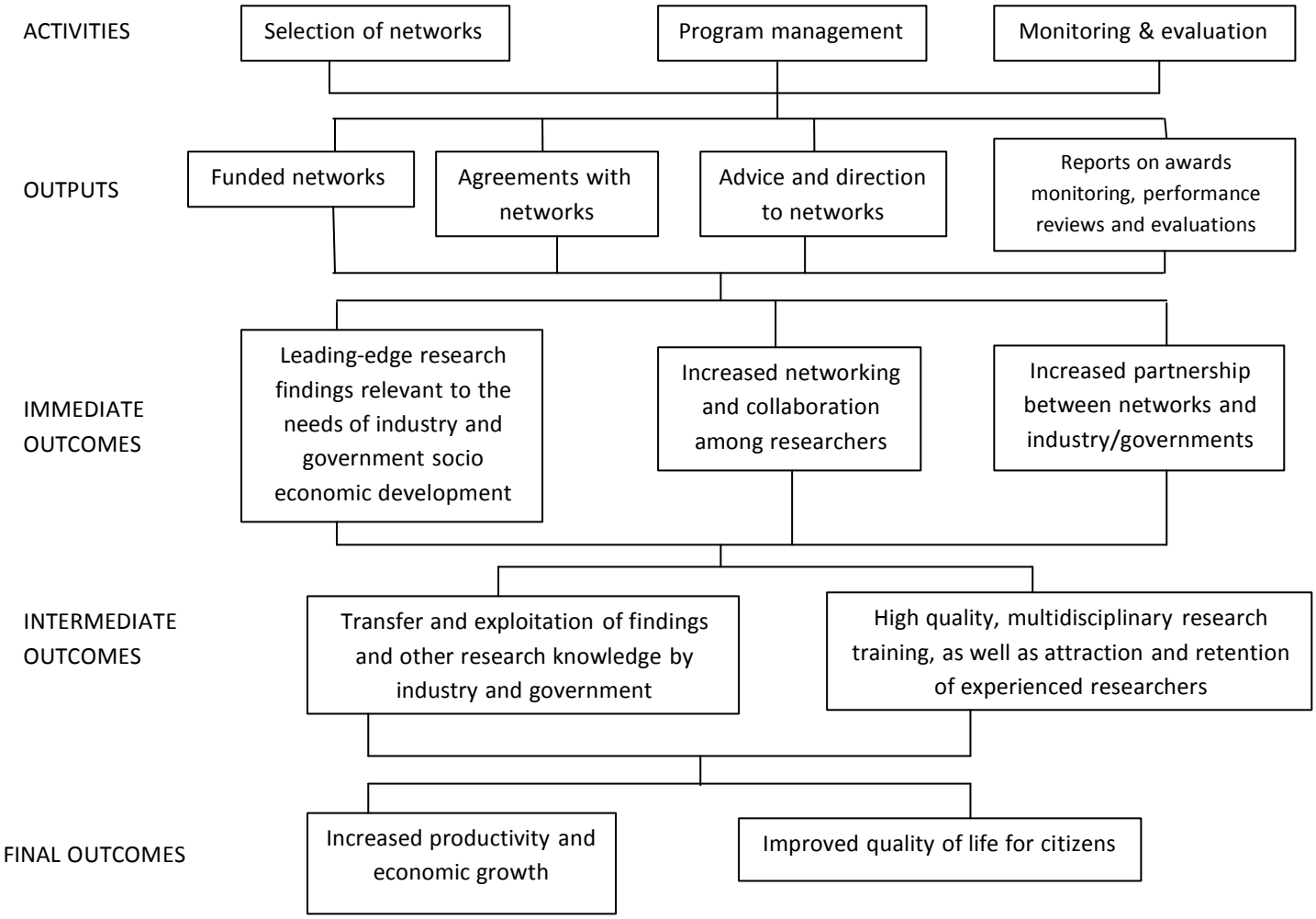
• **Outcomes**: results or changes for individuals, groups, agencies, communities or systems

• **Assumptions**: beliefs we have about the program, the people, the environment and the way we think the program is going to work

• **External factors**: environment in which the program exists includes a variety of external factors that interact with and influence the program action.

Below is a sample logic model/ framework.

Figure 10: Logic Model: Networks of Centres of Excellence



3.5.2 Context Diagram:

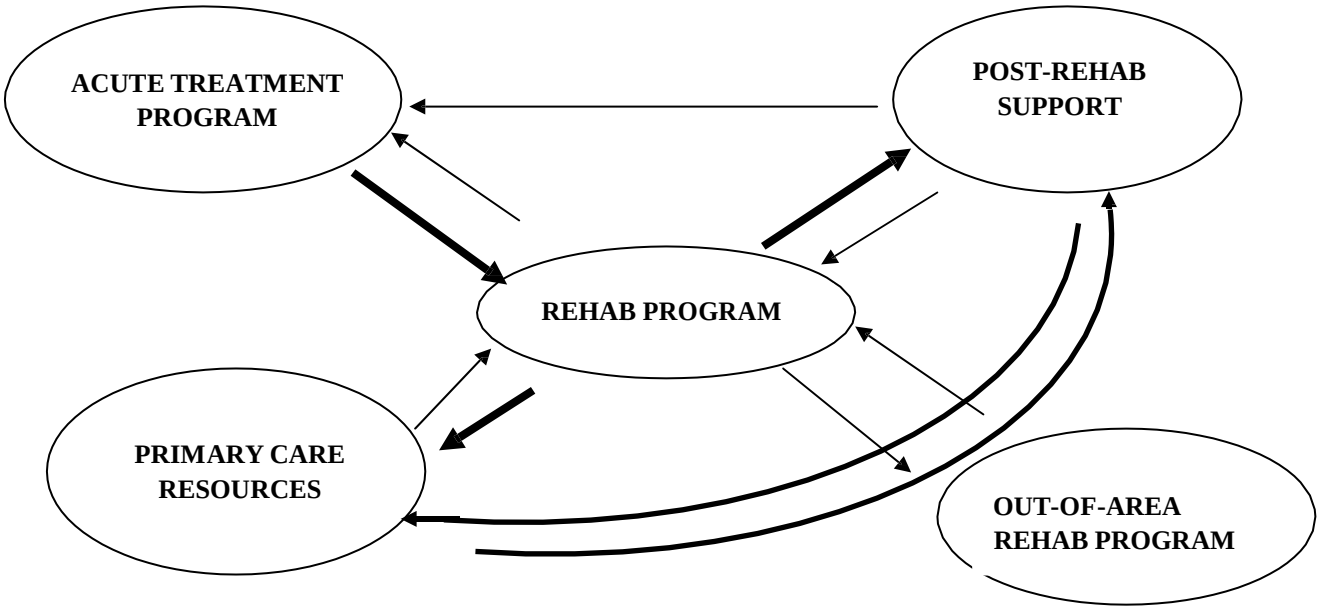
The context diagram is closely linked to SWOT analysis. A context diagram is a picture of the organisation or system and the other groups with which it shares relationships and information. It can show information flow and how well the flow is working. It can therefore highlight areas for improvement and identify opportunities for solidifying alliances and partnerships.

This diagram was developed by a group of persons who are familiar with the organisation and vetted by the whole group who are engaged in the strategic planning process. Many a times the people outside an organisation or system will see the context in a broader perspectives than those inside, and both internal and external perspectives should be captured.

The context diagram can be represented diagrammatic or as a written outline of relationships.

A simple context diagram might look like this:

Figure 11: A Typical Context Diagram



thickness of arrow = volume of client flow

3.5.3 Activity Hierarchy:

This tool visually shows the activities of an organisation, sector or system. At each level within the hierarchy, activities should be broken down into more detailed, discrete elements that are part of the larger activity described in the level above.

Activity hierarchies are useful for planning because they help create a clear picture of what a group does, or is accountable for doing, as part of its mandate. They can also show the impact of change in an organisation's activities or help in the development of new areas of business.

The core elements of an activity hierarchy diagram are:

• description of the organisation/sector/system

• the principal areas of activity

• the more elementary or sub activities that comprise those primary functions.

A hierarchy diagram can be organised in flow-chart format or in pyramidal form.

Figure 12: Ways to Present an Activity Hierarchy

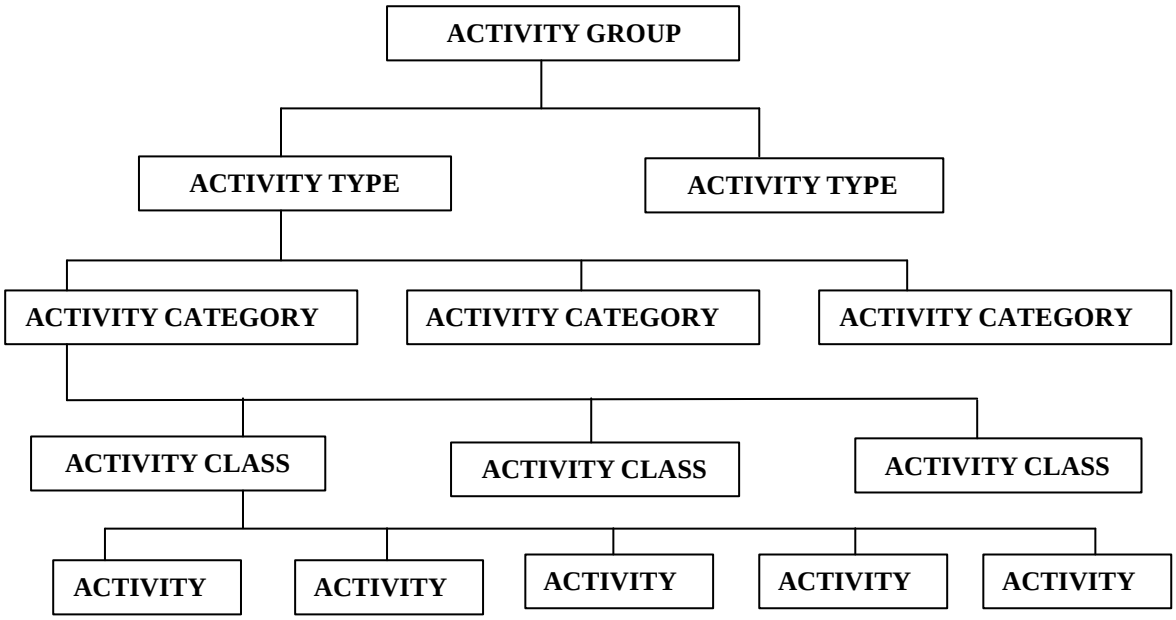
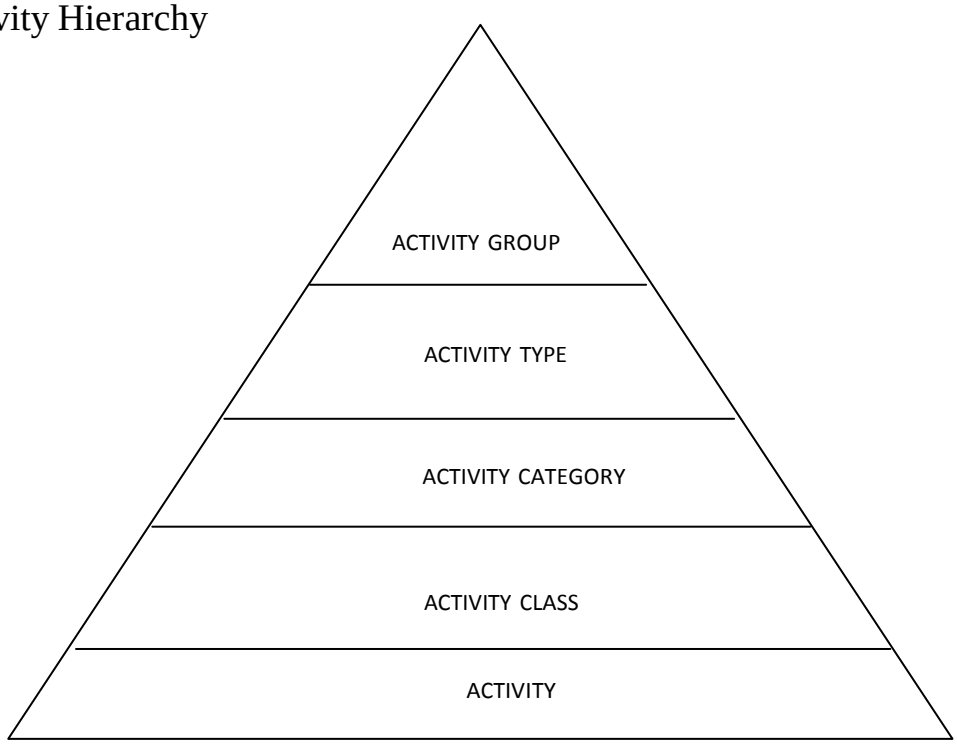


