A CONCEPTUAL BASIS FOR STRATEGIC HEALTH PLANNING IN GOVERNMENTS IN CANADA

By

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ABSTRACT

This study presents a new conceptual model of health planning for planners in government. The model developed in this study is based on concepts from the "sociology of knowledge," a branch of sociological theory. There is currently no universally agreed upon grand theory of health planning. The contribution of the sociology of knowledge is that it allows the analyst to move to a higher level of abstraction in which existing theories or models themselves become the subjects of study. This type of formulation allows the theorist to incorporate existing theories into a conceptual space based on fundamental conceptions of the world. By understanding the location of a planning project in this conceptual space, the planner can identify the sets of theories most appropriate to the project, i.e. a contingency model allowing for the best fit resolution matching a project to its correct model of analysis. Knowing which theories to use allows the planner to develop strategies for action. The model in this study has three components: analysis of the planning environment or context, strategy formulation, and the action required to carry out the planning project. This model is called the Contextual Analysis, Strategy and Action (CASA) model. The validity of this model is tested by applying it to six case studies. The conclusion of the study is that the CASA model is a valid model and has more explanatory power than other documented models of planning.

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1. INTRODUCTION

The purpose of this study is to develop a new conceptual model for health planning. While the model may be useful as a guide to planners in general, it is primarily designed to provide a framework for action for health planners working in the federal, provincial and territorial governments of Canada. These are planners who work in large public sector bureaucracies and who work for senior bureaucrats.

Traditionally, health planning has been dominated by the organizing principles of rationalism and impiricism. This has led to the development of a rational model of health planning. This model is reflected in current planning techniques such as epidemiology, cost benefit analysis, needs assessments and other methodologically and statistically based approaches. This rational model is starting to be criticized for not providing an adequate theoretical framework for planning (Alexander, 1984; Forester, 1982; Kiernan, 1982). At this stage in its evolution, planning cannot be considered to be an exact science with a clearly defined sphere of activity and there is no currently agreed upon definition of health planning. However, there are many approaches which can usefully be used by planners such as action research, decision making and strategy formulation techniques, political theory, small group theory, social animation, policy analysis and other such models and techniques. Some planners use these approaches in the different roles assumed by planners such as the technical

expert, the advocate, the honest broker, the trouble shooter, the conceptual thinker and other such roles. Nevertheless, the planning literature itself is still closely wedded to the rational functionalist model. While each of the above approaches could be developed into a countervailing model of planning theory and while there is some current development of these themes, these types of analyses are still quite limited in number in the current planning journals. In addition, each of the above approaches is somewhat limited in scope and may not provide the best possible guidance to health planners in all circumstances. What is required is an overriding grand theory or meta-theory of planning which can incorporate both the rational model and the other approaches noted above and which can provide a guide for action to health planners. It is the purpose of this study to delineate such a model.

The model developed in this study is based on concepts from the "Sociology of Knowledge," a branch of sociological theory. The unique contribution of this branch of theory is that it allows the analyst to move to a higher level of abstraction in which theories and models of planning or other such activities themselves become the subjects of study. The sociology of knowledge is both a theory and a methodology. It allows the analyst to construct a conceptual space based on fundamental parameters such as the degree to which the world is subjectively constructed or is an objective reality and the degree to which conflict exists. This conceptual space can be seen as comprising a universe. Theoretical models are sub-sets

of this universe. More colloquially, the conceptual space is the forest and the theoretical models are the clusters of trees in that forest. The analyst or theorist who lives in the forest can only see a limited number of trees and generally lives in one cluster of trees, i.e. adheres to one general theoretical model. The analyst who can see the forest can see how various clusters of trees are inter-related, can determine where in the forest he can find and make use of various clusters of trees. He has an allegiance to the forest rather than to any one cluster of trees, i.e. the allegiance is to analytical thought in general rather than to any particular theory or model.

This approach allows planners to define where, in the conceptual space, a particular planning project is located, this in turn allows the planner to identify the set of theories most appropriate to the problem, i.e. a contingency model allowing for the best fit resolution in matching a problem to its correct mode of analysis. Knowing which theories to use permits the planner to develop strategies for action which should allow for a higher probability of successful completion of planning projects.

Thus, this new conceptual model has three components: correctly identifying environmental constraints, strategy formulation, and action. Appropriate strategy flows from a correct understanding of the environment. Similarly, action flows from the strategic plan developed to achieve a given planning goal.

In order to better understand the application of this new conceptual model for health planning, it is important to have an understanding of the health care system itself. De Miguel (1975) in his study of national health systems has developed a causal model of health systems which shows the role of health planning in an overall context. His schematic is presented in Diagram 1. This Diagram shows that health planning, and the organizational context in which it takes place, are directly affected by larger societal factors such as the existing political structure and the state of economic development. These factors are, in turn, influenced by socio-cultural patterns, demographics and the environment. Health planning itself has an effect on the health status of the population.

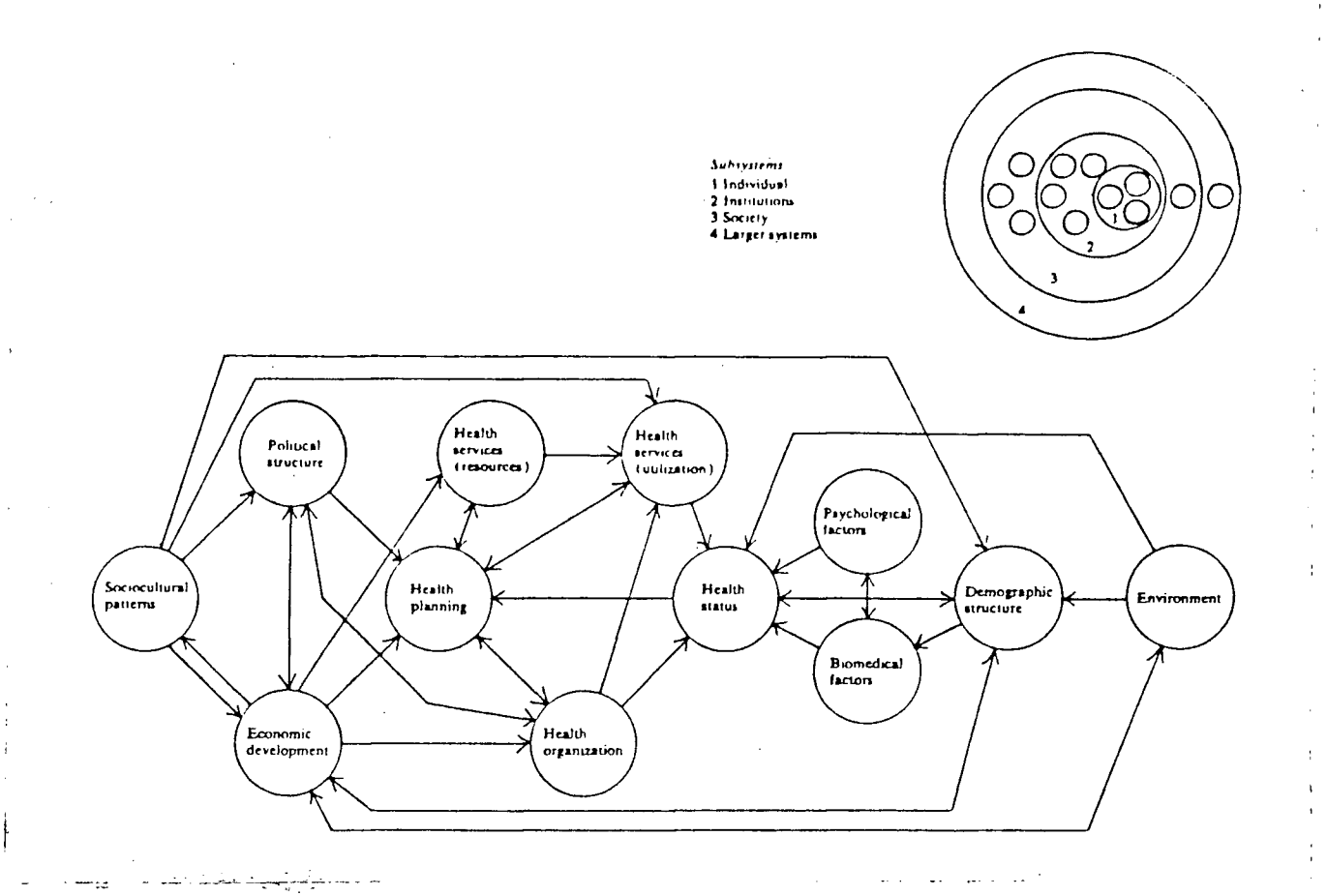
In summary, health planning consists of analysing, developing and implementing programs in a complex and interactive environment. It has been argued that the rational model of planning is often inadequate as a framework for action. Therefore, a new model or conceptual base for planning is presented in this study.

The next chapter will review the methodology to be used in this study. The third chapter will review the Canadian health care system. The fourth chapter will provide an overview of the sociology of knowledge, the conceptual foundation on which this study is based. The fifth chapter will provide a review of organizational theory while chapter six will provide a review of planning theory. The seventh chapter will present the proposed conceptual model for health planning and will use

the model to analyse five case studies. The eighth chapter will present a discussion of the findings of this study and will discuss how the model can be applied by government planners to make a more effective contribution to planning.

Diagram 1

De Miguel's Causal Model for Health Systems



From: De Miguel, J. M. A framework for the study of national health systems. Inquiry, 1975, Supplement to 12 (2), 10-24.

2. METHODOLOGY

The purpose of this study is to develop a new model or conceptual base for understanding health planning. In developing new models, theorists review the state of current knowledge, apply their own knowledge and experience and test the new formulation to determine its validity. This is what is done in this study.

In scientific investigation, there should be congruence between theory and method. In the social sciences there are both quantitative and qualitative methods and parametric and non-parametric statistics. Quantitative methods and parametric statistics are best utilized to test specific hypotheses derived from theory and in which the units of analysis can be quantified in terms of interval or ratio data. Qualitative methods and non-parametric statistics are more appropriate for theory building, exploratory studies and for analysing nominal and ordinal level data.

Planning theory and organizational theory have, until recently, been primarily based on an underlying rational world view. This underlying world view has expressed itself in functionalist theory development and an emphasis on quantitative methods. As current theories of planning and organizational behaviour are challenged, so are the methods that have been used to validate them. There is a growing concern over the inappropriate application of quantitative methods. This is reflected by John van Maanen (1979) when he states:

> There is a growing concern about where quantitative techniques are carrying us. For example, questions have been raised about the extent to which our methods are guiding our theory and concern has been expressed about the degree to which our procedures have become so ritualized that the necessary connection between measure and concept has vanished. Since quantitative methods have held an almost monopolistic grip on the production of knowledge in the field, any serious reflection regarding current organization theory must at some point consider the value of alternate methods. (p. 521)

Theorists are starting to study many aspects of organizational life which require them to consider the use of qualitative approaches. For example, current organizational analysts are looking at the importance of: personal issues such as learned helplessness (Martinko & Gardner, 1982), humour (Duncan, 1982), impression management (Caldwell & O'Reilly III, 1982), and irrationality (Brusson, 1982); interpersonal issues such as power and politics (Cobb, 1980; Farrell & Peterson, 1982; Gandz & Murray, 1980; Kelley, 1976; Pfeffer, 1981a; Schein, 1977; Tushman, 1977), the social construction of reality (Pfeffer, 1981 a&b); and, philosophical and ideological issues (Behling, 1978; Miller, 1981 & 1982; Mitroff & Mason, 1982; Motamedi, 1978; Sanders, 1982).

As new theoretical models emerge, there is an increasing dissatisfaction with conventional quantitative approaches and a call for researchers to use other approaches to understand organizations (Dubin, 1982). There is also a growing acceptance of the use of qualitative methods in organizational analysis (Pettigrew, 1981).

The present study is one of theory building and is compatible with the use of qualitative methods. Furthermore,

as noted there is an increasing acceptance of qualitative methods in organizational analysis and, therefore, the use of a qualitative approach is within the currently accepted boundaries of organizational research.

The methodology used in this study consists of three approaches. The first approach is a detailed analytical review of theoretical and empirical literature on the health system, organizational theory, public administration, and health services planning. The second approach is that of case studies. This is a well-accepted and widely used method in both organizational analysis and in planning. Cases will be presented to demonstrate "real world" planning problems and these cases will then be analysed in relation to the proposed conceptual model. The final approach is that of participant observation.

3. THE CANADIAN HEALTH CARE SYSTEM

3.1. Introduction

In order to better understand the context of health planning in Canada, it is important to understand the Canadian health care system and the power of physicians within the system. These issues will be discussed in this chapter.

The post-war era has seen the gradual evolution of a system of health services in Canada based on the cornerstones of comprehensiveness of service, universality of coverage, portability of benefits, and public administration. While health is defined as a provincial responsibility in the British North America (B.N.A.) Act of 1867 (and remains so after the repatriation of the Constitution in 1982), and while many important programs have been initiated at the provincial level, the major components of the Canadian health care system have evolved through action at the federal level. This evolution has been highlighted by a series of milestones. Each new milestone has had a slightly different constellation of supporters and opponents. An important aspect of the development of these milestones has been the jurisdictional battle between the federal and provincial governments over the power of taxation to pay for health services. The development of the Canadian health care system has been documented by Taylor (1978). The following section presents a brief overview of that development. For a more detailed overview, the reader is referred to Taylor (1978).

3.2. An Overview of the Development of the Canadian Health Care System

There have been a number of important actors who have influenced the development of the Canadian health care system. A review of the positions they have held is useful for health planners as it provides a better understanding of the current positions of these actors and the dynamics of the health care system.

The first major step in the development of the Canadian health care system was the appointment in 1937 of the Royal Commission on Dominion-Provincial Relations (the Rowell-Sirois Commission). The report of the Commission, tabled in 1940, called for provincial autonomy in decision making and stated that provinces should have the means to finance health services. A Federal-Provincial Conference to discuss the Rowell-Sirois Report was held in 1941 but came to a quick end because of opposition by three provinces to the tax proposals contained in the report.

During the early 1940's a number of initiatives were undertaken by the Federal Government in the social security and health areas. The Commons Select Committee on Social Security received the "Report on Social Security for Canada" (the "Marsh Report") and the "Report of the Advisory Committee on Health Insurance" (the "Heagerty Report") in 1943 and a draft of a comprehensive health insurance bill in 1944. By the time the draft bill was received the end of World War II was in sight and it was decided to postpone any action until after the end

of the war. This initiative culminated in the tabling of the "Green Book Proposals" at the Dominion-Provincial Conference of 1945. This report called for the adoption of a provincially based insurance scheme to be subsidized by the Federal Government.

The Green Book Report was supported in principle by the Dominion Council of Health, the Canadian Medical Association (CMA), the Canadian Hospital Council (CHC), and the labour and farm movements. It also received limited support from the life insurance industry. However, the proposals were not finalized due to disagreement between the federal and provincial governments regarding the mechanism of allocating tax revenues between them.

In 1948, MacKenzie King announced the national health grants program and noted that they were the first step in the development of a comprehensive health insurance plan for Canadians. This program followed the 1945 proposal but excluded grants for health insurance. Funds were available for a variety of medical and public health purposes including hospital construction and research.

After 1948, the federal government took the position that it would only involve itself in the issue of health insurance if called on to do so by a majority of the provinces. The federal position was that it would offer grants-in-aid for specific types of programs to ensure health services. It stated that tax revenues collected nationally could only be used if a majority of provinces became part of the program.

The CMA in 1955 officially reversed its 1943 approval of government administered programs. It called for fee-for-service payments and private insurance such as its own Trans-Canada Medical Plan. It was the position of the CMA that government should subsidize low income individuals who could not afford private insurance. The Canadian Hospital Association concurred with the recommendations of the CMA. The life insurance industry also reversed its 1943 position and worked actively to restrict the role of government. It was supported in its actions by the Canadian Chamber of Commerce. The labour movement and the CCF supported the government insurance approach.

Public opinion, increasing press coverage, a commitment to health insurance in the 1953 election, and provincial pressure mandated that the issue of government health insurance be addressed at the 1955 federal-provincial meeting to negotiate tax arrangements. At this conference several provincial premiers called for, or proposed, national health insurance schemes. The federal government prepared a proposal in which it offered to pay one-half of the national cost of diagnostic services and in-patient hospital care. These proposals were eventually accepted and in 1957 the federal government passed the Hospital Insurance Diagnostic Services Act. This Act called for a detailed set of standards and required that services be delivered on equal terms and conditions. This effectively prevented any province from maintaining or adopting a private insurance model.

The effect of this Act was to establish an expensive hospital-based system of health care. Having overbuilt the hospital sector by its health grants, the government now had developed a mechanism to pay for this sector. The decision to first develop a hospital-based infrastructure clearly set the tone for Canadian health care as other alternatives were not possible once this decision was made.

In the years since 1957 there were several changes in personnel in the Liberal Party and by the mid-1960's the federal government was again prepared to take action in the area of insured medical care services. Other factors leading to action for medicare were the NDP and their Saskatchewan medicare program which showed that such a program was feasible and effective and the report of the Royal Commission on Health Services (the Hall Commission), originally commissioned by the Right Honourable John Diefenbaker when the Conservative Party was in power. The report of this Commission called for a universal, portable, comprehensive, and government administered medicare program.

The medical profession and the insurance industry were even more adamantly opposed to "state medicine" than they had been in the 1950's. The Hall report was a major challenge to the medical profession's control of the medical services distribution system. The Canadian Labour Congress (CLC), the Canadian Federation of Agriculture (CFA) and the NDP supported the concept of government operated medicare.

The concept of medicare was discussed at a federal-provincial conference in 1965. At a subsequent Provincial Premiers

Conference provincial opposition was very strong; however, the medicare bill had already passed first reading in the House of Commons and the Liberals did not withdraw it.

While the Medical Care Act of 1966 completed the coverage for most medical services, it allowed for the maintenance of the fee-for-service, private enterprise model of physican services, a requirement of the physician community for acceptance of the program. It also, to a great extent, precluded the adoption of alternate forms of medical care. This Act completed and consolidated the Canadian health care infrastructure based on acute care hospitals and the individual patient, single doctor relationship.

The result of the shared-cost and open-ended mechanism of funding health services was that it reduced incentives to economize. In addition, increases in expenditures no longer resulted in commensurate improvements in health indicators such as life expectancy. Therefore, a federal proposal was developed which provided for block grants to the provinces as long as national standards were maintained. This allowed the provinces greater flexibility in developing new types of health services. This block funding approach was instituted in 1977.

Diagram 2 outlines the forces that were brought to bear on each of the four major decisions. The health grants of 1948 have been omitted as there was no concerted action for or against this proposal.

It is interesting to note that in addition to the Liberal Party, the major catalysts for action were public opinion,

expert reports, and the CCF/NDP Party. However, it may be that these forces were used to legitimize Liberal policy as much as to shape it. Diagram 2 also clearly demonstrates that the Block Funding approach was treated primarily as an administrative matter which stemmed from escalating costs. Except for the provinces, the vested interests of most groups were not challenged by this initiative. The Diagram also points out that once an action was taken which affected a particular group they did not continue to challenge other initiatives.

Diagram 2 also reflects several basic dynamics of the Canadian health care system. For example, federal-provincial relations are generally grounded in the struggle between provincial autonomy and federal control and not on ideology, while outside organizations such as the CMA and private industry frame their arguments in ideological terms. There also appears to be a clear ideological split between subsidized "free enterprise" as championed by the medical professions and private industry and public protection or "socialism" espoused by the NDP and the trade unions.

As growth and specialization in the post war era occurred within the existing framework of health services, funds could not readily be made available for alternate models of health care. This led to a greater emphasis on a model based on technology and physiology which was justified by the existing health infrastructure and maintained through research and development.

As the federal and provincial governments play different roles in the delivery of health services, health planners focus

Diagram 2

Organizational Support for Federal Initiatives

Events	External Catalysts					Initiator	External Organizations						
	Public Opinion	Royal Commission Reports	Special Surveys	CCF / NDP	Other	Federal Governmet	Canadian Medical Association	Canadian Hospital Council	Private Insurance Industory	Organized Labour	Canadian Federation of Agriculture	Provinces	Other
1) 1945 Proposals for Health Insurance	Yes	Yes	Yes	Yes	Minor	Liberals	For	For	For	For	For	Against	For, Several Organizations
2) Hospital Insurance and Diagnostic Services Act of 1957	Yes	No	Yes	Yes	Yes, Provinces	Liberals	Against	Against	Against	For	Neutral	For	Against, Canadian Chamber of Commerce
3) Medical Care Act of 1966	Yes	Yes	No	Yes	No	Liberals	Against	Against	Against	For	For	Mostly Against	Neutral
4) Block Funding	Some	No	No	No	Yes, Escalating Costs	Liberals	Neutral	Neutral	Neutral	Neutral	Neutral	Mixed	Neutral

on different types of activities and face different pressures depending on the level of government for which they work. Planners at the federal level deal with some service delivery issues but primarily focus on the development of health policy, funding for research and planning, and coordinating national initiatives. Planners at the provincial and territorial levels (hereafter simply referred to as the provincial level) deal with issues of appropriate resource allocation, planning and developing new patient care initiatives, documenting perceived inequities in the federal contribution from block funding and other such activities.

In order to better understand the health care sector and the internal and external constraints faced by planners and administrators, it is important to understand the pervasive influence of professional dominance in the health sector. This is discussed in the next section.

3.3. Professional Dominance

Eliot Freidson (1970 a&b) and others have delineated the major components of the "normative" model of health services. The first component of this model is control by physicians of almost all areas of medicine and public acceptance of this situation. As Freidson (1970 a) states:

> Medicine's position today is akin to that of state religions of yesterday - it has an officially approved monopoly right to define health and illness and to treat illness. Furthermore, as its great prestige reflects, it is highly esteemed in the public mind. (p. 5)

The second component of the model is that of the "free enterprise" model of practice (i.e. fee-for-service billing) and the concept of the medical practitioner as an entrepreneur in a "market economy." This is an important ideological tenet for medical practitioners. Since World War II, medicine in Canada has moved toward a "political economy" model in which resources are allocated by the state. However, McLeod (1974) and Freidson (1970 a) point out that the complaint by the medical profession about the movement from a market to a political economy is a red herring. The fact is that governments pay for medical services provided by doctors and fail to exert any direct control over an open-ended and physican-driven health care system.

The third and fourth components of the model are a complex division of labour and a "hierarchy of institutional expertise" in which the medical profession is dominant. This hierarchy extends from the physician to the patient. Individuals and groups find it difficult to make judgments regarding the control of medical care as they are outside the hierarchy of expertise. Individuals in their role as patients occupy the lowest position in this hierarchy. They are expected to follow instructions on faith as doctors feel that patients lack the professional training to make informed decisions.

The final component of the normative approach to medicine is the composition of the body of knowledge which constitutes medicine. This body of knowledge is based on a physiological perspective, focuses on acute episodes of illness and is grounded in medical pathology.

Thus, the normative model of health care is composed of: control of health care by the medical profession, a free enterprise economic model, a complex division of labour, a hierarchy of expertise dominated by the medical profession, and, a body of knowledge grounded in physiology and pathology.

