Planning for Community Health Services

JESSE B. ARONSON, M.D., M.P.H.

DESPITE our historical tradition of rugged individualism, the course of development in the health sciences and arts is inexorably bringing about a pattern of health services requiring the participation and cooperation of many agencies and individuals in the care of a single patient afflicted with a single disease or disability. This trend is only one small facet of the fundamental social changes stemming from the rapid advances in knowledge of biology and medicine and the resultant increase in longevity. The shift from an average lifespan of 50 years in 1900 to 70 years in 1960—1 added year of life in every 3 calendar years—has created an irresistible force leading to change.

Social change often leads to suffering and human wastage. Through community planning and the intelligent use of our most advanced knowledge, we can mitigate the harshness of social change.

In our communities we have an existing community health service pattern. It is usually poorly organized in that numerous governmental, voluntary, and proprietary agencies which provide health services have loose, uncodified, and noncontinuous working relationships. Care directed to a single set of the patient's symptoms is the usual practice; his overall needs are often forgotten.

Dr. Aronson is director, division of local health services, New Jersey State Department of Health, and a member of the Advisory Committee to the Community Action Studies Project, National Commission on Community Health Services. *The paper is based, in part, on an address given at the annual Conference of State and Local Health Officials, Trenton, N.J., on April 2, 1964.*

Administrative barriers to continuity of care are formidable. The unnecessarily repeated X-ray or laboratory test when two agencies are involved in the care of a patient is usually the rule. Prolonged waiting periods between phases of care because of the absence of established and mutually recognized referral procedures is the general experience. Speech therapy may be available to the cerebral palsied child but not to the child with cleft palate in the same town.

Many of our agencies are organized on the basis of neighborhood loyalties and operate on such a small population base that quality services and economic administration are impossible. Our one- and two-nurse VNA's and other fragmented health service agencies cannot provide the essential skills and breadth of service necessary to meet the complex community health needs of today. The erection of a small hospital, lacking many of the expensive but essential services, can no longer be justified when, in an adjacent community, adequate services are available. With rare if notable exceptions, nearby hospitals do not share extremely expensive services such as open heart surgery or cobalt radiation apparatus. Even in our comparatively affluent society we can no longer afford to waste our tax dollars and voluntary dollars by such inefficient operations.

Despite these shortcomings we cannot seriously consider scrapping existing agencies and organizing a single unified community health agency. We cannot afford to lose the abounding social values derived from years of citizen and professional effort which has been expended for each of our community health agencies. More than that, we are convinced that independ-

ent agencies provide the citizens and professionals with an open door to progress, to improved and new services. But, as is characteristic of the democratic society, independence can be preserved only by limiting it through the democratic process so that the common good is served. An overall plan of operations for health services endowed with effective community sanction and support is needed. Such a plan can be implemented if the need is recognized and the leadership is developed.

The Interacting Forces

Planning for and maintaining community health services involves special and more broadly shared sets of values than any other single function of the community. Every person and every family experiences ill health and has an ever present potential of ill health. Illness and disability interfere with all aspects of life, particularly with the economic stability of the family. Most profound is the emotional impact that disease, disability, and death and the fear of such advents have on the individual and family. To this must be added the universally accepted ethical and religious concepts that all of us have a moral responsibility for the ill and disabled among us.

Aside from these broad avenues of citizen interest in community health services there is a series of special interest groups. The health officer and his staff have been employed by the community to make community health their particular interest and responsibility. Physicians with their knowledge of disease and their major role in providing health services have traditionally been asked to guide the community in planning these services. Community hospitals and other voluntary health agencies have over the years developed significant, vested interests in this area. The pharmaceutical industry and the insurance companies have particular interests here. Labor unions, parent-teacher associations, and other groups representing those who use health facilities are directly concerned. Finally, there are a large number of commercial and industrial enterprises whose activities are subject to regulation to protect the health of the community.

