through all the papers that follow. They are addressed to what is required to turn public health planning from fruitless literary exercise into concrete achievement. Obviously, many public health planners have already learned these lessons from personal experience; the practitioners may well be proud of the record in the field. But the years ahead will be a period of new stresses and new ferment. We may not have the time to wait for each new planner to learn the old lessons slowly and painfully. As the papers demonstrate, social scientists may be able to help them avoid some of the pitfalls, disappointments, and hardships they will surely encounter as they ply their craft.

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II. THE MYTH OF PLANNING WITHOUT POLITICS

Basil J. F. Mott, Ph.D., F.A.P.H.A.

PLANNING is an effort on the part of some group or organization to alter the behavior and conditions of other people. No matter how objective or wise planners may be, they are engaged in deciding what is "good" for other people and taking steps to attain that good. Community health planners may try to get prosperous business firms to part with money to provide health services to poor people. Hospital planners may attempt to prevent skilled surgeons from obtaining facilities and staff for open-heart surgery when they feel adequate services are available elsewhere. People and organizations, however, rarely agree with others' judgments of what is good for them. And we Americans do not acquiesce meekly while planning agencies act in our "best" interests. Usually we act to trim the planners' feathers.

The actions of planning agencies to get others to accept the changes they seek, and the countervailing efforts of those who see things differently, is a political struggle in which each party seeks to determine the outcome of the planning process according to its views of what should be done with respect to the matters that interest it.[1] This is not politics in the narrow sense of the term, referring to the behavior of party officials, legislators, and others seeking to influence governmental decisions. By politics, I mean the efforts of individuals and organizations to mobilize and utilize power to attain their ends. Politics in this sense is an inescapable aspect of health planning, and for that matter of all public health activities where men disagree over what is to be done and try to make their views prevail. As Morris Schaefer has said, "the old and well-propagated myth of the nonpolitical

character of public health was a delusion—except, sometimes, in the sense of partisan politics."[2]

Politics could, of course, be removed from health planning if planning agencies were given sufficient power to make sure that their wills would prevail over all opposition, such as the authority planning bodies are reputed to have in the Soviet Union. If planning agencies possessed this capacity, there would be no incentive for anyone to try to influence their decisions, as such efforts would be futile. Undoubtedly planners sometimes wish for such a state of affairs, but it is unlikely to come to pass in the United States, unless we are ready to abandon our democratic institutions. In this paper I propose: (1) to illuminate some of the political factors that influence health planning, and (2) to show how our conceptions of health planning ignore these considerations, thereby causing misunderstanding of the realities of planning and limiting its success.

By planning is meant a process of decision-making that consists of determining what future state of affairs is to be achieved—a goal, for example, such as comprehensive health care, of systematically evaluating alternative courses of action to reach the desired goals, and lastly, of choosing the best course of action.[3] These remarks will be confined to planning attempted by such groups as community councils, regional hospital planning councils, and state comprehensive planning agencies, in which the aim is to make important changes in the health activities of a community or large area.

Political Characteristics

The politics of community-health planning vary markedly from setting to setting, depending upon many factors, such as the scope and functions of the planning body, and the nature of its power vis-a-vis the constituencies and groups affected by its activities. Community-health planning, nevertheless, has certain common political characteristics that profoundly influence its effectiveness.

Community-planning agencies must deal with many different and frequently conflicting interests. This makes it exceedingly difficult to reach agreement on what is to be done and to take action that runs contrary to the interests of any of the participating groups, as these groups perceive their interests. Health endeavor in most communities, and at regional and state levels as well, is divided among a host of specialized agencies, groups, and disciplines. In fact, this fragmentation is often cited as a major reason for planning. Community planning ideology in the field of health also calls for comprehensiveness of scope, and the representation, if not the active participation, of all interested parties in the planning process. Most recently, the Comprehensive Planning Amendments of 1966 require that consumers of health services be represented.[4]

Community health planning agencies are generally unable to make decisions that tread heavily upon the toes of important organizations and groups in the health community, because they rarely possess much authority. They do not have the right to act, or to compel others to act. Even when they have legal authority, or are informally accepted as legitimate bodies, planning agencies seldom have the resources—such as funds, manpower, and prestige—that most organizations use as leverage, in addition to authority, to gain compliance with their decisions. Much lip service is paid to planning, but there is little willingness to give authority and other forms of power to planning agencies. The agencies that are affected by planning decisions do not want to surrender any of their autonomy because doing so might threaten their survival.