Figure: Activity Hierarchy



4.0 Summary

The concepts of strategic and operational planning were discussed in this unit. A clear distinction was made with respect to the two concepts. Furthermore, basic tools that facilitate the application of the respective concepts to health planning were discussed.

5.0 Conclusion

A strategic planning process is used when there is a broad and open question to be answered, and many paths are on the table - for example, identifying the desired model for delivery of children's mental health services in rural settings and determining how to move to that model. Whereas an operational planning process starts from a point of a specific objective, for example to increase the number of clients served through a primary care clinic at a Community Health Centre, and focuses on the range of opportunities within that delivery framework.

6.0 Tutor Marked Assignment

(i) Explain the concept of strategic planning as it relates to health planning. Identify the tools that help in its application in health care.

(ii) Explain the concept of operational planning as it relates to health planning. Identify the tools that help in its application in health care.

7.0 References

Health System Intelligence Project (2006): The Planning Process, Ontario 2006.

Levey, S., Loomba, N. P., Brown, R. E (1984): Health Care Administration: A Managerial Perspective Edition 2, Lippincott Publisher, 1984

McLaughlin, C. P., Kaluzny, A. D (2004): Continuous Quality Improvement in Health Care: Theory, Implementation, and Applications Edition2, Jones & Bartlett Learning Publisher, 2004

Porter-O'Grady, T., Falloch, K (2007): Quantum Leadership: A Resource for Health Care Innovation Edition2, Jones & Bartlett Learning Publisher, 2007

Richard K. (2003): Health Services Planning Thomas, 2nd ed., 2003, 320 p. McGraw-Hill, 2003.

Williams, S. J (2005): Essentials of Health Services (Thomson Delmar Learning Series in Health Services Administration) Edition3, Cengage Learning Publisher, 2005

Unit 7: Health Policy

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1.0 Introduction

This unit answers the following questions: What is a policy? What is health policy? What are the steps in public policy formulation? What are the objectives of health policy and what factors influence policy formulation, implementation and outcomes?

2.0 Objectives

At the end of this unit, learners will:

Define the concept policy and health policy
List and discuss the steps required for formulating policy
Identify objectives of health policy
Enumerate factors that influence policy formulation, implementation and outcomes

3.0 Main Content

3.1 What is Policy?

According to a dictionary definition, policy is "any course of action followed primarily because it is expedient or advantageous in a material sense". As a political theme, 'Public Policy is a concept (usually in a written document), whereby the government or a political party will determine decisions, actions and other matters that will prove advantages to society in general'.

Policies can also be looked at as the principle (be it values, interests and resources) that underlines the actions that should take place to solve public issues. This may be administered through state or federal action such as legislation, regulations and administrative practices.

The starting point for anyone who is producing policies is to realize that there needn't always be consistency in them. This is mainly because the values of society are continuously changing, and policies being the representation of society's preferences and ideals, must change with them. It is at this broad level that policy becomes a complex interplay of "social and economic decisions, prevailing ideas, institutions and individuals, technical and analytical procedures, and general theories about the way policy is made"(Concept by Hawker, Smith and Weller). All of these factors when taken into account will determine how the new policy will affect the following:

- Private Citizens
- Companies

- Corporations
- Associations

There is no right or wrong policy. But the foremost will be one that addresses the masses, and reflects their social values.

Considering that public policy is an action taken by the government that ultimately affects the public, it has been recognized that even when an area of activity is left in private hands, the very act of it being left alone can be viewed as a deliberate policy of the authorities. This could possibly be because the general societies needs did not need to be altered, or because the body that the activity was delegated to will make the necessary changes in the place of the government; possibly because they understand social issues better because of their standing within society, for example local councils.

Many factors influence why a policy is created. Lobby groups, political parties, single issue coalitions, industrial councils, unions and pressure groups play a very active role in this, mainly because their vast size through social support which allows them to contest issues. For a government not to listen and then act on their requests would almost mean certain suicide. This is especially true around election time, when the government also makes a lot of policies that will be looked upon favorably by the voters, and thus help the government in their plight to be re-elected. It must however be acknowledged, that not all large groups such as unions, are given whatever they want especially if it will be a burden to the rest of society.

In general, the purpose of government is to add value to the lives of the people it serves, and this can only be achieved through good policy making. Policies should express and embody society's needs and values, and this is achieved through the comprehensive use of politics involving cooperation from groups outside the government body.

3.2 Definition of policy

The word "policy" is a very elastic term and hence a working definition is required.

A "policy" is very much like a decision or a set of decisions, and we "make", "implement" or "carry out" a policy just as we do with decisions. Like a decision a policy is not itself a statement, nor is it only a set of actions, although, as with decisions, we can infer what a person's or organization's policy is either from the statement he makes about it, or, if he makes no statement or we don't believe his statement from the way he acts. But, equally, we can claim that a statement or set of actions is misleading and does not faithfully reflect the "true" policy.

In some other ways a policy is not like a decision. The term policy usually implies some long-term purpose in a broad subject field (e.g. land tenure), not a series of ad-hoc judgments in unrelated fields. Sometimes, however, policy is conceived not so much as actively purpose oriented but rather as a fairly cohesive set of responses to a problem that has arisen. In the sphere of government development activities, governments have policies, plans, programmes and projects, each of these in succession being a little more short-term, more specific in place and timing than the previous and each successively more executive rather than legislative.

In the light of these considerations, a policy can be defined as a set of decisions which are oriented towards a long-term purpose or to a particular problem. Such decisions by governments are often embodied in legislation and usually apply to a country as a whole rather than to one part of it.

3.3 Objectives and instruments of policy

It is necessary to distinguish three rather different functions in relation to policies.

3.3.1 Policy Making

Firstly there is policy making the act of making the decisions concerned, and policy-making is naturally the prerogative of senior people just how senior depending on the importance of the policy concerned.

3.3.2 Policy Implementation

Secondly there is policy implementation - the executive activity of carrying out the decisions made.

3.3.3 Policy Analysis

Thirdly there is policy analysis the activity of identifying different policy choices and of examining the actual or possible impact of these alternative policies to see how successfully they comply with the policies' objectives**.** Policy-making, policy implementation and policy analysis may all be carried out by the same people, but in countries wealthy enough to afford the trained manpower policy implementation and analysis are often carried out by specialist groups of middle-level officials who advise and receive instructions from the top-level policy makers. This paper is not substantially concerned with policy implementation.

Implicit in the concept of having or making a policy is that one has a choice or option to have this policy or some other one. If, in practice, there is no choice then there can be no policy either. However in considering options it is

necessary to distinguish choices between the objectives of policy - including the objective of overcoming particular problems that have arisen - and choices between the different instruments, i.e. methods, by which these objectives are to be achieved. Objectives and instruments are conceptually distinct and both are integral to having a policy. However, Thomson and Rayner, (1984) restricts the scope of the term to policy instruments.

3.4 Factors influencing policy formulation, implementation and outcomes

Several key factors influence the success of health policies among which are:

1. The context in which the policy operates is important. Formulating a policy requires a good understanding of local needs, opportunities and constraints (population needs, capacities and commitment of local actors).
2. A variety of stakeholders must be taken into account. Health systems depend among others on support from donors, adhesion from the population and commitment of the health workers. It calls respectively for a convincing attitude from the government, specific measure to empower the population and civil society, and complementary measures on the supply side to foster quality and accountability (regulation, incentives and norms).
3. No single health assistance scheme is sufficient to meet the needs of entire populations and it is often better to target specific groups. Policy development must be seen as a search for complementarities and synergies between health financing and health assistance mechanisms
4. Political commitment is of key importance for nationwide strategies. The strategy must integrate a wider arena than only the health sector, as caring for the poor is more than a technical issue. Others ministries (e.g. social welfare) may be involved.
5. Finally, there are no universal solutions, as the strategy depends and impact on the whole institutional setup. It is important to know which conditions made a policy possible, and how this policy changes its environment. It is always the result of a sustained approach that allows adaptation over time in response to experience and changing environment.

3.5 Main Steps In the Public Policy Process

There are four typical and main steps in the public policy process:

1. identifying a problem,
2. formulating a policy,
3. implementing the policy change, and
4. evaluating the result.

Each step is usually followed in the order listed to make sure that the process is done correctly. In many cases, these "steps" are turned into a cycle, with each step being repeated as changes occur; when a policy is evaluated, for example,

it may reveal new problems that need to be addressed. In general, the public policy process can be seen as the steps a government takes to act on behalf of the public.

