

**SELECTED PAPERS ON HEALTH PLANNING**

**—ITS PURPOSE**

**—EVALUATING OUTCOMES**

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## INTRODUCTION

AT THE Fourth Annual Institute for Staffs of Areawide Health Planning Agencies, held at the University of Chicago in December, 1966, an afternoon was devoted to small group discussion of the subject "Methods of Evaluation of Achievement of Areawide Planning Agencies." In the course of this discussion, it quickly became apparent that the main reaction of the planners present was, to use the words of Martin Paley, the chairman of the session, "defensive and hostile." They felt that any activity aimed at evaluating the objectives, assumptions, indices and measures, and success of planning agencies was premature and might be adverse through lack of understanding of the very broad objectives of health planning.

This reaction stimulated the program planners to include, in the programs of both the Fifth Institute in 1967, and the Sixth Institute in 1968, presentations and discussions on the subjects of the purposes and goals of areawide planning agencies as well as a forum for additional exposure of the issue of evaluation.

Out of these efforts grew the present publication. In the first section James Neeley of the American Hospital Association presents a provocative set of arguments for an explicit and conscious effort on the part of areawide health planning agencies to develop and publicize a program against which its activities can be judged. His arguments are discussed and rebutted by Marvin Strauss, of the Graduate Department of Community Planning, University of Cincinnati, and Joseph P. Peters of the Health and Hospital Planning Council of Southern New York. The second section of this publication deals directly with the process of evaluation of an areawide health planning agency's activities. The section contains three papers: the first, by Martin Paley of the Bay Area Health Facilities Planning Association, serving to introduce the topic and the others, by Douglas

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Brown, Graduate School of Business and Public Administration, Cornell University, and Joel May, Center for Health Administration Studies, University of Chicago, to elaborate several views on the subject.

All of the papers included here were presented either at the Fifth or Sixth Annual Institutes for the Staffs of Areawide Health Planning Agencies. They are published in this format as well as in the proceedings, both because of their special interest and because of the immediacy and importance of the subject with which they deal.

## **PART I**

# **THE PURPOSES OF THE HEALTH PLANNING AGENCY**

### **THE “PURPOSE” OF AREAWIDE PERSONAL HEALTH SERVICES PLANNING AGENCIES**

AS I UNDERSTAND my assignment, it is to open up discussion on the topic: Goals and Process of Planning; in the longer range it is to encourage a response action from you who are in the audience.

Basically, what I want to talk about is the need for every areawide personal health services planning agency to define its purpose. The definition of goals and the decision on how process should take place, both of which are assigned charges to this panel, must flow from how purpose is conceived. If an agency has already defined its purpose and done it well, this paper should have no less meaning, for the need for an organization to continually reassess its purpose is equally important.

One of the rewards of being an employee of the American Hospital Association is the unique opportunity it provides to hear and see the reactions of a great many hospital leaders, and leaders from other fields of health care, to the new emphasis on personal health services planning and comprehensive health planning. One of the recent opportunities I have had to see this has been in the Association's effort to explain and obtain support for the new Statement on the Financial Requirements of Health Care Institutions and Services. For this audience it is not necessary to describe the Statement, or to go into any detail about its tremendous significance. It is worthwhile, however, to make some comments on the reactions to the document, as we have observed them in a number of meetings around the country. There have been, as you know, a number of questions raised about matters of detail, but basically, the major criticism of the Statement that has run through all of the discussions is the question of whether it is right and proper to couple planning with reimbursement.

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James R. Neely, Assistant Director, American Hospital Association.

It does not appear that there has been a reaction which questions the theory of planning, but rather a reaction that reflects a basic distrust in the way planning is being organized. Typical comments have been: the document is a sell-out to local political machines; I don't want someone who doesn't know anything about health care telling me whether I can build; I haven't seen a planning agency executive yet who knew enough to tell me whether I should build or expand; I challenge you to show me a single planning agency that has prevented all unnecessary construction and eliminated all unnecessary duplication; all my planning agency cares about is preventing beds from being built. I could go on, but you've all heard many of these same comments. Obviously, they reflect a distrust of planning, some of it justified, some of it not justified. If distrust of planning does in fact exist, what accounts for this distrust? It is my thesis here today, that it exists because planning agencies, specifically planning agency executives, either have not taken the time to fully define the purpose of their agency, or they have not redefined the purpose of their agency in the light of changing times, or if they have done both of these things, then they have not adequately communicated the results of their work.

There are two references that I have used in preparing these remarks. One of them is a book written by Mr. Peter Drucker, probably familiar to all of you, entitled *The Practice of Management*. The other is a publication of the American Management Association, perhaps less well known, entitled *Management Creeds and Philosophies*. It was written by Mr. Stewart Thompson, a business executive from Canada.

It is necessary to define the word "purpose" before going further. Some people might substitute other words. By "purpose" I mean the reason why the organization exists. The military calls it the organization's mission; others may call it creed, or guiding principles, or management philosophy, or primary responsibility. Call it what you will; when I use the term "purpose," I use it in the context of the reason why the organization exists. I believe that the development of a clear statement of purpose, and the regular reappraisal of that statement are absolutely essential to each and every areawide personal health services planning agency, and that communication of that statement to the consumers of health care, the providers of health care, and the financiers of health care, is equally essential.

The stating of an organization's purpose is an extremely difficult task, and one that the panel cannot probe deeply in the short time we have this morning. I do hope the panel will come up with some factors in a statement of purpose that should be common to all agencies, but no one else can, nor should they ever try, to write a statement of purpose for another organization. I hope we will be able to challenge you so that each of you will go home and work on a clear statement of purpose for your own agency, or if you have already done this, that you will work on a reappraisal of your purpose. As a matter of fact, it is probably very fortunate that we do not have time to do more than provide the spark to kindle a flame this morning. A point that is repeated over and over again by Mr. Drucker and Mr. Thompson is that the process of formulating a statement of purpose is nearly always more valuable than the finished statement.

Because the process of formulating a statement of purpose is not easy, it is frequently not done. Peter Drucker says that the fact that the clear stating of purpose is so rarely done is perhaps the most important single cause of business failure. Conversely, he says, wherever one finds an outstandingly successful business, it will almost always be found that its success rests to a large extent on raising the question of purpose clearly and deliberately, and on answering it thoughtfully and thoroughly.

How an organization's definition of purpose can affect the whole nature of a business is well illustrated by another quote from Peter Drucker's book. He says, "One of the earliest and most successful answers to the question (what is our purpose?) was the one that Theodore N. Vail worked out for American Telephone and Telegraph almost fifty years ago: 'Our business is service.' This sounds obvious once it has been said. But first there had to be the realization that a telephone system, being a natural monopoly, was susceptible to nationalization, that indeed a privately owned telephone service in a developed and industrialized country was exceptional and needed community support for its survival. Secondly, there had to be the realization that community support could not be obtained by propaganda campaigns, or by attacking critics as 'un-American' or 'socialistic.' It could only be obtained by creating customer satisfaction. This realization meant radical innovations in business policy. It meant constant indoctrination in dedication to

service for all employees; and public relations which stressed service. It meant emphasis on research and technological leadership, and a financial policy which assumed that the company had to give service wherever there was a demand, and that it was management's job to find the needed capital and to earn a return on it. In retrospect, all these things are obvious, but it took well over a decade to work them out. Yet would we have gone through the New Deal period without a serious attempt at telephone nationalization but for the careful analysis of its business that the Telephone Company made around 1905?"

