HEALTH PLANNING

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There are, in the minds of thinking people, some serious questions about planning: What is planning anyway? Planning for what? Do people know how to plan? Do they know how to plan intelligently? Do they, or can they, have enough authority to plan? Will planning make any difference?

The frequency with which these questions are asked suggests that this paper should begin with a basic analysis of what planning is. Although that approach may appear to be an exercise in belaboring the obvious, the fact remains that most current health care planning does not reflect understanding of, nor make use of, what would seem to be obvious characteristics of a sound planning process.

WHAT IS PLANNING?

Most simply stated, *planning is advance thinking as a basis for doing.* It is applied intelligence, an essential part of almost all human activity. But the planning that everyone does is usually extemporaneous and carried out with little attempt to be systematic and orderly. Most people and most organizations have analyzed neither the contents nor the effectiveness of their planning processes. That is certainly true with respect to the health field, which is marked by people who are, by nature, doers and who are under day-to-day pressures to get things done.

The issue, then, is not *whether* people do or should plan, but rather *how* planning can be improved and made a more useful human activity. Detailed examination of the elements and characteristics of an

orderly and effective planning process should point to methods of improving health planning, to more systematic thinking as a basis for doing.

The process of advance thinking as a basis for doing can be visualized as having three elements: 1. thinking about what to do (goal-setting); 2. thinking about how to get it done (programming); and 3. continuous thinking as the programming unfolds as to whether the goals and programming are correct (re-evaluation). In general, orderly goal-setting is the weakest link in the planning processes, while most attention goes to programming. If planning is to be improved, major emphasis must be placed on challenging people to think in terms of systematically set goals.

All forms of planning also involve three primary dimensions: coordination, contents and time. In some situations, the problem is how to work with others to get something done, while in others it is more significant to set forth a sequence of one's own actions over a period of time. But most planning situations involve solutions to problems requiring both coordination with others and relation to a sequence of future events. Depending on the setting, coordination may be more or less important than sequence planning, and the planning of content may present major or minor challenges. In any given circumstance, it is essential to give appropriate weight to all three.

The dictionary gives two definitions of planning: 1. a scheme of action such as planning a trip, and 2. a scheme of arrangement, such as planning a flower garden. In this paper, the term "planning" is used in the sense of the first definition, since the second definition has only subsidiary usefulness in such a dynamic field as health service. Architectural planning or personnel planning, if not based on functional planning, is apt to be obsolete before it is implemented. Such is the indispensability of the time dimension.

The degree of precision in planning can vary over a wide continuum, both with respect to setting goals as well as to implementation to achieve goals. Extreme precision or no more than a set of flexible guidelines may be involved, depending upon the characteristics of the problem under consideration. Precision in planning should be no greater than the precision in predicting the effect of the program, tending, in fact, to be lower to the extent that other people may act in autonomous ways that bear on accomplishment of the goal.

Usually, the longer the anticipated time involved, and the more human elements to be coordinated, the more general should be the

goal and the implementation program. In addition, the goal and the programming should be general when the implementation program can be designed to add information that will feed back to provide greater insight into the nature and desirability of the goal and the effectiveness of the program. Overly precise formulation of goals tends to interfere with progress in dynamic situations.

Inherently, however, planning is a control process. Advance thinking is designed to limit one's actions to those which fit into the program and to eliminate random and diversionary actions. In a coordinated plan involving a number of independent elements, the action of each element is controlled by the common interest in the goal as well as the programmed relationship to the other elements. Sometimes, assuring a high degree of skill, understanding, and commitment to the goal provides sufficient control of the various elements, while in other situations a stronger element of authority must be built into the plan. In general, everyone is more comfortable with control based on shared goals, which permits each element to innovate in carrying out the plan. In non-innovative situations, in which the goal and the program are fixed and clear, authority may be the preferred method of assuring progress.

Finally, the planning process by nature is continuous and cyclical: establishment of goals, development of a program to achieve the goals, re-evaluation throughout the program of both the goals and the program, setting revised or up-dated goals, revision of the program, another re-evaluation of the goals and program and so forth. Re-evaluation should be allowed for at any point in the program on the basis of newly acquired knowledge or insights, or on the basis of changed events (faulty predictions). In any organization built on human frailty, however, a constant re-questioning of goals or program can interfere with their achievement. Futhermore, if re-evaluation is expected to take place continuously, it may never take place at all. For that reason, it is advisable to build specific points of review into any planning program, most importantly in connection with strategic events that will have a long-range impact on the carrying out of program as, for example, when making major capital investments of recruiting key personnel; and, in addition, on a periodic basis in connection with pseudo-events, such as the preparation of the annual budget or salary review.

In complex "systems" such as hospitals, health departments or the health complex of a community, state, region or nation, systematic planning by the people responsible for every activity at every level, is desirable, but the system should be designed to encourage coordination

of the various planning processes. Everyone in the system should be encouraged to carry out productive advance thinking as a basis for doing, but the time involved in the planning process and the appropriate mix of the various characteristics of planning described above will vary markedly depending upon the level in the system and the type of activity being carried out. That is the key to successful planning.

The problem will now be discussed with respect to one of the stages of the planning process: goal formulation. Goal-setting, as has been pointed out, is generally the weak link in the planning chain. One often sees skilled programming and sound criticism being implemented in the absence of well-defined purposes. All too often, health institutions are artfully designed and skillfully manned ships at sea with neither compass nor destination, and with little idea of whether the artful design or the skilled staff are really suited for the voyage ahead.