Those who have a vital stake in the decisions of community-planning agencies are ordinarily successful in making their views felt at all the stages of the planning process. This is because of the many opportunities to advance and defend their interests, owing to the limited power of the planners and to the large number of groups that generally participate in community health planning. These groups are likely to influence the questions to be considered, how they are to be approached, the alternative solutions to be considered, and the courses of action to be selected. There is of course considerable variation among the participating agencies and groups with respect to the opportunities open to them, and when and where they choose to exert themselves. They also differ in the strategies by which they exercise power, and finally, in their effectiveness. But it is rare indeed when planners can move without adjusting to the preferences of those who are affected by their activities, whether or not they feel it to be desirable.

Therefore, the outcome of community health planning is, to an important degree, the result of a struggle in which the power of the planners is weak. Consequently, successful planning—defining success as the capacity of planning agencies to make decisions that they feel are desirable—rests heavily upon the ability of planners to make the most of what little power they possess and can acquire. In short, they must be good politicians, if they are to achieve much.[5]

Theories of Planning

These realities have largely been ignored in the formulations of planning common in the health field. Here, we shall briefly discuss the limitations of two models of community health planning: the rational decision model and the community action model. Although there is no generally accepted classification of the conceptions of community health planning, these two models fairly represent the principal approaches.

The central features of the rational decision model are familiar. Planning begins with a problem, a present state of affairs is considered unsatisfactory—often an area of unmet health needs. Data is collected to define the problem and to evaluate the performance of the relevant segments of the community—usually the agencies considered to have some responsibility for meeting the problem. Objectives are established—to reduce or eliminate the problem—and alternative ways of achieving the objectives are formulated and evaluated according to objective criteria. Lastly, the course of action that best satisfies these criteria is chosen for implementation.

The rational decision model is politically naive, because it presents planning as essentially a technical process in which experts choose or provide others with an objective basis for selecting means, if not ends. It fails to recognize that in the real world the determination of objectives, as well as of courses of action, is a highly subjective process, especially the selection of objectives. No matter how self-evident the unmet health needs of any group may seem—for example, the needs of the poor or the American Indian—any decision to raise the level of their health must be based upon some set of values that are implicit in the decision, if not explicitly recognized. For example, in the cases cited, one may be seeking justice—the poor should have as much opportunity for a healthy life as the rich—or one may want to act morally—helping the poor is a moral thing to do. Such decisions are value judgments. Although they may be, and should be, arrived at with the benefit of data, they cannot be arrived at objectively. Different men and different groups tend to draw different conclusions regarding what should

be done, if anything, when presented with reports of health surveys. Even a definition of health needs necessarily contains elements of personal or group preference, as is evidenced by the unwillingness of various ethnic groups to accept the middle-class values of health professionals.

Considerable subjectivity also enters into the choice of means to achieve health objectives. Experts usually have different perspectives, depending upon their discipline, and thus often do not agree on what criteria should govern the evaluation and selection of courses of action. For instance, some may emphasize preventive approaches; others curative ones; still others may give priority to social or economic factors. Even within specialized areas of planning, there is a lack of generally accepted criteria on which experts can agree, and on which, in principle, decisions can be based. There is, for example, no technology that will tell one where to locate and how to staff health facilities. About all we have is professional usage.

Consequently, when planners make decisions they necessarily impose their values to some degree and, to the extent that they do so, they cannot claim an objective and thus a scientific basis for their actions. The legitimacy with which they make choices rests ultimately upon community acceptance of their judgments and thus deference to such authority and other influence as they may possess.

