Building Country & Community Health Systems:  
The Futures and Systems Redesign Approach  
for presentation  
III International Congress of Center for  
Latin American Development Administration  
October 1998, Madrid Spain  

by  
James T. Ziegenfuss  

Abstract  
This paper addresses the purpose, process and outcome of designing health systems in the context of country and community futures. Beginning with the recognized need for a proactive search for future, the paper is presented in four parts: (1) proposing a search for country and community futures; (2) pressures for future design and redesign; (3) general "double track" procedure for redesign and (4) a case of community visioning. An example of one patient is used to illustrate various aspects of a care encounter with the health system. Based in systems thinking, the model presented is addressed to both macro level (whole country and community) and micro level work (quality management projects). Discussion of America's future illustrates the macro approach while immunization is the subject of the project level review. A case example of one community's future planning effort is reviewed to illustrate the connectedness of health system development to whole community futures.
"Dad, will our country be healthy when I grow up?"

As parents we should be able to answer the simple but hard questions our children ask. But can we answer this one? We can reply with questions of our own. Will we have economic and social prosperity - including a health system for all citizens? Do we believe that our country's years ahead will be seared by conflict and environmental disintegration or marked by beauty and prosperity?

Citizens can stop personal and social decay and build a durable future through visioning, reengineering and continuous quality improvement. To support health and wellness and social development, countries and communities need a formal visioning and reengineering process for at least five reasons.

- First, few countries or communities currently have a vision of a desired future. Some feel an easy extrapolation of the past will do.
- Second, in years past we might have relied on a leader's single vision of the future but with growing complexity this too is no longer adequate.
- Third, we are increasingly searching for ways to involve citizens to improve productivity and to improve the health of our communities.
- Fourth, we must design country and community futures openly and consciously as a way to generate excitement and hope.
- Last, we need guidance on our day-to-day decision making. How will we know which decisions make sense if we have no desired future?

Responding to questions about how to design a country or community systems means
addressing four questions:

- What exactly are we going to do?
- Why must we redesign for the future?
- How will we approach the design and redesign task?
- Have others successfully completed futures work?

The creation of a country or community's health system is presented here as a parts - whole problem. Health care services, delivery, values and purposes are a "nested system" embedded in a larger context of country and community. This monograph is presented in four parts: (1) a proposal for an approach to social and health system design and development; (2) the pressures urging a future search; (3) a general "doubletrack" procedure for design and redesign; and (4) a case example of one community's effort.

We begin with a search for purposes, processes and outcomes of successful redesign in the public sector. Let us first review a public administration story of one city's reform and redesign--Tilburg, the Netherlands. The "health" of the city is an implied gain in an overall change effort.

_"They really run this city like a business"

"Reinventing government" has become a catch phrase of America's new-breed mayors, who apply private-sector principles to city management. But long before any of them allowed for-profit companies to bid on sewer contracts, the Dutch city of Tilburg had refined the city-as-business concept. Since 1985, the city of 185,000 has been run according to the "Tilburg Model," a management plan so successful that the city trademarked the name and sold its ingredients to multinational accounting giant KPMG.

When the textile industry on which it depended collapsed in the late 1970s, Tilburg declined in a manner familiar to many post-industrial American cities: Steep budget deficits became the norm, taxes soared, and the civil service grew bloated. 'When I first came here, there were five bureaucrats drinking coffee and smoking cigarettes watching three people swim,' says Pieter Bax, who operates four
municipal pools. By the mid-1980s the Netherlands' national government was considering whether it should take over the foundering city.

Tilburg saved itself from intervention. Streamlining was the first step; the number of bureaucratic departments was reduced from 16 to six, each headed by a single director instead of four. And by offering early-retirement packages and semiprivatizing services such as gas and electricity, the city slashed its payroll by almost 1,000--without a single firing.

The remaining workers were instructed to think of citizens as "customers" and of traditional city services--marriage licenses, public parking, even the local museum--as "products." Every year, each agency responsible for a product must submit a minutely detailed "business plan" to the city. Bax, for example, estimates not only the number of people who will use the pools he supervises (this year, 700,000) but also how many will take swimming lessons, eat in the poolside cafes, or lease the facilities for water polo tournaments. The plan becomes a formal contract between Bax and the Social Employment Department, which oversees his agency; in exchange for funding, Bax agrees to provide "products" for his "customers." Three times a year, his plan is reviewed. "If we are not meeting the target, we draw up a new business plan," says Bax. And if his new plan fails? "I may lose my job."

"We turned the civil servant into an entrepreneur," says City Comptroller Pieter G. van der Poel. "He was given increased responsibility and [that] led to a change in his attitude. Annual customer surveys--in which an independent firm polls 1,000 residents--reveal that Tilburg's municipal workers, once notorious for bumbling, now deliver products with the utmost efficiency. Only one worker handles each request for a building permit, for example, and, aware that its work could be farmed out to private bidders, the city's printing department comes through with competitive prices.

The ship-tightening has allowed Tilburg to run a total budget surplus of $44.9 million since 1988. Those funds have been used to build a $5 million soccer stadium and an $8 million concert hall, a showpiece inaugurated by Queen Beatrix last year. The city's taxes have fallen as well: Formerly the Netherlands' third highest, they now rank 31st.1

This brief story of the Tilberg success is only one example of a community "turnaround" of its public sector, what redesign can accomplish through vision, reengineering and total quality management. In both developed and developing countries continuous reinventing is now taken as a
guiding principle with strong potential to create positive change. In the health services a similar redesign need prevails.

Let us now contrast this development in public administration with the state of affairs in one community's health care system. The patient - Alfred Smith is a fictitious composite of several real examples.

On the day of his 63rd birthday, Alfred Smith experienced severe chest pains for a brief period. On telephoning his community health clinic he told the nurse the pain had passed but was told to come right to the office. Unfortunately he had no car - public transportation was his main option. On arrival the nurses showed him into an examination room. His pulse and blood pressure were taken but not reported to him. Dr. Forrester came in to review the situation. Picking up his chart he immediately began talking about the medication Alfred's son was taking - he had been given the son's patient record by mistake (as the son also used this physician group). After review, Dr. Forrester suggested Alfred report to the hospital for stress tests. When asked which hospital he preferred, Alfred said he did not care - he had no way to judge hospital quality.

Following the stress and other tests, Alfred was told he needed a bypass operation - arteries were blocked. He was given several non-invasive options including medication and follow-up. Only one surgical team was available to him - they were "preferred providers." While the operation went smoothly, follow-up care was problem filled. He was discharged after six days with no one to care for him. His initial prescription was incorrect. He struggled after the operation requiring rehabilitation services. His records were lost when referrals were blocked by his insurance group. When the records arrived - they were his son's. His physicians were part of a group competing with the corporate owners of the rehabilitation center. When he began to complain, he found there was no ombudsman and only a lengthy grievance process. Before he could get any satisfaction, the billing paperwork overwhelmed him.

What are the futures and redesign issues here? Some that come to mind include: access to care, information flow to the patient, data on hospital quality and performance, impact of competitor systems and consolidation, the role of privatization and profit in the public health system.

Some critics would attack the health care system and its providers as the focus - this is a
necessary but not sufficient point of departure. For example, the design of health systems is
influenced heavily by the "market maximized" versus "market minimized" orientation of the
country.² We can address the design of the health services system ("part" of a whole country) as an
independent unit. Or, we can follow the perspective of Paul Starr:

"My second premise is that the organization of medical care cannot be
understood with reference solely to medicine, the relations between doctors and
patients or even all the various forces internal to the health care sector. The
development of medical care, like other institutions, takes place within larger fields
of power and social structure."³

Health systems must be considered in the rich context of the social and economic past and present
of the host country. Thus the future of health care delivery is linked to the strategic future of the
country. The health of a nation is based on the health of the nation as a whole. The design and
development of future health systems is therefore part of a general search for country and
community futures.

PART 1: PROPOSING A SEARCH FOR COUNTRY & COMMUNITY FUTURES

As this century closes, public and private leaders must address specific domestic and
international problems, problems that cross national boundaries and parts (or subsystems) of
nations:

• Citizens are without health care in nations with the most advanced medical technologies
  and personnel in the world.

• Homeless people and some families live on the streets; sheltered by cardboard, scavenging
  for food in trash cans.
Little children fight violence and fear in school.

Tyrants continue to oppress the people of third world nations, threatening regional peace while torturing innocent citizens.

Struggling new democracies in South America and Eastern Europe ask for help with health and education system design; a request we have been hoping to see for decades.

Responses to all of these problems are needed but where is our leadership? On its cover, one national magazine headlined: "IS GOVERNMENT DEAD? UNWILLING TO LEAD, POLITICIANS ARE LETTING AMERICA SLIP INTO PARALYSIS." Many citizens in many countries would echo this question in reference to their country as a whole and in reference to parts such as health care.

Founders of nations have vision. In America, the vision was codified as the Articles of Confederation and a Bill of Rights. These "design guides" collectively and interactively offered support for the birth of a nation. Several hundred years later it seems that national leaders in many countries embrace the future by attacking issues in a disconnected fashion - one at a time, without a sense of the whole. We promote wellness and market smoking products simultaneously. Crime - depicted as a trauma center's "knife and gun club" - undermines social health while manufacturing pollutes the environment. We have no feeling for which problems solved first and together will create a "healthier" nation.

