

CHAPTER I

INTRODUCTION

As an introduction to the SHP₅, this chapter includes a review of the philosophy and authority of the Alaska Statewide Health Coordinating Council and the Alaska State Health Planning and Development Agency. An overview of the background, purpose, scope, plan development process and time frames is also presented.

PHILOSOPHY

The planning philosophy of the Alaska Statewide Health Coordinating Council (SHCC) is to provide the framework around which consumers and providers fully participate as decision makers in the health planning process. Broad community participation is utilized in the identification of health needs and the allocation of all available health resources in order to best meet those needs. The planning process values all Alaskan health providers. This includes Federal agencies (Alaska Area Native Health Service, the military health system and the Veterans Administration); State agencies; private organizations and associations; the Regional Health Corporations and local governmental entities. These providers in cooperation with individual consumers provide the incentives, information, policies and guidelines crucial to the development and maintenance of a health system sensitive to the needs of Alaska. This philosophy of participation ensures both the development and implementation of a comprehensive and effective health plan bringing about positive changes in individual and community health.

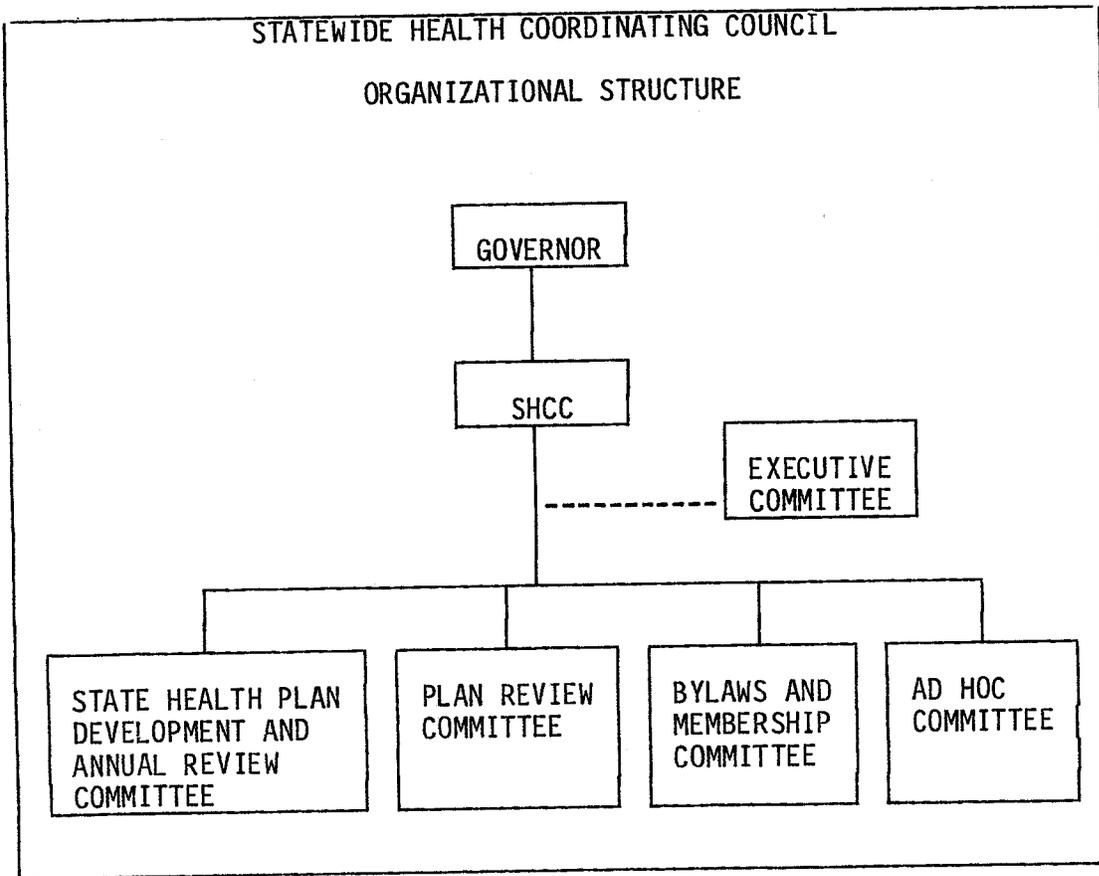
The exclusion of Federal agencies and institutions from P.L. 93-641 remains a major concern of the SHCC. A similar concern exists over the exemption of infirmaries and nursing units of the State operated Pioneer Homes from the State Certificate of Need regulation. Exempting State and Federal health resources from the mandated review and planning process compromises the integration of planning and implementation activities and the efficient allocation of resources. The exclusion produces a health system that duplicates services and produces less effective and more costly health care. To provide the most efficient health care system possible to all Alaskans, the SHCC strongly recommends the inclusion of all health care resources in a coordinated planning and review process.