These are the special elements of social motivation and action that bear on community health services. They operate in conjunction with the basic elements in the power structure of the community—the commercial and industrial forces, the social, cultural, and religious makeup, and the political pattern. The interaction of all of these factors constitutes the matrix within which planning for community health services must be conducted, and the organized groups and leaders who give expression to these motivating factors are the community health power structure.

Choosing the Planners

Planning is defined as designing for action. Planning is therefore a means to an end, in this instance action to change community health services so that they meet present needs. Unfortunately, too many of us fail to recognize that a "plan" is not a plan unless it contains all the elements necessary to bring about action. Our shelves are filled with surveys and recommendations, so-called plans, representing huge expenditures of citizen effort, which in reality were only wishful thinking by well-meaning people.

A group of health professionals can, without assistance, design a blueprint for needed community health services. Such a design is not a plan unless it includes the mechanism for lining up in support of the design the most powerfully motivated elements in the community health power structure and for securing as a minimum the toleration of uninvolved or marginal elements. Such support and toleration can only be expected if both the basic premises of the design and the superstructure in which they are clothed do not violate either the fundamental motivations or the cultural or social shibboleths of each of the groups with which the plan is concerned. It is extremely difficult for a group of health professionals enlisted from the community or from afar to have the wisdom to give proper consideration to such factors—many of which they are unaware—and for most of which they set different values.

The local professional has another, much greater disability, his inevitable concern with the possible effects of change upon his own economic and social status. A retrospective look

at community health studies by the National Commission on Community Health Services has brought into relief the rapid turnover of professional employees of local agencies. Within a short period after a study was completed, it was not unusual for the local professionals, often in the leadership of such planning, to have taken new positions and no longer be residents of the town. The inhibitory effect of this on the implementation of the recommendations is obvious.

Our experience with professional studies has in many instances been very discouraging. The resistance that is often engendered by the recommendations, the major difficulties encountered in mustering citizen and agency support for the implementation of the plan, and the all too frequent filing of the report so that it is difficult to locate—all testify to the weakness of community planning by this method.

We have long given lipservice to the need for citizen involvement in planning: prominent citizens are found who endorse a study; an impressive letterhead carries an extensive list of sponsors; agency executives and presidents of boards are interviewed; a public meeting is called to receive the report and there is anonymous applause.

We must accept the basic rule that the essential foundation of a community plan is the active participation of citizens who lend to the study committee all significant shades of opinion of the various interests in the community and exert, for the committee, leadership in securing acceptance of the plan by their respective interest groups. What then are the steps we must take to conform to this rule?

Ideas of the need for change arise from an infinite variety of social impulses. When such an idea crystallizes within a group of citizens who accept their civic responsibilities, community action may be initiated. Such a group rarely is representative of the community. However, it can compile a list of community interest groups with notations on the relative importance of each group in the health power structure. This list should include those that have a manifest interest in the needs to be met, the services to be provided, and the source of funds required for the project, as well as the professional, business, sectarian, and political groups whose interests may be impinged upon. Each group should be canvassed to select individuals who are recognized as leaders in their respective groups. If possible, avoid official representation from organizations since such persons limit the flexibility of the committee members and of the committee as a whole. Even more important, staff members employed by health agencies should not be members of the committee; they can be asked to serve as professional consultants. An admixture of elder statesmen and younger activists is desirable.

Constructing the Survey Instrument

Years of accepted practice in public health have conditioned us to the standardized survey schedule as the only acceptable pattern for the study of community health services. The American Public Health Association's evaluation schedule is the product of prodigious effort of a succession of professional committees and specialized subcommittees. In spite of the several professional disciplines and the wide geographic areas represented on these committees, the document is a set of detailed measurements of a series of health needs and services based upon standards of "good" practice in communities in which such health services have been accepted over a period of years. There is no mechanism for adjusting these measurements to the social, economic, or political conditions of the community. The same schedule would, therefore, be applied to a predominantly agricultural community in Mississippi and to an upper middle-class suburb on Long Island. The former could not use or afford many of the sophisticated services that are to be measured, and the latter could use only minimal amounts of services that would be essential in the rural South.