Though the terminology used to explain the policy process may differ, each step in the process is focused on the same general purpose. The actual process itself may also vary occasionally, depending on the policy in question. Despite these differences, a look at the general steps most governments, or governmental bodies, follow in most situations can provide insight into how the process generally works.

3.5.1 Identifying the Problem

The first step in the public policy process is to outline the problem. This involves not only recognizing that an issue exists, but also studying the problem and its causes in detail. This stage involves determining how aware the public is of the issue, deciding who will participate in fixing it, and considering what means are available to accomplish a solution. Answers to such questions often help policy makers gauge which policy changes, if any, are needed to address the identified problem. The agenda — which problems are addressed — can be set by the public, special interest groups, or government officials, among others.

3.5.2 Formulating a Policy to Resolve the Problem

After identifying and studying the problem, a new public policy may be formulated or developed. This step is typically marked by discussion and debate between government officials, interest groups, and individual citizens to identify potential obstacles, to suggest alternative solutions, and to set clear goals and list the steps that need to be taken to achieve them. This part of the process can be difficult, and often compromises will be required before the policy can be written. Once the policy is developed, the proper authorities must agreed to it; a weaker policy may be more likely to pass, where a stronger one that deals with the problem more directly might not have enough support to gain approval.

3.5.3 Implementing the Policy Change

A new policy must be put into effect, which typically requires determining which organizations or agencies will be responsible for carrying it out. This is the third step of the public policy process, and one that can be difficult if the people who are tasked with carrying out the policy are not committed to complying with it. During the policy development step, compromises may have been made to get the policy passed that those who are ultimately required to help carry it out do not agree with; as such, they are unlikely to enforce it effectively. Clear communication and coordination, as well as sufficient funding, are also needed to make this step a success.

3.5.4 Evaluating the Effect of the Policy Change

The final stage in the public policy process, known as evaluation, is typically ongoing. This step usually involves a study of how effective the new policy has been in addressing the original problem, which often leads to additional public policy changes. It also includes reviewing funds and resources available to ensure that the policy can be maintained. Historically, this step has not always been treated as very important, but policy makers are increasingly finding ways to make sure that the tools needed for evaluation are included in each step of the public policy process.

4.0 Summary

The unit explained the concept of public policy, its objectives and steps required for formulating policy. The various factors that influence policy formulation, implementation and outcomes were also explored.

5.0 Conclusion

The purpose of government is to add value to the lives of the people it serves. This is better achieved through good policy making. Policies should express and embody society's needs and values. This is also achieved through the comprehensive use of politics involving cooperation from groups outside the government body.

6.0 Tutor Marked Assignment

Explain the concept of policy. What are the steps required in formulating policies? Identify the factors that influence policy formulation, implementation and outcomes.

7.0 References

Levey, S., Loomba, N. P., Brown, R. E., (1984): Health Care Administration: A Managerial Perspective Edition 2, Lippincott Publisher, 1984

Plocher, D. W., Metzger, P. L. (2001): The Case Manager's Training Manual Edition, Jones & Bartlett Learning Publisher, 2001

Porter-O'Grady, T., Malloch, K. (2007): Quantum Leadership: A Resource For Health Care Innovation Edition2, Jones & Bartlett Learning Publisher, 2007

Williams, S. W. (2005): Essentials of Health Services (Thomson Delmar Learning Series in Health Services Administration) Edition3, Cengage Learning Publisher, 2005

Unit 8: Historical Development of Formalized Health Planning in Nigeria

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1.0 Introduction

In this unit, the historical development of health care system in Nigeria is discussed. It started with the role of traditional medicine which still continued to play an important role in Nigeria. The World War II brought about provision of modern health care to Nigeria and has been since. This unit also identifies notable accomplishments in the expansion of medical education, the improvement of public health care, the control of many contagious diseases and disease vectors, and the provision of primary health care in many urban and rural areas. It further recognized the large increase in vaccination against major childhood diseases and a significant expansion of primary health care became the cornerstones of the government's health policies since the 1980's.

2.0 Objectives

At the end of this unit, learners will:

Trace the history of modern health care in Nigeria
Appreciate the role of traditional medicine in the country

Identify the role of modern medicine and role of missionaries

3.0 Main Content

3.1 Background Information

Whereas traditional medicine continued to play an important role in Nigeria in 1990, the country made great strides in the provision of modern health care to its population in the years since World War II, particularly in the period after independence. Among the most notable accomplishments were the expansion of medical education, the improvement of public health care, the control of many contagious diseases and disease vectors, and the provision of primary health care in many urban and rural areas. In the late 1980s, a large increase in vaccination against major childhood diseases and a significant expansion of primary health care became the cornerstones of the government's health policies.

Nonetheless, many problems remained in 1990. Sharp disparities persisted in the availability of medical facilities among the regions, rural and urban areas, and socioeconomic classes. The severe economic stresses of the late 1980s had serious impacts throughout the country on the availability of medical supplies, drugs, equipment, and personnel. In the rapidly growing cities, inadequate sanitation and water supply increased the threat of infectious disease, while health care facilities were generally not able to keep pace with the rate of urban population growth. There were several serious outbreaks of infectious diseases during the 1980s, including cerebrospinal meningitis and yellow fever, for which, especially in rural areas, treatment or preventive immunization was often difficult to obtain. Chronic diseases, such as malaria and guinea worm, continued to resist efforts to reduce their incidence in many areas. The presence of acquired immune deficiency syndrome (AIDS) in Nigeria was confirmed by 1987 and appeared to be growing.

3.2 History of Modern Medical Services

Western medicine was not formally introduced into Nigeria until the 1860s, when the Sacred Heart Hospital was established by Roman Catholic missionaries in Abeokuta. Throughout the ensuing colonial period, the religious missions played a major role in the supply of modern health care facilities in Nigeria. The Roman Catholic missions predominated, accounting for about 40 percent of the total number of mission-based hospital beds by 1960. By that time, mission hospitals somewhat exceeded government hospitals in number: 118 mission hospitals, compared with 101 government hospitals.

Mission-based facilities were concentrated in certain areas, depending on the religious and other activities of the missions. Roman Catholic hospitals in particular were concentrated in the southeastern and Midwestern areas. By 1954

almost all the hospitals in the Midwestern part of the country were operated by Roman Catholic missions. The next largest sponsors of mission hospitals were, respectively, the Sudan United Mission, which concentrated on middle belt areas, and the Sudan Interior Mission, which worked in the Islamic north. Together they operated twenty-five hospitals or other facilities in the northern half of the country. Many of the mission hospitals remained important components of the health care network in the north in 1990.

The missions also played an important role in medical training and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe, for many of the first generation of Western-educated Nigerian doctors. In addition, the general education provided by the missions for many Nigerians helped to lay the groundwork for a wider distribution and acceptance of modern medical care.

The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centers in the 1870s. Unlike the missionary facilities, these were, at least initially, solely for the use of Europeans. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there. The hospital in Jos, for example, was founded in 1912 after the initiation there of tin mining.

World War I had a strong detrimental effect on medical services in Nigeria because of the large number of medical personnel, both European and African, who were pulled out to serve in Europe. After the war, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established. Nigerian physicians, even if trained in Europe, were, however, generally prohibited from practicing in government hospitals unless they were serving African patients. This practice led to protests and to frequent involvement by doctors and other medical personnel in the nationalist movements of the period.

After World War II, partly in response to nationalist agitation, the colonial government tried to extend modern health and education facilities to much of the Nigerian population. A ten-year health development plan was announced in 1946. The University of Ibadan was founded in 1948; it included the country's first full faculty of medicine and university hospital, still known as University College Hospital. A number of nursing schools were established, as were two schools of pharmacy; by 1960 there were sixty-five government nursing or midwifery training schools. The 1946 health plan established the Ministry of Health to coordinate health services throughout the country, including those provided by the government, by private companies, and by the missions. The plan also budgeted funds for hospitals and clinics, most of which were concentrated in the main cities; little funding was allocated for rural health

centers. There was also a strong imbalance between the appropriations of facilities to southern areas, compared with those in the north.

By 1979 there were 562 general hospitals, supplemented by 16 maternity and/or pediatric hospitals, 11 armed forces hospitals, 6 teaching hospitals, and 3 prison hospitals. Altogether they accounted for about 44,600 hospital beds. In addition, general health centers were estimated to total slightly less than 600; general clinics 2,740; maternity homes 930; and maternal health centers 1,240.

Ownership of health establishments was divided among federal, state, and local governments, and there were privately owned facilities. Whereas the great majority of health establishments were government owned, there were a growing number of private institutions through the 1980s. By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospital beds); 3,023 owned by state governments (47 percent of hospital beds); 6,331 owned by local governments (11 percent of hospital beds); and 1,436 privately owned establishments (providing 14 percent of hospital beds).

The problems of geographic maldistribution of medical facilities among the regions and of the inadequacy of rural facilities persisted. By 1980 the ratios were an estimated 3,800 people per hospital bed in the north (Borno, Kaduna, Kano, Niger, and Sokoto states); 2,200 per bed in the middle belt (Bauchi, Benue, Gongola, Kwara, and Plateau states); 1,300 per bed in the southeast (Anambra, Cross River, Imo, and Rivers states); and 800 per bed in the southwest (Bendel, Lagos, Ogun, Ondo, and Oyo states). There were also significant disparities within each of the regions. For example, in 1980 there were an estimated 2,600 people per physician in Lagos State, compared with 38,000 per physician in the much more rural Ondo State.

In a comparison of the distribution of hospitals between urban and rural areas in 1980, Dennis Ityavyar found that whereas approximately 80 percent of the population of those states lived in rural regions, only 42 percent of hospitals were located in those areas. The maldistribution of physicians was even more marked because few trained doctors who had a choice wanted to live in rural areas. Many of the doctors who did work in rural areas were there as part of their required service in the National Youth Service Corps, established in 1973. Few, however, remained in remote areas beyond their required term.

Hospitals were divided into general wards, which provided both outpatient and inpatient care for a small fee, and amenity wards, which charged higher fees but provided better conditions. The general wards were usually very crowded, and there were long waits for registration as well as for treatment. Patients frequently did not see a doctor, but only a nurse or other practitioner. Many types of drugs were not available at the hospital pharmacy; those that were available were usually dispensed without containers, meaning the patients had

to provide their own. The inpatient wards were extremely crowded; beds were in corridors and even consisted of mattresses on floors. Food was free for very poor patients who had no one to provide for them. Most, however, had relatives or friends present, who prepared or brought food and often stayed in the hospital with the patient. By contrast, in the amenity wards available to wealthier or elite patients, food and better care were provided, and drug availability was greater. The highest level of the Nigerian elite frequently traveled abroad for medical care, particularly when a serious medical problem existed.