Look for a minute at the railroad industry. As you know, a number of railroads have gone bankrupt and others have had serious financial problems. One of the major reasons cited by management experts for their problems is that the railroads failed to define their purpose properly. They conceived that their reason for being was to transport people and material by rail. Perhaps if they had defined their purpose: to provide transportation by any means; or to move people, raw material and manufactured products, from one place to another; or to provide the connection between origin and destination for any person or product requiring movement—they might not have had to face the serious financial difficulties that they did. Perhaps, if they had defined their purpose differently, railroads might have flown airplanes and operated ocean tankers instead of limiting themselves to running locomotives as was eventually prescribed by law.

Another example is the movie industry. The movie industry nearly went bankrupt several years ago when television became a competitor. Obviously, it was because the leaders of the industry visualized their purpose as being one of entertaining people with movies. Perhaps if they had identified their purpose as being one of entertaining the public by whatever means possible, they would have gotten into the business of television early, a thing they have since done, but almost too late.

Just as it is important to define purpose, so is it equally important to continually reappraise purpose, to say, "What is our purpose right now, today?" I asked Mr. Bob Toomey, Director of the Greenville, South Carolina Hospital System, and a very close personal friend, to review this paper. He had this to say on the need for constant reappraisal of purpose: "For instance, I think it is extremely inter-

esting to have watched the evolution of medical school hospitals from hospitals that really had as their purpose patient care until gradually they were actually consumed by the university and became a department of the medical school for educational purposes. This represents a movement of purpose from that of providing patient care services to that of providing teaching material, or, if you will, having as their purpose the education of young men and women on both an undergraduate, i.e., medical school level, and graduate, i.e., house staff level.

"More recently, I believe we have seen the evolution of these schools from teaching to research, and, at the same time, in order to fill the gap of teaching clinical medicine to student physicians, the better community hospitals have hired fulltime faculty and have house staffs really numbering in the hundreds."

Well, just as it is important for A.T. & T., for railroads, for the movie industry, or for any hospital to define and to continually reappraise its purpose, so is it important for an areawide personal health services planning agency to define and to continually reappraise its purpose.

As I had the privilege of travelling around the country, listening to reactions to the Statement on the Financial Requirements of Health Care Institutions and Services, I heard all sorts of misconceptions of the purpose of areawide personal health services planning agencies. Some described the agencies as having as their purpose the collection of statistics; others said they exist to create a master plan; others said they were to reduce the number of beds; others said they were to reduce cost; others said they were to be the catalyst to move hospitals and other health care institutions from voluntary control to government control; others said their purpose was to force mergers. Those, of course, are all bad perceptions of an areawide personal health services planning agency's purpose, and everyone in this room probably would say that all are incorrect or incomplete.

Just what is a correct and complete statement of purpose of an areawide personal health services planning agency? Some might say it exists to develop a coordinated system of health care. Others might say it should exist *to assist health care institutions* in developing a coordinated system for the delivery of health care services. This minor difference in terminology, the difference between "to develop"

and “to assist to develop” could make a major difference in how any given agency operates. Others might say their purpose is to develop a system that assures to the public that they will receive the right care at the right time in the right place. In this last example, the statement of purpose has a consumer oriented connotation rather than a provider oriented connotation. Others might go even further in articulating the consumer role in the purpose of the agency. They might say their purpose is to provide an opportunity for the consumer to articulate his health care needs to the providers of health care. Others might say their reason for existing is to serve as a catalyst for interprovider coordination and communication. It is not my intent here today to attempt to hypothesize what the purpose of an areawide personal health services planning agency is or should be; my sole intent is to present to the panel, and, more importantly, to each of you as an executive of an areawide personal health services planning agency, a challenge that will stimulate you to properly state or reappraise your own purpose.

The American Management Association booklet on management creeds and philosophies lists ten questions that must be answered in defining the purpose of a business. It is these questions, somewhat paraphrased, that I would like to leave with you today. I hope the panel will provide some guidelines on how you each might answer them.

In a sense, how you define purpose will depend on the breadth of your outlook. A good anecdote, cited by Peter Drucker to illustrate this, describes three stonecutters who were asked what they were doing. The first replied “I’m making a living.” The second said “I’m doing the best job of stonecutting in the entire country.” The third looked up with a visionary gleam in his eyes and said “I am building a cathedral.”

Now to the ten questions that are suggested by the American Management Association booklet:

The first is: Why does this agency exist? Let me illustrate this from a hospital administrator’s point of view. Does the hospital exist to provide services and skills needed for the diagnosis and therapy of sick patients who are in bed? Does it exist to provide clinical material for research services? Does it exist to provide clinical material for education of paramedical and medical personnel? Does it exist to plan and operate a delivery system that will bring a full

range of health care services to every person in the community that it serves? The way the question “Why does this agency exist?” is answered plays a major role—in fact, a determining role in how the institution will operate. That is why I believe it is so important for every planning agency to define its role. How can an agency which has not defined its own role properly provide counsel to others on how they should define theirs? So the first question to be answered is: Why does this agency exist?

A second question is: What identifiable services does the agency provide? What is the service of an areawide personal health services planning agency? Is your service advice to the financers of health care? Is your service a forum for communication between providers and consumers? Is your service consultation to providers?

The third question is: How is the agency to be evaluated? I’ve heard Hi Sibley point out on occasion that some people have established, as a measure of effectiveness of areawide personal health services planning agencies, the number of beds they are able to put out of business or prevent from being built. Is this really the measure?

The fourth question is: Who does the agency serve? Who are its customers? Do you exist to serve the public? Do you exist to serve institutions? Do you exist to serve doctors? Do you exist to serve unions or business management in the community? For years, as many of you know, this question has been a challenge to Blue Cross Plans trying to decide whether they exist to serve the public or to serve hospitals.

There is a fifth question listed in the booklet, but it is not germane to this discussion, so let’s move on to the sixth.

The sixth question must be broken into two parts. First: What health care organizations does the agency assist? Do you assist only *hospitals* in planning personal health services? Or do you assist extended care facilities and domiciliary care facilities as well? Do you assist only nongovernmental hospitals or do you also assist federal, state and municipal hospitals in your area? Do you assist only non-profit institutions, and proprietary institutions? Second: What is the geographic area of responsibility of the agency? Do you concern yourself with a city, an entire metropolitan area, a county, five counties, ten counties, an entire state? Again, look at this question from a hospital’s point of view. How different would a hospital be that



says it exists to provide services to a suburban community of 50,000 from another hospital which defines its market as being the entire metropolitan area of 2,000,000 people.

The seventh question that must be asked is: How does the agency communicate its recommendations to those who need to know them?

An eighth question that must be answered is: Does the agency plan for facilities, for services, for manpower, for environment, or for all of these?

The ninth question is: What other agencies and organizations are involved in health planning in the area served? Are you in competition with another areawide personal health services planning agency? Is there overlap in your territory? Are you in competition with a comprehensive health planning agency? Are you in competition with a state agency, with Hill-Burton, with a Regional Medical Program, with the Office of Economic Opportunity? If there is competition or overlap with another organization, is it bad? If it is bad, how can it be eliminated, or how can activities be coordinated, or how can communication be set up between the two organizations?

The final question is: How does the agency finance its program—by providers, by consumers, by government, by nonprofit foundations, by insurance companies, by Blue Cross? And I would suggest that, in trying to find the answer to that question, you try to answer it from two points of view: First, what is theoretically proper, and second, what is pragmatically available?

