# Early experiences of the Health Planning Unit in Fiji

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## Introduction

For three years from 1992 the Ministry of Health (MoH) in Suva, Fiji implemented a health planning project, supported by the British Overseas Development Administration (ODA). The objective of the project was to institutionalise a health planning capacity and culture in the MoH that complemented broader Fiji Government planning structures and processes. At the end of the project in 1995 the MoH and ODA evaluated the project's achievements. The evaluation drew on a range of sources: interviews with MoH staff and key individuals from other relevant organizations; internal Fiji Government documents; and project reports.

This article summarizes progress with health planning in Fiji and highlights some of the lessons from this experience. It is hoped that the findings presented here will be of interest and value to other health ministries in the region that may be considering strengthening their planning function.

## Background

Before 1992, health planning activities in Fiji were somewhat dependent on the enthusiasm of particular individuals and on short-term donor inputs. In the years preceding the project, the MoH was aware of shortcomings related to lack of clear sectoral strategy; budgets not being clearly linked to medium and longer term national plans; and lack of timely and accurate information. Similarly, central government recognised the need to control public expenditure and ensure the effectiveness of the health spending in particular. These concerns resulted in a request for external support to build health planning capacity.

The Health Planning Unit (HPU) that was catalysed by the consequent ODA-supported project is one component of planning and policy-making machinery in Fiji. At the heart of the system is the Central Planning Office, a department within the Ministry of Finance and Economic Planning. Responsibility for planning is shared between Central Planning Office and line ministries but a significant weakness in the system is the lack of planning capacity in line ministries, as well as a shortage of social planning skills in the Central Planning Office itself. If a sector policy framework and project priorities are not articulated at line ministry level, they will be decided by default at the Central Planning Office. There is, therefore, a clear case for enhanced planning capacity at ministry level.

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## Inputs to and outputs from the Health Planning Unit

External inputs to the three year project comprised two expatriate health planners, local and overseas training courses, a vehicle, computer and office equipment. Total external project expenditure amounted to some F$500,000 (US$ 360,000). The MoH provided administrative and organisational support for the running of the HPU. This included the formal establishment of four new posts which cost the MoH some F$ 80,000 (US$ 58,000) each year.

By the end of the three years, MoH's progress with delivering six planned outputs was as outlined below.

**A functioning health planning unit:** Four posts were established and filled in the new HPU (Director, Principal Planning Officer, Planning Officer and a part-time Executive Officer). This was a significant achievement considering that prior to the project there was no MoH planning cell. The number of posts appears to have been appropriate; three posts is probably the minimum necessary to establish a viable

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unit but trying to establish a more ambitious number of posts might have led to delays.

The physical and functional proximity of the HPU to most senior staff in the Ministry, including the Permanent Secretary and Minister, was a further indication of the success in establishing an operational HPU. Continual liaison with senior staff raised the profile of the HPU and facilitated a largely realistic understanding of its role and responsibilities.

**Reference documents, including service plans, mission statement and corporate plan:** The HPU decided against aiming for a complete blue-print National Health Plan, anticipating that a completed, bound document would rapidly become out of date. Instead the planning process was made a dynamic one with service plans being built up as chapters in a ring-bound filing system, to be updated individually as necessary. Plans encompassed five year priorities and goals and yearly operational plans. However, this dynamic, process approach to planning did highlight a need for an overarching MoH policy framework for those both inside and outside the HPU. An appropriate development therefore was the initiation of work, in 1995, on a Mission Statement and Corporate Plan for the MoH.

In order to prepare particular service plans, the HPU established planning groups. All groups aimed to include one of the three MoH Directors (Hospital Services, Primary and Preventive Health Services and Nursing Services) as well as HPU staff. These groups provided a means of integrating the HPU into the Ministry. This integration was particularly important as the Ministry was led by four different Ministers and four different Permanent Secretaries during the first three years of the HPU's existence.

Ownership of the subsequent plans by service deliverers was not fully secured in the first three years of the process. There was some confusion over whether responsibility for follow up of a plan lay with the relevant Director or with the HPU, and this led to unsatisfactory implementation and monitoring of some plans. There is clearly a role for the HPU to help plan appropriate monitoring systems.

**A planning manual:** The HPU produced a short informal document outlining the steps in the planning process. Ideally a more formal guide to planning procedures would have been produced to help ensure that the procedures adopted became routine, thus assisting with the institutionalisation of planning. Such a manual could have provided an unambiguous point of reference for staff, and might have been of particular use to new officers joining the HPU (as well as of value to others outside the HPU).

