HEALTH PLANNING

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Australian perspectives

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACHA	Australian Community Health Association
ACHS	Australian Council of Healthcare Standards
ACOSS	Australian Council of Social Services
ACT	Australian Capital Territory
ADL	Activities of Daily Living
AGPS	Australian Government Publishing Service
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
AHRC	Aboriginal Health Resource Cooperative
AHS	Australian Hearing Services
AIDAB	Australian International Development Assistance Bureau
AIDS	Acquired immune deficiency syndrome
AIH	Australian Institute of Health
AIHW	Australian Institute of Health and Welfare
ALOS	Average length of stay
AMWAC	Australian Medical Workforce Advisory Council
AN-DRG	Australian National Diagnosis Related Groups
AN-SNAP	Australian National Sub-acute and Non-acute Patient Classification
APS	Australian Public Service
AR-DRG	Australian Refined Diagnosis Related Groups
ATSI	Aboriginal and Torres Strait Islander
ATSIC	Aboriginal and Torres Strait Islander Commission
AUSAID	Australian Agency for International Development
BCG	Boston Consulting Group
BEACH	Bettering the Evaluation and Care of Health
BOD	Burden of disease
CADE	Confused and disturbed elderly (units)
CATI	Computer-assisted telephone interview
CBA	Cost-benefit analysis
CBD	Central Business District

CD	Collection District
CDC	Center for Disease Control (now known as Centers for Disease Control and Prevention)
CEA	Cost-effectiveness analysis
CEO	Chief Executive Officer
CHASP	Community Health Accreditation and Standards Program
CHF	Consumers' Health Forum
CHP	Community Health Program
COAG	Council of Australian Governments
COMCAS	Community Health Data Collection System
CONA	Community-oriented needs assessment model
CRS	Commonwealth Rehabilitation Service
CSAHS	Central Sydney Area Health Service
CT	Computer tomography
CUA	Cost-utility analysis
DALY	Disability adjusted life year
DARE	Database of Abstracts of Reviews of Effectiveness
DART	Dengue Action Response Team
DCSH	Department of Community Services and Health
DFMP	Dengue Fever Management Plan (Qld)
DHAC	Department of Health and Aged Care
DHCS	Department of Health and Community Services
DO	Day only
DOH	Department of Health
DPWS	Department of Public Works
DRG	Diagnosis-related group
DVA	Department of Veterans' Affairs
EBM	Evidence-based medicine
EDIS	Emergency Department Information Service
EEO	Equal employment opportunity
GDP	Gross domestic product
GFA	Gross floor area
GP	General practitioner
HBGs	Health benefit groups
HBG	Health building guideline
HEALY	Health adjusted life year
HHSC	Hospitals and Health Services Commission
HIV	Human immunodeficiency virus
HOOP	Health outcome-oriented problem
HOOPS	Health outcome-oriented problem segmentation
HPPA	Hospital Purchaser-Provider Agreement
HPU	Hospital planning unit
HRGs	Health resource groups
HSRG	Health service research group
HTIC	Health Targets and Implementation Committee

ICD	International Classification of Diseases
ICD-10-AM	International Classification of Diseases, 10th Revision, Australian Modification
ICU	Intensive care unit
IEC	Information, education, communication
ILAP	Integrated Local Area Planning
ISC	Inpatients Statistics Collection
ISCOS	Health Inpatient Statistic Collection On-line System (New South Wales)
ISO	International Organization for Standardization
KRA	Key result area
LGA	Local Government Area
LOS	Length of stay
MAV	Municipal Association of Victoria
MBS	Medicare Benefits Schedule
MH-CASC	Mental Health Classification and Service Cost Classification
MHSB	Metropolitan Health Services Board (WA)
MOU	Memoranda of Understanding
MPHP	Municipal Public Health Planning
MRI	Magnetic resonance imaging
MSAC	Medical Services Advisory Committee
NESB	Non-English-speaking background
NGO	Non-government organisation
NHIMG	National Health Information Management Group
NHMRC	National Health and Medical Research Council
NHS	National Health Service (UK)
NHTAP	National Health Technology Advisory Panel
NPHP	National Public Health Partnership
NSW	New South Wales
NSW AHRC	New South Wales Aboriginal Health Resource Cooperative
NSW DOH	New South Wales Department of Health
NT	Northern Territory
OBBF	Outcomes-based block funding
OD	Organisational development
OECD	Organisation for Economic Cooperation and Development
PANCH	Preston and Northcote Community Hospital
PATCH	Planned approach to community health
PBMA	Program budgeting and marginal analysis
PBS	Pharmaceutical Benefits Scheme
PCR	Polymer chain reaction
PEST	Political, economic, social, technological
PET	Positron emission tomography
PFS	Procurement Feasibility Study
PHERP	Public Health Educational and Research Program
PHEST	Political, health, economic, social or technological

PHRDC	Public Health Research and Development Committee
PMR	Perinatal mortality rate
POE	Post-occupancy evaluation
PRA	Participatory rural appraisal
PRECEDE	Predisposing, reinforcing and enabling causes in educational diagnosis and evaluation
PYLL	Potential years of life lost
QACS	Queensland Ambulatory Classification System
QALY	Quality Adjusted Life Year
QIC	Quality Improvement Council
Qld	Queensland
QoL	Quality of life
RAF	Resource Allocation Formula
RAWP	Resource Allocation Working Party
RCT	Randomised controlled trial
RDF	Resource Distribution Formula
RGH	Repatriation General Hospital
RPAH	Royal Prince Alfred Hospital
RTP	Resource Transition Program
RVS	Relative Value Study
RVU	Relative value unit
SA	South Australia
SAHC	South Australian Health Commission
SARAR	Self-esteem, associative strength, resourcefulness, action planning, responsibility
SCHS	Sisters of Charity Health Service
SCOHM	Standing Committee of Health Ministers
SDG	Service development group
SDS	Services delivery strategy
SES	Senior Executive Service
SF-36	Medical Outcomes Study Short-form 36
SMR	Standardised mortality ratio
SRG	Service-related group
SSR	Standardised separation ratio
SWOT	Strengths, weaknesses, opportunities and threats
SWS	South Western Sydney
SWSAHS	South Western Sydney Area Health Service
TAC	Tharawal Aboriginal Corporation
TAFE	Technical and Further Education
TB	Tuberculosis
THS	Territory Health Services (NT)
TPHU	Tropical Public Health Unit (Qld)
TPHUN	Tropical Public Health Unit Network (Qld)
UDAG	Urgency, disposition and aged groups
UK	United Kingdom

UNFPA	United Nations Fund for Population Activities (now known as United Nations Population Fund)
UNSW	The University of New South Wales
US	United States of America
VACS	Victorian Ambulatory Classification System
VHPF	Victorian Health Promotion Foundation (also known as Vichealth)
VMO	Visiting medical officer
WA	Western Australia
WHO	World Health Organisation
WIES	Weighted Inlier Equivalent Separations
WSAHS	Western Sydney Area Health Service

PREFACE

This book is about health planning, both its theory and its practice. We have written it in the Australian context, although many of the issues we discuss have wider application.