Within any "system," formal or informal, individuals at different levels will necessarily have different goals. Indeed, no two organizations and no two units within the same organization share precisely the same goals (and even if they did, they might disagree to the means to achieve them). The conflicts with respect to goals not only pervade any "system," but are desirable if the "system" is to improve and progress. The conflict may be constructive and even inspiring, or it may be diversionary or deadening. It may be useful one week and a nuisance the next. It is a fact, however, that is inescapable. The problem is not how to achieve acceptance by all of the same goals, but rather how to interrelate and coordinate goals to attain minimum conflict that might interfere with productive action.

Conflict occurs when the actions of one part of the system in achieving its goals interfere with the achievement of another's goals, usually reflecting failure of either party to give adequate consideration to the other's goals in formulating his own program. Adequate provision for interdependence in the programming of all parties will minimize such conflicts or, at least, enable the conflicts to be resolved with minimum disruption.

In organizational settings, these conflicts among goals at different levels and at the same level tend to be resolved by the individual with greater authority. He, in turn, must be in a position to justify his resolution of the issue to the next higher level. Those at any level recognize that achievement of their own goals depends upon their ability to adapt the goals of their subordinates to the broader goals of the organization. It should be stressed that conflicts should not be avoided by determina-

tion of goals for all individuals at all levels by the highest level. Even in a completely structured or authoritarian system (such as an army during a war), the "highest" level cannot effectively determine goals with precision for all individuals at all lower levels, for two reasons. First of all, the highest level cannot possibly know as much about the circumstances surrounding each individual at each level as those closer to that level, and mistakes will be made. Secondly, morale will be affected.

Resolving conflicts within a "system" is made even more complex because individuals always have more than one goal, with different degrees of intensity associated with each. But that also makes it possible to resolve conflicts with relative satisfaction to all. For example, a promise of future action may encourage an individual to greatly reduce the urgency associated with one of his goals.

In community service activities, in which the profit motive and traditional marketplace forces do not play the same role as in commerce and industry, no automatic mechanism assures optimum productivity and distribution. Incentives and mechanisms for cooperation and coordination must be built into such systems at all levels, not only for goal-setting, but also for the other two elements of the planning process: programming and evaluation.

Implications for the Health Field

Planning, then, is an integral part of any system; it permeates the production and distribution of health services; and tremendous amounts of time are currently devoted to planning in the health field (little of it identified as such). But clearly, planning activities in the health field, as in all fields, are inefficient and should be improved. The key answers to the question of how the planning processes can be improved involve motivating and helping individuals in different positions to plan more efficiently and more effectively. Although this need not proceed from an academic notion of the planning process, it is essential that the structures and procedures throughout the system encourage the systematic application of intelligence to the setting of goals and the programming of content, in the context of a sufficient time period of action and with maximum coordination as needed.

Also essential is a way to translate this planning into action, and this may be the point to state a principle: *Planning can be transmuted into action only by those with operational responsibility for the action.* Mischief will result if an attempt is made to give a planner authority

to impose action if he is not, at the same time, to be held responsible for the results of the action.

Some authority is not flatly "compulsory," to be sure. A planner may be armed with data, ideas and logic to win his point. Failing that, he may be armed with the power of his press relations and of his backers to influence those with operational responsibility for dispensing funds or other necessary ingredients. But the more that planning is dependent on power rather than data, ideas and logic, the more the planner assumes responsibility for the operations. If a planner does not in fact have such responsibility, nor a mandate to assume it, it is pointless to speak of compulsory planning.

It is not pointless to consider methods to require orderly planning by those with operational responsibility, however. Although the imposition of plans of action makes necessary an assumption of operational responsibility, that is not the case if a central authority simply requires evidence of a sound planning process. Almost all planning is, and should be, carried out by those with operational responsibility for the action being planned, but part of the planning process can be separated from operations, and indeed may be strengthened through such a separation. It is a nearly superhuman expectation to think that an administrator who is fully occupied with operational burdens can find the energy and the perspective to undertake sound, long-range planning. Increasingly, methods are being developed to augment the planning capacities of the responsible authority in an institution, either by engaging staff to carry out the planning process, or by employment of "outside" consultants. Further, a growing tendency is to establish centralized planning agencies, not to supplant, but to supplement the planning process of each entity in the system; and to stimulate and encourage decentralized planning—conceivably even to require it.

Who should be held responsible for health care planning? Who should plan for health care? The answers to these, and some of the other questions frequently raised about health planning may now be suggested, with the context supplied by the preceding discussion.

First, anyone who contemplates taking any health care action should be held responsible for health care planning; that is, everyone should, including consumers. Everyone should be stimulated to think through his own goals, and to plan in relation to them. Likewise, everyone should coordinate with, and attempt to influence, goals and programs of entities that touch him, but for which he does not have operational responsibility.

Next, whether planning should be compulsory or voluntary is a false issue, since no thinking person can avoid planning. If someone has operational responsibility for the activity of a particular element of the health care field, however, and if careful analysis shows that such compulsion will produce a beneficial result, that particular element should be forced to conform to the conclusions of his planning. In addition, all elements of the health care field should be required to justify their proposed programs in terms of adherence to specified planning procedures. Although one unit may be unable to undertake detailed planning on behalf of other autonomous units, it can effectively influence the results by insistence on orderly processes.

Then, one does know enough to plan. In any dynamic situation such as the health field, one can never know enough to complete a fully efficient planning process, but plan he does and plan he must. When operators must make decisions, they should use all relevant data on hand. More data seem to be forever desperately needed, but data alone will never justify planners imposing their wills on operators.

Planning should be carried out by both government and nongovernment entities, as well as by the kind of quasi-governmental entities that are rapidly growing in importance, since they are involved in health care action. Coordination within each sector, and between both sectors, is required at all levels at which they touch each other. The issues in coordination of planning between the government and nongovernment sectors are not really different from the issues of coordination of elements within the nongovernment sector and within the government sector, or within any system.