Recognizing these limitations, the National Commission on Community Health Services is experimenting with what is hoped will prove a more flexible planning guide, a modification of the APHA evaluation schedule, for use in the 20 community self-studies participating in the Community Action Studies Project. At best, a standard study guide can serve only as a checklist to assure the study committee that items

considered significant in other communities have not been passed by because of ignorance or inadvertent error. The specific problems in a community often require detailed investigations which far transcend the material called for in any of the published evaluation schedules. The committee must therefore construct its own study instrument, utilizing material from the standardized schedule and from special schedules designed to study specific facilities, as well as ad hoc material prepared specifically for the local study. The selection of the survey committee and the construction of the survey document complete the initial phase of the planning activity.

Assessment and Action

The second phase is the task of assessment. Using the survey document members of the committee, organized into subcommittees, examine specific community health needs and existing services designed to meet these needs. These findings should be recorded in detail. It is in this factfinding activity that the staff of local agencies and other local professionals can assist the subcommittees and make an important contribution to the study. The comparison of health needs and available services should clearly expose problem areas—community facilities that require rearrangements or additions today and in the period immediately ahead. The participation of community leaders in factfinding gives them that awareness and understanding of community health which readies them for the tasks ahead.

The next step in the assessment process is the most critical; the adoption by the committee of specific goals, recommendations to meet these goals, and a time schedule for their implementation. We must recognize that these must be empirical decisions based upon a variety of health-related factors, each weighted by local considerations. Objective criteria serve well, but only as guideposts.

This is the time when the expert professional consultant can be used most effectively. For each problem area identified, the appropriate consultant can outline the several alternative courses for its solution. He should indicate the advantages and disadvantages of each alternative in the light of the particular conditions in the community as brought out by the findings of the committee.

Careful consideration must be given to the feasibility of securing sufficient funds and their source, the readiness of one or another community agency to assume the administrative responsibility for the needed service, community interests that can be mobilized to support the recommendations, and community interests which may be unfavorably disposed to the recommendations. Armed with professionally sound alternative recommendations so annotated, the committee must then, in executive session, determine its definitive recommendations which it is willing to carry forward into the third phase of community planning.

This is the action phase. If the committee has had within its membership the effective leadership in the power structure, if there is general unanimity within the committee regarding the final recommendations, if the recommendations are clearly and explicitly framed as to operating responsibility, cost, source of funds, and schedule of implementation, if during the several phases of committee activity both the operating agencies and the financing agencies have been consulted constantly and their special interests taken into consideration, and if care is taken so that the committee procedures and the form of the recommendations minimize the provocation of potential opposition groups—then the community is ready for necessary action.

At this point the work of the committee has not been completed; two major functions remain. Foremost is the evaluation of the progress made and of the effectiveness of the services developed. Further, it is necessary to maintain flexibility in the entire project by providing a mechanism for adjustment to meet unforeseen problems and needs.

Roles of the Health Officer

The health officer has a very special and difficult role in planning for community health services. His relationship to the community has multiple facets, each giving rise to motivations drawing him in somewhat different directions. His major role should be that of a com-

munity leader whose training and experience give him the knowledge and perspective to recognize and understand the health needs and to evaluate the services provided to meet these needs. He is well informed regarding the health professions and can appreciate their capacity to participate in health activities. He thus has a broad obligation to give health guidance to the community, its official and voluntary health agencies, and in particular to its health planning body.

At the same time he is employed as the administrator of the health department and is personally responsible for assuring that his department renders proper and effective health services within its special field. This position as director of an official agency of local government also invests the health officer with the role of "cabinet member," advisor, and lieutenant to the head of local government and advisor to the legislative or budget-making body. He must necessarily be responsive to the political problems of the incumbent local officials. This dual administrative and political function, while giving him the opportunity to bring health planning directly to the attention of the governing officials and to influence them in the use of tax money for health purposes, yet may, on occasion, seriously limit his freedom of action as a participant in a community planning body.

In most instances the health officer is a physician and an active member of the medical society. Here he is again in an ambivalent position as an advisor to his colleagues on their legal and medical responsibilities to the community as a whole and as a member of an organized group which has a major function protecting the welfare of private medical practitioners.