This book has its origins not just in our practical planning experience, but also in our experiences as teachers of health planning. After a fruitless search for a comprehensive text for our students, we decided to take the plunge and write our own.

As three experienced health planners, we have participated in just about all of the processes we describe. But be aware that all three of us are generalist planners. We set out to write a book by planners, for planners and for students of planning. We are not architects, statisticians, economists, political theorists, sociologists or engineers, although we draw on all of these bodies of knowledge.

Readers looking for expert knowledge on specialist issues such as statistics, health economics, hospital design and so on should look elsewhere. Many of the chapters of our book require (and in many cases have) a book or more in their own right to address in detail the issues we have canvassed in just a few pages. For that, we make no apologies. Our interest is in health planning, both as a technical activity and as a way of thinking, and our challenge in writing this book was to draw together and synthesise expertise from many different disciplines.

Likewise, we have chosen to focus on health planning and not on health policy, though we recognise that the two are intertwined. Health policy articulates the values, goals and priorities of the health system, both now and in the future. Health planning is purposeful and focuses on the future. Health planning aims to bring about change, meet a desired objective, or translate health policy into practice.

Planning is essentially about change management, and for the last 30 years planners have been people who have implemented the prevailing reform agenda, whether it be in the expansionary period of the 1970s and 1980s or the contraction and privatisation period that typified much of the 1990s. Planning is a technical activity, but it is also a political process. This is reflected in several themes that run through our text, many of which reflect current tensions and challenges in the Australian health care system:

- market forces versus planning;
- social values versus political imperatives;
- planning for individuals versus planning for populations;
- equity of access versus equity of outcome;
- technical efficiency versus effectiveness; and
- health versus health services.

This book adopts an unashamedly instrumentalist orientation, since our concern about planning is how to do it and to do it well. We recognise the diversity of voices and the complexity of society. We fall back on modernist mechanisms as tools to help navigate through the complexity, but also give the warning that you adopt a rational comprehensive approach at your own peril.

Our advice is to adopt and nurture a range of tools and perspectives and always be reflexive. As such, we take a definitive position on this being a project in the capacity-building tradition.

We have included models of various planning processes throughout the book, but these are for conceptual purposes only. Planning in the 'real world' is often likely to be more iterative or more circular than the models suggest, as mentioned in the chapters.

Our task in writing this book has been made easier by the experience and expertise contributed by our case study authors, to whom we owe our thanks and appreciation. As experienced clinicians, planners, managers, economists and statisticians, they contribute both their considerable technical expertise and their experience in 'doing planning'.

We also wish to thank Libby Eagar for her research assistance, particularly with Chapter 9, and Evelyn Sharman for her work in editing the final text. We also thank the staff of Allen & Unwin, particularly Elizabeth Weiss, who have patiently and expertly guided us through this process.

Finally, we take this opportunity to thank our families (David, Jordan, Marcus and Georgina; David, Maya, Sasha and Kina; Libby) and our colleagues who not only took over many practical tasks but also supported us and protected us from distractions so that we could think about, and write about, the how and the why of health planning in Australia.

Kathy Eagar, Pamela Garrett
and Vivian Lin

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Part I
Overview and Context of Health Policy and Planning

1 INTRODUCTION TO HEALTH PLANNING

Since the Second World War, governments in Western industrialised countries have engaged in the planning of health services (Rodwin 1984). Health planning institutions and approaches have varied, but they have shared a common range of concerns. These include:

- How should health needs be assessed and met?
- How should a health system be organised and financed?
- What is the appropriate role and scale of hospitals? and
- What are the appropriate responsibilities for public health programs?

Over the years the focus of health planning effort has changed. Health planning has evolved from the post-war expansionary phase to issues of cost containment and now to a concern with accountability and health outcomes. The early successes of creating a 'medical–industrial complex' have led, ironically, to a need to critically examine issues of effectiveness, efficiency and equity.

This chapter introduces the main theoretical issues and debates pertaining to planning in general and health planning specifically. It describes the different ways in which planning is conceived and practised. Definitions of key terms are provided. The fundamental dilemma of planning — whether to plan for health services or to plan for health improvement — is also raised.

WHAT IS PLANNING?

Planning can be thought of in numerous ways and is applicable to numerous activities. Most people try to arrange ahead many of the events of life. Budget planning is concerned with the allocation of limited and finite financial resources. Town planning is concerned with the control of influence on the future pattern of urban development and urban services. Most countries — at the national, state or local levels — engage in national security planning, economic planning, social planning, environmental planning and regional development planning (Friedmann 1987). Dictionaries typically define the verb

'to plan' as meaning 'to arrange the parts of', 'to realise the achievement of' or 'to intend'. In the colloquial sense, then, 'planning' is concerned with deliberately achieving some objective by assembling actions into some orderly sequence.

Green (1999) suggests that planning, as a separate identifiable activity in organisations, emerged from three strands of development. First, the rise of modern, complex industrial organisations in the late nineteenth century required decisions about the future to be taken in a considered and explicit manner. Second, the Russian Revolution of 1917 led to the attempt to build an economy based on nationally determined plans and, hence, to the need for formal state planning (and planning bureaucracies). Third, the shortages experienced during the Second World War led to centralised controls in many Western countries.

In Western industrialised democracies, planning as a generic activity and as a profession is commonly identified as emerging in the twentieth century, particularly after the Great Depression of the 1930s. Planning evolved as an attempt to mitigate the negative consequences of a laissez-faire market economy that was characterised by unrestrained pursuit of self-interest by individuals and corporations (Friedmann 1987). The idea was for the state to intervene in markets through planning instruments in order to protect the collective interest. Public planning has thus had a long association with the notion of the welfare state and it has often been seen to be in conflict with private interests.

Definitions of planning often reflect a tension between the technical tasks undertaken by the profession and the end objectives to be achieved by the tasks. In a generic and technical sense, planning can be conceived of as:

- 'the process of preparing a set of decisions for action in the future, directed at achieving goals by preferable means' (Dror 1973, p. 330); or
- 'making current decisions in the light of their future effects' (Reeves and Coile 1989, p. 2).

However, ways of thinking about planning have evolved with changes in society and the economy. In the 1940s, planning was concerned to set up the desired future end state in detail (that is, blueprint), but by the 1960s planning concentrated on the objectives of the plan and ways of obtaining them or systems planning (Hall 1992). Hall suggests that, in the 1970s, planning became more heterogeneous and diffuse, and it could be characterised as continuous participation in conflict. Friedmann (1987) would emphasise that planning, as the application of technical reasoning to specific problems and leading to action or policy intervention, occurs in a social and political context.

