oward an Invisible College:

Training of Planning Personnel for Local and State Agencies

Human history becomes more and more a race between education and catastrophe.—H. G. Wells

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ALL THEM "health systems agencies," but think of em as educational institutions with an unusual and dical mission: to teach the people of the communi- they serve a new way of thinking and behaving out community health and health care services.

This "new way" calls for communities to invent, titute, manage, and evaluate comprehensive systems governance and accountability for the health serv- industry. It calls for reallocation of resources to new national, State, and local priorities. It calls for move from laissez-faire to massive community inter- ntion. It calls for sensitivity to consumer perceptions d demands. It calls for these changes to be initiated the context of a declining economy and declining ources. Given the likelihood of strenuous and force- l opposition, it calls for development of a constitu- cy to support such change.

The nation, with limited experience in such system- de planning, must learn how to do it. Hence, the lth systems agencies and their counterparts at the te and Federal levels must learn how to function as quasi-educational institutions and how to develop and translate new knowledge and experience into community practice.

HSA as an Educational Institution

As an educational institution, the health systems agency is deviant in form as well as function. It has none of the appearance of a traditional university. It offers no degrees, no courses, no lectures. It requires no registration and no tuition. It has a staff, but no one labeled

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"professor," and certainly no one with tenure. It has no endowment, no supportive alumni. Its students are adults, often with graduate or professional degrees; leaders in their professions, in business, in education, in community affairs; representatives of significant constituencies; controllers of major resources of funds, manpower, and facilities; molders of public opinion. They are formidable students who will challenge planning personnel working in a teaching role.

In order for the health systems agency to carry out its mission in a difficult and often hostile environment, several elements are necessary:

1. Planning personnel must learn how to function as planner-educators, using a variety of nontraditional educational tools, such as board meetings, public hearings, regulation, resource development, conflict, confrontation, and negotiation.

2. Planning personnel must mobilize a new teaching resource in their communities. Deviant providers and deviant consumers—that is, those who challenge accepted assumptions and practices, those who take risks to meet new health needs or test new ideas—constitute a major educational force that must not be overlooked.

3. Planning personnel must call upon universities to accept new responsibilities in support of those working for change in the health services industry.

These elements must be linked in what Boulding has called "invisible colleges," that is, "small groups of people with similar tasks who are in close, constant communication and operate as a discipline, so that the mistakes of one can be avoided by another" (*1*).

Competencies for Health Planning

What kind of competencies do health planning personnel need to function effectively as planners-educators? Professional competence is obviously essential, as noted by Cleveland city planners (*2*):

> The power to influence decisions is directly related to professional competence. Politicians, high ranking bureaucrats and other important actors in the public decision-making process are not interested in rhetoric . . . Nor are they interested in planners' political "feel" of an issue. Most of them have a far better grasp of such matters than any planner. What frequently does interest them is informed recommendations directed at tangible objectives, backed by careful analysis and sound data, and presented in a matter that is meaningful to them.

Technical orientation. Public Law 93–641 specifies the technical expertise required of the health systems agency: administration, the gathering and analysis of data, health planning, and development and use of health resources. Other kinds of competencies can be, and undoubtedly will be, added. But traditional technical competencies, while essential, will not suffice; they never do because health policy is always complex and ambivalent. For example, current policy calls for controls to reduce the escalating costs of health care services. On the other hand, as Havighurst and Blumstein point out, "Increasing governmental involvement in health care . . . carries with it a major risk that very large amounts of spending will be necessitated simply to maintain government's humanitarian image" (*3*). They cite the example of the extension of Medicare coverage in 1972 to all victims of chronic renal failure.

Managerial orientation. Another comment on technical competence comes from Battistella and Smith, who urge caution in the application of traditional managerial techniques to the health services industry (*4*):

> Despite claims of objectivity and value neutrality, by virtue of their roots in business-industrial applications, managerial techniques are biased in favor of the selection of simplistic private sector solutions. By virtue of their emulation of science and its methods, they are biased in favor of the selection of quantifiable programs. By virtue of their foundation in normative theory they are highly reductionistic and unrepresentative of the realities of applied decision making. They also tend to be highly insensitive to the social, political and moral dimensions of problem solving which are the cornerstone of social policy, and differentiate it from decision making in the private sector . . .