How can leaders and citizens weave a country's problem solving actions into a coherent tapestry - an attainable vision of a desired future? All leaders - public, private, community, academia - presume to know what their nation would like to become, and the best strategies for
taking us from here to there. In America, the Clinton health care reform effort in 1993 was one outstanding example of public administrators' assumptions about a health care future for clinical providers and citizens. Since citizens did not systematically discuss what their country or community health system future was to be, our leaders assumed they knew, or guessed, or both. The expected match between our desired future and leadership toward that future was a gamble too much driven by luck. In our American case, large scale reform was dramatically rejected.

Citizens in all countries are asked to choose among alternate paths to the future (more government in health care or less; healthy environment versus jobs) and even different futures. But in most countries the path to a future for the country and community is unmarked and the destinations are unknown.

Citizens have limited methods for communicating individual visions, hopes and aspirations. Sometimes (often?) the situation seems to be that leaders "talk at us but do not listen to us." We have endless government reports and speeches, hospital and insurance strategic plans, educators' lectures of history - independent disconnected thoughts and actions that would have us reengineering our country one part at a time - health care but not crime, commerce but not education. This approach has failed for companies, and for schools and hospitals struggling to define their own successful destinies. Many leaders and citizens want truly to improve society's prospects. But leaders and citizens have no means to foster clear and connected visions of their country or communities - either as wholes or parts such as health care.

THE PROPOSAL

What should citizens do about this? Citizens and leaders must present an answer to the
little girl's question "How healthy will our country be?" Will we have a population of healthy citizens with access to cost-effective quality health care?

Can we not cultivate countrywide efforts in many nations to create visions of a "healthy" public future in a broad sense and with regard to medical care? In corporations, communities, schools and government agencies; leaders, citizens, teachers and students can contribute their ideas and their dreams to a vision of where their country or community is going to - engaging in a nationwide search for future. Leaders and citizens of Tilberg searched for and found public administration success in city government. Efforts like Tilberg need to be extended to countries and communities with a dual focus on the whole and on the parts such as health care.

The quality management and reengineering work by the citizens of Tilberg was part of an implied vision of the city's future - more efficient and effective public management. We can begin by asking - what are visions? Uniquely defined by their creators, visions are pictures that recognize the past but with creative dreams and current driving forces added. A country's or community's strategic vision is developed through attention to four activities: an analysis of trends past and present; a vision of the desired future; a comparison of the fit between present and vision; and a set of strategies and programs that become a bridge to the future. An open, participative approach requires that public and private leaders use existing groups and institutions to understand and build on their nation's competitive advantage. Four groups could lead "forgotten citizens" in a futures search in their respective territories. The subject is the whole of the country/community with our focus here the health care part.

1. Community leaders hold "town meetings" to discuss the country-at-large and the
conditions and aspirations of their communities including health care delivery, new services, population health status and wellness and prevention goals.

2. Corporate leaders could define and describe the health system most supportive of business, identifying what they need from the nation and what they will give back to their respective communities (from employee health to wellness promotion).

3. Teachers in secondary schools and colleges could turn classrooms into design exercises, examining the country and community future in whole and in parts (e.g. from healthcare to transportation by electric car to education over distance), moving students away from rote memorization of the past and present characteristics of their community.

4. Political leaders and government agencies could formulate their own visions based on their domestic and foreign agenda.

With each group, leaders encourage and empower citizens and employees at all levels to contribute to a "watercolor sketch" of a desired future. In practical terms this strategic vision could be a short read for those citizens so inclined, widely disseminated by newspapers and magazines in every state, region and community. Beginning as a grand sketch, specifics are added to the vision over time. Citizens neither expect nor want detailed directives that become limits - well illustrated by the public rejection of the American health reform plan that would have reduced choice for citizens.

When leaders join with citizens to publicly produce a vision, countries and communities benefit in at least four ways.

- An opportunity is given for citizens to participate in the shaping of their destiny—a chance
for real voice and involvement in systems that will serve and support the health of their children.

- A **challenge** is offered to citizens and leaders to be **creative**, to paint an exciting picture of the future - of both whole countries and communities and critical parts such as health care.

- **Consensus** can emerge around a shared vision--one citizens and leaders could jointly work to build.

- Last, national attention will shift, moving from problem specific rhetoric - limited access to health care and unnecessary surgery - to the more difficult task of **defining** the health system of the future and the **path** that will lead us there.

Plans and speeches often contain the essence of public leaders' visions. In this partnership with citizens, public and private leaders compile and communicate their ideas directly and openly, even though creating a vision will be threatening by virtue of the decisions demanded.

How do we convince public administrators and citizens of the usefulness of this future-oriented proposal? Several commentators, including Professor Russell Ackoff, refer to Lewis Carrol's *Alice's Adventures in Wonderland* to illustrate the power of future thinking. As Alice journeys through the forest she arrives at a fork in the road. Faced with a choice of direction, she turns to the Cheshire Cat.

"Would you tell me, please, which way I ought to go from here?"
"That depends a good deal on where you want to get to," said the Cat.
"I don't much care where--," said Alice.
"Then it doesn't matter which way you go," said the Cat.

Our national and international futures experience tells us that the national, regional and local decisions of any country's leaders - daily ones - must be grounded in a vision of where the choices
will take them *and* of which path to choose.

If a country or a community is to move from the present to a most "desired and healthy" future, citizens must know and believe in the destination. And, they must see the path among the thicket of social and economic barriers to access and quality. If we expect our leaders to guide us from here to there, we should know quite clearly whether our visions are shared.

Despite the elite's cynicism about fading dreams, many citizens in poor countries and in outback areas have faith and are more than willing to put their shoulders behind forward actions. With bobbing and weaving and ill-timed, disconnected actions, leaders may be failing citizens. But as Ackoff notes, citizens too are to blame. "The principal obstruction between us and the future we most desire is ourselves". Some analysts clearly feel that the current reinvention work in American government will fail because of the lack of public interest and the deficiencies in leadership. We fail to be "empowered," both assertive and aggressive in defining what we mean by a healthy future and in moving toward a system that promotes population and personal wellness and which has the capability to treat illness of all of its citizens.

____________________________________

**PART 2: THE PRESSURES FOR FUTURE DESIGN & REDESIGN**

When you ask citizens what they think their country or community will be, most often they respond with versions of "the present", or they just shrug. Citizens think of the future as an extension of what exists - with health care, housing, education and crime as usual. The underlying assumption, however, is that current decisions and policies are expected to lead us to a higher standard - a more beautiful country with healthier and safer citizens. Were AIDS and the
continuing public health problem of addictions a part of the expected American future? As citizens, voters and managers, how do we know which public and private policies will support "progress" if we don't know where we are going?

If my daughter asked me the question "Will America be healthy when I grow up?", I'm not sure how I would answer. America may not have the countrywide vision and the courage to redesign and reengineer what does not work. Without a clear vision and implied policy, how can we decide how far to go in helping other nations address health care problems, e.g. AIDS in Africa? How do we respond to the myriad questions beyond health care including international business, energy and environmental actions, exploration of space and use of the Antarctic? Should we not expect to have some guiding direction that will help us in reengineering and quality management?

Some years ago we discussed with both interest and fear Alvin Toffler's *Future Shock*. We learned the concept of looking forward but I would restate this idea relative to the future of countries and communities.

*The "shock" of a future not desired is shock generated by lack of attention to creating the future we do desire.*

We tend to think that "others" will be shocked for example by a health care system less supportive than expected. We do not see that Alfred Smith's encounter could easily be our own.

The missing vision - of the country as a whole and of the health care part - is not derived from an absence of planning. We have had planning in private corporations, in government, and increasingly in our health and human service organizations. But we recognize that central planning is dead as demonstrated by the massive failures of controlled economies. Most of our
plans, as planning expert Russell Ackoff tells us, are simply linear extensions of the current. Extending a country's current programs in health, housing and transportation requires no different thinking, as leaders define present activities, add five to twenty percent and draw them out into the future. A plan appears - one without substantive change - a plan without vision and absent any radically reengineered processes.

The most troublesome aspect of this kind of thinking is that public and private leaders neglect the most critical facets of future building. The "easier" problems arise after we have decided what it is we want to do -- guarantee access to health care, cure cancer; increase immunization; be a protector of the environment. In reengineering, we apply our best organizational and managerial skills to increase efficiency and effectiveness, use resources wisely, and generate support from interested citizens. But unless and until a country has a vision, there is no target to which citizens can apply their best reengineering efforts.

Vision building work is a primary part of leadership, facilitating the creation of future by a partnership of citizens and public and private leaders. What each country becomes is a complex combination of our actions and the "environmental context" in which the country exists. In like fashion the health care system is nested in this larger environment. "Context" is a fluid linkage of politics, values and factors within our country and those external influences of a global society. A sample of these forces was identified in *Megatrends 2000* and is illustrative of the pressures on countries and communities and eventually on their respective health systems.\(^\text{15}\) The trends cited included these:

- Economic considerations transcending political considerations
The movement to worldwide free trade

The powerful drive of telecommunications

The relative abundance of natural resources

Competition for reduced taxes

The downsizing of economic output

Inflation and interest containment

The Asian consumer boom

The advancement of democracy and the spread of free enterprise

The obsolescence of war

Our new attentiveness to the environment

These are not just random disconnected events; they relate to and reinforce each other, a confluence of forces shaping a new world.