Mainstream planners typically work for the state, although increasing numbers also work within civil society. The planning profession has historically seen the discipline as 'basically a methodology, a set of procedures applicable to a variety of activities aimed at achieving selected goals by the systematic application of resources in programmed quantities and time sequences designed to alter the projected trends and redirect them toward established objectives' (Robinson 1972). Such a perspective emphasises the technical and rational

aspects of planning. Taylor and Reinke (1988, p. 5) expand on this perspective when they agree that 'effective planning requires stepwise application of selected multidisciplinary methods and procedures to designated programs and projects within specified time frames'. They add that 'planning is not simply a technical exercise; it is an ongoing process of learning, adapting to change, and educating'.

As planners move into positions of facilitating change, the traditional model of rational planning is inserted into, if not transformed by, political practice. The values inherent in planning are made explicit by Blum (1974). Planning, he says, 'is devoted to directing and attaining social changes of a specific and desired nature' and is the 'preferred means of achieving deliberate change' (p. 14). Friedmann (1987) also sees planning practice as linking scientific and technical knowledge to processes of societal guidance, if not social transformation. In the 'societal guidance' model, planning is articulated through the state and is concerned with systematic change, while the political practice of system transformation becomes the focus on planning practice concerned with social transformation.

Parston (1980) suggests that planning is both an occupation and an idea. As an occupation, planning is work, a job. As an idea, planning is 'a process which is undertaken to meet some desired objective or to fulfil some purpose' (p. 23). He argues they are inseparable. Forester (1982) also sees an activist role for the planner, in that planners are not only involved in problem solving; they are also concerned with problem finding or the mobilisation of attention to issues of concern.

WHY PLAN?

As an activity that all organisations carry out with a greater or lesser degree of explicitness, planning involves making choices. When carried out by the public sector, planning is often conceived of as an intervention in the free market. In theory, the market allows equilibrium to be established between supply and demand as resources move in response to price signals. State intervention is limited, and 'non-market goods' are produced in a complementary public sector. Classical economists see the market as the most efficient means of operating an economy. However, certain key conditions have to be met. These include good knowledge by the purchaser (or consumer) of the goods or services on offer, buyers and suppliers operating independently, and the market operating independently to the extent that a purchase by one consumer does not necessarily affect the decision by another to purchase.

Planning, as an instrument of state intervention, has been justified on a number of grounds since the second half of the twentieth century. Milton Friedman, an economist who champions the free market, supports state intervention in the presence of natural monopolies and externalities. The liberal perspective (such as espoused by Galbraith, Titmus, Lindblom and Musgrave)

suggests that state intervention is justified in order to correct market failure, to redistribute income, and to manipulate fiscal and monetary policies in order to affect aggregate demand. Structuralist critiques of the state (such as those by Habermas, O'Connor and Offe) suggest that the contradictory need to maintain the conditions for capital accumulation and to raise revenue to meet its own obligation creates the need to convey an image of pursuing common and general interests of society as a whole, allowing access to power and responding to justified demands.

Planning has also been more recently criticised for its utilitarianism. Modern statecraft has been described as 'devoted to rationalising and standardising . . . a social hieroglyph into a legible and administratively more convenient format' (Scott 1999, p. 3). State planning schemes can be seen as a means of social engineering, greater regimentation of communities and daily lives, and enhanced state capacity.

Different conceptions of the role of the state will drive views on the nature and extent of state intervention required. For the health sector, views on the need for, and the nature of, state intervention depend on whether the state is seen as regulator, service provider, financier or policy formulator for the health sector. In relation to health planning as a form of state intervention, the pro-market position argues that health planning is likely to increase administrative controls and reduce professional autonomy and consumer choice. Health services delivery systems based on a professional model or a competitive free enterprise model (such as in the United States) would be favoured. The radical critique, in contrast, would see health as a right rather than a commodity, and would prefer distribution of health resources on the basis of need. A model that requires central planning and regionalisation of health resources, such as the National Health Service in England prior to the Thatcher reforms, would be favoured. A mid-way position, represented by liberals, would accept a mixed system of public and private service provision and financing, and focus state intervention on criteria such as accountability, rationality and equity.

Irrespective of their ideological positions, all governments ultimately need to make allocative decisions. As shown in Figure 1.1, allocative decisions are required across various sectors as well as within the health sector.

Given that pure markets do not exist in the Australian context and that public sector financing and provision are dominant features, the setting of health care priorities is largely determined through health planning. The question, then, is not whether health care should be planned, but what to plan, by whom, how and when.

PLANNING TRADITIONS

Friedmann (1987) classifies the intellectual traditions of planning theory according to their political ideology as well as the intended use of knowledge. He identifies four distinct tendencies, as shown in Table 1.1.

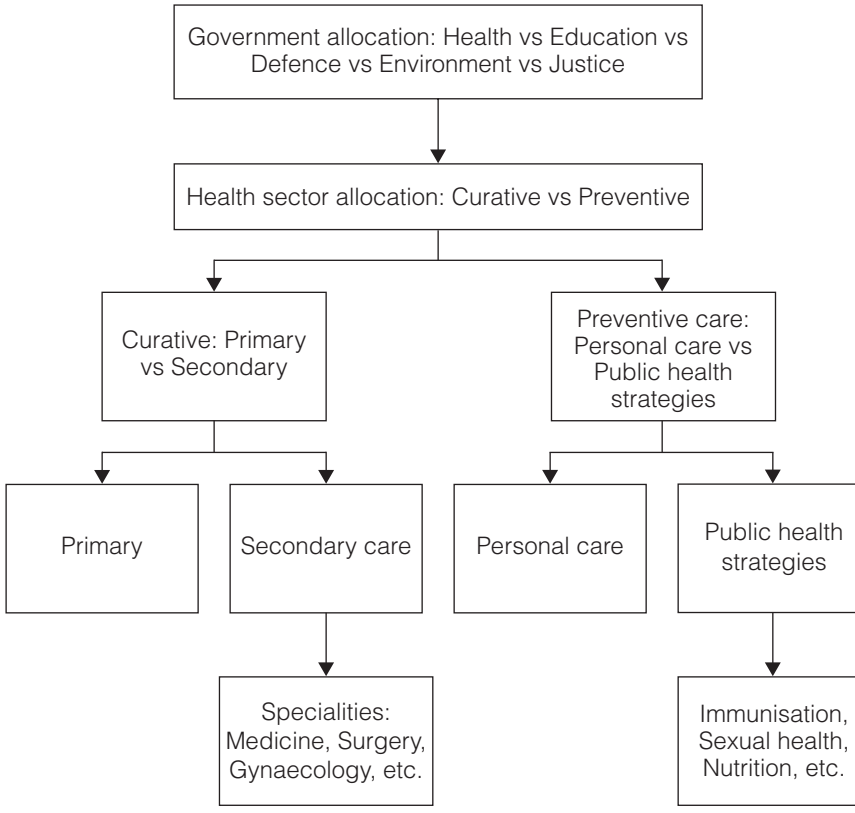

Figure 1.1 Levels of allocative decision making by government
Source: adapted from Green 1999 p. 5.

