REVIEW OF H.R. 13995 FOR ALTERNATIVE ORGANIZATIONAL STRUCTURES

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When one reviews H.R. 13995, one is struck by the variety of activities the area-wide health planning agency (the HSA) will be expected to perform. There seem to be three types of major activities representing three types of functions:

1) the planning function which includes the technical activities of determining the types and kinds of health services and other community needs to assure a healthy population. This set of activities includes the development of criteria, in coordination with state and federal standards, against which services now or in the future can be evaluated. Under this function is also included the development of the Health Systems Plan (the HSP); the Annual Implementation Plan (the AIP); and the analysis and assembling of data concerning health status, health resources, and utilization of the health delivery system(613 a,b.1,2,3,4).

2) the evaluation function: That is, the critical assessment, evaluation and review of current and proposed health services; review and approval of proposed use of Federal funds in certain health areas(613 e);review and comment for Sec.1122 of the Social Security Act (613 f);certificate of need reviews (613 g). Although sanctions differ within these different types of evaluative activities (e.g. withholding of Federal funds versus state disapproval as in certificate of need),the function is essentially an evaluative one. Included here is also the technical assistance

and other means of assisting providers not approved to change the service in the desired direction or to eliminate the service. 3) the developmental function, that is, the encouragement of the development of new services, whether through demonstrations, innovation, or just adding services not previously available. Technical assistance activities may also be a part of this function. Its main emphasis, though, is that of encouraging a planned change process within the community.

All of the activities involved in these three functions are expected to be administered efficiently; and the agency is expected to coordinate its activities with those of other agencies such as PSRO's whose functions somewhat overlap with those outlined for the HSA. Provisions are included in the legislation for at least, annual reporting to the public; for holding public meetings; and for approval by the Governor of the State.

Conflicts Within and Between Functions

It is important to this analysis to note that the evaluation function and the developmental function are essentially antithetical in that they represent two opposing views of the meaning of planning. The first implies that planning is control while the second implies planning is guided growth. In reality both meanings may be of importance to a community. However, usually separate institutions or agencies have served to carry out conflicting purposes in a community; thus, allowing the processes of accomodation to resolve conflict or to permit it to exist without the occurrence of social disintegration. In this case, one agency is being asked to serve conflicting purposes. For example, critical review of institutional and home health services for certification

purposes (613g) implies the imposition of control mechanisms on the natural or 'normal' development of services. The implication is that the local community, as represented by the area-wide HSA, can apply local, state, and federal standards and criteria (and these may not always be compatible) for the assessment of need for such services within the area. It implies also that there will be assessment of quality of these services. (The legislation specifically states that one function of the HSA is to work with providers not certified as needed for the improvement or elimination of such services-613 g). Control here is the use of negative sanctions with the threat that unless a service changes it will be eliminated in terms of either permission to operate or of refusal of reimbursement by third party payors.

On the other hand, the availability of developmental funds implies that new services will be added. What the agency determines as the criteria for developmental funding will, of course, determine how much emphasis is placed on new services. But, in general, the use of developmental funds implies that planning is analogous to growth while the evaluative function implies negative sanctions and control. Again, it should be stated that both functions may be needed in any one community at the same time, but it will be difficult for one agency to serve as both the advocate for a set of services and as the critical assessor in a different context. Project officers become identified with the projects for which they are responsible and it is not easy to critically assess a project in which your agency has a financial interest.

Organizationally, therefore, it is important that these opposing functions by integrated and incorporated as integral parts of a total planning system. There are many kinds of strategies that can be used to avoid actual conflict within the organization. Some of these are:

--operate the agency as if it were two agencies.

--contract out one function: for example, the evaluative function could be taken on by the local health department or the PSRO for the area.

--contract out developmental activities to the private sector.

--set up voluntary peer-review type of evaluative process whereby the HSA finances a self-policing by the provider system.

