Artigo Original

Health planning – a global perspective

Planeamento em saúde - uma perspetiva global

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Resumo

O termo planeamento em saúde pode englobar um amplo conjunto de diferentes atividades, desde o planeamento estratégico de longo prazo de um sistema de saúde ao desenvolvimento, a curto prazo, de um serviço, ou desde o planeamento de recursos humanos e financeiros ao planeamento de intervenções que correspondam às necessidades das populações. Tal como os dois exemplos apresentados neste artigo o demonstram, o planeamento pode ser executado de várias formas. Todas as metodologias têm as suas fraquezas e, na realidade, a maior parte das mudanças e melhorias na saúde resultam da ação política, da liderança clínica e outros empreendedores, numa aprendizagem baseada na experiência prática e da cuidadosa aplicação dos avanços da ciência. O planeamento é, contudo, muito importante e este artigo conclui como os processos de planeamento podem envolver líderes empreendedores, o trabalho com parceiros de outros setores, englobando as melhorias geradas por indivíduos e equipas que estão a aprender e a inovar em tempo real.

Palavras Chave:
Planeamento em saúde, qualidade dos cuidados de saúde, desenvolvimento de programas e contributos da ciência.

Abstract

The term health planning can cover a wide range of different activities from long term strategic planning for a whole system to the short term development of a service and from human resource and financial planning to planning interventions to meet population needs. Moreover, as two examples described here show, it can be undertaken in very different ways. All methodologies have weaknesses and, in reality, most changes and improvements in health come about through political action, the leadership of clinical and other entrepreneurs, *learning by doing* and the careful application of improvement science. Planning is, however, important and this paper concludes by considering how planning processes might engage entrepreneurial leaders, work with partners from other sectors and embrace the improvements generated by individuals and teams learning and innovating in *real time*.

Key Words:
Health planning, health care quality, program development, improvement science.

What is meant by health planning?

Health planning is a term which can be used to describe a multitude of different activities. These include the creation of strategic, operational, budgetary, capacity, service, human resources and technology plans and much more. It can also cover different time scales with, for example, annual plans, 3 year plans and longer strategic plans. Moreover, planning may also be undertaken at local, regional, national or international levels with many countries allocating different planning responsibilities at these different levels and setting out how they relate.

The way planning is undertaken is also very variable as will be illustrated with two examples later. However, a quick overview globally suggests that most health planning is very technocratic in nature and undertaken by specialist trained groups of staff rather than by practising clinicians and managers and with relatively little engagement of the public and wider stakeholders. This overview also suggests that most planning is concerned with service provision.

Health and health care are profoundly affected by other sectors and need to be seen in the context of education, housing, employment, environmental policies and all the other external factors that help determine the health of individuals and populations. An important part of health planning, therefore, is the extent to which it takes account of these wider issues. This has led many planners to aim for a *Health in All Policies* approach where other sectors are involved in assessing their own policies in order to maximise their health impact. [1]

This breadth of issues also raises questions about governance and accountability and the extent to which external stakeholders are involved in both. Planners need to be thinking about questions such as the following. To what extent are representatives of external sectors, education or social care for example, directly involved in the decision making and governance of health planning and health care delivery and not just consulted for their opinion? How far is the health sector accountable to these wider stakeholders and the public and not just to its funders and patients?

Figure 1 lists some of the main external dimensions that need to be taken into account in health planning. It is notable that successive Portuguese National Plans have been very comprehensive in this regard and seen all these different actors, including citizens, as important contributors to

- Relationships with the economy, the affordability and costing of plans
- Integration with education, social care, housing and other social policies
- Understanding of the labour market and the ability to train and recruit
- The extent to which developments will be market-driven rather than planned
- Policies and legislation about the environment, food, alcohol, drugs, smoking, health and safety all of which affect health
- The engagement of and accountability to the public and wider stakeholders

improving the health of the population.[2]

The relationship between planning and implementation is also of fundamental importance and can take a number of different forms. Some plans barely refer to implementation – reflecting the fact that the planners and the implementers in a health system are often two distinct groups - while others offer detailed prescriptions. This latter approach may be equally unpopular with the people who have to implement the plans because it may offer no flexibility and freedom of manoeuvre. There is a balance to be struck here between making sure that plans are implementable, piloting or road testing them for example, and leaving the implementers the scope to learn and adapt as they implement. In doing so they will encounter obstacles and discover unforeseen opportunities.

