Health planning in this paper is considered as a developmental process in which different types of planning appear at different times. These types are discussed and the place in the complex health care system developing in the United States is assessed.

Types of Planning in the Health Care System

Darwin Palmiere, A.M., M.P.H.

Introduction

One task of the theoretician is to impose order on the phenomena in the subject area of interest to him. He looks for patterns in structure and process which can be abstracted into a representational image of the reality under analysis. There are many patterns which may be imposed on a set of phenomena depending on the purposes to be served by the analysis. In other words, the map is not the territory; and, many different kinds of maps may be drawn from the same territory.

The territory of health planning has been discovered only recently as measured by academic time. As a result, it has been explored only superficially. The maps are few and contain only the barest outlines of the area. In addition, there is disagreement as to the appropriate interpretation of even the major features of the territory. However, only as maps are drawn and tested against the reality will we extend our understanding of this complex territory. In this spirit, the following map of planning in the health care system is offered for examination.

Health Care System

The United States now has a highly complex set of professional practitioners, organizations, and consumers which provide, pay for, and use health care services. From a phenomenological point of view there are simply a very large number of people acting individually and collectively according to their needs, wants, interests, and capacities.

From a theoretical point of view, however, it is possible to analyze the individual and collective behaviors of people and abstract from these certain patterns of structure and process related to a purposive definition of health care. One may then interpret such patterns in terms of a health care system—a complex network of selected activities generally related within a framework of cultural values and a social structure of role-status relationships. This network is a dynamic mechanism, constantly changing, yet subject to no single set of controls.

From the perspective of the health care system, health planning always occurs. The relevant issues concern who does the planning, to what ends, how does it occur, what social structures support it, and what are its cumulative effects on the health care system.

From an historical perspective, health care planning may be viewed as a developmental process encompassing three categories of planning activities. Each successive "category" of health planning has developed as a result of specific limitations in the capacity of the previous category to respond fully to forces impinging on the health care system. Each new category of planning has not, however, replaced the previous ones. It has, instead, acted to support previous types of planning while limiting their negative effects on the health care system.

Dispersed Health Planning

The earliest developed, most pervasive, and continuing form of health planning is that undertaken by each provider, consumer, and financing organization which make up the health care system. This form of health planning consists of the many decisions made by all individuals and organizations in the health care system as they attempt to provide, finance, and use health care services. Such health planning decisions may be divided into four groups: 1) the definition and selection of health problems, goals, and standards which are considered relevant and worthy of consideration; 2) the establishment of priorities among valued problems, goals, and standards and the acquisition or allocation of resources in accord with such priorities; 3) the establishment of coordinative and integrative activities with other health system personnel and organizations; and 4) the choices of day-to-day activities in the performance, use, or financing of health care services.

For example, each physician selects the problems and goals of his professional practice in the process of selecting a specialty within medicine. He also decides where he will locate his office and with which hospitals he will affiliate. In doing so, he is choosing the socioeconomic class of consumers he will accept as patients. In his daily activities, he repeatedly makes choices concerning the severity and complexity of illness and disability which he will attempt to treat. He also decides on the standards of performance he will use in providing medical services. Since he must frequently supplement his own services with those of other health care workers, he must also plan relationships with personnel in hospitals, nursing homes, health departments, and other independent professional practitioners.

Each health care consumer does his own health care planning in a similar fashion. He defines his own health problems and goals in accordance with the values of his family and subculture. He decides which health problems and goals are most important and worth the investment of time and money in seeking their alleviation. He fits his health care activities into his daily schedule, weekly budget, and family and work relationships. He ties together the services of one or more physicians, dentists, optometrists, and relates

to these the acquisition of drugs, eyeglasses, and other products necessary to receiving reasonably adequate health care.

Each financing organization also makes planning decisions which follow the same pattern seen in the decisions of providers and consumers. Types of diseases, disabilities, health services, and health facilities are identified and ranked in priority for the distribution of available capital or operating funds. Detailed plans are set up for their allocation. Since health care funds are supplied through many different voluntary and governmental programs, plans must be developed for their coordination in the interests of comprehensive care and efficient use of resources.

The planning activities of providers, consumers, and financing organizations are expressed in a series of sequential interactions among these groups. Each individual and organization balances his own self-interest with the self-interests of other individuals and organizations whose help and cooperation are required. Transfers and exchanges of goals, problems, resources, and services occur continuously as plans are translated into health care behaviors. The cumulative effect of the planning decisions of the multitude of providers, consumers, and financing organizations is reflected in the nature of the health care system. In other words, the health care system represents the net result of the dispersed planning decisions of each and all of its units.