The 'policy analysis' tradition (including Dror, Benveniste and Wildavsky) derives from organisational theory, particularly how large organisations might improve their ability to make rational decisions. It is a rational–technical approach which builds on public administration, systems analysis, and welfare and social choice theory, and offers no distinctive philosophical position. The 'social reform' tradition (including Lindblom, Etzioni and Perloff) is concerned with institutionalising planning practice and making action by the state more effective. Planners within this tradition tend to advocate a strong role for the state, which has both mediating and authoritative functions. Building on institutional economics and political sociology, they are interested in planning instruments and technical tools that help to manage the economy in the public interest.

The 'social learning' tradition is derived from organisational development approaches and focuses on the relationship between theory and practice. Rather than treating scientific knowledge as a set of building blocks for the reconstruction

Table 1.1 Intellectual traditions of planning theory

	Political ideology	
Knowledge to action	*Conservative*	*Radical*
In societal guidance	Policy analysis	Social reform
In social transformation	Social learning	Social mobilisation

Source: Friedmann 1987, p. 76.

of society, planning is viewed as an ongoing dialectical process in which the main emphasis is on new practical undertakings. The 'social mobilisation' tradition (including Mumford, Alinksy, Freire, Illich and Castells) departs from all others by asserting the primacy of direct collective action from the grassroots (that is, the community). It is an ideology of the dispossessed, is concerned with social solidarity and aims to change the status quo.

All of these traditions can be found in the brief history of health planning in Australia (see Chapter 3) and they continue to co-exist. The Australian health care system has historically been characterised as a publicly planned and regulated system of supply. Even in the Australian private sector, risks are pooled through insurance arrangements and both private health care and insurance are heavily subsidised. Rational-technical planning models have been a feature of decision making about resource allocation in the health system for several decades.

At the same time, the Australian approach reflects strong cultural values about health care: that access should be determined by clinical need and not by the ability to pay; that people have a right to health care when they need it; and that health care is a key responsibility of government. Within this cultural context there have been significant shifts in policy, including a move away from institutional health care to community-based health services. Such policy debates and the ensuing processes of change often put planners within the social transformation mode.

Green (1999) argues that the track record of planning internationally is often not good, as plans often fail either to be implemented or to respond to the real needs of the community. He suggests that failures arise due to:

- an emphasis on the formal process of planning, leading to it becoming a bureaucratic function or an end in itself;
- technical failure to analyse needs appropriately or to estimate resources accurately;
- imposition of plans from the centre in a top-down fashion, without involvement of providers and communities; and/or
- isolation from other decision-making processes (such as budgets or human resources management).

The lessons are equally relevant to Australia and other countries — planning efforts will fail if planning is constructed as a narrow notion of apparently

rational procedures being applied by a small group of technocrats who are oblivious to the broader political factors. Planning involves choices and change and, as such, will always have its opponents. Planning is neither ideology nor all-powerful, but it does exist and have its effects (Huxley 1986). Understanding power structures and historical constraints, alongside the technical analysis and recognition of opportunities for action, is central to successful planning.

MODELS OF THE PLANNING PROCESS

Early planning thought is dominated by the *comprehensive rational model* (Parston 1980; Benveniste 1989). In this model the set of procedures essentially consists of:

- *Goal setting*, through identification of problems to be solved, needs to be met, opportunities to be seized, and aspirations of stakeholders to be met.
- *Plan formulation*, through systematic analysis of alternatives, setting of criteria to choose amongst the options, and examination of consequences of proposed actions.
- *Plan implementation*, through deploying a range of actions such as budgets, project schedules and regulatory measures.
- *Monitoring and feedback*, through reviewing achievements and updating the information, thus maintaining the currency of the plan.

Such understanding of the planning process implies a systems view and a systems approach. The strength of this comprehensive, rational approach is that it is analytical, information-based and allows system design to be a central concern. It also allows for the introduction of normative thinking and valuation into planning. It is a set of technocratic or analytical processes that can be applied to a range of political and social contexts. The outcomes of the planning process reflect the definition of the planning problem, the information used for planning, the governance arrangements for the planning process and the extent to which the planning process is subject to public scrutiny.

The difficulties associated with this model — recognised over time — include the fact that planners seldom start with a blank slate and often do not have access to full information. The comprehensive rational planning model essentially conceives of planning as a technical and top-down activity led by expert planners. In reality, however, planning activities tend to be iterative with various activities occurring in parallel, rather than a chronologically ordered cycle of events. Furthermore, many problems require political rather than technical solutions. Nonetheless, the essential planning skills needed to cope with complex and changing environments can still be built upon the foundation of rational planning.

An alternative approach is the *mixed scanning model* advocated by Etzioni (1967). Rather than considering comprehensively the alternatives for action,

mixed scanning focuses only on selected areas of interest. Once the priority areas are chosen, the analytical process hones in on the marginal changes that are possible. This model is more pragmatic than the rational comprehensive model, insofar as it is a less costly process in terms of time and information resources. The analytical process is otherwise comparable.

The critique of the rational planning model rests primarily in the political nature of planning. A third and distinct model is *incrementalism*, or what Lindblom (1959) terms 'muddling through'. The planning process is neither cyclical nor iterative, as the model is simply one of moving from the present position to the desired objectives by acting on a series of political windows of opportunity. The essence of this model is a series of disjointed steps, in contrast with the process of pure rationalism. Its emphasis on the political dimensions more accurately reflects the real world. It is also more flexible and allows for a faster response to changing environments. However, incrementalism may serve to institutionalise existing power relations rather than encourage change, or it may lead to a lack of direction.

LEVELS OF PLANNING

Whether the model is comprehensive rationalism or mixed scanning, the analytical, problem-solving process outlined above can be applied to different levels of planning. These different levels are relevant across different fields of planning, be it health services, organisational development, urban affairs or military engagement.

Dever (1980) outlines three levels of planning:

- *Policy planning*, which deals with what *ought* to be done, is the most conceptual and important in establishing system design. Planning at this level is normative and oriented towards future goals. There is also emphasis on design, on what should be rather than what is.
- *Strategic planning*, which deals with what *can* be done, is concerned with possible activities, implications for system structures and effectiveness, and creation of instruments for action. The emphasis is on analysis (of need, of systems and institutions, or of stakeholders) which can lead to defining means to achieve desired goals.
- *Operational planning*, which deals with what *will* be done, is the most concrete. The focus is on specific activities to be undertaken and the resources required for implementation. The final outcome is an operational or implementation plan.

Friedmann (1987) places the levels of planning within a political and bureaucratic context. At the higher level of bureaucratic practice, planning may be focused on societal guidance and covers activities concerned with system maintenance and change. It is usually a top-down management of public affairs and incorporates policy planning and strategic planning as outlined above. The

next level of bureaucratic practice is administrative planning. This involves both management of program routines and developing processes for institutional change. It is comparable to operational planning above.

STYLES OF PLANNING

Planning at the macro level can be seen as synonymous with policy making. Planning becomes a process of strategy formulation with concerns focused on power in political systems, consensus versus conflict views of how society functions (Walt 1994), and questions about issues such as the role of government, the media, interest groups, political parties and global politics.