More importantly, however, it should be emphasized that unless a HSA establishes a specific mechanism such as the above, the agency will not be able to give equal emphasis to all of its functions. As a matter of fact, no agency can give equal emphasis to all of its activities:-- prioities develop; sub-units compete for resources; and one or another function begins to take precedence. It is important that the HSA's be organized on the basis of a consistent organizing philosophy that reflects how the disparate functions of the agency can be integrated. Some functions may be played down; and the mode of operations should differ based on the organizing philosophy. Such an organizing philosophy identifies the major mission of the agency; the prioities given to its various functions; how it relates to its environment; and what will be its strategic plan for operations. Obviously, the community milieu in which the organization is embedded, as well as the state and condition of the health service

systems within the HSA's jurisdiction and the historical context of social change within the area, will be the determining factors of a successful organizing philosophy.

An organizing philosophy is defined here as the sets of assumptions by which an agency or organization operates. These assumptions represent a kind of organizational 'world view' about the role of the agency and about the many issues with which such an organization is faced. The general philosophical mission or goal is part of the organizing philosophy. For example, if the goal is one of guiding institutional change, staff should work differently than if the mission is perceived as preventing unwarranted (however that is defined) activity. Thus, the general mission of the agency should indicate its purpose for existence and something about the ways in which its purposes are expected to be achieved. When an agency takes on two or more conflicting missions, one generally has to take precedence or the agency will usually default in all functions.

Some Operational Issues in Health Planning

There are a number of philosophical issues that effect the operation of organizations. These are seldom explicitly identified in an agency but the solutions to these problems pattern the organizing philosophy of the agency. For health planning agencies some of these philosophical problems are:

1) What is a plan?

Although there are those who feel that this should not be an issue, the meaning of the term plan is variable. A plan can be perceived as a blueprint for the future; or, as a changing or evolving matrix of policies about the health system; or as a set of minimum standards below which the community will not tolerate

a health service. All three perceptions are implied in the legislation and it is likely that different communities at different stages of existence require these three points of view. For example, in a sparsely populated state such as Montana, where they are losing population and where only a miracle would provide a great infusion of resources, it may be necessary to perceive the 'plan'as indicating the absolute minimum that will be tolerated. On the other hand, an area such as the San Fransisco Bay area may have to work in terms of a continuously changing and evolving matrix where some services may be below a minimum and others are on the cutting edge of change and innovation in the system. Communities of rapid growth (e.g. new towns) may have to focus on the far future because dealing with the present would be completely unrealistic. A stagnant, versus a stable versus a rapid growth community requires different approaches to the connotation and meaning of the term"'plan'.

2) What is the motivation of the providers?

Although this issue is often skirted, it is important to the ways in which an agency expects to work. May agencies operate on the assumption that the providers are enemies; other assume that the providers are partners; in still others, the providers and the agency are synonomous. Some agencies defer to the providers as experts, while others operate on an adversary basis. Again each situation will warrant analysis but, in general seeing the provider as protagonist will be unproductive in effecting change in the health system. Much of the review and comment or evaluative function implies an adversary context rather than a partnership

context. The sets of assumptions about the role and motivation of the provider will determine the style or mode in which the evaluation is carried out. Every licensing and inspection agency in local or state government has had to come to terms with this type of issue of how the groups being regulated should be perceived. If it is expected that the providers are looking to change then the use of incentives such as developmental funds will be appropriate, If an adversary position is taken, then negative sanctions will be more likely to be employed. Although positive reinforcement has always been proven to be more effective from the beginnings of the old saying "honey catches more flies than vinegar" to social science studies on motivation in recent years; there has been a mythology about the effectiveness of the threat of negative sanctions.

3) What is the role of the consumer?

Although this has been an issue for some time, the assumptions that are made about the role of the consumer representatives is important to the agency's operations. There has been a tendency to consider 'representation as "a sample of" rather than as "a spokesman for". When many sub-classifications of population characteristics are used to determine who shall be representative of special groups in the community, there is a loss in the quality of decision-making that can be expected. It is important that the special skills of influence, so necessary to community action, be brought to bear in the health planning process. This is where the consumer can contribute more than mere information about an interest group.

4) What is long-range?