Management in a decline. When resources seem unlimited, the nation placed little emphasis on planning. The fact that health planning exists and is being strengthened symbolizes a new way of thinking about the social, political, and moral dimensions of health policy. For it is recognized that resources are limited, even when goals are humanitarian. In a declining or uncertain economy, growth in health services will no longer come from massive infusions of new resources, as in the past. Health planning agencies will manage an industry in decline, in a process characterized by redistribution of finite resources; from people who have choices to people who have not, from treatment services to preventive services, from traditional modes of delivery of services to variations which have thus far been considered deviant and unacceptable.

Boulding, in the context of his prediction of a general era of decline in our societal institutions, comments (*1*):

> The skills of managing a declining institution are not only different from but are probably in some sense greater than those required to manage institutional growth. There is in the former greater need for empathy and for an all too rare mixture of compassion and realism, and for creative widening of agendas. The manager of a declining institution is required to think of more things that haven't been thought of. In a growing institution mistakes are easily corrected; in a declining institution they are not.

He concludes: ". . . we know so little about decline that we are not even sure what these (management) skills are."

Perhaps the major skill is to manage humanitarianism efficiently, ethically, and with empathy.

Humanistic orientation. Battistella and Smith suggest a humanistic orientation to management that recognizes that (*4*):

Health services play a major role in keeping society together . . . Health services also partially fill the emotional-spiritual void in today's highly developed society created by the breakup of family structure and other primary groups, the decline of religious faith, the trauma of accelerating rates of social and technologic change, the cultural uprootedness and emotional maladjustment associated with high rates of population mobility, the pressures of urban-industrial living, and the depersonalization of interpersonal relationships caused by bureaucratization.

Efficient humanitarianism on the part of health planning personnel will require a high level of ego development which relates to cogitive, interpersonal, and organizational skills. In a 1970 publication Loevinger (*5*) described a progression in ego development, in stages beginning with the "presocial," and ending at the highest level with the "autonomous" or the "integrated." A person functioning at the autonomous level of ego development would have a cognitive style that includes objectivity, a tolerance for ambiguity, the ability to understand complex patterns, and conceptual complexity. Interpersonal patterns at this level include such qualities as respect for autonomy, concern for communications, mutuality, and a strong sense of responsibility. The motives for education of a person at this level of ego development might include the desire for a deeper understanding of self, of the world, and the development of an increased capacity to manage one's own destiny.

Institutional functions that correspond to this level of ego development would include asking key questions, posing key dilemmas, confronting significant discontinuities and paradoxes, and providing for new experiences. Finally, the learning processes that facilitate the integration of the person and the institution at this level of ego development are seeking new experiences, reorganizing past concepts, developing new paradigms, and creating new dialectics.

The planner-educator must organize, give support to, and receive support from a new teaching community, powerful enough to introduce new ideas into the community's concept of health services and health. Two elements of this teaching constituency are of special interest to health planners: deviant consumers and deviant providers, who function at the periphery of the industry, but who address new priorities in new ways.

Traditionally, consumer participation in health affairs was limited to the more affluent members of the community, and these laymen and health professionals were fairly compatible and cohesive. Then came the Federal legislation of the sixties, with requirements for participation of consumers representing a socioeconomic profile of the community.

New roles and relationships for new consumer representatives, ranging from advisory to control, were hammered out in the new programs of the sixties, such as model cities, OEO community agencies, and neighborhood health centers. These programs served as training grounds for members of low-income and minority groups who had previously been excluded from policy making. New concerns, previously foreign to traditional health professionals, surfaced: for example, inner-city residents' distrust of having their health records maintained in the same computer used by the police department for police records. New styles to achieve social change emerged, for example, the use of confrontation and conflict tactics created problems for health professionals accustomed to negotiating differences over cocktails or through memos. But along with discomfort came some changes, including a new but modest resource base, such as neighborhood health centers. In addition, some people who started as consumer representatives in the sixties went on to further education and degrees and are now professionals in health planning and health administration.

