A Model Health Planning Process

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THE SUCCESS of a comprehensive health planning process will bear a direct relationship to the extent that concerned groups are meaningfully involved. To say specifically who has to be involved is difficult, but it is clear that other groups besides the major providers of health services must participate. If health planning is to be comprehensive, the inputs of many persons and agencies will be required.

This participation does not mean, however, as one health officer believed, that advisory councils must be comprised of every concerned health group and a large number of consumers (in his case, a council of at least 70 members). It does mean that at appropriate points in the planning process the concerned groups must be involved. The following description of a comprehensive health planning process illustrates this point, although the model itself is not necessarily advocated by the Office of Comprehensive Health Planning of the Public Health Service.

Information Needed for Planning

We would probably agree that the basic tool of the comprehensive health planning agency is information. The planning agency needs to know a great deal about its society—the society's resources, problems, potential, and aspirations. These data are, in part, of the traditional sort—statistics on morbidity and mortality and manpower development, facility and manpower utilization data, scientific data on the state of the health sciences, social data about the problems and movements of people, economic data, and so forth. Information is also needed about the aspirations of the society, not only what it wants but also what it would probably want if it had the knowledge and resources.

Many of these data already exist in agencies around the community. We recognize immediately the necessity of involving the traditional health agencies in the planning—the hospital councils, medical societies, medical schools, and health and mental health departments. We can also readily recognize the potential data contribution of other agencies, such as education and welfare departments, voluntary health agencies, and health and welfare councils. We should not forget, however, that such agencies as the Urban League, labor unions, the Housing and Urban Development (HUD) areawide (701) planning agency, economic development agencies, and legislative committees may also have pertinent data. Some of these data may not exist; some of them may be judgmental. The judgmental data may be technical, requiring expert medical judgment; some of the information may relate to community values.

In any event, to develop the data, extensive involvement of community groups on the advisory council and on the council's subcommittees will be useful, if not essential. The com-

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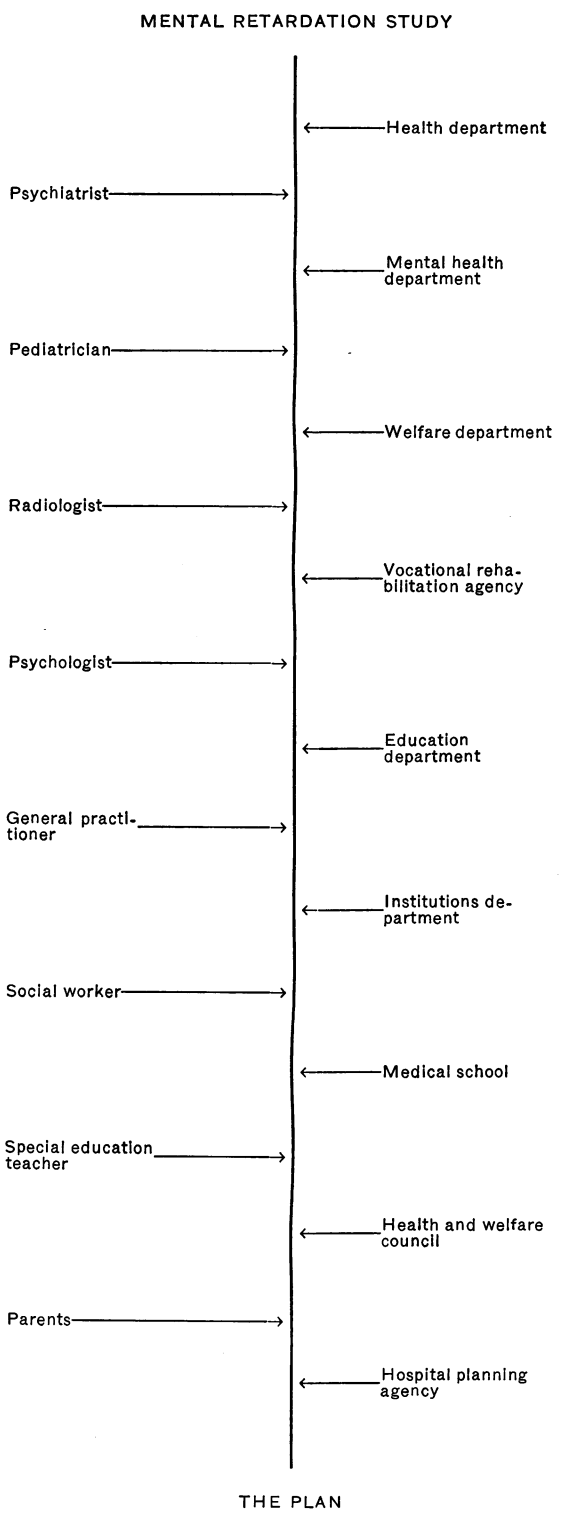