In 1900, this form of health planning was the only kind which occurred. Even today, a large share of planning in the health care system is dispersed among the individuals and organizations which provide, finance, and use health services. Some people believe that dispersed planning by a multitude of persons and organizations, each pursuing his own ends in a shared interacting context, results in a cumulative selection of important problems, goals, and standards, and an optimal balance in the distribution of human and material resources. However, between 1900 and the present, dispersed health planning has become less and less adequate as an exclusive basis for planning the health care system. Scientific, economic, and health value changes in the society have increased the complexity of the health care system. Specialization, population expansion, centralization of industry, social mobility, and rising expectations of health care as a social right, have contributed to an increase in the difficulty with which each provider, consumer, and financing organization can carry out his own planning without some kind of external help.

In addition, it has become increasingly apparent that total reliance on dispersed health planning has resulted in a variety of problems caused, or not amenable to solution, by this form of planning. The cumulative results of dispersed planning have been found to be less than the sum of its constituent elements. This has become more and more evident in the duplications, gaps, and inconsistencies in the distribution of health care personnel and facilities. The dispersed planning decisions of some providers, consumers, and financing organizations have resulted in negative consequences for others who have not been involved in making these decisions. Thus, locational decisions by physicians and hospitals have resulted, in part, in the lack of access to adequate health care by minority and disadvantaged groups in the population. Finally, it has been recognized that some problems and goals, some priorities and resource allocations, and similar planning issues cannot be resolved through the dispersed planning of many separate, independent, individuals and organizations.

These limitations in dispersed planning have resulted in the gradual development of two additional kinds of health care planning during the past fifty years. These new types of planning have been superimposed on dispersed planning. They have been designed partly to supplement dispersed planning, partly to guide it, and partly to limit its negative consequences for the health care system.

Focused Health Planning

Focused health planning refers to the voluntary association of persons and organizations in an attempt to solve problems which they have in common (although the effects may be felt differently) or to attain goals which they cannot achieve on an individual basis. Focused planning brings together simultaneously the attention and efforts of a relatively large number of persons and organizations. In contrast, dispersed planning involves a multitude of concurrent and sequential relationships; each, however, involving only a few persons and organizations at a time.

Early efforts at focused planning occurred on an ad hoc and informal basis. Professional practitioners, health agency administrators, and consumers met together, frequently through the stimulation of a charismatic leader, to analyze and plan for the solution of specific problems in the health care system. However, the increasing complexity of society gradually undermined the capacity of ad hoc and informal processes to bring people together to engage in focused planning. As a result, several kinds of organizations have been created during the past fifty years so that focused planning could be facilitated by a formal structure. These organizations have been variously known as councils of social agencies, health and welfare councils, health facility planning councils, and comprehensive health planning councils. Despite their varying labels, these organizations have shared certain features which also set them apart from other types of organizations. For example, focused planning organizations are established *solely* for the purpose of organizing the voluntary efforts of persons interested in planning together to solve problems in the organization and financing of health care. These organizations do not, themselves, offer health services. Nor do they control and allocate funds for construction of health facilities or payment for health services. Neither do they exclusively represent any specific group interested in a single disease, disability, or type of health care.

Almost all focused planning agencies are voluntary, non-profit organizations incorporated under the relevant laws of the state in which they are located. The entire structure of these organizations is expressly designed to facilitate the focused planning process. Boards of directors and project and advisory committees are all designed to encourage a broad pattern of representation of professional health personnel, health service and financing organizations, and consumers. All of the funds available to these agencies are directed to the performance of focused planning activities, as are the efforts of the staff employed in these agencies.

Focused health planning makes several kinds of contributions to the continuing development of community health care systems. It provides a framework to which the dispersed planning of individual providers and consumers

of health services can relate. It offers a way to balance the self-interests of individuals and organizations making decisions with the interests of others who are indirectly affected by those decisions. It also offers an opportunity to analyze the cumulative effect of many individual planning decisions on the health care system as a whole. Focused planning offers a way to analyze health care problems which have not been amenable to solution through the dispersed planning by individuals and organizations. Finally, focused planning offers an opportunity for providers and consumers to voluntarily pool their respective interests and resources towards goals that could not be met by independent individual efforts.

The expansion in the number and type of focused health planning organizations during the past two generations is a clear indication of their functional utility. Focused planning agencies have: 1) facilitated the dispersed planning by individuals and organizations; 2) identified residual problems in the operation of the health care system; 3) produced a partial re-allocation of resources available for health care; and 4) produced a partial re-alignment of the activities and relationships of health care practitioners and organizations.

Focused planning organizations also have had their limitations. Their attention to residual problems in the health care system has sometimes resulted in the creation of new organizations, thereby adding to the complexity of the system. In addition, remedial action concerning residual problems may have obscured the need for more basic changes in the structure or operation of the health care system, or in the structure or operation of other parts of the society.

The lack of control of resources by focused planning agencies has limited their ability to implement planning recommendations arising out of the focused planning process. Voluntary action by other individuals and organizations is necessary to carry out such recommendations. Disagreement with planning agency proposals by those who control resources necessary for implementation has resulted in inaction. Conversely, recommendations which require large amounts of resources often cannot be implemented through the voluntary action of many independent units. Finally, some focused planning agencies have been dominated by selected interest groups, or have developed their own self-interests which have interfered with their performance of the functions they were intended to serve.