The consumer enters health care planning at all levels, but especially at the most basic level of primary service. A most fundamental problem is the sketchiness and informality of the health care planning of the patient and potential patient (the consumers). The operation of the health care field is almost entirely dependent upon what the consumer does; with the exception of that tiny fraction of cases consisting of acute "emergencies," most consumer behavior is almost purely volitional. The more that he can be stimulated to plan his health care in an orderly process, and the more that is known about his plans, the easier will be the planning task of everyone else. If each consumer could be encouraged to formulate sound health care goals and to decide where he hopes to place his primary reliance within the health care establishment, that could provide a relatively firm basis for planning throughout a whole system, even if the consumers maintained their

freedom of choice at time of need. Too few health providers have programmed action to meet that clear need.

Beyond the fundamental involvement of the individual consumer in his own health care planning, he has a significant place whenever consumers act in groups to attack some health problem: operating a hospital, a prepayment plan or a health agency; negotiating future benefiits in a collective bargaining agreement, etc. In such capacities, he assumes operational responsibilities with a valid place in the planning picture. The leadership and the scrutiny of members of the community provide the stimulus and the balance that characterize the health system. As independent health planning agencies develop, community members play a vital leadership role.

Independent planning agencies seem to have proven useful in industrial development and urban renewal. In the health field, they are too new to assess fully, except to say that some circumstances in the health system would seem to enable the regional planning agency to serve a unique and essential role. The health system is a discontinuous one, with thousands of autonomous units, rather few of which at present undergo careful and systematic planning; the planning agency has, as a first responsibility, the challenge of inciting orderly planning processes throughout the system. As the proliferation of units doing systematic planning occurs, the job of the planning agency evolves to one of assuring communication and coordination among the units, and a time will come, which ought to be anticipated now, when more attention will need to be paid to coordination among regions and between the health field and other areas of community action. The proliferation of agencies corresponds to the proliferation of major health interests and communities; intercommunity coordination is an ultimate imperative.

Finally, the question is already current as to how to coordinate the work of state and, especially, federal agencies that plan for health. That is not only a matter of deciding a mix of national versus local autonomy; it also concerns the discontinuous nature of the federal government itself. Probably a half-dozen federal agencies furnish major capital funds for local health programs, and an equivalent number furnish major operational funds. At least four cabinet-level departments are involved. Instances of noncoordination have arisen in the past; it is likely that these will occur more frequently, even within the Department of Health, Education and Welfare. For example, who is attempting to coordinate in the community, the work of Hill-Burton, the Re-

gional Medical Programs, Medicare, the Community Mental Health Program, Social Rehabilitation Services, Medical Assistance and the Veteran's Administration, to name a few?

EXISTING OBSTACLES TO EFFECTIVE PLANNING IN A PLURALISTIC HEALTH ESTABLISHMENT

Public and professional concern about health care planning processes suggests that current planning processes leave much to be desired. The preceding discussion may provide a framework for assessment of specific weaknesses and for development of strategy and tactics to achieve more effective health care planning. Before attempting to make suggestions for improved planning, however, an examination of some specific obstacles may be helpful. Six important obstacles will be discussed, although only the first will be given detailed consideration.

Confusion of Primary Goals

It appears to be a characteristic of this country that when one really makes up his mind as to what he wants to do, he has a special genius for overcoming all obstacles and for getting the job done. The problem is usually deciding on goals, and that is the chief problem in the health care field. Each element in the health field appears to have a multiplicity of goals, often poorly visualized, with little coordination of interrelationships and priorities. In part, that is due to the changing technological and social base on which health care rests. Lack of explicit formulation and definition of goals inevitably results in overlapping, duplication, gaps and inefficiencies.

The goals of hospitals in the United States, for example, have been developed in an historical sequence, with each new goal superimposed upon, rather than superseding, earlier goals. Community service, or protection of the community by custody of patients, was the primary goal of the earliest hospitals, which were established primarily to remove unpleasant and dangerous individuals from the community, mostly those with communicable diseases and mental illness. Then, as these early hospitals achieved more stability and permanency, a second goal could be identified: humane care for the unfortunate patients. At first the goal of humane care seemed to be in conflict with the original goal of community protection on such issues as overcrowding and cost, but although this conflict continues to this day in some custodial care hos-

pitals, most institutions succeeded in developing goals that are primarily patient-oriented. That was true even when the patients were drawn largely from the least affluent segments of society.

Following the first use of antiseptic and aseptic methodology, and the myriad of specialized and expensive techniques that followed, physicians found that the hospital was superior to the home or office as a place in which to care for the seriously ill. A new set of goals emerged—meeting the needs of individual physicians—and soon was in top priority position in most hospitals. The purposes of hospitals widened to include not only community and patients, but also physicians, with the individual physician all-powerful. Much of the working jargon of the hospital stems from this period.

Following the Flexner report, the development of specialization and the activities of the American College of Surgeons, hospitals began to develop an additional institutional goal: patient care of high quality. At first, this goal seems frequently to be at odds with the goals of the hospital as a doctor's workshop, but quality care has now achieved top priority among the goals of most hospitals; not, however, without much struggle on the part of some individual physicians who were forced to adapt their own professional goals to institutional goals. Education and research programs were introduced in most hospitals because they furthered the basic goal of better patient care, and that still appears to be the justification for these activities in almost all hospitals. An increasing number of important hospitals, however, now seem to view education and research as primary goals that may require high quality patient care as a means to an end, rather than as an end in itself.

As hospitals are becoming the locus of an ever greater proportion of the community's ever more complex health care resources, observers are adding a new goal to the list of hospital goals: optimum health services for people. As this goal gradually moves into top priority position in the years ahead, hospital organization and service will undergo dramatic changes. To date, however, the individual hospital has tended to view optimum health services for people as an inevitable consequence of fulfillment of other hospital goals, rather than as a primary goal in itself.