AUTHORITY

Federal: Public Law 93-641 requires that the Statewide Health Coordinating Council develop a State Health Plan (SHP). Also, under P.L. 93-641, the SHCC can require revisions of the Health Systems Agency plans to achieve appropriate coordinating or to deal more effectively with statewide health needs.

State: Alaska Statute 18.07, enacted in 1976, authorized the Office of State Health Planning and Development to act as the designated State Health Planning and Development Agency. In addition, AS 18.07 established the Statewide Health Coordinating Council and broadened the State's involvement in the regulatory aspects of health care by establishing the State Certificate of Need program. The legislation also created a funding mechanism to assist Alaska's three regional Health Systems Agencies to meet their planning responsibilities. (In 1980 the Office of State Health Planning and Development was granted Division status.)

Figure 1-1



BACKGROUND

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) established areawide health planning bodies known as Health Systems Agencies (HSAs) and Statewide Health Coordinating Councils (SHCC). These organizations, together with the State Health Planning and Development Agencies, have broad authority over the allocation of health resources. Both consumers and providers are represented on the governing bodies of these organizations, with consumers constituting a majority of the membership. (For definitions, refer to the Glossary.)

The three Health Systems Agencies established in Alaska are:

the Southeast Alaska Health Systems Agency
(SEAHSA);

the Southcentral Health Planning and Development, Inc.
(SCHPD);

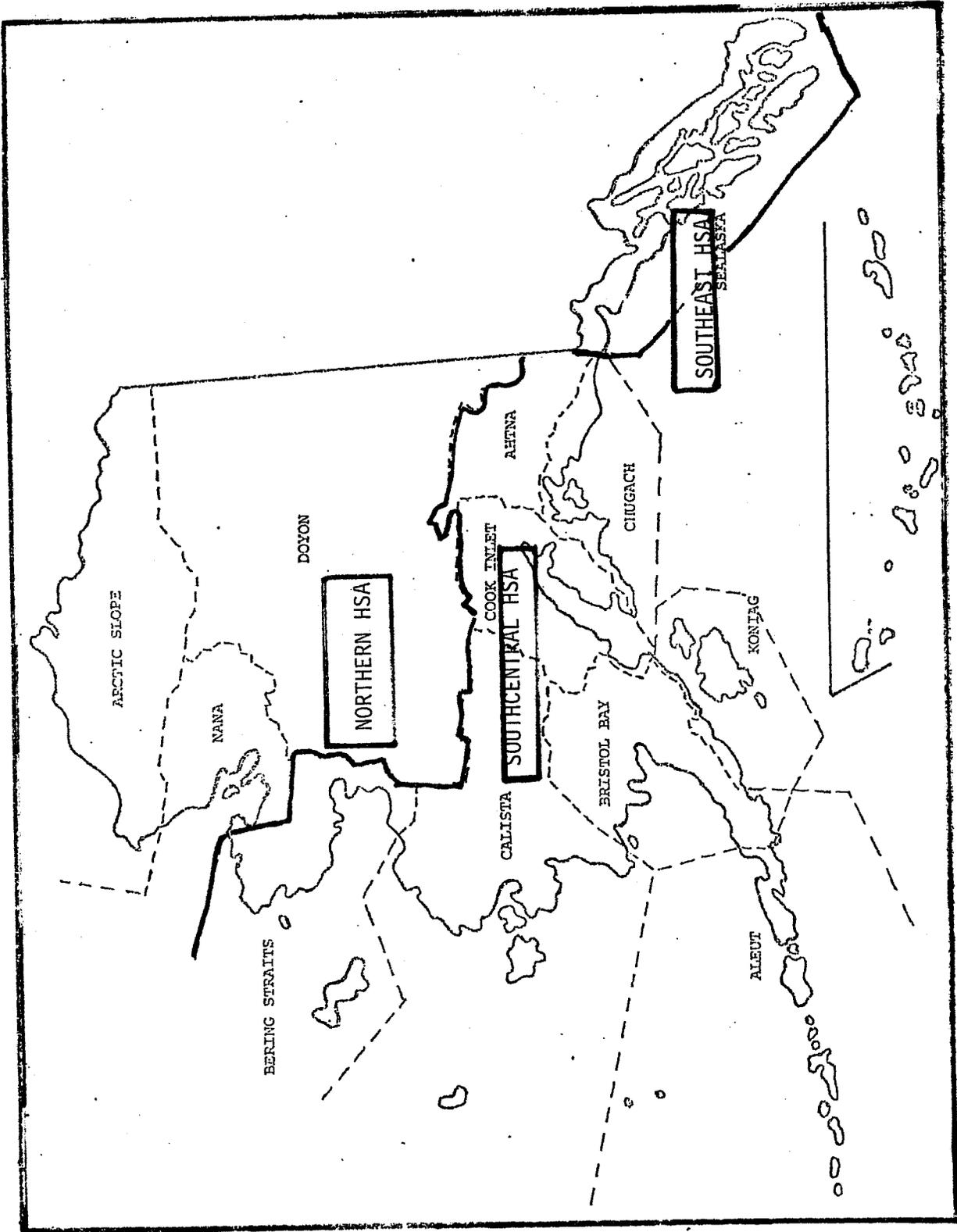
the Northern Alaska Health Resources Association, Inc.
(NAHRA).