By the late 1960's, this model of medical health care had reached its zenith in Canada and questions started to be asked about some of the inherent contradictions and anomalies implicit in this model. The model did not appear to meet the needs of the people. More and more money was spent but society no longer received a commensurate benefit. This point is highlighted by Van Loon (1978) when he states:

> Between 1931 and 1961 the proportion of GNP devoted to health care increased 1.75 percent and life expectancy rose by eight years. Between 1961 and 1971 the proportion rose an equal amount, but life expectancy rose by only one year. (p. 457)

The medical profession came under increasing attack from a number of areas. It was attacked on its economic base as government wanted to cut costs and the public sought alternatives to traditional care. It was attacked at the organizational level as provinces such as Nova Scotia and Quebec developed new controls of licensure over a broad array of health services. Major studies pointed out that what was needed was not more money but coordination. The medical profession was attacked on its conceptual model of health care by the move to develop community medicine and by demands to expand the definition of the medical model to a health field or health care model. Finally, its position of dominance based on the hierarchy of

expertise was challenged by the demand for citizen participation at all levels of health care and by alternative models such as holistic health.

However, the medical establishment has been able to hold on to much of its privilege in spite of these criticisms by virtue of the doctors' position as gatekeepers and definers of "legitimate medicine." Many organizations have found it expedient to adapt to the prevailing model by focusing on specific and measurable medical concerns. This has increased acceptance of such organizations within the medical community and their activities have become increasingly legitimized.

More recently, the pressure for change in the health care system has abated while the issue of the economic survival of the medicare system itself, has gained ascendancy. This change in focus has led to a basic acceptance of the existing health system.

As the role of the federal government is primarily that of a funder of services and research, much health planning takes place at the provincial level. Therefore, it is important to understand health planning at the provincial level. In the next section the health system of the Province of British Columbia is analysed.

3.4. The British Columbia (B.C.) Experience

The delivery of health services is a provincial responsibility. Each one of the provinces may organize its delivery and administrative systems differently from any other province.

Thus, to discuss provincial systems in general would require a fairly high degree of abstraction. While the present study is analytical in nature, it does necessitate very close scrutiny of real world organizations to see how abstract principles correspond with day-to-day activity. As a number of the cases discussed in chapter six are from B.C., this province will be examined as a concrete example of a provincial health system.

British Columbia is Canada's most westerly province. It has a strong labour movement and has, on a comparative basis, a more volatile political environment than most other provinces. There has been a progressive polarization of right and left since a newly formed Social Credit Government came to power in 1952 under the leadership of W.A.C. Bennett who held office until 1972. Campbell, Miller, Mysak and Warner (1981) describe the organization of government during that period in the following manner:

> From 1952 to 1972 policy, planning and financial management for the Government of B.C. was conducted by one man--the Hon. W.A.C. Bennett. Treasury Board during this period was referred to as 'he' by both Cabinet Ministers and Civil Servants. Bennett's style was highly personal and autocratic. His small business ideology and approach to government had no use for the complex organizational structures and reporting and control procedures now associated with financial management and policy-planning in government. Policy and planning proceeded from the top down, and the structure of the Cabinet was entirely traditional with no committees, staff or staff agencies. (p. 22)

The NDP came to power in 1972 under the leadership of the Hon. David Barrett. The NDP implemented a large number of new social democratic policies and corresponding administrative

structures. In 1975 the NDP was defeated by the Social Credit Party under the leadership of the Hon. William Bennett, the son of W.A.C. Bennett.

The 1975 election was important in that it further polarized B.C. politics leaving only one member from the Liberal Party and one Progressive Conservative in the B.C. Legislature. In the May 1979 election, the polarization became complete as no Liberals or Progressive Conservatives were elected.

Since 1975 there has been an ongoing professionalization of the government bureaucracy in B.C. Campbell et al. (1981) describe this change as follows:

> The Social Credit Party under the leadership of the Hon. William Bennett was re-elected in 1975 . . . . He deemphasized the politics of personality in his government, and introduced the corporate viewpoint and a Cabinet Committee approach to the government. One of his first acts on assuming office was to establish planning and control agencies at the cabinet level.
>
> New cabinet committees, including a planning priorities committee, were introduced. An Office of Inter-Governmental Relations was established within the Premier's Office to coordinate intergovernmental affairs and to provide staff support for both the Premier's Office and the new cabinet committees. A sizable Treasury Board staff was assigned responsibility for expenditure planning and management review of the operations of government. These and other changes were largely borrowed from other Canadian jurisdictions. They represented a belated introduction in B.C. of organizational structures, coordinating mechanisms and financial mangement in modern governments. (p. 23).

The administration of health care in B.C. has a history which in many ways parallels the changes at the political level. As Campbell et al. (1981) note, prior to 1975 senior bureaucrats in the B.C. Ministry of Health were drawn primarily

from the medical profession. In 1976, J. R. Mainguy, a non-medically qualified administrator, was elevated to the position of Deputy Minister. Mr. Mainguy was very active during the period 1976-77 in negotiating with the Federal Government the new fiscal arrangements enacted in 1977.

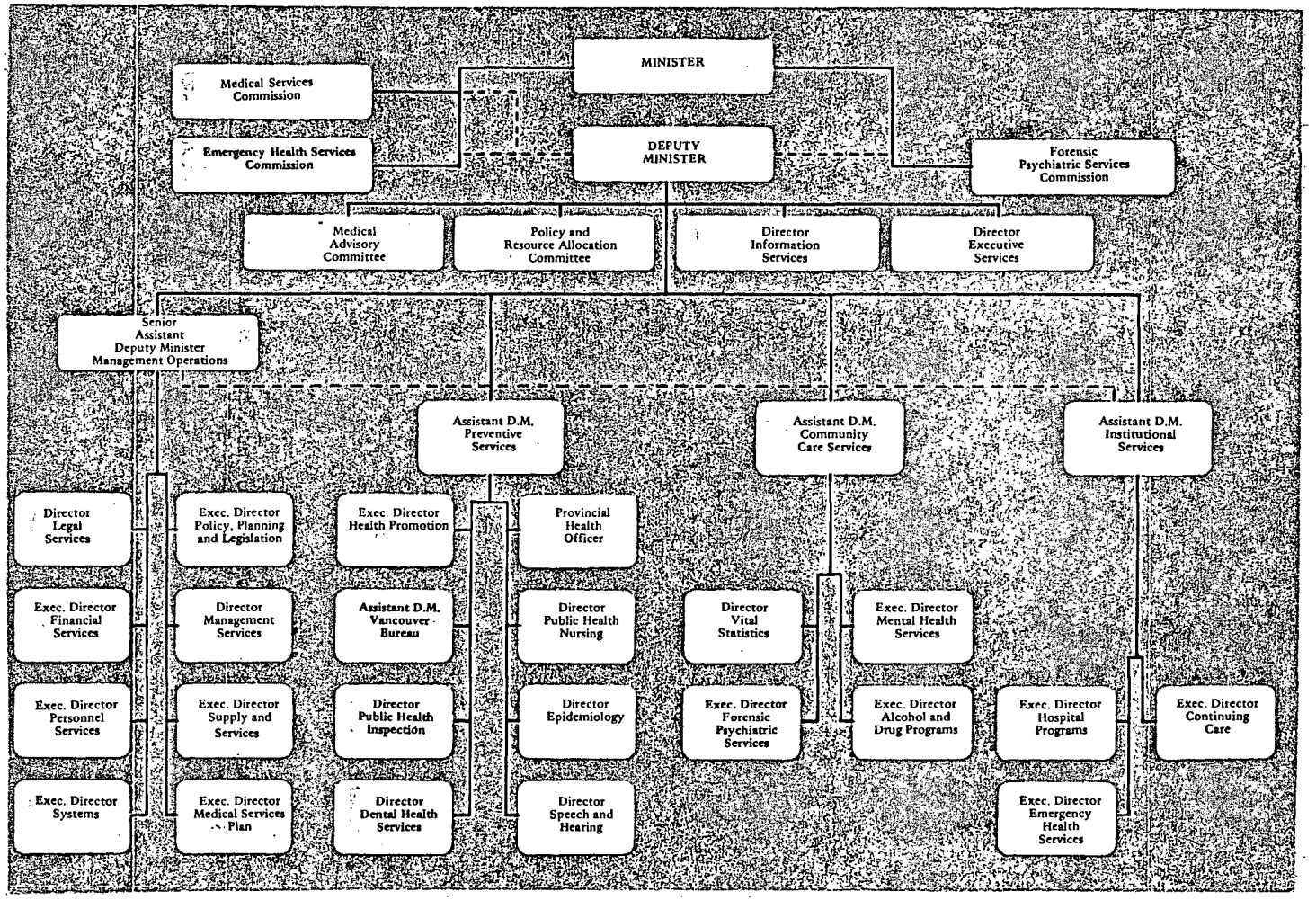
Mr. Mainguy was succeeded in 1978 by Dr. Chapin Key, a physician and administrator who focussed on long range planning and health status. With increasing cost containment, Treasury Board staff became more powerful and Dr. Key was replaced by Mr. Peter Bazowski, a professional administrator. With the appointment of Mr. Bazowski there was a noticeable shift from program planning and development to cost control. This was a reflection of changes occurring throughout government as Treasury Board Staff and the Comptroller-General's staff were integrated into the Ministry of Finance.

Since his appointment in 1981, Mr. Bazowski reorganized and brought in a new team of administrators to manage the Ministry of Health. He started to reduce the inflation adjusted portion of hospital funding. Campbell et al. (1981) note this as a change from management by professionals to professional management. The consequence of these changes was a considerable centralization of control in the B.C. Ministry of Health.

The most recent published annual report, as of May 1985, is the Ministry of Health Annual Report for 1983. Diagram 3 is taken from this report and shows the organization of the Ministry of Health. Diagram 4, also from the same annual report, indicates the comparative expenditures for the 1982/83 fiscal year.

Diagram 3

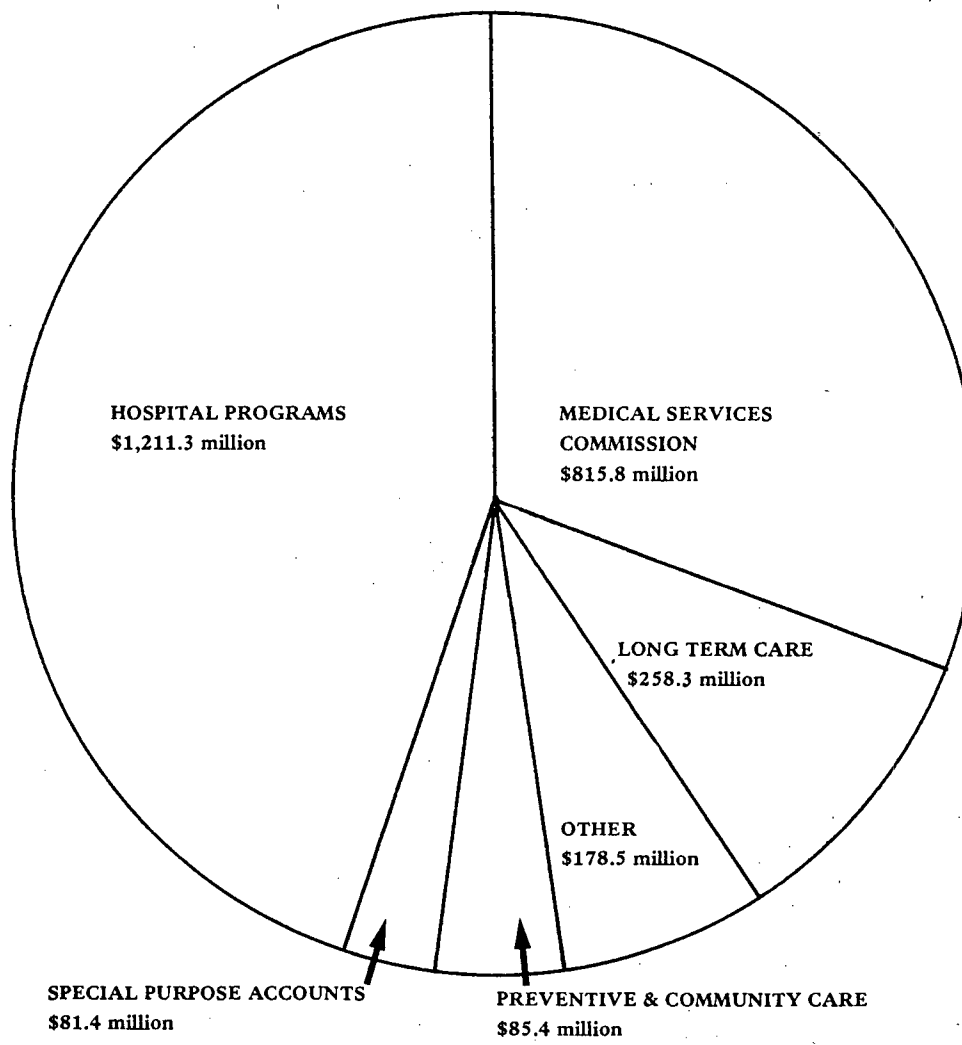
Organizational Chart of the British Columbia Ministry of Health



From: Province of British Columbia. Ministry of Health Annual Report 1983. Victoria: British Columbia Ministry of Health, 1984.

Diagram 4

Expenditure by Principal Categories in the Ministry of Health for the Fiscal Year 1982/83



OTHER:

Administration . . . . $58.5 million
Service Delivery . . . . $109.0 million
Service Delivery Grants $11.0 million

SPECIAL PURPOSE ACCOUNTS:

Drug, Alcohol & Cigarette Education, Prevention & Rehabilitation .$ 3.6 million
Health Cost Stabilization Act . . . . . .$ 77.8 million

TOTAL HEALTH SERVICES IN 1982/83: $2,630.7 MILLION

From: Province of British Columbia. Ministry of Health Annual Report 1983. Victoria: British Columbia Ministry of Health, 1984.

It is important to note that by far the major part of the health budget is paid out to individuals or organizations which are not under the direct administrative control of the Ministry of Health. Most of the funds expended by the Medical Services Commission are direct payments to health practitioners who bill the plan for their services. Hospitals are administered by "independent" hospital boards. These boards are given a global budget from the Ministry. Many community based services are also provided by non-profit or for-profit agencies which are not directly part of the government bureaucracy.

3.5. Discussion

As noted, many health services are delivered through independent third parties. This limits direct control by government and in turn government must work with service delivery agencies and their respective associations. The public and other interested parties also bring pressure to bear on provincial ministries of health.

Thus, the B.C. Ministry of Health is operating in a turbulent environment both politically and administratively; politically due to the volatile and polarized nature of B.C. politics and administratively because of cost-sharing arrangements which are renegotiated every five years. In addition, deputy ministers and assistant deputy ministers have become political appointees instead of forming part of the civil service. The B.C. Ministry of Health (and other provincial health ministries) can be seen as operating in an open system and as

being subject to a variety of stimuli which affect it and which it can affect, to varying degrees, in return.

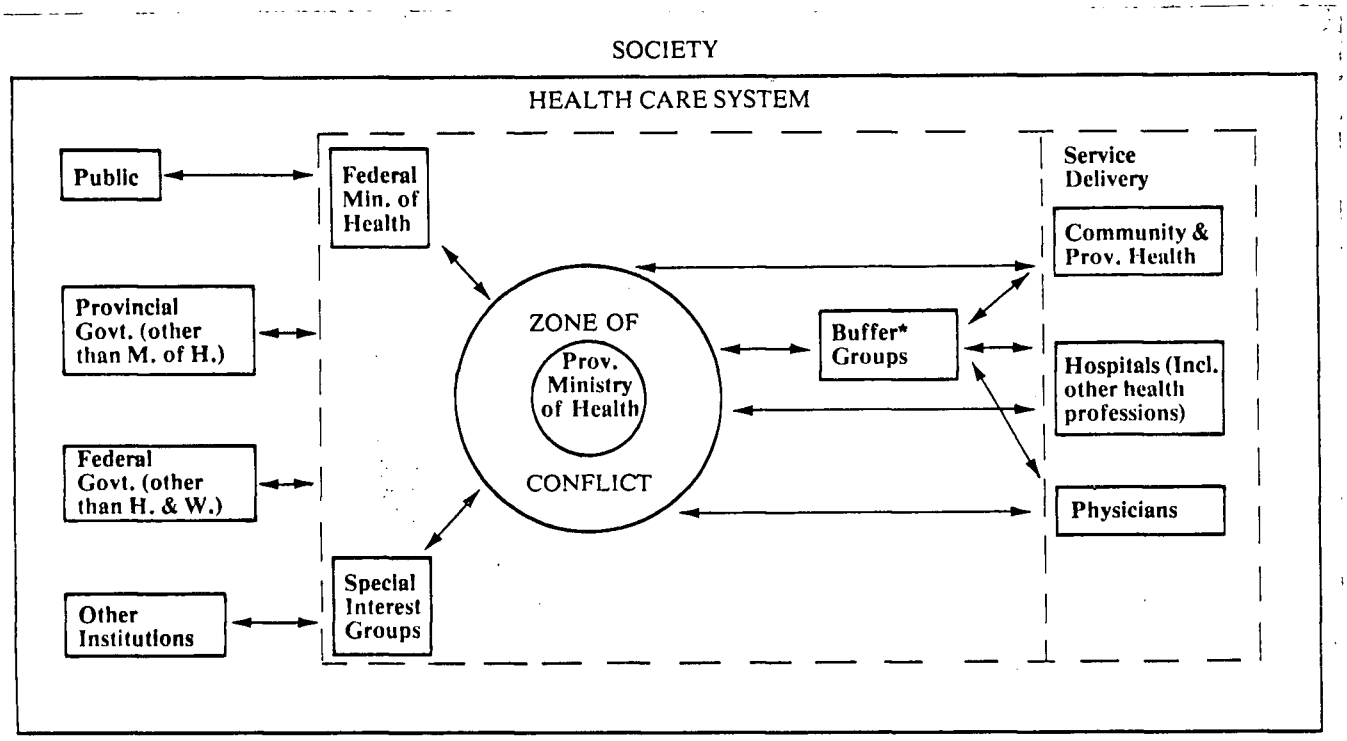
Diagram 5 represents the B.C. health care system. This diagram identifies the major orgaizations which impinge on the B.C. Ministry of Health. The arrows indicate the mutual relationship between the key actors. Diagram 6 illustrates the areas of congruence and discordance in attitudes to health policy issues by the major actors in the health care system. The chart helps to identify potential areas of conflict between actors. For example, there is a clear split between the funders and providers of service regarding provincial control over funding and professional monopoly. Similarly, areas where issues are generally felt to be motherhood issues, i.e. goals on which everyone can agree, may also be sources of conflict since operational definitions of how these goals are to be achieved may differ. For example, while everyone sees efficiency and effectiveness as desirable goals, bureaucrats and service providers may well disagree on how these terms are to be defined.

With regard to the relative power of the actors, special interest groups and community and preventive health services can be considered as being weak in relation to the Ministry of Health. This is also true of the federal Ministry of Health and Welfare as it performs an advisory function and does not directly control the disbursement of cost-shared funds.

The hospitals and physicians are powerful groups, they have the resources to engage in public relations activities and

Diagram 5

The Provincial Health Care System



*Major buffer groups in British Columbia are:

1. Regional Hospital Districts
2. B.C. Health Association
3. Health Labour Relations Association
4. United Way
5. Consultants

These and other groups act as intermediaries in contract negotiations and as disseminators of funds for service delivery and capital expenditures.

From: University of British Columbia Health Policy Study Group. Current issues in health policy making for the Government of British Columbia. Health Management Forum, Autumn 1982, 3 (3), 27-86.

Diagram 6

Attitudes of Special Interest Groups Toward Health Policy Issues, 1981

SPECIAL INTEREST GROUPS / HEALTH POLICIES	Efficiency	Effectiveness	Equality of condition*	Provincial $ control	Accountability to the Province	High technology	Standards of cure	Standards of care	Professional monopoly
Corporate Planners									
Politicians	♀	♀	♀ :.	+	+	+	+	♀	-
Top Managers	+	♀	♀	+	+	-	♀	♀	-
Health Planners	+	+	+	+	♀	+	+	+	-
Health Entrepreneurs and Workers									
Physicians and Surgeons (fee-for-service)	+	♀	♀	-	-	+	+	+	+
Hospital Service Workers	♀	♀	♀	-	♀	+	+	+	+
Hospital Trustees	♀	♀	♀	-	-	+	+	+	-
Hospital Admin. (C.E.O.'s)	+	+	♀	-	-	+	+	♀	-
Public Health Workers, (incl. Doctors)	♀	+	+	-	♀	-	♀	+	+
Consumers									
Taxpayers	+	+	+	+	+	+	+	+	-
Patients	+	+	+	-	♀	+	+	+	♀

\+ = positive attitude
\- = negative attitude
♀ = "motherhood," or neutrality
* = Two forms: minimal standards and equitable distributions
** = Attitudes vary according to party

NOTE: This chart was developed in November, 1981 and recent events have tended to make the participants harden their positions with an attendant increase in potential and actual conflict.

From: University of British Columbia Health Policy Study Group. Current issues in health policy making for the Government of British Columbia. Health Management Forum, Autumn 1982, 3 (3), 27-86.

have control over the actual service delivery function. The public is generally weak except when an issue captures its collective interest, in which case it can become very powerful.

Thus, the pressures and conflicts inherent in the health care system, and the lack of direct control, imply a strategy of negotiation for provincial Ministries of Health. It is, in fact, such negotiation which has limited, to some extent, the supply side of the health care system and which has enabled Canada to maintain health expenditures at a fairly steady proportion of GNP.

The reality of the health care system is that of turbulence and negotiation. This has important implications for planners. If in fact decisions are based on negotiation, power, implications for federal/provincial cost sharing, cost containment considerations, and other such factors, then straightforward rational planning may not be the most effective approach. In addition, if projects are to be implemented in an environment of competing interests it would seem that planners must develop skills in the negotiation process, skills quite different from those of rational, empirical analysis.

In addition to dealing with external agents, planners must also learn to deal with changes that have been taking place within the government bureaucracy. As Campbell et al. (1981) and Crichton (1984) note, there has been a shift from a political network model of organization to a corporate model with a greater concentration of power in central agencies.

These new realities require a new way of understanding the planning process and this study presents a new conceptual model for health planning. As one should understand the relationship of current theories of planning to the underlying rational model which provides the epistemological basis for these theories, so too is it necessary to understand the epistemological basis for the new model proposed in this study. The proposed model owes a considerable intellectual debt to the sociology of knowledge. A review of the sociology of knowledge approach is provided in the next chapter.

4. THE SOCIOLOGY OF KNOWLEDGE

The new conceptual framework for health planning (presented in chapter seven) owes a considerable debt to the sociology of knowledge. This is an area of sociology which takes as its subject matter the basic assumptions underlying what people take for granted as fact and the social process by which a particular way of viewing the world is developed and maintained.

In the social sciences, each theory or model contains a basic set of assumptions about the way the world is structured, the nature of man, and other such basic premises. It appears that some clusters of basic assumptions seem to have an internal consistency which allows them to predominate in theory building. Each cluster forms the underlying assumption for a particular theory of sociology, organizational behaviour or planning. Therefore, while one can understand numerous theories in any of the social sciences, the sociology of knowledge provides a vantage point from a higher level of abstraction, i.e. a meta-theoretical perspective. From this vantage point the conditions under which the explanatory power of any theory is maximized can be determined. It also allows for the analysis of the internal consistency of a theory based on its core set of assumptions.

As the sociology of knowledge allows for the identification and analysis of numerous clusters of basic assumptions which have a logical coherence, it can be seen as the

theoretical equivalent of certain multivariate statistical techniques such as cluster analysis or factor analysis. Theories based on similar sets of premises can be clustered. This allows for a better understanding of the basic conditions under which theories have explanatory power and allows for the identification of any outliers, i.e. theories which represent unique combinations of basic assumptions.

