Review Article

Strategic planning—a health system operational perspective

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Abstract: Strategic planning is frequently presented to health managers and leaders as a rigorous and systematic process that enables clarification of purpose and unites staff to achieve organisational goals. However, there is little evidence that the planning process and the production of a documented plan contributes to the achievement of objectives and improved health performance. Nevertheless, in the absence of such evidence or an alternative way with which to navigate a way forward, health systems continue to put significant effort into strategic planning as a way of publicly authenticating purpose and direction.

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Introduction

Strategic planning has been promoted in the management literature as an approach to improve organisational outcomes with promises of highly structured, future orientated management techniques adopted from the best run business operations (1-3). Strategic planning is an example of one of the many tools that the health sector has adopted from the business sector in an attempt to manage an extremely complex and financially constrained system, which often exists in conflict with political and professional pressures. The Bain Survey of Management Tools (4) demonstrated that in the ten years between 1996 and 2006 strategic planning was the most popular technique used by companies to inform business decisions, futures planning and to navigate complex and competitive marketplaces.

More recently, Bain and Company (5) wrote that 'the six most popular tools of 2012 remained in the top six for 2014, with customer relationship management the number one, followed by benchmarking, employee engagement surveys, strategic planning, outsourcing and balanced scorecard'. Comparing the top 10 tools over a 10-year period, strategic planning, benchmarking, outsourcing, and mission and vision statements consistently remain in the top 10.

The healthcare industry is described (5) as one of the heaviest users of such management tools however, it could be argued that there is little evidence regarding the effectiveness of significant effort into business planning and futures thinking. There may be a number of reasons for this but, perhaps the health system, often described as a complex adaptive system, is approaching strategic planning too rigidly and too linear. Perhaps also, while strategic planning is an event most health executives have been involved with, the subsequent implementation of the plan has been left in limbo—referenced on occasion but for the most part—ignored.

Discussion

Healthcare has long turned to other industries for management strategies that could potentially be adopted to drive operational improvement and interventions that enhance the quality and safety of care. However, prior to using such approaches, it is suggested that a necessary first step is to consider the environmental context within which the intervention will occur. Dixon-Woods (6) suggests the notion of a plug-and-play solution is consequently misguided—the features of context (clarity of vision, infrastructure, organisational systems, values, skills and so on) that made an intervention work in another setting would need to be reproduced too.

Additionally, we know that the healthcare environment

is complex and dynamic; in fact the description of the health sector as a complex, uncertain and ever-changing environment has become almost a requisite prelude to studies of healthcare organisations (7-10). It is argued that complexity, increasing demand and financial uncertainty, challenge the ability of health care managers and leaders to deliver on strategic objectives. The same factors are also used as a defence against criticism and as such, this viewpoint is perpetuated with each generation of healthcare managers. Healthcare leaders have long described the change they witness as unprecedented. As far back as the 1960s the healthcare industry was being described as volatile and changing; the 1970s were characterised by financial uncertainty and the 1980s were rapidly changing and often threatening. In a similar fashion, the 1990s were turbulent and highly competitive, with unstable environments and organisations facing a highly unpredictable and uncertain future (7,8).

Over the past 10 years, the language of unprecedented change has continued however increasingly this language is targeting more specific issues including unprecedented funding pressures, unprecedented transformation, unprecedented changes in the age structure of populations, and the unprecedented challenges of climate change on health systems.

Conversely, there are also views that the healthcare system is in fact change-averse. One author (7) suggests that health care moves at glacial speed compared with most other industries, and that hospitals and physicians have organisational time clocks that are geared more to geological speed than to Internet speed. This view was also suggested by the President of the Australian Medical Association (AMA), Dr. Andrew Pesce, in his 2009 address to the Congress on National Health Reform, where he identified this glacial speed as the real problem with healthcare reform.

The problem with such perceptions lies in the subsequent approach to planning. It can launch the investment of significant time and resources to ensure clear understanding of the environment and required strategic direction, or alternatively, perceptions of chaos and uncertainty can cause planning to be perceived as futile. Additionally, the past experiences of planning and its capacity to change systems and processes confirms the perceptions of many that plans are destined to the shelf of dreams.