Each HSA has gathered and analyzed health data and has prepared a Health Systems Plan (HSP), which is a detailed statement of goals for improving the health of its local residents. The HSAs also prepare an Annual Implementation Plan (AIP) which defines yearly objectives for implementation activities of the HSPs. The governing body of each HSA, which contains a majority of consumers (between 51% and 60%), assists with the development of the HSP and the AIP, and after approval, submits these to the State Health Planning and Development Agency for incorporation into the preliminary State Health Plan.

To avoid conflicting districting and multiple boundary areas, the three HSA service areas are compatible with those of the 12 Native Regional Corporations. Figure 1-2 illustrates the consistency of the HSA service areas and the Native Regional Corporations.

Figure 1-2

HEALTH SERVICE AREAS
NATIVE REGIONAL CORPORATIONS



State Health Planning and Development Agency (SHPDA): The State Health Planning and Development Agency, designated by the Governor, conducts health planning at the State level. The SHPDA for Alaska is located in the Department of Health and Social Services, Division of Planning, Policy and Program Evaluation. Functions of the SHPDA include assisting the SHCC in the performance of its duties, preparing the preliminary State Health Plan and assisting the Council in the development of the approved State Health Plan.

Statewide Health Coordinating Council: Since 1977, the State Health Planning and Development Agency has been working with the 30 member, Governor-appointed Statewide Health Coordinating Council. Because of the reduction in Federal funds for the SHCC and the reduced budget for the State Department of Health and Social Services, the SHCC at its February 1982 meeting reluctantly voted to reduce the membership from 30 to 20 members. This reduction will ultimately have an effect upon the mandated functions of the Council. Presently, the functions include project and categorical plan reviews, reviewing and coordinating Health Systems Agencies' applications and plans, and statewide implementation activities. The SHCC has both statutory and informal operating relationships with health-related State Advisory Boards.

State Health Plan: From the preliminary Plan, prepared by the SHPDA, the SHCC develops the proposed and approved State Health Plan. The State Health Plan is used by the SHPDA and SHCC in the performance of their functions mandated by P.L. 93-641. The SHP is a five year Plan with updates and revisions required annually. The Alaska State Health Plan was approved by the SHCC in February 1979 and thus has a five year cycle from 1979 to 1984.

SCOPE

The SHCC, the SHPDA, and the three HSAs have endorsed a holistic approach to health planning. The preliminary Plan examines factors in four broad areas which affect health:

Environment- aspects of the physical and social surroundings over which the individual has little control.

Lifestyle- decisions made by individuals which affect their health.

Health Care System- the quantity, quality, arrangement and relationship of people and resources involved in the provision of both physical and behavioral health services.

Biology- aspects of health which are related to the human body as a consequence of genetic inheritance and basic biology of the individual, including the aging process.