Some of the linkages to health care system design and delivery include: economic pressures to hold service costs down; explosive new technologies; taxation of no longer public non-profit hospitals; inflation and interest impact on the capital for hospital expansion; attention to "environmental health" and its personal health impact; and even the reduction of war and the issue of what to do with Veterans' hospitals.

Here is an example of the real impact of general megatrends on subsystems - health care in particular. In 1989, Coile presented twelve financial trends that would affect payment and pricing of services by hospitals.16

• from institutionalization to non-institutionalization
• from acute to ambulatory
• from invasive to non-invasive
• from third party to direct contracting
• from health insurance to integrated health plan
• from the insensitive consumer to the price conscious buyer
• from high-margin to low-margin pricing
• from local markets to global markets
• from long-term debt to equity capital
• from case payment to carload purchase
• from single product to diversified portfolio
• from public relations to marketing

These were suggested ones a decade ago. We have only to look quickly to the American health care scene to see that many/most have become industry reality.

The more general external change pressures on countries and communities constitute a "push from without" while the internal forces and actions of citizens are the "pull from within". Both insist on and influence reengineering and the creation of a desired future - for a country or a community and for their health care systems.¹⁷

EXTERNAL & INTERNAL CHANGES
- THE PUSH & THE PULL

What reasons comprise the urgency for redesigning country and community futures, including their health systems? Nine points define the external pressures for redesign - the push from without illustrated by a connection to the health care design problem.
1. **Cultural values must be visible in the designed future.** Will a leading value be constraint-free competition in domestic commerce? Hospitals are now considered competitive businesses that are taxable. Will we continue to pursue a market-maximized orientation toward health system design? Or do we create new regulation and greater governmental involvement in a move toward "public utility" status for health care?

2. **Technology is a threat and an opportunity for society.** How citizens control the continued development and use of technology means defining the role of technology in our future generally and particularly in our health care future. Will society reengineer with technology or find itself reengineered by technology? We can pursue unlimited acquisition of new technologies from genetic engineering to organ replacement, or we can control development. Citizens even now worry about the effects of innovation and technology on the human side of medicine and on costs.¹⁸

3. **Master the international economic climate.** Countries can expect to compete with other countries and whole regions nearly organized as a business conglomerate. Developed countries will compete with countries where standards of living and corresponding labor rates are very low, access to health care is limited and insurance coverage as part of the employment contract is far less prevalent. We can move production to sites where health care coverage is not required, or we can value health insurance as a mandate for our employees.

4. **Educational needs predominate.** Many leaders discuss the poorly developed or crumbling educational systems beginning, for example, with troubled school districts within cities. In America, we fear that education has lost its leadership advantage over other countries. For example, Japanese educational systems seem more capable of developing citizens that can move
quickly to the workplace by making stronger contributions earlier. In many communities there are vast differences between the teaching resources in high-powered suburban complexes and the inferior public schools in the inner cities and rural areas. Leaders and citizens have thought little about the nature of future educational systems that will need to serve a high tech society and prepare "consumer-oriented" patients. As society changes, we mindlessly rely on what educational philosophy and practice we have in place now.

5. **Natural resource and environmental stewardship is required.** In the latter 1990s, energy may be less of a problem for us than it has been in the past. Hopefully this will continue through uncertain developments in the Middle East, through oil spills, and through nuclear contamination. Leaders now debate air pollution, water shortages and the "greenhouse effect", postulating that environmental causes of disease are "opportunities" for improvement. Whether this becomes a crisis in the near term is less important than establishing a vision of a more distant future that ensures dissolution of current and emerging conservation and resource problems such as medical and nuclear waste.

6. **Leadership and management of social change.** Will we merely observe and react to social changes or move assertively to direct them toward our most desired future? Consider these examples. Many western societies have continuing high levels of divorce - nearly 50%. The workforce now includes single parents and more women, resulting in an increase in the demand for daycare. Countrywide effects on the development of many day-care children are unknown. The population is aging with attendant social and economic consequences. Some citizens assume that they will live next in a nursing home, a vision they may not appreciate.
7. Adapt to demographic changes such as increased immigration. Immigrating citizens must be integrated into society, an especially important issue when they comprise larger proportions of the population. A practical problem in hospitals is having interpreters. The impact is felt in changing cultural values in competition for jobs and in debates over language in schools. An aging population experiencing greater longevity will have a greater need for medical care.

8. Law and lawyers must support not degrade societies. Some citizens feel that their daily lives are enmeshed in reels of red tape originally designed to assist society. Fears of medical malpractice distort health services. Commentators have noted that some countries have far more engineers than lawyers, whereas in America we have the reverse - more lawyers than engineers. Will a redesign of the future limit these intrusions into the care giving process with a lean and effective system of law or will we allow a rampant expansion to further affect our actions?

9. Choices of political orientation. Will a liberal or a conservative agenda prevail? The changing approaches to government in developing regions - Europe, South America - means adaptation of traditional views about care. Social activists lobby for access to personal health care and social "safety nets," while economic conservatives argue that too strong a net undercuts motivation. Again, the ideological choice of market-maximized, market-minimized arises with survival of the fittest one option.

All of these "pushes" are shaping every country's future - some from outside the subject society. Are citizens powerless, able only to watch without a visible attempt to turn these influences to the direction they desire? The design challenge is to create a "best fit" between the push - the pressures and outside directions - and the pull - the internal values and activities of
There are many "internal pulls" for creating a vision of the future - five points identify the pressures from within our countries and communities, pressures affecting the future design of health care systems.

1. **A pull for future derives first from citizens.** By creating a vision, political and corporate leaders are painting a picture of a future country and community. The Clinton health care reform proposal reflected governmental leaders' and interest group perspectives but not citizens. The picture that our leaders present as candidates for president, for the parliament and for governorships, will tell us whether they "hear" the values and interests of citizens-at-large. Without listening, politicians freely define the future - autonomously - and too often in the direction of interest group advice.

Creating a country or community level vision that citizens can debate increases participation. Through considering such design choices as public versus private control of health care, citizens can voice the values they believe are critical to the future of their country and community.

2. **Justice and equity of opportunity are design requisites.** These values are founding premises of country and community; but some citizens believe justice and equity are elusive. The rich are in "health care luxury," the poor fight for access to primary care. Citizens of the inner cities are struggling more than ever with environmental health. Futures design is an opportunity to restate beliefs in justice and equity and to deliver on the promises whose failure is so often seen in the "knife and gun club" participants of trauma systems.
3. Future is influenced by the level of turnover and stability in society. Ineffectiveness results in part from a lack of shared direction. Turnover through corporate merger and acquisition creates instability in company plans and insecurity in managers and employees. American health care plans' consolidation at present is an example. Citizens and companies pursue independent goals. Special interests - from medical corporations to environmentalists - constantly pull countries in different directions. How can commitment to a shared health care future exist when there is no shared consensus on the country's direction-at-large?

4. A "directional light" supports conflict resolution of differences. Without a sense of the future, we cannot begin solving conflicts ranging from responsibility for the uninsured to environmental pollution. We are back to Alice's decision-making problem in Wonderland - which way to turn. How would citizens resolve disputes, for example:

* between the interests of private hospital chains buying non-profits and communities protecting their caring and public tradition?

* between residents of a region interested in health safety and the need for nuclear waste disposal sites?

* between drug manufacturers' interests in fast approvals and advocates for patient protection?

* between the need to increase health care coverage versus the already overburdened tax system?

Without vision, resolution of these disputes is driven by the loudest and most forceful group, not by those citizens whose direction is most consistent with where the country is going.
5. A vision of the future is a more effective way of getting to the future. When all citizens understand more clearly where it is we are going, they are more likely to help us to get there. Patients and physicians can work toward conservative action and personal behaviors that promote health and wellness.

How publicly recognized is the need for a stronger future? One issue of *U.S. News & World Report* described citizens' views of American governmental leaders. The cover "shouted,"

*THROW THE BUMS OUT!* "Government is paralyzed and voters are angry. Is there any way out of the political mess?"

This is descriptive of too many governments in too many countries. If public sector leaders are immobilized by the present, private sector leaders and citizens will need to take action.

CITIZEN ACTIONS REQUIRED & RESULTS EXPECTED

Alexis de Tocqueville summarized the attraction of the search for future in the context of democracies and of their parts from health care to commerce.

Democratic nations care but little for what has been, but they are haunted by visions of what will be; in this direction their unbounded imagination grows and dilates beyond all measure. . . Democracy, which shuts the past against the poet, opens the future before him.

With these pressures for designing the future, citizens should begin search processes in community forums, in schools, in governmental sessions, in business and industrial corporations and in labor union meetings. Under the title reinvention, work has begun in local government, state agencies and foreign governments. In some communities, citizens have been at work. As
the interest grows it will be evident that citizens need approaches and design methods to guide their futures work.

The process must generate excitement and involve citizens in discussion of the "whole" and the "parts" including: health, justice, commerce and labor, agriculture, education, housing and urban development, resources and environment, transportation, science and technology, and arts and humanities. Often leaders have tried to reengineer parts -- health care -- but have not thought about their connectedness to the values, structure and functions of other "parts." Can we develop patients as informed consumers without education, without the technology of public health data and without the economic support to meet the cost? I think not.