These diverse viewpoints are further evidenced in the literature. Begun and Kaissi (2) suggest that strategic planning is not useful in complex adaptive systems, including healthcare delivery systems. Boyne and Gould-Williams (11) on the other hand argue that the need for planning is especially great when many circumstances in an organisation's environment are changing rapidly.

Hammer's thesis (12) titled '*Strategy Development Process and Complex Adaptive Systems*', began with the question—does complex adaptive systems theory enlighten the strategy development process? The focus of the research was a single Case Study Organisation (CSO) being a small university in the United Kingdom (UK).

Hammer noted that in the case of the university sector, complexities are caused by the increasing interactions of UK demographic trends, international market demand and supply, increased competition from existing and new areas, changes and uncertainties in government priorities and the impact that has on funding streams, student expectations and employers' needs. Hammer demonstrated that from a theoretical perspective, applying complex adaptive systems thinking over the strategic planning process may better inform the approach to strategic planning from an operational perspective.

Previous research undertaken by this author (13) sought to examine two main problems:

(I) The ambiguity of concepts such as strategy, strategic planning, strategic management and strategic thinking and, the practical implications of such ambiguity in health service management and;

(II) How strategy is formed and how plans are then developed and executed where objectives can often stem from the policy mandates of government and, in the case of Australia, by different levels of government.

The research examined strategic planning in three health care services—Calgary Health Region in Canada, Central Northern Adelaide Health Service in South Australia and, Western Health in Victoria. Key questions explored the perceived meaning and value of strategy and strategic planning in the public health sector and, how plans are developed and importantly, implemented.

Approaching the research questions predominately through an operational lens facilitated the identification of a number of reasons why strategic planning in health (from the perspectives of the health service planner) was not considered a useful tool. The key reasons cited included:

- A lack of ownership by people who needed to contribute to implementation
- No implementation/no discussion about '*how we are going to get there*';

- ❖ Motherhood to the extreme, trying to please everyone;
- ❖ No political will—'no burning platform';
- ❖ Change of government;
- ❖ No leadership;
- ❖ No change management strategy/no change agents;
- ❖ Integration of a multitude of plans;
- ❖ No commitment to resourcing and rolling out;
- ❖ Not politically appropriate;
- ❖ Timing was not right;
- ❖ Cynicism from the past;
- ❖ Expectation that the shelf is where they will sit i.e., a self-fulfilled prophecy;
- ❖ System was in a rapid change mode;
- ❖ Perceived to be solving the wrong problem by people at the coalface;
- ❖ Department expectation that a plan will be developed, therefore tick box only mindset.

Research respondents made specific statements such as:

'They're more pre-occupied with the discipline, integrity and virtuosity of the plan itself than they are with how it could be implemented.'

'I think also that there is a reluctance, particularly because some of the key stakeholders are clinicians and they've been involved in so many planning sessions that it gets to a point when they sit there and say that it's just going to be like the other one – why don't you just do the same thing again! They suggest that we just re-write the same document. I think that they've all had experiences about contributing to what we thought would be a really valuable plan that is never seen again nor used.'

It was also clearly evident from both the literature and research findings that the impact of political agendas cannot be dismissed when considering strategy formation in the public sector. There were numerous examples where changes in government followed by subsequent changes in political priorities, resulted in previously agreed strategic plans left on the shelf of yesterday's dreams. It is the complex environment in which public health systems operate. Health leaders need to understand the opportunities that political support can provide in terms of strategy implementation but also understand the impact of an absence of such support. Strategy formation as a political process needs to be acknowledged, however perceptions that the public health system is constantly responding to the whims of politicians also needs consideration in terms of how to engage stakeholders in the planning and delivery of strategy.

Stewart (14) argues that policy strategy, which sits within the realm of Ministers and senior government officials, is often *ad hoc* and determined by short-term media driven priorities. If strategy is perceived as political whim, then perhaps the challenge for health leaders, as it is for Ministers, is the translation of *ad hoc* political decision-making into a leadership and management context that creates some consistency and, importantly connects to overarching strategic intent.

Key opportunities

There are a number of opportunities to enhance our current approaches to the strategic planning process and to create conditions where the value of this management tool is maximised.