PURPOSE OF THE PLAN

The purpose of the State Health Plan is to provide a starting point for designing a decision-making framework concerning resource allocation in the development of health services, health manpower, and medical facilities. As stipulated in the DHHS Guidelines for the Development of the State Health Plan, the State Health Plan is to be a policy statement and to serve as an instrument for cost containment. More specifically, the purpose of the Plan is to present guidelines which can be used by anyone who makes decisions affecting the health and well-being of the Alaskan citizen, with the ultimate aim of allocating resources in such a way as to control costs and also attempt to achieve the health status and health systems goals and objectives of the State Health Plan. As summarized in the Guidelines:

"The purposes of the State Health Plan are: 1) to develop and articulate state health and health related policies; 2) to guide resource allocation in the achievement of equitable access to quality health care, at a reasonable cost; and 3) to develop a coordinated and comprehensive approach to the identification and resolution of health problems within the state."

The final document, which is revised and modified annually, is intended to serve the central framework for all health planning activities in the State. The State Health Plan is used to:

locate and assign responsibility and accountability to the various components of the health care community;

formulate and clarify problems and solutions to these problems and evaluate alternatives;

resolve conflicting interests;

avoid fragmentation, duplication and improper utilization of resources;

provide a long-range, systematic approach to making necessary adjustments in the health delivery system.

With these purposes foremost, the SHCC also reinforces the statewide nature of this Plan. As a Plan which integrates and coordinates the regional Health Systems Plans, the various plans and reports of the Regional Health Corporations, information available from the Alaska Area Native Health Service, the public hearing comments from approximately 200 individuals and organizations, and the categorical plans of the Department of Health and Social Services, the State Health Plan represents more than a Plan intended only for the Department of Health and Social Services. The State Health Plan is designed and intended for all Alaskans, as is its implementation.

PLANNING PROCESS

The process used for the 1983 revision of the State Health Plan was similar to that used in the production of the previous Plans. Figure 1-4 summarizes the process utilized in producing the SHP.

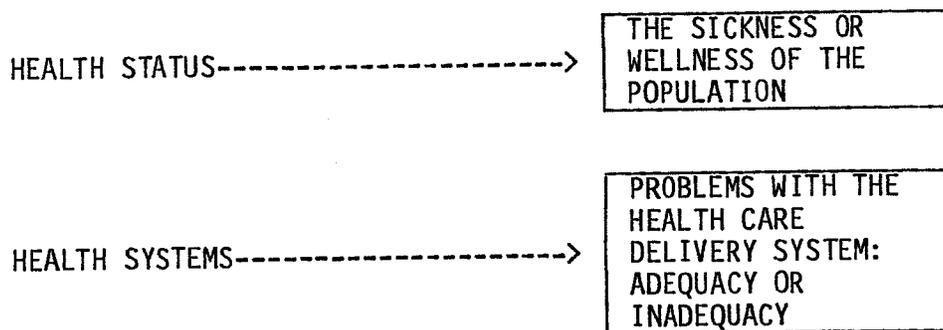
In the analysis of health status, a procedure is utilized in which HSA and other data are incorporated into a statewide framework using a problem-solving approach. Information concerning health systems responses to categorical problems is added where available, to help provide closer linkages between health status problems and health systems solutions. Health services utilization is also included to demonstrate the linkages between health status and health systems.

Using the Levels of Care criteria and recommendations from the former approved State Health Plan, a statewide analysis is completed which compares existing resources to the recommended resources of a basic health care system, the visible aspects of the analysis being availability and accessibility. Cost aspects are implicit in the Levels of Care concept and additional financial analysis will be available for Levels I & II in January 1983. More definitions have been added to the Levels of Care with the inclusion of the "Village Clinic" and "Community Clusters and Highway Communities" reports.

