New Dimensions of Health Planning

William H. Stewart, M.D.

Surgeon General, U.S. Public Health Service

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THE SPEAKER

Dr. William Huffman Stewart, a United States Public Health Service officer since 1951, was appointed Surgeon General by President Johnson on September 24, 1965. He attended the University of Minnesota in his native Minneapolis, and received the M.D. degree from Louisiana State University in 1945. Dr. Stewart was resident pediatrician at New Orleans' Charity Hospital from 1948 to 1950, and maintained a private pediatrics practice in Alexandria, La., in 1950 and 1951. Since coming to the Public Health Service he has served, among other capacities, as epidemiologist at the Communicable Disease Center, chief of the heart disease control program, chief of the Division of Public Health Methods, and director of the National Heart Institute. Dr. Stewart is a Diplomate of the American Board of Pediatrics and a member of the American Public Health Association and the American Medical Association.

THE SERIES

The lecture series was established in the name of Dr. Michael M. Davis, medical care pioneer, by his friends and admirers. Dr. Davis opened the series in 1963 with an address entitled "America Challenges Medicine." Each year a distinguished leader of medicine, the social sciences, hospital care, social welfare, government, labor or management is invited to address persons interested in the improvement of medical services. The intention is to stimulate free and open discussion and to furnish a forum in which medical care programs may be proposed, examined, and presented for public consideration.

THE OCCASION

Dr. Stewart delivered this talk at Billings Hospital, the University of Chicago, on May 25, 1967.

In doing some homework for this Michael Davis Lecture, I undertook a rapid re-reading of Dr. Davis' book, *Medical Care for Tomorrow*, published in 1955. It was not a very successful job of skimming, for the book is difficult to skim—largely because each paragraph is packed with information and ideas that are very much alive today. In the process I acquired, or reacquired, a great many useful concepts.

But I was interested also in something I did *not* find in Mr. Davis' book. Unless I missed it somewhere, I found no discussion of health planning as such, in anything resembling the context and terminology we are hearing everywhere today.

This omission reflects no criticism on Dr. Davis. As all of us know, his mind has been ranging far out in front of most of us for nearly half a century. The point I am seeking to make is that *even* Dr. Davis didn't write about health planning twelve years ago, because this concept had not yet appeared over our horizon. It is a very new idea. Max Ways calls it a "new style in problem-solving."

Because it is new, and widely discussed, and generating a great deal of heat and confusion, I thought that this new style in health planning would be an appropriate topic for my Michael Davis Lecture. I don't promise instant clarification. But I do believe that in this new style lies our best hope of meeting unlimited aspirations with limited resources.

For that is the heart of the contemporary dilemma in health and medicine. Public expectations for health care have been immeasurably

heightened by the advance of biomedical capability, public awareness of that advance, and simultaneous social changes that have rejected for all time the notion of privilege. Access to good health care, like access to education, has been accepted as a right, for everybody.

Impressive Growth

Meanwhile, resources available for health have been growing, too—in terms of manpower, facilities, and plain money. Well over 40 billion dollars were spent for health purposes in the United States last year. This represents an impressive 6 per cent of our Gross National Product as compared with less than 4 per cent when Dr. Davis published his book. Yet even this growth has not yet kept pace with public expectation.

Therefore the answer to the question, "Why plan?", is simple and clean. Whenever desires exceed resources, choices must be made. If they are to be made intelligently and productively, they must be based on an intelligent assessment of alternatives. Planning is the process of serving up alternative courses of action and their foreseeable results.

At this point let me offer my first word of warning. Planning is *not* a decision-making process. Rather, it is a process of projecting and documenting alternatives. The choices are made through the political and social decision-making processes of society. Ultimately they are made by the people themselves.

Along about here in any discussion of planning, a troublesome question arises in the minds of the professionals who have been on the firing-line a long time. "Why all the fuss about planning? Haven't we been planning for years?"

The answer is both yes and no. If by planning we mean a process of distributing a given quantity of resources among a given number of programs, year by year, then planning is what most administrators do, most of the time. Given a certain number of bricks and a certain quantity of mortar, it is fairly easy to determine how many buildings can be put up and how large the buildings can be.

A certain amount of this tactical, hand-to-mouth planning always needs to be done. But unless a great many dimensions are added to it, the results over a period of years are likely to become less and less responsive to the real needs. We tend to multiply the same old structures, year after year. We tend to count the growing number of structures and measure progress by it. Vested interests develop, based on refined expertise in constructing the same things. Budget requests and allocations are cast in the comfortable, conventional terms. Voices crying that maybe we should use lumber instead of bricks, or make different kinds of buildings, or possibly not construct buildings at all, are increasingly ignored.