It is suggested that this is achieved:

(I) By confirming and communicating accountability structures for strategy including linking the political and organisational dimensions. This would better prepare the healthcare organisation and specifically its managers and planners to understand roles, responsibilities and to make decisions. It incorporates clear acknowledgement of the political environment and the locus of influence of managers and planners over organisational strategic intent.

(II) By recognising the complexities of the environment and acknowledging its unpredictability. This requires the need to incorporate flexibility and emergent strategy in planning processes and being prepared to adjust or 'change with the wind' while keeping the destination as a clear focus. Responsiveness replaces preparation.

(III) Through consideration of the timeframes for strategic plans. Smith [2005] argues that long range planning in complex organisations is impossible. While this should not be interpreted as dismissing any possibility that organisations can influence their futures, it suggests a balance needs to exist between being able to influence, and an over confidence in being able to control through planning. The timeframe therefore in which health care organisations plan needs to be realistic and acknowledge the complexity of the environment including the influence of politics and funding and, emergent opportunity.

(IV) By avoiding strategic planning that leads to an immediate restructure without clearly understanding the root cause of problems. Moving lines around on the organisational chart

seems the most frequent and obvious change strategy however; there is minimal evidence that such an approach delivers the intended outcome. Instead it often causes disruption, confusion, cynicism and, usually is costly to implement.

(V) By avoiding strategic plans that have too much going on. Plans need to be simple and easily understood. They need to ensure people have clarity regarding how the plan is going to be implemented and what their part is in delivering the strategies. The plans need not only to be measurable, but measured and reported—the successes, challenges and those strategies that failed. Important lessons can be learnt from what did not work and why.

(VI) Through supplementing data and information with intuition or tacit knowledge; less quantitative and more qualitative analysis.

(VII) By recognising that people need to be engaged and not feel disenfranchised from the process. Given that there is no one size fits all approach and as evident from the research, healthcare systems can vary from serving populations of 750,000 to those exceeding three million; it will be necessary to consider the reasonableness of purporting to engage everyone or, as an alternative, providing opportunity to be engaged and ensuring effective communication. Such processes need to acknowledge also that consultation will not always result in consensus and expectations will need to be managed.

(VIII) Through the operationalisation of strategy there is little to be gained from developing a plan *per se*. There is everything to be gained from the thinking that lies behind the plan and the action that follows it. A strategic plan that remains a theoretical concept and is never actualised serves only to add to negativity about the intent of planning. The operationalisation of strategy requires identification of priorities, leadership, communication and resourcing. It requires a commitment to change management and reporting of both the successes and failures. The monitoring of planning outcomes should not be artificially compressed into what can be easily collected and measured as clearly defined key performance indicators (KPI). Caution should be applied in taking this path as the KPIs can quickly become the drivers while the strategic intent and emerging opportunities are lost.

Conclusions

The healthcare system is frequently described as a complex adaptive system; a collection of individual agents that have the freedom to act in ways that are not always predictable. Complex organisations, such as the public health system, have demonstrated adaptive, creative and capable ways of developing solutions to problems for decades and many of these innovations have arisen from the bottom up. However, in attempting to make sense of the future and to create some sense of control and stability; scenario analysis and other such predictive tools have been utilised to support a predominantly top-down approach to strategic planning. Smith (8) argues that such linear approaches are flawed because they are founded on the faulty expectation of causality, even though the notion of strategy itself is on the reduction of uncertainty.

People will participate in planning and support the implementation of plans if they value the intended outcomes and believe they are achievable. If the strategy does not fit with their current lived experience and seems intangible, then the challenge lies in gaining commitment. This needs to be part of the thinking associated with the planning process and not an add-on function once the plan is documented.

It is acknowledged that predominantly health service managers and leaders are held accountable for deliverables in the short-term. Targets such as budget performance, access/wait times and activity are in fact the reality of a public sector health service. However given the complexity of the system and an environment of unprecedented change, perhaps the health system would be better served by leaders who had the capacity to link short-term targets to the stability offered through strategy or as Smith (8) suggests, perhaps we are better led by senior officers who are able to manage boundaries that govern equilibrium, as it is in this environment that innovation and creativity are likely to emerge.

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Footnote

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Ethical Statement: The author is accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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