The health service industry cannot rely indefinitely on the generation of low-income and minority leaders that came to prominence in the sixties. Reductions in Federal funding and program support have all but eliminated the training and service opportunities that might have nourished the next generation. The National Association of Neighborhood Health Centers, with its regional community health training institutes for staff and board members, is one of the few major resources remaining. Health planning will have to find additional ways to learn from and to strengthen low-income and minority consumer groups and to draw upon them as a resource for community education and change.

The second group is composed of deviant providers: professionals involved in serving publics overlooked by the traditional system, in redefining community concepts of disease and health, in redefining professional roles, and in establishing new delivery systems. These professionals are working in neighborhood health centers, free clinics, alcoholism and drug abuse programs, community mental health centers, rural clinics, occupational health programs, home health agencies, and even health departments and HMOs. They include professionals such as nurses who are developing new roles and responsibilities in the health care team. They include women and members of minority groups who may bring new perspectives as they enter the professions.

Many of these providers and consumers do not consider themselves radicals—they are simply responding to community needs—yet in the context of the traditional health care industry, they are deviants. At the moment, they are weak allies, not in communication with each other and unaware of their potential power. Their representation on health planning boards and committees is likely to be minimal. Yet they, along with sympathetic providers working in traditional settings, can be constructive voices for change. Through involvement, training, reenforcement, and skillful re-

source allocation, they may be helped to organize into a cohesive and effective force.

Education for management. An important, indeed essential action element is to improve the management of the several kinds of nontraditional agencies and services to assure their effectiveness, efficiency, and survival. It is of interest that the Commission on Education for Health Administration recently estimated that 50,000 to 60,000 persons are carrying out executive level administrative functions in the health system in the United States. "Data available to the Commission indicate that only about 25 percent of currently practicing health administrators have had formal education for health administration practice and that most of the 25 percent are practicing in hospitals and public health agencies" (*6*).

In addition to the need for formal education and credentials for administrators, designed to help them stay in and influence the health industry, it will be necessary to provide supportive training for board members.

Obviously, universities will have to be enlisted in this effort, given their control of professional credentials. However, given the magnitude and difficulty of the task and the paucity of resources, it is unlikely that traditional universities will be able to help. Thus it will be necessary for health planning agencies again to seek out innovative institutions willing to be responsive to new kinds of students and the community needs they represent.

Universities in Supportive Roles

If the health planning agencies are indeed deviant agencies, charged with bringing about major changes in the health service industry, then their training needs are also deviant, requiring deviant action by universities that wish to be responsive.

Accessibility of health services, particularly to undeserved populations, has become a national issue. Accessibility of educational services is equally an issue. There are some 20 States in which no university offers a graduate program in health planning or health administration. Existing programs may require full-time enrollment and admit no part-time students. They may offer no evening or weekend courses. Some courses may be offered only once in a 2-year period. Their admissions criteria are designed to assure production of distinguished alumni, rather than to respond to individual or community needs. Astin argues (*7*):

> If one accepts the idea that colleges exist to educate, then selective admissions based on test scores and prior grades make little sense. If an institution exists to educate students, then its mission is to produce certain desirable changes in students, or, more simply, to make a difference in the student's life. This "value-added" approach to the goals of higher education suggests that admissions procedures should be designed to select students who are likely to be influenced by the educational process, regardless of their performance at entrance.

Traditional graduate programs which require full-time enrollment create problems, especially for women and members of minority groups who cannot leave families or jobs for a year or two. Persons who have worked their way into responsible administrative positions, particularly in small agencies, also have difficulties; they cannot be spared to become full-time students.

Appropriateness of health services has become a national issue; appropriateness of educational services is equally an issue. Graduate programs are often locked into curriculum or course requirements; they may be locked into assumptions—such as the hospital being the core of the health services industry—which have limited relevance to new national priorities; they may be locked into requiring use of university resources simply because they exist, for example, business administration courses geared to production, rather than service industries. Graduate programs may have faculty with little knowledge or experience related to new priorities, who cannot function adequately as role models for students; the programs may not address new areas of expertise, such as consumer participation, health politics, or the regulatory function; they may not offer field placements in new types of agencies or services.