In the early 1980s, because of shortages of fuel and spare parts, much expensive medical equipment could not be operated. Currency devaluation and structural adjustment beginning in 1986 exacerbated these conditions. Imported goods of all types doubled or tripled in price and government and public health care facilities were severely affected by rising costs, government budget cuts, and materials shortages of the late 1980s. Partly as a result of these problems, privately owned health care facilities became increasingly important in the late 1980s. The demand for modern medical care far outstripped its availability. Medical personnel, drugs, and equipment were increasingly diverted to the private sector as government hospitals deteriorated.

Government health policies increasingly had become an issue of policy debate and public contention in the late 1980s. The issue emerged during the Constituent Assembly held in 1989 to draft a proposed constitution. The original draft reported by the assembly included a clause specifying that free and adequate health care was to be available as a matter of right to all Nigerians within certain categories. The categories included all children younger than eighteen; all people sixty-five and older; and all those physically disabled or handicapped. This provision was, however, deleted by the president and the governing council when they reviewed the draft constitution.

3.3 Primary Health Care Policies

In August 1987, the Federal Government launched its Primary Health Care plan (PHC), which President Ibrahim Babangida announced as the cornerstone of health policy. Intended to affect the entire national population, its main stated objectives included accelerated health care personnel development; improved collection and monitoring of health data; ensured availability of essential drugs in all areas of the country; implementation of an Expanded Programme on Immunization (EPI); improved nutrition throughout the country; promotion of health awareness; development of a national family health program; and widespread promotion of oral rehydration therapy for treatment of diarrheal disease in infants and children. Implementation of these programs was intended to take place mainly through collaboration between the Ministry of Health and participating local government councils, which received direct grants from the federal government.

Of these objectives, the EPI was the most concrete and probably made the greatest progress initially. The immunization program focused on four major childhood diseases: pertussis, diphtheria, measles, and polio, and tetanus and tuberculosis. Its aim was to increase dramatically the proportion of immunized children younger than two from about 20 percent to 50 percent initially, and to 90 percent by the end of 1990. Launched in March 1988, the program by August 1989 was said to have been established in more than 300 of 449 LGAs. Although the program was said to have made much progress, its goal of 90 percent coverage was probably excessively ambitious, especially in view of the economic strains of structural adjustment that permeated the Nigerian economy throughout the late 1980s.

The government's population control program also came partially under the PHC. By the late 1980s, the official policy was strongly to encourage women to have no more than four children, which would represent a substantial reduction from the estimated fertility rate of almost seven children per woman in 1987. No official sanctions were attached to the government's population policy, but birth control information and contraceptive supplies were available in many health facilities.

The federal government also sought to improve the availability of pharmaceutical drugs. Foreign exchange had to be released for essential drug imports, so the government attempted to encourage local drug manufacture; because raw materials for local drug manufacture had to be imported, however, costs were reduced only partially. For Nigeria both to limit its foreign exchange expenditures and simultaneously to implement massive expansion in primary health care, foreign assistance would probably be needed. Despite advances against many infectious diseases, Nigeria's population continued through the 1980s to be subject to several major diseases, some of which occurred in acute outbreaks causing hundreds or thousands of deaths, while others recurred chronically, causing large-scale infection and debilitation. Among the former were cerebrospinal meningitis, yellow fever, Lassa fever and, most recently, AIDS; the latter included malaria, guinea worm, schistosomiasis (bilharzias), and onchocerciasis (river blindness). Malnutrition and its attendant diseases also continued to be a refractory problem among infants and children in many areas, despite the nation's economic and agricultural advances.

Among the worst of the acute diseases was cerebrospinal meningitis, a potentially fatal inflammation of the membranes of the brain and spinal cord, which can recur in periodic epidemic outbreaks. Northern Nigeria is one of the most heavily populated regions in what is considered the meningitis belt of Africa, stretching from Senegal to Sudan and all areas having a long dry season and low humidity between December and April. The disease plagued the northern and middle belt areas in 1986 and 1989, generally appearing during the cool, dry harmattan season when people spend more time indoors, promoting

contagious spread. Paralysis, and often death, can occur within forty-eight hours of the first symptoms.

In response to the outbreaks, the federal and state governments in 1989 attempted mass immunization in the affected regions. Authorities pointed, however, to the difficulty of storing vaccines in the harsh conditions of northern areas, many of which also had poor roads and inadequate medical facilities.

Beginning in November 1986 and for several months thereafter, a large outbreak of yellow fever occurred in scattered areas. The most heavily affected were the states of Oyo, Imo, Anambra, and Cross River in the south, Benue and Niger in the middle belt, and Kaduna and Sokoto in the north. There were at least several hundred deaths. Fourteen million doses of vaccine were distributed with international assistance, and the outbreak was brought under control.

Lassa fever, a highly contagious and virulent viral disease, appeared periodically in the 1980s in various areas. The disease was first identified in 1969 in the northeast Nigerian town of Lassa. It is believed that rats and other rodents are reservoirs of the virus, and that transmission to humans can occur through droppings or food contamination in and around homes. Mortality rates can be high, and there is no known treatment.

The presence of AIDS in Nigeria was officially confirmed in 1987, considerably later than its appearance and wide dispersion in much of East and Central Africa. In March 1987, the minister of health announced that tests of a pool of blood samples collected from high risk groups had turned up two confirmed cases of AIDS, both HIV Type-1 strains. Subsequently, HIV-2, a somewhat less virulent strain found mainly in West Africa, was also confirmed. In 1990 the infection rate for either virus in Nigeria was thought to be below 1 percent of the population.

Less dramatic than the acute infectious diseases but often equally destructive were a host of chronic diseases that were serious and widespread but only occasionally resulted in death. Of these the most common was malaria, including cerebral malaria, which can be fatal. The guinea worm parasite, which is spread through ingestion of contaminated water, is endemic in many rural areas, causing recurring illness and occasionally permanently crippling its victims. The World Health Organization (WHO) in 1987 estimated that there were 3 million cases of guinea worm in Nigeria--about 2 percent of the world total of 140 million cases- -making Nigeria the nation with the highest number of guinea worm cases. In affected areas, guinea worm and related complications were estimated to be the major cause of work and school absenteeism.

Virtually all affected states had campaigns under way to eradicate the disease through education and provision of pure drinking water supplies to rural villages. The government has set an ambitious target of full eradication by 1995,

with extensive assistance from the Japanese government, Global 2000, and numerous other international donors.

The parasitic diseases onchocerciasis and schistosomiasis, both associated with bodies of water, were found in parts of Nigeria. Onchocerciasis is caused by filarial worms transmitted by small black flies that typically live and breed near rapidly flowing water. The worms can damage the eyes and optic nerve and can cause blindness by young adulthood or later. In some villages near the Volta River tributaries where the disease is endemic, up to 20 percent of adults older than thirty are blind because of the disease. Most control efforts have focused on a dual strategy of treating the sufferers and trying to eliminate the flies, usually with insecticide sprays. The flies and the disease are most common in the lowland savanna areas of the middle belt.

Schistosomiasis is caused by blood flukes, which use freshwater snails as an intermediate host and invade humans when the larvae penetrate the skin of people entering a pond, lake, or stream in which the snails live. Most often, schistosomiasis results in chronic debilitation rather than acute illness.

4.0 Summary

In this unit, the historical development of health care system in Nigeria is discussed. Role of traditional medicine played was studied. The World War II however brought about provision of modern health care to Nigeria. Some of the accomplishments during this era include: expansion of medical education, improvement of public health care, the control of many contagious diseases and disease vectors, and provision of primary health care in many urban and rural areas. In addition, it recognized the large increase in vaccination against major childhood diseases and a significant expansion of primary health care became the cornerstones of the government's health policies since the 1980’s.

5.0 Conclusion

The modern health care as we have it today started from the traditional. In view of the different administrations in the country, different policies were implemented in health care delivery. However, there is still a long way to go if the future of the citizens is to be guaranteed.

6.0 Tutor Marked Assignment

(a) Briefly trace the history of modern health care in Nigeria. (b) Explain the Primary Health Care Policies of Nigeria in the early 1980's

7.0 References

Abosade, O. (2003): Primary Health Care in Medical Education in Nigeria University of Lagos Press 2003.

Abubakar B.D. (2007): The Administration of Community Health Services in Nigeria Taninwla Press, Ilorin

Nwangwu, P. U., *M.Sc., Pharm.D., Ph.D:* Healthcare Delivery in Nigeria: Contributions of Nigerians in Diaspora: Address To the Convention of Nigerian Professionals in Diaspora, At Paris, France: www.nwangwu.com/.../HEALTHCARE%20DELIVERY%20IN%20NIGERIA.doc

Major Issues Facing Nigeria from Colonial Times to the Present *www.africaw.com/.../major-issues-facing-nigeria-from-colonial-times-to-t2112/*

UNIT 9: THE NIGERIAN HEALTH SYSTEM

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1.0 Introduction

Although, this course is concern with ethics, community health professional ethics, morality and other related concepts as well as regulatory bodies. It would be difficult to discuss all of the above without first discussing the Nigerian health system and community health practice.

Thus, this in unit we shall focus on the Nigerian health system, because this will give us the required background knowledge to be able to discuss ethical and non-ethical issues as well as regulating matters connected therewith. And in considering the Nigerian health system we shall take a snap shot at the concept of system, health system, history of health services in Nigeria, the levels of health service delivery and finally the responsibilities of the various levels of government in health service delivery.

2.0 Objectives

At end of studying this unit the learner should be able to:

Define systems
Define health system
Narrate the history of health services in Nigeria
State the various levels of health service delivery
State the responsibilities of the various tiers of government

3.0 Main Content

3.1 Definition of System

According to Martin and Powell (1992) "a system is a collection of entities which are interrelated to each other and to their environment so they form a whole".

While the Oxford Advanced Learner's Dictionary defined system as a group of things or systems working together as a whole.

From the two above definition you can see clearly that when we talking about system, we are referring to several things working together in unity under the control of one entity for efficiency or optimization.

It also means different things doing different work but less than one entity or whole for the successful functioning of that entity or whole. Thus in any system there are always subsystems that are constantly interacting.

3.2 Health System

According to Adundu (2007) "The health system is simply an amalgam of various elements, part or subsystems that are interrelated interdependent, and rely on each other's contribution for attainment of set health objective success or failure in one part affects the entire system".

She went a step further to argue that a health system comprises of functionally interrelated components that provide diverse health services to the people through work performed by professional, and non-professional health workers in the Community, and health facilities.

However, a health system can be defined as the various functional units and elements within the Health sector that interact and interrelated to ensure the efficiency of the health sector. We used the word health sector because for the health system holistically speaking would involve other sectors.

3.2.1 Subsystem of a Health System

Having dealt a little with health system, the next issue we want to consider in this unit is what are the subsystems of a health system?