A more instrumentalist perspective tends to inform planning as strategy development at the organisational level. Mintzberg (1973) sees strategy development in organisations as occurring in one of three ways:

- *Leader-driven strategy*, where the strong leader determines strategy.
- *Adaptive strategy*, where small (often disjointed) reactive steps are taken to resolve problems/issues (incrementalism).
- *Formal planning (rationalism)*, where analysis is used to develop explicit strategies.

Some organisations rely on the visions and strategies of a single *charismatic* or *powerful leader* who may derive their power from expertise, position, shared values or ideas, or coercion. Such a top-down approach is likely to discourage others from being innovative and creative. Further, it does not recognise the increased effectiveness associated with collaboration with communities and stakeholders.

In contrast, *adaptive* or *power–behavioural approaches* rely on negotiation, bargaining and the importance of coalitions. This approach recognises that multiple goals can co-exist in organisations (Quinn 1991) and that there is a need to constantly reflect, plan and amend strategies. Incrementalism can be a useful perspective as it provides for organisational plurality, supports an analysis of organisational power, and questions whose interests will be served through a particular strategy. But it may also lead to 'muddling through' without direction.

Formal planning can provide a set of concepts, directions and procedures to help people to think and act strategically, with a view to developing a comprehensive short- and long-term agenda. Formal processes can potentially provide an organised approach to developing innovative ideas and for involving people at all levels. A plan, however, is best seen as just one building block in a series of events that determine macro-level strategy (Quinn 1991). Moreover, there is a wide variety of values and approaches to formal planning which may be more or less participatory, planned or impulse-driven, top-down or bottom-up, implicit or explicit, focused on the past or on the future, or concerned with both.

Macro-level strategic planning often involves a mixture of formal planning, incrementalist (power–political) processes and management techniques (Hax and

Majluf 1988), depending on the issue and context (Mintzberg 1973; Quinn 1991). There may even be times when openness to new ideas, information and approaches, and a strong commitment to a particular issue or goal are more important than a brilliant strategic analysis (Mintzberg and Quinn 1991). Hall et al. (1975) suggest that when an issue has high legitimacy, feasibility and support, it is likely to become an agenda item.

Insofar as planning is an activity concerned with effecting change, the planner is not a neutral technocrat. Benveniste (1989) suggests two essential approaches to planning in terms of how the planner defines his/her role:

- *Advocacy planning*, where planning is a means of redressing the imbalances between different groups with different power, and the role of the planner is to take an active role in facilitating change.
- *Apolitical planning*, where planning is the use of technical knowledge to achieve political or managerial compromise.

In the classification offered by Friedmann (1987), 'apolitical planning' is comparable to 'allocative planning', which is concerned with distribution of scare resources among competing claimants or uses. 'Advocacy planning', however, is sub-divided into 'institutional planning' and 'radical planning', with the former oriented towards facilitating institutional change and the latter attempting to draw on organised citizen power to promote social transformation. The former can also be conceived of as adopting a pluralist approach involving negotiations with key stakeholders and communities to reach an equilibrium or consensus. The latter, on the other hand, may adopt a structuralist analysis and be based on collaboration between planners and communities in order to confront and address the determinants of inequity.

Sandercock (1998) offers a typology of planning approaches based on the evolution of urban planning models. These include:

- The *rational comprehensive model*, where the planner is indisputably the expert.
- The *advocacy planning model*, where the planner represents the interests of the disadvantaged (though leaving intact the workings of plural democracy).
- The *radical political economy model*, where planning is an instrument of the capitalist state and the planner's role is as the revealer of contradictions and an agent of social innovation.
- The *equity planning model*, where the planning effort consciously seeks to redistribute power, resources or participation.
- The *social learning and communicative action model*, which acknowledges the value of local and experiential knowledge.
- The *radical or emancipatory planning model*, where the planner's allegiance is to the community rather than the state and his/her role is to work for social transformation through community-based organisations.

In examining the evolution of planning practice, Sandercock suggests some new pillars for post-modern planning:

- greater and explicit reliance on practical wisdom;

- people-centred, as opposed to focusing on the planning document;
- need to access multiple ways of knowing (for example, community experiences);
- greater emphasis on community empowerment; and
- recognition of the existence of multiple publics and developing multicultural literacy.

She stresses different sources of information and evidence for planning, with the keys being: knowledge through dialogue; knowledge from experience; learning from local knowledge; learning to read symbolic and non-verbal evidence; learning through contemplative or appreciative knowledge; and learning by doing, or action planning.

The inherently value-laden nature of planning thus raises some critical questions about who should be involved in the planning process, how they should be involved and when they should be involved. The answers to these questions are often informed by an understanding of why a planning process is being undertaken. It can be asked:

- Is planning an aid or replacement to political decision making?
- Is planning a means of improving social justice?
- Is planning a means of getting some focus on the future?
- Is planning a gentle, persuasive route to turn ideas into action?
- Is planning a method for shared decision making?
- Is planning a means of improving the quality of effort applied to problem solving?
- Is planning a means of control?

Clarity about the answers to the above questions will result in different ways to resolve the issues which frequently occur in 'doing' planning, such as:

- What should be the process for developing a plan?
- Who should write the plan (for example, consultants, planners or managers)?
- What are the merits of a centralised versus decentralised approach?
- Who should be involved in the planning activities (for example, managers or consumers)?
- What should be the governance arrangement for the planning process?
- What are the merits of group consultation versus individual consultation?

Some of these questions may appear to be purely technical, yet most embody notions about the distribution of power, the winners and losers in any changes to the status quo, and the legitimacy of the planning exercise as perceived by the stakeholders.

PARTICULAR FEATURES OF HEALTH PLANNING

The particular features that distinguish health planning from other forms of planning relate to the peculiarity of the health system. Palmer and Short (2000)

suggest that the distinctiveness of health policy results from three broad defining factors:

- the unique role of the medical profession;
- the complexity of health care; and
- the nature of community expectations and values associated with health.

Some see that health care is distinguished by its hierarchical nature and by the dominance of the medical profession. Medical dominance is seen as being achieved through professionalism (freedom from scrutiny), authority over other health workers and professionals, and by shaping social beliefs and understandings about health (Navarro 1978; Willis 1989; Palmer and Short 2000). Furthermore, the orientation towards curative care, including resource allocation to this area, is reinforced by the nature of the medical profession.

Shortell and Kaluzney (1994) identify a number of operational features that distinguish health care organisations. While they recognise that many other organisations may possess one or more of these features, health care organisations will display a combination of these factors. Amongst these are:

- Definition and measurement of output is difficult.
- Work is variable and complex.
- Work is likely to be emergency work.
- There is little capacity for error.
- Activities require considerable coordination amongst a range of professional groups.
- Work is highly specialised.
- Workers are highly professionalised with strong allegiances to their profession.
- There is little control over doctors, yet they generate the costs.
- Dual lines of authority often operate.