Concern for the integrity and dignity of the patient or consumer of health services has become an issue. Similarly, there must be concern for the integrity and dignity of students. Graduate programs should promote and support the highest level of ego development in students; instead adult students are often given little opportunity to exercise responsibility for their own learning and are simply processed through a curriculum which is comfortable for the faculty.

Training Models

The University of Cincinnati is testing several education models which attempt to address the issues and needs just described. Tests of the models are supported by contracts with the Bureau of Health Resources Development, Health Resources Administration: the inner-city work-study program for health professions faculty by contract No. NO1–MB–44213 and the external master of science degree program in health planning/administration by contract No. NO1–MB–44178.

Inner-city work-study program for health professions faculty. This project brought a group of faculty members from college and university programs in health administration, nursing, and health education to Cincinnati for a 4-week period during the summer of 1975. They spent half their time in field placements in inner-city neighborhood health centers, contributing their expertise to solving administrative problems

of the centers. Another major portion of their time was spent in seminars with speakers drawn from academia and from neighborhood health centers. Their major assignment was to develop curriculum models to take back to their colleges and universities for implementation. This community-university project was co-sponsored by the National Association of Neighborhood Health Centers. A major objective was to help participating faculty introduce new consumer-oriented curriculum ideas and content and serve as role models who would help motivate their students to seek careers in inner-city health services. A second objective was to provide technical assistance to Cincinnati area neighborhood health centers. Preliminary reports indicate that the projects met both objectives.

A similar model could be used in health planning: university faculty placed in health systems agencies, health planners placed in inner-city health centers, consumer representatives placed on university faculties, and health planners placed in health systems agencies which have special expertise to share, or which need inputs of expertise they lack.

External MS degree program in health planning/administration. Students in this program design individual, self-paced programs of independent study to achieve competency goals. They may use a variety of learning modes, including university courses, tutorials, apprenticeships, or multimedia learning resource units developed and provided by the University of Cincinnati. Admission is limited to persons who have a baccalaureate degree and are employed or involved, for example as board or committee members, in community health agencies, organizations, and facilities. Students are not required to give up their jobs and move to Cincinnati, which reduces costs considerably, and increases accessibility. The program requires completion of 60 quarter credit hours, including 9 hours in each of three core areas: applied theory, health systems, and quantitative and analytic skills; a 9-hour comprehensive action project, and 24 hours of electives. The flexibility of the curriculum enables the student to design a program tailored to individual needs and career objectives.

Student-faculty interaction in this program is predicated upon recognition of each student as an adult who is aware of his or her knowledge base and learning needs. Students use faculty as mentors or consultants, or both.

The program assumes that the student has an educational history and an educational future; while the master's degree may be a terminal degree for many persons, it does not represent terminal learning. Thus the program attempts to address concurrent learning, that is, it supplements and complements what the student learns on the job and in other environments; and sequential learning, that is, it builds on what has been learned previously and influences what will be learned in the future. The student is considered to be mature enough to determine both sequences and consequences.

The program asks the student to demonstrate sensitivity to consumer needs and to value and ethical issues in community health. It also emphasizes redistribution of health services to meet needs of underserved populations.

Students are encouraged to enroll in geographic clusters, so that they can meet periodically to discuss mutual interests and problems. Present enrollment includes a group in Tennessee, where the State department of health is the demonstration site, and a group drawn from Ohio, Kentucky, Indiana, and West Virginia. Applications for admission have exceeded the present capacity of the program.

A variation of this program is being tested in cooperation with the Ohio Department of Health's Division of Alcoholism, which is sponsoring a group of students who spend 2 days per week on campus and then work 3 days a week, under supervision, in the administration of alcoholism programs.

In the external MS degree program, the University of Cincinnati functions somewhat along the lines of the model of the health systems agency as an educational institution as described previously.

As more universities began to deviate from tradition and offer programs similar to those being tested by the University of Cincinnati, health planning agencies may find a useful new resource to reenforce their educational mission.

Certainly there is need for a visible effort to create invisible colleges in health planning, to link the deviant elements of the health services industry as a discipline and as a force for education for constructive change to assure "the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living" (*8*).

References

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