According to Adundu (2007) "a Health System is made up of four broad subsystems which are, the people and their health need as a subsystem, resource subsystem, management subsystem, and services subsystem."

It is imperative to distinguish between a health service delivery system and health system. In our opinion there is some confusion about a health care service delivery system and a health system.

A health care service delivery system consists of the ministry of health and its parastatal hospitals, clinics and health posts. This means these are the functional subsystems that interact to ensure the efficiency of the health service delivery system.

However, for the purposes of this unit a health system shall be said to consist of the following subsystem which are; the households, the communities and government. This is because for any health system to function effectively and efficiently, the households where the family units exist; the communities and the government must all put hands on deck by interacting and interrelating.

(i) Household subsystem: The household as a health subsystem consist of all those activities and function undertaken by the household that contribute to effective and efficient health services. These include; personal hygiene, home management, environmental sanitation and preventive services.

The household is an important subsystem, because an average child spends about seven hours at school, at least 2-3 hours in a health facility in case of any need for health services, while the rest 14-15 hours is spent in the household.

(ii) Community subsystem: Another subsystem within the health system is the community subsystem and its contribution include; mobilization, supervision, monitoring, provision of facilities and policy formulation as well as implementation.

As Ibet-Iragunima (2006) rightly stated "the down-up approach is an approach that see primary health care as a health care that requires planning from the community level or grass root to the local government, state and federal level its planning, implementation and evaluation should come from the foundation or

downward and flow upwards. Therefore, the approach should start from the communities".

(i) Government subsystem: This consist of all those services and functions undertaken by government at all levels with all its agencies and department to ensure proper policy framework, promotion and evaluation, supervision and technical support to the other two subsystem (household and Communities) to ensure proper interact and interrelation within the health system entity.

3.3 History of Health Services in Nigeria

The next issue we shall discuss in this unit is the history of health services in Nigeria. However, it is important to mention that what is referred to here is the history of modern health services as Nigerian has its own traditional health services before the advent of either trade across the Sahara desert and the Atlantic Ocean; and the entry of missionary activities which stepped up modern medical services in Nigeria.

According to Kale (2006) "in the first phase of the pre-colonial era, all Community had some form of organized social structure, an important component of which was a health care system. Attention for the provision of personal health care usually centred on individuals with expertise in preventive, creative and rehabilitative medicine."

Although, there is no consensus as to the exact date health of services commence in Nigeria. But most scholars hold the common denominator that it was during the period of the trans-Atlantic Slave trade and Sahara Trade, and the missionary exploit that modern health service was introduced into Nigeria especially, the catholic mission in Abeokuta and subsequently the Army medical corps.

From the above it is hoped you now know the brief history of health services in Nigeria.

3.4 Levels of Health Service Delivery in Nigeria

The Nigeria health care system is divided into three levels. These are the Primary level or system, Secondary level and Tertiary level. This classification is synonymous with the three levels of government recognized in the 1999 constitution of the Federal Republic of Nigeria though nothing to be the extent is expressly stated in the constitution.

Primary level of care:
This is the first level of health care service delivery in Nigeria the services provided at this level of care which also regarded as the first level of contact

with the Nigeria health system include, preventive, promotive, curative and rehabilitative health services. It managed by the local government councils.

Secondary level of care:
The secondary level of care in Nigeria render secondary health services using cottage Hospitals, Maternities, General Hospitals and state specialist hospitals. It deals with complicated health conditions that are referred from the primary level and is managed by the state government.

Tertiary level of care:
This is a level health care where specialized health services are rendered. It handles very complicated cases or health conditions that require higher level of specialization compared to those managed at the secondary health care level. These services are rendered in the University Teaching Hospitals attached to colleges of medical or health sciences of various Universities. They also include; Orthopaedic Hospitals, Eye and Psychiatric Hospitals among others. Although, in the recent past Federal Medical Centre are being run as tertiary health institution, we strongly feel that the difference between services rendered in these centres and the General Hospitals of the states have a very thin line dividing them. Nevertheless, they are still regarded as tertiary health institutions. It is managed by the federal government.

3.5 Roles of the various tiers of Government in Health Service Delivery.

The responsibilities of the various levels of government are not expressly mentioned in any legislation especially the 1999 constitution. In fact, the constitution is not only silent, but also deaf on the issue. And this has indeed caused a lot of confusion as to who does what, how, when and where. Rightly so of course some critical minded commentators have argued that, this is one of the reasons for the inefficiency of the health system. As Erin so (2006) rightly stated "the roles and responsibilities of the various tiers are not clearly stated in any enabling law or statute". However, some of the roles and responsibility of the various levels of government in health include:

Federal government:
The roles/responsibilities of the federal government in health service delivery include the following but limited to the following:

* Formulation of broad based health polices and strategies
* Management and supervision of all tertiary health institution
* Coordination of development partners
* Representation of the country at international health fora and forum
* Provision of technical and logistic assistance to states and local government, and management of port health services
* Response to epidemic and endemic diseases.

State government:

The role and responsibilities of the state government in terms of health care services delivery include:

Formulation of state health policy based on peculiar health needs, but with reference to existence federal policies
Implementation of federal government health policies
Management of secondary health institutions
Preparation of primary health care polices
Provision of technical, financial and logistics assistance to local governments.
Response to state epidemics and endemic diseases.

Local government:

The role and responsibilities of the local government in terms health services delivery include:

Formulation of primary health care implementation strategies
Provision of essential drugs and local logistic for the delivery of health service
Management of primary health care facilities
Notification of epidemics
Training and recruitment of primary health care staff.
Implementation of immunization campaign and other child survival strategies among others.

However, since there is not water tight compartmentalized of their roles in any statute the federal government acting through the federal ministry of health perform some state and local government roles vice versa the states and local governments.

4.0 Conclusion

In this unit you have learned about system and health system. You have also learned about the subsystem makes up a health system and the difference between a health care delivery system and a health system. Equally, you have learned about the history of health services in Nigeria, the various levels of care and the role/responsibilities of the various tiers of government.

It is believed you should now be able to define a health system and describe its subsystem. You should also now be able to give a brief history of health services in Nigeria and the nature of health care services delivered at the various levels of health care service as well as the roles and responsibilities of the various tiers of government.

5.0 Summary

This unit focused on the definition of system and health system as well as its subsystem. It also considered the history of health services in Nigeria, the various levels of health care and the role and responsibilities of the various tiers of government in health service delivery.

6.0 Tutor Marked Assignment

(1) Define a health system in your own words and list its subsystem
.

(2) (a) What are the various levels of health care services in Nigeria

(b) State some of the role and responsibilities of the federal government in health service delivery.

7.0 Reference/Further Reading

Abosade, O. (2003): Primary Health Care in Medical Education in Nigeria University of Lagos Press 2003.

Abubakar B.D. (2007): The Administration of Community Health Services in Nigeria Taninwla Press, Ilorin

Erinsho O. (2006): The Stewardship Role of Government: Nigerian Health Review: Publication of the Health Reform Foundation of Nigeria.

Ibet-Iragunima M.W (2006); Fundamental of Primary Health Care: Paulimatex Printers Port Harcourt

Kale O. (2006). History of the Nigerian Health Sector: Nigeria Health Review: Publication of the Health Reform Foundation of Nigeria.

Schram, R.A. (1971) Brief History of Public Health in Nigeria: University of Ibadan, Press

Unit 10: Challenges of Nigeria Health Care System

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1.0 Introduction

It is believed that the Nigerian public health care system just like any other sector has failed in meeting the health care requirements of its citizens. Hence, the provision of adequate health care services to the citizens of Nigeria has left much to be desired. In spite of the current health sector reforms by the government, the public health care system in Nigeria is still inefficient in all ramifications. It is therefore argued that the problems facing the public health care system in Nigeria could be traced to poor implementation of National Health Policy as well as other health-related policies and programmes. Also, the implementation of National Health Policy and the current reforms in the health sector are therefore expected to address the perennial problems inflicting public health care development in Nigeria. This unit examined the various challenges facing the sector and the way out.

2.0 Objectives

At the end of this unit, learners:

Identify critical indices in Nigeria Health sector

Determine critical challenges confronting Nigeria Health system

Proffer effective solutions/recommendation to the challenges

3.0 Main Content

3.1 Health Policy Indices As At 2010

Fifty years after independence, Nigeria's health status indicators have remained poor despite the country's wealth in natural and human resources and notable achievements by Nigerians in every walk of life (including the health sector) inside and outside the country. The National Strategic Health Development Plan 2009 t0 2013 (NSHDP) rehashes that "t*he health status indicators for Nigeria are among the worst in the world* and that on the *average, health status of the population has declined, compared with the indicators of a decade earlier*. Life expectancy at birth has continued to drop and was reported to be 47years by the 2008 Nigerian Demographic Health Survey (NDHS) report, 6 years lower than the 53years average for the least developed countries (LDC) while maternal

mortality ratio was estimated at 545 per 100, 000 live births, one of the highest rates in the world. This translates to 4 maternal deaths per hour, 90 per day, and 2,800 per month totaling about 34,000 deaths annually. The NSHDP further highlights that one out of every 7 to 8 children dies before her/his first birthday and one out of 6 before her/his 5th birthday. The prevalence of communicable diseases remains unacceptably high with attendant high mortality while non-communicable diseases (hypertension, diabetes, kidney failure, arthritis etc) are on the increase especially among urban and well to do populations. The 2008 sero-prevalence survey reported an adult HIV/AIDS prevalence of *4.6%, so Nigeria has about 3.5 million people living with HIV, one of the highest numbers of infected people in the world.* Nigeria has the fourth highest TB burden in the world.

Besides general poor health status, Nigeria also has huge disparities in health status between geopolitical regions and income groups. Infants and children under 5 years are more likely to die in the northern region of the country than in the southern region and under-5 mortality rate is 87 per 1,000 among the wealthiest population and 219 per 1,000 amongst the poorest (DHS 2008).

The persistent poor health indices have raised concerns about Nigeria's ability to achieve the millennium development goals (MDGS) by 2015. They also have serious consequences for the economy, as a healthy workforce is needed to have a vibrant economy. Unhealthy individual not only do not contribute to productivity but also cannot take care of himself and his dependants; and he may eventually become an economic and security burden to the society. These and other social welfare challenges have contributed to Nigeria's poor human development index ranking of 158 out of 182 countries in 2009 (UNDP HDR 2009).