While the development of the sociology of knowledge owes a debt to many writers, particularly Marx and Weber, its full expression was first articulated by Karl Mannheim (1936) in his book Ideology and Utopia: An Introduction to the Sociology of Knowledge. Mannheim stated that the sociology of knowledge is both a theory and a historical sociological method of research. To Mannheim the understanding of the world and the method by which social phenomena should be studied had to come from an understanding of what he called social existence. An important aspect of Mannheim's conceptualization was to analyse the social determinants of knowledge. Mannheim (1936) states:

> To summarize: the approach to a problem, the level on which the problem happens to be formulated, the stage of abstraction and the stage of concreteness that one hopes to attain, are all in the same way bound up with social existence. (p. 278)

Mannheim was also aware that his approach would lead to a questioning and critique of the existing social order but he saw this as positive in that it brought about understanding at a higher level. While it can be stated that Mannheim was aware of power, he distanced himself from it by the high degree of

abstraction he brought to his analysis and by his focus on what he called the "perspective of the thinker."

In his preface to Ideology and Utopia, Louis Wirth provides a good review of the major aspects of the sociology of knowledge. This review can be summarized by stating that the sociology of knowledge:

i) Searches out the motives behind intellectual ideas and analyses how thought processes are influenced by the participation of the thinker in the life of society.

ii) Studies the styles and methods of thought and the historical contexts in which they occur.

iii) Studies how the interests and purposes of certain social groups find expression in certain theories, doctrines, and intellectual movements and the proportion of a societies' resources that are devoted to them.

iv) Studies the shifts in social relationships based on new knowledge.

v) Studies the way in which ideas are diffused and the degree of freedom of inquiry that prevails.

vi) Systematically analyses the institutional settings in which intellectual activity is carried out.

vii) Studies the bearers of intellectual activity, i.e. the intellectuals.

In general, the potential of the sociology of knowledge approach has not fulfilled its promise as a sociological theory or method of analysis. Analysts have often been bogged down in

the relativism of this approach and have therefore not been able to develop new theoretical constructions, predictive hypotheses or moral imperatives. This may in part be because of an inability to determine, and focus in on, the appropriate level of abstraction and a particular point in the grid of multiple perspectives. Some authors have been able to do this and their works have been well recognized and are often used as touchstones in a wide variety of intellectual areas. Perhaps the best example of this is Thomas S. Kuhn's (1962) book entitled The Structure of Scientific Revolutions. Kuhn popularized the concept, now widely accepted in social science, of a "paradigm." For him, paradigms were agreed upon explanatory models which defined the scope and nature of inquiry of a community of practitioners. Kuhn was clearly in the sociology of knowledge tradition in that he used a historical sociological approach to analyse the way paradigms developed, evolved and were replaced and the people and institutions involved. Kuhn was able to develop a new theoretical model of scientific development which contained in it numerous hypotheses for further research. Due to his moderate degree of abstraction, Kuhn was also more clearly able to analyse the impact of power in his analysis.

Another well known expression of the sociology of knowledge is the book The Social Construction of Reality: A Treatise in the Sociology of Knowledge by Peter L. Berger and Thomas Luckmann (1967). They applied the sociology of knowledge approach to the field of social psychology. They were interested to study how a taken-for-granted reality

"congeals" for the man in the street. Their contention was that the "sociology of knowledge is concerned with the analysis of the social construction of reality" (Berger and Luckmann, 1967, p. 3).

Berger and Luckmann also discuss the dialectical relationship between man and his society and institutions by analysing objectivation, institutionalization and legitimization. Their book is primarily about the ways people are socialized and in turn affect the society in which they live. This is illustrated when they state:

> Knowledge, in this sense, is at the heart of the fundamental dialectic of society. It 'programs' the channels in which externalization produces an objective world. It objectifies this world through language, that is, it orders it into objects to be apprehended as reality. It is internalized again as objectively valid truth in the course of socialization. Knowledge about society is thus a *realization* in the double sense of the word, in the sense of apprehending the objectivated social reality and in the sense of ongoingly producing this reality. (Berger and Luckmann, 1967, p. 66).

The power of the sociology of knowledge approach is that it provides a degree of conceptual freedom beyond that of most other theories or models. Its more abstract perspective allows the theorist to go beyond the constraints of existing theories and to see the theories themselves as the subjects of study. As noted earlier, it allows the analyst to see the forest and not just aggregations of trees.

The power of the sociology of knowledge approach for the health planner is that it allows the planner to better analyse the fundamental assumptions underlying any planning task. The

planner can then analyse the degree of congruence of the belief systems of relevant actors with the underlying assumptions of the planning task. This allows the planner to determine the degree of potential conflict or misunderstanding between actors due to their ideologies. Being able to better understand the constellation of basic assumptions underpinning the planning task also allows the planner to look for existing theoretical models congruent with the task at hand. This match of the planning problem with appropriate theoretical formulations allows the planner to tap into an already developed mode of analysis for guidance in dealing with the planning task.

Finally, the sociology of knowledge serves to broaden the analytical horizons of health planners in that it allows them to diagnose and overcome their analytical "blinders" and reveals to them that in order to act successfully as planners they require organizational and other skills in addition to their methodological and statistical skills.

As planners work in organizations they must better understand their organizational environment and its impact on their work. The next chapter provides a review of public and private organizations and presents a sociology of knowledge based analysis of organizational theories.

5. ORGANIZATIONAL THEORY

5.1. Introduction

Organizational theory is still evolving. There are numerous competing theories of organizations and organizational behaviour. Current theories have evolved from academic studies and from the "cookbook" approaches of practitioners. Thus, there is currently no universally agreed upon conceptual model in the field of organizational theory. Instead, there is a continuing movement to develop explanatory models which more accurately explain organizational life. Currently there are several new models which have been developed but each of these approaches can be criticized as only providing a partial explanation.

While there is still some discrepancy between organizational theory and organizational reality, it seems that the sociology of knowledge approach, while still quite controversial, is one which can bridge this gap and provide a theoretical basis for action. This chapter will provide an overview of the development of organizational theory, a review of the three major models currently in use, an overview of organizational theory from the sociology of knowledge perspective and a review of public sector organizations.

5.2. The Development of Organizational Theory

This section will provide a brief overview of the development of organizational theory. This is a subject that has been well documented in the literature and the reader is referred to Stoner (1978) or other basic texts for a full review of the subject.

Much of the development of organizational theory has taken place as a dialectic between what are generally referred to as classical organization theory and the human relations approach. Classical organization theory was developed by Taylor, Fayol and Weber (Stoner, 1978). The basic components of Taylor's approach were the use of efficiency techniques such as time and motion studies, the scientific selection of employees and the "one best way" approach to work design. Taylor's work has been referred to as "scientific management."

While Taylor focussed on the mechanics of production, Fayol and Weber were interested in defining the structure and function of organizations. Weber's (1964) model of bureaucracy is characterized by: a hierarchical organization, the restriction of authority to official obligations, specific spheres of competence, a contractual relationship between the employer and employee, fair hiring practices, payment by salary, systematic discipline and control of employees, and the separation of management and workers. In addition, the work of the employee constitutes a career in that there is opportunity for promotion based on merit and the job is seen as the primary occupation of the employee. Fayol developed fourteen principles of

management which are somewhat similar to the above points of Weber.

With increasing complexity and modernization, changes occurred which placed a strain on the explanatory power of classical organization theory. Perrow (1980 a) notes the increasing power of the trade union movement, increasing technological complexity, and the related specialization of skills which put a strain on classical organizational theory. He also notes that the increasing complexity of markets and changing technology brought about a requirement for more adaptive organizations.

As these changes were taking place there were other theorists like Mary Parker Follett and Chester Barnard whose theoretical approach focused more on the needs of the individual worker and on groups within organizations (Stoner, 1978). What had been a sub-theme of organization theory in the early part of the 1900's developed into a competing model of organizational theory with the work of Elton Mayo and others at the Hawthorne Plant of Western Electric (Stoner, 1978). This model has come to be called the behavioral or human relations model.

Researchers had conducted a study of the effects of lighting on work performance at the Hawthorne Plant of Western Electric Co. and found that work groups participating in the experiment which had no change in lighting, or even decreased lighting, still increased productivity. Elton Mayo and his Harvard associates conducted a further set of experiments.

They found that when workers were given special attention by management their productivity increased irrespective of working conditions. Investigating further they found that the social environment, i.e. the work groups, had a great influence on productivity. Mayo and his associates concluded that the need for recognition and social satisfaction was an important aspect of worker productivity and that norms in work groups were as strong, if not stronger, than management control policies in shaping the performance of workers. A number of theorists developed psychologically based theories of human behaviour which become important in explaining the findings of Mayo and other researchers. Argyris, McGregor and Maslow took the approach of defining the worker as a "self actualizing man" (Stoner, 1978). Maslow's work is best known in this regard. Maslow (1968) states that man works his way through five layers of need arranged in a hierarchical manner from physiological needs through needs for safety, love, esteem and self-acutalization. Man focusses on needs primarily related to the level within the hierarchy of need which he is at. This meant that workers would focus on different needs depending on where they were in the hierarchy.

While classical organization theory and the behavioral model have been, and still are, important components of the analysis of organizational reality, a number of new approaches have also been emerging. By the mid 1970's the beginnings had been laid for three other approaches to organizational analysis, these are: the systems/quantitative approach, the

contingency approach, and the power/organizational politics approach.

5.3. Current Models of Organization Theory

5.3.1. Systems/Quantitative Theory

The introduction of computer techniques after World War II gave impetus to looking at organizations from a system's perspective. The systems model sees organizations as unified, purposeful, and balanced entities composed of interrelated parts called sub-systems. Organizations are generally conceived of as "open systems," that is, systems which interact with their environment. Systems have inputs (such as natural or human resources), outputs (goods and/or services) and, feedback mechanism.

In general, systems theory has presented a very rational and empirical approach to understanding organizations. However, the systems approach has been criticized for its use of mechanistic and organic analogies (Burrell & Morgan, 1979) which have restricted the potential explanatory power of this approach. These analogies contain assumptions such as linearity, system maintenance, and the coherence of system parts. These assumptions limit the power of systems theory to explain socio-political systems which are constantly in flux and in which individuals try to maximize their advantage. In order to go beyond the limiting assumptions of current systems theory thinking, some writers have rejected the restrictions of mechanistic and organic analogies and have started to explore

other ways of thinking within the "systems" framework. One such attempt is that of Checkland (undated). Checkland has developed a systematic developmental learning approach to systems which he calls soft systems theory and he contrasts this with more traditional rational systems analysis. He states:

> To soft systems methodologists, however, it is not taken as given that the world contains systems. The world is taken to be highly complex and ultimately mysterious; but the approach to trying to understand it, it is assumed, can be systemic, using intellectual constructions of a systems kind . . . to compare with reality in order to gain insights as part of a cyclic learning process which in itself is systemic: it is a process which learns . . . .
>
> The two paradigms of a systems approach are complementary to each other, but the newer paradigm is likely to be the more useful in any problem situation dominated by meanings which actors in the situation attribute to what they observe. Health service systems can usefully be *characterized* by the older paradigm, in order to describe them in a consistent and complete way. But *problem solving* within them, as in other ill-structured problem situations, is likely to require the systematic learning cycle of the newer approach. (Checkland, pp. 5-6)

A similar approach has been taken by Geyer and van der Zouwen (1978) in their book Sociocybernetics. The articles in their book cover a great deal of ground including the application of systems theory to social change and the application of catastrophe theory to a reconceptualization of the Marxist dialectic. Geyer and van der Zouwen state that this "new cybernetics" has a set of common themes. In discussing this new cybernetics they note that it recognizes the subjective nature of knowledge and recognizes science as being an observer dependent activity. In addition, they state that

the new cybernetics can bridge the gap in social science analysis between the macro or societal focus and the micro or individual based focus. Finally, they discuss the need to re-analyse taken-for-granted concepts about stability, temporality, independence, structure and other basic concepts.

While the systems method has often been touted as a theory of organizations and while some systems theorists are pushing the frontiers of this approach, no overall systems model has been developed which can explain the complexity of organizational life. Other theorists have noted that different approaches to leadership, motivation, organizational design and other such aspects of organizational life seem to be effective in different circumstances. These observations have led to what is called the contingency model of organizational analysis.

5.3.2. Contingency Theory

There is a considerable body of literature on contingency theory. Luthans and Stewart (1977 & 1978) have attempted to develop a General Contingency Theory of Management. This represents the most abstract level of contingency theory and also represents a "synthesis" approach to contingency theory in which all contingent variables are placed into a unitary framework. Miller (1981) has approached contingency theory from the perspective of developing taxonomies of "organizational gestalts." This could be called the "taxonomic" approach.

While much of contingency theory is realted to analysing the impact of technology and environment, some writers have looked at differences in organizational actors to explain differing organizational realities. This could be called the "individual differences" approach. Spector (1982) analysed the impact of the locus of control of organizational participants. He found that the locus of control is related to motivation, effort, performance, satisfaction, perception of the job, compliance with authority and supervisory style. Miller et al. (1982) found that the locus of control of executives was significantly related to corporate strategy and that there was an indirect relationship to environment and structure.

Mitchell (1982) looked at worker motivation from a contingency perspective. While rudimentary, Mitchell tried to develop a fourth model of looking at contingency theory, that of a flow diagram or "decision matrix" approach (the first three were synthesis, the taxonomic, and the individual difference approaches). A more developed model of motivation based on the "decision matrix" approach is presented by Sussmann and Vecchio (1982) who look at the impact of social influences on worker motivation.

The contingency theory approach has proven to be very popular among organizational theorists. It has been used by writers trying to explain organizational behaviour from the "human relations" perspective (Dewar & Werbel, 1979; Herold, 1978; McGill, 1977; Nemiroff & Ford Jr., 1976; Porras & Berg, 1978; Umstat et al., 1978). It has also been used by theorists

writing about leadership (Barrow, 1977; Bryson & Kelley, 1978; Sashkin, 1976; Stewart, 1982), organizational structure (Bell, 1967; Mintzberg, 1979; Tushman & Nadler, 1978), power (Farrell & Peterson, 1982; Hawley & Nicholes, 1982; Hofstede, 1978; Twomey, 1978), and strategic decision making (Beach & Mitchell, 1978; Bryson & Delbecq, 1979; Nutt, 1976).

Chakravarthy (1982) presents a contingency framework based on a complex variable, that of adaptation. This is an important departure from the more rigidly defined parameters of most other studies. In fact what Chakravarthy is implicitly stating is that the independent variables governing contingent choices cannot be defined by a limited set of variables but constitute complex human processes. A similar type of approach is used by Ginter and White (1982) when they use the social learning approach in developing a contingency model for strategic management. Another related approach is the use of gaming/simulation in decision making (Duke, 1982).

These last three examples of contingency theory indicate the natural evolution of this approach. At first universal approaches are disgarded, then mid-range theories or variables are used to develop situational parameters leading to a synthesis, a taxonomy or a decision matrix which acts as a guide in choosing the most congruent response to one's location in the contextual matrix. These approaches are either too limited in their explanatory power or too abstract to provide specific guidance. Therefore, the logical step is to move to a more complex way of defining the context using complex

variables such as adaptation, social learning or gaming. The problem with using these complex variables is that they have limited predictive value and can not be operationalized in a simple and useful way.

5.3.3. Theories of Power and Organizational Politics

Since the late 1970's there seems to have been an increasing interest in the study of power and organizational politics within the field of organizational theory. Studies in this area have focussed on the type and nature of organizational power, the decision making process involved in becoming a political actor, theories and paradigms of power and organizational politics, and other such matters.

One of the formative works in the theory of power in organizations was the article by French and Raven (1972) called "The Bases of Social Power," first published in 1959. In their article French and Raven recognize the inter-related nature of power and the fact that there are many possible bases of power. They focus on five bases of power: reward power, coercive power, legitimate power, referent power and expert power.

Other writers have tried to expand French and Raven's original formulation, for example, Cobb (1980) looked at perceived sources of power among work unit peers. Tushman and Nadler (1980) attempted to expand French and Raven's bases of power by adding:

i) control over resources critical to the organization,

ii) absence of routinization, as routinization provides less opportunity to exert power beyond that prescribed to maintain routine functioning,

iii) access to powerful others,

iv) assessed stature and visibility, a manager's ability to negotiate and get his way depends on his assessed stature with significant others,

v) exchange, a manager can have a positive balance of organizational credits over debits which he can call on if needed, and

vi) group support of the manager by his subordinates.

While most organizational actors have an intuitive understanding of power or organizational politics, there does not appear to be a generally accepted definition of power. Some writers have tried to define organizational politics in terms of organizational sub-units competing for scarce resources (Nord, 1977; Tushman, 1977) while others have relegated organizational politics to aspects of power that are outside of the normative organizational process. An example of such a definition is given by Mayes and Allen (1977) when they state:

> Organizational politics is the management of influence to obtain ends not sanctioned by the organization or to obtain sanctioned ends through non-sanctioned influence means. (p. 675)

Pfeffer (1981 b) in his book Power in Organizations, perhaps the most comprehensive analysis of power and conflict in organizations to date, provides a critique of the above definition. He points out that what is or is not sanctioned in organizations is a result of the exercise of power in the

organization. Therefore, power holders by definition do not engage in political activity (as their activity is sanctioned) while those out of power and wishing to obtain it, would inevitably engage in political activity (as their activity would not be sanctioned). Pfeffer also points out that the above definition "gives the concept of organizational politics a sense of sinfulness" (Pfeffer, 1981 b, p. 8). Pfeffer attributes this attitude to a type of schizophrenia in the organizational literature in that it is all right to use the concept of power in analysing government and politics but it is considered to be illegitimate or pejorative as an analytical concept for understanding organizations. Pfeffer (1981 b) offers his own definition of organizational politics when he states:

> Organizational politics involves those activities taken within organizations to acquire, develop, and use power and other resources to obtain one's preferred outcomes in a situation in which there is uncertainty or dissensus about choices. (p. 7)

While some writers complain about the dehumanizing aspects of power in organizations (D'Aprix, 1976; Nord, 1978) others are willing to accept organizational politics and to work to develop strategies and tactics for the exercise of power (Dubrin, 1978; Korda, 1975; Machiavelli, 1947).

An excellent book on organizational politics is The Invisible War: Pursuing Self-Interests at Work by Samuel Culbert and John McDonough (1980). They discuss various strategies for political behaviour in organizations which highlight the importance of subjectivity and shared meanings. They note that the subjective attributions of meaning by organizational players are very important in the tactics of organizational politics.

Another important contribution of Culbert and McDonough is their concept of "alignment" as a way to reconcile personal and organizational goals within an organizational context. They state:

> Each time people enter a new work situation they engage in the implicit process of *aligning* personal values, interests and skills with what they perceive to be the task requirements of their job. They seek an orientation that maximizes self-pursuits and organizational contribution. *Alignment* is our term for the orientation that results from such an effort . . . . We say an individual possesses an 'effective' alignment when the orientation directing that person's actions and view of reality allows him or her to represent important self-interests while making a contribution to the organization. (Culbert & McDonough, 1980, pp. 60-61)

Pfeffer (1981 a&b) mirrors these same points in his discussion of language, symbolic action, and the creation of meaning.

There are a number of points regarding the organizational politics model which have particular importance for health planners. Shifting coalitions, access to information, interdependence and the role of subjective meaning all clearly point to the importance for the planner of organizational networks. Planners are dependent on their manager patrons and must work to keep their positions in light of other staff departments with similar skill sets. Also, it is important for planners to develop a good alignment if they are to succeed.

Systems theory, contingency theory and theories of power all have their strengths and weaknesses. Each is based on a particular set of underlying assumptions and is bounded by these assumptions. The next section looks at the application of the sociology of knowledge perspective to organizational theory.

5.4. The Application of the Sociology of Knowledge to Organizational Theory

5.4.1. Introduction

One of the early attempts at using the sociology of knowledge perspective to analyse organizational behaviour and decision making was Graham Allison's analysis of the decision making process during the Cuban missile crisis (Allison, 1969). In his review, Allison analysed the Cuban missile crisis from three different perspectives and articulated the underlying assumptions of each perspective. The three perspectives were the Rational Policy Model, the Organizational Process Model and the Bureaucratic Politics Model.

In the late 1970's and early 1980's an increasing number of articles were published which challenged the existing rational model of organizations. It was noted at that time that organizational theory was starting to go through a paradigm shift away from the rational model. Writers started to write about subjectivity in organizations (Eden et al., 1981), ideologies and their impact on various aspects of organizational behaviour (Brusson, 1982; Dunbar et al., 1982; Salaman, 1980; Starbuck, 1982; Watson, 1982), the role of phenomenology in organizational research (Sanders, 1982) and the symbolic management of meaning by organizational leaders (Pfeffer, 1981 a&b; Smirchin & Morgan, 1982). By 1982 the concept of paradigm shift was articulated in the popular literature by Peters and Waterman Jr. (1982) in their book <u>In Search of Excellence: Lessons from America's Best-Run Companies</u>.

Perhaps the most comprehensive attempt at using the sociology of knowledge approach to understanding organizational reality is the book Sociological Paradigms and Organizational Analysis by Gibson Burrell and Gareth Morgan published in 1979. They present a grid composed of four different paradigms. By codifying the four competing paradigms Burrell and Morgan help to clarify the debate around the issue of a paradigm shift. Their analysis also raises the possibility of a synthesis of these perspectives into a more highly abstracted meta-paradigm of organizational theory. The next section will provide a summary of the work of Burrell and Morgan (1979).

5.4.2. Burrell and Morgan

Burrell and Morgan describe two basic dimensions which intersect to provide four distinct paradigms. These dimensions are a subjective-objective dimension and a regulation-radical change dimension.

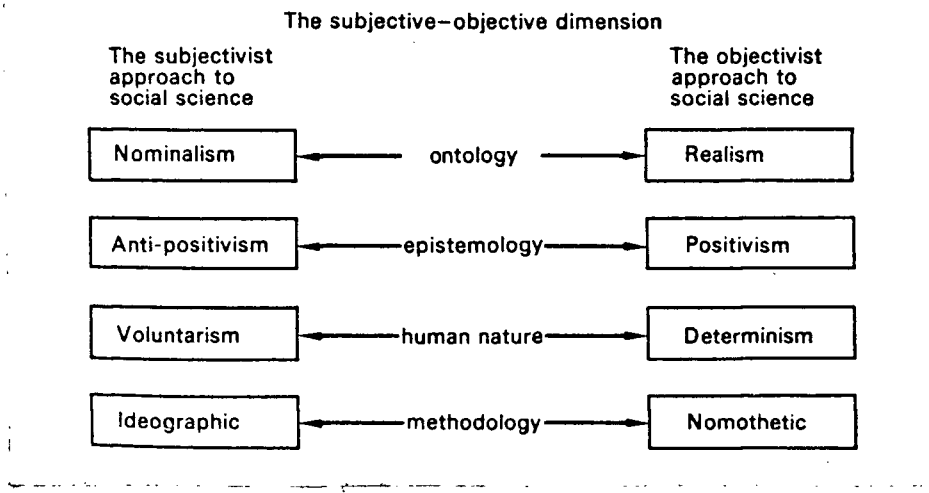
There are four sets of assumptions each of which constitutes a continuum along an overriding subjective-objective dimension. This is illustrated in Diagram 7. The regulation-radical change dimension is an articulation of the various forms of the "order-conflict" debate which has been an ongoing aspect of sociological theory from the time of Marx. The regulation-radical change dimension is illustrated in Table 1.

Burrell and Morgan have attempted to fit all of the major streams of sociological theory and organizational theory into their basic framework. This framework is presented in Diagram

Diagram 7

Burrell and Morgan's

The Nature of Social Science



From: Burrell, G. and Morgan, G. Sociological paradigms and organizational analysis: elements of the sociology of corporate life. London: Heinemann, 1979.