Well, those are the questions that I would like to leave with you and with the panel today. As I said earlier, I have no anticipation that full answers can be provided, or even that the surface can be scratched deeply. The point that I am making is that my experience in listening to the many objections that have been voiced throughout the country to the policy of coupling planning and reimbursement, as expressed in the AHA Statement on the Financial Requirements of Health Care Institutions and Services, has led me to the firm conclusion that planning has a bad name today. It is misunderstood by government, it is misunderstood by the public, and most importantly, based on my own recent experiences, it is misunderstood by the providers of health care. It may be a failure of communication. I personally do not believe that it is. I believe it is a failure of areawide personal health services planning agencies to adequately find answers to the questions that have been cited here.

So that you may follow the questions as the panel struggles with them, I have had copies prepared for you.

### COMMENTS ON "THE 'PURPOSE' OF AREAWIDE PERSONAL HEALTH SERVICES PLANNING AGENCIES"

Of course, I agree with Mr. Neely that it is essential for any agency to define its purposes. However, I disagree with some of his premises and recommendations, and would comment as follows:

1. It is not essential, or even possible, that a health planning agency be "trusted" or liked. There may be some value in being mistrusted. What we in the academic world call "creative tension" may be helpful in facilitating planned change.

2. Mr. Neely proposes an oversimple answer to the complex question which many agencies and organizations, in addition to hospitals, are asking, namely: "What does comprehensive health planning mean to us?" If anything, it means that they must re-examine their own purposes. Certainly the purposes of comprehensive health planning agencies are spelled out to a considerable degree by Public Law 89-749 and Public Health Service policies. No amount of semantic exercise can wish away some of the implications of comprehensive health planning.

3. Written statements of purpose are often abstract and do not really tell what an agency is going to do. There are many concrete ways of communicating purposes, by the types of personnel hired, the size and scope of the budget, the types of techniques or tools used, the daily activities. These are far more meaningful cues than words on paper. Purposes cannot be separated from the methods used to achieve them.

A word of advice: It is important that comprehensive health planning agencies avoid defining their purposes too narrowly. Do not make the mistake that "comprehensive" city planning agencies did. They talked and wrote about doing comprehensive planning, but

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Marvin Strauss, Director, Health Planning Program, Graduate Department of Community Planning, University of Cincinnati, Cincinnati, Ohio.

usually confined their activities to the limited sphere of land use and economic development. Words like “comprehensive” and “health” are very powerful in terms of the potential activity they represent. Do not define them so narrowly as to limit your ability to adapt to and deal with new situations.

4. Finally, the questions which Mr. Neely cites as those which evidence sound management thinking have only limited applicability in the public sector. Indeed, many modern corporations go far beyond questions of efficiency and profit to ask questions that reflect a new sense of social responsibility. Hospitals and comprehensive health planning agencies can do no less. Hopefully they will ask questions like these: Are health agencies and organizations and institutions serving the public interest? What are the social costs of the action they take or fail to take? Are they accountable to the public? Are as many viewpoints as possible represented in the planning process? Are we reducing the gap between the development of new health knowledge and its utilization in the community? Are we contributing to the ability of people to solve community problems democratically? Are we doing what should be done to achieve “the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living?”

#### **COMMENTS ON “THE ‘PURPOSE’ OF AREAWIDE PERSONAL HEALTH SERVICES PLANNING AGENCIES”**

IN A SENSE, Mr. Neely is asking us to draw up a functional program for our agencies—just as we in turn ask hospitals in our communities to draw up such programs as an essential first step in the planning process. But it seems to me that this will not be easy—partly because we are not operational agencies with easily defined purposes, partly because of the forces which have shaped the development of our agencies, partly because we are dealing with a process (or at least

many agencies have elected to do so), and partly because our role seems to be primarily one of influencing others.

Mr. Neely has presented a laundry-list of basic questions which are designed to encourage a process of introspection and self-analysis. How can I disagree with the idea that such introspective self-analysis is necessary? And, who am I to disagree with Peter Drucker or the American Management Association? But, I believe that we can easily get hung up on words: that we can make a series of declarations an end in itself, or that we can say one thing but really mean something else, or that we can define our mission quite precisely, but for one reason or another, fail to carry it out or even take actions which are in direct opposition to our stated mission. For example, A.T. & T. can claim that its business is service, but what a howl would be raised if it neglected its customers. And so it seems to me that much of the misunderstanding of the role of areawide health planning agencies centers not so much on what they claim is their mission, but how they carry it out or fail to carry it out. Therefore, I would suggest that we not waste too much of our time on introspection, but that we get down to the real business of planning.

But, here I must hedge, for sooner or later agencies must make basic decisions on what constitutes planning on an areawide basis. Is such planning merely encouraging others to plan? Is it doing the actual planning for the institutions and agencies? Is it policing the planning of institutions and agencies? Is it devising a master plan which specifies the role and distribution of various facilities and services within its planning area? Or, is it something else which none of us have clarified as yet?

Perhaps the basic issue which all of us must face up to centers on what the community expects of us. And, here, I will state my belief that a planning agency should represent the community and that it should not represent or identify itself with the providers of health service, even though it must, of necessity, work closely with the providers. It is for this reason that our Council has carefully avoided soliciting funds from local hospitals, hospital associations or other provider groups. If you accept this point of view—that we are creatures of the community and responsible to the community—then I believe that you will agree that our mission is quite different than it would be if we allied ourselves with the providers of service.

Our task then, it seems to me, is one of keeping abreast of public

expectations—to generate a sense of direction, or if you will, to offer a series of intelligent options so that our evolving capabilities and our evolving values can move hand in hand. Experience indicates that we cannot accomplish this by the establishment of a so-called master plan, even though many elements of the public often wonder why this is not possible. Neither can we plan for individual institutions. But, these are merely two of the many alternatives. Jim Neely has listed several others in his paper and has wisely avoided any appraisal of the validity of any particular approach.

It is stating the obvious that we are witnessing basic changes in public attitudes towards the relationship of health care institutions to the community. Current patterns of organizing and providing health services are rooted in the past and do not necessarily reflect the expectations of today's consumers. Planning has been regarded as an institutional prerogative; with the broadening base of financing health care, there is growing evidence that the public does not necessarily endorse this right of institutional self-determination. Institutions may continue to claim this right and may even band together in issuing statements to same. They can even protest the propriety of coupling planning with reimbursement or making government grants for construction contingent on the endorsement of State and local planning bodies. But, whether or not they can continue to convince the public in this regard, is open to question. In short, the public may answer Jim Neely's questions for us—not by giving us the words, but by demanding that we take specific actions to meet new expectations and new demands for better health services.

Next month, I will complete eleven years of service with the Southern New York Council. I have seen it operate as purely an advisory body whose effectiveness rested upon the soundness of its judgments and the confidence it was able to instill in the public and the institutions concerned. For the past three years, I have also seen it operate under the provisions of the Metcalf-McClosky and Folsom Laws of New York State. Actually, however, the nature of the agency has changed little over the years—it is still essentially an advisory body. But now the Council not only advises hospitals, it also advises the Commissioner of Health of New York State who does have the power to apply specified sanctions and controls. The difference is that the Council is now consulted in regard to many mat-

ters that previously did not officially come to its attention. This is particularly true in relation to nursing home and intermediate care facilities, proprietary hospitals and neighborhood health centers.

It seems to me that part of the problem to which Jim Neely has alluded is due to the newness of many of our agencies. They are distrusted—not because of unpopular actions, but because they have not had an opportunity to prove themselves. Public acceptance does not necessarily accompany the agency at birth—particularly if the birth was the result of a reluctant partnership.