To the extent that these other goals can be identified at individual hospitals at the present time, they represent some kind of accommodation to a mixture of a. higher quality of patient care, b. better educational and research results, c. meeting the needs of the doctors on the

medical staffs in their private practice, d. providing comprehensive care for the disadvantaged segments of the community, e. fiscal solvency and institutional survival and f. prestige for those associated with the institution. Little evidence is available to indicate that pursuit of these goals by individual hospitals will automatically result in optimum health service for the people. Increasing evidence suggests not. As patient care has become better and better because of its increased specialization and mechanization, its component parts have also become more and more fragmented and, in effect, less and less available to the individual. The people in need of care have greater and greater difficulty in making effective contact with the complex system so as to find their way to the right place at the right time. Although personal health may be steadily improving, the gap between what is, and what could be, is widening.

That may be one reason why many basic health indices in this country, which were declining rapidly for many years, are now leveling off—and at worse levels than in some other countries with more orderly distributive (though possibly less innovative) systems of medical care.[1] Most hospitals today have no knowledge of community-based health indices, no particular concern for how well the community is doing. No one is assigned responsibility for knowing; no one seems to care. It is almost as if hospital officials expect the people to serve the hospitals (by generating a flow of patients) rather than the hospitals to serve the people; only their worthy motives keep the hospitals above suspicion.

Hospitals have tended to concentrate on the *productive* processes and have relatively neglected the *distributive* processes of health care. Needs are thought of in terms of patients, rather than people. As a consequence of that approach, most hospitals do not cast their goals in terms of community needs, as distinct from needs of *their* patients and *their* service programs. The very best hospitals are often most divorced from community needs, concentrating on the newest features of high-quality patient care, education and research. To these hospitals, community service is often a euphemism for service to the poor, although the poor are becoming a smaller and smaller segment of most communities. In major teaching hospital circles, "community hospital" is often a belittling term describing a hospital that is not first rate.

As the hospitals have simultaneously become the chief community health resource while largely avoiding direct identification with community needs, conditions have been created that require another major

shift in the goals of individual hospitals, with the new emphasis on optimum health services for people. The new, broader focus will be on people and their total needs, with patients recognized as special cases (albeit very special cases) of people, and on delivering comprehensive health care services of high quality, convenient availability and lowest possible cost. The pressure for a shift in goals can be expected from governmental agencies, politicians, prepayment agencies, medical groups, consumer groups, hospital associations and individual hospital leaders, among others.

Already, the Board of Directors of the American Hospital Association has issued a statement on Optimum Health Services,[2] which concludes:

> The hospital, with its medical staff, is now the major health resource in most communities. To meet the expanded responsibilities of this position it is essential that it widen its concerns to include the totality of health services and, with others, to provide leadership in their attainment. The hospital should be prepared to assume a primary position in the implementation of community health plans. Each hospital, then, through its governing body, medical staff, and administrator, has a clear mandate continuously to examine its organization and facilities in the light of this central role in coordinating the principles of optimum health services.

The statement has provided the most authoritative definition of optimum health services to date, identifying six characteristics:

1. A team approach to care of the individual under the leadership of the physician.
2. A spectrum of services, including diagnosis, treatment, rehabilitation, education and prevention.
3. A coordinated community and regional system.
4. Continuity between hospital and nonhospital aspects of patient care.
5. Continuity between hospital inpatient and outpatient services.
6. Continuing programs of evaluation and research in quality and adequacy in meeting needs of the patient and the community.

Of these six characteristics of optimum health services, the third is most relevant to a discussion of planning:

> A coordinated community and/or regional system that incorporates the full spectrum of health services and provides for coordination of care from the time of the patient's primary contact with the system through the community hospital to the university hospital and/or medical center and other health agencies. Each should provide the portion of the total spectrum of

health services that is feasible in terms of the type of community it serves and the over-all pattern of health facilities of the region in which it exists.

Evaluation of almost any hospital's program in terms of the Statement on Optimum Health Services can be a distressing experience, since only a handful of hospitals can measure up. The situation is comparable to that which faced hospitals when the Standardization Program of the American College of Surgeons was first tested in 1918. In both situations, a new set of standards—logical beyond dispute, and required by a new set of conditions—defined a crisis situation for hospitals. Since most hospital officials and public representatives are as yet not aware of the wide gap between optimum health services and the existing programs of the hospitals, no crisis exists as yet.

Most hospitals and physicians can be expected to have great difficulty in applying the AHA Statement to a specific institution. The broad ideas of optimum health services are not easily understood, and are therefore not yet taken seriously. The American Hospital Association and other groups now face the task of translating the broad generalities of optimum health services into a series of specifics which will be understandable and useful to hospital officials, including leaders of the medical staffs, in redefinition of hospital goals.

One point is clear. Except in very unusual circumstances, a single hospital, by itself, cannot be expected to provide optimum health services. Coordination with other institutions is required. Each hospital would have to become a part of a structured or unstructured multihospital group or system, including also nonhospital resources. That conclusion is equally applicable to the medical school teaching hospital, to the large nonaffiliated teaching hospital with approved intern and residency training program and to the small community hospital. If the goals of each of these different kinds of hospitals are to be related to optimum health services, each of them—but especially the teaching hospitals—must join forces with other institutions.

A history of shifts in identifiable goals similar to that of the hospital, and similar confusion among a variety of goals today, would be revealed by detailed analysis of other autonomous elements of the health care system. Such an analysis would also point to a new emergent primary goal: optimum health services. The confusion on goals, new and old, is currently the major obstacle to more effective health care planning. The other major obstacles to more effective health care planning will be touched on only lightly in this paper.