This brief overview of health planning has attempted to describe the main issues across the whole field. The remainder of the paper will concentrate on one broad area: health service planning for a nation, region or large population. In doing so it will, of course, raise issues relevant to other types of planning and plans. This broad area is well summed up in the following quotation from WHO Africa

"Health service planning aims to improve health service delivery and/or system performance to better meet the health need of a population. It comprises the process of aligning the delivery of existing health services to meet the changing patterns of need and use of services. This aims to make the most effective use of available and future health resources (funding, staff and infrastructure)." [3]

Two examples of health planning

The following two examples of health service planning illustrate some of the common features and the differences between approaches in two countries which both spend highly on health. The one, Queensland, is a good example of a well-worked through, detailed and technocratic approach. The other, England, is essentially a market driven approach. The author is familiar with the English model but has only read about the Queensland one and chosen it from a brief survey of the materials published on the internet as a particularly good exemplar of its type.

Queensland's planners, like many others, have adopted a cyclical approach where planning is followed by implementation and review – which in turn feeds into planning. The literature is rich in similar policy and planning cycles which illustrate the dynamic nature of planning and its constant evolution and development. The Queensland version is shown in Figure 2.

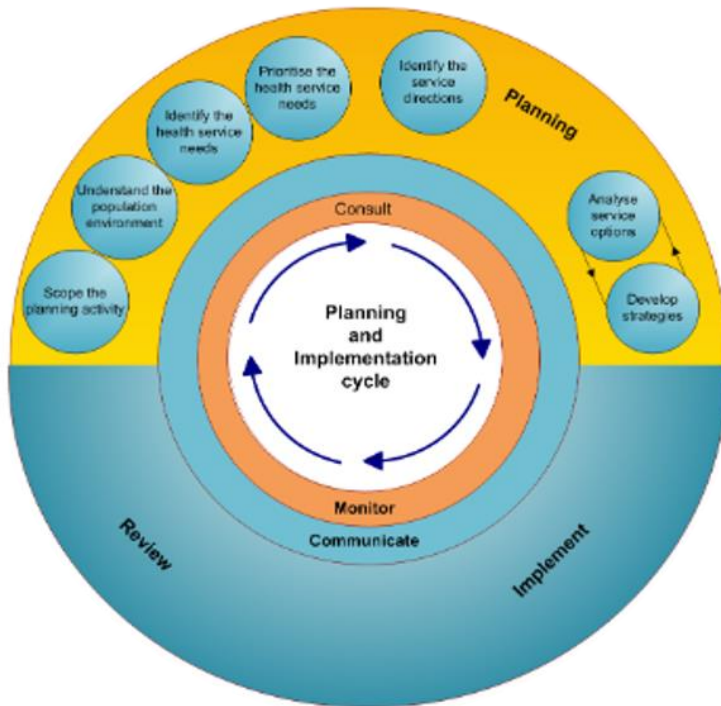Fig. 2: The Queensland Planning and Implementation Cycle [4]

Figure 2 shows some of the elements that go into the planning part of the cycle, locating the plans firmly in a wider analysis of the population and their health needs. Each of these elements is described in the planning guide. Figure 3 below identifies the different elements of the supporting and enabling functions from the clinical support services to funding and the workforce which need to planned for and aligned with the wider plan. The whole process represented by these two figures is a complex and logical approach to planning which attempts to make sure that every relevant factor is considered before the plan is complete.