The time frame of a community has always been a difficult issue in planning. It is extremely difficult for any persons to think beyond a 20 year span and even 5 years may be too long for some. Certain communities are changing so rapidly that forecasting beyond a 5-year span would not be valid. Obviously, if a 20 year span is used as a long-range parameter, estimates of the future will have to be cast in general terms, since the longer the time frame the more general the forecasts will have to be. The time frame is also somewhat dependent upon the traditionalism of the community. This, too, stems from the historical background of the area. Often the more traditional communities are rural or of a small population. There is distrust of rapid change. Thus, if the time frame for a health plan implies rapid change, certain communities will not support the implementation of program. Although it may be less effective for enhancing the health of the population for a traditional community to think in very long-range terms, this is more likely to be the orientation. Often such long-range terms are not explicit but are implied. A rapidly growing community would best think in very long-range terms to achieve health goals, but may not be able to mobilize interest in the longer view. Thus the time frame that is more appropriate for certain communities, may be inappropriate in dealing with the solutions to the problems. The HSA will need to find ways to help the community operate on a more appropriate time frame.

5) Which are more important--horizontal or vertical relationships?

Warren in his Community in America indentifies two sets of relationships among agencies: horizontal and vertical. The

horizontal relationships are the locality relevant relationships among the local groups and the vertical relationships are those with the organizations and groups outside of the local scene.. For example, agencies representing the horizontal relationships of a health planning agency would be the local Chamber of Commerce; local government; local hospitals, etc. The vertical relationships would be represented by the state agencies with which the HSA works, by the U.S. department of HEW, by national professional organizations, etc.One might conjecture that where there is a very diffuse power structure within the community that the vertical relationships may be the most important and where there is a strong power base the horizontal relationships may be the most important. Often there are conflicting demands upon an agency from the two sets of relationships. It is logical to assume that where horizontal relationhips are most important there will be less emphasis on the evaluative funtion and more emphasis on either planning or development. The issue is one of local orientation versus a kind of professional orientation although one orientation is not less professional in the broad sense than the other. There has been little study of these relationships and community action, but they are important in determining organizational priorities.

6) How much trust is put in technical competence?

In general, the more complex and populated a community is the more likely will there be reliance on expertise. In the larger metropolitan areas, those providers and consumers serving on the Board and on committees are often experts themselves and therefore

they are more likely to expect others to represent a special expertise and competence. In areas with smaller populations, with less complexity and diversity of occupations, more people are generalists and distrust expertise. In the areas of smaller population, the social infrastructure is moreclose to the surface and there is an interdependence that is not seen in the complex metropolitan community. One of the basic organizational difficulties is that the sparsely settled area that needs expertise will not accept it. Additionally, because of the sparse population the HSA has to be organized on a wider geographical basis. Thus the organization that needs an adequate staff and mechanisms for engendering trust in small local populations will be inadequately funded. Without a heavy investment in community organization and education there will be distrust of the planning process. One solution is to provide greater resources to such communities for community education and for strong community organization activities. Only after such communities trust the process will they begin to trust expertise. As current legislation stands there will be inadequate funding for these HSA's. Certainly, any agency serving communities where there is a distrust of expertise should emphasize community organization as its main mode of operations.

Skills Required for Planning

There are a variety of tools of planning and therefore the skills required within a planning agency will necessitate developing particularly those skills required for the organizing philosophy that will prevail. Not only is there need for technical competence in prediction, forecasting, decision-making, data analysis, etc.,

there is a need for variation in the conceptual directions of the planning process. These, however, are all a kind of technical competence. If planning is to be more than just the design of a technical plan, then there is another set of skills that is required. Miller in his study Community Health Action has called these "skills of influence". The following descriptions are adapted from Miller, These skills of influence have to do with how effectively social change can be guided and directed. If implementation of any program is to occur, especially within a democracy, then these skills are essential to the implementation process. Each set of conditions where action is desired will require a different mix of these skills, but they are all important at one time or another. Eight skills of influence seem most important:

1. The skill of expertise or knowledge. In special situations the knowledgable advice of an expert can influence behavior. An attorney can influence action (or non-action) based on his advice as to its legality. Too often task forces are set up that may have certain expertise, but are missing other important expert knowledge. It is important that committees and task forces be organized to represent areas of expertise as well as points of view.

2. The skill of manipulation of symbols and of communication. When action is desired it is important that the persons to take action understand what is expected of them. Although most people over estimate their ability to communicate, there are persons with special skills in writing,, in art work, in speaking. Availability of these skills be vitally important for success.

3) Skill in providing access to special and needed resources. This skill is more than having power and authority. It includes a knowledge of where resources are available and how they may be tapped. It often is necessary that the person with this skill is highly trusted by those who have the resources. Resources may not only be money, but one might include personnel; special skills, expertise, or access to other skills of influence.