Public administrators cannot independently create a vision of a country's future. No centralized group has the ability to understand the complex internal and external tensions associated with each of the "parts." And, centralized political groups cannot create community visions because communities are best created and directed by local citizens.

Many commentators and researchers have noted that vision building and redesign is successful when those who are being planned for are involved in the process. This means that citizens - both leaders and followers - must co-produce the path that will take them to their desired future. Without this involvement, there is little likelihood that they will get engaged in the actions needed to realize the vision.

Why should citizens and leaders spend precious time and energy creating the country and community future? Because citizens are the ultimate "managers of country and community."

For the one certainty about the times ahead, the times in which managers [and
When citizens engage in creating the future they desire, they are "managing" by looking forward. Only by thinking hard about the country's future - by choosing a desired future - can we establish a framework for making strategic and operating decisions and for reengineering both parts and whole. Since commitment of time and resources is significant - we expect noticeable outcomes.

Redesign contributes to at least five outcomes illustrated here by the health care system focus.

• A desired future for country and community will improve quality of life and induce change (as core values and as part of a sought after vision) e.g. continued health system development and improvements in population health

• A systematic and ongoing review of the environment identifies internal and international standards (benchmarks) as a base for comparison, e.g. comparative health delivery models with data on access, cost and quality.

• Investment in reengineering can result in significant cost savings (reengineering is cost containing), e.g. clinical pathways, hospital consolidation, technology reviews

• In a changing health system environment - one loaded with cost versus quality confrontations - citizens will need to monitor system performance to protect and improve society, e.g. health care quality assessment, improvement and control.
As a result of the futures design process, we can expect new goals, planned change, data based decision making, quality improvement and improved population health status. Part Three begins the presentation of how to redesign. Involving all citizens in the creation of the future requires tools.

PART 3: GENERAL PROCEDURE FOR REDESIGN: DOUBLETRACK

A desired future for health systems assumes an overarching vision of country and community future. Future design and redesign for a whole country, a whole community and a subpart such as the health system can benefit from our work on the organization level. Reengineering and allied initiatives under the labels total quality management and continuous quality improvement have clearly excited the private industrial sector with the academies and non-profits increasingly interested. To apply this concept at the country and community level, we must answer to two questions:

• What are the tasks for the leaders and citizens as they plan for a whole country and community future?

• What are the protocols and steps for project teams attacking specific problems and tasks?

Citizens need "a common pathway to redesign". Recognizing that there is no one best way, a general procedure can be tailored to fit the specific needs of specific public and private citizens in their own countries and communities.

First we can describe some faulty assumptions about problems and design. When our
patient Alfred Smith experiences a low quality delivery system, we often move quickly to blame the clinical team. But the problems in society and in communities do not arise by accident as Juran noted:

"A principal finding has been that...quality problems are planned that way, which means that the quality problems are largely traceable to deficiencies in the methods used to plan for quality. Those deficiencies are still in place. To get rid of those deficiencies we must revise the quality planning process and then learn how to acquire mastery over that revised process."^{31}

With a futures orientation, we address existing deficiencies in health care delivery such as those encountered by Alfred Smith by providing an opportunity to purposely reengineer excellence into the future. Redesign - here defined as visioning, reengineering and quality improvement - means rejecting the view that what was done in the past will be sufficient in the future. Disconnected remedial actions by public administrators can reduce discrete problems, such as highway crowding and citizen dissatisfaction with trash disposal. But each country and community must create a unique future by considering each of its parts to be co-producers of a desired future for the whole.

Traditional change involves reactive responses aimed at attacking deficiencies in existing processes such as hospital discharge or incomplete community vaccinations. The procedures are often operations-oriented, focused on the "shop floor." In contrast, "whole system redesign" is a preventive approach that eliminates problems at both the design stage and in operations. Professor Ackoff considers this *dissolving* the conditions that gave rise to the problem in the first place.^{32}

The visioning, reengineering and quality improvement processes described here can be used by nations, states, regions, cities and communities. The procedures are both process-oriented and strategic in perspective, different yet consistent with the way many think of reengineering and
There is one leading question about futures work that appears so basic it is often overlooked.

• Can we describe futures and redesign processes in clear procedural terms that are accessible to citizens at all levels?

The answer to this question leads us to a "synthesized" general procedure that links visioning, reengineering, and total quality management.

Consider the case of Alfred Smith. Confronted with the task of designing future services for heart patients, the hospital could proceed in one of three directions:

• improving the management of bypass operations to insure low levels of complications and unexpected death (incremental, continuous quality improvement)

• radically reengineering its clinical pathways for heart patients using medications, monitoring and advanced laser surgery (reengineering)

• dropping the heart services deciding to specialize in other clinical areas where the institution could build a center of regional or national excellence (new vision)

In each option a changed future will best occur with an open participative process that can proceed on two tracks.

The Double Track concept means country and community change leaders must attack problems on two tracks (or levels). 33 *Track 1* is the whole country/community level. Leaders make
a public and strategic commitment to improve quality, e.g. to improve health care delivery throughout the community. This strategic level of the procedure requires top leaders to promote the strategic importance of redesign and create a vision of an improved future. This "procedure" is a well-established strategic planning and visioning path used in the private sector for years.

Track 2 is the project (or team level) track. This track involves very specific and operational problems, e.g. hospital discharge planning, operating room turnover, how to inform poor families about immunization and nutrition needs, placement procedures for recruiting and retaining rural physicians. Once a problem is identified, a team is formed and the question quickly becomes, "What do we do?" - i.e., what problem solving procedure do we follow as a team? There are numerous reports of reengineering and quality improvement protocols to guide our efforts.

The combined double track approach is based on several common purposes. Each of the procedures - quality improvement, reengineering and visioning/strategic planning - are used for the following three purposes:

- teaching and learning (e.g. about health service delivery models and their processes)
- organization change and development (e.g. improvement in health care access)
- evaluation and assessment (e.g. of current service delivery and of change impacts)

The procedural work has developed over the last thirty years under three somewhat distinct streams of concept and practice: quality improvement, reengineering and visioning.

First, *quality improvement work* led by Deming,\(^{34}\) Crosby\(^{35}\) and Juran\(^{36}\) has been emphasizing the search for quality as an organization-wide philosophy and approach. Over the past 20-30 years, but particularly the last ten years, specific methods and tools have been developed.
Juran for example offers a process for planning and reengineering that stresses the forward thinking and whole organization perspective but which is more directly tracked on quality. Juran's "road map" involves nine steps: (1) identify who are the customers; (2) determine the needs of those customers; (3) translate those needs into our language; (4) develop a product that can respond to those needs; (5) optimize the product features so as to meet our needs as well as customers' needs; (6) develop a process which is able to produce the product; (7) optimize the process; (8) prove that the process can produce the product under operating conditions; and (9) transfer the process to the operating forces. When we substitute citizens for customers the redesign of country and community involves steps of a trilogy: planning, quality control and quality improvement. Juran's focus on the customer (citizen of country and community) and his attention to planning for improvement, monitoring, and ongoing gains are key. For example, teams of citizens could attack immunization, wellness and physician recruitment/retention in cities and rural areas.

*Reengineering* has both extended and adapted total quality management and systems thinking. Reengineering is a "blowing up" of existing business processes\(^{37-40}\) but not usually a redesign of the whole organization. Here there is a definitive emphasis on radical results - changes to core business processes. Rather than an incremental continuous improvement of existing processes, designers are asked to think of bold change. Moving from fee-for-service reimbursement health care to capitation is an example.

*Visioning* is an attempt to address the whole of the organization\(^ {41-49}\). Ackoff's work on idealized design takes a systems and whole-organization perspective. Participants are asked to consider the question: "if we could redesign our whole organization immediately to be more
effective in this environment what would it look like”? Rather than incremental change, this approach pushes for a radical redesign that will serve as a change incentive. Ackoff’s idealized design - creating new organization designs through strategic planning processes - incorporates some of the continuous improvement and reengineering thinking.\textsuperscript{50,51} And it has been applied to university hospitals.\textsuperscript{52,53} His works have elaborated this model over the past 25 years while quality management was unfolding with Deming, Juran and Crosby offering both the philosophy and the procedure of continuous improvement. Hammer and Champy's work on reengineering is both more recent and a derivative of these original streams of quality improvement and new strategic vision.

Ackoff offers a strategic planning framework and simultaneously a mechanism for continuous individual and organizational development. Ackoff's basic concept is that all companies (and countries and communities) must continually seek an ideal. This continuous process requires constant design/redesign attention, with successive approximations to the desired best configuration. His process includes five phases: formulation of the problem, ends planning, means planning, resource planning, and implementation and control. Defining the quality of life (the "mess" you are in such as high health care costs and limited access) is followed by defining a desired future state (quality, efficient accessible health services). His process uses interlocking boards of planners and co-designers to insure wide representation with participation, continuity and coordination stressed. Improvement can emerge as a part of the greater strategic effort that includes financial and human resources concerns. Either way, leaders are able to establish a process for change (increased quality of life in the country and community). The approach is one way to structure the country or community futures effort.
There are five assumptions common to the redesign and futures processes in use.