Lack of Knowledge

Although the body of knowledge about the health care system has been growing rapidly in recent years, ignorance about most of the fundamentals is appalling. Accepted working definitions of optimum health service and even of quality patient care are lacking, as are methods of measurement of these basics. It is not yet known how to assess the results of a health care system so as to compare the effectiveness of different systems. Little is known about how physicians spend their time, about the characteristics of the patient-physician relationship, about what motivates patients in seeking health services, about the factors that influence various health personnel in interrelating their activities and about how they can be motivated to coordinate more effectively. Patterns of care and utilization are changing so rapidly that even solid data provide no clear direction for the future, and, most importantly, almost nothing is known about the relationship between good health and medical care. Most of the studies in these areas are so novel and so fragmentary that they raise more questions than they answer. Some have turned out to be simply wrong. Small wonder that many operators, facing key planning decisions, prefer to rely on "seat-of-the-pants" intuition. They assume an unpredictable setting, concentrate on meeting day-to-day pressures, and attempt to build in flexibility to adapt to change and self-sufficiency in relation to other health agencies.

Examples of planning programs resting on sound factual bases are conspicuous by their absence from the literature. Examination of the reports of consultants is an almost totally disappointing exercise.

Rapid Growth and Development

Within the past 25 years, the health care field has been expanding so rapidly and so continuously in almost all directions that institutions developed out of the most ineffective planning processes hardly ever seemed to "fail." This has led to a feeling that one can hardly go wrong and so need not plan in a tedious fashion. The need has appeared to be so great relative to the demand that anything done was better than nothing.

In particular, the experience of most general hospital officials suggests that inpatient usage will continue to rise indefinitely. The officials seem to believe that the larger the projected facility, the more forward-looking is the plan. The idea that general hospital inpatient utilization

rates will shortly follow the trend in tuberculosis and mental hospitals and "peak out" is so contrary to experience as to be unacceptable.

Fragmentation and Lack of Communication

Most communities are characterized by a myriad of autonomous health agencies, each of which is singlemindedly devoted to some specific phase of the total continuum of care. Each is surprisingly uninformed of—and often apparently uninterested in—the activities and plans of agencies with which it appears to have close functional interrelationships. For an elemental example, most hospital officials have never so much as visited a nursing home or even the neighboring hospitals, let alone the health department. Such contacts as do exist frequently lead to misunderstanding rather than cooperation. Even within an individual institution, barriers to open communication and trust among departments and services and among the trustee-medical staff-administrator triad are formidable.

In the absence of open communication, relationships among the fragments of the health system are often characterized by lack of knowledge, lack of trust and error in assessment of the other's actions, motives and future plans. Under these conditions, coordinated planning is next to impossible and each element is subject to gross errors in its own planning resulting from improper implicit or explicit assumptions about the other's plans. If better communication is rejected, the only feasible planning approach for the individual agency is to program for maximum self-sufficiency and for clear-cut, self-defined limitations of responsibility along the health care continuum.

Newness of Planning Ideas

Planning as a distinctive process of organization has been a subject of attention and study for little more than 25 years. Like most new disciplines, and especially those that touch on fundamental human processes, it has bred confusion, misconception, suspicion and opposition. It has attracted slick promoters and sloppy scholarship, in addition to the responsible advocates. By some, it has been misunderstood as someone else doing his thinking for him with regimentation of human activity by an elite. By others, it has been correctly understood as more systematic throught in an improved frame of reference. In any case, the notion of planning as a distinct discipline is distasteful and threatening to most people.

Tradition of Rugged Individualism

Nineteenth century traditions of rugged individualism are especially strong in the health field, where the physician finds the patient and the patient's family so dependent upon him. He knows that he is ultimately responsible for the outcome of the care he prescribes, and naturally and necessarily develops a strong, forthright professional ego.

But although institutionalization of health care, the development of team medicine and the modern hospital, have greatly increased the physician's ability to control physiological processes, they have done so only through increasing his reliance on other health care personnel and facilities not subject to his complete authority. His professional instincts tell him to maintain control of all services for his patients, but simple necessity causes him to relinquish more and more as specialization of skills and facilities becomes stronger. Still the tradition of strong individual initiative among doctors lives on, fueled by the life-and-death responsibilities inherent in the endeavor. It is by no means the only paradox in this field that the psychological conditions of medical practice can get in the way of coordinated planning efforts.

The evolving health care system reflects great ingenuity in adapting ever more complex organizational requirements to the needs of the individual practitioner to provide a continuing sense of independent responsibility for the care of his patients. An ever more complex system, in which control must remain at the most basic level in the system, creates many unique planning problems (as noted above, control only at the top retards development of the planning process throughout.

All these various obstacles to the development of a more effective planning process in the health care field need not lead to a sense of discouragement. Equally tough obstacles exist in other fields—economic planning, for example—in which much headway has been made. Many of the obstacles to better planning in the health field simply reveal the difficulty of improving the planning processes and increase the level of the challenge. Simplistic solutions obviously cannot be found, and improvement of the health care planning processes will require an evolutionary, developmental approach over a long period of time, a continuous weighing of alternatives and values, and efforts to change basic attitudes.

STEPS TOWARD MORE EFFECTIVE HEALTH CARE PLANNING

What specific steps can be recommended for improvement of health care planning? Clearly, steps should be taken to help everyone con-

nected with the health care system to a. recognize his own involvement in health care planning, b. gain greater insight about the planning process and to plan better, and c. understand the necessity to interrelate planning processes in relation to common and interdependent goals and programs.

What mechanisms, tools and positive and negative incentives can be devised to achieve these purposes? What steps should be taken first, and by whom? How should administrators plan for better planning? Assuming that goal setting is the weakest element in the planning process, and that improved goal formulation will almost automatically stimulate improvement in all elements of the process, recommendations for both national and local action would include the following.