Fig. 3: Queensland – the Enabling and Supporting Functions [5]
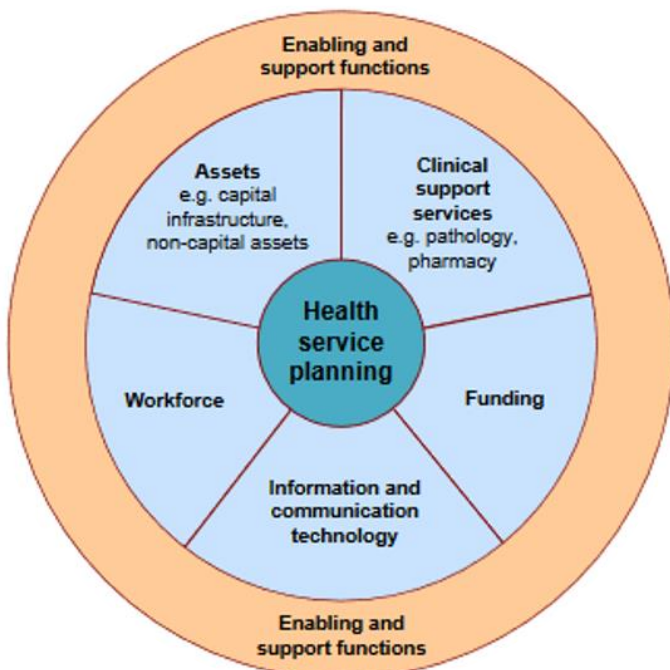
Since 2012 England has adopted has adopted a far simpler and more market-driven approach to planning. It is summarised in a rather simplified version in the following paragraph and Figure 4.

At the national level the Government agrees an annual mandate with NHS England which sets out the Governments objectives and funding for the year. [6] As part of this, NHS England and all health bodies are required to work within the framework of existing national policies on everything from professional regulation to accountability and patient safety. NHS England is an arms-length public body accountable to Parliament (rather than Government) and is responsible for arranging the provision of health services in England. It in turn allocates funding and provides guidance to the purchasers of health services, which are mainly family doctor's practices, to *commission* services for their local populations. These commissioners contract "any willing provider" from the public, private or voluntary sectors to deliver services. [7]

The English model is very different from the Queensland one. It is focussed on delivering objectives rather than on determining how this should be done and, in the original intention of the Bill that introduced it, on promoting competition between providers. There was

Fig. 4: Simplified version of how services are commissioned in England
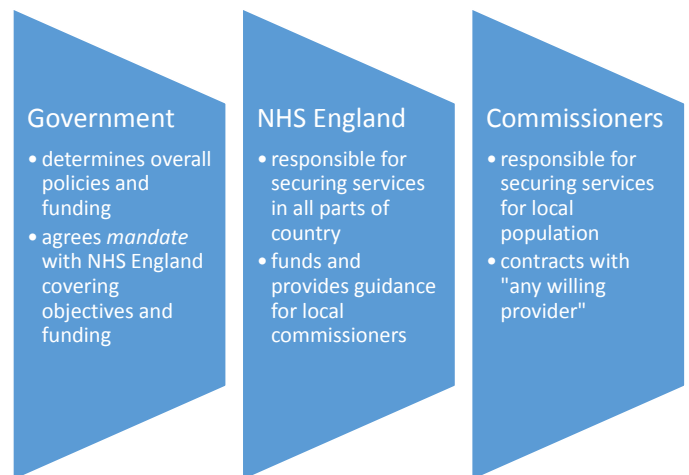
an underlying assumption that regulation and the invisible hand of the market will provide better solutions and services though competition than planning could ever do. This model means that planning in the Queensland sense is almost entirely the responsibility of the 221 local commissioners or Clinical Commissioning Groups which on average serve populations of about 220,000 people.

A more extreme version of this model can be seen in the US where Government regulates but does not provide a *mandate*, there is no equivalent of NHS England

and service planning is undertaken by insurers which generally aren't linked to a specific geographical area and have no responsibility for population health.

The UK model has already changed considerably from the original intention of the Bill. In practice competition is largely managed so as to prevent major disruptions to local services – and unnecessary duplications of service - and most recently to introduce a level of planning at a higher level in the system. The system as introduced meant that, with the exception of highly specialised services which are commissioned nationally, no one had responsibility for planning across the local commissioning boundaries. This meant that many important decisions about the configuration of services across boundaries were not taken and potential improvements in quality and efficiency were not realised. Neither markets nor planning were delivering the solutions that were needed.