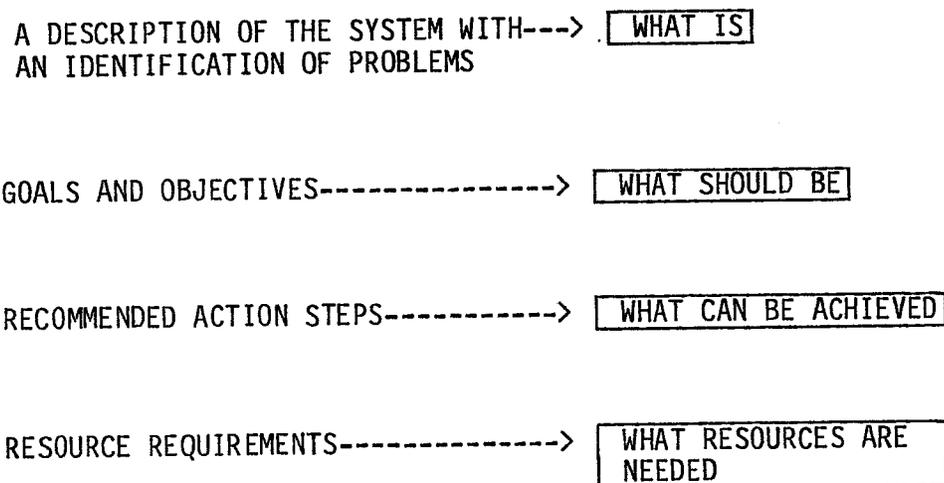
HSP goals, objectives and actions are assembled in a program categorical framework. These are discussed with State government agencies, particularly the Department of Health and Social Services program managers. The HSPs are compared with State government programs, budgets, goals and objectives, and plans. In reconciling objectives and actions for the preliminary State Health Plan, consideration is given to HSP recommendations, State government program expertise and documents, and indicators from the health status and health systems analysis.

The planning approach taken in developing the State Health Plan is the problem solving process. This requires that goals, objectives, and recommended action steps be based on a thorough identification and analysis of health problems.

Briefly summarized, the health problems were divided into two categories:



The content areas for each include:



The key to the analysis is the Levels of Care concept explained in Chapter 5. The Levels of Care components provide the linkages between health status and health systems, goals and objectives, and actions and resource requirements.

One of the analytical tools used in the State Health Plan planning process is the Taxonomy of the Health System Appropriate for Plan Development (Department of Health, Education and Welfare report, 1979). This classification has been used by both the HSAs and the SHPDA in the development of the plans. The concept has been especially useful for the SHPDA in providing a framework for:

- the analysis of the Health Systems Plans;
- the analysis of the health services;
- the development of goals, objectives, and actions.

The taxonomy provides a classification methodology which organizes health care activities into two dimensions: services and settings. Figure 1-3 presents the listing of services and settings as defined in the taxonomy.

Figure 1-3

SERVICES		
. Community Health Promotion and Protection		
..Health Education Services	. Habilitation and Rehabilitation	
..Environmental Quality Management	..Medical Habilitation and Rehabilitation	
..Food Protection	..Therapy Services	
..Occupational Health and Safety	. Maintenance Services	
..Radiation Safety		
..Biomedical and Consumer Product Safety		
. Prevention and Detection		
..Individual Health Protection Services	. Personal Health Care Support Services	
..Detection Services	..Direct Patient Care Support Services	
	..Administrative Services	
. Diagnosis and Treatment		
..Obstetric Services	. Health System Enabling Services	
..Surgical Services	..Health Planning	
..Diagnostic Radiology Services	..Resources Development	
..Therapeutic Radiology Services	..Financing	
..Clinical Laboratory Services	..Regulation	
..Emergency Medical Services	..Research	
..Dental Health Services		
..Mental Health Services		
..General Medical Services		
SETTINGS		
. Home	. Ambulatory	. Free Standing Support
. Mobile	. Short-Stay Inpatient	. Community
	. Long-Stay Inpatient	

Figure 1-4 illustrates another of the components used in the planning process for analyzing health status and health systems problem areas.

Figure 1-4

PROBLEM ANALYSIS		
INPUTS:	Health Status Data Health Systems Data State Plans & Program Data HSA Identified Problems	
ANALYSIS:		
DESCRIPTOR/ INDICATOR	HEALTH STATUS	HEALTH SYSTEMS
	Morbidity Mortality Disability	Availability Accessibility Acceptability Continuity Quality Cost
COMPARATIVE MEASURES	Subarea Region State Nation Target Population Trend	Population Communication Transportation Isolation Existing Services Need
INTERVENTIONS/ CAUSAL FACTORS	Environment Lifestyle Biology Medical or Health Care System	Health Services Health Settings
Questions forming the PARAMETERS OF THE ANALYSIS <ul style="list-style-type: none"> -Health Status within the State -High Risk/Target Populations -Characteristics of the Health Systems -Common problems with the delivery and performance of Health Systems -Deficiencies in the Health Systems which require a State response 		

The preliminary State Health Plan is reviewed first by the SHCC Plan Development Committee (PDC) and then by the full SHCC membership. Prior to the SHCC review, a distribution is made to other interested parties whose comments provide additional guidance to the SHCC. Acting on recommendations of the PDC, other reviewers, and other SHCC members' input, the Statewide Health Coordinating Council then approves revisions it deems appropriate to produce a proposed State Health Plan (PSHP). The proposed State Health Plan is the copy for the public hearing process. The Plan Development Committee considers these comments and presents them to the SHCC for review and approval.

