THE LINKAGE BETWEEN HEALTH POLICY MAKING AND PLANNING*

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My remarks on the linkage between the making of health policy and planning will consist of an introductory definition of terms, a discussion of the levels and loci of policy making and planning in our society and the realities of their complex interrelations and linkages, one specific suggestion for better linking of policy making and planning by rearranging money flow, and a short concluding note.

DEFINITIONS

My mother taught me early that honesty is the best policy. That is the first use of the word "policy" I can remember, and I think of policy within that general framework. Following my mother's basic policy suggestion, I confess that appearing on a panel on the "etiology of health policy" was intriguing primarily because it could be a learning experience for me, whatever it might be for others. I had never heard the phrase "the etiology of health policy" before, hadn't the vaguest idea what it meant, and was initially intuitively negative, as most of us are to anything strange, unknown, and therefore threatening.

According to the dictionary, etiology is the study of causation. As far as I can tell, the causes of health policy have not been explored because we have not had an explicit health policy in this country. Probably the word "policy" should not be applied to health in the singular anyway.

The primary cause of attention to health policy seems to be that the health field always likes some new word every year or two to encompass old contradictions. Over the years, some of the most popular words have been planning, management, delivery, comprehensive care, national health insurance, coordination, effectiveness, access, systems, and now policy.

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Today, a young graduate student in health administration, when asked what he is interested in going into, almost invariably answers "health policy." After some discussion, it is never quite clear to me—or to him—just what he would do during working hours to justify a regular pay check. Nevertheless, graduate students tell me that commercial consulting firms get a lot of health-policy business, mostly from government, and hire a lot of health-policy specialists. What is health policy? According to Duncan Clark, "principles that govern action directed toward given ends." Dr. Clark adds that it should be "rational and take account of evidence and experience as well as values and opinions." Larry Brown defines policy in terms of specific strategies of intervention. Apparently policy means different things to different people.

My topic is not policy, but the linkage between policy making and planning and I think I have defined one clear-cut linkage between policy making and planning. Both mean many different things in different settings.

For example, in the health field it has rarely been clear when "plan" referred to a scheme of arrangement, such as a plan for allocation of scarce resources in a geographic area, or a scheme of action, such as planning for adaptation of professional organization and behavior to changing health problems. Nor was it clear whether planning was essentially part of any individual's or agency's or institution's management process, or specific processes identified with something called a planning agency, or both. It was not clear whether planning was something done only by professional planners or something that all of us do more or less all the time as we try to base our actions on more rational thought and data bases.

Even more confusion exists as to what the word "policy" means because it has not commonly been used in discussion of health problems for as long.

I listened to President Jimmy Carter's speech on the nation's energy problems very carefully to distinguish between his use of the terms "energy policy" and "energy plan." As far as I could tell, he used the terms interchangeably. It may be that the only linkage at this time between health policy and health planning is that both imply a higher degree of rationality and a larger context than most people can apply to their own health problems or activities.

Certain common threads do seem to emerge from discussions of either

planning or policy making: some recognition of change taking place and of the inevitability of change, some dissatisfaction with the status quo, some concern with getting things done in complex situations, some understanding that activity and movement does not automatically lead to progress or to the achievement of specific goals, some understanding of the extent of interdependence in achieving complex goals, and recognition of the necessity to stop acting as though unlimited resources were available for any health objective, some recognition of the need to make choices and the desirability of greater rationality in making implicit and explicit choices, some recognition that value systems play a significant part in complex goals and must be considered explicitly, recognizing that ambiguity is imbedded in our value systems. Both planning and policy making also involve specific recognition of potential trade-offs among various options and the importance and limitation of consensus among various forces and interests. Planning and policy making each involves all of these kinds of considerations, an effort to reflect dynamics, complexity, scarcity, reality, values, and rationality in the solution of important problems. I think that for most but not all people, policy making generally reflects greater generality and concern with values and directions, whereas planning tends to consider specific goals and programs to get things done. Beyond that, I am not sure that very many people have given much useful thought to linking policy making and planning during the next few years. Assuming that these terms continue to be useful, possibly greater consensus will develop as to what they mean and how they are related. Certainly such consensus would be extremely useful.

The Locus of Health Policy Making and Planning

Health-policy making and planning are processes that can be carried out by an individual or a family or by a wide variety of voluntary, proprietary, or governmental institutions and agencies on a neighborhood or community basis, or at the municipal, state, or federal levels as well as at the international level. With respect to both policy making and planning, it is most important to identify the level or locus under discussion and the nature of the interrelations between various levels and loci. It is both dangerous and naive to think that planning or policy making at any given locus or level will have a predictable impact on planning and policy making at any other locus or level. Such an idea is inconsistent with the

rationality commonly attributed to improved planning and policy making.