Table 1

Burrell and Morgan's

Regulation-Radical Change Dimension

The regulation—radical change dimension

The sociology of REGULATION is concerned with:	*The sociology of RADICAL CHANGE is concerned with:*
(a) The status quo	(a) Radical change
(b) Social order	(b) Structural conflict
(c) Consensus*	(c) Modes of domination
(d) Social integration and cohesion	(d) Contradiction
(e) Solidarity	(e) Emancipation
(f) Need satisfaction†	(f) Deprivation
(g) Actuality	(g) Potentiality

Notes

* By 'consensus' we mean voluntary and 'spontaneous' agreement of opinion.

† The term 'need satisfaction' is used to refer to the focus upon satisfaction of individual or system 'needs'. The sociology of regulation tends to presume that various social characteristics can be explained in relation to these needs. It presumes that it is possible to identify and satisfy human needs within the context of existing social systems, and that society reflects these needs. The concept of 'deprivation', on the other hand, is rooted in the notion that the social 'system' prevents human fulfilment; indeed that 'deprivation' is created as the result of the *status quo*. The social 'system' is not seen as satisfying needs but as eroding the possibilities for human fulfilment. It is rooted in the notion that society has resulted in deprivation rather than in gain.

From: Burrell, G. and Morgan, G. Sociological paradigms and organizational analysis: elements of the sociology of corporate life. London: Heinemann, 1979.

8 and their application of this model to organizational theory is presented in Diagram 9.

The functionalist paradigm is the one in which most organizational and sociological theory has been developed. Sociologically the functionalist paradigm has been strongly influenced by positivism. Functionalists have had an ongoing debate with theorists from the other paradigms. This has led to an integration of some of the theoretical concepts from the other paradigms into the functionalist paradigm. The influences of Marxism and German Idealism, for example, have been articulated within the overall functionalist theory. Coser (1956) has written on the functions of social conflict while the tradition of German Idealism has been subsumed under theoretical developments in Interactionism and Social Action Theory.

In general, it can be stated that functionalism assumes a regulated order and is objectivist in its point of view.

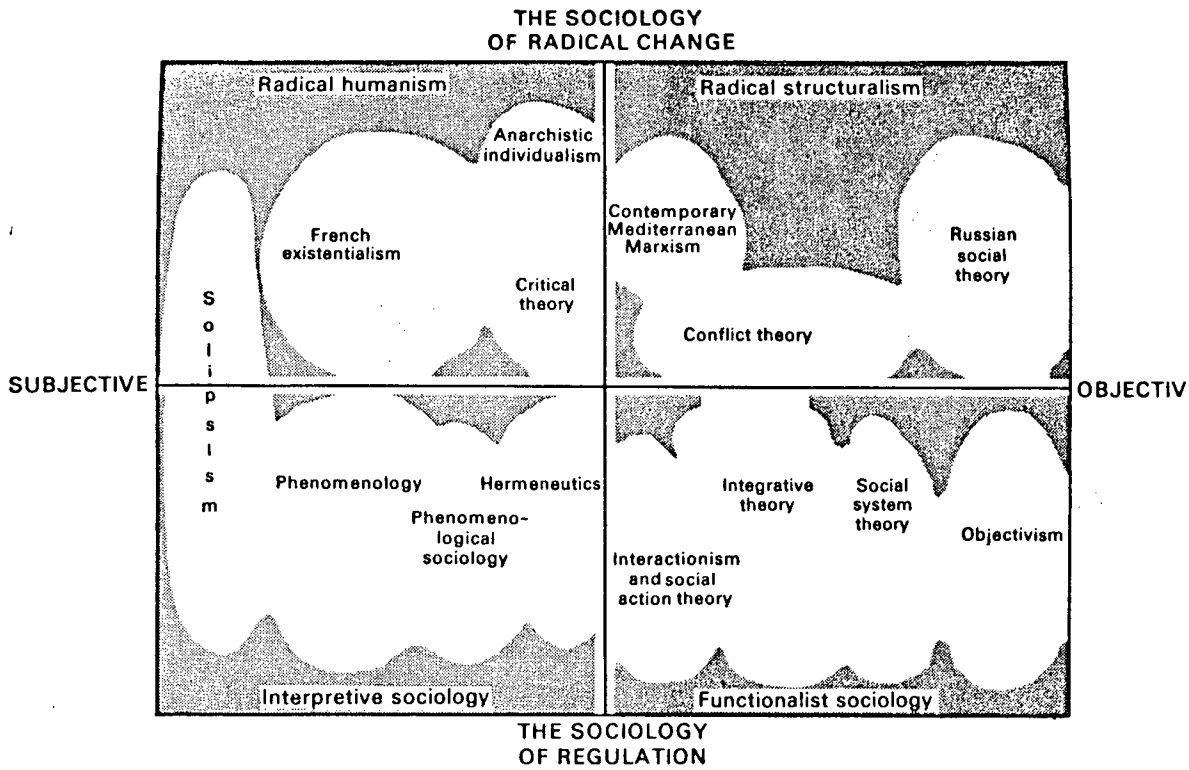
> It is characterised by concern for providing explanations of *the status quo*, *social order*, *consensus*, *social integration*, *solidarity*, *need satisfaction* and *actuality*. It approaches these general sociological concerns from a standpoint which tends to be *realist*, *positivist*, *determinist* and *nomothetic*. (Burrell & Morgan, 1979, p. 26).

As in sociological theory, organizational theory in the functionalist paradigm also contains an ongoing debate. Burrell and Morgan (1979) state that the dominant perspective within the paradigm is that of social systems theory and objectivism. They see contingency theory as the most recent major trend in the functionalist paradigm and one which tries to reconcile its scientific and human relations perspectives.

Diagram 8

Burrell and Morgan's

Four Sociological Paradigms

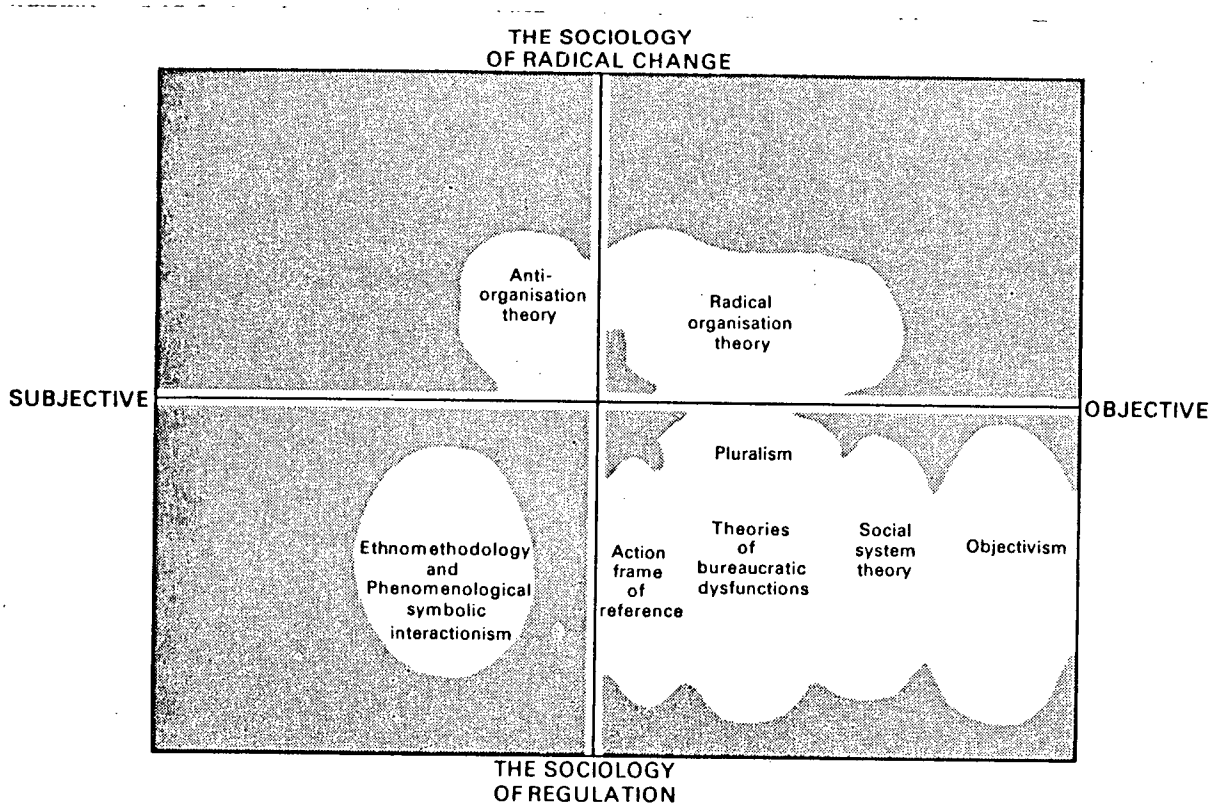


From: Burrell, G. and Morgan, G. Sociological paradigms and organizational analysis: elements of the sociology of corporate life. London: Heinemann, 1979.

Diagram 9

Burrell and Morgan's

Main Schools of Organizational Analysis



From: Burrell, G. and Morgan, G. Sociological paradigms and organizational analysis: elements of the sociology of corporate life. London: Heinemann, 1979.

The Interpretive Paradigm derives from the German idealist tradition of social thought. In explaining the sociological aspects of this paradigm Burrell and Morgan (1979) state:

> The interpretive paradigm is informed by a concern to understand the world as it is, to understand the fundamental nature of the social world at the level of subjective experience. It seeks explanations within the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of the action.
>
> In its approach to social science it tends to be *nominalist*, *anti-positivist*, *voluntarist* and *ideographic*. It sees the social world as an emergent social process which is created by the individuals concerned. Social reality . . . is regarded as being little more than a network of assumptions and inter-subjectively shared meanings. (pp. 30-31)

With regard to organizational theory, the interpretive paradigm questions whether organizations exist in anything but a conceptual sense. In contrast to the functionalists who take organizations as given in their analysis, ethnomethodologists and phenomenologists take the organization as the subject of study. They also state that organizations are social creations based on shared definitions of reality.

The Radical Humanist Paradigm tries to develop a theory of radical change from a subjective perspective. It is concerned with overthrowing or transcending the limits of the existing social order.

> One of the most basic notions underlying the whole of this paradigm is that the consciousness of man is dominated by the ideological superstructures with which he interacts, and that these drive a cognitive wedge between himself and his true consciousness. This wedge is the wedge of 'alienation' or 'false-consciousness,' which inhibits or prevents true human fulfillment. The

> major concern for theorists approaching the human predicament in these terms is with *release* from the constraints which existing social arrangements place upon human development . . . .
>
> In terms of the elements with which we have sought to conceptualise the sociology of radical change, the radical humanist places most emphasis upon *radical change*, *modes of domination*, *emancipation*, *deprivation* and *potentiality*. The concepts of *structural conflict* and *contradiction* do not figure prominently within this perspective, since they are characteristic of more objectivist views of the social world, such as those presented within the context of the radical structuralist paradigm. (Burrell & Morgan, 1979, p. 32)

With regard to organizational theory there has been little work in this paradigm. Burrell and Morgan state that the result of the development of this paradigm would be the development of an anti-organization theory.

The Radical Structuralist Paradigm focuses on radical change and power relationships from an objectivist perspective.

> Radical structuralism is committed to *radical change*, *emancipation* and *potentiality*, in an analsis which emphasizes *structural conflict*, *modes of domination*, *contradiction* and *deprivation*. It approaches these general concerns from a standpoint which tends to be *realist*, *positivist*, *determinist* and *nomothetic*.
>
> Whereas the radical humanists forge their perspective by focusing upon 'consciousness' as the basis for a radical critique of society, the radical structuralists concentrate upon structural relationships within a realist social world . . . . Common to all theorists is the view that contemporary society is characterised by fundamental conflicts which generate radical change through political and economic crises. It is through such conflict and change that the emancipation of men from the social structures in which they live is seen as coming about. (Burrell & Morgan, 1979, p. 34)

Burrell and Morgan also note the development of "conflict theory" as an outgrowth of the exploration of the interface

between Marx and Weber and its counterpart in organization theory, particularly the the developing school of radical Weberians. They note that the notions of totality, structure, contradiction and crisis provide the underpinnings of the emerging radical structuralist paradigm which, like the radical humanist paradigm, was developed initially as a critique of functionalism.

5.4.3. Discussion

With regard to the four paradigms identified by Burrell and Morgan, each has its strengths and weaknesses. The benefit of the Functionalist Paradigm appears to be its focus on a systematic and "scientific" approach to thinking and a focus on observable and objective reality. Its weakness has been to be too simplistic, to use inappropriate analogies and to fail to understand the impact of the interaction of the actor on his environment. The benefit of the Interpretive Paradigm has been to explain the impact of the actor in creating his environment. It also points out the relative nature of reality. This has been a strength and a weakness as relativity can lead to paralysis of action. Another weakness is the tendency to solipsism or complete relativism. The Radical Humanist Paradigm shares this shortcoming. In addition, Burrell and Morgan characterise this paradigm as an anti-organization theory in which individuals fight to free their spirit. It seems that Burrell and Morgan have inadequately detailed the important aspects of this paradigm. The role of the ideology of the organization

and its leaders is a very important one. Leaders' ideologies shape not only the goals, structure, and function of the organization but also its culture and the inter-relationship of its participants. Therefore, understanding ideologies is critical for health planners as ideology shapes what can be done and how things can be done in organizations. For example, there appeared to be a shift in focus when Peter Bazowski was brought into the British Columbia Ministry of Health as deputy minister. The Ministry's agenda shifted from a liberal focus on health care to a conservative focus on cost containment and efficiency.

The Radical Structuralist Paradigm has been receiving ever increasing study. The strength of this paradigm is its identification of organizational politics. The negative aspects are that there may be too great an emphasis on conflict, one which goes beyond existing requirements. Another shortcoming is the attempt to generalize to Marxist principles of class warfare.

It is possible to think of Burrell and Morgan's two dimensions as being continuous rather than dichotomous and, therefore, as constituting a conceptual space into which existing theories can be placed. The extreme boundaries of this space, i.e. the external boundaries in Diagrams 8 and 9, form the bounds of the conceptual map. The analyst can move freely within the map and need not be restricted by its internal boundaries. Therefore, one can analyse a situation to identify the underlying cluster of basic premises which exist. The theories which best explain that particular reality can then be

used to better analyse the given problem or situation. Another important point to note is that Burrell and Morgan seem to shift their focus of analysis from the observer in the objective side of their paradigm to the organizational actor in the subjective side. This is similar to the macro-micro problem of social science analysis in which some people look at a system from a macro, societal, or top-down perspective while others use the micro, individual or bottom-up perspective. This is an important point for health planners as they should develop the ability to be both a participant and an observer with regard to their organizational environment. As observers they can analyse their situation and develop strategies to deal with it, then as participants they can carry out the strategically correct action required to accomplish goals.

Using the sociology of knowledge perspective, organizations can be defined as:

> Socio-political systems of human interaction bounded by mutually agreed upon, but shifting, social constructions of reality based on diverse power relationships.

Health planners work in public organizations. These organizations are believed to be more prone to conflict and subjective constructions of reality than private organizations. Therefore, the next section will provide an overview of public sector organizations.

5.5. Public Organizations

There appear to be some major differences between public and private organizations. In particular, these differences are manifested in three major areas: the influence of powerful external actors, the restraints imposed on managers in their ability to deal with subordinates, and the measurability of the product produced. These issues plus the structure of governmental organizations and the boundary issues for planners working in government will be discussed in this section. All of these factors have an impact on the health planner in terms of the strategies and tactics which the planner can use to complete a planning project.

5.5.1. Differences Between Public and Private Organizations

A private company can make its own decisions as long as it can satisfy its shareholders. Public organizations are subject to influences from numerous external agents who may have differing perceptions about the role of the public organization and the degree to which it is meeting its goals. Newman and Wallander III (1978) note that a characteristic of public organizations is that resource contributors may intrude on the internal management of the operation.

If, as Kotter (1980 b) notes, the degree of uncertainty in management engendered by dependence on others is related to politicization, then it is clear that public sector management will be more political than private sector management. Another

impact of the power of external agents is that of creating goal ambiguity within organizations. This in turn limits management's ability to plan on a rational basis, to set clear goals and to delegate to subordinates as decision making is guided not by a clear goal statement but by a process of accommodation and negotiation.

Another important constraint on public sector management is the reward incentive structure, or more correctly, the lack of an incentive structure. Spicer (1982) points out that public managers can not keep any cost savings generated by good management and that the rewards which accrue to bureaucrats are either unrelated, or only indirectly related, to the quality of their management. Therefore, the public sector manager has fewer controls over his employees and his ability to reward or punish is no longer related to actual performance.

Unlike the private sector where a specific product is produced which can be analysed for its acceptance in the marketplace, the product in the public sector is often such that it can not be readily defined or operationalized.

Spicer (1982) notes that the consequences for the National Health Service in Britain of a lack of measurable and meaningful output measures is that efficiency measurements are based either on inputs or on the subjective judgment of experts such as doctors. The impact on government managers of a lack of measurable outputs is that they become more likely to manage for effect than for results. Thus impression management, or the ability to create realities that are acceptable to the many

powerful actors who can have an influence on government managers, becomes an important part of the skill set of the government manager.

It can be seen from the discussion in this section that, if anything, the social and political aspects of organizational life are heightened in public sector organizations. This is of particular relevance to health planners as it clearly points out that reliance on a purely rational methodology would have a low probability of success unless a number of conditions were met which would produce a congruence of goals among all actors.

5.5.2. The Changing Structure of Governmental Organizations

In addition to the constraints noted in the previous section, there has been an ongoing evolution of governmental structures which has increased the control of central agencies and which has led to a more complex organizational environment for the health planner. Some of these changes were noted previously in the section on the British Columbia Ministry of Health.

In general there has been a shift from the traditional "Westminster Model" of government in which there was a modest sized cabinet and each Minister had considerable autonomy for his own area of responsibility. Ministers were accountable to Parliament and had full authority over their Ministries. Cabinet decisions were made in meetings of the full Cabinet with the Prime Minister or Premier presiding over the discussion.

Since the 1970's there has been a shift at both the federal and provincial levels to move to what has been called a corporate model of management. At the federal level this change has been documented by Van Loon (1981 & 1983). Leger (1983) has documented the changes in the government of New Brunswick while Campbell et al. (1981) and Crichton (1984) have documented the changes in British Columbia.

The common features of this new model of government are the development of senior cabinet committees for major areas such as social and health services, economic development, planning and priorities, and Treasury Board. These Cabinet Committees generally review all major policy decisions for the set of Ministries represented on their particular committees. This means that there has been a reduction in the authority of Ministers as they must now move their proposals through a Cabinet Committee which will discuss the respective Minister's proposal and make recommendations to the full Cabinet or an Executive Cabinet of Senior Ministers.

In addition to these changes at the Ministerial level there has been an increase in the power of central agencies such as the staff of Treasury Boards, personnel services divisions, and Comptroler Generals. Central agencies now have the authority to control and audit the financial and personnel resources of each Ministry. For a detailed review of these new governmental arrangements the reader is referred to Van Loon (1981 & 1983) and Leger (1983).

Crichton (1984) summarizes this new bureaucratic reality when she states:

> The setting of objectives and the allocation of resources for meeting these objectives has been coordinated and rationalized. No longer can the Ministry of Health determine its own activities. These are dovetailed into the total government thrust by Treasury and Public Service Boards. Within governments there has been a major restructuring and shifting of power as the new mechanisms have been tried out. Cabinet Committees now set priorities, Treasury Board scrutinizes estimates, Public Service Board calculates staffing allowances, special service groups such as systems corporations and building corporations provide support . . . . (p. 20)

This shift to a corporate model may mean that planners themselves will begin to function in a central agency framework. Line services will require planning services to rationalize resource allocation and there may be an ongoing tension between centralized planning and planning at the program level.

These internal changes have implications for planners in that their plans can no longer be as readily implemented as previously. Plans must now be made in accordance with the overall policies of numerous central agencies. The planner must then learn to work with, negotiate with, cajole, and by other means deal with central agency staff in order to implement his plans. Thus, both internally and externally the planner lives in an environment based on negotiation.

5.5.3. Boundary Issues

The previous section has noted the emergence of central agencies in government. This has changed the nature of the boundaries for government planners. These internal changes have been matched by changes external to government with, at

least in British Columbia, the emergence of groups representing care providers and the increased militancy of professional associations and unions. Thus, unlike the 1970's when planners only needed to consider senior officials in their Ministry and some external groups, the environment has become much more complex for the health planner in government.

Miles (1980 a) describes an environment characterized by a high degree of movement or change and a high degree of interconnectedness as a turbulent field. Turbulent fields create a great deal of uncertainty and require complex management skills and the development of appropriate networks ("multilateral agreements"). They are also likely to increase the probability of differentiation in organizational structure. These complex organizational environments require senior personnel to take on integrator roles and the development of cross-functional teams or matrix management to achieve the coordination required for high degrees of differentiation.

Health planners have two levels of externalities that they must consider. The previous section outlined the emergent power of central agencies and the Cabinet Committee structure of government. These expand the within-government boundaries of the planner. Planners can no longer simply consider the impact of their recommendations on their own Ministry. Implications for other Ministries must be considered as plans or proposals may be taken to committees of Ministers or Deputy Ministers for review and any implications for other Ministries must be thought out and documented. Similarly, any projects

with financial or personnel considerations will have to be reviewed by central agencies such as the staff of Treasury or a governmental personnel agency.

With regard to the outside-government boundaries, consideration must be given to various interest groups and buffer groups such as those noted in Diagram 5 on page 29. In order for health planners to be successful they must understand the complexity of their new environment and the types of responses required to work effectively within such a turbulent environment. For some, a successful approach is to work closely with very senior officials and be seen as their assistants. This insulates the planner from having to deal directly with external agents as this is handled by the senior official. Another response might be to develop appropriate networks in order to determine what the response to new plans may be and to build constituencies to support the work of the planner. Whatever the response, planners must understand the complexity of their environment.

The next chapter reviews current planning theory.

6. PLANNING THEORY

6.1. Definition of Planning

While there are numerous definitions of planning (Davidoff & Reiner, 1973; Dror, 1973; Faludi, 1973; Hudson, 1979; Reinke, 1972; Taylor, 1972) there does not appear to be one which is universally agreed upon. In order to get around this problem and to recognize the diversity of planning activities, some writers define planning as being what planners do (Dror, 1973; Faludi, 1973). Nevertheless, a review of existing definitions indicates several common features. Planning uses rational thought and special knowledge and this thought is generally directed toward future action. Planning is also a process which uses systematic and scientific procedures. Planning is involved with the rational allocation of scarce resources and with allocating these resources in a way that maximizes the public good. Planning also has to do with setting goals, establishing needs and ordering priorities.

6.2. The Role of the Planner

It has been noted that there is no universally accepted definition of planning and that planning can be thought of as being what persons called planners do. Planning as such can be conceived of as part of the analytical component of management and as part of the development process to the extent that

planners are involved in program implementation. This is particularly true in the area of health planning.

With the increasing growth and complexity of health services there has been an ever greater differentiation in the analytical component of management. This has led to the emergence of a series of new professions to assist health administrators with the analytical and developmental components of their tasks. Persons who can potentially assist administrators with such tasks are researchers, systems analysts, evaluators, financial analysts and policy analysts. Each of these disciplines define themselves as having fairly large areas of responsibility. Their self-definitions show considerable overlap both theoretically and empirically. Therefore, if planning is what planners do, health planning in governments in Canada is the outcome of a process of organizational competition among a series of newly emerging professions each trying to maximize its sphere of responsibility.