As a result in 2016 NHS England asked local commissioners to work with their neighbours, local authorities (which are responsible for social care, education, housing and other public services) and other partners in 44 areas with an average population of 1.1 million to produce *Sustainability and Transformation Plans* "showing how local services will evolve and become sustainable over the next five years."[8]

Planning and reality

As the Scottish poet Robbie Burns poet puts it "The best laid plans o' mice an' men gang aft agley" [9] or, to adapt German military strategist Helmuth von Moltke famous quotation to a civilian context, no plans survive contact with reality. [10]

Plans, even those that are very well conceived and designed, may not be implemented for a variety of different reasons. Sometimes plans are unsuccessful because of problems with the planning process itself. They might, for example, have not been tested properly; people who are key to implementation may not have been consulted and may not cooperate; or the implications for support services may not have been fully understood. There can also be external problems: politics and unexpected events can intrude and mean plans have to be changed; key individuals from the health minister onwards may change and commitment to the plans can be lost; or other priorities may arise that mean plans are not followed through.

Continuity and long–term commitment are particularly important in health planning where results are often not immediate but require years of determined work. Health care planners in every part of the world can point to examples where these external factors have undone months of hard work.

Similarly there are examples where consistent political will, sticking to the plan and continuity of personnel have led to major improvements. The enormous improvements in health in Portugal since 1974, particularly in child and maternal health, are a testament to the importance of political will, public support and good leadership over many years. The improvements in the English NHS [11] and the development of the Mexican, Brazilian and Rwandan health systems are other examples where political will, sometimes going across political parties, have been extremely important components of success.

This discussion suggests that further thought needs to be given to the relationship between planning and implementation and, in particular, to understanding how change and improvement is brought about. The next section looks at some real life examples of major changes which are the product of individuals taking charge of a situation and deciding to act. In some ways they are the antithesis of any formal planning process.

Making improvements

Some of the most impressive improvements in health care have come about through processes which hardly seem to involve any planning at all but, rather, depend on the continuous testing and adapting of ideas until they achieve the desired results. This experimental and entrepreneurial approach is seen for example in Parkinsonnet.org which was started in Holland by a neurologist who believed there was a better way of dealing with the disease. From an initial start in one area Parkinsonnet.org now brings together over 2,700 health professionals into regional networks with patients and carers to provide information and services throughout the Netherlands and into neighbouring countries. They are supported by a coordination centre and academic specialists at the Radboud University Nijmegen Medical Centre. [12]

Parkinson's Disease is a generic term for a very complex disorder which may lead to a wide range of different problems needing attention from different carers. This network ensures that patients are able to reach the appropriate professionals and, by having access to all the information and protocols in the network, to play a full role in their own care.

The model breaks down all the rigidities of the traditional system with new roles for professionals and patients, home and community based care and extensive