From my point of view, health care is basically an individual, family, and community affair, with a wide variety of important state, national, and international aspects—largely reflecting cost-benefit potential and idiosyncrasies of money-flow patterns. Admittedly, from a purely cost-benefit approach to problems of ill health and premature death the greatest return should come from activity at the international level, which presumably means primarily at the World Health Organization (WHO). At some point in the future, knowledge of interactions among various levels and the degree of commitment between various levels will be such that policy formulation and planning may increasingly focus at WHO and other international health institutions and organizations. This is probably many years away. The same arguments for seeing a bright future and a dim present for policy making and planning at the international level probably apply to some extent to policy making and planning at the national level in the United States. Primarily because of overexpectation about rapid implementation of comprehensive national health insurance on a compulsory controlled basis, current discussions of policy making and planning in the United States tend to focus on the national level. I think it can safely be predicted that this will change during the next few decades, with more attention being paid at the state and community levels. This seems almost inevitable, because the degree of national crisis in health (except for peculiarities of money flow) is much harder to explain than national crises in other fields, such as energy, for example. We may learn something about national health-policy making and planning by watching the successes and failures in the energy field.

At this point in history it is most productive for any consideration of health-policy making and planning to start with the individual and the family, the individual provider and the individual health institutions and agencies at the local level rather than at the national level. Certain realities become clearer to anyone who starts with policy formulation at this level. For example, at the local level it becomes clear that most people and agencies have never explicitly formulated any policies and are not explicitly aware of the details of their own planning processes, but these do exist, are deeply imbedded, and are not easily changed in predictable ways given our existing level of understanding.

Ambiguity in policy formulation and in policies appears to be the natural state of the health-care community at the present time, most easily ob-

served at the local level. Many examples could demonstrate how easily all but the most rigidly rational people live with extreme ambiguity in the policy-formulation aspect of their lives. With respect to planning, the major characteristic is not ambiguity, as in policy making, but the extent to which short-range planning dominates long-range planning, both short range in time and short-sighted in the sense of consideration of interdependencies. Most individuals and institutions plan all the time, but with limited consideration of the past and future and without much attention to the plans of other individuals and institutions upon which their own planning activities are dependent.

One might sum up the basic policy-making and planning activities of individuals and institutions at the local level by characterizing them as having extremely extemporaneous intuitive qualities that are most curious and appealing so long as one is not obsessed with formal rationality or with the tragic waste of life-saving resources. For those concerned with formal rationality, the nature of policy making and planning in the health field in this country, at its base, is extremely frustrating. It seems to be characterized by concentration by each element of the health field on protecting its ability to seek self-fulfillment on the basis that what is good for it is automatically good for society. Society is much too complex for very many people to turn the whole thing around and to agree that what someone else says is good for society as a whole should guide their behavior. This may well evolve from current planning and policy-making activities, but evidence for the conclusion is not very clear at this time.

Those interested in improving policy-making and planning are well advised to consider that whatever they try to do will be treated by each element in society as just another factor with which to cope in its own policy-making and planning. Further, it would be well to consider that one's interest in policy-making and planning or even one's credentials and mandate are not likely to carry a great deal of weight unless one becomes intimately involved with policy-making and planning processes of individuals and institutions. And this is quite difficult to accomplish unless one really controls required resources and is both able and willing to withhold them in the face of strong public pressure, or unless one accepts the major features of the individual or institutional policies in the first place. It would also be valuable for those interested in improved planning and policy making to consider that the promulgation of rules, regulations, and controls to influence individual and institutional policy making and planning

will usually bring about less change than expected, including unexpected changes. In general, as regulators become co-opted or retreat into bureaucratic formulas, most individuals and institutions, depending on their power and imagination, will influence or bend all such rules and regulations to fit their own policy-making and plans rather than docilely to adapt to the new rules.

The other day I listened to a discussion by some officials of a new health systems agency (HSA) of what they should do about a proposed multimillion-dollar replacement of a teaching hospital by a great state university with one of the nation's outstanding football teams. Most officials of this HSA were convinced that the university and its medical school could get along quite well—or even better—without replacing the teaching hospital, and further felt that the millions of dollars involved could be used in better ways to benefit the people of that state. This all seemed so obvious that they quickly concluded that they would not approve the replacement proposal, which of course would kill it. After a little more discussion, they concluded that the regents of the university were determined to replace the teaching hospital and that the regents had popular support to do so, even if it meant a total change in health systems agency personnel, with a corresponding reduction in the HSA's influence in dealing with other institutions. After further discussion, the HSA officials thought that it might not be a bad idea to sit down and chat with representatives of the regents to see if there was any possibility of influencing their thinking in any way before approving the project. Clearly, at this stage in its history the HSA has little power in comparison with that of the regents, irrespective of what laws and regulations say. Health care involves extremely complicated formal and informal political processes. Any rational approach necessarily builds these processes into policy-making and planning.