Figure 1-5 illustrates the developmental steps that were involved in the production of State Health Plans.

Figure 1-5

STATE HEALTH PLAN DEVELOPMENT		
	ACTIVITY	Completion Date
HSPs CROSS REFERENCED ↓	SHPDA staff assembles each HSP according to the SHP format	9/83
PROBLEM IDENTIFICATION ↓	SHPDA identifies Health Status & Health Systems Problems using: -Health Status Data -Health Systems Data -State Plans & Program Data -HSA Identified Problems	9/83
PROBLEM ANALYSIS ↓	SHPDA reviews HSA information and analysis and assesses the applicability from the perspective of statewide need SHPDA analyzes the HSA responses utilizing: -Services & Settings -Agency Meetings -Consistency with: National Priorities & Guidelines State Priorities & Policies	9/83
↓	SHPDA performs analysis to determine: -Health Status -High Risk/Target Population -Health Systems Characteristics -Common problems with the delivery of services and the performance of the health system -Deficiencies in the system	10/83
GOAL/OBJECTIVE SETTING ↓	SHPDA builds upon the planning efforts of: -HSPs -State Government Agencies -Private & Federal Agencies SHPDA reconciles goals and objectives of HSPs & State Government Agencies	10/83

Figure 1-5 Continued

STATE HEALTH PLAN DEVELOPMENT		
	ACTIVITY	Completion Date
RECOMMENDED ACTIONS	<p>SHPDA reviews:</p> <ul style="list-style-type: none"> -HSPs actions -State Government Plans/ policy/budgets -Alternatives <p>SHPDA determines feasibility of implementing Actions</p>	10/83
↓		
RESOURCE REQUIREMENTS	<p>SHPDA reviews Resource Requirements from a statewide perspective of:</p> <ul style="list-style-type: none"> -Manpower -Facilities -Financing -Equipment -Feasibility 	10/83
↓		
pSHP ₅ COMPLETED	<p>SHPDA completes pSHP₅, finalizing the integration of the HSPs</p> <p>SHPDA publishes pSHP₅</p> <p>SHPDA distributes pSHP₅ to:</p> <ul style="list-style-type: none"> -SHCC/Plan Development Comt. -HSAs -State Government Agencies -Interested private agencies -DHHS/Region X 	11-83
↓		
SHCC Proposed SHP	<p>SHPDA meets with SHCC Plan Development Committee (PDC)</p> <p>SHCC reviews pSHP₅ & PDC recommendations. SHCC approves proposed SHP</p>	11-83
↓		
	<p>SHPDA revises pSHP₅ in accordance with SHCC revisions</p>	1-84
↓		
	<p>SHPDA distributes proposed SHP₅</p>	1-84
↓		
PUBLIC HEARINGS	<p>SHCC holds public hearings</p> <p>SHCC PDC reviews public hearing comments & provides recommendations to SHCC</p>	2-84 4-84
↓		
SHCC APPROVED SHP ₅	<p>SHCC reviews PDC public hearing report, incorporates comments and approves SHP₅</p>	5-84
↓		
Final SHP ₅	<p>SHCC approved SHP₅ submitted to the Governor; Governor approves State Health Plan</p>	7-84

WELLNESS

People who practice high level wellness take responsibility for their own health in many ways, not all of which seem health-related in the usual sense of the word.

Donald B. Ardell

The organizational structure of medicine in the United States is geared primarily toward curative and therapeutic services. Less than 2.5 percent of the annual United States expenditures for health care is spent on prevention. Most incentives are to cure people, not to keep them well. This attempt to reconstitute health once it has been destroyed does little to reduce demand for services.

With the available resources limited because of an ever-increasing demand brought on by a general national affluence and third party payment for health services, it is imperative that more attention be given to looking beyond the present health care system toward achieving the basic goals of health, well-being, and wellness. Those goals are expressed in the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity".