On the other hand, even prior to legislation, I believe that our Council was well accepted. Jack Haldeman has said time and again that we are respected because we have developed sound leadership on our Board—and that the authorities of our local hospitals know this and are therefore willing to listen to us. Perhaps this is “our unique field of competence,” to cite Jim's eighth question. In any event, it seems to me that our competence—our effectiveness—rests in our ability to provide a community-wide point of view, objective guidance and the services of a technically competent staff. This is what the Southern New York Council tries to provide when it gives advice. In recent years, the legislature of New York State has provided a legal underpinning to these activities; but, as I said earlier, this really has not changed our basic process.

I mention our experience because I have the feeling that what has happened in New York will happen elsewhere. In time it may become the common pattern for planning. What I am therefore saying is that the public through its elected representative will set the stage for us and will give us the script. Whether or not this is good or bad, only time will tell. But, at least you may receive some answers to the ten questions posed by Jim Neely.

**PART II**

**EVALUATION OF  
HEALTH PLANNING ACTIVITIES**

## EVALUATION—THE INDISPENSABLE PHASE

EVALUATION is an indispensable phase of management. It is equally appropriate for the testing of products on an assembly line as well as the effectiveness of the planning agency.

The nation is making an unprecedented effort to improve the planning of health affairs. A veritable army of citizens has been recruited. New organizational patterns are being designed. Methods of influencing institutional behavior are being explored. However, the simple question of alternative approaches and tests of effectiveness are still undeveloped. Planners have not yet been able to answer such pointed inquiries as "Is your planning program better than no planning at all?" or "Can Planning achieve increased effectiveness and efficiency in health services best under government leadership or volunteer direction?" "What methods of planning are more successful than others?" "Is there a disciplined means for generalizing from one planning experience to another?" In short, does community oriented planning make a significant and positive difference?

It is apparent that all evaluations must begin with a clear and complete statement of goals of the planning agency. These should be goals of the organization itself, in contrast to the goals for the health resources which serve as the focus of planning. Each planning agency should consider the importance of establishing evaluation procedures at the outset. Each agency should formulate criteria for success and periodically test the levels of success of its activities.

The absence of evaluation will prevent us from learning. The absence of evaluation will prevent us from improving the practice of community health planning, but even of greater significance, failure to evaluate will undoubtedly impair the effectiveness of this national effort directed to health planning which offers such great promise.

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Martin A. Paley, Executive Director, Bay Area Health Facilities Planning Association, San Francisco, California.

## EVALUATION OF HEALTH PLANNING

### *Introduction*

I WOULD LIKE to advance a framework for your consideration as well as first give my impressions of your feelings on evaluation—opinions I have encountered in visits to some thirty areawide planning agencies this past year in conjunction with an overall study of the health planning process.

I must advise you at the outset that I have no intention of trying to assess current planning efforts; you have told me there are enough self-proclaimed critics of the activity already—serving a very questionable utility. Neither do I have any pat answers relating to the evaluation process. Nevertheless, perhaps you will find solace in hearing that your colleagues share many of the same apprehensions about this subject. As the following will suggest, the evaluation mission is potentially exciting, but, for the moment it remains especially excruciating and disturbing for those of you closely involved in the health planning effort.

There are only a few aspects of the health planning endeavor causing greater apprehension than the debate revolving around the question: How do you evaluate the effectiveness of the planning activity?

The planners are extraordinarily sensitive about this matter particularly when probed in efforts to measure their councils' effectiveness. The reasons for the planners' defensiveness are not difficult to discern.

First of all, it is safe to say that practically no one likes to be evaluated and the planners are no exception. Furthermore, the plan-

ners by and large appreciate the rationale for evaluation and the growing necessity for implementation of the idea, but for reasons outlined here (and there are undoubtedly others), they have been unable or unwilling to operationalize this facet of the planning process. And, seeing the logic of evaluation—at the same time they impede its development—the planners feel somewhat remiss in carrying out their obligations to their professional field and community.

In his summary of the 1968 Chicago session which dealt with the topic of evaluation, the seminar chairman, Martin Paley, detected several fears accounting for this resistance to evaluation. He reported:

Many felt that the Public Health Service was testing prematurely the efforts of areawide planning agencies in order to eliminate consideration of these groups under the newly passed legislation, PL 89-749. Others felt the granting authority, the Division of Hospital and Medical Facilities, was responding to pressure of the Federal Hospital Council and thus imposing inappropriate requirements on a new and undeveloped field. In any event, the reaction growing out of the several discussion groups was strong, loud and sharply critical.<sup>1</sup>

Although the planner is quite convinced that what he is trying to do is in the best interests of the community at large, it is becoming increasingly more difficult for him to demonstrate conclusively that the council's efforts are meaningfully allocated; and the pressure is beginning to be felt by each of the planners as a result of the heightened dialogue concerning newer approaches to evaluation and program development.

Progressively assaulted on several sides, the planner encounters a new rhetoric imposed on his activity—that of PPBS with its systems and cost-benefit analysis—something he has yet to fathom. While he may reject outright “new panaceas” which he doesn't understand, the planner is beginning to examine cautiously and critically the profitable use of these tools for the planning endeavor.

Even so, the essential point to be made here is that the planners would prefer to shelve the whole question of evaluation for the time being—this, despite the fact that problems of resource allocations

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<sup>1</sup> Martin A. Paley, “Methods of Evaluation of Achievement of Areawide Planning Agencies,” *Papers From the Fourth Annual Institute for the Staffs of Areawide Health Facility Planning Agencies*, December 12–17, 1966 (Chicago: Center for Health Administration Studies, Graduate School of Business Administration, University of Chicago, 1967), p. 74.

and effectiveness receive increasing attention from many quarters. "There are more important considerations to worry about," they argue. Thus, routine evaluation, when it does invade the health planning field, will have to arrive in a form not threatening to the planners themselves—that is, if their cooperation is desired.

### *Experiences and Unanswered Questions*

What are the councils doing to measure their effectiveness? What is it about evaluation of the planning activity that makes it so troublesome?

While this finding is open to individual interpretation, this investigator concludes that none of the thirty councils visited was devoting much of its energies to the task of evaluation. True, many of the councils have attempted a superficial assessment of their activities for incorporation in their annual reports, and one council, for development purposes primarily, has approached the problem more systematically by comparing (and writing-up) its accomplishments with the guidelines set forth for planning agencies in the Report of the Joint Committee of the American Hospital Association and Public Health Service, "Areawide Planning for Hospitals and Related Health Facilities."<sup>2</sup> But, in the main, it seems that the current list of priorities in the planning process has relegated evaluation of council effectiveness to somewhere near the bottom.

In addition to the aforementioned general reservations accounting for the resistance to evaluation, there are a number of operational constraints at the council level. For instance, the planners declare that they have been busy doing and have had little opportunity to examine the effects of their labors. The typical council, born in strife, nurtured on the uncertainties of community process, has also had to struggle with problems of chronic underfinancing and staff shortages. Some planners report that mere survival has been a formidable chore. They state that the planning activity has been from the outset a process of human engagement—and only secondarily a process of

data and results. For the planner, the world of reality has been one in which involvement and exchange by more and more people has ruled the day; it has been the participation of community individuals and groups with each characteristically having a different stake in the planning venture.

"Our problem is getting people to work together," a planner emphasized, "not fancy computer programs and systems analysis. We just don't have those kinds of skills. That is something for the future."

"Yes," another planner confided, "we have been too busy to think about the effects of our activity; but is there any evidence that greater thought instead of action would have advanced the course of planning further?" A fair question.