Achieving Consensus on Health Goals

Within recent years, throughout the health care system a growing consensus appears to be emerging with respect to the general shape of health goals. Instead of merely best patient care, more is now heard about optimum health service. This implies two dimensions in addition to quality and compassion: and added emphasis on delivery of service in contrast to the productive processes; and a recognition of the principle of diminishing returns in health care, both with respect to competing components within the health field and with respect to the health field as a whole in relation to other forms of human activity.

The idea of optimum health services has not yet been spelled out in sufficient detail to serve as a practical guide in detailed goal setting by health agencies, but the most basic characteristics of optimum health services are fairly well agreed upon. They are expressed in such words as "comprehensiveness," "continuity," "regionalization," "accessibility," "team approach" and "the right patient at the right place at the right time," and found in pronouncements of such important professional groups as the American Medical Association, the American Hospital Association, the American Public Health Association, and the Group Health Association of America, as well as legislative and executive organs of parious levels of government.

A useful step would be to assemble these groups to work together on an accepted statement of the essential characteristics of optimum health services. Such a statement should be sufficiently detailed to provide meaningful guidance to autonomous units in their goal formulation, but brief enough so that it can become widely known and understood; it should be sufficiently specific to be useful, but not so specific as to

serve to impede progress, initiative and innovation. It can be adopted as an essential part of governmental and nongovernmental standards accreditation and licensing programs as well as grant and reimbursement programs. An acceptable statement along these lines could be developed on the basis of the consensus that already exists. The statement of the American Hospital Association represents one attempt, not fundamentally different from the efforts of the Health Advisory Committee to the Applachian Regional Commission or other efforts by other groups.

Once the framework of reference of optimum health services has been agreed upon, every autonomous unit in the field can be encouraged to formulate and publish its own goals, using the accepted statement as the starting point. Each entity should specify its own aspirations toward contributing to the over-all goal, and how and where it wishes to fit into the total picture. Its goals will specify what people it wishes to serve, what services it wishes to provide and what relationships it wishes to develop to assure optimum services for the people it plans to serve. In developing its goals in relation to optimum health service, each entity will necessarily have to consider the goals of other health units serving the same people. It may attempt to influence these goals, and will expect to be influenced in turn. Efforts of related units to coordinate their goals should lead to efforts to coordinate their programs.

A continuing national body should be established with the active support and participation of key consumer and health professional groups and government and nongovernment health agencies 1. to define optimum health services, 2. to subject the definition to periodic reevaluation, 3. to promote the use of this definition in goal formulation throughout the health field, and 4. to assist national health groups to formulate effectively interrelated goals within the framework of the over-all goal of optimum health services.

Identifying and Filling Gaps in Knowledge About Health Goals in Relation to Optimum Health Services

If goals are to be guides to programs of action rather than mere platitudes and exhortations, they must be quantifiable and quantified. Precise formulations are not necessary, but some general orders of magnitude are. If a specific health agency expects to plan in relation to optimum health services of a specific population group, it should know the characteristics of the population and its illness patterns; what

the optimum health service of such a group would amount to; what services the people are presently receiving; and so on. With this information it is possible to identify gaps and poor utilization of service, and to develop meaningful programs to improve the range of services. If, in addition, an institution develops knowledge to anticipate the direction and nature of changes that can be expected, it will be able to develop even more effective programs.

Given a workable frame of reference, planners and operators will be able to quantify each of the factors in as much detail as appears to be desirable for programming. Systematic collection and analysis of relevant data will contribute to more precise assumptions and more reliable programs. Of course, explicitly or implicitly, assumptions are being made now in planning activities, but many of the key assumptions underlying current health planning are not systematically formulated, and this fact contributes to the ineffectiveness of current health care planning. The effort to set forth the key assumptions in quantifiable form—even without data-collection programs to produce estimated quantities—will be a great aid to those who are charged with translating goals into workable programs in specific settings.

Most important are carefully documented, detailed studies of utilization patterns of population groups, with identification of illness patterns and other characteristics of the population, and of the health service ecology (availability and organization of resources, including financing patterns). Such studies, especially in relatively "optimum" settings, should provide a basis for ever more refined quantification of optimum health services and clues to ways of overcoming obstacles to achieving optimum health services. To develop findings of general applicability to specific situations, the completed studies should be subjected to comparative analysis. Eventually, it may be worthwhile to construct alternative prototypes or models for application at the community level.

In addition to systematic research studies, many health agencies and groups of health agencies will require relatively simple data to help them to identify where they have been, what they are, and where they seem to be going. With imagination, much data can be obtained as a by-product of the administrative flow of information. Surveillance of these types of data will also provide many clues for useful detailed research studies.

The continuing national body recommended above should include an arm with special relationships to general research groups and government and non-government health research agencies 1. to outline

needed areas of research to test health planning assumptions, 2. to encourage, sponsor, finance and carry out selected studies, 3. to provide guidance to groups in the conduct of research studies, and 4. to help in the appropriate dissemination of findings and conclusions.

Assisting Health Agencies in Goal-Setting in Relation to Optimum Health Services

Throughout the health care system, individual agencies will need help in formulating goals to enable them to play their appropriate role and make a maximum contribution to optimum health services. Even an agency that is able to employ and make good use of adequate planning staff will need help in achieving perspective, in obtaining data outside of its own control and in obtaining understanding, cooperation and agreement with other agencies.

That type of help can be provided most effectively by a planning agency with no operational responsibility at the local or regional level. Such planning agencies can help individual health institutions by:

1. Identifying the characteristics of a sound planning process and the steps involved.
2. Guiding the initial steps in the planning process.
3. Collecting and supplying data.
4. Establishing a framework as a guide for each health agency to find its own contribution to the area's optimum health service.
5. Helping with interchange of information among agencies with respect to goal setting and with introductions among agencies.
6. Evaluating specific goals developed by individual agencies.
7. Helping to publicize each agency's goals.