In addition to these administrative, professional, and political relationships, the capable health officer has a direct relation with the public as a health educator, as a promoter of new and more effective services, and as the health watchdog calling attention to present or threatened health hazards.

He has a clear responsibility to delineate health problems as he sees them from his vantage point. He likewise is obliged to bring this knowledge to the attention of interested citizens and officials as well as the general public. He certainly should encourage rational planning for community health services. He should make the extensive data easily accessible to him available to the planning committee. He should be ex officio consultant to the committee. Yet a planning committee whose membership does not include employees of health agencies may very well be stronger than one which does and, without question, will have greater freedom of action.

The health officer can take on major responsibilities during the action phase of planning. By making use of his well-established relationship with local government, community agencies, professional organizations, and citizen groups he can assume leadership in encouraging acceptance and implementation of the study recommendations. His knowledge of administration—budgeting, personnel, project grants, contracts—can smooth the way for programs which at first seem to have formidable barriers.

Voluntary Agencies and Hospitals

The local chapters of the voluntary health agencies have on their boards citizen leaders who are dedicated to and knowledgeable about the health needs of the community. These groups often plan their own activities very carefully. At the same time it must be recognized that the nature of these organizations, and especially the framework in which they obtain financial support, often present special problems in overall community planning. Sharing of facilities, personnel, and services, which may be utterly rational in terms of economy and effective use of scarce personnel, may seem quite threatening to small agencies, especially to their executive directors. Therefore, it is important that the boards of voluntary agencies be involved through the appointment of their natural leaders to the planning body, while official representation, particularly by employees, should generally be avoided.

The community hospital has an especially significant position in planning for health services. The board of the hospital usually includes some of the most responsible elements in the community power structure—persons of influence who over the years have been made

acutely aware of the nature of health services. Unlike the medical society, the hospital medical staff association has as its primary purpose the organization of medical procedures so that the hospital will be a more effective agency in serving the community. The public in general looks upon the hospital as the center for health services—emergency care, inpatient care, and special laboratory services as well as a place where volunteers work and citizens give blood.

The modern hospital, like the health department, can no longer be an agency responsible only for certain limited areas of operation, isolated from concern with the overall health problems of the people. It follows that a health planning body without strong involvement of both the board and medical staff of the hospital is deprived of an important segment of health leadership. As a corollary we must seriously question the proposition that there must be a hospital planning body isolated from the planning activities of other health agencies and citizen interest groups.

Conclusions

This discussion has been confined to the community self-study method. Health planning can be accomplished by authoritative governmental planning bodies. Such bodies are most likely to be State or Federal rather than community based. An authoritative planning body may be necessary in a large metropolitan community and, even more so, in a metropolitan area if the very complex health problems in such multi-municipal aggregates are to be resolved rationally. The social and political structure of our medium-sized, small, and rural communities seems to call for citizen leadership and responsibility in health planning. Our health problems have become so far reaching and so complex that organized community solutions seem to be inevitable. The self-study method involves citizens working together and reacting in a fashion that continues and enlarges upon the pattern of community decision-making most consistent with our democratic genius.

Lake Erie Pollution Control Study

A reporting network of 17 current-metering stations was staked out on Lake Erie in May 1964 as part of a 6-year study of the waters of the Great Lakes begun in 1960.

Target of the Great Lakes study is provision of a sound scientific basis for the development of a comprehensive water pollution control program in the Great Lakes area. Initial work was on Lake Michigan and the Illinois River. In cooperation with the Great Lakes States and Federal agencies, studies will be completed on all the Great Lakes, showing information on sources of water pollution and data on water quality and lake currents.

The current-metering stations are marked by a float at the surface of the water. Below the surface, instruments are attached to a line going to the lake bottom. Every 3 months scientists pick up the data recorded by the instruments. The stations on Lake Erie will be in operation 1 year. They were set up in a week-long operation in which a Canadian Coast Guard vessel and scientists from the Great Lakes Institute at the University of Toronto participated.