We would all be better off if more people who are interested in health policy-making and planning recognized that a long-term effort will be required to encourage every element associated with health services to introduce just a bit more rationality into their processes, and to deal with just a bit more of the reality of change processes in any individual or institutional policy formulation and planning. As a first step, all of us, especially those who have a special interest in planning and policy making, would benefit a great deal by lowering expectations associated with improving these processes, especially at the national level.

One Specific Suggestion

Let me offer at least one specific suggestion, among a large number of recommendations that might be mentioned. In my opinion, anything the federal government can do to link people and key health institutions and money flow—all three—at the local level is most likely to improve policy-making and planning and improve health. Conversely, anything that separates and compartmentalizes people and health institutions and money flow at the local-level encourages unreality and ineffectiveness in individual and institutional health policy-making and planning. One simple recommendation to be considered relates to controlling reimbursement for hospital service, the first step in the Carter administration's move toward national health insurance. Great benefit might accrue if all hospital reimbursement for enrolled populations such as Medicare, Medicaid, and Blue Cross—the majority of the population—were based on a uniform, age-adjusted capitation-rate schedule. This can readily be done without interfering with choice of hospital or physician. Today, most people prefer to pay for most of their hospital care on a capitation basis through Blue Cross, federal taxation under Social Security, and commercial insurance. But these agencies upset incentive linkages by paying hospitals by units of service instead of by capitation. To pay by capitation it would be necessary to identify each individual with a hospital, preferably a hospital of his own selection. This could be done without interfering with the individual's choice of a hospital in time of need. If all hospitals were paid on a capitation basis and each hospital therefore had a group of people with whom to identify, an important potential link is automatically created between the planning and policy-making of these people and these hospitals. The hospital would have economic incentives to understand the people's health behavior and to try to keep these people healthy, to serve them on an outpatient or home basis instead of on the most expensive inpatient-care basis, and so on. The hospital also would have new economic incentives to develop regionalization arrangements with other hospitals to assure that the patient is in the most efficient location for any particular condition.

Because patients would have free choice of hospital and since no hospital can provide comprehensive service to an individual anyway, many patients would go to hospitals other than the one with which they are identified. In such instances, of course, the hospital receiving the capitation payment would have to pay the other hospital for the service required.

As a result, hospitals would receive their income partly on a uniform age-adjusted capitation-rate schedule and partly on the basis of a variable cost-related unit of service from other hospitals—or through Blue Cross. In such situations, most community hospitals would have as much interest as anyone else in keeping hospital utilization and rates of payment for costly secondary and tertiary care as low as possible. The economic motivation, at least, of most hospitals and their medical staffs could be quite turned around from what they are today. Many hospitals might respond to economic incentives and begin to serve as community institutions and consumers' agencies as well as provider institutions and agencies. By simply going back to the concept of Blue Cross as originally outlined by Justin Ford Kimball at Baylor University in 1929, all of the economic incentives involving people and the hospitals could be turned around to begin functioning in the community interest. The analogy with the health maintenance organization (HMO) is significant. The ease of making this kind of change in reimbursement methods, in comparison with the complex organizational changes involved with the HMO, is also striking. As we all know, everyone is completely in favor of the HMO idea, except for most physicians and most patients. Many patients hesitate to give up their freedom of choice, and many physicians hesitate to tie their incomes too directly to new organizational frameworks. The proposal which I have outlined has many of the advantages of HMOs but maintains freedom of choice by patients and avoids immediate direct involvement with physician income or new forms of physician organization. Hospital capitation-reimbursement arrangements can be worked out with minimum underwriting risk by hospitals, certainly in the early phases of this development.

I mention this relatively novel, simple restructuring of one aspect of our financing patterns to demonstrate the complexities of our system and the extent to which policy formulation and planning may be influenced by the nature of money flow and the nature of relations between various elements at the local level. I suggest that anything that will bring consumers and providers and community leaders and money flow together at the community and neighborhood level can lead to improved policy making and planning by all elements. National planning and policy-making probably should aim at this type of linkage at the local level through redirection of money flow on a population basis. Probably only when we can identify the unique features, positive and negative, of policy making and planning approaches that will emerge in a variety of localities from population-

related reimbursement shall we be able to progress with more sophisticated national planning and policy making. At present, it is not possible to identify such planning and policy-making in many metropolitan or rural areas. This should indicate the distance to go before we can expect to see much concrete achievement at the national level.

Conclusion

I hope that this conclusion does not appear to be too skeptical or pessimistic. I find great excitement and great potential for progress in the idea of lowering our sights to the community level and encouraging consumers and financing agencies to use institutional money flow to link directly with providers to solve their health problems, based on a commonality of self-interest rather than confrontation. Only in this way, as I see it, can we quickly move toward Dr. Ford's three objectives—by widening the epidemiological perspective of the hospital medical staffs, by giving hospitals economic incentives to make greater use of public health experts, and by involving individual citizens more directly with an epidemiological approach. By shifts in money flow at the community level to more closely link the policy-making and planning of individual consumers and providers serving them we may be able to move forward at a rate beyond any current expectation.