This is an oversimplified metaphor. But something like it has happened in health, in education, in welfare, in armaments, in theology—at one time or another it has happened in virtually every field of human endeavor. The new style of planning and problem-solving is designed to substitute a more effective process for the traditional muddling-through.

Consider, for example, a problem familiar to all of us—providing health care for the children of America. The traditional approach to planning would call for an effort to train increasing numbers of pediatricians and supporting personnel, establish increasing numbers of child health

clinics, carry out larger immunization campaigns, and so on. The product of these programs would constitute the quantitative measurement of progress. Each of these separate lines of attack would have its vocal champions, and they would be vigorously competitive for the lion's share of the resources devoted to the health of children.

Different Approach

The new style of planning would approach the problem quite differently.

It would begin with a definition of goals. How healthy do we want our children to be? Do we mean all children or just those for whom private pediatric care is readily accessible? Are we interested only in mortality, or do we care about morbidity as well?

The next step, growing out of the first, would be the refinement of these broad goals, insofar as possible, into measurable terms. What level of infant mortality are we shooting at? What is an attainable objective over a given period of time for mortality rates in childhood, in adolescence? How low can we expect to bring the incidence of communicable diseases, of chronic diseases, of accidental injuries?

Then comes a stage of intensive input of information. How many children will we be dealing with in 1975, according to best present estimates? What will be their pattern of sickness and health if current trends persist unchanged? Where and in what circumstances will those children live? How many of today's children are being served by today's pediatricians and clinics, and how many of tomorrow's children will tomorrow's resources be capable of serving?

Now we need to project our objectives against the information we have gathered. What

does it take to get there from here? Will a major effort to develop "more of the same" do the job? If not, what shifts in priority or emphasis give promise of carrying us farther toward our child health goals? Should we be training an entirely new breed of health worker? Should we be experimenting with new systems of delivery of care that conform to none of the traditional patterns?

Resource Investment

Finally, we need to consider how this child health effort relates to the larger world of health programming, and to the still larger world of national resource investment. How much can we ask the nation—or the state, or the city—to invest in child health services in relation to the investment in care of the aging, in biomedical research, in housing, in transportation? What are the tradeoffs, and what are the payoffs?

Obviously this is an immensely complicated process. Also obviously, I have hit only the high spots and have skimmed with a brief phrase a number of procedures that may require an exhaustive exercise in data gathering and projection. Looking at the enormity of the task, I think it is prefectly fair to ask the question that many are in fact asking these days: Is the game worth the candle?

I am convinced that it is. In fact I am convinced that we in the health business have no alternative but to learn the rules and play the game to the hilt.

We have no alternative because health is too big a business—a $43 billion business; it is too high on our society's list of priorities; it is too close to the heart of society's highest goal—the fulfillment of the individual. We could get by

with our old hit-or-miss methods in the days when medical science was a pill and a prayer, and when health care was tacitly assumed to be a privilege for the rich and a pacifier for the poor. But no longer. Not when access to the best in health care is the expectation of every American and that expectation is too often unfulfilled.

Set of Alternatives

Let me return now to the process I described a moment ago. The product of that process is not a master plan or blueprint for the future. But—as I suggested earlier—a set of alternatives. It places before the decision-makers a set of means to achieve objectives leading to a broad social goal. Insofar as possible it indicates the amount and kind of investments required—in terms of money, manpower or other resources—to accomplish certain ends. The system says, in effect: "So much input here can be expected to produce so much output there. On the other hand, if you choose this alternate mix of priorities, you should get this other result." Sometimes they are administrators; sometimes they are politically responsible officials; sometimes—always, in the long run—the decision-maker is society itself. The identity of the decision-maker depends upon the nature and level of decision required. But the planning process never makes the choice.

Moreover, these decisions we are talking about are not made once and for all time. The process is continuous. New information is constantly being fed into the system. New assessments of objectives are constantly being made as the terms of the total equation change. In our field of health, for example, a sudden advance in knowledge and technology may cause a complete re-shuffling of the deck of priorities and methods. Or success in attaining one objective may lead to the creation of new problems requiring high priority attention. If the planning process is working well it is sensitive to the shifting winds that should lead to modifications in operation.

Having followed the planning process through to its point of presenting alternative courses, and having identified the decision-makers, we need to discuss one rather important additional matter. Someone has to implement the decisions.

In the United States we have evolved a health services system which is really not a system at all. It is rooted in pluralism and individualism. Its basic elements are the private practitioner, the community hospital, the health department, the voluntary agency, the educational and research institution, and—sometimes forgotten but very important indeed—the consumer of services. No mechanism exists, nor is such a mechanism contemplated, that will dictate what each or any of these components shall do at any given moment. We sometimes talk about "mobilizing our health resources" but we are using a very loose figure of speech. Our health resources are not an army, conditioned to respond when someone pushes a button, but a proudly and fiercely individualistic group of elements linked only by their common commitment to health.