The issue of the boundaries of these merging professions is starting to be addressed in the literature. For example, Alterman and MacRae Jr. (1983) address the overlap of planning with policy analysis in their article "Planning and Policy Analysis: Converging or Diverging Trends?" They compare planning and policy analysis along eight dimensions. They note a considerable overlap in planning and policy analysis functions. It is interesting to note that where there are areas of divergence between planners and policy analysts they seem to focus on the aspects of planning which are more radical or

community based. These differences are most pronounced in the areas of roles, ethics and the definition of the client. Policy analysts are defined as being primarily staff advisors to government who do not have a particular social philosophy or an allegiance to particular values. Planners, or at least a sub-set of planners, are seen as advocates and community organizers with a philosophy and commitment to social welfare values and the public good.

Health planners in governments in Canada may hold a variety of philosophical positions but their positions structurally are quite similar to policy analysts in that their formal client is the senior bureaucrat or administrator within a government ministry. Therefore, there may be a considerable overlap in the functions of government planners and policy analysts. This is certainly true in the British Columbia Ministry of Health where researchers, planners and policy analysts all work in the same department.

The outcome of an organizational process which defines which tasks are appropriate for planners is such that planners may be asked to take on a number of different roles and to engage in a wide variety of activities. Gunton (1984) defines eight different roles for planners. He states that planners can be seen as technocrats, public servants, referees, advocates, bureaucrats, stage agents, social learners and social reformers. Health planners in government can be asked to take on any of these roles except that of radical social reformers. However, they may have to deal with external social reformers

and should, for that reason, understand the social reformer role as well. The reader is referred to Gunton (1984) for a detailed review of each of these roles. Thus, planners can be seen as having their roles defined through an ongoing and changing bureaucratic process which serves up a variety of planning tasks which require a variety of skill sets.

6.3. Planning: An Overview of the Dominant Rational Model

It should be noted that current planning theory seems even more deeply wedded to the functionalist paradigm than organizational theory. This may be because of its initial development in the field of urban planning which was originally dominated by engineers and architects. Over time there was an introduction of the behavioral sciences into the planning field. There have also been some attempts to develop different planning paradigms. In general, it appears that the development of planning theory is where organizational theory was in the late 1960's and early 1970's. As part of the search for an acceptable paradigm to compete with the "rational" (functionalist) model, the Task Force on the Future of the Planning Profession (1982) stated that theorists should begin to work on a model of planning which is based on current practice. This is another version of the "planning is what planners do" definition of planning. It also indicates the realization by planners that their current theories have little explanatory power for the practitioner. This section will provide a brief overview of planning as it is currently documented in the

planning literature, i.e. the rational functionalist perspective of planning. This rational model of planning will be compared in chapter 8 to the model developed in this study to determine which approach has greater explanatory power.

6.3.1. The Purpose of Planning

Davidoff and Reiner (1973) have defined three purposes for planning. Their first purpose of planning is to allocate scarce resources in an efficient and rational manner. Planning would not be required if there was an infinite abundance of resources. The second reason is as a market aid or replacement. They state that planning would be of little use if a fully open and competitive market existed. They note that some people see planning as a market aid to move society closer to a competitive market system, while others see planning as a replacement for a market system. They note that planning either as a market aid or a replacement requires the collection, analysis and publication of information in order to make reasoned decisions. The third purpose of planning is to change or widen the choices about the existing allocation of resources. Davidoff and Reiner (1973) note that in modern society citizens delegate decision making. It is incumbent on those who have been so delegated to publicize the range of choice of future conditions, goals and means. They note that planners should clarify the implications of the existing status quo and the implications of alternative choices.

With regard to health planning by planners in federal and provincial governments, the purpose of a planning system would be to: ensure public accountability for the expenditure of resources, provide a greater integration of services, improve managerial decision making by presenting and analysing options, involve significant groups in the decision making process, analyse the need for health services, assist managers to obtain needed resources in competition with other branches of government, increase the efficiency and effectiveness of resource allocation, and help managers to set priorities.

6.3.2. The Planning Process

Most descriptions of the planning process are fairly straightforward and rational. An example of this is Taylor's (1972) description of the planning process. He outlines eight stages in planning.

i) Planning the Planning and Developing Planning Competence: This stage is the stage in which the context of the planning project is determined.

ii) Statements of Policy and Broad Goals: Planners work to define goals and mobilize public opinion although officially policies and goals are politically determined.

iii) Data Gathering: Planners collect and analyse data for decision making. They also determine which data is most relevant for an issue. In health planning there is a reliance on demographic, epidemiological, economic and service utilization data.

iv) Priority Statement of Health Problems: In order to analyse alternatives and assist in setting priorities, planners must develop skills in a variety of fields. Taylor notes that the setting of priorities is seen by most health administrators to be at the heart of the planning process.

v) Plan Outline With Statement of Major Alternative Proposals: Having defined priorities and gathered data, the next step is to develop a clear statement of alternative approaches. Points to note include a definition of the technical aspects, the organizational framework, the personnel and facilities needed, and the comparative costs and benefits of the alternatives.

vi) Development of a Detailed Plan With Targets and Standards: Once the alternative(s) of choice is selected the next step is to develop a detailed plan document which sets out targets and standards for performance. Standards and targets can be improved and refined by ongoing monitoring and adjustment.

vii) Implementation as Part of the Planning Process: As planning is a dynamic activity, implementation must be included in the planning process. Developing complex plans and leaving it to line managers or field units to implement has generally not been successful. The first step in implementation is to get the plan accepted. The probability of acceptance is greater if the people

affected such as health personnel, politicians and consumers participate in the planning process.

vii) Evaluation: At one time planning, implementation and evaluation were seen as separate steps but Taylor states that the modern view is that it is all one cyclical process with evaluation leading to the initiation of a new planning cycle. Taylor notes two types of evaluation; continuing evaluation and monitoring for administrative purposes, and a more focused evaluation specifically for revising the existing plan.

A very detailed description of the initial phases of planning is provided by Nutt (1982) in his article "Hybrid Planning Methods." He focusses on planning techniques and develops a series of tree diagrams showing which sets of techniques should be used in each stage of the planning process given different planning contexts. The reader is referred to Nutt (1982) for a summary of the technical methods used in the planning process.

6.4. The Current Critique of Planning Theory

The previous section outlined the rational functionalist model of planning. This section will review the level of the current critique of the rational model.

As noted earlier, planning theory seems to be in a position similar to that of organization theory in the late 1960's and early 1970's. For example, in the 1984 winter edition of the Journal of the American Planning Association,

Ernest Alexander published an article entitled "After Rationality What? A Review of Responses to Paradigm Breakdown." He cites Kuhn and states that planners formulated the paradigm of rational planning to guide the planning field but that there has been growing evidence of paradigm breakdown. He notes the contribution of Simon in developing the concept of "satisficing" (choosing the first acceptable alternative) and the critique of Lindblom (1959) and its focus on successive limited comparisons. Alexander (1984) notes four types of responses to paradigm breakdown: ritual, avoidance, abandonment, and search. He goes on to point the direction for planning towards a focus on a meta-theoretical framework which leads to contingent decision making about operational aspects of planning. This is, in fact, the type of planning model presented in chapter 7.

Kiernan (1982) criticizes the apolitical rational model from the perspective of ideology and power relations. He calls for a political epistemology of planning and develops an approach of positive discrimination to aid the disadvantaged. John Forester (1982) focuses on the organizational and political context of the planner and calls for a critical theory of organizational action.

Thomas Hall (1972) takes a somewhat less strident approach to analysing the political aspects of planning in his article "The Political Aspects of Health Planning." He notes that there is general agreement that a planner's political ability is a primary determinant of success as a planner.

There have also been attempts to place planning theory in a more sociological framework. For example, Joe Bailey (1975) in his book Social Theory for Planning published in 1975 looks at various sociological theories such as functionalism, conflict theory and interpretive sociology and applies them to planning. This is an approach similar to that of Burrell and Morgan and is in the tradition of the sociology of knowledge.

Other streams in the theoretical literature are the tying of theory to practice. As noted earlier, the Task Force on the Future of the Planning Profession (1982) discusses rational and process models of planning and calls for a practice-based theory.

A more sophisticated approach to planning theory has been evident in the organizational literature with regard to decision making and strategy formulation. As noted in the previous chapter, some writers apply complex concepts to theory formulation. In the strategic management literature this has been done by Ginter and White (1982), and Chakravarthy (1982). It is interesting to note that there seems to be little cross-referencing between the planning literature and the strategy formulation and decision making literature in organizational theory.

6.5. Substantive Planning

It has been noted that it is important to understand the context from which a planning task emerges. Areas of planning such as health planning, urban planning and others all have

their own unique contexts and constellations of important actors. Therefore, it is important to delineate the substantive nature of health planning in order to better understand its critical elements.

There are a number of sub-areas within the general field of health planning. These areas range from planning problems that may be fairly objective and which have little potential for conflict such as financial and facilities planning to areas which may be more controversial such as the planning of service delivery systems or manpower planning. While the following overview does not encompass every type of planning possible in the health field it does summarize the major recognized approaches.

i) Health Manpower Planning: Baker (1972) summarizes the aspects of this type of planning in his article "Health Manpower Planning." The purpose of this type of planning is to ensure that the health system has enough health workers to meet the needs of the health system. This is particularly important when estimates of demand and supply are produced. Supply is based on losses and increases of health workers. Losses can be from death, retirement or migration while increases are based on the availability of applicants, educational plant capacity, availability of education funds and the availability of teachers.

ii) Facilities Planning: Bonnet and Ruderman (1972) in their article "Physical Facilities" outline the components of facilities planning. Facilities planners must develop an

appropriate way to classify facilities and this must be done in relation to the health care service delivery system. Bonnet and Ruderman (1972) offer one such categorization scheme but point out that no single accepted categorization scheme exists. They also point out that in addition to the development of facilities to meet demand, facilities planning also includes analysing levels of care and other factors.

With regard to facilities planning, the following factors must be considered: size of facilities, size of population, geographic distribution of the population, up-to-date analysis of facilities and services, needs and demands (Bonnet and Ruderman refer to this as time trends), facility design, and financing. Unless special interest groups are involved in some aspect of facility development, facilities planning is one of the more objective forms of health planning.

iii) Service or Program Planning: This type of planning refers to the planning of the services delivered by the health care system. Analysis of the demand for service focuses on age, sex, the geographic distribution of the population and other such factors. More importantly, however, service delivery planning focuses on ways to improve the efficiency and effectiveness of existing methods of service delivery. This is done by developing and analysing operational indicators of management effectiveness and by evaluating the effectiveness of existing interventions. As the amount, type, distribution and cost of health services are of interest to a variety of groups, service delivery planning can be a very contentious area. For

example, it is not uncommon for two adjacent small communities to compete vigorously for the placement of a new hospital or clinic in their community.

iv) Financial Planning: This refers to approaches to the reimbursement of health providers as well as the usual aspects of revenues and expenditures. Much of the money disbursed to health providers is done on a grant or fee-for-service basis. Financial planning refers to the development or improvement in methods of reimbursement, revenue generation and other such matters. Hospitals, which in British Columbia can keep surpluses, also need to plan their investment. Unless funds are reduced or redistributed, financial planning is generally not very controversial.

v) Other Types of Health Planning: In addition to the above substantive areas, it should be noted that the planning literature speaks of strategic and comprehensive plans which are plans that generally have a wide scope and are for 10 years or longer. The literature also notes operational plans which are shorter in duration (generally not more than 3 years) and more focused in their application. Another major type of planning is called advocacy planning. Davidoff (1973) outlines the major aspects of advocacy planning. In brief, he states that planners should be advocates of the public good. This can be done by working for special interest groups or by general advocacy without a specific sponsor. Davidoff also calls for the end of independent planning commissions and states that

planning should be carried out at the executive or legislative level.

Finally, Friedman (1973) discusses two other types of planning, adaptive planning and developmental planning. Adaptive planning refers to planning in which the decision making process is heavily influenced by external actors while developmental planning refers to planning in which the planners have a fair degree of autonomy in setting goals and in the choice of the means to attain these goals.

6.6. Application of the Sociology of Knowledge Perspective to Planning Theory

Section 6.4. reviewed the current critique of the dominant rational planning model. Many writers noted the need for a paradigm shift and their discussion centered on a critique of the existing rational model. While the current critique does reflect an approach based on some understanding of the sociology of knowledge, there has been little development of and overall frame of reference by which it is possible to better understand the relative position of theories of planning in a broader context. Perhaps the closest thing to a conceptual framework for planning comes from the related field of organizational decision making in the work done by Allison (1969). His Rational Policy Model is a straight rational functionalist model. The Organizational Process Model is similar to Lindblom's (1959) successive limited comparisons or disjointed incrementalism which assumes a pluralist structure of

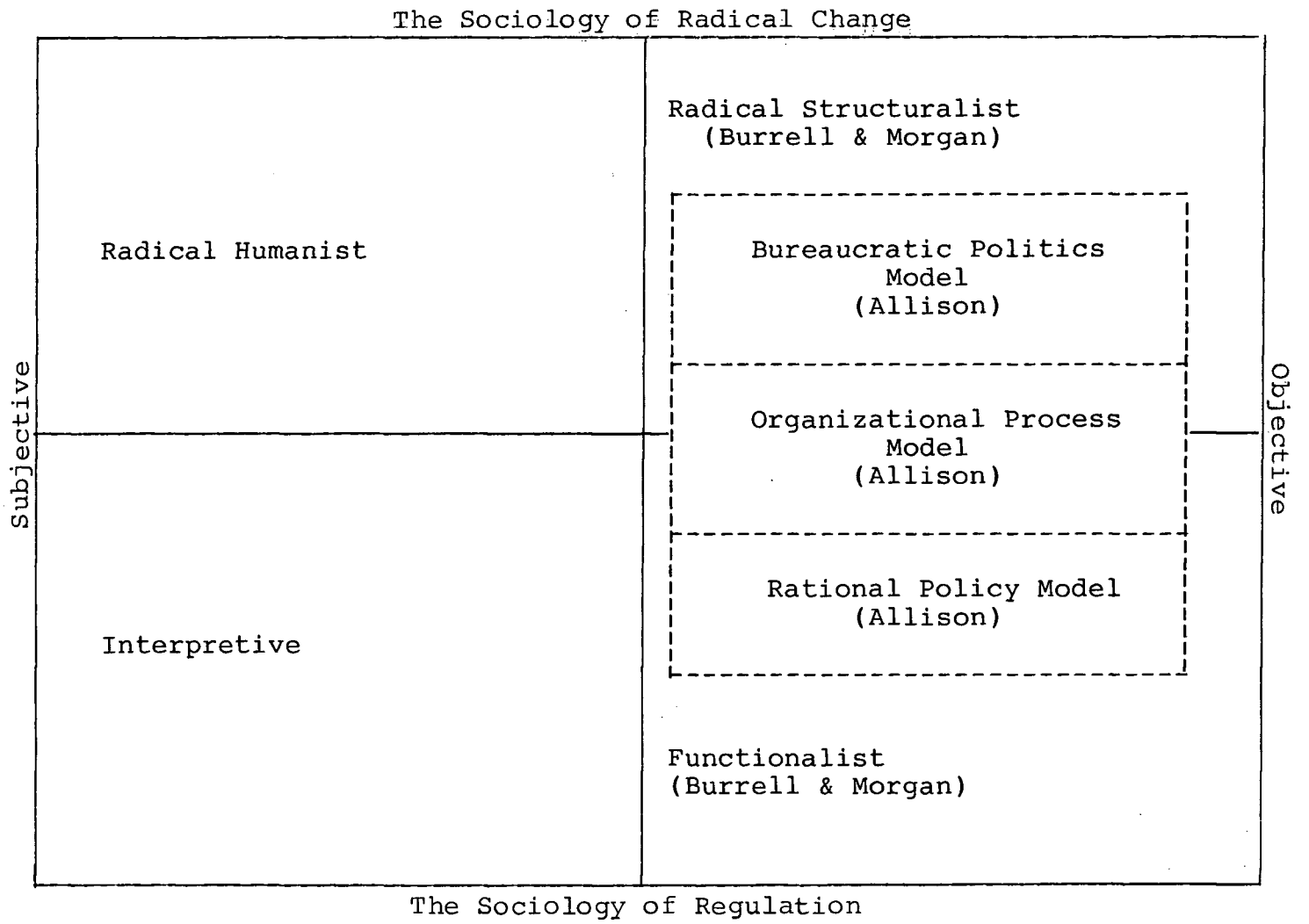
competing organizational sub-units. The Bureaucratic Politics Model is similar to the oranizational politics approach discussed in the previous chapter.

Allison's models all appear to be fairly objective in nature. If one compares Allison's three models to the four paradigms of Burrell and Morgan it appears that while Burrell and Morgan have dichotomized the regulation-radical change dimension to produce the Functionalist and Radical Structuralist Paradigms, Allison has trichotomized this dimension to produce his three models. The relationship of Allison's conceptual framework and that of Burrell and Morgan (1979) is presented in Diagram 10.

The nature of planning in organizations is such that it appears to fall primarily into the objective side of Burrell and Morgan's framework. While Allison (1969) discusses the decision making process, he is really also discussing the organizational context in which decisions are made. The three models presented by Allison are robust ideal type models of organizational contexts in which decision making or planning can take place. It is hypothesized that the two primary dimensions which shape various models of organizational contexts for planning are the degree of ideological conflict or congruence around an issue and the degree of politicization of the issue or project. Each planning project will have a unique context based on the interplay of these two variables. This framework of planning contexts is presented in Diagram 11. The degree of ideological conflict, is trichotomized into low, medium and

Diagram 10

The Relation of Allison's Model to Burrell and Morgan's Model

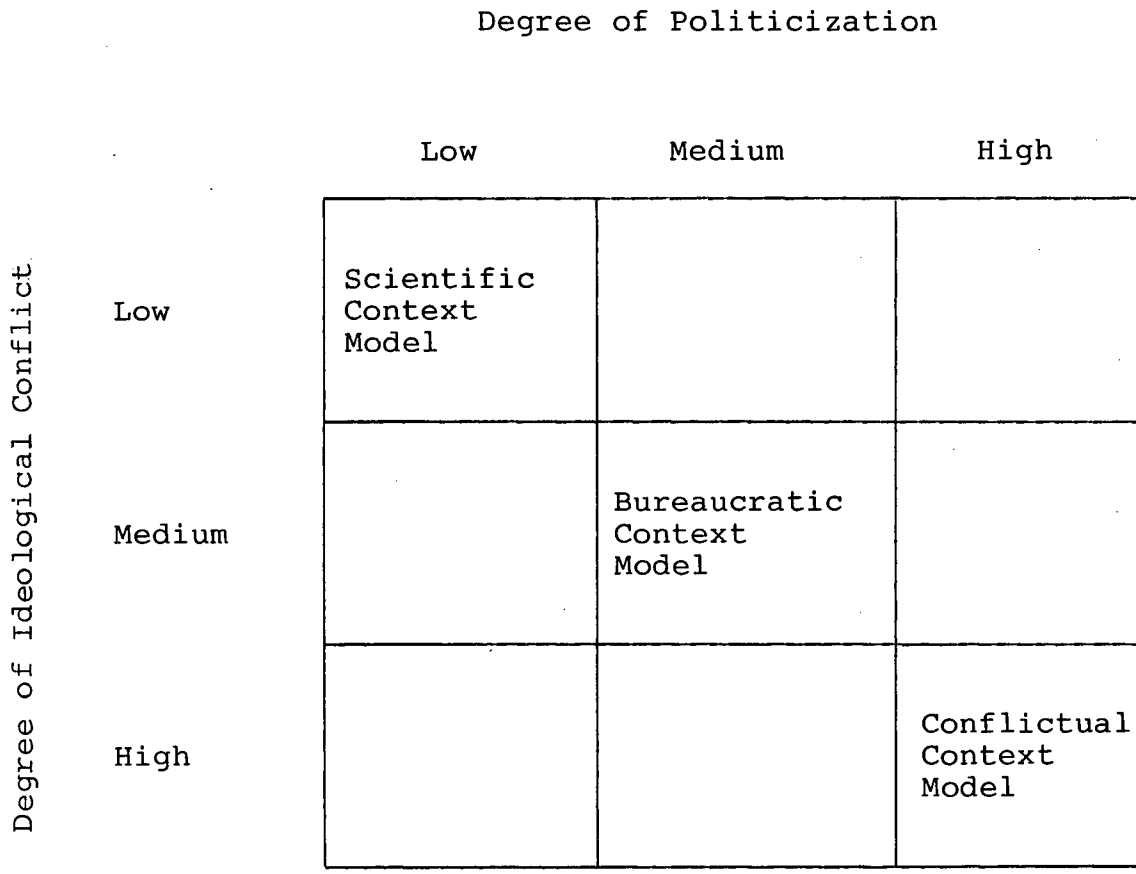


high ideological conflict. Similarly, the degree of politicization of a planning project is also divided into a low, medium, and high degree of politicization. In this model the three most congruent contexts are similar to the models for decision making used by Allison and, therefore, Allison's typology represents a sub-set of the model presented in Diagram 11. The Scientific Context Model is similar to Allison's Rational Policy Model. There is little ideological difference among key actors and the issue is seen as being non-political. In this context planners can use a rational and scientific approach to their planning project. The Bureaucratic Context Model is similar to Allison's Organizational Process Model. In this model there is moderate ideological conflict and politicization. In this context planners take a more bureaucratic approach and work for change at the margins, negotiate and broker differences, and engage in the "disjointed incrementation" described by Lindblom (1959). The Conflictual Context Model is similar to Allison's Bureaucratic Politics Model. Planners should seek to avoid involvement in projects in this type of organizational context or be prepared for a very rough ride as there is little likelihood of any ultimate agreement by organizational actors.

While less common, it is possible to have planning projects in organizational contexts represented by the blank boxes. For example, planning could occur in a context where there is little ideological conflict but a high degree of politicization. This happens when two or more factions,

Diagram 11

Planning Contexts



operating under a shared set of values, compete for dominance. This is the context of electing a new leader for a political party or a sports contest with two competing teams. Similarly, planners may have a project which is not politicized but in which the actors have a high degree of ideological conflict. This is a case where people agree to disagree.

As noted in the section on the sociology of knowledge, any overriding framework such as that of Burrell and Morgan, or the one presented above, to define different planning contexts should be able to assist the analyst in better understanding the dynamics and limitations of existing theoretical models. In order to look at the relationship of the planning context model to current theories of planning, the three contexts are looked at in relation to amalgamations of planning theories which have been published in the literature to determine the degree to which current theories fit into the three major contexts. This discussion is summarized in Table 2.

Friedman and Hudson (1974) have delineated four intellectual traditions in planning, Philosophical Synthesis, Rationalism (including Systems Theory), Organizational Development and Empiricism (including Natural Planning and Urban Planning). Rationalism and Empiricism would fall into the Scientific Context Model while Organizational Development would fall into the Bureaucratic Context Model. As the Philosophical Synthesis Model grew out of efforts to deal with large scale social conflict, it falls into the Conflictual Context Model.

Table 2

Planning Typologies and Planning Contexts

Planning Typologies	Planning Contexts		
	Scientific Context Model	Bureaucratic Context Model	Conflictual Context Model
Friedman & Hudson	- Rationalism - Empiricism	-Organizational Development	-Philosophical Synthesis
Hudson	-Synoptic Planning	-Incremental Planning -Transactive Planning -Advocacy Planning	-Advocacy Planning -Radical Planning
Rothman	-Social Planning	-Locality Development	-Social Action
Corey	-Nondirected Internal Advocate Planning -Directed Internal Advocate Planning	-Directed Internal Advocate Planning -Nondirected External Advocate Planning -Educational Advocate Planning	-Directed External Advocate Planning -Educational Advocate Planning -Indigenous Liberation Advocate Planning
Allison	-Rational Policy Model	-Organizational Process Model	-Bureaucratic Politics Model

Hudson (1979) has outlined five types of planning with the acronym SITAR standing for Synoptic, Incremental, Transactive, Advocacy and Radical Planning. Synoptic Planning is essentially the same as Rational Planning and fits into the Scientific Context Model.

