# EDITORIAL

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## Health planning – A global perspective

*The term health planning can cover a wide range of different activities from long term strategic planning for a whole system to the short-term development of a service and from human resource and financial planning to planning interventions to meet population needs. Moreover, it can be undertaken in very different ways. All methodologies have weaknesses and, in reality, most changes and improvements in health come about through political action, the leadership of clinical and other entrepreneurs, learning by doing and the careful application of improvement science.*

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

The way planning is undertaken is also very variable. However, a quick overview globally suggests that most health planning is very technocratic in nature and undertaken by specialist trained groups of staff rather than by practicing clinicians and managers and with relatively little engagement of the public and wider stakeholders. Moreover, most planning is concerned with service provision. Health and health care are profoundly affected by other sectors and need to be seen in the context of education, housing, employment, environmental policies and all the other external factors that help determine the health of individuals and populations. An important part of health planning, therefore, is the extent to which it takes account of these wider issues. This has led many planners to aim for a Health in All Policies approach where other sectors are involved in assessing their own policies in order to maximize their health impact.

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

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

### Planning and reality

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

the plans can be lost; or other priorities may arise that mean plans are not followed through.

Continuity and long–term commitment are particularly important in health planning where results are often not immediate but require years of determined work. Health care planners in every part of the world can point to examples where these external factors have undone months of hard work. Similarly, there are examples where consistent political will, sticking to the plan and continuity of personnel have led to major improvements. The enormous improvements in health in Portugal since 1974, particularly in child and maternal health, are a testament to the importance of political will, public support and good leadership over many years.

Some of the most impressive improvements in health care have come about through processes which hardly seem to involve any planning at all but, rather, depend on the continuous testing and adapting of ideas until they achieve the desired results. The model breaks down all the rigidities of the traditional system with new roles for professionals and patients, home and community-based care and extensive use of it.

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

Looking forward I would argue that health planning needs to develop in two different ways. Firstly, it needs a better understanding of implementation, the role of leadership and the development of relationships. These understandings will help improve and develop the whole doctrine of planning. They need to be built on improved skills and an understanding of the science of improvement. Secondly, the whole agenda needs to be widened and thought about in a different way. This built on the growing understanding of the social and wider determinants of health in recent years which are at last being incorporated into policy and planning globally and beginning to find their way into action on the ground.

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

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