The limitations of focused planning and dispersed planning to deal with certain kinds of issues in the health care system have resulted in the development of another type of planning which may be called central planning.

Central Health Planning

Central health planning refers to the planned use of power controlled by an individual or organization to force other individuals and organizations to use their own resources in accordance with its plans. It differs from dispersed planning in which the scope of power available covers a narrow segment of health care activity. It differs from focused planning in which the planning agency has no power to implement its plans.

Central health planning power may be based on the legal responsibility of one profession for all health care services provided to an individual patient. For example, in the clinical practice of medicine, a physician uses his legal (and professional) authority to direct the actions of other health personnel in accordance with his plan for meeting the health needs of a patient.

Central health planning power may also be based on funds controlled by a health care financing organization. Through the Medicare program, the Social Security Administration has required hospitals to perform certain activities intended to improve the efficiency and effectiveness of these institutions. Because Medicare finances the hospital care of a substantial proportion of patients, hospitals have had little choice but to follow these centrally established plans of the Social Security Administration.

Another base of power for central health planning is the authority of state governments. About one-half of the states now exercise this authority to control most construction of health facilities within their jurisdictions. Many other states are reported to be considering similar "franchising" programs. In states with such programs, health facilities may not be established, expanded, or modified without permission from the franchising agency of the state. The availability of capital funds, medical staffs, or waiting lists of patients are of no consequence without state government approval of an institution's plans.

As of 1971, central health planning in the United States has been confined to these few explicit segments of the health care system. Americans have generally tended to be suspicious of the centralization of power, especially power based on governmental authority. In addition the personal nature of health care problems and services has reinforced the fear that central health care planning might result in an impersonal, routinized health care system.

Three Types of Health Planning as an Integrated Process

Dispersed, focused, and central health planning are considered to operate as differentiated aspects of an integrated health planning process. Through this process, the society defines problems, establishes goals, norms, and standards, ranks priorities, allocates and translates resources into actions, and integrates the operation of the many different units in the health care system. Dispersed planning expresses the individualistic values of our culture and continues to be the dominant approach to health planning at the present time. Focused planning reflects that segment of our value system which emphasizes voluntary cooperation. Its rapid expansion in recent years may be attributed both to its basic acceptability and its compatibility with the individualism of dispersed planning. Central planning expresses the concern of our culture for rationality and efficiency in the organization and use of resources. However, the use of power, particularly that based on governmental authority, is perceived as directly antithetical to the individualistic values of the culture. Thus, central planning has had limited expression in the health care system.

Planning efforts shift from one type of planning to another as decisions made in one planning context create a need for other types of planning. For example, dispersed planning decisions by individuals and organizations leave gaps and duplications in the allocation of health care resources. These set in motion focused planning efforts to

solve such problems by voluntary cooperative efforts. However, focused planning may uncover the need for governmental authority or control of substantial financial resources to solve part of the problem. This may result in the creation of an authoritative unit to carry on a limited amount of central planning.

In the future, it appears that the three types of health planning will continue to be important processes in the operation of the increasingly complex health care system. Health planning will continue to facilitate the decisions of providers, consumers, and financing organizations. Simultaneously, these health planning processes will bring about changes in the structure and operation of the health care system which will extend and improve the health care available and accessible to the population. Imagination, creativity, and leadership will be required in the analysis of health care system problems and in the development of proposals for change in the system. With extended participation and broadened perspective, the appropriate application of health planning in all of its forms will be a force for improving the level of health for all of the population.

Mr. Palmiere is Dean, Human Services Faculty, State University College, Brockport, N.Y. This paper was presented before the Community Health Planning, Public Health Education, and Social Work Sections of the American Public Health Association at the Ninety-Ninth Annual Meeting in Minneapolis, Minnesota on October 13, 1971.

Call for Toxicology Papers

The annual scientific meeting of the Society of Toxicology will be held at the Waldorf-Astoria Hotel in New York City on March 18-22, 1973. Anyone interested may attend.

Papers for the 1973 meeting may be submitted by members of the Society. Persons not members of the Society of Toxicology may present papers at this meeting if the paper is sponsored by a member. Titles should be submitted to Dr. Joseph F. Borzelleca, Medical College of Va., Richmond, Va. 23219, no later than Oct. 2, 1972.

At the 1972 meeting in Williamsburg, Va., 165 papers on all phases of toxicology were presented. Abstracts of these papers will appear in *Toxicology and Applied Pharmacology,* Vol. 22, No. 2, June 1972.

Program, accommodations, and registration information for the meeting will be sent to all members of the Society and to those nonmembers presenting papers. All others should contact the Secretary for this information:

Dr. Robert A. Scala, Secretary
Society of Toxicology
Esso Research and Engineering Co.
P.O. Box 45
Linden, N.J. 07036