The rational decision model also ignores the capability of planners, or others, to carry out their decisions. In emphasizing the technical aspects of planning, it says little about the impact upon planning of the organizational and institutional context in which it takes place, and the accompanying political dynamics. The rational model tends to view planning as though it were the acts of a single decision-maker, or mind. It either assumes that planners are able to act, or it is inclined to regard the question of the implementability of plans as outside the planners' responsibility.

In reality, the planner is seldom, if ever, an individual; planning invariably is carried on by organizations. Even when community-planning agencies employ individuals known professionally as planners—there are several kinds—such persons are unlikely to be given sole responsibility for planning. As paid members of organizations, planners are accountable to one or more superiors who must be satisfied—an executive, a coordinating committee, or a board of directors. They must also work with peers, and function within the constraints of their agency's relationships with the organizations and groups on which it depends for survival. Planners are constrained in what they can do by the same realities of organizational life as other members of organizations, including the internal and external politics affecting their agency.

In conclusion, the rational decision model ignores the principal sources of the politics of planning: namely, the aspect of subjective judgment in planning decisions, which results in differences among planners and others over what should be done; and the organizational context of planning, which limits the ability of planners and planning agencies to carry out their decisions. In doing so it avoids the most difficult problem of planning—feasibility.

The community action model incorporates many of the features of the rational decision model, such as the stress on rationality, the collection of data, and the weighing of alternatives. However, it is different in several important respects. Primarily the community action model calls for active participation in the planning process of the groups having a major stake in the outcome. The task of the planning body,

whether it be a permanent planning agency or an ad hoc committee, is to develop agreement on goals and means of implementation among the interested parties. Planning is in large part seen as a process of group decision-making in which development of consensus is a central feature. A basic underlying premise of the community action model is that little planning can be accomplished unless planning decisions are acceptable to those affected by them.

The community action model is more politically mature than the rational decision model in that it attempts to deal with the question of feasibility. Implicit in it is recognition of the limited capacity of planning bodies to make decisions that are unacceptable to powerful segments of the health community. Nevertheless, it has serious deficiencies, because it does not face squarely the political realities of group and organizational behavior.

The community action model fails to recognize the limits of consensus as a means of getting action. It does not take into consideration the fact that issues involving fundamental differences among the groups that participate in planning cannot be resolved through consensus. It expresses a naive faith in the ability of surveys of health problems and community participation in planning to produce acceptance of planning decisions. It is felt that if those having an interest in planning take part in the study of health needs, and if the facts become known to them, they can reach agreement on the nature of the problems to be tackled, and on what to do about them. There is a failure to see that important conflicts among the participants derive from different interpretations of health data, which are rooted in differing values and interests, and, moreover, agency survival may call for different and divergent responses to potential changes in the health system. For example, disease-oriented voluntary agencies see health needs from a different perspective than official health agencies or medical schools, and cannot be expected to agree to proposals to combine their functions. No matter how much an organization may wish to be cooperative, it will not agree to decisions that sacrifice its vital interests if it has the capacity to resist them. The only way that an organization can be influenced to accept a decision that runs contrary to its interests, is for another group or organization to make it more costly to resist than to accept the decision.[6]

The community action model, therefore, does not come to grips with the underlying basis of the limited capacity of planning bodies to deal effectively with tough issues—situations in which someone gets hurt—namely, such agencies lack of power and need for political skill to make the most of what they have. Although the community action model has done much to encourage the development of feasible community plans, its usefulness has been largely limited to guiding discovery and exploitation of consensus in problem areas where the interests of participants converge.