1. **Redesign is sociotechnical in nature.** Future search includes what we have traditionally paid attention to both (a) products/services - economics - technology issues and (b) concerns for the social psychology of commitment and attitude change. In health care we must move beyond new clinical surgical procedures to address physician willingness to change, the psychology of alliances and networks and individual problems of burnout for example.

2. **Future building is both intended/rational and emergent/intuitive.** We can create an "intention" to build a desired future but the path is not linear. Hospital consolidation is dependent on leadership, economy changes and political strategies of regulation which can and do change. The ability to develop strategy is craft not science, the adaptation to events an almost "artistic" action.  

3. **Redesign procedures are "rough guidance" not a mechanical blueprint.** Each country and community process will produce a "directional sense" of the path to the future. In one community, getting to hospital consolidation - from eight independents to five hospitals in two health systems and one alliance - required about six years of "travel" on convoluted "dirt paths." There was no easy direct route.

4. **Procedural adaptation is required for each unique setting - creative, innovative use of the model.** Each time the procedure is used, participants tailor-make the process. Some processes are more participative and longer than others. One hospital merger involved three years of open community discussion. Sale of another hospital to a health plan followed only three months of private, closed meetings with 6-10 executives. Both produced radical change in health system
5. *The model is still evolving. No one best way currently exists so adaptation and testing is warranted.* What works as a process in one community may fail in another. We have as yet no real consensus approach. Participants must test and adapt as they work.\(^{55}\)

The lessons from visioning quality improvement and reengineering programs mean a procedure must: engage the leadership; empower citizens; use data; work through teams; provide training; follow up on progress and recognize and celebrate success. We will not further consider the history of each stream of concept and practice here other than this remark. Their concurrent development reflects the general dissatisfaction with the status quo and the need to develop formal procedures for moving forward into a vastly changed future at both the operating level of production systems and on the whole organization level (culture, values, and grand strategic design).

Each of the Double Track approaches is now presented in more detail with both a whole country and a health system example.

**TRACK 1-MACRO: WHOLE SYSTEM PROCESS**

Track 1 is a system-wide process for country or community run concurrently with project efforts at the citizen team level. This holistic initiative portrays futures design as a strategic concern promoted by top leadership. Leaders and citizens urge each governmental department and unit and social organizations to plan for a quality future on both an organization-wide and an individual subunit basis. The leaders often promote a significant "stretch" goal well beyond the status quo.\(^{56}\)
The effort from the top is to change the "collective mind" of the citizenry, convincing them of the potential for a better future. Citizens throughout a country and a community individually and in groups must be in control as the designers of their future. Future design is at its highest level of accomplishment when the participants are actively engaged in ongoing debate. Thomas Jefferson's point of view is amazingly current.

I know no safe depository of the ultimate powers of the society but the people themselves; and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion.

(Thomas Jefferson)

The general strategy formation process is a guide for work at the whole country or community level, typically with the following elements representing a composite of strategy development and strategic planning steps.

### Table 1
Vision & Strategy Process

- **Step 1**: Planning to Create a Vision
- **Step 2**: External Analysis
- **Step 3**: Inside Review
- **Step 4**: Creative Design: A Vision of a Future
- **Step 5**: Matching the Current and the Future
- **Step 6**: Choosing Strategies
- **Step 7**: Identifying Actions and Programs
Step 8: Link to Operations and Budgeting

Each step is relatively simple to understand but can be extremely challenging to carry out. In some cases - such as our country level example - steps are consolidated. The richest outcome is not a thick plan but the dialogue that occurs between leaders and citizens.

Track 1 Example: Country Visioning Case

Citizens can and should undertake debates about their future on their own in their own communities. Each country should also have a formal vision-building process led by public administrators and private sector leaders. To each citizen in his/her own country we could ask whether there is now a whole country vision and strategies for the parts - education, health care, transportation, and the others. Most public leaders have “a vision and a reengineering plan” in their heads as they govern. Some of the plans were developed in political campaigns and adapted after the reality of office provides further data. This approach suggests that the vision be more formally shared with community and private sector leadership and most importantly, with citizens. Consider this following example for America but substitute any country or any community. In this example, health care is one part - a nested system - but not the sole focus.

**STEP ONE: PLANNING TO CREATE A FUTURE.** After deciding that there is a need to address the future, the first action is developing a procedure for the work. The leader of country or community could take the initiative by assembling government and private sector leaders. This team can then consider the design of the approach - e.g. the level of public/private participation, who would be involved, personnel of what type and level, the extent of the data to be used, staffing...
levels, costs, timing and how progress will be monitored.

Each leader should tailor-make the process to fit his/her own style and "management culture". A sample design could include the following characteristics.

- A team of senior executives with an equal number of civic and business leaders and citizens (e.g., 50-60 in all) would plan for six months;
- An open process driven by participation and dialogue would be used;
- Three staff (senior analysts) representing each area/field from health care to commerce to education would support the main visioning team;
- Data would include both numbers-oriented, trend information and intuitive "sense of the world" information presented in short executive summaries;
- A coordinator would be used to guide the process with outside facilitators used;
- Results would be presented in a report and published in national newspapers and magazines;
- The team would reassemble every six months to assess progress.

About six months of lead time would be needed to select members and staff support. After the start, however, the deadlines would be firm. Several groups would be natural organizers of the futures work. Forums sponsored by corporations, churches, civic clubs, unions and schools would offer meeting opportunities. Students could be asked to redesign "parts of the country or the community" - to deepen and expand our thinking on the parts such as health care and environment, simultaneously enhancing their knowledge and understanding of their country. Arguments in executive suites, coffee shops and union halls over the direction of education and the cost and
quality of health care would become stimuli for change. Informal debates between citizens and
students at all levels - elementary, high school and college - would foster a deep interest in creating
a vision of the future, a dialogue that would be especially welcome for national, state and local
elections. This brief sketch of the process would be elaborated.

**STEP 2: DEFINING THE PRESENT.** Where and what is our country now? Leaders and citizens must first "see" the reality of today - both past accomplishments and current ugliness. Many visionaries put too much emphasis on the past - believing that the future is a mere extension. This is a treacherous choice as Odin Anderson noted:

"Planning [vision-building] is like the experience of a motorist who is driving on a narrow, dangerous, and winding mountain road in the rain. He chances to meet a car at a mud puddle. On passing the other car, the motorist driving up the mountain has his windshield splashed with muddy water. He turns on his windshield wiper but it does not work. Being innovative, he adjusts his rearview mirror so that he can see backward as far as possible. He thereupon extrapolates where the road ahead is by watching the curves in the road behind. The moral, of course, is that this is the state of the art of planning in the health services."

Going forward successfully as a country builds on history and tradition, but not exclusively, as there are many domestic and foreign turns in the road.

We must describe and acknowledge the *present* state of our country including our external conditions (e.g. changing foreign policy regarding Latin America and Eastern Europe) and domestic status (internal issues such as access to health care and crime). An external review relies on the issue and trend information discussed in relation to each of the parts - health to commerce to transportation - plus additional data identified by the participants. What should we pay attention to - immunization, the greenhouse effect, European integration, conflict in the Middle East and/or Russia's restructuring? The basic notion is to look outside the boundaries of the country to identify
the significant trends and pressures that will affect the future and our arrival at that future.

The design team would look to nine broad topics for important worldwide issues and trends: economics, politics, education, technology, demographics, social structures, legal issues, natural resources, and culture. Selecting down to only the most important ones is the most difficult challenge. We might, for example, find that addictions, AIDS, Arctic pollution, world trade and terrorism are all increasing and in need of attention.

Community, corporate and governmental leaders must help us to identify the changes and challenges of poverty, global trade, environmental preservation, and starvation, classifying them as opportunities or threats. For example, outside our nations these are situations on the international scene - a "downpour" of external influences on our country's future.

- In place of major power face-offs and the cold war, we find now that "The bell of every regional conflict tolls for all of us" (Gorbachev). We must consider whether these regional conflicts are preludes to disaster (threats) or opportunities for peace and progress.
- Some nations have the opportunity to be aggressive leaders in their regions advocating the development of new democratic nations.
- The power of each nation's business/industry group--fostered by competition, innovation and speed--is now challenged by foreign nations and regions (a threat).

Issues of energy, environment and the health affects of world poverty might also be on the "external issues" list to be sifted and ordered in terms of importance to our country's future.

An "inside review" of country and community is conducted next. What does the team think of the current state of transportation, of education, of the economic situation? The inside review
process can use five topics as a guide to its capabilities and core competencies.67,68 With a systems
approach, the design team would review all organizational subsystems 69,70 looking for structural
conflict in the present and the organizational architecture for the future.71,72

- **Values** and culture of country or community as a whole.
- Strengths and weaknesses of individual parts - health and human services, crime, economic
development, labor, education, housing and urban development, energy, transportation, and
arts and humanities.
- **Structure** - e.g., regionalized, centralized?
- **Psychology** of the citizens - e.g., satisfied, committed, anxious, involved?
- Public and private management - e.g., quality of leadership, development and organizing
success.