The independent health planning agency also can serve a vital role in mobilizing a community's power structure and resources in support of programs to promote optimum health.

Ultimately, each metropolitan area should have a single health planning agency, covering the surrounding territory as well, and closely linked to the "comprehensive" community planning authority. Such an agency may evolve from the increasing coordination of a number of separate agencies assisting in planning within limited geographic areas, or with limited subject matter foci. The evaluation may well be fostered by the proliferation of these narrow-interest planning agencies, as well as the growing demand of individual health agencies for personnel with

planning experience and skills, which are already subjecting the small existing supply of planning manpower to unfamiliar pressures.

In sum, to stimulate and assist individual health units with goal-formulation and other planning functions, continuing metropolitan or regional health planning agencies, without operational responsibility, should be established with the active support of key consumer and health professional groups and government and nongovernment agencies.

Provision of Incentives for Goal-Formulation in Relation to Optimum Health Services

In the existing health care system, every health agency has a myriad of relationships with a wide variety of government and nongovernment operational agencies from which it requires some positive act (or the withholding of a negative act) to continue to carry out its mission. In some cases, money is involved as, for instance, with Hill-Burton and other governmental grant funds, reimbursement by Blue Cross, the Social Security Administration and public welfare agencies, United Funds and Community Chests and other philanthropic agencies, including corporate foundations and agencies granting tax exemptions. With the Joint Commission on Accreditation of Hospitals, the Accreditation Program of the National League of Nursing, the medical specialty boards, professional membership organizations such as the American Hospital Association and the Association of American Medical Colleges, professional status is involved, and in some instances, it is continued self-determination or institutional survival, as with medical, hospital, nursing home and other licensing bodies and hospital medical staffs.

In each case, health agencies have demonstrated willingness to conform to conditions set forth by these agencies, especially when adequate provision is made for an appropriate advisory role and for review procedures. Some of these agencies already require a written statement of purpose or goals as a condition of support or cooperation. If all of them did so, specified that the goal must be defined in relation to optimum health services and asked for evidence of an effective planning process, more than enough incentive would be provided to assure that the task would be carried out by virtually every health agency. Each of the "incentive" groups could specify over a period of time that its continued support of local health units will not only require goal-setting in relation to optimum health service, but that it will also, with the help

of the continuing national body mentioned above, outline the basic characteristics of the goal that must be specified. Every effort should be expended to assist the individual agency in formulating acceptable goals, and to test the agency's program development in relation to the goal.

That approach is entirely consistent with present procedures in the health field. The Joint Commission on Accreditation of Hospitals requires a written and tested disaster plan of each hospital, even though the hospital may never face a disaster. The Social Security Administration requires a utilization plan. The Accreditation Program for Nursing Schools of the National League of Nursing requires a statement of goals and purpose. Why not also require a plan of community service for the future? Why not a plan to meet the health needs of people? Every operating agency that provides funds, professional status, or license to health agencies should incorporate a requirement of a written statement of goals related to optimum health service.

The Hospital Planning Association of Allegheny County: An Example

The Hospital Planning Association of Allegheny County, Pennsylvania, is an example of a non-operational planning agency that is attempting to carry out, in one metropolitan area, the approach outlined in this paper. The basic approach was developed under the guidance of the Association's first Executive Director, C. Rufus Rorem, one of the earliest exponents of coordinated health service planning in the country.

The Hospital Planning Association of Allegheny County was established in 1960, as a nongovernmental civic organization to develop a flexible, coordinated plan for development of hospital service, education and research. Originally financed exclusively by contributions from corporations and corporate foundations, it now receives half of its funds from a federal Hill-Burton grant. Its Board of Directors was originally limited to civic leadership and drawn from industry, commerce, the law and the clergy, but now also includes the medical profession and Blue Cross. Labor and government are as yet not represented. Hospitals and other health agencies as such do not have direct representation, but most members of the Board of Directors have affiliations with one or more health agencies. Hospital administrators and physicians serve on advisory committees, whose advice is obtained before action by the Board of Directors on any plans. The population served numbers 1,600,000, of which less than a majority live in the city of Pittsburgh.

The approach of the agency has been to develop an over-all plan by encouraging each hospital to initiate a continuing systematic planning process, to define specific goals for itself in terms of a unique role in relation to comprehensive community needs and existing resources, and to develop and publish an approved program based on these goals. The agency has developed planning principles as a guide to coordinated goal-setting by each hospital, as well as a guide to a systematic planning process. It provides a program of assistance to the individual hospital in its planning process, including data and a framework of suggested interrelationships, and to assist hospitals in gaining support of their plans, an approval program has been designed.

The planning principles of the Association were developed in 1960, with the active participation and approval of the representatives of the hospitals. Reflecting the idea of optimum health services, they are used as a guide to each hospital's planning program and as the basis for the Association's approval of programs. In effect, these principles represent a "master plan." They provide that:

1. The hospitals of Allegheny County should be established or expanded solely in terms of community need for service, education, and research.
2. Each hospital should plan its services and facilities with respect to a specific geographic area, which may be shared with other institutions.
3. Each hospital should be a center for comprehensive health service, either by direct provision of care or coordination with other institutions.
4. Volume and scope of service at each hospital should be sufficient to achieve high professional standards, reasonable costs and effective administration.
5. Hospitals should assume responsibility for public understanding of their programs of patient-care, education and research.

To apply these principles, each hospital must decide *whom* it wishes to serve, *what needed services* it wishes to provide and *what affiliations* it wishes to develop for those aspects of comprehensive care it does not wish to provide. The hospital plans in relation to people and their comprehensive needs rather than patients and their care. It develops its plans in relation to other health resources and in terms of meaningful relationships.