Thus, planning is conceived by the individuals caught up in it as a highly human process which places far greater weight on participation by the "appropriate" people—for purposes of implementation of decisions eventually reached—than on carefully prescribed end products as such. In other words, the process is more concerned with action than with ideal notions about what the health care system ought to be. The faith here is in people, fallible as they are, rather than in measured rationality of health services. The resultant, by necessity, becomes less than what any group wanted but more, the advocates argue, than would be possible under any other nonautocratic arrangement. The name of the game is change, desirable change, based on compromise. Hence, the path toward rationality is a desultory one which presents special problems in devising methodologies for evaluation.

Other assorted problems and questions relating to agency evaluation are enunciated by the planners. For example: "Just *what* do you measure?" "How do you assess success?" "What are the dimensions of the planning activity?" "Are the organizational aspects of the councils the key to evaluation?" "Or, are the actual operations of the councils the important factor?" "Is planning primarily plans or process?" "If it is process, how can it ever be evaluated?" "How important is data in planning?" "How important is broad community representation in the planning effort?" "Is the number of projects reviewed a consideration?" "How important is council financing?" "What are the important goals in community planning?" "What are the ultimate purposes of planning?" "Can a planning council be as-

<sup>2</sup> Public Health Service Publication No. 855 (Washington: U.S. Government Printing Office, July, 1961). More recent principles have been produced by a Subcommittee on Comprehensive Health Planning of the Program Area Committee on Medical Care Administration and Public Health Administration of the American Public Health Association, "Guidelines for Organizing State and Areawide Community Health Planning," *American Journal of Public Health*, XXVI (December, 1966), pp. 2139-2143.

sessed against its own stated objectives?" "And what about unstated operational goals?" "How do you cope with value judgments?"

"Indeed," a planner asked, "will the evaluation of goals turn out to be disruptive to the planning process at the community level? Some important goals like group medical practice must remain unspoken if planning is to succeed."

And, the planners go on: "How do you measure?" "What criteria do you use?" "For example, how do you measure the 'better use of health manpower' or 'closer relationships among health institutions'?" "And what is 'better health care'?" "Is it more and higher quality services?" "Is it more or less hospital care?" "Is it reflected in morbidity and mortality rates?" "Indeed, are these measures even relevant?" "Are there significant factors here other than medical care?" "How do you control for all the variables when one factor is measured?" "What are the time considerations involved?" "Is the PPBS approach relevant to health planning?" "If so, how?" "How do you measure the actual impact of the planning activity?" "Can the council take credit (or blame) for all the health developments in the community?" "What would have happened in the area without the planning council?"

Finally: "What is the purpose of evaluation?" "Is it really a plot by government to undermine community control of the planning activity?" "Will evaluation be administered by the agencies themselves or will standards be imposed from the outside?" "Is its purpose development or external control?" "Will evaluation actually become an educational force or will the 'tools' become an end in themselves and stifle the planning process?" "Will the 'people side' of planning become overshadowed?" "As a result of this movement, do the planners themselves run the risk of being replaced eventually by the systems—quantitative specialists?"

This sample of the planners' thinking on evaluation provides some idea as to why they are hesitant to immediately embrace the concept. They would like to see these and many other questions answered first.

#### *The 1966 Institute*

Out of the 1966 Chicago Institute came some interesting comments which illustrate the prevailing frustration with the evaluation question. Although some of the planners at the meeting felt that

evaluation was neither possible nor desirable at this stage, others argued that their agencies are being evaluated informally all the time by various "publics." Moreover, some of the planners saw the need for an internal kind of evaluation which would look at the organizational aspects of the council, e.g., board membership and meetings, advisory committees, staff, financing, while others reported the beginnings of attempts to more systematically assess health care advances in the community in light of the council's objectives—a sort of "box-score" method. This latter practice was apparently geared to "educate" the public and demonstrate to the providers of funds the achievements of the activity. It was quickly pointed out by one of the planners present that, under this kind of reporting, the council could easily manipulate its own "batting average."

Further suggestions along these lines took the form of setting out community health service goals—short and long term—in much more definitive ways so that some measurement could be employed. One planner suggested that obstacles relative to certain ends might be identified as well so that assessment could be made periodically on how well the council was dealing with these obstacles.

Finally after such discussion, the final assembly concluded that any attempt to evaluate health planning must face up to the question of health results, i.e., what happens to *people* in the final analysis vis-à-vis their comprehensive health care needs? To what extent do the various quantitative and qualitative health indices reflect an improving state of affairs for *all* the population? And to what degree are the gains attributable to the efforts of the planning council?

It was hard for the planners to believe that these latter dimensions are not important despite the formidable problems in gathering and measuring the pertinent data.

#### *Criterion of Success*

In current operational terms, what constitutes success in the planning endeavor?

The responses to this question by the planners have one common denominator: success is invariably equated with the degree of acceptance of the planning function in their area and particularly the extent to which the major health institutions are cooperating in the planning activity. In short, the measure of accomplishment is directly related to a council's progress in operationalizing a viable



planning process. Although the planners pointed to many kinds of specific results to illustrate their successes, the achievement considered to be most important is an established ongoing planning process. Thus, process becomes the primary focus from which all other attainments evolve. Involvement by the right people, long-range planning in individual institutions etc., is considered the *sine qua non* of the planning venture. Consequently, according to the respondents, the successful planning council is one which can claim participation in the planning activity by all the appropriate parties in the region. The actual results of the process while important, of course, are really felt to be secondary to the process itself. A planner considers himself more than half-way home if he has been successful in gaining participation of the principal individuals and groups in the community.

Taking what appears to be an unrealistic position, one planner suggested that "planning may be designated a success when there is no longer a need for the planning agency." The assumption was that the various agencies and institutions would eventually be able to long-range plan for themselves in addition to correlating their plans so successfully that there would no longer be a need for outside assistance such as the planning council affords.

In addition to a viable planning process, what do the planners cite as examples of productive output?

As told by the planners and as listed in their reports, agency achievements include the following: the review by the council of a specified number of proposals originating in the area; the promotion and development of various community health care programs; the provision of consulting services to individual health care organizations; the compilation and dissemination of information, special surveys and studies; the development of a community information and referral service; the sponsorship of various educational institutes and other community relation programs; the development of more effective interrelationships among the health service organizations in the area, including cooperative ventures such as hospital mergers and affiliation agreements; the development of planning guidelines; the formation of planning advisory committees; the completion of successful fund raising programs by hospitals.

A very interesting output often cited by planners involves the number of hospital beds approved and disapproved in the review

processes and the number of unnecessary hospital bed projects blocked by the council. Although the agencies point with pride to additions to community short-term hospital bed services when this is deemed advisable, they take special delight when they are successful in holding down the number of beds "not conforming to community needs." Indeed, most of the councils illustrate as evidence of their progress the fact that they have been responsible for preventing or discouraging the construction of so many beds at such and such a saving to the community.

A few of the planners admit that they are not so sanguine about depressing the number of hospital beds as their "official" pronouncements would have you believe; but this posture is necessary, they say, in order to stimulate hospitals to think about alternative programs—such as home-health services, long-term care facilities—and to demonstrate to all concerned their sincere efforts to control rising health care costs. At any rate, except for a few of the planners who are located in regions where the need for more short-term hospital beds is quite apparent, most of the planners are sure that their council has been more or less successful in keeping down the number of newly constructed beds of this type.

On the other hand, most of the planners can list the addition of other needed services and facilities as resultants of the planning process, and programs for the long-term care patient are mentioned the most often. Several of the planners take the position that planning has caused more of a realignment in the use of hospital beds in the area than an increase or decrease in the overall number. One planner indicates openly that his organization's achievement is measured in terms of how many new proprietary hospitals have been prevented from organizing the past year.

From the planners' point of view, how have the councils actually fared? How successful have they been?