3.2 Critical Challenges

There are numerous factors responsible for the poor health indices, but those that require the most urgent attention, to reverse the current trend and get back on track towards achieving the MDGs are highlighted below:

3.2.1 Weak primary health care system

The 2005 mapping of health facilities by the federal ministry of health (FMOH) estimated that 85.5% of all health facilities in Nigeria are primary health facilities. These are the facilities that are closest to the people and by policy, should be able to provide the minimum ward package which include the cost effective interventions for improving maternal and child health (immunization, treatment of diarrhea diseases, antenatal care, deliveries, management of malaria, TB and HIV/AIDS prevention and basic care etc). Unfortunately the PHC system has been largely abandoned and is not able to provide quality primary health care. Financing of the health sector is skewed in favour of the

tertiary sector with the primary care level grossly underfunded and poorly managed leading to decay of infrastructure, lack of necessary health commodities and the right quantity and mix of staff. The problem is compounded by the fact that the LGA which is the least funded tier of government with the weakest management capacity and governance structures is saddled the responsibility of funding and managing primary health care. All these have resulted in lack of access to basic packages for a significant proportion of the population especially the poor and rural dwellers.

3.2.2 Human resource (HR) for health challenges

Nigeria produces a huge number of health care workers every year, but despite this production, most facilities especially the primary health care facilities have huge inadequate number and mix of health care workers. Data from the HRH strategic plan 2008 shows that 88% of the 26,361 doctors practicing in the country work in hospitals, most of them (74%) in private hospitals, with only about 12% in private or public sector PHC facilities. Migration outside and within the country (health care workers are migrating outside the health sector), poor motivation and differentials conditions of service contribute to the shortages. Mal-distribution, poor skill mix and lack of performance management lead to inefficiency in the use of existing staff. HR needs are not matched with training plans leading to inadequacies in some staff cadres and excess in some and eventual sub-optimal mixes.

3.2.3 Financing health care

The goal of a health financing system is to provide all people with access to needed health services of sufficient quality and ensure that the use of these services does not expose the user to financial hardship (universal coverage). Out of pocket health expenditure (OOP) has been recognized to create access barriers especially for the poor and has the potential of pushing households into poverty or further into poverty and it is recommended that all countries move away from OOP to be able to make progress towards universal coverage. WHO reports that globally, 150 million individuals experience catastrophic expenditure on health1 and 100million are pushed into poverty every year (WHR 2010).

The WHO further posits that it is only when OOP falls to 15-20% of total health expenditure that incidence of catastrophic health expenditure and improvement falls to negligible proportions. *OOP currently constitutes about 69% of total health expenditure in Nigeria (NHA 2003-2005)!*

As at 2010, Nigeria was not one of the 6 countries that had achieved the *Abuja* declaration of 2001 by African heads of states to allocate at least 15% of the total budget to health, despite being the host of the declaration! It is noteworthy

that countries that have achieved this are smaller and poorer countries namely Liberia, Malawi and Burkina Faso, Djibouti, Botswana and Rwanda!

Besides government and donors, non-traditional additional resource mobilization means such as dedicated taxation for health and special funds have not been fully explored and developed.

1 Expenditure on health more than 40% of income after deducting food expenses

3.2.4 Weak and unclear governance structures

There are obvious weakness in the stewardship and governance of the sector as demonstrated by the poor coordination of vertical health projects (by programmes and donors), numerous and sometimes conflicting policies from different programmes/departments/agencies, lack of clarity of roles and responsibilities amongst key players and poor regulation of public and private health services provision.

Weak planning, budgeting, information management, HR management and logistics capacity is evident at all the levels especially the LGA level which is expected to manage primary health care. Lack of proper planning and adequate coordination of key players leads to wastes of resources through duplication of efforts or application of resources towards non-priority issues.

Poor regulation of the private and inadequate private sector involvement in the national health plan creates huge missed opportunities for tapping the enormous resources within that sector to increase access. The Ghana health service, partner's not-for-profit health facilities in rural areas to increase access to Ghanaians, by deploying trained staff to these facilities. There is also a huge but unregulated traditional medicine sector.

3.2.5 Provider focused rather than client focused health system

The Nigerian health system is more providers focused than client/customer focused. The discussion is always about the availability of health facilities, equipment, drugs and health care workers, with little attention to responsiveness of the system to the needs and/or expectations of the consumers. There are no systematic processes for assessing client needs and satisfaction with services, ensuring patient's rights and responsibilities and addressing complaints. Quality is mostly viewed from what is available in the health facility without recourse to the clients who the health system should be centered on.

The emphasis on the supply side also reflects on the inadequate attention to family and population focused interventions such as community based care,

health awareness creation and other health promotion and prevention activities that could have reduced the need for some of the expensive hospital based care.

3.2.6 Poor drug and medical commodities management

Procurement supply chain management of drugs and medical commodities has improved in recent times, but a lot still needs to be done. Poor forecasting skills in the public sector lead to either expiries or stock outs. Recent assessments of the central medical store in Oshodi showed that most of the stores are in a pathetic situation, some are not adequately cooled and drugs are often poorly packed raising concerns about the integrity of these drugs by the time they leave the store. Most of the state stores are worse off and a lot of LGAs don't have functional medical stores. Vertical distribution leads to unnecessary duplication and waste of resources. An example is HIV/AIDS, tuberculosis (TB) and family planning commodities leaving same warehouse for same facility via 3 different routes/vehicles because there is no coordinated distribution between the 3 disease programs, leading to unnecessary costs. In some cases, procured commodities never make it to the facilities because there are no plans/funding for distribution. Procurement of commodities for HIV/AIDS, TB and malaria is still hugely donor, creating worries about sustainability and commodities security moving forward.

It is important to note that most indigenous pharmaceutical companies are not WHO pre-qualified, excluding them from the donor supported multi-billion dollar HIV/AIDS, TB and malaria commodities procurement contracts that could have grown the sector, created more jobs and contributed to GDP growth.

3.2.7 Weak information management

The health information system in Nigeria has remained very weak such that at the LGA, state or federal level, it is difficult to find in any one place, comprehensive information on health services, utilization and outcomes. Vertical disease programmes house data specific to their programmes and data is rarely aggregated across disease programmes except during report preparation. Data transmission from facilities to the national level has mostly been driven by donor requirements rather than a local need for information. As a result, information flows upwards without people making use of it at the different levels.

It is hard to get reliable information on non-donor funded programme areas.

The lack of reliable comprehensive health data makes it difficult to determine priorities, plan and show evidence of what works and outcome of huge investments in health. Data from Nigeria is occasionally missing in international reports due to either data availability or reliability.

3.3 Suggested Remedies

These myriad of problems requires a well thought out comprehensive approach to reviving the health sector. The current prescriptions which look at one or two of the problems will not achieve much besides short lived reliefs. Some key ingredients of any effort to improve the sector are listed below

3.3.1Service delivery

Passage of the National Health Bill (which provides additional funding for primary health care should be given the highest priority)

Primary Health Care should be the bedrock of Health Care delivery as the most cost-effective, acceptable and affordable healthcare service to the greatest number of Nigerians and should be taken as priority by all tiers of government

Access to improved Maternal, Newborn and Child Health as strategy for poverty reduction and national well-being

Minimum package for primary, secondary and tertiary facilities – minimum infrastructure, staffing, equipment and services for each level

3.3.2Human resource for health

Review and roll out the national human resource for health policy – should look at assessment of needs based on mandate, review of training needs and package, review of recruitment and retention policies

Introduction of strict performance management - basis for salary increase and incentives, disciplinary actions etc

3.3.3Health financing

Increase government allocation and expenditure to meet at the minimum, the Abuja declaration of 15% of Annual budget

Improve transparency and accountability in the use of resources

Health insurance should be compulsory, with pooling of contributions across different occupational, income and social groups

Introduce insurance schemes for the informal sector and rural dwellers and introduce safety nets for the poor (e.g. equity funds from which their insurance premium is covered)

Target additional resources through innovative financing schemes such as dedicated tax e.g. tobacco and alcohol tax, foreign exchange or air flight tax etc

The Legislators should ensure resources are made available for improved health system performance and life expectancy

3.3.4Governance

Capacity building for health planning, policy development, implementation, monitoring and evaluation should be given a high priority by the political parties

Management and leadership training for health managers

National planning commission to use national sect oral plans as basis for negotiation with donors – donors should support national priorities and not their own priorities

Clarify the legal frameworks for healthcare delivery, strengthen regulation and ensure protection of consumers

Linkage with other sectors – education, women affairs, agriculture, information etc

3.3.5Drugs and other commodities

Revamp the central medical store Oshodi as an emergency action and establish regional stores

Develop a national PSM plan that amongst other things, identifies cost effective mixes of public and private warehousing and distribution strategies

Scale up fight against fake drugs and reporting/management of adverse drug reactions

Support WHO certification of local firms and remove all barriers to certified local firms participating in procurement from agreement with donors e.g. don't grant waivers for importation of commodities that are locally produced

3.3.6Information management

Develop national health M&E plan with national indicators, tools and reporting platforms which all stakeholders including donors must agree to

Biannual health reports developed from NHMIS

Strengthen NHMIS to receive, warehouse and analyze on a routine basis, comprehensive health data from facilities and states

Independent validation of data

3.3.7Provider focused rather than client focused health system

Enforce patients rights and responsibilities

Routine patient, household and community surveys to get consumer perspective

Focus on health promotion and prevention activities

There should be sensitization and effective Health promotion

Community mobilization, education, engagement, and ownership for health interventions should be improved.

4.0 Summary

The unit focuses on challenges of health care delivery in Nigeria. They range from human resource (HR) for health challenges to weak primary health care system, poor financing health care and unclear governance structures which are very weak among others. Necessary remedies that can lead to a reversal of the current poor state of health are also enumerated and discussed.

5.0 Conclusion

Available statistics confirmed that about fifty years after independence, Nigeria's health status indicators remained poor despite the country's wealth in natural and human resources and notable achievements by Nigerians in every walk of life (including the health sector) inside and outside the country. A lot of problems confront the system which must be effectively addressed for the health status of Nigerians to improve.

6.0 Tutor Marked Assignment

Enumerate at least eight (8) the critical problems that militate against effective health care delivery in Nigeria. What suggestions do you recommend for improvement?

7.0 References

Erinsho O. (2006): The Stewardship Role of Government: Nigerian Health Review: Publication of the Health Reform Foundation of Nigeria.

Ibet-Iragunima M.W (2006): Fundamental of Primary Health Care: Paulimatex Printers Port Harcourt

Kale O. (2006): History of the Nigerian Health Sector: Nigeria Health Review: Publication of the Health Reform Foundation of Nigeria.