Both the Incremental and Transactive Models would be related to the Bureaucratic Context Model. Advocacy and Radical Models of planning would be primarily in the Conflictual Context Model as both are related to a demand for redistribution of scarce resources whether it be money, housing, or legal justice.

Three community organization practice models identified by Rothman (1970) can also be analysed with regard to the model presented in Diagram 11. Rothman (1970) suggests that the Social Planning Model is most likely to appeal to welfare councils and government bureaucracies, the Locality Development Model to neighbourhood or overseas community development agencies and the Social Action Model to welfare rights and 'cause' groups.

Some theoretical work has also been done in the area of advocacy planning. A comprehensive typology of advocacy planning is presented by Corey (1976). He states.

1. Nondirected-Internal Advocate Planning: This advocacy type finds the professional planner working within an establishment or elite institution and attempting to plan in support of a perceived constituency or so as to promote his own ideology. This is a form of planning for people . . . .

2. Directed-Internal Advocate Planning: The professional planner operates from within an institutional base and plans on behalf of organized

interests that are autonomous and outside the institution.

3. Nondirected-External Advocate Planning: Under this form of advocacy the professional plans from an organizational base that is non-elitist; this is a clientless type of advocacy where the planner promotes his own personal ideology . . . .

4. Directed External Advocate Planning: This type of advocacy has the professional planner providing technical planning in the service of a client . . . .

5. Educational Advocate Planning: The primary function of this form of advocacy is to teach; particularly this has meant the instruction of non-elites on the procedures of planning, such that they might be in a better position to counter plans not of their making . . . .

6. Indigenous-Liberation Advocate Planning: This type of advocacy is largely theoretical to date. Simply, it is residents planning and advocating for themselves and their community . . . . (p. 268)

The next chapter will outline a new conceptual base for strategic action in planning which builds on the framework developed in this chapter.

7. A CONCEPTUAL MODEL FOR STRATEGIC ACTION IN HEALTH PLANNING

7.1. Introduction

Previous chapters have outlined the current state of organizational theory and planning theory and have described the health care system in Canada. In this chapter a conceptual base or model is described for health planning. This model can be used as the basis for strategic action in health planning. Several health examples are provided to show the application of this model to health planning.

7.2. A Conceptual Base for Strategic Health Planning

Previous discussion has pointed out the complexity of organizational reality. Organizations were defined on page 63 as:

> Socio-political systems of human interaction bounded by mutually agreed upon, but shifting, social constructions of reality based on diverse power relationships.

Organizations form the environment of the health planner in government. In order for planners to be effective they must be able to meet three conditions. They must be able to understand their environment (the particular organizational "gestalt" (Miller, 1981) of which they are a part), they must be able to determine appropriate strategy for action and they must have the ability to act effectively.

7.2.1. Understanding the Environment of the Planning Task

While Burrell and Morgan have chosen to dichotomize their two continua to provide four paradigms, it is possible to use their schematic as a bounded conceptual space which allows for an infinite variety of conceptual frameworks for understanding organizations. Diagrams 8 and 9 on pages 57 and 58 show the placement of various sociological and organizational theories in the conceptual space as defined by Burrell and Morgan (1979). Each theory represents what its originators consider to be the best explanatory model of reality based on the originators' beliefs about the philosophical bases of reality as they perceived them. The power of the sociology of knowledge approach is that it allows for a conceptual leap to a higher level of abstraction. Thus, instead of being bounded by one set of beliefs about the world and a few theoretical constructions which are appropriate to that particular set of beliefs, it is possible to think of multiple models or theories based on differing constellations of beliefs about the nature of society.

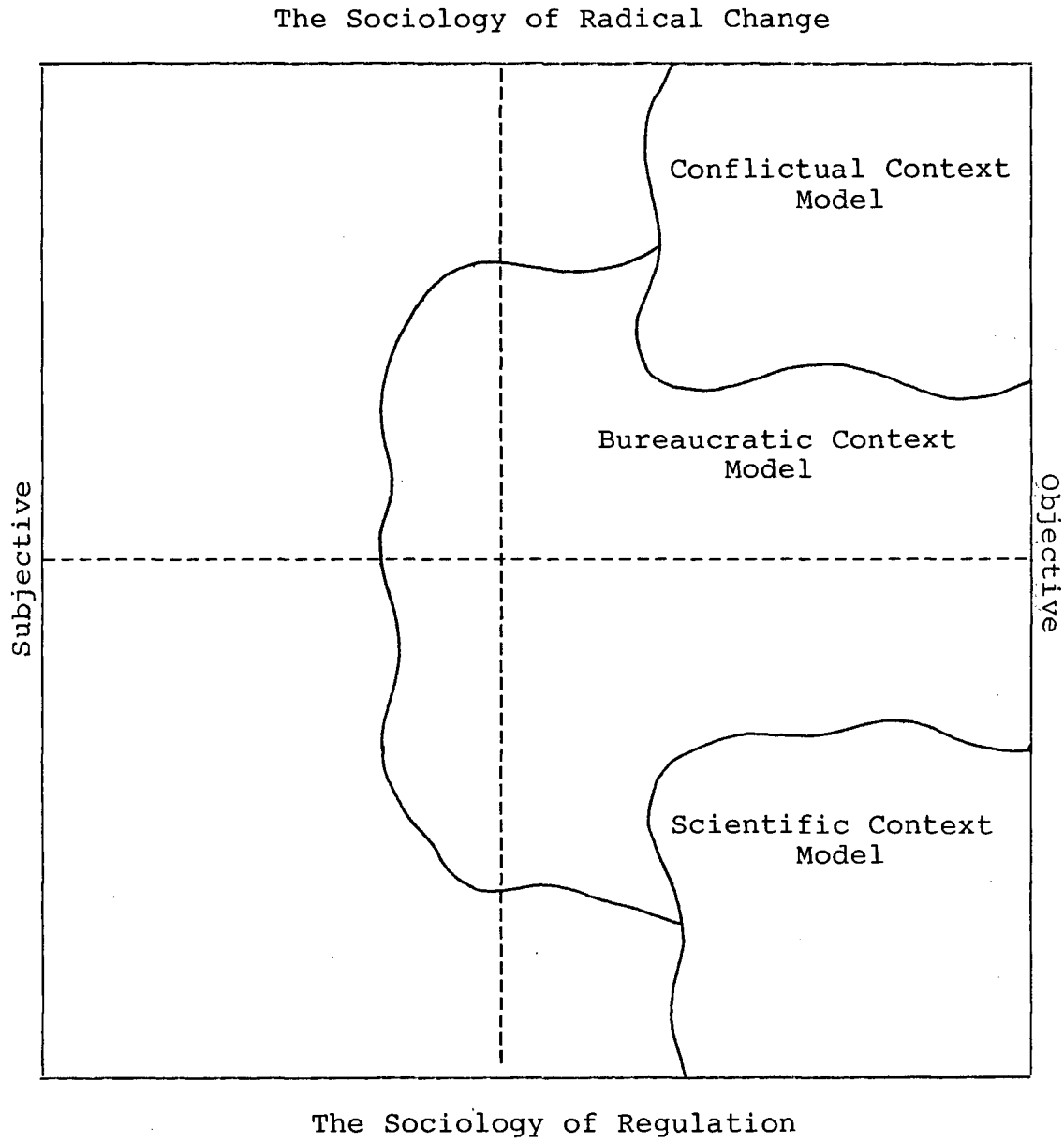
Diagram 12 presents the inter-relationship of Burrell and Morgan's analytical framework with the three major types of planning contexts noted in chapter 6. This diagram can be used as a blueprint on which to overlay the specific boundaries of any planning task.

As can be seen in Diagram 12, the far left portion is empty space. It is unlikely that highly subjective Solipsism will emerge as a theoretical model of relevance to planners.

Diagram 12

The Integration of Planning Contexts Into

Burrell and Morgan's Paradigm



Similarly, planners seldom work in realities congruent with French Existentialism, Phenomenology, or Anarchistic Individualism. While it may be possible to have planning realities or contexts which fit into the uncharted parts of Burrell and Morgan's paradigm, such contexts will need to be identified by other investigators. These same areas were left empty by Burrell and Morgan in their conceptualization of organizational theory as can be seen in Diagram 9.

In Diagram 12 the Scientific Context Model occupies the bottom right or highly objective part of Burrell and Morgan's paradigm. The Conflictual Context Model occupies the upper right hand side. The Bureaucratic Context Model is the one in which planners do most of their work. This context spills over into the more subjective areas of Burrell and Morgan's paradigm as there is often a greater scope for planners to engage in changes in, or definitions of, reality in relation to a particular planning project. While the three models are "ideal types," appropriate study and definition will allow a planner to map out the unique organizational context for each planning project. For example, it may be that a particular context has elements of all three models. That is, there is some scientific work to be done that is agreed upon, some aspects of the project require brokering and some aspect may require conflict resolution.

A final point to note is that definitions of reality may "shift." This is a very important point. Planners must constantly be alert to a shift in context and must adjust their strategies to account for the shift.

While Diagram 12 represents an overall framework for defining planning contexts and shows the space used in this framework by the three ideal types of planning contexts discussed in chapter 6, each planning task has its own unique context. While it is not possible to definitively determine the context of any planning task, the following five analytical steps can greatly assist planners to approximate the actual context:

i) Define the Boundaries: Determine which actors (persons or groups) have an interest in the issue.

ii) Determine Ideological Congruence: Determine the degree of ideological congruence among key actors in relation to the program to be planned.

iii) Determine the Degree of Politicization: For each actor determine the degree to which he will be neutral, will act to support the project or will oppose the project, and the degree of his political strength.

iv) Determine the Degree of Subjectivity Involved: Determine whether a concrete response is required or whether a symbolic response will suffice.

v) Determine the Feasibility of the Project: Determine if the project is feasible.

By following these steps the planner can derive an approximation of the particular "gestalt" or environmental context in which he is placed.

The advantage of a meta-theoretical perspective, such as the one noted above, is that it allows the planner to define,

to the best of his ability, a different reality for each planning project. The definition of reality will only be approximate but it will provide an estimate of the boundaries of that reality, the belief systems in it, the actors in it, and some of its internal dynamics. Having defined the conceptual boundaries of the planning task, the planner should use this knowledge to develop strategies appropriate to his task. Strategy development is discussed in the following section.

7.2.2. Developing Strategy

Using the approach outlined in the above section, planners can determine the best strategy to achieve their goals. By defining the conceptual boundaries, it is possible to determine the shape of the reality of the planning project and where it fits into Burrell and Morgan's conceptual space. By knowing where the reality is located planners can determine which existing theories or approaches are most congruent with the hypothesized reality of the particular planning project they are facing. For example, if a planning project is such that there is general agreement that it is congruent with a strong and widely held ideology, that there is a low degree of politicization and that in all ways the task at hand is simply one of doing standard technical analysis (the Scientific Context Model) then the use of systems theory or other highly objective approaches would be appropriate.

A completely different environment or reality would be defined for a highly political planning project such as a

project to decrease the number of billing numbers of physicians and to allocate existing numbers on a more equitable basis throughout a province (the Conflictual Context Model). In this reality there is ideological conflict with government following a cost constraint and service equity ideology versus the free enterprise philosophy of physicians. These ideological differences are readily transferred into a high level of political confrontation. Planners faced with such a task should move to models of conflict theory and radical organization theory for guidance in this type of situation.

A third example might be the type of planning which takes place on the margin and in which planners may be able to shape or redefine reality (the Bureaucratic Context Model). This type of planning environment or reality would be in the central part of the Burrell and Morgan paradigm and could most appropriately be handled using action theory or some aspects of phenomenology and symbolic interactionism. An example might be the development of a new method of accountability for service providers. In this case there is some ideological divergence between the independence of funded health agencies and the need for public accountability of such agencies. These agencies may have a moderate degree of will to take political action against the project. In this example what is required is for the planner to assist in negotiating common ground between government and the affected agencies. In such an example, the planner may wish to introduce new analogies into the discussion to shift that discussion to a frame of reference compatible to

both sides. For example, funded non-profit or for-profit agencies may insist on their right to manage their affairs independently like other businessmen, while government wants public accountability. Shifting to a conceptual framework in which funded agencies are seen as independently franchised businesses which have the ability to run their own business within a certain framework that ensures standard quality and financial reporting to the company holding the right to franchise (in this case government), may assist agencies to understand their relationship with government in the context of their "business" frame of reference. This would in turn assist the planner in developing and implementing changes in accountability mechanisms.

Having defined the context and developed an appropriate strategy, the planner must be able to act to carry out the plan. The skills and abilities required for appropriate action are reviewed in the following section.

7.2.3. Skills and Abilities for Strategic Action

In chapter 6 it was noted that planners may have to perform a variety of different roles requiring a variety of skill sets. This section will discuss the knowledge and skills required to be successful organizational actors.

i) Technical Skills: Almost every planning task or type of planning requires some technical work. While there are specialized techniques and conventions for each type of

planning, a sound knowledge of statistics including multivariate statistics is required for all of them. In addition, a sound knowledge of a variety of methodological techniques is also required.

A mundane but critical task for planners is to ensure data integrity. Planners must, in many cases, conduct a process of data clean-up before they can begin analysis. This requires a good knowledge of research basics such as the validity and reliability of data, developing appropriate operational definitions and, often, integrating data from several different production type data systems. Once the data are valid and reliable, planners can analyse the data. In order to do simulations and projections for manpower planning, strategic planning and planning for the equitable delivery of services, planners should be conversant with multiple regression techniques. A promising new approach for making projections is that of Markovian Models. This is a specialized approach but as with other special approaches, can be readily learned by a planner who has a thorough grounding in methods and statistics. Health planners should also be familiar with epidemiological approaches.

While the above is not an exhaustive list of statistical approaches, it does point out that skills should be broadly based and at a very high level of technical expertise. In addition, it should be noted that a thorough familiarity with non-parametric statistics is also required as much of the data used by planners is nominal or ordinal.

With regard to methods, planners are often required to do needs assessments, to establish accountability systems, to develop new approaches to service delivery and so on. Again, a broad base in methods is required, particularly in the areas of survey sampling methodology, questionnaire construction and the development and validation of new measurement instruments. As there are relatively few standardized measurement instruments in the health planning field, planners must be able to adapt existing instruments or develop new data collection instruments for each new planning task. In order to do this appropriately rigorous methodological training is required.

ii) Organizational Skills: The context of a planning project often requires skills in mediation and brokering differences between competing parties. If a planning context is such that it requires negotiation, planners must have highly developed sets of organizational skills and abilities. These are generally not taught in courses on planning because much of the planning establishment still adheres to the rational model of planning. Nevertheless, in order to generate support for a project, particularly if the project was developed by the planners themselves, organizational skills are required. One of the most important skills is that of developing sound and extensive networks with key organizational actors. This allows the planner to be seen as an independent and unbiased broker of differences and will enable the planner to put his case forward to key decision makers. As Culbert and McDonough (1980) note, it is the observers to a conflict who determine the winner.

Good networks provide supportive observers if the planner finds himself in conflict with others.

Personal power is very important if the planner is to be an effective organizational actor. As has been noted earlier, there are numerous bases of power and planners should develop as many of these as possible to as high a degree as possible. If a person is perceived as being powerful, others are less likely to challenge that person over issues of low or moderate importance to them. Swingle (1976) outlines the importance of a proven track record, particularly for non-negotiable or "game of chicken" type situations. These situations are zero sum games in which one person wins and another loses. If neither participant yields then both parties lose. As the stakes can be high if the conflict is escalated, one person will generally yield. The reader is referred to Swingle (1976) for a more detailed description of strategies and tactics for such non-negotiable conflicts.

iii) Political Knowledge and Skills: Planners are sometimes faced with projects in the Conflictual Context Model. If it is not possible to pass on the political aspects of this type of project to senior managers, the planner may have to get involved. In order to be effective a good knowledge of the political system is required as outside groups will often go directly to the political level and bypass the bureaucracy. Outside groups or unions may also have sponsors in one or more opposition parties. In cases where the conflict does not escalate to the political level, planners must be able to use

the authority which has been delegated to them in a judicious way. Political conflict is a complex area, requires a high level of strategic ability and is generally learned through exposure to conflict situations. The reader is referred to Alinsky (1969 & 1971) and Machiavelli (1947) for useful hints about political strategy.

iv) Marketing: One of the most important assets that a planner can have is the ability to package and market his product and his service. If planners believe that a certain type of project is needed and will be of benefit, they must be able to get their point across to senior management. If planners are dealing with buffer groups or funded service providers, they must be able to convince them of the merits of the particular projects in question. For example, if planners are developing a new accountability system they must, as was noted earlier, be able to sell their concept to service providers. Similarly, while there may be consensus in government about establishing an accountability system, planners may have to convince senior managers to give them the time and resources to conduct critical sub-studies to ensure the validity and reliability of the new system.

v) Reality Construction: Planners have to be alert and sensitive to their environment and must have an understanding of how the organizational reality in which they work has been constructed, how "reified" each part of the system is and what latitude there is to alter existing definitions of reality.

This requires an ongoing search for knowledge and a constant readjustment of one's perceptions of reality. Pfeffer (1981 a&b) has noted that it is the role of managers to be the makers and reinforcers of organizational meaning. Those planners who are also administrators must be aware of this in their dealings with subordinates, colleagues and superiors.

vi) Organizational Respect and Power: If planners are to have a relevant role, they must develop respect within their organization. This can be done by developing the various bases of power discussed earlier and by two important concepts introduced by Culbert and McDonough (1980) those of framing and alignment. The concept of alignment was discussed in chapter 5. It is the balancing of organizational and personal interests. Framing is the process of constructing and marketing a reality that allows others to value one's overall orientation and the contribution that can be made within that framework. Culbert and McDonough (1980) state:

> . . . framing has three components: (a) a simple story that links an individual's commitments to a highly principled logic, connected to (b) the tangible products or practical consequences flowing from such a commitment backed up by (c) the appropriateness of or authority base underlying this position . . . .
>
> Framing is an activity that forces others to relate to entire structures, not just single arguments . . . skillful framing erects an underlying structure that allows others to differ on specific points without jeopardizing the basic position on which the points are based. (pp. 80-81)

The maintenance of respect within the organization is an ongoing activity of maximizing one's bases of power, and

maintaining a good frame and a good alignment. This is often quite difficult but must be done if planners are to have an effective role in serving the public good.

vii) Professional Ethics: It is a constant battle for planners to market projects, reconstruct reality, engage in political action and do all of the other things that are required and at the same time maintain high standards of ethical conduct. It is easy to get carried away by power, by fear, or by a host of other pressures and circumstances. Nevertheless, it is imperative to maintain sound ethical standards. It is tempting to let ethics slide in the tough hurly burly of planning activity, to make minor compromises, or to look the other way. While each planner must make his own interpretation as to what constitutes ethical behaviour, each planner must engage in an ongoing self-analysis to ensure that they maintain a defensible ethical posture in all their activities. Planners who compromise too much come to be seen as partisans and "political hacks." Once this happens it is hard to maintain a proper career path. Neutrality, fairness and ethical integrity are in fact what make planners effective in their dealing with others. Eversley (1973) makes a similar point when he notes that the future of the planning profession may be dependent on the ethical positions that planners take in carrying out the public trust.

Planners who compromise their ethics trade short term gain for long term pain. They lose the respect of others and their framing and alignment start to disintegrate.

7.3. A Conceptual Model of Strategic Action in Health Planning

Diagram 13 presents a conceptual model of strategic action in health planning. This model is called the CASA (Contextual Analysis, Strategy, and Action) model.

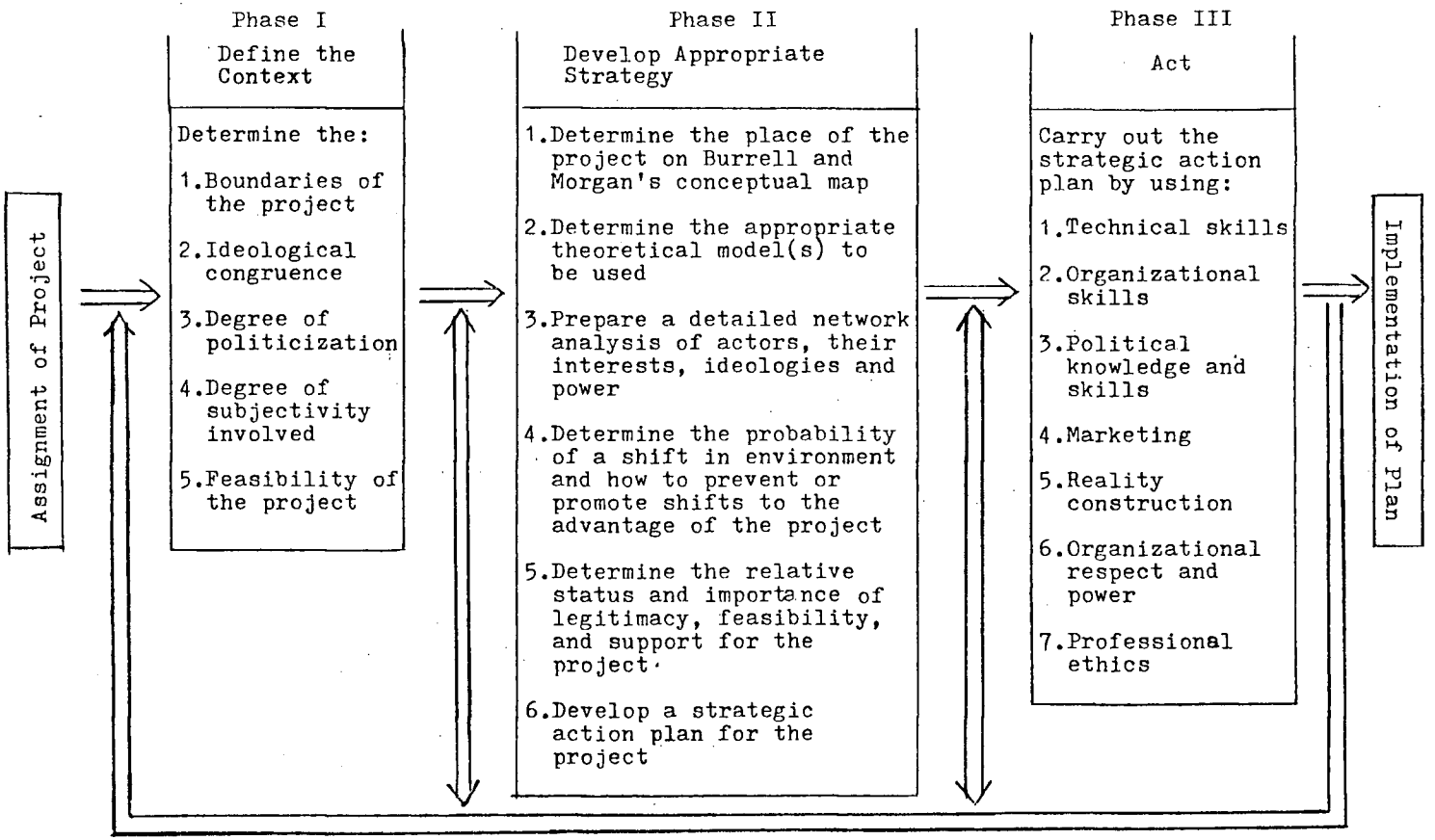
The CASA model is a summary, in schematic form, of the points made in this study. The health planner who is given a planning task or project would proceed in the following ways if he was to use the CASA model.