An "internal review" examines the condition of each country and community from urban
quality to employment to the availability and cost of health care. Citizens, leaders and students
must identify competing conditions and needs--e.g. from health care reform to crime levels in cities
to the challenge "to boldly go where no man has gone before." For example, classrooms could be
filled with captivating study as students critically investigate citizen fascination with violence and
its impact on the health system through trauma care tragedies, approaches to education and the
potential of the "information highway." Student groups could be enthused by debates over
alternative designs for cities and environmentally protected energy production methods.

Here is an example of one internal review - a first cut in broad terms. Would citizens agree
with the following illustrative strengths and weaknesses or would other issues lead their list?
Table 2
A Sample of the American Present: The Beautiful & the Ugly

- Individuals and organizations are loosely linked in a health system that is based on stunning knowledge and skill in medicine and healthcare; but it is a system with many holes through which the young and the old fall, sometimes to their death.

- American transportation enables citizens to move freely within and without the country with certainty of arrival, if not always ease and comfort. But roads, bridges and public subways freely exhibit their needs for repair and redesign.

- A complex national educational system exists, supporting opportunities for citizens to gain knowledge and skills; but the system is crumbling--eroded by inertia from within and waves of change from without.

- Defense capability is the strongest in the world but the fall of communism and the rise of uncontrolled nuclear power present severe pressures for change.

- Government is suspect, viewed by its citizens as intrusive, ineffective and irrelevant.

Using anecdotes such as the experience of Alfred Smith and large data sets, each subsystem - health care, education, housing - is evaluated. With increasing availability and reliability of health and medical data, we can determine the likelihood of Alfred's success in a heart operation, how often these procedures are chosen over non-invasive ones and the difference in cost from one community to another. The ability to formally assess the efficiency and effectiveness of health services delivery provides the substance of our internal review and the data confirm or disconfirm
the individual's experience as a common characteristic of the whole system.

These analyses are combined to form a picture of the "present" - an outside and an inside view. Corporate, community, and school-based visionaries thus present the country's strengths - to be preserved and built on - and the country's weaknesses, to be attacked and improved. These appraisals are the start for our prospective redesigners.

**STEP 3: THE FUTURE.** Visioning most of all calls for creating a picture of the future, a colossal challenge for both leaders and citizens. Future design is often initiated with a flourish that presents - to use a cliche - the "forest" but not the trees and their idiosyncratic arrangement. The team offers a broad sweep of this vision at the country level to be detailed later by individual citizens and citizen groups in communities and regions. The vision is defined but the means for accomplishment are left to citizens (methods are free choices). This is less new than we think. Visions of the country are already all around us. They can be negative or positive, specific and general. We might find an ugly vision if we ask our children for a present day view. Would they answer this way?

"Papa, it seems my country is and will be scary. Already I am afraid to go to school. We live in the city so drugs are sold nearby. I am told that I have not had all my immunization shots but I most fear the shots of a drive-by shooting. My friends warn me about AIDS and all we talk about at lunch is the dirty river and the trash on the beach."

Perhaps this is just a "modern city" scenario. But we want a vision that is desired and which eliminates the conditions that create this girl's image.
This vision could include the following:

• statements of critical values—such as health care for all, environmental protection, world leadership in commerce;

• policies that support our core businesses and technologies—emphasizing high technology, manufacturing or agriculture or some mix; wellness in the workplace;

• specifying the desired attitudes of the citizenry (competitive, safe, diverse, satisfied, angry); and

• defining how the country should be managed - centralized, decentralized; through state or regional systems; smaller or larger government.

The challenge is to build a vision that is based on historical traditions and culture, that maintains the strengths of the present but identifies creatively the parts that will be different and better, healthcare, trade, education, homelessness. The vision emerges in stages.

"Design is a cumulative process. It is usually initiated by using a very broad brush. Therefore, the first version is a rough sketch. Then details are gradually added and revisions are made. The process continues until a sufficiently detailed design is obtained to enable others to carry it out as intended by its designers."74

When we ask for characteristics of the future, broad design points are requested—an impressionistic water color or a charcoal sketch; not an architect's blue print. We can debate the structure of health services delivery and whether we are taxed too much or too little. We want not just programs but values and philosophy expressed. When we talk about health "programs" for the elderly and the poor, the discussion should go beyond cost and delivery mechanisms to include a statement recognizing our commitment to providing health care for all citizens - rich and poor, young and old. With discussion of such country-founding goals as freedom and opportunity, we can remember the
pain of discrimination, the stigma of disability and the humiliation of joblessness and we can design into our future corrections and protections-for health care, for education, for employment.

Other citizens may differ but I would include the points in Table 3 as desired characteristics of the future America. They recall and reiterate core values and desired characteristics. States and communities could use specifications such as these as a guide for organizing their actions and contributions to our country's tomorrow.

<table>
<thead>
<tr>
<th>Table 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of An American Future</td>
</tr>
<tr>
<td>America will be a country</td>
</tr>
<tr>
<td>• where health, housing, jobs and transportation are a part of every citizen's life;</td>
</tr>
<tr>
<td>• where citizens are safe, our elderly are respected and our young are nourished;</td>
</tr>
<tr>
<td>• where business flourishes backed by careful money management and creative scientific developments;</td>
</tr>
<tr>
<td>• where the environment is protected, energy is abundant and agriculture thrives;</td>
</tr>
<tr>
<td>• where arts and humanities are in partnership with business, both equally supported by education and by advances in scientific knowledge;</td>
</tr>
<tr>
<td>• where American defense is built on worldwide leadership and contributions to foreign nation development.</td>
</tr>
<tr>
<td>• where opportunity and freedom and brotherhood prevail among all.</td>
</tr>
</tbody>
</table>
States and communities could then independently and creatively choose how access to health care and transportation, protected environments, and quality education are provided. The broad national vision allows "space" for regional needs and means - actions of free choice. Some areas may choose to heavily support public transportation, while others may push for recreational space and housing. Futurists in the capital region case (see Part 4) are focusing on education, economic growth and development, and quality of life. To create a vision, leaders and citizens develop only an outline for the nation as a whole--substantive and finer points of design are to be produced by communities according to their needs and interests.

**STEP 4: COMPARISON OF PRESENT WITH FUTURE.** Identifying future building actions requires a comparison of the desired future with the "hard-headed" assessment of the present. In order to obtain a sense of what must be done, the designers must define the difference between where the country is now and where it would most like to be. Here the analytical work can be demanding. Several broad questions would begin the comparison process:

- Are the activities and structures of the country's parts - from the economy to law to education to health services - similar or very different (present and future)?
- What citizen attitude and commitment differences exist, for example, illustrated by low voting participation in the present, high involvement in the desired future?
- How would governmental and private leaders manage the country in the present and the future (more or less centrally controlled)?

In a less developed country, the vision of a comprehensive health care system would be compared to the actual state - only one hospital, inadequately equipped. Data on hospital bed and physician
availability can be compared, beginning to establish substantive and measurable goals.

In America, if international software leadership and health care for the poor are desired parts of our future, are we positioned to bring them about? Illustrative gaps between the American present and the future might include these.

Table 4
Gaps Between America's Present & Future

- expanding health care costs threaten to demand greedy portions of our country's resources yet do not provide access for the poor.
- changing defense requirements to accommodate regional flare-ups
- needed redesign of roads, bridges and utilities
- educational failure from poorly designed curricula and absent competition

Until we address these gaps - illustrated here as relevant defense capability, strong infrastructure, quality education and access to health care - the characteristics of America's desired future will not be realized. Side-by-side with leaders, citizens can make their own comparisons and evaluate leaders on the completeness of their analysis, and their proposed actions. The analysis by citizens, by government corporate and community leaders, by teachers and students leads us to the required grand policies and resources needed to attain the future.

**STEP 5: STRATEGIES & ACTION PLAN.** At this point in the future building process, citizens need grand strategies that define and guide how the country will get to its desired future.
Do we seek major growth in the development of health and education systems? Must we focus on a dire financial situation as some of the South American countries? What words will act as the "grand guides" to the future? Strategy choice begins with the whole vision. From that point individual strategies for the parts are chosen for their degree of fit into that general strategy. Citizens must select both grand strategies for the whole country and strategies that will guide decision-making within the parts; e.g., from health care to education to housing and environmental protection.

Several grand strategies such as *development*, *collaboration* and *strategic alliances* could be used to guide the decision making on education, defense and other parts of a developing country. In America, we must develop the health system capability to manage and contain costs - while expanding access to those currently uninsured and while watching the population age. The *financial* strategy seems to be driving American health designers in the late 1990s. In other subsystems, other strategies dominate. In place of a unilateral response to Middle East conflict, Britain, France and America *collaborate*, coordinating a joint defense of freedom and international law.

With vision and strategies chosen, citizens define the actions and programs to make the vision reality. Choice of priority actions and follow through is key. Importantly, actions and programs are no longer separate from each other or from the whole but are now decided according to their degree of fit with the future and with the strategies. Housing and health care programs are aligned with where we want to go as a country, consistent with core values of equity and quality of life.
Future-building demands action—the critical programs and activities that will close the gap between present and future. We must answer the question: "If we are to continuously improve our country and community, what areas do we propose to start with?" Should we attack domestic or international issues first—trade quotas, defense downsizing, or educational choice? At the national level, many problems compete for attention—drug addiction, the economy, homelessness and natural disasters such as floods and earthquakes. If there is to be attention to both foreign and domestic concerns, is it equal or weighted toward home or foreign affairs?