Hospitals, of all health service organisations, may be particularly impervious to changes in the external environment. As 'closed systems', hospitals have what Taylor (1970) described as the hospital's 'cult of efficiency': long-established work patterns, routines, roles and power relations. The hierarchy is maintained with tight scheduling, numerous rules and regulations, and control mechanisms. The rigidity, control, tight scheduling, and official rules and regulations in health service institutions have long been critiqued (Goffman 1968; Illich et al. 1978). Health service agreements, awards, commitments and understandings also serve to mitigate against organisational change (Degeling and Anderson 1992). The bureaucratic culture is determined by the accumulation of the decisions of clinicians (Gilbert and Braithwaite 1994).

In more recent times, the traditional power base of doctors may have been partly eroded in the face of health care reform, managerialism, the strengthening power base of other professions in the health field (including economists, planners, nurses, lawyers and alternative medicine), unremitting cost control and the growth of active consumer interest groups (Hancock 1999). Organisational boundaries are also being blurred with horizontal integration and collaboration

between hospitals and community-based health services, and between the private and public sectors. Networks of services are increasingly becoming more useful descriptions of the health system (Shortell and Kaluzney 1994). The complexity of promoting health in the face of increasing societal inequity and environmental degradation is challenging health professionals to work in different ways.

Health planning has also been challenged by the rapid pace of change. Public sector reforms, including the introduction of purchaser–provider split models, initially raised questions about whether there is a role for state planning. Experience with formula-based output payments, however, still suggests that the state health authority has to plan for the volume and types of services to be purchased (Lin and Duckett 1997). More recently, purchasers have learned that their planning needs to be at a finer level, since the need for health services is a more specific concept than the need for health (Stevens and Raftery 1994).

The particular features of the health system described above have several implications. One is the relationship between health management, health planning and clinical practice. Should health planning be an integral component of health management? Should health planning be the bridge between clinical practice, health management and the political process? Should health planning be the process by which clinical knowledge is channelled to drive health system reform? Another important issue is the relationship between health planning and health financing and accounting. Should health planners be advocates for health and for patients? Should health planners be technicians involved in the distribution of finite health dollars? Should health planners be the decision makers who decide what to purchase in a purchaser–provider relationship? In practice, all of these roles are present in health planning to a greater or lesser extent.

Health planning is thus practised in an environment where technical and bureaucratic traditions exist simultaneously with complexity and change on both technological and social dimensions.

MODELS OF HEALTH PLANNING

Health planning is essentially concerned with improving health and with improving health services delivery or system performance. These two aims, however, require somewhat different approaches to planning (Tannen and Liebman 1978).

A planning effort concerned with improving population health (also called population-based planning) usually employs the following iterative process:

1 Select health issue(s) of concern.
2 Identify risks.
3 Evaluate population risk levels (at present and in future).
4 Select programs to eliminate or reduce risks.
5 Compare needed programs with existing programs.
6 Adjust resources.
7 Evaluate.

A planning exercise focused on improving health services delivery (also known as institution-based or resource-based planning) is also iterative and may use similar logic but has different starting points. The general model is:

1 Select health service(s) of concern.
2 Determine current demand.
3 Forecast potential demand.
4 Compare forecast with present resource capacity.
5 Adjust resources.
6 Evaluate.

Despite comparable logic, there are significant differences between the two models in orientation and methodological requirements. The population-based planning model establishes resource requirements based upon assessment of the risk levels and the health status of a given population. As such, it incorporates a broader understanding of the determinants of health, particularly the social and environmental factors influencing health outcomes. Its tendency is to focus on preventive programs and reorientate the health care system towards primary health care. It also gives recognition to the need for intersectoral collaboration and for community action in achieving health status improvement. Its main problems rest with gaining an accurate assessment of health status and risk levels, and testing the capacity of the health sector to influence broader determinants of health.

The resource-based planning model can be applied to a service or a facility. It is largely an attempt to match supply with demand, and its implementation is concerned with adjustments within the existing delivery system, most commonly with rationalisation of existing resources. This form of health planning is the dominant approach.

At a broader level, the differences in population-based and resource-based planning models also reflect different political interests. The resource-based approach is largely concerned with institutional growth and development, and serves the dominant interests of the institutional sector. In the health sphere, the dominant institution is the hospital and the dominant interest it serves is the medical profession. The population-based approach, on the other hand, is concerned (by definition) with community and societal interests. It requires the planner (and the planning body) to address the needs of the population as the central issue in the planning process and, as such, to become an advocate for community interests.

The history of health planning is characterised by movement from facility-based planning to a focus on health outcomes. This reflects a number of important trends. First, there has been a shift in health policy, from expansion of hospital facilities to the need to rationalise resources, through to a concern for the health return on the investment. Second, this shift in orientation itself has reflected the contest in policy space between dominant professional interests and community and consumer interests, supported by ‘corporate rationalisers’ (Alford 1975; Duckett 1984). Third, there has been a shift from relegating

planning to a technical analytical function, to becoming an integral part *of* management if not an approach *to* management. It can be expected, then, that the judicious combination of resource-based planning and population-based planning will be the direction for future development.

Health planning operates in a complex and changing environment. Planning can be highly technical or solely political. It can be done to help with 'muddling through' of daily decision making or with a radical envisioning of the future system. The essential problem faced by health planners is as follows. While there is general agreement among policy makers and the community that all people should enjoy good health and have access to health care, planners are not, and have not been, able to specify what constitutes an optimal system of health and related services for keeping the population healthy. The challenge is not solely in the technical design of a health system. Insofar as a health system reflects societal norms and expectations as well as the resources available, planning is a political process and requires a multitude of tools for implementation. The planning predicament, then, embodies the tasks associated with leveraging support for action.

CORE HEALTH PLANNING PRINCIPLES

There are a number of planning parameters which are commonly used and essentially form the 'language' of health planning. The core health planning principles include equity, accessibility, efficiency, quality and effectiveness. Each is discussed in turn.

Equity

Equity in health planning is often defined as *equity of access*, which means that an individual will receive an equal opportunity to receive health care, irrespective of personal characteristics such as income, race, gender or place of residence. Equity may be assessed through consideration of the definition of the target group, the methods for promoting access, and analysis of the geographical or locational equity.

An important alternative concept is *equity of outcome*, which refers to the fairness of the outcomes from a particular health care intervention or service. This approach to equity takes into account the range of sociological, economic and other factors that may mitigate against a fair distribution of health chances. Equity of outcome implies the need for redistribution such that new or additional resources are targeted to redress inequity.

Accessibility

Access is the capacity or potential to obtain a service or benefit. Access incorporates notions of geographical access, physical/architectural access, cultural/linguistic access, service acceptability and affordability.

Service accessibility may refer to several things: geographical accessibility (for example, travel time to the service, or transport routes); cultural accessibility (for example, availability of interpreters for non-English-speaking background (NESB) immigrants, Aboriginal health workers, or the appropriateness of the environment for young people); physical accessibility (for example, ramps for disabled people or people with prams); service availability (for example, waiting times, opening hours, access for people working, and so on); or financial access (that is, whether the cost of a service constitutes a barrier).