The first step would be to define the context of the planning project. By following the five steps noted in the first phase the planner can determine the correct context of the planning task. Proper definition will allow the planner to determine which theoretical model(s) are most congruent with the planning context. Having defined the context the planner can move to the second phase of the process or can loop back to reexamine his analysis of the context if there is any reason to suspect that the context may have changed or that the initial analysis is incorrect.

The second phase is the one in which the planner, using his own experience and knowledge, and the theoretical formulations appropriate to his planning task, develops a strategic framework for action. The planner would determine the boundaries of the planning task in relation to the conceptual blueprint provided in Diagram 12 and identify the relevant theoretical models appropriate to his planning task. He would then, as required, develop a detailed map of the existing

Diagram 13

Strategic Action in Health Planning:
The CASA (Contextual Analysis, Strategy and Action) Model



actors, their ideologies and power. Next, the planner would check himself by defining under what conditions the planning context may change and how to adapt to change if it occurs and by reviewing legitimacy, feasibility and support. The final step would be to develop a strategic action plan. This could take various forms from a detailed step by step plan to an overall framework within which a series of sequential steps are taken in which each new step is contingent on the outcome of the previous step, i.e. a decision tree approach. After completing the second phase the planner can move to the third phase or can loop back to review his definition of the context and his strategy to see if modifications are required.

The third phase involves the carrying out of the strategic plan. Here the individual skills and abilities of the planner to act come into play. If the planner does not have all of the skills and abilities required he may have to adapt his strategy to fit his personal strengths and weaknesses until such time as he can master all of the areas noted in the action phase of planning. The planner may move directly forward until the project is implemented or may loop back again through any of the three phases as required.

It should also be noted that in second or subsequent iterations new information from a more advanced phase can be used as input into reformulating a previous phase. For example, once the planner begins to act he may learn that he has misread the context. This requires a review of the first phase and subsequent adjustments in phases two and three in order to

develop a more appropriate strategy and mode of action. Thus, the whole planning process is readjusted and fine-tuned in an ongoing process of context definition, strategy formulation, and action.

An important aspect of the use of the CASA model is that there must be a congruence between each of the three phases of the model. To be successful, planners must be able to correctly carry out the requirements of each stage of the model and to do so in a coherent and integrated manner.

The next section will present five case studies. Each study is analysed using the CASA model.

7.4. Case Examples of Planning in Action

7.4.1. Introduction

The CASA model can generate numerous hypotheses which can be tested through future research. In this study, the CASA model will be used to analyse a number of case studies to determine its power as an explanatory framework. This will be done by applying the model to short case descriptions of successful and unsuccessful planning attempts. Due to the scarcity of specific documented case studies on planning projects conducted by planners in federal and provincial governments in Canada, three sources will be used: 1) existing published case studies on health planning by government officials, 2) other published material on planning or planning type problems, and 3) direct field study.

Analysis of the case studies will also refer to the policy development work of Hall, Land, Parker and Webb (1975). Hall et al. (1975) note that for any new task or project to be developed and implemented, it requires that the project have legitimacy, feasibility and support. Legitimacy is essentially a question of ideological congruence, that is, projects have legitimacy if they conform to a prevailing ideological framework. Support is an issue at the bureaucratic and political levels. To have support means that the majority of important actors are in favour of the project. Feasibility is the technical or scientific level.

The concepts of Hall et al. (1975) interrelate with the three ideal type planning contexts discussed in chapter 6. In the Scientific Context Model, the issue of legitimacy is already covered as there is little if any ideological conflict. Similarly, in terms of support, the project has not been politicized. While low politicization does not guarantee support it means that there is no opposition. If the sponsor is an important organizational actor, this may be all the support that is required. In the Conflictual Context Model there is no agreed upon legitimacy or support. Unless planners have excellent negotiating skills or unless one side is clearly more powerful, such projects are very difficult and their feasibility is of minimal importance until the issues of legitimacy and support are sorted out.

In the Bureaucratic Context Model, the planner needs to use technical skills (feasibility), political skills (support),

and reality definition skills (legitimacy). This is the most difficult environment in which to work as it requires a great variety of very different skills.

With regard to the case studies, it should be noted that they are simplified statements of complex situations involving multiple actors. Each actor or group of actors may have a different view of the case and may have different interpretations of why things happened in certain ways. Persons involved in the cases may have their own interpretations of "the facts" and their own explanations for the flow of events which occurred. In addition, many of the cases are summaries of descriptions written by other authors. It is not clear to what extent such descriptions represent a concensus view of the reality perceived by the actors involved in the case. It is important to note that while every effort was made to accurately summarize each of the cases based on the material available, the cases may describe a reality different from the one perceived by the actors involved. Therefore, these case descriptions should not be taken as the ultimate truth of the situation but as simplified descriptions of perceptions of the situation held by the person describing the events which occurred.

Similarly, the interpretation of the cases using the CASA model is simply a joining together of a series of hypotheses derived by applying the model to the case study in question. The interpretations of the cases are not statements of fact, they are hypothetical explanatory frameworks. Determining the

validity of the explanations of the cases is beyond the scope of this study. However, the validity of the CASA model is compared to other possible explanatory frameworks in the next chapter.

7.4.2. Case 1. Changes in the B.C. Ministry of Health

7.4.2.1. Case Summary

This case has been documented by Campbell et al. (1981), Chrichton (1984), Bonham (1981) and by the University of British Columbia Health Policy Study Group (1982).

The Social Credit Government came into power in British Columbia in December, 1975 and started to move to a more corporate model of organization. During the late 1970's Cabinet became more concerned about the cost of government and introduced a number of measures to increase accountability and to control costs. Thus, while Cabinet had given tacit approval to a liberal health care ideology, it was shifting quickly in the late 1970's to a focus on cost control. A reflection of this shift was a draft Financial Administration Act proposed in 1980 which was to give the Ministry of Finance and Treasury Board greatly increased power over the fiscal affairs of quasi-autonomous non-governmental organization (QUANGOS). The draft Act was severely criticized and subsequently revised and modified. This initial rebuff forced Treasury Board to reconsider its approach and it decided to penetrate more deeply into existing Ministries, particularly the largest spender, the

Ministry of Health. This had several results, it meant that what was required by Treasury Board was no longer estimates of health status but financial accountability. Treasury Board scrutiny exposed existing practices such as covering hospital overruns. Treasury Board staff became more rigorous in their review of the Ministry of Health. As Bonham (1981), a former Assistant Deputy Minister states:

> Dramatic 'overruns' of $200 million were obvious before the end of fiscal year 1980-1981 and the continued escalation of health spending gave rise to the interpretation that a hard-nosed management team was required to replace the bureaucracy which was seen to be dominated by health professionals. The ascendancy of the Treasury Board staff occurred between 1978 and 1981, by which time their junior staff had considerable authority over deputy ministers. Before the major staff changes occurred Treasury Board staff scoured the Ministry of Health seeking in vain for millions of hidden or forgotten dollars; nothing was found. The truth is that the managers had almost no discretionary control over spending and available funds had been legitimately commited. (p. 585)

In 1981 the Ministry of Health received a new Minister and Deputy Minister. Shortly thereafter there was a major change in personnel at the Assistant Deputy Minister level.

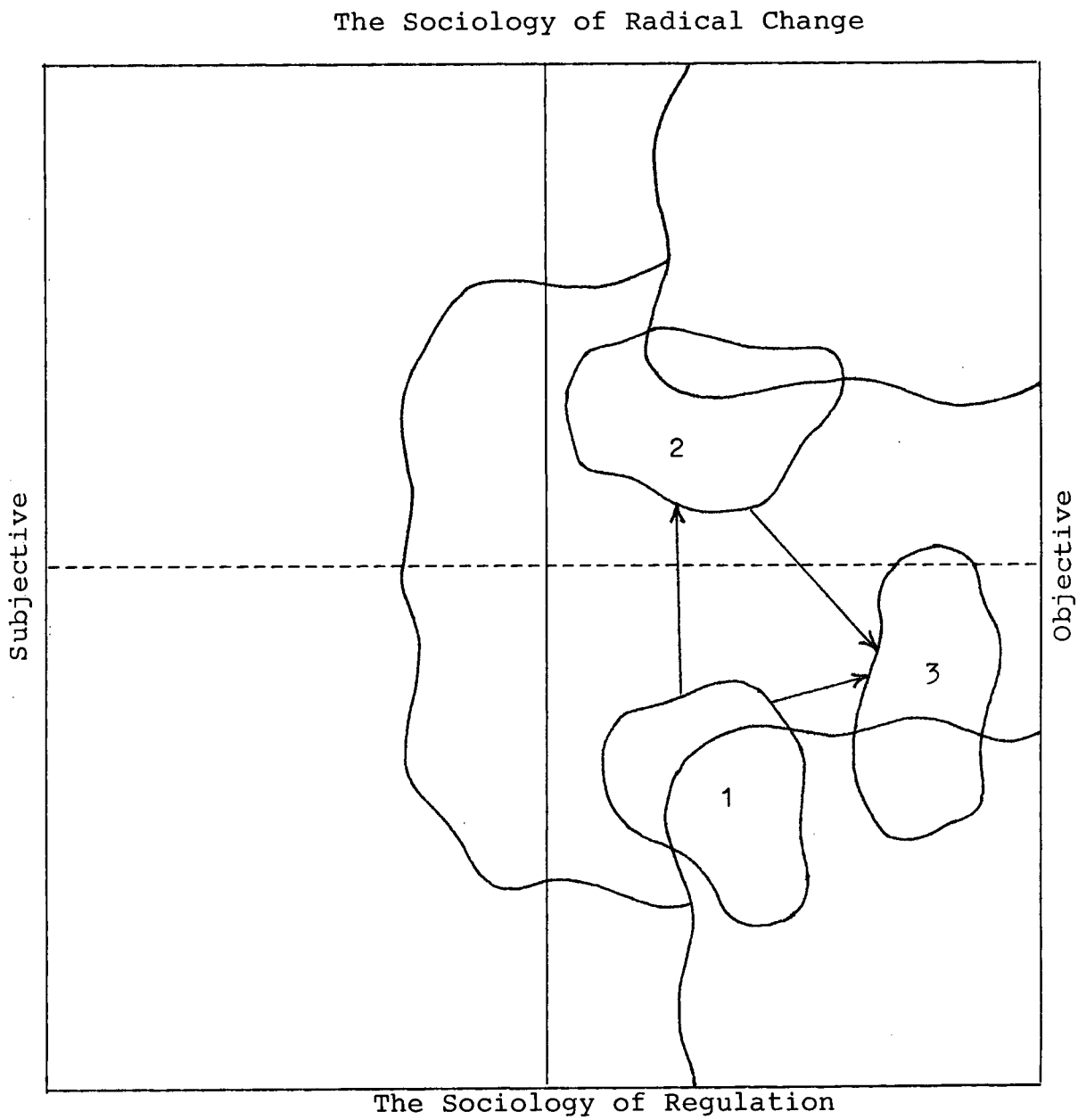
7.4.2.2. Case Discussion - Case 1

It is unlikely that the dramatic change in which the whole senior level of the B.C. Ministry of Health was replaced could have been avoided. There appeared to be a very strong ideological shift to cost containment in the late 1970's at the Cabinet level. In Diagram 14, this shift in context has been mapped on to the three different contexts of planning noted in Diagram 12.

Position 1 represents the planning context in 1977-1978 when there was legitimacy and support for the rational long range planning of health services. By the early 1980's maintenance of that position had shifted the Ministry of Health to Point 2. There was a difference in ideology between a health services model and a more powerful cost containment model. In the early 1980's this difference was still primarily confined to the bureaucracy and had limited impact on the public domain and therefore context 2 only intrudes partially into the Conflictual Context space. However, context 2 is in a more subjective area. When there is a shift or struggle over ideological ground, there is a greater ability for actors to redefine reality. Similarly, context 2 is clearly on the conflictual side of the Bureaucratic Context Model which means that one can assume serious struggle within the bureaucracy. This is clear from the actions of Treasury Board staff. As Bonham (1981) notes, they worked aggressively to shift the perception of Cabinet about the competence of senior Ministry of Health officials. Cost overruns which had previously been accepted as normal practice were defined as "dramatic" and offered as proof of the fiscal irresponsibility of the management team. Thus, it appears that Treasury Board staff were able to link criticism of the management team to the new ideology of restraint. It was possible to do so because a restraint ideology could not have room for the previous practice of covering hospital deficits. A new reality had to be defined which called for "hard-nosed" managers to replace

Diagram 14

Analysis of Shifts in Context for Case 1



the existing team. The changes which resulted in a change at the senior levels of the Ministry of Health to a more cost conscious management team resulted in another shift in context to context 3.

Under less turbulent conditions, it may have been possible for the senior management team to move with the shift in ideology. This could perhaps have been done by shifting the planning emphasis from service delivery planning to financial planning and accountability. This would have shifted the context to point 3 instead of point 2. Context 3 is in a space which is a bit more objective and a bit more bureaucratic than context 1. It is more objective as the new ideology was well defined and methods of analysis would be more quantitative. It allows for more bureaucratic conflict as Treasury Board would still have become involved. However, instead of leading the change to greater fiscal accountability, it may have been possible to define them as being partners and technical assistants in the Ministry of Health's efforts to restrain costs.

7.4.3. Case 2. The U.S. Agency for International Development (AID)

7.4.3.1. Case Summary

While the AID is neither Canadian nor a planning agency, Jameson's (1981) review of AID provides numerous important points for planners. AID is a government bureaucracy not unlike Canadian bureaucracies. Also, it deals with assistance

projects and because of its project basis has many similarities to planning agencies in government.

At the time Jameson was with AID it was mandated by the United States Congress to provide developmental assistance funds to Third World countries. Congress was seen as the Executive Board of the Agency. Congress outlined policies for AID to enact and these policies were translated into Handbooks which Jameson states were inconsistent and incomplete. In addition, Jameson states that some guidelines may have been inappropriate. For example, there was a guideline that projects must have at least a 15 per cent rate of return to be acceptable. Jameson notes that many of the conditions for the use of benefit cost analysis such as scarce resources being allocated among competing uses were not met, in part, because of arbitrary policies such as the 15 per cent rule. In addition, there were only a limited number of projects and with few projects, benefit-cost analysis has no more force than the injunction to be fair and reasonable in allocating funds for projects. Jameson notes that after battles in Congress to approve funds, AID had to spend the funds they received in the fiscal year in which they were received. Therefore, Jameson states that AID officials searched frantically for projects to which they could allocate funds. Jameson further notes that the 15 per cent rate of return rule was useful in discouraging critics as it fitted into a commonly accepted Congressional format. Finally, there were staff cuts at AID prior to the implementation of the requirement to conduct economic analyses

on each project and many technically skilled people were lost to the Agency.

Jameson states that in terms of actual results, fewer than half of the projects had adequate economic analysis. There was wide variability across geographic regions and types of projects regarding the quality of the economic analysis. Jameson (1981) summarizes his findings when he states that the problems he encountered around benefit-cost analysis at AID were:

> . . . inappropriate use of the technique and misleading guidelines for its application; dominance of organizational interests over analytical requirement; inappropriate staffing and support for the analysis; and use of the analysis as a tool in internal struggles. (p. 421)

7.4.3.2. Case Discussion - Case 2

While AID may have been in an impossible position to improve its operations, the analytical model presented in this study would suggest that the problems may have been attributable to a real inability to act, to the lack of competence of the senior officials, or to a calculated strategy of self-protection by managers. The managers may have correctly perceived that they were in a bureaucratic and conflictual context and may have chosen to accede to the dictates of Congress which imposed a rational model on them, inappropriately. It is not clear if management fought vigorously for the staff that Congress had let go. They appeared to rely on form rather than substance in their

screening process in using at least partially inappropriate criteria which were accepted by Congress. It is not clear from Jameson if they ever recommended more appropriate criteria to Congress. There also seemed to be an absence of project proposals in the bank which could be approved as soon as Congress passed the appropriations. The search for projects may have been used to construct a reality of important and intense work to meet Congressional goals but may have been done more for form than substance.

The CASA model has three parts, definition of the context, development of strategy and action in planning. The AID appeared to have limited staff with the required technical skills to conduct the analyses that were required. Senior managers did not have, could not use, or chose not to use, organizational skills to obtain organizational respect and personal power. Had they had such respect they may have been able to propose credible changes to operating procedures. Jameson makes no mention of such proposals and also does not mention efforts at constituency building and networking at the political level to facilitate budget approval and scrutiny in Congress. Jameson also does not mention any attempts at marketing the Agency and its activities. If such activities did not in fact take place, then almost all of the requirements that allow planners to act effectively appear to be absent.

7.4.4. Case 3. Augmenting Funds for Fitness and Amateur Sport

7.4.4.1. Case Summary

Laframboise (1973) has outlined the planning and development process in which he engaged to double the budget of the Fitness and Amateur Sport Section of Health and Welfare Canada.

In the spring of 1972 Philippe de Gaspe Beaubien, President of the National Advisory Council on Fitness and Amateur Sport decided that the time was propitious to ask for increased funding for physical recreation and sports activity. The Prime Minister and Minister of National Health and Welfare shared an interest in amateur sport. Increased funding addressed two important issues of the day, the use of leisure time and the rising cost of health care which, it was believed, was caused in part by the lack of fitness in the general population. It can be assumed that bureaucrats who would benefit by having their budget doubled were also in favour of the proposal.

In discussions with the Minister and Deputy Minister of National Health and Welfare in the spring of 1972, a consensus developed in favour of a comprehensive ten-year plan for Fitness and Amateur Sport which included greatly increased funding. A document was to be prepared for consideration by the National Advisory Council on Fitness and Amateur Sport and would be submitted by the Council to the Minister of National Health and Welfare. Staff of the Ministry of National Health and Welfare would play a key role in development of the

document. As Laframbois (1973) states:

> The following strategy was adopted for preparing the ten-year Master Plan. An official was chosen to coordinate the preparation of the document; an advisory committee was formed of knowledgeable senior officials; discussions were held to present and review ideas; Directors of Recreation from several provinces were invited to come to Ottawa and express their views; a Dean of Physical Education accepted an invitation to present his ideas; and interviews were held by the coordinating official with individual senior managers including some from the Health side of the Department. (p. 5)

Tight deadlines were in place to have the document completed by June of 1972. This would allow time for inclusion into the platform of the Liberal Party for an anticipated election in the fall of 1972. In order to present the report most effectively a marketing specialist was hired to package the proposal in accordance with the best marketing principles.

In June 1972 the National Advisory Council considered the plan, made some modifications and asked the marketing consultant to put the proposal into its final form. The final document was presented by the Council to the Minister of Health and Welfare on June 30, 1972 and was received enthusiastically. Subsequently, the decision was made to include an increased Fitness and Amateur Sport Program into the party platform of the Liberal Party.

In order to maintain momentum, it was decided to hold a national conference to include leaders in medicine, recreology and physical education. There was considerable enthusiasm for the conference to be held in the late fall of 1972. In fact the conference was held just at the time decisions were being

made as to what would be included in the Throne Speech of January 4, 1973. It was the inclusion in the Throne Speech which signalled the final approval for a much expanded program for Fitness and Amateur Sport.

7.4.4.2. Case Discussion - Case 3

This planning exercise was very successful. Its success can be readily analysed by the CASA model. The project context was primarily in the Bureaucratic Context Model. However, Laframboise recognized that he had to cover scientific and political aspects of the project as well in order to reduce the probability of a shift in context. In terms of the political aspects, there was agreement by government and representatives of the public and various interest groups represented by the Council. Fitness was a concept which could be readily integrated into the ideological set of the NDP and Progressive Conservative Parties. The package was prepared so that it would easily fit into Liberal Party election strategy if the party chose to use it.

With regard to the scientific aspects, a limited amount of work was done but it was done by recognized experts on the committee preparing the document and by experts who attended the fall conference. Therefore, the report had the approval of key experts from across Canada.

There was considerable work done at the bureaucratic level. Existing networks and organizational respect were used to interview, and obtain the cooperation of, senior officials

from the Welfare side and from provincial representatives. Officials from the Health side were interviewed and probably coopted into the process in order to obtain their support.

With regard to the ability to take appropriate action, all of the conditions were met. Laframboise recognized the critical importance of timing regarding when the proposal was made and when the report was presented to the Minister. In addition, a marketing expert was employed to ensure the proposal was presented in the best possible way. Laframboise must have had organizational respect and power in order to accomplish the brokering needed within the bureaucracy and he clearly had a good knowledge of the political system. He notes that if the proposal had been delayed until October, 1972 it would have been too late to include it as a plank in the party platform and it may not have been implemented.

The technical aspects of the project were handled by outside experts. Laframboise makes the point that governments often put more weight on what they hear from people outside the system than inside of it. This is why he used external technical experts and why the proposal was routed through the National Advisory Council on Fitness and Amateur Sport.

While there was little reality construction involved, Laframboise makes the point that those who are sympathetic to a proposal help to move it along and they look at proposals with rose-coloured glasses, overlooking potential drawbacks and accepting less rigorous evidence. This is a very important point and it is also made by Pfeffer (1981b) in his example of

a young graduate who prepared ever more technically brilliant analyses for his new boss. Finally, someone advised the young man to find out what his boss wanted and to give it to him. The young man prepared a sloppy document which reflected the view of his boss. He was soundly praised and given a raise. Planners must recognize that there is a great deal of latitude in the rules of evidence required by managers depending on their feelings about a proposal. Laframboise recognized that the proposal already had support and only limited technical work was required for its acceptance.

7.4.5. Case 4. Development of an Accountability System

7.4.5.1. Case Summary

In 1974-75 the writer developed the first province wide computerized information system to monitor the number and types of clients receiving services from agencies funded by the Alcohol and Drug Commission of British Columbia. The development and implementation of this system is documented by Hollander (1977) and by Hollander, Marin and Downs (1978).

The Alcohol and Drug Commission of British Columbia was established in the summer of 1973 and originally was part of the B.C. Ministry of Human Resources (it was transferred to the Ministry of Health in 1977). After an initial start up phase it became clear that a system to monitor the clients receiving services was required. A small staff group within the Commission was assembled to develop, implement and monitor such a system.

In 1974 there were numerous treatment agencies throughout the province. Each had its own method of data collection and this information was neither readily accessible nor standardized. The Commission wanted comparative data on clients in different treatment centres and wanted to be able to track the movement of clients from one agency to another. The Commission conceived of the concept of a "System of Care" in which clients would flow from one agency to another depending on their treatment needs. The staff of the Commission's Research and Planning Division were given the task, in the fall of 1974, of developing and implementing the required system by April 1, 1975. The purpose of the system was:

> . . . to provide the Commission with data about the number of clients in treatment, their characteristics and their movement through the system of care. In addition, the Monitoring System was to provide information relevant to the treatment agencies themselves as well as to researchers, government bodies and the public. (Hollander, 1977, p. 3)

One of the first actions of the developers of the system was to obtain a firm commitment at the senior levels. It was agreed that all agencies would be required to participate in the information system and that the Commission would be firm in this regard by making participation in the system a condition of funding. A number of important issues were reviewed in the early stages of development including which agencies and which clients would be monitored and the type of feedback which would be given to agencies. A unique identification system was developed based on the client's name, birthdate and sex. This allowed for client tracking while maintaining a high degree of

confidentiality. Developers of the system conducted extensive visits to agencies to inform them of the coming system, to obtain copies of existing data collection instruments and to hear their opinions about the type of system that would be acceptable to them. Based on this information, a prototype form was developed which, wherever possible, incorporated the suggestions of agency administrators.