Fig. 5: Parkinsonnet.com
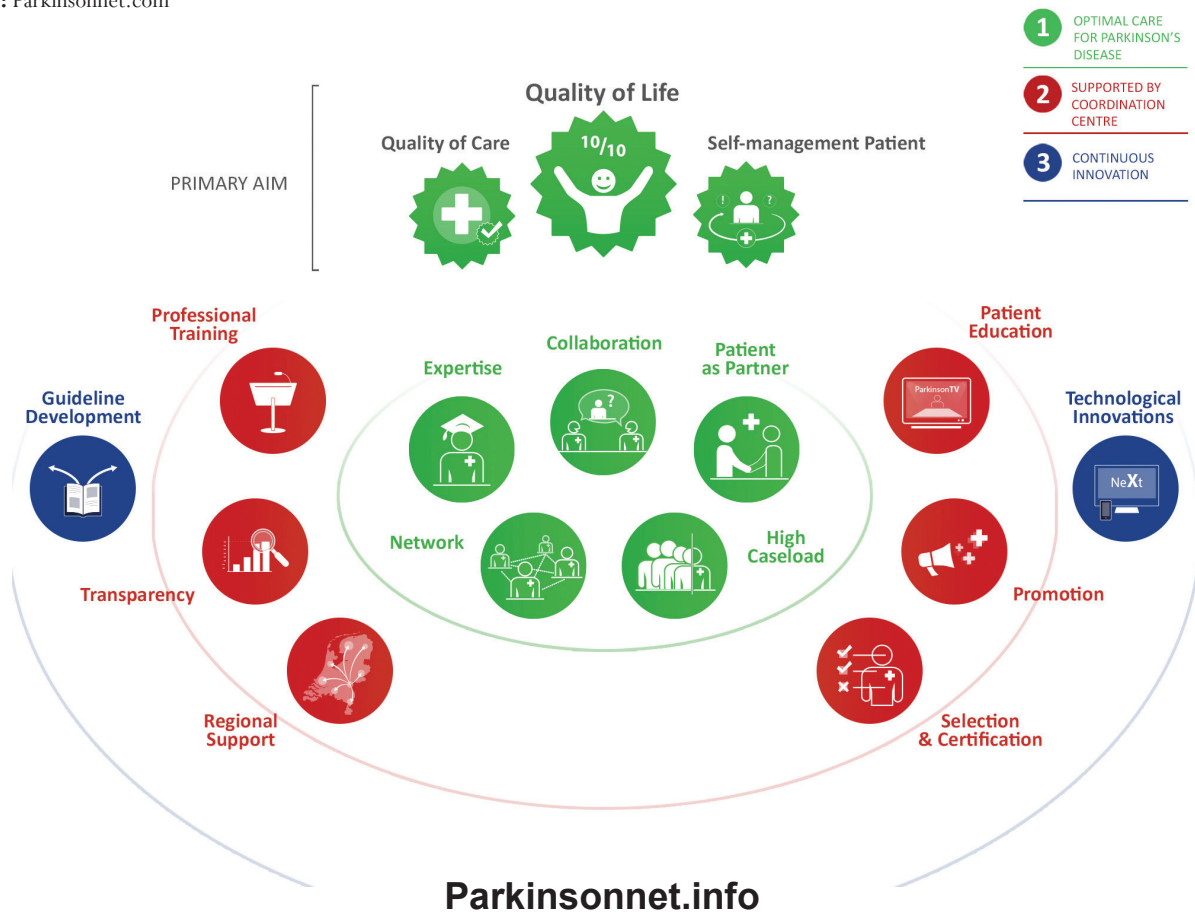
use of IT. Figure 5 shows the main components.
Parkinsonnet.org may well be a forerunner of similar developments for other chronic and long-term diseases. In this context it is interesting because it wasn't planned by any formal authorities but was developed by a clinician who was dissatisfied with the previous services and how they were organised and delivered. Professor Bas Blom didn't have a fully worked up plan in his mind at that start but talks about "starting small, thinking big and moving fast". He continuously learned from his actions, taking on problems as they emerged and finding solutions.

Parkinsonnet.org is led by a clinician but other examples involve entrepreneurial leaders from different backgrounds. A good example is the St Paul's Way Transformation Project which brings together a wide range of private, public and third sector partners to re-generate an area in east London and has created links between the local school, health facilities, housing and pharmacy as well as with universities and multi-national companies working in the area.[13] Interestingly, St Paul's Way is not purely or even primarily focussed on health but nevertheless has a big impact on health in the area. Some of the partners are shown in Figure 6.