Efficiency

Efficiency focuses on the maximisation of total benefits from the use of a given amount of resources. *Technical efficiency*, or productive efficiency, refers to maximising service or strategy outputs by using minimal inputs. In some social services, measures of efficiency are defined as being synonymous with cost-effectiveness in that they relate outcome to input (such as the cost of obtaining one extra year of life). In this book, efficiency will be related to service *outputs*, not to *outcomes*.

The efficiency of a particular service or strategy can be assessed or planned for in a number of ways. One approach is to compare the service or strategy to other similar services/strategies on the basis of agreed outputs. It may be important that these output indicators be adjusted to reflect casemix, where such information is available.

Allocative efficiency is concerned with maximising the health and welfare of the community through ensuring an appropriate distribution of benefits. This is particularly important in considering the balance of investment between inpatient and community-based services, between preventive and curative services, and between ongoing professional care and the self-help and support services provided by lay volunteers.

Dynamic efficiency is concerned with adaptability of the system over time. It is an economic concept that has yet to come to the fore in the health arena, but it can be expected to assume greater prominence as issues of sustainability attract greater attention.

Quality

Quality measures the degree to which a health care professional or service conforms to pre-set standards. Quality measures may include process measures (that is, the activities undertaken as a part of the service) or outcome measures (that is, the result). Ideally, both process and outcome measures would be used.

Information on the quality of processes can be obtained through analysing selected performance measurements (for example, casemix adjusted measures

of complication errors, medication errors, transfers to higher levels of care, readmission rates, customer satisfaction, employee surveys, timeliness, waste and defects) or by generating information on a particular issue (for example, the proportion of people with acute myocardial infarction who receive streptokinase treatment within an hour of arriving at hospital). For some services, there are existing broad quality measures that cover the totality of the organisation, such as the Australian Council of Healthcare Standards (ACHS), the Quality Improvement Council (QIC), ISO 9000 and the Australian Quality Council. Standards range from the minimally acceptable, to the achievable, to the optimal.

Effectiveness/outcomes

Effectiveness is the level of benefit when a service is rendered under ordinary circumstances by average practitioners for typical patients (National Health Strategy 1991a). This is distinct from the concept of *efficacy* (the level of benefit expected when health services are applied under ideal conditions). A *health outcome* is a change in the health of individuals or a group of people or populations that can be attributed wholly or partially to a health intervention or a series of interventions (AHMAC 1993). The key issue is how to identify the best indicators or measures of benefit or health gain. Health gain indicators, or 'outcome measures', should be directly relevant both to the health needs and to the health intervention. For instance, the percentage of the infant population immunised is a relevant indicator for an immunisation campaign. When the immunisation level can be attributed to the intervention (in this case, the immunisation campaign), it can constitute a 'health outcome'. When it cannot be attributed to the intervention, the percentage immunised is a 'health status' measure and not a 'health outcome' measure.

A service should ideally collect and analyse its own data on the outcomes of its interventions. If the service is provided as part of a broader treatment/care stream (for example, physiotherapy post-orthopaedic surgery), it is difficult to undertake outcome evaluation as outcome evaluation is best undertaken across a whole service intervention. Services should identify whether the target group is an individual or a population. Consumers/communities should ideally be involved in deciding the value of the outcomes of the service/intervention. There are often difficulties in obtaining valid information about outcomes in ordinary service settings, due to differences in consumers/target groups/communities and the multiple factors that may influence outcomes.

As reflected by the core principles of health planning, most of the planner's work is concerned with the efficient and effective delivery of health care services. Does health planning actually make a difference to health status or the level of health experienced by individuals and communities? The answer to this question is complicated by differing understandings of what health is and what health planners do.

DEFINITIONS OF HEALTH

There are many definitions of health. Health can be defined by its presence or its absence, and it can have individual or societal parameters. In 1946 the World Health Organisation (WHO) defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1946). In this definition, health is defined as a positive experience rather than the absence of sickness, and as a social rather than a solely individual phenomenon (AIHW 1998a). Critics argue that it defines health as 'perfect health', a concept which is unable to be measured or obtained and is always future-oriented.

Definitions of health and what health planners do, however, vary according to the frames of reference used. Doctors, administrators and consumers may view health differently, and therefore have different views on how health needs should be met, what health services are needed and how they should be delivered. Major health frames of references include biological/biomedical, clinical health sciences, population health, ecological public health, social health and everyday life. Planners typically focus on population issues, morbidity and demography. Table 1.2 summarises these frames of reference.

DETERMINANTS OF HEALTH

The causes of illness are complex, and the social, cultural and environmental impacts on health are now well documented (Syme and Balfour 1993; WHO 1998). The determinants of health interact in complex ways, with diseases sharing common risk factors and risk factors clustered in socioeconomic groups.

Broad determinants of health may include socioeconomic structures, physical, human-made and ecological environments, health service access or quality, individual biology, cultural beliefs, personal behaviour and lifestyle choices. Specific determinants may include nutrition, infectious agents, trauma, congenital or inherited problems, the physical environment (sun, radiation, altitude), tobacco and alcohol consumption, age, gender, occupation, stress and social isolation (Lawson 1998). Epidemiological evidence increasingly points to the importance of social factors in explaining health status differences across populations (Berkman and Kawachi 2000).

Epidemiology is at the core of contemporary understanding of the distribution and causation of health and disease at the population level. Over the past 150 years, epidemiological concepts have undergone a number of shifts, from infectious disease epidemiology (based on germ theory) to the 'classic triad' (physical, genetic and environment causes), to the current interest in chronic diseases and multiple risk factors (Susser and Susser 1996).

Contemporary public health approaches critique both the biomedical model and an 'illness-centred' focus on the physical risk factors of individuals and groups. The more comprehensive 'web of causation' takes biological and social

Table 1.2 Frames of reference for health

Frame of reference	*Example of concept, meaning*	*Example of related indicator/category*
Biological/biomedical health sciences	Health-related neurotransmitters	Endorphin secretion
	Endocrine regulation of coping with stress	Secretion of stress hormones
	Immunological competence	Immunological measures of resistance against disease
	Cardiovascular health and functioning	Blood pressure, heart rate, fitness
Clinical health sciences	Disease, impairment, handicap, disability, death	Morbidity/absence of disease Disability/absence of disability Mortality
Population health sciences/ epidemiology	Health expectancy • Disease-free life span	Disability adjusted life years (DALYS)
	• High quality of life span	Quality adjusted life years (QALYS)
	• Healthy life span	Health adjusted life years (HEALYs)
	Life expectancy	Life expectancy at age 'X'
	Healthy populations (aggregated individuals being healthy/perceived to be healthy)	Prevalence of well-being, social functioning, etc.
Ecological public health	Healthy, equitable and ecologically sustainable public policy Environment and health-oriented community action Supportive and sustainable environments Personal skills and attitudes Reoriented health services	Well-being Health potential Quality of life (QoL) measures Health expectancy measures Disability or absence Morbidity or absence Mortality Social and economic equity measures Environmental health measures, (e.g., pollution levels, etc.)
Social health sciences	Overall well-being Physical, psychological, social well-being	Proportion of people feeling well
	Functioning in social roles (occupation, family) Health-related (QoL)	Proportion of people functioning well at work, in personal life Proportion of people judging QoL to be high
Everyday life	Not being ill, sick, disabled Feeling good, energetic, strong	Common language categories of feeling well, functioning well, staying well
	Being able to do what one likes Holistic health, 'web of causation' of being well	Common language accounts of 'causes' of health