A complete package of material which included draft forms and definitions was sent to each agency and the forms were pilot tested in one large agency of each component of the system of care. There was some initial resistance by affected agencies to implementing the pilot test but once the test period of two weeks was over all pilot agencies continued to use the forms until the final forms were implemented in April, 1975.

The packages describing the system and the results of the pilot study were the basis for discussion of the new system at a workshop in late February, 1975 which was attended by all agency administrators. In a one half-day session closure was reached on all variables and definitions to be included in the final data collection form for what was to be called The Client/Agency Monitoring System. The system was implemented in April and May of 1975 and remained in place without revision for more than five years.

7.4.5.2. Case Discussion - Case 4

As in Case 3, this case falls generally into the Bureaucratic Context Model. The developers of the system recognized this context and acted in a way that was congruent with it. Like Laframboise they recognized that there was a latent possibility of the context becoming more politicized. In order to lessen the probability of the context shifting, commitments to the project at senior levels were consolidated. Efforts were also made to ensure a thorough and technically defensible development of the system.

The firm commitment that participation in the system was a condition of funding helped to reduce possible resistance and shifted discussions with agencies from one of legitimacy to one of feasibility. Legitimacy at the political level was reasonably assured as basic accountability for the expenditure of public funds was a goal on which all political parties could agree. Support was still considered to be tenuous. Therefore, every effort was made to consolidate the support of the agencies for the system. The way the data recording forms were constructed with two sizes of the same one page form which could also be used as a card file were important both practically and symbolically. Practically, it allowed for the continuation of a familiar process for agencies which had used card files. Symbolically, it clearly gave a message to agencies that the Commission was listening to their input and was prepared to go out of its way to accommodate the wishes of the agencies whenever possible.

As most agencies had one page forms, keeping the information to one page was considered to be an important marketing principle. It enabled developers of the system to say that the new form was a standardized one page form which contained most of the items agencies were already collecting plus a few additional items. Therefore, the amount of work to change over to the new system, and to use the new system, was to be minimal. The positive side of the new system was that it could provide comparable provincial data and that agencies would be given information regarding their performance compared to provincial averages.

Another important point in gaining acceptance of the system was that the confidentiality of clients would be ensured and that only the agencies would be able to use the unqiue identifier to identify actual clients. Finally, another very important selling point of the system was that funding decisions would be based on a variety of factors, of which information from the system would only be one moderately important component. The Client/Agency Monitoring System was intended to raise questions and issues which could be worked on jointly by the Commission and its funded agencies to improve operations and service delivery.

In summary, developers of the system worked to bracket the system into the Bureaucratic Context Model by doing adequate technical work and obtaining the needed political backing for the project. They then proceeded to build support through a concerted marketing effort.

7.4.6. Case 5. The Planning Model of a Community Planning Agency

7.4.6.1. Case Summary

The Voluntary Association for Health and Welfare for British Columbia was started in Vancouver in 1966. Two years later it amalgamated with the B.C. Association for Funds and Councils. The new agency was named the Social Planning and Review Council (SPARC) of British Columbia. SPARC is a non-profit community group whose objectives include: broadening public understanding of health and welfare issues, arousing community awareness of social problems, coordinating the work of government, encouraging the planning and provision of community resources, the voluntary sector and community agencies, and carrying out planning and research activities in the health and welfare field.

In 1981 the approach used for the planning and development of programs for the disabled was studied by the writer and Mrs. Wendy Morton as a project for the M.Sc. Program in Health Services Planning at the University of British Columbia.

In 1980-81 SPARC had 647 individual members, 141 organizational members and an additional 155 members serving on various committees. SPARC has been committed to working within the system. The Executive Director, in 1981 when this case study was conducted, described SPARC's efforts to work within the system by saying that SPARC is:

> . . . not trying to overthrow anything. Instead SPARC is figuring out the loopholes, influencing people, and giving people information to make

> their own decisions . . . . It is educating people and changing people's attitudes and bringing about collective action. All these things make social change really happen without necessarily confronting or destroying.

In the 1981 study, SPARC's general approach to planning was discussed with particular emphasis on four projects for the disabled. SPARC developed a coordinating committee to speak for the disabled, particularly in the International Year of the Disabled, called Access 81. It had worked on an ongoing basis since 1970 to change building codes, remove environmental barriers for the disabled and to ensure proper enforcement of city bylaws which would benefit the disabled. SPARC also worked in the area of ensuring appropriate transportation for the disabled. Preliminary work was done on this project but it was believed that the project could have more impact if it was delayed until 1986, the year of Expo 86, a world transportation and communications exposition to be held in Vancouver in 1986. SPARC also worked in the area of developing appropriate terminology to refer to the disabled.

Overall, SPARC used several approaches in its planning and development efforts from preparing newsletters and reports to the development of groups which become politically active in advocating particular issues. In general SPARC in 1981 used a planning typology similar to that of Rothman. Overall, the SPARC approach uses a rational model but specific tactics may vary considerably from those generally used in rational planning. The planning sequence as outlined by the Executive Director was:

1. Identify needs,
2. Work out various alternative actions to meet the needs,
3. Priorize the alternatives,
4. Select the best alternative,
5. Act on the alternative,
6. Conduct education and training as required, and
7. Evaluate and, if necessary, refine the action or refine the problem.

Examples of tactics and techniques used by SPARC are: act as an intermediary between groups, provide an independent forum in which government bureaucrats can surface issues publicly, lobby behind the scenes to get desired changes, provide information to particular groups, act as a broker and go-between between groups, establish committees, provide information, develop policy statements which bring out and legitimize issues, identify individuals and groups who can develop activities around certain issues and develop rational plans and policy statements.

7.4.6.2. Case Discussion - Case 5

While SPARC is a non-profit society, many of its strategies are relevant to health planners in government. In addition, government planners should be aware of the way in which non-governmental agencies perceive the planning process as they may have to interact with such agencies in their work.

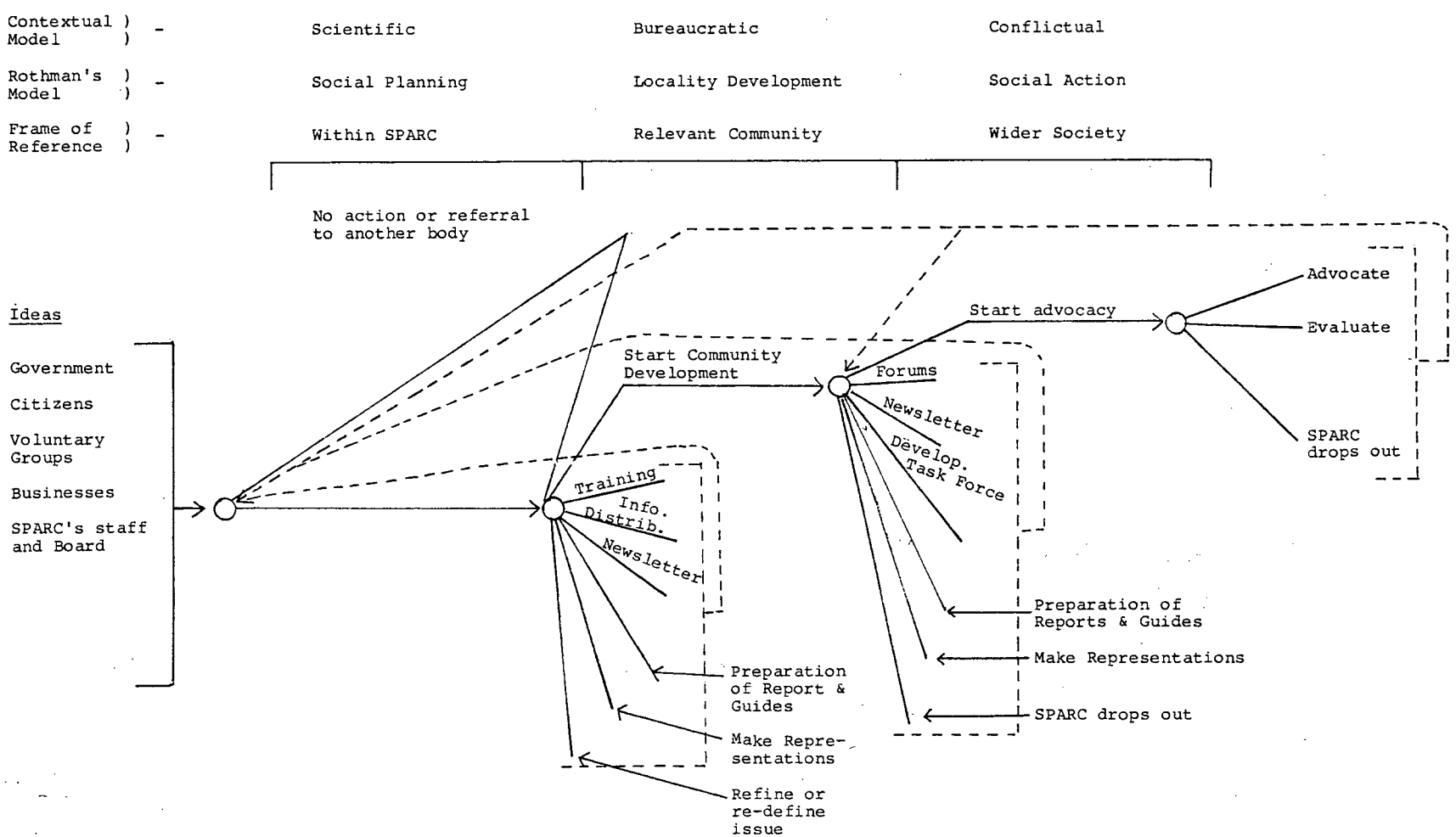
The SPARC planning model fits readily into the conceptual framework presented in this study. The feedback and redefinition of issues is a particularly important aspect of the SPARC approach. It is essentially a recognition of shifting contexts of planning and a systematic way to adjust when strategies and

tactics do not seem to be working in a particular context. The SPARC model is presented in Diagram 15 which includes an overlay of the three contexts presented in this study.

As noted in Diagram 15, all projects go through a rational model screen in which the project is reviewed within the Scientific Context Model and action, as appropriate, is taken. This can include training, preparing a report and other such activities. If a strictly rational model is not the best choice, the project moves into the Bureaucratic Context Model which involves community development and the development of task forces or other appropriate lobby groups or coalitions. The Bureaucratic or locality development approach may evolve into more direct advocacy if lobbying, conflict resolution, consensus building and other such approaches do not result in the desired ends being achieved. At each stage of the progression from the rational to the social action approach there is an important feedback loop to the initial step of project review. For example, for a particular issue it may be that a certain amount of training is required to educate key participants to certain aspects of planning. This might be done through a formal educational process or SPARC may act as a facilitator to a group which believes in the rational model. In such cases the group may fail in their efforts and SPARC could use this failure as a ground for consciousness raising. The project would be looked at again and the next time would progress to the Locality Development phase where it might meet with greater success.

Diagram 15

SPARC's Planning Model and the Planning Context



SPARC staff clearly understand the importance of the various skills and abilities of successful planners. While they do not engage very much in direct advocacy, they are fully aware of the political process and its implications for planning strategies. They clearly have a well developed knowledge of the strategies and tactics to be used in the Bureaucratic Context Model and know the importance of building constituencies and marketing their plans and ideas. SPARC staff have technical skills and use experts as required to ensure an adequate level of technical competence in their projects.

The next chapter will provide a discussion of the CASA Model.

8. DISCUSSION

8.1. Introduction

The basic test of any new conceptual model is its validity. Simply put validity refers to the extent to which an instrument, procedure, or theoretical model does what it purports to do. In this study the CASA Model purports to provide a useful framework to guide the actions of health planners in governments in Canada and to do this better than other existing models of health planning.

There are at least four types of validity. Content or face validity refers to the degree to which experts in a field judge that the instrument or model in question is constructed in such a way that it is likely to do what it purports to do. Criterion related validity refers to the extent to which the results of a procedure or model correspond to some criterion of measurement. There are two types of criterion validity, concurrent and predictive validity. Concurrent validity uses a contemporaneous standard, for example, measuring a sun dial against a watch. Predictive validity uses a criterion which does not become available until a future point in time. Construct validity refers to the degree to which an instrument or a model corresponds to a theoretical construct. While not a type of validity, instruments or models must also exhibit sensitivity and specificity, that is, the ability to accurately make moderate or fine discriminations not just gross discriminations.

The most appropriate measures of validity for a study of this nature are face validity and predictive validity. It would also appear reasonable to review concurrent validity but there is no universally accepted standard (i.e. analytical model that has been found to have great validity). The CASA model will be compared to other models but as these models may have less validity than the CASA model, such an analysis will only allow a comparative analysis of validity.

While it is useful to test new measurement instruments for their construct validity this is less useful for analytical models. These models are already amalgams of constructs and a comparison of a new model to existing models would really be another version of concurrent validity and would have the same pitfalls noted above.

The CASA model shares the shortcoming of other existing models in that outcomes may not be reliable. The abstract nature of the model does not allow for fine tuned prescriptive guidance, that is, models such as the CASA model can only have a limited sensitivity and specificity.

In this chapter the CASA model will be analysed with regard to its internal coherence, sensitivity and specificity, and its ability to predict in order to see if the model can stand the tests of validity. It will also be compared to other models to determine its face and predictive validity in comparison to other current models of planning.

8.2. The Validity of the CASA Model

As the CASA model is a model which guides the decision making process, the most appropriate validation of the model would be a study of decision making and action in which each critical decision point constituted an experiment in which knowledge of the CASA model constituted the experimental condition. Unfortunately, it is not possible to conduct such a study due to the methodological constraints imposed by such a design. However, an approximation of this approach would be to analyse case studies of successful and unsuccessful planning projects to determine the degree to which the CASA model can explain, i.e. retrospectively predict, the outcome of the project. That is what is done in this section. The next section will compare the explanatory power of the CASA model to other existing models.

Table 3 provides a summary of the major steps of the CASA model. Each of the case studies is reviewed to determine the extent to which the key actors were able to carry out the steps in each of the three phases of the model.

The clearest discrimination between the successful and unsuccessful planning projects is in the ability of the key actors to correctly define their environment. This was particularly true in the first case. This is in large part due to the massive nature of the change which took place. The shift from a Ministry focussed bureaucracy to a governmental corporate model was complicated by a parallel shift from an expenditure to a restraint ideology. This may have been

Table 3

A Comparison of Successful and Unsuccessful Planning Projects Using the CASA Model

Components of the CASA Model	Successful Projects			Unsuccessful Projects	
	Project 5	Project 4	Project 3	Project 2	Project 1
Ability to Define the Environment					
1) Boundaries	Good	Good	Good	Moderate	Poor
2) Ideological Congruence	Good	Good	Good	Moderate	Poor
3) Politicization	Good	Good	Good	Moderate	Poor
4) Subjectivity	Not clear	Not clear	Not clear	Not clear	Poor
5) Feasibility	Good	Good	Good	Moderate	Moderate
Ability to Develop Strategy					
1) Place on the Conceptual Map	N/A	N/A	N/A	N/A	N/A
2) Correct Theoretical Models	Good	Good	Good	Not clear	Poor
3) Network Analysis	Good	Moderate	Good	Moderate	Moderate

Table 3 (con't)

	Project 5	Project 4	Project 3	Project 2	Project 1
4) Probability of a Shift in the Environment	Good	Good	Good	Poor	Poor
5) Legitimacy, Feasibility & Support	Good	Good	Good	Moderate	Moderate
6) Strategic Plan	Good	Good	Good	Not clear	Not clear
Ability to Act					
1) Technical Skills	Good	Good	Good	Moderate	Good
2) Organizational Skills	Good	Good	Good	Moderate	Good
3) Political Skills	Good	N/A	Good	Moderate	Good
4) Marketing	Good	Good	Good	Moderate	Good
5) Reality Con-	N/A	N/A	N/A	N/A	Moderate
6) Organizational Power	N/A	Moderate	Good	Poor	Moderate
7) Ethics	N/A	N/A	N/A	Not clear	N/A

coupled with the effects of medical dominance. The senior officials of the Ministry of Health were primarily physicians. As noted in chapter 3 physicians are used to controlling the medical care delivery system. The training and past experience of the senior officials would have made them less sensitive to the possibility of a wholesale shift at the senior level to non-medical managers.

The changes in the bureaucracy were also pervasive and far reaching with the ascendancy of Treasury Board Staff and the growth in importance of other central agencies. Similarly there was a shift in political ideology which was not overtly articulated until the change process was well in place. Therefore, there were changes in boundaries, in ideology, and in the degree of politicization. These led to an increase in the degree of subjectivity in the bureaucracy which was exploited by Treasury Board staff to the detriment of the senior officials in the Ministry of Health.

The planning projects which succeeded existed in a less turbulent environment. While the possibility of a change in environment was considered, it is not clear if the projects would have been as successful in an environment experiencing significant change.

The inability to correctly read the environment may have led to the use of incorrect models of action. The case studies do not discuss whether the actors used theoretical models so that it is only possible to make inferences from their actions. This is true for most of the components of the strategy

section. One can only infer that measures were not taken to adapt to a shift in the environment.

The ability to act must also be inferred to some degree from the quality of the actions taken and from the positions and backgrounds of the participants. It should be noted that there seems to be only a modest difference in the skills and abilities of the key actors in the successful and unsuccessful case studies. This highlights the importance of the ability to define the environment and to determine the best strategy, two central features of the CASA model.

It can be seen from Table 3 that the CASA model can serve to explain the reasons for success and failure of the planning projects discussed in this study. While it would be inappropriate to make the conclusion from this that the CASA model has predictive validity, the results of Table 3 are encouraging.

The internal coherence of the model can really only be analysed in terms of face validity. The components form logical parts of a whole and the steps in each phase appear reasonable and are grounded in accepted theory and practice. There also seems to be a logical flow such that the failure to correctly identify the environment appears to affect the strategy used and the actions taken.

It appears that the model can make reasonably fine discriminations. For example, the model points to the hypothesis that the planning projects which failed did so in large part because of the inability to deal with the environment. Case study 1 documents the changes in the context which occurred.

Therefore, there is some empirical validation to the analysis provided by the model. In addition, the CASA model points out that the ability to act was fairly similar among the key actors of both the successful and unsuccessful projects. This demonstrates that the model is capable of producing independent analyses for each component of the system, thereby allowing analysis at a fairly fine level of detail.

Thus, it appears that there is some preliminary evidence to indicate that the CASA model meets the test of being a valid theoretical model. However, further independent verification is required to thoroughly test the validity of this model.

Given that the CASA model appears to have some validity, is it a better model than other current models? This question will be addressed in the next section.

8.3. A Comparison of the CASA Model to Other Planning Models

Chapter 6 provided an overview of the rational model of planning and the existing critique of this model. The main features of the rational model are that it does not account for subjectivity or power relationships. It assumes a world premised on a scientific logic and reason. Planners gather data, review priorities, develop alternatives and make recommendations. They may also be involved in implementation but there are a limited range of options available to the planner. This process again appears to assume the rational man who is willing to put aside his selfish interests for the greater good of society.

In terms of face validity the CASA model appears to be superior to the rational planning model. The rational model assumes a scientifically based and non-conflictual environment. The literature on health services and organizational theory recognizes conflict. The CASA model accounts for a variety of different environmental contexts for the planner. This study has documented the fact that the assumptions of the rational model regarding the environment of the planner are at best only partially correct.

The rational model essentially only has one form of strategy. This strategy is that if a thorough scientific analysis is conducted, the logic of the evidence will compel senior officials to make the appropriate choices. The CASA model allows for a variety of strategies. It recognizes power and the necessity for political and bureaucratic strategies. It also recognizes that sometimes working to change perceptions is all that is required to meet the requirements of the planning task.

With regard to the skills required, the rational model focusses primarily on the technical skills required. The case studies demonstrate the importance of other skills and abilities such as marketing, organizational skills, personal power and other such attributes.

Thus, at the level of face validity, it appears that the CASA model is a more comprehensive model for health planners than the rational model. In fact, the rational model appears to form a sub-set of this more comprehensive framework.

With regard to predictive validity, the case studies demonstrate the weaknesses of the rational model. The rational approach was used in each of the two unsuccessful cases. The planner using the rational model would be hard pressed to provide explanations for the lack of success of these projects while they can readily be explained using the CASA model. Thus, both in terms of face validity and predictive validity it appears that the CASA model is superior to the rational model of planning.

While it has been noted that the rational model is still the predominant planning model, other models have been discussed and are used by planners. How does the CASA model compare to other planning models?

The major competing model to the rational model of planning appears to be a community action type of planning. This includes most forms of advocacy planning, planning related to community development and action research. These approaches are similar in that they focus on the people who are being planned for, they may include a power dimension and the planning process is often interactive and iterative.

This model overcomes some of the shortcomings of the rational model but it also appears to be inferior to the CASA model. While this model accounts for conflict and negotiation it essentially assumes the Bureaucratic Context Model with some aspects of the Scientific and Conflictual Context Models. However, having developed in opposition to the rational model this model does not incorporate the rational model within it.

Therefore, the CASA model which can account for a variety of contexts is still more inclusive in its domain. The community action model may de-emphasize the importance of the technical aspects of planning. For example, it would be inappropriate to use action research or community development techniques in a context where only a thorough technical analysis is required. The CASA model fully recognizes the importance of each of the skills and abilities required by planners.

Another area that has many similarities to planning is the field of strategy formulation in the organizational theory literature. While this area covers strategy development, and by implication, the definition of the planning context, it is not as comprehensive as the CASA model in that the action component has not been fully developed in this model.

8.4. Implications of the CASA Model for the Training of Health Planners

The CASA model helps explain just how complex and demanding is the field of health planning. While the CASA model was developed primarily for government planners, many of its key aspects have applicability to planning outside of government. Thus, it is possible to discuss the implications of the CASA model for the training of health planners.

Graduate programs in health planning and administration provide a basic set of courses on the health system, organizational behaviour, administration, information systems, evaluation, planning, methods and statistics, and other relevant

training including field practicums. The CASA model would indicate that certain of these courses should be highlighted and that other courses should perhaps be added to the curriculum. The area of health policy making is important for planners. Policy courses should include a discussion of issues such as political theory, ideologies, boundary issues, and discussions of the overall process of policy and decision making by senior officials. Health planners must have an understanding of such processes to better understand their environment and develop strategy.

Courses on organizational behaviour should recognize the new trends in the field relating to power and the subjectivity of meaning. They should also include specific techniques and drills related to network analysis. This will assist future planners in their ability to do detailed analyses on their context.

Courses on the basics of administration such as budgeting, personnel and other related activities should be taught at a significant level of detail. Planners will need to understand such things in order to be credible with senior administrators. A high level will also be required in the development of technical skills. Students should be taught advanced methods and statistics and be made computer literate with regard to statistical packages and the development and manipulation of large data sets.

In addition to heightening the areas noted above, students should also be exposed to marketing techniques. This could be

done in courses on organizational behaviour or in special courses on how to market ideas to the bureaucracy, special interest groups and the public. Finally, there should be a course to provide training techniques which can be used to develop respect and power in organizations. This course should include a rigorous assessment of the students' strengths and weaknesses in this area.

8.5. Conclusion

The field of health planning is very challenging as planners must be politicians, technocrats and bureaucrats all in one. Considerable training and self-development are required to become a successful health planner. It is hoped that the CASA model can provide a framework and a set of guideposts to mark the way for those who choose to follow this lumpy, and winding, but challenging and rewarding road.

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