Conclusions and Implications

What conclusions and implications follow from our analysis of prevailing conceptions of community health planning? Although it has been necessary to oversimplify, it is fair to conclude that current theories of community-health planning tend to be statements of the logic of our intellectual processes, especially the rational decision model, rather than formulations reflecting the realities of individual and group behavior.[7] Consequently they neither describe well what happens, nor are they very useful as guides to action. Because of the lack of political realism of theories of community-health planning, there is a di-

chotomy between thinking and behavior that has seriously retarded the effectiveness of planning. On the one hand, planners—especially the most successful ones—deviate greatly from the official orthodoxy and must do so to accomplish anything. To an important extent, planning practice is the head of our ideas. On the other hand, in most discussions of community-health planning, planners pay obeisance to current theories, and many individuals and organizations try hard to follow their prescriptions. Moreover, our ideas about planning necessarily influence our behavior, and should, for this is one of the main reasons for thinking systematically about planning. Thus, in providing health planners with an approach that ignores politics, our theories have reinforced existing professional biases that politics should be kept out of health. This has encouraged planning that is not feasible and a degree of self-indulgence on the part of planners that is irresponsible and wasteful of scarce resources. It also has contributed to failure of feasible plans for want of political know-how and skill.

There is, therefore, a need to develop an approach to planning that will contribute to more effective results. What is needed is to bring into the body of planning know-how the latest knowledge of how political power works in planning settings. For example, it is important for planners to know how the power structure in their community, and their agency's connections with it, may be expected to shape and constrain the planning process. Similarly, they need a basis for determining what the possibilities for effective action may be in different situations, and for assessing the prospects for mobilizing the necessary power. Planners must be helped to acquire skill in employing political strategies. Knowledge of the political dynamics of planning would also contribute to development of more realistic theory to guide practice, to theory that reconciles the rational elements of the current models with relevant political factors.[8] It is difficult to see how planning can be made more effective, regardless of improvements in planning technologies, data collection, and analysis, without explicit recognition of the functions of power, and thus of politics, in making decisions that involve conflicting values and interests.[9]

The success of a more realistic approach to community health planning, however, rests upon a larger question: namely, acceptance by health professionals of the political dimensions of health. There is a need in the health field to see that politics is not a perfidious activity, but an inherent and necessary ingredient of all human endeavor arising out of the real differences among men over what they consider important, and their willingness and ability to strive for what they believe in. Politics is something in which we are all more or less engaged, whether or not we recognize our behavior by that name. In accepting politics as a part of health, we are more able to recognize our relationships with others having different perspectives, and thus to increase our effectiveness in attaining what we seek.

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9. The development of health planning theory will not be an easy task: Many of the weaknesses of present theory are the result of limited knowledge and weak conceptual tools. There are few systematic studies of actual planning and almost none that deal explicitly with the political factors. Two dealing with political factors are: Conant, Ralph, The Politics of Community Health, National Commission on Community Health Services. Washington, D. C.: Public Affairs Press, 1968, and Mott, Basil J. F., ibid. The improvement of theory will require carefully conceived studies of actual planning experiences.

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III. THE CHANGING POLITICAL CHARACTER OF HEALTH PLANNING

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Background

THE term "planning," as used by health professionals, originally referred to facilities planning. More recently, the term has begun to encompass a broader kind of activity in an attempt to integrate the health resources of a community, so as to better provide for the community's needs. Public Law 89-749, the Comprehensive Health Planning Act, has expanded the scope of health planning to include environmental health and manpower needs.[1] This act has been a major cause of the recent increased attention paid to planning by health professionals. However, it has had little effect on the political character of health planning which is changing primarily because of broader social factors.

There seems to be general agreement that past efforts at community health planning in the United States have not been very successful.[1-4] This has been true of planning both for environmental health and for the provision of personal health services. This paper primarily discusses the latter.

We have had this lack of success because, first, there has been little agreement on goals (except in abstract terms); on the priority ordering of goals; and on the means by which goals might be implemented. The goals of the planners have often been different from the goals of those who must implement the plans.

Second, community health planning has been institutionally separated from actual operating functions. As a result, such planning as has been implemented has not been that of the planners, but rather that of the providers of health