Figure 1. Representative inputs for a mental retardation study

prehensive health planning agency may also hold public hearings and well-conceived and well-conducted community surveys to collect some of the information it needs. Any information collected, however, should be both meaningful and appropriate for the planning process. The planning agency should take care to avoid collection of data for its own sake or as justification for a computer, which may or may not be necessary for comprehensive health planning.

The data gathered by the comprehensive health planning agency will help give a picture of the area for which the agency is planning. These data will consist essentially of abstractions describing the system which the planning process is expected to order in a reasoned manner. As data become available, they will have to be assessed for their planning implications—not before the planning begins, but on a continuing basis throughout the planning process. As it monitors these data, the planning agency will identify problem areas and will then set its priorities as to which phases of the comprehensive health planning process attention is initially to be directed. Priority may be given to a health category, a population group, a geographic area, or an organizational problem. As a practical matter, the comprehensive planning agency may have identified and begun to address itself to some or all of the priority areas long before the hard data are at hand. It may have set these priorities on the basis of judgment and experience.

We need not concern ourselves here with how the agency's priorities are determined. Rather let us assume that the planning agency has decided that the major concern is mental retardation and that it should study this problem. To structure such a study, the planning agency will need a great deal of information.

The principal organizations and persons from whom data inputs would be required in conducting a study of mental retardation are shown in figure 1. The list of inputs in the figure should not, however, be considered exhaustive.

Each of the organizations and persons listed probably has a meaningful input to make. The professionals and the parents have experience, judgment, and knowledge which are vital to the process of planning in the mental retardation area. Many of the organizations control re-

sources and thus probably have data, expertise, and judgment which can contribute to the plan. What is more, unless each of these groups participates meaningfully in the planning process, the chances of getting them to act later are lessened, since many of the agencies have, or are developing, their own program plans, which may require modification if they are to be compatible with the comprehensive health plan. Some of these agencies, because of independent sources of financial support or because of strong political support, can also ignore planning recommendations with impunity. If they are meaningfully involved in the planning process, however, they come into agreement on goals and will in turn develop or modify their own program plans in accord with the comprehensive health plan. Prof. Charles Lindblom has described this type of process as ". . . partisan mutual adjustment . . . a method for calculated reasonable, rational, intelligent, wise—the exact term does not matter—policy making" (*1*).

The Comprehensive Plan

The end result from all these inputs is a plan for meeting the problems of mental retardation, a blueprint for action. If the plan is good, it will be comprehensive in scope, dealing not only with the mental retardation agency, but also with all aspects of mental retardation and with all the appropriate linkages to other groups and agencies. But the plan will not be detailed to the *n*th degree. Rather, the plan will be, as Surgeon General William H. Stewart stated in 1967, "less concerned with targets and more concerned with directions." It will provide, generally speaking, the broad schematic by which the program agency will then program-plan.

Comprehensive mental retardation plan. For example, the plan to deal with mental retardation may provide broad recommendations for needed services, facilities, manpower, and research (fig. 2).

Each component of the mental retardation plan should call for action by someone or some program agency, and the call for action becomes an input into that program agency's plan. Thus, when the medical school works on its plan, part of the input—for example, the need to provide general practitioners and pediatricians with continuing education related to mental retardation, the need for research in that field, and the need for manpower—may come from the mental retardation plan. (I say "may" because some of the recommendations in respect to mental retardation possibly will be directed, depending on the State or area, to the medical society or the academy of general practice.) But let us assume in this instance that the recommendations are targeted to the medical school.

Medical school plan. If the medical school's plan is a good and comprehensive one, it will deal with the program requirements for mental retardation, as well as those from other program areas. How it will deal with them and by what means are for the medical school to determine so long as it effectively satisfies the needs.

The medical school's plan might consist of the following items, stated here in general terms but which would include elements designed to meet mental retardation needs:

1. Laboratory requirements for teaching and research.
2. Continuing medical education programs.
3. Intake of students sufficient to meet insofar as possible the manpower needs in the community.
4. A residency training program to meet insofar as possible the needs in the community for the medical specialties.
5. Service activities, including those designed to meet teaching requirements and the needs of the community.