With the endorsement of hospital and medical leadership, the Hos-

pital Planning Association has recommended that each hospital create a long-range planning committee, with representation of trustees, medical staff and administration, to carry out an effective planning process on a continuous basis. It has suggested the methods of organization and functioning of such committees, including staffing.

The staff of the Hospital Planning Association is continuously available to help each hospital; in encouraging participation of the entire hospital family in the planning process; in analyzing key characteristics of the hospital; in providing information about the hospital that it is impossible for the hospital to obtain by itself; in providing information about the community; with introduction to other hospitals; in providing information about medical trends; with exploration of opportunities for collaboration; in formulating goals; in informing the public about a hospital's plans; and in recruiting planning staff.[3]

Based on existing patterns of utilization, program, patient flow and medical staff appointments, an over-all framework has been developed by the Association that provides guidance for each hospital with respect to service area, scope of service, medical staff appointment policy and affiliations. The guidelines are general, and are suggestive only, but have helped some hospital officials to come to grips with the Association's planning principles. The Association approves or disapproves planning programs brought to it by individual hospitals and publicizes its actions in the community to those who might wish to support the hospital. The major sources of capital funds—Hill-Burton and industrial foundations—all have established policies of seeking the Association's advice before acting on any request for funds.

Seven years after the establishment of the Association, almost all hospitals have created long-range planning committees and some of them are functioning quite actively. Two have employed full-time planning staff. Some of them are beginning to understand and accept the Association's principles; only a very few are enthusiastic as yet. Officials of some hospitals have had great difficulty in understanding the Association's approach or in believing that the Association is committed to this approach. Even the sympathetic hospital official has had great difficulty in achieving acceptance of the Association's approach within his own hospital family. Many of the issues that must be faced in an individual hospital planning program have never before been discussed in groups of trustees and medical staff representatives in hospitals, and, as a result, a long period of "wheel spinning" frequently takes place before the hospital's long-range planning committee gets to work.

With a long way to go, indications are that planning processes at the individual hospitals are beginning to improve, and at an accelerated pace. As yet, no dramatic results have been achieved, but all approved building programs reflect change from their original idea. With two exceptions, all building programs have been based on plans endorsed by the Association. The program of one hospital was disapproved during the agency's first year, but the hospital went ahead with a construction program anyway and is currently providing accredited care. One other hospital carried out a major building program without seeking Association approval. It is unlikely that any future building programs will be initiated without the Association's support, however, and it is hoped that no future program will be disapproved by the Association, since the Association staff attempts to work closely with the hospital to develop the best possible program before the hospital decides to initiate the formal approval process. In recent years, no hospital has wished to undertake this approval process against the advice of the Association staff.

The Association has occasionally been accused of trying to tell each hospital what its plans should be, but it has in fact studiously avoided doing so, despite strong pressures from individual hospital officials. One hospital, which appears to have developed its program in part to please the Association more than to please itself, failed in its effort to implement the program, and closed down a new $1,600,000 building within two years of its opening.

CONCLUSIONS

Although the Association's program is much too new for evaluation and assessment of its success, some conclusions drawn from its experience may be of value to other groups concerned with health care planning.

The real problem, it appears, is stimulating sound community-focused planning, rather than blocking the products of inadequate planning. Very few hospitals develop programs that are obviously "bad" in terms of narrow institutional focus, but existing planning processes of hospitals are very sketchy. Because of the degree of fragmentation and inadequate communication within a hospital, and because of the pressure of day-to-day service and the necessity for uninterrupted patient care, it takes time and effort for individual hospitals to shift from an institutional to a community frame of reference for planning.

Therefore, interim programs must frequently be supported while an individual institution struggles with new ideas. The necessity for such compromises decreases with time, however.

Free and open communication is also lacking between the planning agency and the individual health agencies. The greatest challenge facing health planning agencies is to devise effective methods of helping individual agencies to improve their planning processes.

The greatest need is acceptance by all in the health field of the basic implications of optimum health service. A workable program cannot be planned for an institution in which the key officials have not achieved understanding and common agreement about the underlying assumptions of the program. In fact, it is unlikely that the key officials can achieve the necessary degree of commitment to a program that they have not developed themselves. The problem, then, is both to obtain the understanding of hospital officials and, more important, to obtain their enthusiastic involvement.

The Hospital Planning Association has the support of enough groups with powerful "incentives" to require the cooperation of the hospitals, but power is clearly not enough to produce the desired effect. A major problem exists in expressing community planning ideas in terms that hospital trustees, medical staff representatives, and administrators can understand, and community representatives—especially those considering the establishment of new hospitals—tend to have even less appreciation of community planning ideas than those associated with hospitals. They want accessible services and do not readily grasp the excitement of innovative approaches. The general public cannot presently be counted on as a strong source of support for a community health planning agency in disputes with individual hospitals. A vigorous public education program is badly needed.

At present, the fundamental health planning agency in the community is the hospital, the one agency that has the potential to serve as institutional catalyst for the interplay of all the forces in the health field. It is developing key relationships with individual medical practitioners, health departments, voluntary health agencies, other hospitals and specialized institutions, and educational institutions and financing mechanisms, as well as civic and consumer groups. Essential to its role is an acceleration of the trend toward changing the composition and point of view of hospital boards of trustees, who are beginning to evolve from being institutional guardians to representatives of the broad public interest. Equally essential is acceleration in the trend for medical

staffs to evolve from private clubs and mechanisms for quality control to become the key medical unit for planning and coordinating health services at the community level; and acceleration in the trend of broadening function of the administrator from institutional management alone to leadership in coordinating all forces involved in providing optimum health services.

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