Virtually all of the planners interviewed point out that they have made progress in establishing an ongoing planning process but most acknowledge that they still have a long way to go. Furthermore, on balance most of the planners indicate that they have won more battles than they have lost—at least the battles in which they have chosen to become engaged—while a few say they have experienced more planning failures in their region than successes.

The failures cited by the planners usually are considered to be

rather important in the development of a logical health care system in their community and so, hold particular interest for us. One glaring example involves the construction of a local government hospital for indigents "at a time," the planner laments, "when everything suggests that this manner of operation is completely outmoded." The planner attributes this action to political machinations and failure on the part of responsible agencies, health and otherwise, to marshal the necessary power to offset the decision. Several other planners describe cases in which various voluntary and proprietary hospitals ignored the recommendations of the council and proceeded—most often to build acute care beds. Developments in the proprietary nursing home field are mentioned only occasionally as successes or failures inasmuch as the councils have just begun to formulate definitive guidelines for this field.

#### *Approaches to Evaluation*

It appears evident that the evaluation movement is destined to expand in the health planning field and it is equally apparent that basic study and a great deal of discussion among planners is required if evaluation is to become accepted and implemented. But, the task of finding appropriate methodologies for evaluation will not be an easy one.

#### *The Donabedian Model*

As a point of departure, it would seem that an overview of the various approaches to evaluation of the planning activity would be helpful. In this connection, it is suggested that an appropriate framework for categorizing possible methods for assessing the achievement of the planning councils is to be found in Avedis Donabedian's work on evaluating the quality of medical care.<sup>3</sup> Although it does not encompass all the facets of the planning endeavor, the Donabedian model closely relates and is easily transferable.

In his Milbank paper, Donabedian describes three general methods for assessing the quality of medical care. In transposing his proposal, one may advance the following approaches as appropriate for evaluation of the health planning activity:

<sup>3</sup> Avedis Donabedian, "Evaluating the Quality of Medical Care," *Milbank Memorial Fund Quarterly*, XLIV (July, 1966), pp. 166–206.

1) *By structure*—This would involve an appraisal of the "setting" or "instrumentalities" of planning such as council auspices, council purposes, goals and guidelines, composition of the board, formation of advisory groups, staff organization (number, qualifications and division of labor), adequacy of financing, facilities, etc., and appropriateness of the planning region.

As Donabedian points out, the assumption here is that given the proper settings good practices—in this case planning—will follow. These aspects of the planning process are important and they do offer the advantage of dealing with fairly concrete and available information. But, as Donabedian suggests further, this approach does have a major limitation in that the relationship between structure and results is not always well established. And, there is the difficulty, as well, in determining what is desirable (standards) in terms of staff, formal organization, etc. For instance, what kinds of people should be appointed to planning council boards?

2) *By process*—This approach would include assessment of the planning activity itself. How is the structure being applied? That is, what is the council doing and are its functions appropriate? What are the important values and sub-goals operating here? What is the nature of the interaction among people involved in the planning effort? Are all the health institutions in the area participating? What kinds of information are gathered and used?

Process, too, is a relevant dimension in the appraisal of the planning activity and, as with structural conditions, presents certain problems in evaluation. The difficulty here is mainly one of determining the standards or criteria to be used in measurement of process considerations. For example, how do you assess the involvement of physicians in the planning activity, or, how do you resolve the hospital bed need determination problem?

It would seem that the development of operational standards for application in the planning field is essential, but again, the amount of research required to answer some of these questions will undoubtedly be substantial. In the opinion of the author, the attention and support given this area has been all too inadequate thus far.

3) *By outcome*—As the planners concluded in their 1966 Institute in Chicago and as Donabedian suggests in his paper, the end results of the process—what actually happens to people—are the "ultimate validators" of effectiveness. Using this approach to assess the planning activity, one can consider two of Donabedian's suggestions—health outcomes and satisfaction. Health outcomes might take into account, for example, general as

well as particular morbidity and mortality figures for the population within the planning region. In addition, attempts could be made to gather and analyze data relating to the occurrence of preventable morbidity and disability in the population for such things as rheumatic heart disease and diabetes; and restoration considerations following physical and mental illnesses could be included as well.

An exciting—but not new—possibility consistent with this approach would encompass methods to get at the question of unmet health needs in the population. Perhaps short of periodic house to house surveys—including a medical examination and appropriate laboratory work—we may never be certain that all members of the community are actually sharing in the benefits of advancing scientific medicine, much less in the area's own available health services, whatever they may be. A formidable chore, admittedly, perhaps the National Health Survey<sup>4</sup> idea could be extended and adopted at the local level, or at least the concept of automated multiphasic screening of the population might be applied.<sup>5</sup>

The other aspect of outcome suggested by Donabedian is satisfaction. Though difficult to evaluate, the opinions of the individuals participating in the planning process and citizens at large would seem to be an important dimension in any planning council appraisal. How do they perceive the activity?

The shortcomings of the outcome approach are probably self evident. First, there is the problem of relevancy—are the indices selected really related to the planning function? Is there a cause and effect relationship? There is also the dilemma of definitions: What is optimum health? What are its dimensions?<sup>6</sup> And, there is always the difficulty of measurement and standards. What are the criteria of success for any given program? Are all the factors influencing outcomes taken into account?

Thus, it appears that most of the methods proposed for evaluating the planning activity fall under one of the basic approaches outlined

<sup>4</sup> Forrest E. Linder, "The Health of the American People," *Scientific American*, CCXIV (June, 1966), pp. 21–29.

<sup>5</sup> Morris F. Collen, "Periodic Health Examinations Using An Automated Multi-test Laboratory," *The Journal of the American Medical Association*, CVC (March 7, 1966), pp. 830–833.

<sup>6</sup> For elaboration of this problem see Daniel F. Sullivan, *Conceptual Problems in Developing an Index of Health*, Public Health Service Publication No. 1000, Series 2, No. 17 (Washington: U.S. Government Printing Office, May, 1966).

here. This is not to say that these are hard and fast categories—indeed, certain dimensions cannot be "categorized" if that is the case since they reflect many aspects of the activity. Moreover, it is likely that most attempts to evaluate an actual planning operation would do well to incorporate several different approaches; of course, which of the many possible methods and criteria finally selected for assessment would have a significant bearing on the conclusions reached. Finally, it must be kept in mind that the information collected through various evaluation techniques cannot be expected to answer all the questions relating to the allocation of a planning council's attentions and energies. Planning, it must be remembered, is rooted in a fertile field of human exchange.

### *Sources of Information*

Before progressing further, let us look at the sources of information for planning council evaluation. Once again Donabedian's insights are valuable. He suggests three ways of obtaining appropriate information:

1) *Reports, studies and statistical data* emanating from within the agency will provide certain information about the council's purposes, procedures and activities. Additionally, data from reports produced outside the council and pertinent to the planning activity are normally available from numerous health and welfare organizations and departments of local and state government. It is hardly necessary to point out the limitations of depending solely on written materials prepared by the agency itself to provide a complete and accurate picture of the council's achievements and current efforts.

2) *Direct observation* of the agency in action offers another method of obtaining information useful for appraisal. Indeed, with the unavailability of commonly accepted guidelines and standards in the planning field, it is difficult to envision how any serious evaluation attempt can leave out this particular approach, at least for the moment. The problem with this method, of course, is the observer's time involved (with its costs) and his own particular biases. How the observer discerns the planning process obviously influences his judgments concerning effectiveness.

3) *Opinions* of the people associated with the planning endeavor and others in the community provide useful insights into the operations and achievements of the planning agency. But, as is true whenever different views are sought, the responses garnered will often be "colored" by the respondents' own stake in the planning process which may have little to do with hard criteria applicable to the effectiveness of the system.