*E J Duru, E. J., Nwagbos, C. I. (*2007*):* The problems and prospects of public health care development in Nigeria\'s local government system, *Global Journal of Social Sciences* Vol. 6 (1) 2007: pp. 51-56, http://www.ajol.info/index.php/gjss/article/view/22826

Health Policy Brief For the 2010 Nigerian Elections: *www.herfon.org/docs/Health_Policy_Brief_for_2011_Elections.pdf*

saturday.tribune.com.ng/.../health.../27876-how-nigeria-can-achieve-quality-health-services-ex-nma-boss

Unit 11: RECORDS & REPORTS: DOCUMENTATION

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- 3.4 Types of Records
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- 3.6 How to write reports

4.0 Summary

5.0 Conclusion

6.0 Tutor Marked Assignment

7.0 References

1.0 Introduction

An effective health record shows the extent of the health problems' needs and other factors that affect individuals their ability to provide care and what the family believes. What has been done and what to be done now also can be shown in the records. It also indicates the plans for future visits in order to help the family member to meet the needs.

2.0 Objectives

At the end of this unit, learners will:

- Enumerate purposes of records

- Identify principles of record writing
- State the values and uses of records
- State types of records and how records can be filed

3.0 Main Content

3.1 Purposes of Records

Provides staff member, administrator, or any other members and not only members of the health team with documentation of the services that have been rendered and supply data that are essential for programme planning and evaluation.

To provide the practitioner with data required for the application of professional services for the improvement of family's health.

Records are tools of communication between health workers, the family, and other development personnel.

Effective health records show the health problem in the family and other factors that affect health. Thus, it is more than a standardized sheet or a form.

A record indicates plans for future.

It provides baseline data to estimate the long-term changes related to services.

3.2 Principles of Record Writing

Nurses should develop their own method of expression and form in record writing.

Records should be written clearly, appropriately and legibly.

Records should contain facts based on observation, conversation and action.

Select relevant facts and the recording should be neat, complete and uniform

Records are valuable legal documents and so it should be handled carefully, and accounted for.

Records systems are essential for efficiency and uniformity of services.

Records should provide for periodic summary to determine progress and to make future plans.

Records should be written immediately after an interview.

Records are confidential documents.

3.3 Values and Uses of Records

Record provides basic facts for services. Records show the health condition as it is and as the patient and family accepts it.

Provides a basis for analyzing needs in terms of what has been done, what is being done, what is to be done and the goals towards which means are to be directed.

Provides a basis for short and long term planning.

It prevents duplication of services and helps follow up services effectively.

Helps the nurse to evaluate the care and the teaching which she has given.

It helps the nurse organize her work in an orderly way and to make an effective use of time.

It serves as a guide to professional growth.

It enables the nurse to judge the quality and quantity of work done.

Records help them to become aware of and to recognize their health needs. A Record can be used as a teaching tool too.

Record serves as a guide for diagnosis, treatment and evaluation of services.

It indicates progress

It may be used in research

The record helps identify families needing service and those prepared to accept help.

It enables him to draw the nurse’s attention towards any pertinent observation he has made.

The record helps the supervisor evaluate the services rendered, teaching done and a person's actins and reactions.

It helps in the guidance of staff and students – when planned records are utilized as an evaluation tool during conferences.

It helps the administrator assess the health assets and needs of the village or area.

It helps in making studies for research, for legislative action and for planning budget.

It is legal evidence of the services rendered by each worker.

It provides a justification for expenditure of funds

3.4 Types of Records

1) Cumulative or continuing records

This is found to be time saving, economical and also it is helpful to review the total history of an individual and evaluate the progress of a long period. (e.g.) child's record should provide space for newborn, infant and preschool data.

The system of using one record for home and clinic services in which home visits are recorded in blue and clinic visit in red ink helps coordinate the services and saves the time.

2) Family records

The basic unit of service is the family. All records, which relate to members of family, should be placed in a single family folder. This gives the picture of the total services and helps to give effective, economic service to the family as a whole.

Separate record forms may be needed for different types of service such as TB, maternity etc. all such individual records which relate to members of one family should be placed in a single family folder.

3.5 Filling of Records

Different systems may be adopted depending on the purposes of the records and on the merits of a system. The records could be arranged

Alphabetically

Numerically

Geographically and

With index cards

Registers

It provides indication of the total volume of service and type of cases seen. Clerical assistance may be needed for this. Registers can be of varied types such as immunization register, clinic attendance register, family planning register, birth register and death register.

Reports

Reports can be compiled daily, weekly, monthly, quarterly and annually. Report summarizes the services of the nurse and/ or the agency. Reports may be in the form of an analysis of some aspect of a service. These are based on records and registers and so it is relevant for the nurses to maintain the records regarding their daily case load, service load and activities. Thus the data can be obtained continuously and for a long period.

3.6 Purposes of Writing Reports

To show the kind and quantity of service rendered over to a specific period.

To show the progress in reaching goals.

As an aid in studying health conditions.

As an aid in planning.

To interpret the services to the public and to other interested agencies.

In addition to the statistical reports, the nurse should write a narrative report every month which provides as opportunity to present problems for administrative considerations.

Maintaining records is time consuming, but they are of definite importance today in the community health practice in solving its health problems.

4.0 Summary

This unit focuses on the purposes of records, clearly identified the principles of record writing and emphasized on the values and uses of records. Furthermore, types of records and how records can be filed were also discussed.

5.0 Conclusion

Records and reports revels the essential aspects of service in such logical order so that the new staff may be able to maintain continuity of service to individuals, families and communities. Good record system also facilitates early identification of areas of improvement both in the lives of the clients/customers and also in the service process.

6.0 Tutor Marked Assignment

a) Enumerate purposes of records (b) Identify principles of record writing (c) State the values and uses of records

7.0 References

Gupta, S. & Kanth, S. 92004): Hospital Stores Management, An Integrated Approach. (First Edition). New Delhi: Jaypee Brothers; 2004.

Kulkarni G R. (2003): Managerial Accounting for Hospitals. Mumbai: Ridhiraj Enterprise; 2003.

Mantas, J. (2000); Health and Medical Informatics Education in Europe *Volume 57 of Studies in health technology and informatics Volume 57 of Biomedical and Health Research,* IOS Press, 2000

McKenzie, J. F., Pinger, R. R.,Kotecki, J. E. (2011): An Introduction to Community Health Jones & Bartlett Publishers, Ontario Canada 2011

WHO (1994): District Hospitals- Guidelines For Development. Geneva: HTBS publishers; 1994.

Williams, S. J., Guerra, S. J., (1985): A Consumer's Guide To Health Care Services Publisher Prentice-Hall, California

Unit 12: Health Care Executives Competencies & Vocabulary

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1.0 Introduction

Human resource is a key factor of production. Even if other factors are available in the right quantity and quality, a defective human resource will destroy others. Therefore this unit looks at the competencies required by health care executives. It also examines some common terms that professionals must be conversant with.

2.0 Objectives

At the end of the unit, learners will be able to:

Explain the usefulness of Competencies

Identify the core competencies of a health care executive

Explain basic terms and terminology in health

3.0 Main content

3.1. **Healthcare Executive Competencies Assessment Tool**

Healthcare Executive Competencies Assessment Tool serves as an instrument to assist healthcare executives in assessing their expertise in critical areas of healthcare management.

It will help health care executives to identify their areas of strength as well as areas they may wish to include in their personal development plan.

Healthcare Executive may choose to have their immediate supervisor use the tool to assess them, and then compare results from own self-assessment with perceptions of their supervisor. When it is used in such a manner, the competency self-assessment can be a powerful tool in facilitating feedback about gaps in skills necessary for optimizing performance.

Healthcare organizations also may choose to use this as an assessment tool to better define the requirements of specific roles within the organization. Once defined, the organization then can respond with a targeted training and development plan for those roles. Certain tasks also may require teams with a blend of strengths, and the self-assessment tool can be used to compose an ideal skill mix among such teams.

Within the HLA Competency Directory, the competencies are categorized into five critical domains: Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment and Business Skills and Knowledge. The definitions for the domains are as follows:

1. Communication and Relationship Management

The ability to communicate clearly and concisely with internal and external customers, establishes and maintains relationships, and facilitates constructive interactions with individuals and groups.

Communication and Relationship Management includes:

A. Relationship Management

B. Communication Skills

C. Facilitation and Negotiation

2. Leadership

According to the Healthcare Leadership Alliance and the American College of Healthcare Executives Communication and Relationship Management includes:

A. Leadership Skills and Behaviour

B. Organizational Climate and Culture

C. Communicating Vision

3. Professionalism

The ability to align personal and organizational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement.

Professionalism includes:

A. Personal and Professional Accountability

B. Professional Development and Lifelong Learning

C. Contributions to the Community and Profession

4. Knowledge of the Healthcare Environment

The understanding of the healthcare system and the environment in which healthcare managers and providers function.

Knowledge of the Healthcare Environment includes:

A. Healthcare Systems and Organizations

B. Healthcare Personnel

C. The Patient's Perspective

D. The Community and the Environment

5. Business Skills and Knowledge

The ability to apply business principles, including systems thinking, to the healthcare environment.

Business Skills and Knowledge include:

A. General Management

B. Financial Management

C. Human Resource Management

D. Organizational Dynamics and Governance

E. Strategic Planning and Marketing

F. Information Management

G. Risk Management

H. Quality Improvement

Healthcare executives should demonstrate competence in aspects of all five domain areas. As you work your way through the self-assessment tool, we hope you will find it valuable and that it helps you along the path of lifelong professional education as you face the ongoing challenges of leadership. We also hope you will share it with other healthcare executives, and we have made it available as a

Glossary of Health Terms

health,

n a bodily state in which all parts are functioning properly. Also refers to the normal functioning of a part of the body. A state of normal functional equilibrium; homeostasis.

health assessment,

n an evaluation of the health status of an individual by performing a physical examination after obtaining a health history. Various laboratory and functional tests may also be ordered to confirm a clinical impression or to screen for possible disease involvement.

health behavior,

n an action taken by a person to maintain, attain, or regain good health and to prevent illness. Health behavior reflects a person's health beliefs.

health care clearing house,

n an entity used to process or aid in the processing of information; may also be called a repricing company, billing service, community health information

system, community health management information system, or "value-added" switch or network.

health care operations,

n.pl the functions performed by a health care provider, health care plan, or health care clearing house to conduct administrative and business management activities.

health care professional,

n a person who by education, training, certification, or licensure is qualified to and is engaged in providing health care.

health care provider,

n an individual who provides health services to health care consumers (patients).

health education,

n an educational program directed to the general public that attempts to improve, maintain, and safeguard the health care of the community.

health hazard,

n a danger to health resulting from exposure to environmental pollutants such as asbestos or ionizing radiation, or to a lifestyle influence such as cigarette smoking or chemical abuse.

health history,

n previously diagnosed physical or mental condition of an individual. Also called
medical history.