4) Skill in legitimating action. This is a skill in making the desired action seem to be the right thing to do. In some communities it is often held by one person who, if he supports the idea, will provide all the legitimation necessary. Too often this skill in mistakenly believed to reside in a position rather than in a person. For example, the president of the local medical association will not have this skill by virtue of his office. He may have it personally..

5) Skill in organizing and arranging people and resources. This is often thought of as an administrative skill. For example, there is no one organizational structure that is best for a hospital or for a HSA. Rather each structure will engender certain types of problems and the appropriate structure is one that meets the organization's mission without too many difficulties that are costly. Certain people have a skill in finding the effective ways in which to organize people so that work is done effectively and efficiently.

6) Skill in engendering enthusiasm and trust. The need for trust has been mentioned previously. Without it little can be accomplished. Unless this skill is available to the HSA little will be accomplished in planning.

7) Skill in bargaining and in conflict resulution. Often action cannot proceed unless conflict is resolved or compromises have been developed. There are some persons who make a career of this skill as in collective bargaining. It is a skill that is necessary for every HSA if any change is to come about through the planning process.

8) Skill in predicting the effects of action or non-action. Although this is somewhat akin to the technical skill of forecasting, it differs in that it represents a kind of intuition based knowledge of the many complex factors that may be operating. It is often difficult to articulate why predictions are made, but there are persons who have this skill and they are valuable to any planning agency.

There are no doubt other skills that are of importance to the implemnetation of health plans. But, these seem to have been most useful to the communities in MIller's study. These skills do not have to reside in staff alone or in the volunteers alone. But, these skills are more important for implementation than input from many special groups through a representative mechanism. Every Baard member should be selected and elected; every task force and committee member should be selected and every staff member hired on the basis not only of technical knowledge or representativeness but on the basis of what skills of influence he can bring to the agency's work.

Organizing Philosophies

As stated earlier, an organizing philosophy is defined as the sets of assumptions by which an agency operates. It includes the purpose of the organization and the basic strategies by which it expects to accomplish that mission. Three different types of functions for HSA's have been discussed: the planning function; the evaluative function; and the developmental function, and some of the issues or problems with which HSA's are faced were discussed. Given these three types of functions there are three potential models for organizing philosophies for health planning agencies. Each will have a slightly different way of resolving the philosophical issues confronting it; each will require slightly different sets of skills. No one model is best; rather, each serves to meet different kinds of community needs within a social context. The models are as follows:

I. The Plan Implementation Model

In this model, the HSA's major mission is considered to be the implementation of a blueprint for the future. Under such an organizing philosophy, emphasis is on the development of a plan that is focused on the future but that has a great deal of specificty for judging current activities and for estimating future activity of various services and institutions. Once the plan is developed, then implementation for the future becomes the major emphasis. Staff emphasis would have to be on developing consensus within the community for the Health System Plan, and on providing a strong public education and public relations program to maintain an informed public that will anticipate needs, demand that services

be developed;and support those developments to meet future needs. The evaluative functions-- review and comment and assessment of need--would be minimized with public pressure from an informed public serving as the main sanction.Staffing would require two major skill areas; technical competence in forecasting (or in developing contract for forecasting information); and skills in community education and organization. Selection of Board members and or oommittee members would emphasize the skills of legitimation and of engendering enthusiasm and trust. This model would like be most appropriate in terms of planning needs for a rapidly growing community; however, it is more likely to work in a slowly, steadily growing area that includes urban and rural residents but is not a complex metropolitan area.

II The Evaluation Model

Under this model the general mission of the HSA would be the continuous evaluation of health service needs for its jurisdictional area. Emphasis here would be on the present rather than on the future and on future needs. Prioity would be given to review and comment and asessment of need.There would be some developmental activity, but the major emphasis would be on the change of current unacceptable services to those that were acceptable with elimination of unacceptable services. The major differences from the Plan implementation model arethe current orientation versus the future orientation and the modes of work/ This type of organizationwould require a strong technical assistance programeither provided through staff or contract services. The techncial assistance to health service agencies would possibly be tied in withstudy committees that continually reviewed services.Some developmental activities would be carried out but these would not take precedence and monies

for developmental purposes would likely go for task force or study committee 'planning'. In order to carry out a continuous evaluative procedure committees would likely be formed on short-term or task force bases. Development of a strong peer review mechanism would be of value and coordination would have to be close with the state certification of need program and with the PSRO. Staff skills would of necessity have to be highly analytical and the major skills of influence required would be those of legitimating action and of conflict resolution. Essentially the evaluative process would work best if used as an educational process. The type of community that needs this type of model is the area with sparse population, low economic base and inadequate services.