In response to these goals, there has been a growing shift in the belief system today regarding the physical/medical health care system and the relationship to wellness. The element of this shift includes such concepts as holistic medicine, primary prevention, health promotion and education, self-actualization, and stress adaption or management. This shift has profound implications for the design of health programs. It is no longer sufficient to think of health in terms of "physical" well-being. Different paradigms are being developed to enhance a broader universe which encompasses the concept that individuals have a responsibility for their wellness and illness.

The State Health Plan endorses the concept that there is more to health than the absence of illness and that there are things that can be done as individuals and as a society to enhance health and well-being. This concept is frequently expressed as wellness and can be characterized in the following ways:

First, it is not so much a state or a condition as it is a goal and a process. It is a process which evolves and continues through time with the goal being one of maximizing each person's potential.*

Second, it is active and involves initiative. Unlike good health, which people often experience regardless of their action or inaction, wellness involves intentions and actions, attitudes and life styles.*

Third, an individual may experience wellness while at the same time experiencing clinical symptoms. While wellness and illness are at opposite ends of a health continuum, they are not mutually exclusive.*

Fourth, it involves an integration of the many dimensions of human life: physical, mental, spiritual, social and environmental. Its orientation is toward wholeness and away from fragmentation.*

Fifth, there is both an individual and an environmental dimension to wellness. There is a strong emphasis on personal responsibility but a clear recognition that social supports and reinforcement are essential components of a wellness orientation.*

What these characteristics illustrate is not only the need for consumer responsibility, but also the need for a dynamic balance in the health system in which individuals can receive the mix of healing interventions most beneficial to "High Level Wellness". A unifying principle for wellness is consciousness. It is towards a new consciousness of wellness that this Plan is dedicated.

*These five characteristics were developed by Roger T. Williams, in his paper "Prevention/Wellness in Rural Settings", presented at the conference "Primary Prevention: An Idea Whose Time Has Come and Come and Come", held May 9-11, 1979 at Wonder Valley Ranch near Fresno, California.

LINKAGES

The concept of wellness as a linkage between health status and health systems is not a new idea but one which is still in the process of development and change. Dr. Robin MacStravic, in the report entitled SHP Development: Principles, discusses this concept. He relates health status and health system linkages to health services utilization and expands the interface to include lifestyle and behavioral components as well:

The linkage between health status and health systems is health services utilization. If people are to become healthier because of changes in what the health system does, it will be because they change how they use the system. On the other hand, it is by no means the fact that use of health services is the only way to change health status: diet, exercise, use of tobacco, alcohol, drugs, etc. The behavior of organizations may either promote or endanger health: public health immunization, sanitation, education programs, industrial pollution, occupational hazards, etc. If any significant changes are to occur in health status or health systems performance, it will be through changing how people and organizations behave.

This revision of the State Health Plan presents the linkages of health systems to the goals and objectives, using the above linkage concept. The identification of health status problems and their causal factors in Chapters 3 and 4 provides an initial analysis in recommended health systems responses. The existing health resources responding to the current health status problems are described in Chapter 5 as the corollary to the health status chapters. The possibility for improvements in health status as related to proposed health systems is further expanded through the Levels of Care concept which describes the reality of providing appropriate health care resources for Alaskan communities. The health status and systems needs and analysis defined in Chapters 4, 5, and 6 form the basis for the goals and objectives of Chapter 7.

PRIORITIZATION AND IMPLEMENTATION

Priorities for the Statewide Health Coordinating Council were determined at the May 25, 1984 meeting. This meeting saw the culmination of several activities designed to provide a data base upon which the SHCC could form their recommendations for priorities.

The priorities for the State Health Plans are:

- Mental Health Problems
- Alcohol Abuse
- Accidents
- Maternal and Child Health
- Suicide
- Heart Disease
- Drug Abuse

As in previous years, priorities provide the basis for the development of implementation plans. The SHPDA is currently developing implementation plans for Mental Health Problems, Alcohol Abuse and Accidents. These will be reviewed in August and the SHCC will revise and approve these plans at their September teleconference meeting.

Implementation activities will be the focus for the Statewide Health Coordinating Council and SHPDA, Health Planning staff for FY 85. An Implementation Chapter is currently being developed for State Health Plans and the Executive Summary of the State Health Plan.