Fig. 6: St Paul's Way
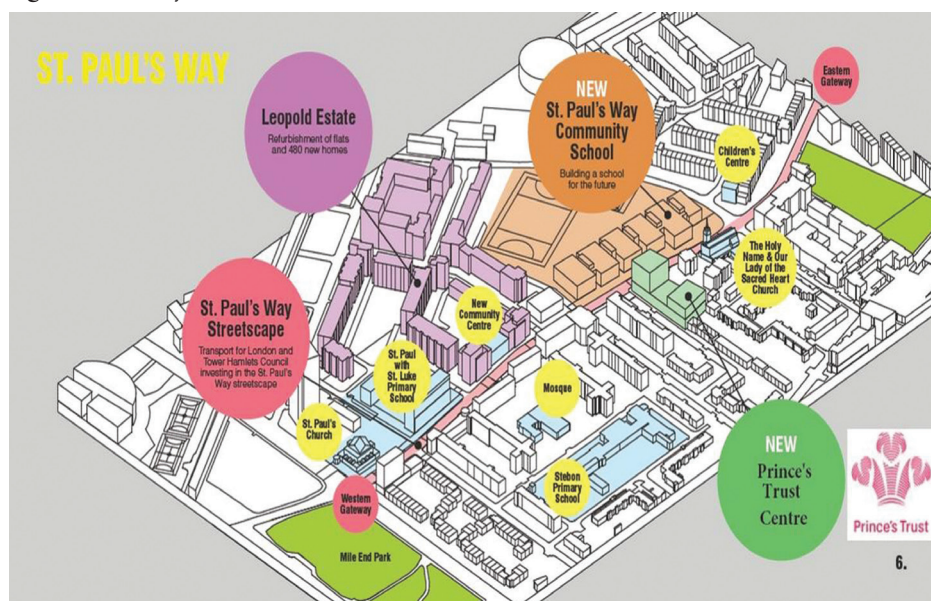
The lessons from St Paul's Way are being transferred to 10 towns and cities in the north of England through a newlycreated organisation called Well North with support from Public Health England. [14] Like Parkinsonnsnet.org this approach is characterised by experimentation and "learning by doing" combined with committed long-term leadership. It also has a focus on building relationships and not just on creating systems. Both are important but the significance of relationships tends to be ignored in formal planning mechanisms.

These two examples can be rather crudely characterised as succeeding *despite* the system. Lord Andrew Mawson the founder of the St Paul's Way Project talks explicitly about how the way that the NHS and local authorities operated often caused problems for him and his colleagues. The normal ways of doing things were too slow and bureaucratic and didn't allow for the sort of experimentation and creativity which brought the big results. He also noted that there tended to be high turnover in leaders in these public bodies and that he had to keep starting at the beginning with their successors.

These examples, which are characteristic of many, present a challenge for health planners: how can they structure their work so that it can support this type of activity – rather than frustrate it – and in doing so develop a different way of thinking and behaving?

This question has been partly addressed in recent years with the development of improvement science which explicitly adopts an experimental and learning approach to making improvements and builds on the work of theorists and practitioners of continuous quality improvement. Juran, for example, sees quality planning alongside quality improvement and quality assurance as part of his trilogy of essential activities for making improvements in quality. [15] His work has been adapted for healthcare by the Institute of Healthcare Improvement which is now having a great influence globally, while other organisations are using similar approaches and training health workers in different ways of thinking and working. [16,17]

Improvement science is now being used in many countries to develop and improve services, learning in part from the examples of people like Professor Blom in Holland. However, it has not yet become very developed in dealing with the multi-sectorial activity that is so important in St Paul's Way, with its focus on a range of improvements to peoples' lives, of which health is just one. More work needs to be done on this and in understanding the appropriate styles of leadership as well as the ways of developing the productive and creative relationships that are so evidently important.

Conclusion

This brief paper provides an overview of health planning and some of its weaknesses particularly in relation to supporting visionary and entrepreneurial leaders; however, planning also has important strengths. It can look at the big picture setting out the priorities such as the Sustainable Development Goals which will guide and shape health and development over the coming years.[18] It can address strategic questions which the entrepreneurs may ignore such as: are there enough health professionals being trained, how much should be invested in research and development; and where are the gaps in healthcare provision.

Health planning is at its best when it deals with evidence and priorities, seeks answers to these strategic questions and – something that is sometimes missed – brings people together to build consensus. Planning together can be an enormously important prelude to working together. Planning is at its worst when it deals inadequately with implementation or attempts to prescribe in detail what they need to do to deliver the plans. As health planners with their planning and policy cycles know very well, planning needs to be dynamic, responsive and inclusive.