health information,

n recorded information in any format (e.g., oral, written, or electronic) regarding the physical or mental condition of an individual, health care provision, or health care payment. See also

health information, individually identifiable,

n recorded information in any format (e.g., oral, written, or electronic) regarding the physical or mental condition of an individual, health care provision, or health care payment. It contains demographic information able to specifically

distinguish an individual. In some cases, this information may not be considered "protected." See also health information, protected.

health information, protected (PHI),

n recorded information in any format (e.g., oral, written, or electronic) regarding the physical or mental condition of an individual, health care provision, or health care payment. It contains demographic information able to specifically distinguish an individual. See also health information, individually identifiable.

health maintenance organization (HMO),

n a legal entity that accepts responsibility and financial risk for providing specified services to a defined population during a defined period at a fixed price. An organized system of health care delivery that provides comprehensive care to enrollees through designated providers. Enrollees are generally assessed a monthly payment for health care services and may be required to remain in the program for a specified amount of time.

health, patient,

n the state of bodily soundness of the patient; the patient's absolute or relative freedom from physical and mental disease.

health physics,

n the study of the effects of ionizing radiation on the body and the methods for protecting people from the undesirable effects of radiation.

health policy,

n **1.** a statement of a decision regarding a goal in health care and a plan for achieving that goal; e.g., to prevent an epidemic, a program for inoculating a population is developed and implemented.
n **2.** a field of study and practice in which the priorities and values underlying health resource allocation are determined.

health promotion,

n an educational program or effort directed at a targeted population to improve, maintain, and safeguard the health of that segment of society. See also health education.

health resources,

n all materials, personnel, facilities, funds, and anything else that can be used for providing health care and services.

health risk,

n a disease precursor associated with a higher than average morbidity or mortality. The disease precursors may include demographic variables, certain individual behaviors, familial and individual histories, and certain physiologic changes.

health risk appraisal,

n a process of gathering, analyzing, and comparing an individual's prognostic characteristics of health with a standard age group, thereby predicting the likelihood that a person may develop prematurely a health problem associated with a high morbidity and mortality rate.

Health Impact Assessment

Health impact assessments look at the effect on health of policies implemented outside the health care

Information in this appendix includes excerpts from the following sources:

• Mindell et al. A Glossary for Health Impact Assessment, Journal of Epidemiology and

Community Health 2003; 57(9): 647-651, BMJ Publishing Group Ltd. 2003

• Blau G and Mahoney M. The Positioning of Health Impact Assessment in Local Government in Victoria,

Health Impact Assessment Unit, Deakin University, Australia, October 2005.

Health impact assessment has its roots in environmental impact assessment. However, the scope of health impact assessment has broadened from this traditional risk/environmental/health protection model to public health/health promotion applications that can be applied to all activities that may have an impact on human health.

It has long been recognised that health and its determinants are strongly influenced by policies outside the health care sector, for example, transport, regeneration projects and housing. In recent years several countries have

introduced health impact assessment to ensure that potential effects on health are taken into account. It involves identifying disbenefits and benefits to health, interpreting health risk and potential health gain, and presenting this information to aid decision-making.

Health impact assessment is a multidisciplinary activity that a consensus paper published by the WHO Regional Office for Europe describes as *"a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population"*.

The Aim of Health Impact Assessment

All definitions of health impact assessment agree that the aim is to maximise the health gain (and minimise the loss) that might result from a proposal, even when the proposal does not have health improvement as its aim:

• Health impact assessment should be multidisciplinary, intersectoral and participatory, and should include a focus on health inequalities.

• Both quantitative and qualitative evidence should be used.

• The main values underlying the conduct of health impact assessment are:

• sustainability

• the promotion of health

• participation

• democracy

• equity

• equality (of all stakeholders in the process, but in particular of the community affected)

• the ethical use of evidence.

Health Inequalities Impact Assessment (HIIA)

This form of health impact assessment used in the UK aims at assessing impacts of a proposal on the health and well-being of people in the community who experience health and other inequalities in relation to age, sex, ethnic background or socioeconomic status, to identify whether there is a differential distribution of impacts.

The current consensus is that all health impact assessments should consider inequalities and/or the distribution of potential health effects.

Levels of Application

Health impact assessment can be applied to three main levels of proposal: a *policy*, a *programme*, or a *project*:

• A **policy** represents the way in which government or an organisation seeks to achieve the objectives it has set. Health impact assessment at this level can be strategic, enabling health concerns to be incorporated early on and a global view to be taken.

In some cases (taxation for example) there is no lower level at which health impact assessment could be applied.

• A **programme** is a series of related activities that give effect to *policy*.

• A **project** is a component of a *programme*, and is a discrete activity often undertaken at a specific location.

Health impact assessment at the programme and project levels allows health impacts to be assessed that are specific to a particular locality or community. It is more tactical, with aims relating to proposal modification and implementation.

Comparison of Policy Options

Ideally a health impact assessment will compare all possible options that could be under consideration. This gives policy makers the most explicit information on the health consequences of their actions and increases the possibility of integrated assessment.

Stages

Health impact assessment comprises six stages:

1. screening

2. scoping

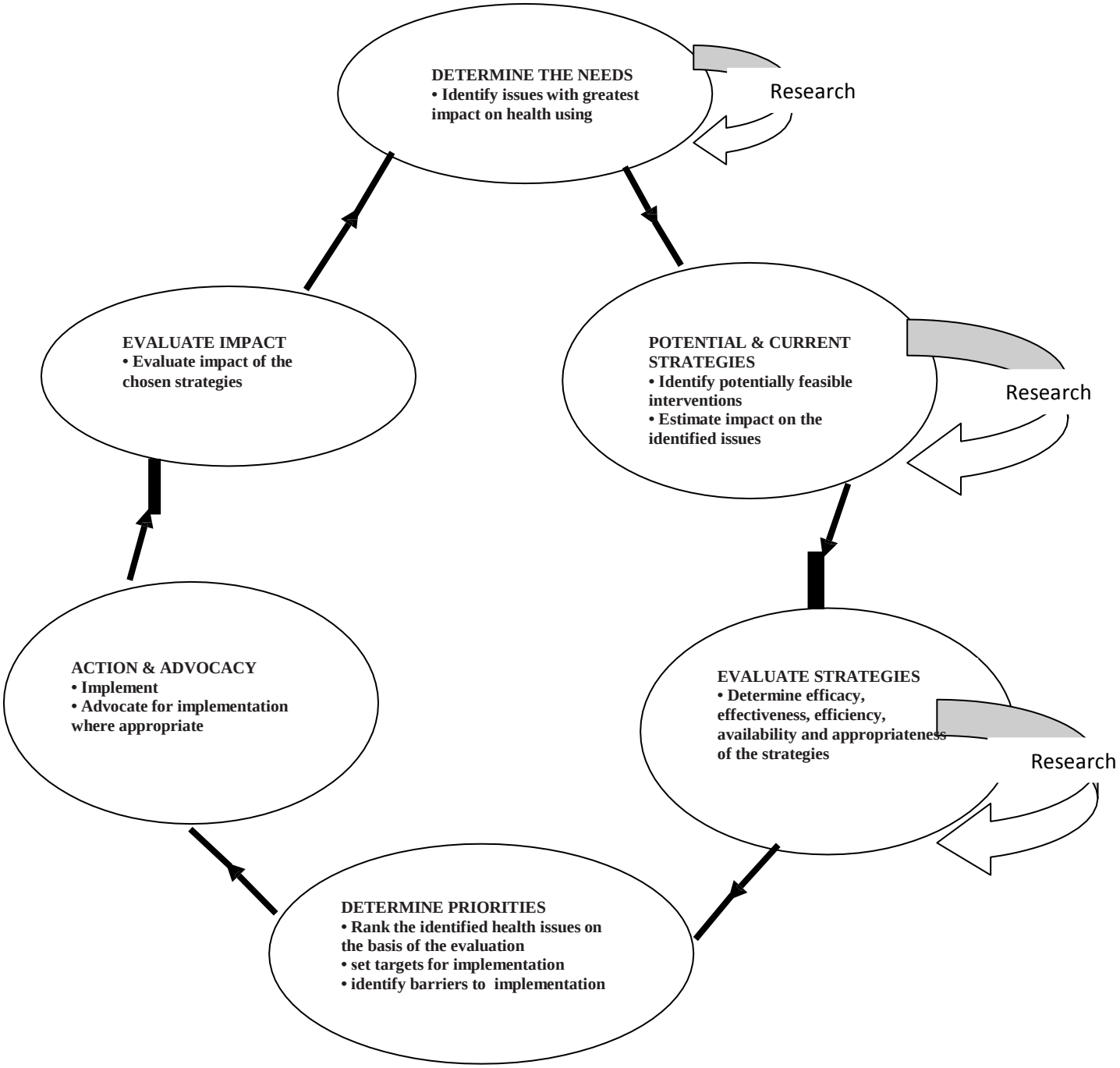
3. appraisal or risk assessment

4. preparation of report and recommendations

5. submission of report and recommendations to decision makers

6. monitoring and evaluation.

Needs Impact Based Planning Model



Source: Needs/Impact Based Planning Committee. A Guide to Needs/Impact Based Planning: Final Report to Ministry of Health. 1996.

4.0 Summary

In this unit, attempt was made to explain the usefulness of competencies in health care. The various competencies that have been proved to be worth its while were enumerated and discussed. In order to assist the health care

professional, common day to day terms were identified and explained all view a view to increasing their vocabulary.

5.0 Conclusion

Human resource is very vital to the success of any endeavour – health care inclusive. The competence matrix in this unit will help professionals to do a kind of self assessment to determine personal development plan on one hand. It will also be useful in getting feedback from subordinates or even superiors if applied as such.

6.0 Tutor Marked Assignment

(i) What are the core competencies required for a professional health care executive?

(ii) Explain the concept of Health Impact Assessment.

7.0 References

Blair, J. D. (2007): Strategic Thinking And Entrepreneurial Action In The Health Care Industry *Volume 6 of Advances in health care management Elsevier Book Series,* Emerald Group Publishing, 2007

Blau G and Mahoney M. The Positioning of Health Impact Assessment in Local Government in Victoria,

Health Impact Assessment Unit, Deakin University, Australia, October 2005.

Liebler, J. G., McConnell, C. R. (2004): Management Principles for Health Professionals Edition 4, PublisherJones & Bartlett Learning, 2004
Longest, B. B. (1990): Management Practices for the Health Professional Edition4, Appleton & Lange Publisher, 1990

Mindell et al. A Glossary for Health Impact Assessment, Journal of Epidemiology and

Mosby's Medical Dictionary, 8th edition. 2009, Elsevier.

Needs/Impact Based Planning Committee. A Guide to Needs/Impact Based Planning: Final Report to Ministry of Health. 1996