Balanced attention to all needs simultaneously is leadership ducked—a failed strategy. Leaders must start somewhere, even as we intend ultimately to beautify all of our country's future. The programs that might be proposed as leading ones—Health Insurance Reform, Head Start, International Trade Agreements—are the "stepping stones" of a strategy path—the bridge between present and future.

If we envision a country active in world trade, with safe cities and an effective safety net for the poor, our "policy and program stepping stones" might be free trade agreements, community policing and welfare reform. They are how we will go from where we are to where we would like to be—a future of economic growth, safe cities and support for the poor.

Any expenditures are likely to move us to a future that can happen by chance and by the design of other countries. The budget should present the citizens' vision of a desired future in terms of resource commitment. This final step is linking the strategies, actions and programs to "operations," translating the vision into budgetary requirements. Leaders may need to find new resources or redistribute existing resources currently being used in other programs.
Track 2 Micro: Project & Team Level Process-The Immunization Case

The second stream of visioning, reengineering and quality improvement effort is directed at the project or team level. Instead of the macro (whole country) level where visions and policies are "grand" and far reaching we are working at the micro (project) level with focused attention to a narrow and specific process. These "project level" improvement efforts might focus for example on the steps and timing of discharging patients from the hospital. Typically, project improvements do not include attention to the higher level strategic policy issues, e.g. should two hospitals be merged. To create the future, leaders must take both tracks - strategic level and project level initiatives - not one or the other.

There are many different methodological processes used by project improvement teams. One model developed by the Hospital Corporation of America is illustrative of the general approach.\textsuperscript{77} Nine steps are suggested: (1) find a process improvement opportunity; (2) organize a team who understands the process; (3) clarify the current knowledge of the process; (4) uncover the root cause of variation and poor quality; (5) start the "plan do check act" cycle; (6) plan the process improvement; (7) do the improvement, data collection, and analysis; (8) check the results and lessons learned; and (9) act by adopting, adjusting or abandoning the change. The steps force the team to focus their effort, to experiment with solutions and to examine data about results (parallel to some views of reengineering processes). For example, improving hospital discharge planning...
requires understanding the internal workings of last day tests, final physician review and transportation availability for patients going home.

Plsek identifies another redesign methodology created by a public utility - Florida Power and Light. The steps include: (1) identifying reasons for improvement; (2) describing the current situation; (3) analysis of the problem; (4) countermeasures; (5) results; (6) standardization; (7) future plans. Still another model created and promoted by the Juran Institute is organized in four steps: (1) project definition and organization; (2) diagnostic journey; (3) remedial journey; and (4) holding the gains. All of these variations of improvement processes use modified scientific methods to address a wide range of problems (in both public and private sectors). Some practitioners label this activity action research.

The following five-phase procedure is synthesized from existing protocols and is guided by the well known scheme of organizational development - organize, diagnose, plan, act and evaluate - five phases with ten total steps. Consider the public health problem of immunization simplified here for the purposes of illustration. Alfred Smith's community is interested in insuring that all citizens are protected from such diseases as smallpox, tatanus, polio and diptheria.

PHASE I - Organize

Within the context of a whole country plan to improve the health status of the population, specific public health functions could be improved. All citizen teams attacking community problems must create a mini-plan, insuring that members are fully representative and that time lines and procedures for the redesign process are established. In developing countries, basic immunization is an essential need as it is in the urban areas of so-called developed countries.
Alfred Smith's community could be in Haiti or in a large American city.

Step 1. Identify Process to Redesign. Choose a key process in your community that you would like to improve. Immunization would be an important target with great potential impact. Both general prevention and epidemics would be targeted, including infants, children, adolescents and adults.

Step 2. Select a Citizen Team and Confirm Process. Select a citizen and professional team that knows the process, and is representative of various aspects of it. Members include neighborhood and primary health care centers, public health and school officials and parents. Have the team confirm their present interest in how to ensure community-wide immunization.

Step 3. Define and Describe Customers. Begin by identifying the key customers of the process: who receives the outputs; who benefits from the changes. Citizens throughout the community are the "ultimate customers," including infants, children, adolescents and adults. Physicians and nurses may be internal customers for parts of the delivery process.

PHASE II - Diagnose

In the second phase, the search is on for the root causes of the problem; what Juran calls the diagnostic journey. In this case - immunization is the issue. We begin our journey with a study of the current efforts to immunize citizens. The activities reviewed could include educational programs, ongoing disease surveillance systems, enforcement of school immunization regulations, disease investigations, assessment of immunization coverage, immunization registry and tracking systems, outbreak control interventions and special prevention efforts.

Step 4. Diagram the Selected Process. As a group, describe a process to be improved in a
flow chart. In one community group school-based immunization processes could be chosen. The flow chart helps to educate the group about the process and begins to target points for redesign. Begin a search for benchmarks, e.g. collect examples of school immunization approaches in other communities and measures of success. Impact can be measured, for example, by process counts of student contacts and by outcomes such as disease reduction.

Step 5. Diagram Causes and Effects. Identify the expected outcome of the process and diagram its causes and effects (e.g. Fishbone chart). Search for the possible reasons why there is variation in immunization rates in the schools in the community that would undercut the goal of one hundred percent coverage.

Step 6. Collect Data on Causes and Analyze. Collect data on the major causes of variation and create a chart that defines how much each cause contributes to variation. Here the activity is applied research with all of the methodological issues arising (e.g. data availability, quantitative/qualitative mix, reliability, validity).

PHASE III - Plan

In Phase III the project team redesigners develop alternatives and time targets.

Step 7. Create and Plan Solutions. Create and plan the solutions that are to be used to attack the major defects of the process. If needed, identify a "quick fix" to take pressure off the problem and allow time to search for root causes, (e.g. mobile units are dispatched to schools where huge gaps in immunization coverage exist) while the study is in progress. An analysis of the costs of focused attention to lagging school districts is developed as well as a plan to reach full compliance and maintain it over time. Consider alternative solutions and the costs, benefits, and
resistance of each one. Address all relevant questions regarding implementation such as: Will additional manpower be added? Will new diseases be attacked?

PHASE IV - Act

In Phase IV the planned solutions are put into place but with an experimental orientation - embedding the idea that further redesign may be necessary.

Step 8. Implement Action Solutions. Develop multiple actions to support the redesign. Since immunization itself is a system there will be technical issues: of which vaccines to use and how they are delivered; of the structure of school and community-wide contact; of financing; and of managing and mapping the results. For example, if one school district is found to be significantly below the baseline in student immunization, a media/information blitz could be a part of the action. Team members would use a five piece strategy for promotion in the following fall semester. The actions would include radio and television ads, billboards, corporate partnerships, newspaper articles and press releases and a fall media recognition event.

PHASE V - Evaluate

Phase V is the evaluation component designed to make a judgement - solution success or failure. But the evaluation can also provide information that may help the team to redesign and intervene again if the solution is not totally successful (summative and formative approaches to assessment). The lagging school district would receive directed attention to determine whether the "blitz" had an effect.

Step 9. Identify Performance Benchmarks. Search for benchmarks to use to evaluate performance, e.g. internal based on past experience; external using national standards published by
professional societies and organizations. Comparative data using other communities and countries can be obtained to help in developing school immunization information processes and to assess impact.

Step 10. Evaluate Results. Using the data from the diagnostic phase, evaluate changes in performance and compare to benchmarks. Over several years of the review, the citizen and professional teams will be able to analyze this impact using the data to push further - toward the goal of 100% immunization.

The final and ongoing work is holding the gains and diffusing the successful solution throughout the community. This immunization case briefly illustrates the procedure for addressing project level issues in the health system or in other parts of a country - education, transportation.

**Summary.** Together the Double Track approach addresses the leadership and technical strategy of the whole organization and the people issues including purpose, philosophy and the psychology of celebrating and rewarding success. Double Track redesign is a systems approach to futures change and it is a multisystem strategy for improving quality. This part offered a process for creating a *desired* future for countries and communities. Countries are in a war of sorts - an internal struggle to maintain civilization, spirit and a sense of progress. Futures and redesign work is founded on a belief that a bright future can be created as our countries were first created by the visions of founders. Building on an organization perspective regarding both teams and systems thinking, a Double Track model offers both a strategic level visioning process and a set of steps for guiding the work of project level reengineering and quality management teams. The strategic level process - Track 1 - consists of steps that enable leaders to come to and promote redesign and
futures positions. Track 2 - the project level procedure- offers steps to guide the individual problem-solving work of citizen teams. Leaders seeking to design the future must first begin to perceive the task in two-level systems terms.

Citizens using local sessions in schools, offices, plants and community organizations must think about and propose their views of future and they must attack local problems. Country and community leaders must create a formal process for building a vision and for encouraging local reengineering and quality improvement (like the Tilberg success). The two processes can and should support each other.

If government is not dead, it will take the lead in keeping countries and communities from dying. If government is dead, citizens and private sector leaders must assume again the responsibility of creating the future. The task is important, challenging and one that ensures that we will have a future we desire to be in. One famous leader put it this way:

I must soon quit the scene, but you may live to see our country flourish; as it will amazingly and rapidly after the war is over; like a field of your Indian corn, which long fair weather and sunshine had enfeebled and discolored, and which in that weak state, by a sudden gust of violent wind, hail, and rain, seemed to be threatened with absolute destruction; yet the storm being past, it recovers fresh verdure, shoots up with double vigor, and delights the eye not of its owner only, but of every observing traveler.