Therefore, implementation of even the best-laid plans is voluntary. In most cases it is sporadic and uneven. But two elements of the planning process can help to make this voluntary implementation work. One is the success and skill with which the alternatives are developed and documented. The other is the breadth of participation in the planning process itself.

People and institutions dedicated to health goals will—as they have demonstrated many

times—act promptly and effectively if they are convinced that the proposed action is best calculated to advance the nation's health. And people and institutions dedicated to any goal will participate vigorously in a course of action that they have helped to shape.

Means and Ends

Max Ways, to whom I have already referred, presented a useful six-point summary of some of the characteristics of this new planning process in an article in *Fortune* magazine this past January:

1. A more open and deliberate attention to the selection of ends toward which planned action is directed, and an effort to improve planning by sharpening the definition of ends.
2. A more systematic advance comparison of means by criteria derived from the ends selected.
3. A more candid and effective assessment of results, usually including a system of keeping track of progress toward interim goals. Along with this goes a "market-like" sensitivity to changing values and evolving ends.
4. An effort, often intellectually strenuous, to mobilize science and other specialized knowledge into a flexible framework of information and decision so that specific responsibilities can be assigned to the points of greatest competence.
5. An emphasis on information, prediction, and persuasion, rather than on coercive or authoritarian power, as the main agents of coordinating the separate elements of an effort.
6. An increased capability of predicting the combined effect of several lines of simultaneous action on one another; this can modify policy so as to reduce unwanted consequences or it can generate other lines of action to correct or compensate for such predicted consequences.

To these six I would add two more, although both are implicit to a certain extent in a couple of Mr. Ways' points.

The first is that the planning process should have the broadest possible base of input, representing not only the private individuals and public and private institutions involved in providing health care but also the private individuals and institutions involved in receiving it, and in relating health to other activities of society. This breadth of participation has two vitally important virtues: it improves the planning, and it enhances the likelihood of implementation.

My second point is that planning should be done and decisions made where the problems are —as close to the people as possible. National planning is important and necessary, but it must indulge in generalities of uneven application across the nation. Regional planning and state planning are better able to establish meaningful priorities and produce workable sets of alternative actions. Local planning is most relevant of all for the practical application of resources to the solution of genuine problems.

These two principles, in conjunction with the broad concept of planning outlined by Mr. Ways, underlie the two major experiments now underway for which the Public Health Service has responsibility—the comprehensive health planning program under P.L. 89–749, and the regional medical programs authorized by P.L. 89–239.

Rich in Promise

I submit, therefore, that planning in the new

style is rich in promise for health. I believe it can help relate our fragmented efforts to each other, and relate our total efforts to the broader currents of society. I do not envision it as a great white magic, but as a useful way of getting the most health for our very large investment.

I am aware as a physician that no one should prescribe a new course of therapy without taking into account its possible harmful side effects. There are hazards involved, some of which can be inferred as the converse of the principles I have outlined.

One hazard—the one which has caused many to fear the word "planning" for many years—is the idea of one master-plan or blueprint superimposed on the nation from above. No such master-plan exists, nor is it likely to exist, nor does the means exist for superimposing it. Rather the tide is running strongly the other way—toward local determination.

Another danger, more real and present than the first, is the danger of rigidity. Regardless of where planning is done, it is possible that a course of action, once chosen, will tend to be fixed for eternity. To be successful, planning must be ever sensitive to change and decision-making ever flexible.

A third hazard is that planning may become an end in itself, rather than a means to an end. New techniques and methodologies can generate a kind of cultism that seeks to force problems into a preconceived mechanism, instead of continually adjusting the means to the ends.

Fourth, as I have already stressed, there is the danger that planning can become divorced from those who must carry out the action and those who are affected by it. There is a world of difference between "planning for" and "planning of and by" the people.

And one final word for those of you who, like myself, occasionally have the uneasy feeling that something of warmth and humanity might go out of the world of health as the emphasis on planning comes in. William Gorham, who was one of Secretary McNamara's assistants in the Department of Defense when some of the new planning techniques were being pioneered and who is now an Assistant Secretary of Health, Education, and Welfare, had this to say in a recent talk:

"It must be obvious that economic criteria are not the only criteria which should be applied to the allocation of resources and the distribution of program outputs. Not do the analyses made . . . constitute a pre-packaged Instant Decision Maker intended to replace judgment, common sense, and compassion or turn resource allocation decisions over to computers."

There is still room for judgment, common sense and compassion. In fact they are as indispensable as ever. The new style, the new techniques, seek to give judgment and common sense a firmer base in truth and a clearer look at consequences. They seek to open doors so that compassion can reach more people to greater effect. So long as our ultimate goal is the fufillment of the individual human being, sensible and compassionate human beings remain the ultimate weapon.