**Formal and informal channels of communication with other Government of Fiji departments and with aid agencies:** The Central Planning Office, the Ministry of Finance and Economic Planning, the Public Service Commission and Public Works Department all perceived improved interactions between their departments and the MoH following the establishment of the HPU.

The Central Planning Office and Ministry of Finance and Economic Planning valued the improved quality of submissions they received from the MoH and that these arrived already prioritised. HPU inputs to the Medium Term Capital Expenditure Programme were particularly valued. The production of operating cost projections for capital projects was also appreciated, for example projections produced for the development of the national referral hospital. As a result of regular notice about forthcoming MoH work, Public Works Department felt better able to schedule their own work programme.

The HPU became a key point of contact for many aid agencies with programmes in the health sector. Those multilaterals with largely vertical programmes liaised to a greater extent with relevant Divisional Heads but bilateral donors tended to see the HPU as their main point of contact. Within the HPU, the two expatriate Health Planners were the predominant points of contact for donors which raised questions about the sustainability of the links.

It was widely felt that having a policy and plan in place helped attract increased funds from donors and that these funds were better coordinated. Examples cited included MoH's increased ability to direct donor resources to meet its own objectives, both attracting appropriate extra resources and scaling down or redesigning inappropriate donor-led projects with considerable operating cost implications for the MoH.

**Capital and operating financial submissions that reflect service plans:** The HPU had moderate success aligning planning and budgeting processes within the MoH. The MoH would have benefitted from the HPU defining and documenting the role of other parts of MoH in the planning process, especially the roles of the personnel and accounts sections.

In the initial 3 years of its existence, the HPU concentrated its energies on the capital budget, in particular infrastructure projects, to some extent at the expense of attention to the operating budget which represents between 90 and 95% of the total MoH annual budget. While it was important in the early stages of the project for the HPU to demonstrate impact on capital allocations, it is equally important for a planning unit to give adequate emphasis to the analysis and planning of operating resources.

Overall, the HPU clearly improved the alignment of MoH plans and national budgeting processes. Other departments felt that the HPU had a good appreciation of what resources were available at the national level and in 1994 the MoH was able to keep within budget for the first time in several years.

**Functioning information and monitoring systems in place:** Not all the planned outputs of the HPU could be delivered during the initial three years. For example, little work was done by the HPU on strengthening the MoH's weak information systems. Data on service activity levels, patient throughput and private sector activities remained extremely limited and financial information suitable for planning was also lacking. The problem was compounded by frequently changing responsibility for the Medical Statistics Unit.

## The extent to which the Health Planning Unit achieved its purpose

The overall purpose of the first three years of the HPU Project was to institutionalise a health planning capacity and culture in the Ministry of Health. To assess the success of achieving this purpose, indicators might include:

- HPU formally acknowledged in MoH's organization chart.
- Posts in HPU filled.
- HPU included in key policy and planning meetings, both within MoH and with external organisations.
- Rolling plans updated to schedule.
- Policy statements updated as necessary.

During the initial three years a functioning health planning capacity existed in the HPU and a planning culture was established. At the time external support ended all established posts in the HPU were filled with appropriately qualified officers and HPU staff felt that they were included in most key policy and planning-related meetings. In the absence of MoH Annual Reports and an organization chart it was difficult to confirm that the HPU was formally institutionalised within the structure of the MoH but it was felt that the HPU would feature in future production of those documents. Whether the structure, systems, capacity and culture will be sustained and institutionalised remained to be seen at the time external support ended.

The HPU arose from the perceived needs of senior MoH staff and its development over the three years was at least in part attributable to the continuing recognition of that need. To be maintained the HPU must continue to meet the needs of the MoH and other government departments.

To be fully accepted the HPU must be seen to operate as an integral part of the Ministry. There is no possibility of institutionalising a planning culture if the HPU is marginalised from Ministry operations. The HPU encouraged integration by: establishing planning groups; ensuring initial objectives were action-oriented and simple; fostering linkages with other parts of the ministry; developing the planning-budgeting nexus through simple prioritisation exercises; producing a planning framework which was available to all MoH staff; and becoming involved in speech-writing. A key lesson from the project was that institutional integration takes time. Three years would seem the minimum time necessary to establish a sustainable Planning Unit.