Similarly, the other recommendations in the mental retardation plan become inputs into the plans of other agencies. Home care services and day care centers may have been targeted to the local health department, to the voluntary hospitals, or to the mental retardation association; preventive services to the health department; and so forth.

Comprehensive plans for other problems. Likewise, when the comprehensive health planning agency directs its attention to other problems, a similar process goes on. The inputs are different because the problems are different. If the problem of concern relates to health services in economically depressed areas, the participation of labor unions, the Urban League, and the HUD areawide (701) planning agency

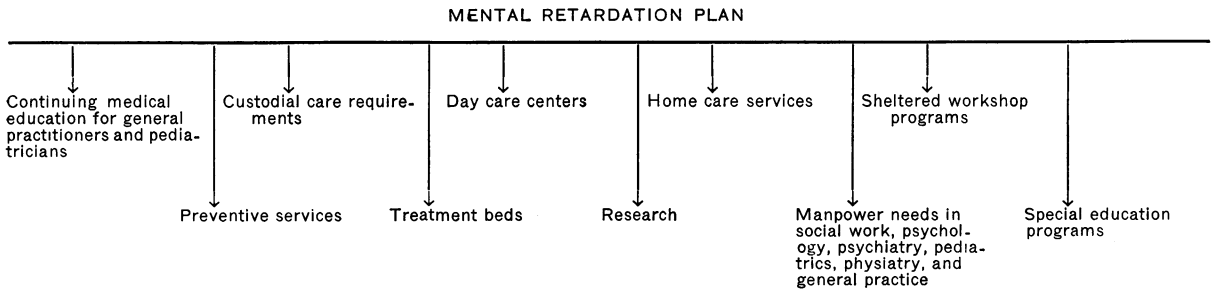

Figure 2. Representative outputs from a mental retardation plan

would be vital. If the problem is connected with environmental health, still different—drastically different—inputs would be made. In dealing with air pollution, for example, significant contributions to the planning process might be made by geographers, economists, agronomists, meteorologists, chemical engineers, psychiatrists, internists, pathologists, the agency on aging, the health department, the public works department, the HUD areawide (701) planning agency, and citizen groups, to name just a few.

If the problem of concern relates—as it did in one State—to the establishment of a neuropathological institute, the inputs of organizations might come only from medical schools, the State mental hygiene department, and the medical examiner's office; the major inputs from professionals might come only from pathologists, ophthalmologists, and psychiatrists.

Discussion

From the model we can get some idea as to the way groups and persons concerned with a particular problem can provide inputs for, and become involved in, the comprehensive health planning process. As the model suggests, not all the groups or persons concerned need to serve on the advisory council. Some may most effectively participate by serving on subcommittees of the council; others may find their inputs to be effective in a staff-to-staff working relationship. Unless, however, there is a meaningful involvement of the concerned agencies, groups, and persons at proper points in the planning process, the end product may not be truly comprehensive and may fail to elicit the support and action of those who are called upon to implement key elements of the plan.

The details of the planning model may suggest that I consider the comprehensive health planning agency to be all seeing, all knowing, and concerned with every nook and cranny of the health system. Such is not the case. The comprehensive health planning agency will not normally direct itself to day-to-day affairs. Its plans will be "less concerned with targets and more concerned with directions." Of course, some program agencies have planned effectively, and should continue to plan, for both targets and directions. The hazards in doing so, however, are considerable, since the program agency operates not only under daily pressures to perform, but also under political and budgetary restraints. Both the pressure for performance and the restraints may cause shortcuts in the planning process so that the end result will be less than optimal, less than comprehensive. While all agencies must be wary of these pressures, the program agency which seeks to plan comprehensively must be particularly careful.

Conclusion

The comprehensive health planning process is concerned more with health problems than with organizational lines. Unless the planning process is addressed to administrative arrangements in the State or area, concern for organization comes into play only when it targets the recommendations for action by specific agencies. Thus, the comprehensive health planning process, because it relates program objectives to one another and to the overall needs and resources of the State or area, provides a framework for strengthening program planning efforts. The intimate involvement of concerned public and voluntary agencies, groups, and persons is vital.

Who specifically has to be involved in the comprehensive planning and in what way depends on the answers to the following questions:

1. What is the problem for which a plan is being developed?

2. What information is needed to develop a plan which will be comprehensive in scope?

3. Who has the required information—including the experience and judgment—for input into the development of the plan?

4. What groups and agencies will be expected to act on the plan? The answers to these questions will indicate who will have to cooperate and in what way to make the comprehensive health planning process work effectively.

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