III The Evolving Model

Although this is also a long-range approach it is not a blueprint type of planning. Rather the mission is to meet a long range set of general policy guidelines that are expected to change as new information is brought to bear. Examples of this type of guideline might be "equal access to health care for all" as compared to a goal of "primary care facilities within 20 miles of every citizen" that might occur under the blueprint type of plan. Such general guidelines would provide a time span during which as many options would be left for the community as possible. All criteria for health service assessment or institutional certification of need would be subject to continual review, and would involve ranges rather than absolutes. Under such an organizing philosophy the HSA would invite the community and particularly the providers to participate heavily in the development of the planning design. Some planning activities might be contracted out to providers.

Under this type of model the major staffing requirmments would be for experts in data analysis, in preparing RFP's, and in overseeing contract work. Developmental funds would be used for demonstration and innovation and evaluative activities would be used as information gathering for plan development. Assessment of need and review and comment would be a minimal activity, except as a peer activity. There would be local orientation with expertise coming from the local area. The major skills of influence would be the skill of expertise; skills in providing access to resources; and skills in organizing and arranging people and resources.

Figure 1 (attached) attempts to show the differences between these three models as discussed above. It should be noted that no organizational pattern will represent a model exactly. However, from this analysis it seems that these basic organizing philosophies would be of value to HSA's, and that one or another of these models should fit in general the needs of any one aommunity at a point in time. To the extent that a HSA mixes approaches, it seems there will less liklihood of success in the planning process. This suggests that the guidelines for HSAs emphasize organizational consistency with an explicit mission, rather than a preconceived pattern of organization. The mission, however of each HSA cannot be based on the same organizing philosophy. They will have to differ if health planning is to be successful

There has been some concern as to the size of HSAs and whether a state-wide HSA would be feasible. This has been of particular interest in states where the population is sparse. Under such

circumstances, the most appropriate modelmight logically be the Evaluation Model where close cooperation with the appropriate state agencies and the PSRO would be necessary. In some ways the HSA would become the evaluative arm of the state. This would not be inconsistent with the reality situation in thsoe states with a very small population. The HSA would emphasize the provision of technical assistance and voluntary review of the health services of the area. In more complex areas where the need is probably for an Evolving model, a state-wide HSA might not be as appropriate.

Three models for organizing philosophies for HSA's have been presented with an analysis of how such organizations would differ in orientation and in the skills needed to carry out their functions. It should be emphasized that these models are only for analytic purposes and that the important aspect of organizationfor the HSA is in developing a consistent organization that will meet the planning needs and the work modalities of the area it serves.

Figure 1 Elements of

Organizing Philosophies for HSA's

ORGANIZING PHILOSOPHY	Mission of Agency	Major Activity Emphases	Major Work Strategies	Time and Specificity Orientation	Staff Skill Needed	Important Skills of Influence	Probable Type of Community
PLAN IMPLEMENTATION MODEL	Implement a blueprint of the future	Plan development and implementation.	Public education and public relations; high consumer participation.	Long-range and specific	Technical, planning; community education	Legitimation; manipulation of symbols; communication; engendering trust	Reasonably stable; some steady change; urban-rural, but not metropolitan
EVALUATION MODEL	Continuous evaluation of health service needs	Review and comment; assessment of need	Short-term study task forces; technical assistance; coordination with state and PSRO	Short-range; immediate; specific	Analytical technical, especially regarding health services	Legitimation; expertise; conflict resolution	Poor economic base; loss of population; sparsely settled
EVOLVING PLAN MODEL	Development of a continuously evolving plan	Developmental activities	Funding demonstration heavy provider participation resource development	Long-range but general and non-specific	Data analysis; contract supervision; leadership	Expertise; access to resources skill in organizing	Complex; metropolitan; growing population; strong economy