There are, however, two factors which militate against the independence of the HPU. The first is that for the initial three years for many people the HPU was personified by the two expatriate advisers. In all institutional development projects, the need to develop systems, rather than dependence on any particular individuals within them, should be emphasised. The second is the relatively high turnover of HPU staff, resulting in part from the HPU's small size. With only four staff, losing even one will cause disruption and discontinuity.

The acid test of the institutionalisation of a planning culture might be considered to be the ongoing revision and implementation of rolling plans and policy documents and this is not yet assured. The first round of overarching policy documentation, the production of the Mission Statement and Corporate Plan, was only undertaken towards the end of the initial three years and it is premature to comment on whether this will prove more than a one-off exercise. The service plans were, however, produced from an early stage and by the end of the 3 years plans were partially out of date and service deliverers were uncertain about where responsibility for updating them lay.

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In theory, annual operational plans were to be reviewed each year and updated, modified and reprioritised if necessary. In practice, rather than being updated, they tended to be replaced by the operating and capital submissions to the Central Planning Office and the Ministry of Finance and Economic Planning and the annual staffing proposals to the Public Service Commission. This is likely to prove counterproductive to the institutionalisation of the planning process. Furthermore, budget submissions were not as readily accessible and useful to MoH service staff as planning documents that describe strategy, priorities and goals in a narrative fashion. There must, therefore, be a risk that many of the plans may become one-off documents rather than dynamic plans.

## The extent to which the Health Planning Unit achieved its goal

The goal of establishing a Health Planning Unit and institutionalizing a health planning capacity and culture in the MoH was to enhance the efficiency, equity and quality of health

**Table 1. A summary of the successes and shortcomings of the Fiji Health Planning Unit**

**Successes**

- The Public Service Commission established and filled four posts in the new Health Planning Unit (HPU).
- The HPU established health planning processes that are largely congruent with national planning procedures.
- The HPU encouraged its own integration into the Ministry by: establishing planning groups; fostering linkages with other parts of the ministry; developing the planning-budgeting nexus through simple prioritisation exercises; producing a planning framework which is available to all Ministry of Health staff; and becoming involved in speech-writing.
- The HPU made considerable progress towards the production of a National Health Plan and the formalisation of Ministry of Health policy.
- Rational planning led to more transparent decision-making and helped counter political pressure on the allocation of resources. This came about through the establishment of planning groups where decisions have to be publicly justified and defended.
- Links between planning and budgeting within the Ministry of Health were strengthened.
- Working relationships were developed with all levels of the Ministry of Health, with donors to the health sector, and with other government agencies, notably the Central Planning Office and the Budget Section of the Ministry of Finance and Economic Development. The two government agencies valued the improved budget submissions received from the Ministry of Health.
- The project appears to have enhanced the efficient use of donor funds and improved coordination of those funds. Not only did the activities of the HPU attract appropriate extra resources, inappropriate donor-led projects were successfully scaled down and redesigned.

**Shortcomings**

- The HPU took on a range of management and implementation responsibilities which, whilst strengthening the management function of the Ministry, did have opportunity costs in terms of planning activities foregone (for example, the development of essential information systems in the Ministry).
- Planning efforts were focused on the capital budget at the expense of the recurrent budget. The former, although highly visible and therefore politically important for HPU support, constitutes only 5-10% of the total annual Ministry of Health budget.

services in Fiji. Although it is presently beyond the scope of the HPU to measure objectively its effect on efficiency, equity and quality of health services, below are some general comments on the impact that it is likely to have had.

## Efficiency

The HPU was not in a position to undertake any work on cost-effectiveness in the initial three years because of the weakness of information systems and consequent lack of data at its disposal. There was not, therefore, any tangible evidence of impact on health service efficiency. Better planning should have led to better use of resources but implementation of plans fell largely outside the remit of the HPU. A more structured planning cycle led to better resource planning but some allocations were still made in response to crises and these allocations may not have represented efficient use of resources.

As mentioned above, the HPU appears to have enhanced the coordination and efficient use of donor funds. Closer monitoring of donor funds resulted in their being used more efficiently. There were no underspent funds to be returned to donors at the end of the financial year as had been the case in the past.

More accurate appraisal of new initiatives, and estimation of their recurrent cost implications, may have led to their more efficient implementation. Efficiency might be further enhanced if links between planning and budgeting and between operating and capital budgets are further strengthened.