Source: Adapted from Noack 1997.

factors and interventions into account and may span the genetic to the societal (Kreiger 1994). The central concept in the web of causation is that many variables may be related to a single effect through direct and indirect causes. The main evidence for determinants of health comes from the prevalence of disease differences between different population sub-groups. The available data about the distribution of determinants are often poor, however, and this makes planning for health (with any sophistication) difficult.

If the ultimate goal of health planning activities is to impact positively on health status, then decisions have to be taken about which of the myriad of factors/determinants are priorities for action and what can be done about them. Certainly, it is not necessary (even were it possible) to understand causal mechanisms fully in order to undertake prevention. The knowledge of small components in the web of causation can significantly contribute to prevention or improved treatment/therapy (MacMahon and Pugh 1970; Taylor 1998). The Ottawa Charter suggests five core strategies for health improvement: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services. The challenge in health planning is to act successfully on the social determinants of health (Marmot and Wilkinson 1999).

HEALTH SERVICES AND THEIR IMPACT ON HEALTH STATUS

The importance of public health measures in improving health has long been recognised. The dramatic decline in mortality in the last 100 years has been widely attributed to the first public health revolution resulting in environmental improvements, including sanitation, nutrition, water supply, housing and education (McKeown 1979). These improvements led to significant overall declines in infectious diseases such as tuberculosis, typhus-typhoid, cholera, dysentery and diarrhoea, smallpox and scarlet fever. Medical and scientific advances such as the development of antibiotics, the development of the Salk and Sabin vaccines for poliomyelitis, and developments in surgery contributed to reduced death rates in the 1950s; however, these only marginally improved mortality rates. The decline in population mortality in the last century has coincided with, rather than been caused by, the rise of modern medicine (McKeown 1979; Russell and Schofield 1986; Davis and George 1992).

The impact of medical access on overall health status is likely to be less than the impact of improving working and living conditions. Current studies estimate that 60–80 per cent of current disease is preventable through social change (Brown 1992). The Center for Disease Control (CDC 1977) in the United States attributed only 10 per cent of premature mortality to inadequate health care.

Despite the contention that medical interventions have a relatively marginal impact on the overall mortality levels of a community, medicine generally enjoys great community credence. Science and the scientific method is most frequently

credited with having the explanations for illness and health (Davis and George 1992), and the 'curative' health system continues to consume the bulk of the health budget (AIHW 1999).

Nevertheless, whilst national mortality rates tend not to respond to increases in hospital and medical resources, medical care does contribute to the reduction of non-fatal diseases, disability, discomfort and distress (Sax 1984). Health services extend life through interventions such as immunisation, accident and trauma services, and cancer treatments. Quality of life may also be improved through relief of pain, improved mobility (joint replacements), and effective treatment of many non-life-threatening conditions (National Health Strategy 1991a).

The challenge for health planning is to ensure equitable access to cost-effective health care while harnessing complementary strategies for health improvement.

PLANNING FOR EQUITY AND HEALTH

Equity or fairness in health has been defined as a 'focus on the distributional impact of health policies on different individuals and families' (National Health Strategy 1991b, p. 5). *Health inequality* can be defined as differences in health status, whereas *health inequity* links differences in health to social injustice and implies unfairness and the need for amelioration (Bauman 1996). Equity in health, whilst often appearing in the rhetoric of plans or policies, is rarely adequately examined and is differentially understood and applied, despite being generally applauded as a planning goal.

There are (at least) three main approaches to equity in health: equity as the minimum standard equity of access; and equity of outcome.

Equity as the minimum standard

Equity is achieved when health care is provided as a safety net for the disadvantaged. Examples of this system include the current US health care system and the health care system that existed in Australia prior to the introduction of Medicare in 1972.

Equity of access and equal health care

Equity is achieved when an individual receives equal health care irrespective of personal characteristics such as income, race, gender or place of residence. This does not imply equal treatment in the sense of the same treatment. Rather, the treatment or care should be tailored to meet diverse individual needs and circumstances (for example, providing an interpreter for a patient who does not speak

English). This approach has been the goal of much policy and planning in the last 30 years.

Equity of outcome

Equity is achieved when the outcomes from a health care intervention — regardless of whether it is intersectoral, prevention, treatment or palliation — are fairly distributed across population groups and individuals. Where the current distribution of outcomes is unfair, this approach provides for redistribution. Consistent with this view, a public health approach, for example, would define equity as 'affirmative action on any resource differentially distributed in the community — for example, housing, education, income and political power. It implies access to these resources by those with the least opportunities at present' (Lincoln School of Health Studies 1989, p. 3).

Key questions in health planning therefore include:

- Should plans focus solely on the health care sector, or is a broad-based multisectoral approach required?
- Should equity of outcome replace equity of access? As a corollary, should a goal be to simply maintain (but not improve) the current health standing of advantaged Australians whilst new resources are targeted to improve the health status of the most disadvantaged groups?

CONCLUSION

This chapter, in introducing key concepts in planning, has suggested that planning is both a technical and a political activity. Planning arose as a form of state intervention, in part, to address the failure of market rationality. It is a tool for social rationality. As a body of theory, planning draws from economics, politics, statistics, sociology, engineering and business. As a sphere for policy action, it is a confluence of technical rationality, political rationality, societal values and culture.

Health planning, as a particular arena for application of planning principles, has at its core concerns about equity, access, quality, efficiency and effectiveness. There are, however, inherent tensions between the need for planning for institutional or provider interests and planning for the needs of the community. A further tension resides in the extent to which planning for health services can actually contribute to population health gain.

A health planning system, in intervening into the complexity of the health system, will require balancing a number of demands and tensions. As the rest of the book will detail, a health planning system should be assessed on the following criteria:

- Is the purpose and role of the planning system clear and appropriate?

- Is the planning system based on explicit values?
- Are the functions of, and relationships between, the stakeholders well articulated?
- Are decision-making structures and processes of the planning system open and transparent?
- Is there appropriate involvement of stakeholders at various levels and at various points in time?
- Are the planning processes linked in with other decision-making processes?
- Does the planning effort balance long-term strategy with short-term imperatives?
- Is there a variety of planning processes, tools and information systems used?
- Does the planning system balance technical and political analyses (Green 1999)?

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