Looking forward I would argue that health planning needs to develop in two different ways. Firstly it needs a better understanding of implementation, the role of leadership and the development of relationships. These understandings will help improve and develop the whole doctrine of planning. They need to be built on improved skills and an understanding of the science of improvement.

Secondly, the whole agenda needs to be widened and thought about in a different way. There needs to be a shift in focus away from an over-concentration on health services towards wider concepts of health and well-being as described, for example, in the Gulbenkian's Commission's "Future for Health in Portugal". [19] This built on the growing understanding of the social and wider determinants of health in recent years which are at last being incorporated into policy and planning globally and beginning to find their way into action on the ground.

In the UK I and a group of clinicians, scientists and social entrepreneurs have recently published a manifesto that draws out 4 themes which we are argue will be essential in the future:

• The linkage between health and the economy – where a healthy workforce improves productivity and the bio-medical and life sciences strengthen the economy

• The importance of transitioning from a hospi-

tal and illness focusses health and care system to a home, community and health based one

- The role that "health creation" by all sectors of society can play in building healthy and robust individuals and communities

- The part that scientific and health organisations and institutions – with their values of objectiv-

ity, openness and solidarity - can play in building a healthy and prosperous society

Health planning in the future needs to look at these wider aspects as well as at its traditional territory of health need, services, financial flows and the professional workforce.

References

1. http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/health-in-all-policies-seizing-opportunities,-implementing-policies Accessed 30 December 2016

2. Government of Portugal: Plano Nacional de Saúde; Lisboa, 2015 http://pns.dgs.pt/ Accessed 1 January 2017

3 WHO Africa: Planning and implementation of district health services; Brazzaville, 2004

4. Queensland Health;: Guide to Health Service planning; Version 3, Canberra, 2015 p 15 https://www.health.qld.gov.au/__data/assets/pdf_file/0025/443572/guideline-health-service-planning.pdf Accessed 30 December 2016

5. Queensland Health;: Guide to Health Service planning; Version 3, Canberra, 2015 p 14 https://www.health.qld.gov.au/__data/assets/pdf_file/0025/443572/guideline-health-service-planning.pdf Accessed 30 December 2016

6. Department of Health: The Government's mandate to NHS England 2016/17; London, 2016.: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf Accessed 30 December 2016

7. UK Government: Health and Social Care Act, London, 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted Accessed 30 December 2016

8. https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/ Accessed 30 December 2016

9. Burns R: To a Mouse; Edinburgh, 1785

10. "On Strategy" (1871), as translated in *Moltke on the Art of War: Selected Writings* (1993) by Daniel J. Hughes and Harry Bell, p. 92

11. Crisp N: 24 Hours to Save the NHS – the Chief Executive's account of reform 2000-2006; CRC Press, London, 2010

12. http://parkinsonnet.info/ Accessed 18 October 2016

13. http://www.stpaulsway.com/ Accessed 1 January 2017

14. http://www.wellnorth.co.uk/ Accessed 18 October 2016

15. Juran JM: The Quality Trilogy; Juran Institute, Connecticut, 1986 https://www.juran.com/wp-content/uploads/2015/07/TheQualityTrilogy-by-JM-Juran.pdf Accessed 1 January 2017

16. http://www.ihi.org/Pages/default.aspx Accessed 1 January 2017

17. The School for Health and Care Radicals http://theedge.nhsiq.nhs.uk/school/ Accessed 1 January 2017

18. The United Nations: The Sustainable Development Goals 2015-30; New York 2015. http://www.un.org/pga/wp-content/uploads/sites/3/2015/08/120815_outcome-document-of-Summit-for-adoption-of-the-post-2015-development-agenda.pdf accessed 1 January 2017

19. Gulbenkian Foundation: The Future for Health in Portugal; Lisbon, 2014. The Commission that wrote the report was chaired by the author of this article.