The HPU was able to highlight savings and recommend reallocation and virement between budget subheads which may have enhanced the efficient use of funds. There was a general perception that the HPU has attracted resources and staff to the MoH.

## Equity

Equity of health services was not explicitly addressed by the HPU. Nonetheless, rational planning clearly led to more transparent decision-making and helped counter inevitable political pressure on the allocation of resources from senior MoH officials, politicians and donors. These achievements came about through the establishment of planning groups where decisions were publicly justified and defended. The rolling Medium Term Capital Expenditure Plan also lent some stability to decision making processes. The resulting decisions of the planning process were probably more equitable than they would otherwise have been. The allocation of resources may not have matched the plans exactly but was certainly influenced by them.

**Table 2. Lessons from establishing the Fiji Health Planning Unit**

- A new health planning unit should be accorded as much status as possible within a Ministry of Health. Ensuring physical and functional proximity to senior officials should enhance the unit's influence and also protect it from being undermined by other officials.
- The unit needs to be aware of the political ramifications of attempting to introduce rational planning.
- As planning is a political as well as a technical process, attempting to introduce planning from scratch may be more successfully done by a team than an individual.
- External advisory inputs to planning units should, wherever possible, be provided with MoH counterparts.
- A realistic amount of time should be allowed for establishing a new planning unit. Three years plus some 'aftercare' external inputs was found to be the minimum necessary in Fiji.
- The credibility and pertinence of the planning unit may be enhanced by recruitment into the unit of at least one clinically qualified officer.
- Realistic and achievable objectives for the unit should be set at the outset. To enhance credibility, it is important to be seen to be having some tangible success early on rather than be struggling with over-ambitious objectives.
- The value of a dynamic and flexible approach to planning may outweigh the expressed need for a completed National Health Plan.
- Planning capacity and information systems should ideally be developed simultaneously as the absence of the latter can limit the efficiency and effectiveness of the former.
- Some flexibility in the role of the planning unit must be allowed, especially during its early stages. Some non-planning support to senior members of the Ministry can help embed a new unit. Apparently diversionary activities, such as speech writing, can help formulate and institutionalise policy as well as win favours. Some involvement in implementation can help counter the perception of a planning unit being an elite, non-integrated section of the MoH.
- A planning unit must continually be aware of becoming overly involved in management responsibilities. For example, officers designated as planners should resist being nominated as counterparts for implementation of aid projects.
- A planning unit should be aware of the risk of becoming solely an 'Aid Unit' or becoming a parallel Ministry of Health, rather than an integral part of the present functions of the Ministry. Integration can be enhanced through the use of planning groups that include relevant senior staff.
- A planning unit should be realistic about the quality of the plans that the planning groups, or their equivalent, produce. A planning unit should avoid becoming an unreasonable and unpopular task master.

## Quality

The HPU did not tackle quality of health services head on but appropriately planned recurrent resources, including staff and supplies, should have enhanced the quality of service delivery. As an example, the Pharmaceutical Services Plan is thought to have led to improved pharmaceutical supplies.

Impact on quality of service delivery has largely been seen where the HPU has taken management responsibilities upon itself, that is acted as much as a management strengthening unit as a health planning unit. This is particularly the case in relation to the implementation of capital plans.

The HPU has constantly been trying to define the boundaries of its role in planning, implementation and monitoring. Some involvement in implementation can help counter the perception of a planning unit being an elite, non-integrated section of the MoH. Being a new unit, the HPU had a vested interest in seeing early plans implemented successfully and hence convincing the MoH of the value of planning.

The risk of diversion into non-planning responsibilities can be underestimated and a planning unit may compromise its efficiency if it spends too much time implementing and managing rather than planning activities. There may, therefore, be a case for the HPU to limit its involvement in management activities. The time may now be ripe for the HPU to formally define its own objectives, role and function through some form of mission statement and formalize a regular, timebound work programme. These tools might help deflect non-planning work and further enhance the efficiency of the planning function of the HPU.

## Conclusion

In conclusion, the Health Planning Unit in Fiji appears to have achieved a number a significant successes during its initial three years. Shortcomings have also provided valuable lessons. These successes and shortcomings are summarized in Table 1. The resultant lessons from the Fiji experience are summarized in Table 2 and it is hoped that these will be of interest and value to health ministries in other Pacific Island Countries that may be considering strengthening their health planning function. □