### *Standards*

The last reference to the Donabedian paper relates to the difficult

problem of standards. Where do they come from and how valid are they? Two sources are identified:

1) *Normative* standards are those recognized to be “good” or “ideal” practices. Most often these are enunciated by recognized leaders in the field or are the result of research, special commissions and task forces. The stipulation that new hospitals should have at least 200 beds is an example of a normative standard. The difficulty with normative criteria is that there can be honest differences of opinion as to what is correct and realistic. There is, moreover, the problem of application of the standards to different settings. What may be appropriate in New York City may not be applicable to Seattle.

2) *Empirical* standards are derived from actual practice and can be used to make comparisons of certain indices selected from among the planning councils. An example of the empirical standard approach would be the comparison of a number of agencies in relation to specific features such as consumer representation on the board. This kind of comparison would allow for each of the councils to know where it stands in relation to others. The problem here is one of the gap between desired levels and actual practices and the negative influence this might have on change.

### *The “New Style” and PPBS<sup>7</sup>*

As we began, the planners recognize the merits of evaluation and anticipate the adoption of means to carry out this task—someday—but not now. For the present, efforts in this direction are considered premature and actually dangerous to the planning endeavor—particularly if the tools of analysis are indiscriminately applied by people unacquainted with the realities of the planning process. To the planner this process is not primarily a technological act, it is an act of interpersonal relations and community organization—an act which is heavily value laden. As a result of the apprehension about making the process more structured and quantified, PPBS with its unfamiliar jargon has failed to be understood and accepted by the planning practitioners.

It is not the intention of the author to argue the merits of PPBS and the so-called “new style” of problem solving in the health field—the case has been eloquently expressed in a host of publications, seminars, and speeches that have appeared recently. But, it might be helpful to digress just briefly to trace these developments.<sup>8</sup>

<sup>7</sup> Program—Planning—Budgeting Systems

<sup>8</sup> The ideas for this section were taken principally from William L. Kissick’s lucid overview of the subject, “Planning, Programming, and Budgeting for Health,” *Medical Care*, V (July–August, 1967), pp. 201–220. See also Max Ways,

The proponents of the “new style” argue that the time has come for greater rationalization of our society’s presently fragmented health care system. Too long characterized by “muddling through,” the health endeavor must come of age if we are to deal with the problems that confront us. We simply cannot do all that we would like to do, they contend—our aspirations far exceed our abilities to produce—so, choices must be made among the many competing alternatives. The principal thrust of the new approach is to make these choices more apparent and deliberate; PPBS and systems and cost effectiveness analysis are viewed as the tools for the “new style.”

The Planning—Programming—Budgeting Systems—first employed in the Department of Defense and now being introduced throughout the Federal Government—is frequently defined thus:

PPBS is a system aimed at helping management make better decisions on the allocation of resources among alternative ways to attain government objectives. Its essence is the development and presentation of relevant information as to the full implications—the costs and benefits—of the major alternative courses of action.<sup>9</sup>

The intent of PPBS is not to replace common sense but to offer an opportunity to make everyday judgments even more meaningful by providing a systematic means for sharpening objectives. Hence, PPBS is not portrayed as the final answer but as a useful tool for thinking through the health planning endeavor.

Actually the whole “new style—PPBS” approach may be considered to parallel another outgrowth in American society which is attempting to focus on “quality of life” goals with their related “social indicators.”<sup>10</sup> The emphasis here is on the development of new concepts and social information to enhance both private and public policy making in our changing society.

To apply these new concepts and tools, of course, one must first understand them. And, for the health planner, in particular, this

“The Road to 1977,” *Fortune* (January, 1967); National Health Council, *Planning for Health*, Report of the 1967 National Health Forum (New York: National Health Council, 1967).

<sup>9</sup> Selma J. Mushkin, *What is PPBS?*, State-Local Finances Project (Washington: The George Washington University, January, 1967), p. 1.

<sup>10</sup> See *Social Indicators*, Raymond A. Bauer (ed.) (Cambridge: The M.I.T. Press, 1966); “Social Goals and Indicators for American Society,” *The Annals of the American Academy of Political and Social Science*, CCCLXXIII (May and September, 1967).

becomes a necessity if he is to grasp the advantages and limitations of the various approaches now being suggested for application to the health endeavor. In due time, the planner will undoubtedly demonstrate a greater awareness of these developments since his task will be so directly affected.

Indeed, assuming the human side of the "new style," process is highlighted rather than the highly rigorous quantification side; one may venture to guess that these new considerations will turn out to be not so foreign to the planner after all. By nature, it would seem that he is already acutely sensitive to the broad-scale needs of people—this is the concern he expounds and strives to remedy in practice—and he is searching for methods of solution. Thus, he is probably more sympathetic to the "new style" than he now realizes. But, he will be struggling with these emerging proposals for some time to come since they are shrouded in the mystery of a peculiar jargon and methodology, and the planners haven't had the time as yet to devise an adjustable way of dealing with them.

In any event, for discussion purposes, it seems fairly clear that the tools of PPBS and systems and cost-effectiveness analysis will find their way into the health planning endeavor; that is, with some pain and anxious moments these methods will be modified as required and eventually adopted. When this finally occurs the planner will find that he has acquired another professional dimension to accompany the interpersonal-community relations skills he already recognizes as so essential to his work.

#### *A New Service*

Whatever is developed to implement evaluation procedures and more sophisticated methods for problem solving in the health planning field, it can be hoped that the development will be approached from the viewpoint of self-education and organizational guidance rather than as an external control—that it will become a basic, continuous and natural feedback function of the planning activity. In this connection it would seem that the *Professional Activity Study*<sup>11</sup> approach would be more valid than the method employed by the Joint Commission on Accreditation of Hospitals for the reason that, instead of imposing external criteria, PAS attempts to upgrade practice by introspection and internally derived standards.

But, to do this, to help the councils with their organizational and effectiveness problems, it is becoming increasingly apparent that some kind of external source—a nonthreatening one—is needed to serve in an advisory-information system capacity. A newly established organization, probably best under the auspices of the Association of Health Planning Councils, could play a vital role in the program planning field, and perhaps this body could also carry out research and development activities. Certainly the planners have enough questions they need answered.

The evaluation program sponsored and launched by the American Medical Association in 1967 has attempted to fill this void in addition to carrying out its primary function of stimulating physician participation in areawide health planning. However, apparently it has met with only partial success insofar as the councils' benefit is concerned. This is not to disparage this particular voluntary effort but simply to suggest that the needs of the planning councils extend far beyond what this particular program is designed to accomplish. In any event, whatever form a new undertaking of this sort might take, in all probability it should not carry the label "evaluation"—the planners have been unduly sensitized to the term.

<sup>11</sup> Commission on Professional and Hospital Activities (Ann Arbor, Michigan).

## REMARKS ON EVALUATING THE HEALTH PLANNING AGENCY

SUPPOSE I were to take each one of you aside and ask you the following question, "Are you or your agency doing the best you can, under the circumstances?" The odds are that most of you would answer, "Yes, but I could do better if. . ."

The fact that this question can be answered at all implies: a) there is a standard or set of standards against which you can (at least subjectively) measure your performance, b) you are aware of the constraints or shortages or restrictions imposed on you by your environment, and c) you can imagine a new course of action opening to you if the restrictions were lifted or the shortages alleviated.

The point is that, given the environment in which you are operating and the goals and standards you have set for yourself, you have been able to judge your performance. You have evaluated yourself!

The reason that evaluation is an issue at all is that there is perhaps some possibility that, in the process of evaluation, the goals or standards against which the evaluation is to be made will be unrealistic or arbitrary or inappropriate. Some fear that this may be the case when an outside organization attempts evaluation of a phenomenon as complex and difficult of measurement as areawide planning. Another reason why evaluation is an issue is that there is a possibility that insufficient consideration may be given to the constraints which the environment imposes upon an agency. Some of these constraints may be lack of community support—either financial or organizational—, provincialism on the part of those whom the planning process touches, or local conditions which make cooperation with a planning agency unlikely.

Finally, evaluation is an issue because it requires that subjective judgments be translated into objective standards. This is a process

to which we all object in some measure or other. As long as an idea remains an idea, it can be criticized only on the grounds that someone has another which he considers better. But when an idea is translated into a program, the impact of that program and its efficacy are much more easily observed—and much more easily measured.

### *Functions of a Planning Agency*

In some broad sense, planning consists of at least some of the following components:\*

(1) *Identification of broad social goals.* It may come as a surprise to some to see the planning agency's function described as the identification of goals rather than the setting of such goals. However, it seems to me that society establishes for the planning agency the broad outlines within which their program development will take place and the agency simply recognizes and responds to them. It has been frequently said that medical care has become a right to which all people are entitled. Society has determined that this is the case. As a result, it is inappropriate for a planning agency to treat medical care as a market-place good which can be bought by those who can afford it but is not available to those who cannot. It is in this sense that the goals of the health service system are set by society rather than by the planning agency.

(2) Within the framework of the broad social goals, the planning agency is responsible for *development of alternative programs of action*. It is here that the initiative and wisdom of the planners come to the fore. In order to adequately meet this responsibility, planners must not only have at their disposal data concerning the relevant area; they must also be aware of the attitudes and abilities of the many individuals and agencies involved in the provision of health care to the community. Given the broad social goals, it is the planning agency's responsibility to develop programs or sub-goals to accomplish them. This statement implies that the development of a single program to the exclusion of all others is not appropriate behavior for a planning agency. The ideal situation would be in

which *all* alternatives were identified, though this is not practically possible. A reasonable level for the planning agency to seek is one at which a number of alternative courses of action, each of which will ultimately bring about approximately the same end result, are described, the costs associated with them are identified, and the benefits accruing are listed. For example, it may be that, in order to provide adequate care for those living in "ghetto" areas, either an existing teaching hospital could build and staff new facilities in the area or the voluntary hospitals already in and near the area could extend their programs so as to care for the residents. Both of these programs may have the same end result, though one may be more difficult to accomplish, more costly or less satisfactory than the other. It is incumbent upon the planners to recognize that alternatives exist and to assess the relative costs and the benefits of each.

(3) Once the alternatives have been established and listed, the planning agency must *make a choice from among the alternatives*. This choice should be based on a practicality, feasibility, workability, and cost. It has been said that the planning agency does not have the responsibility for making such a decision—that the agency's role is to identify the alternatives, but the choice among them is the responsibility of a diverse group in society via the democratic process. True, the interests of many groups must be considered in choosing a program of action, but with the broadening representation on the boards and advisory councils of planning agencies and in the absence of an alternative group in society capable of and interested in making such decisions, it appears that the planning agencies, at least in the foreseeable future, must bear this responsibility.

(4) The planning agency is responsible for the *implementation of the program* (selling the program). In this area there are great differences of opinion among planners concerning the role of the agency. Having worked hard on developing a plan you become personally committed to the program and, it seems to me, it is most difficult to avoid getting involved in at least the encouragement of its acceptance. Furthermore, when sources of financial support view the planning agency, they tend to think in terms of accomplishments and base their continuing support on such accomplishments. If the planning agency has had many good "ideas" none of which have come to fruition, it is unlikely that support will continue over a long period of time. The only way to translate ideas into results is by

\* It should be noticed in passing that, on the one hand, some will argue that the list is not complete, while, on the other, some will argue that it contains elements which do not appropriately belong in the planning purview. It is suggested here as a framework for thinking about planning, not as an all-encompassing definition thereof.

implementation. Whenever a reason for planning is given or a rationale for its existence is proposed, it involves improving, reducing, correcting, preventing, or encouraging some aspect of the system. These are action verbs, and one infers from their use that some efforts at implementation are expected from the agency. For these reasons I include implementation in the purview of the agency.

### *Some Evaluation Techniques*

The evaluation process can and should take place at each of these stages. Evaluation with respect to success of the agency in identifying the broad social goals is quite simple—indeed obvious. To paraphrase one of the speakers at the institute, “We don’t know if we’re doing the right thing, but we know we’re not 180° off course.” The fact that he knew that his agency was headed in at least roughly the “right” direction indicates that he had, to his own satisfaction, identified the broad goals which society has handed down to health planners.

Evaluation of the success of the agency in developing alternative programs of action is somewhat more difficult, but remains in the realm of the subjective. Here, evaluation takes the form, “Has the agency identified all relevant alternatives and have they adequately assessed the costs and benefits related to each?” Obviously, no matter how many alternatives have been listed and assessed by the agency, at least one more can be thought of. Therefore, the planners are not to be faulted for failing to see one of the (possibly obscure) alternatives, but they do have the responsibility for identifying those which obviously bear on the question at hand.

The third item above—making a choice from the alternatives based on its practicality, feasibility, workability and cost—is perhaps the most difficult one to evaluate. We’ve all heard some about program planning and budgeting (PPB) and read more. Many can scoff (albeit lightly) at cost-benefit analysis on the basis of the difficulty of measuring the appropriate costs and benefits, but they can’t dismiss it, nor can they ignore it. It is here to stay. In fact, some very interesting applications have been made to areas as esoteric and diverse as research expenditures for specific disease entities, syphilis control programs, etc. In these studies some very creative benefit and cost measures have been devised and used which at least shed some light on the question and may aid in the decision process.

Typically PPB or cost-benefit analysis is an *ex ante* form of evaluation. Alternatives are listed, benefits and costs of each computed, and the “best” alternative (best is not an unambiguous word in this context) chosen. In an *ex post* evaluation process, such as the one under consideration here, the technique is similar. The question you must answer first is, “What have I accomplished?” Listing accomplishments of an agency as complex as an areawide planning agency is a difficult task, but at the same time a fundamental one. The next question is, “How much has it cost?” This list may be easier to make, but, to be complete, it should include, in addition to dollar costs, what economists call “opportunity costs”—in this case the alternative accomplishments foregone as a result of the program choice or policy which has been adopted. The last step—at the same time the most important and most difficult one—is obtaining an answer to the question, “Was it worth it?” This should not be a subjective answer. True “hard-nosed” evaluation procedures require that the validity of your answer to the question “was it worth it” be objectively demonstrable to all concerned. This requirement should not be threatening to planning agencies. If the purpose of an agency is to effect change in the health services system, that change should be describable and measurable. If the role of the planning agency is to change relationships within the system or views concerning the system, again such changes should be identifiable. In fact, in the absence of such objective means of evaluation, the whole question of whether or not planning agencies should be evaluated becomes meaningless.

Evaluation of a planning agency with respect to the fourth component—encouragement of implementation—is closely tied to evaluation of the third. If the alternatives have been appropriately chosen, and if the agency has been successful in their implementation, it has, by definition, been effective.

A crucial point with respect to evaluation is that most proposed programs of evaluation or sets of criteria by which to accomplish it are based on the question, “What is being done today?” That, certainly, is an important question. But a far more important question, and the one upon which evaluation should be based in the future, is “What might we do that we are not doing and what are the costs of not doing it?”