(Benjamin Franklin,
Letter to Washington, March 5, 1780)

The next section - Part 4 - presents a case of futures planning and redesign in one community.

PART 4: A CASE OF COMMUNITY VISIONING
We have reviewed and proposed procedural approaches to creating country and community futures. There are places where this activity is already underway. In the United States, one community has begun the process of creating its future. The case both mirrors the Tilberg, Netherlands work and is broader in scope illustrating the community context in which an integrated health care delivery system is developed.

The Capital Region Case. In a three county region of approximately 1.6 million people, the quality of life is high, costs are relatively low, employment is abundant and there are limited skirmishes with the modern problems of crime, drugs and traffic. The stability of employment established by state government and the combination of available housing, decent schools and recreational areas creates an attractive setting for raising families. The question for this community was not how to obtain a high quality of life with a supporting health system but how to maintain it in a period of growth and development.

Of particular concern were the data showing:

• high health care costs and high unused capacity in the health system
• the loss of young people going elsewhere to seek high technology jobs and career opportunities.
• growing congestion on area highways
• the need to protect a clean environment
• dissatisfaction with school systems

This community's futures and redesign process was not created new here but builds on what other communities have been doing for some years.  

83
Experiences, Structure and Process

The approach taken in this state capital was used previously in 40 communities including Jacksonville, Florida and Mobile, Alabama. In each case the community was able to generate open discussion on the future, coming to some consensus on the key tasks to be tackled to move forward.

Some solid outcomes have been realized in these communities to date including focused efforts to improve economic development and securing of a sports franchise generating jobs, entertainment and tourism.

Each of the communities used a slightly different futures approach. But each one began with a democratic openness to debate and discussion. In this capital region case, acknowledgement of the diversity of viewpoints was recognized at the outset. The outside facilitator was a veteran of the Jacksonville and Mobile processes, commenting at the start up of this one:

"Developing a consensus in an area such as the Capital Region which has 104 municipalities and 22 school districts in its three counties is not easy....

"It's difficult to have a community-shared vision for the future," he said. "It's tough working with a large number of people deciding what you want to be"....

But, he said, "My experience has been that people really come together through this process."

The Envision Capital Region community futures project used a steering committee, task forces, open "town hall" discussions and a series of eight steps as the primary structure. In this case, the "whole community" was the target - education, environment, housing, transportation and so on. Health care was included but not as the sole focus. The structure and process of the procedure included the following:

1. **Founding Partners.** Public and private leaders were recruited to support the effort both
personally and financially.

2. **Steering Committee.** A large steering committee representative of the public and private sectors was appointed to provide operational leadership.

3. **Focus Groups & Interviews.** Data were collected from key representatives through interviews to build some background assessment of the current state of the community.

4. **Stakeholder Summit.** A "town hall" type meeting was held with an open invitation to members of the community to join the visioning effort, further organizing the project.

5. **Vision Task Forces.** Individual task forces were created to tackle specific areas such as education, crime, transportation and housing.

6. **Vision Publication.** The community newspaper provided "front page" coverage to the visioning effort, beginning with early meetings and continuing throughout.

7. **Town Hall Meeting.** A follow-up meeting was held to present the findings of the assessment and the visioning work and to allow for further discussion.

8. **Implementation.** The project moved to begin specific projects with scheduled follow-up sessions to review progress and with written commitment to action from leaders and organizations.

The project design intention was to use public and private leaders to start the process but to keep it open and participative, as inclusive as possible.

In a newspaper article directed toward the public, the process was described as follows:

"In the state capital area, the process [of future design] is already in motion. A steering committee of 30 area business, civic and political leaders has been selected. By mid December [1997] the committee will finalize selection of 150 people who will comprise the visions task force."
On January 21 the public is invited to a "Stakeholder Summit" to develop consensus on the capital region's top 10 priority issues. "This is open to the whole community" Luke said. "Anybody who wants to get involved can be involved"... Task force members will then meet four times for two hours each time to formulate strategies, core values and benchmarks to follow progress toward vision goals. On April 30 the task force will report its work at a town hall meeting."

The Capital Region group chose the following top ten issues facing the region. The ten issues selected for attention become the "context" in which the health system future will be enacted.

1. education

2. economic growth/development

3. quality of life

4. regional cooperation

5. transportation

6. land use

7. government

8. infrastructure

9. environment

10. workforce development

In this case the citizens did not feel that the development of an integrated health delivery system was a high priority issue. The reason - a separate health care futures group had been at work for several years reviewing the current system and defining gaps and goals.

Here we have an excellent example of our parts - whole challenge in country and community futures design. The community as a whole is receiving the planning attention but these
top ten issues become influential in the evolving design and operation of the health system. For example, some of the connectedness includes:

- educational institutions and programs must be strong to support one of the top five employers (health care organizations)
- excellent health care service is a requisite for recruiting and retaining both companies and employees (economic development)
- quality of life is more encompassing but includes health care service and wellness
- regional cooperation is already producing hospital alliances and consolidation as two institutions merge and three form a shared system
- public transportation to hospitals and clinics is a fundamental requirement of the city
- economic concerns have arisen over the political move to tax the large hospital/health systems

While these are issues common to many regions, each community is unique and could have a dramatically different "top ten issues" list.

The ten priority areas were reviewed by the steering committee and leaders in comparison to six "foundation areas" every community needs to successfully compete in the modern world (to be "healthy" in the broadest sense of the term). These six are: quality of life, infrastructure, education, government, economic development and private sector leadership. The comparison was used to stimulate further dialogue about required community structures and development and to begin to identify actions to move forward. For example, the comparison helped to underscore one gap - the need for strong science, engineering and technology educational support for economic
development. With the health care system's base in technology and innovation, this was an important gap for hospital leaders.

Implications for Health System Development

In this state capital case, community citizens have not defined health care system development as one of the priority tasks for the immediate future. Why is that? The community was fortunate enough to have three solid starting points: (1) an already developed health care system with some significant overcapacity; and (2) an active Health Futures group that was already engaging health care leaders in debates about the future; and (3) a very turbulent private sector that produced the merger of two major hospitals and the buy-out of a university hospital by a large health plan.

Health system leaders were involved in the more general community visioning process for several reasons that demonstrate the interactive nature of futures and community system building. First, health care is a leading employer in the area. Any economic development efforts must consider the impact on the health industry and its need for labor, skills development and high level leadership. Second, the leading priority for attention in the community was education. Health care as a leading employer depends heavily on a well-educated work force to support its "science and technology" business. With the emerging demands of new health care technologies, it is nearly impossible to create and manage a modern health care system without state-of-the-art primary and continuing education. For example, the medical school and the local colleges and universities would be relied on for developing the needed health care talent (a national work force problem) and for helping to retain some of the young persons now leaving the area (a defined problem by the
One of the priority issues was economic growth and development, including employee retention. Communities have long known that a strong health care system is one of the "attractors" for both "juniors with talent" and experienced senior executives. The ability to recruit and retain is based on citizen comfort levels with primary care, with obstetrical care and with significant acute care episodes such as that experienced by Alfred Smith.

Health system leaders are pulled into the community visioning because of the "mixed economy" status of the modern hospital. With increasing consolidation of the hospitals and the arrival of private corporate health care plans, the question of whether health care service is a private taxable product arises. In fact, the merger of the two large community hospitals was approved on the basis of its ultimate contribution to the community. This contribution was defined in a concrete way as meaning $70 million in savings over five years (to be returned to the community). In theory, this money could be used to further the education, economic development and environmental protection work of the region.

Finally, we can even connect this case of community visioning back to our Alfred Smith example presented earlier. Alfred's encounter with the health system led him to highly personalized questions of education about his treatment options, transportation to and from the service sites, expected future quality of life and capability for work. Thus on an individual and a systems basis health care interacts with the community as a whole.

When we plan for the future of a community, the health care system is both a direct and an implied part of the visioning work. Even when the system is not specifically targeted by the futures
group, the interconnections between other "parts of the system" and health are quickly evident.

**Themes of the Process**

This brief description of the case surfaces some critical themes of structure and process which seem to be common to many futures and redesign processes, elements that are present in the capital region case.

- **Public private partnership.** Country and community visioning transcends individual public or private initiatives. The "community" is neither public nor private, an obvious but often overlooked starting point. Unbalanced processes dominated by either public or private groups will not be successful. In the United States this "mixed economy" of public and private is particularly descriptive of the health care system where redesign requires collaboration from both sectors.

- **Visible leadership.** Corporate and community leaders must come forward and stay "forward" throughout the process. In American communities, hospital executives and health insurance company leaders and even physicians would be visible.

- **Participative design.** The vision building is open to and includes all members of the community - by design and by action. This includes not just "big revenue" hospitals but small groups such as the American Cancer Society, Easter Seals and Mothers Against Drunk Driving.

- **External assistance.** An outside expert is recruited to help with the design, to be a facilitator and to mediate conflict. The outsiders are not "owned" by any of the core interest groups - hospitals, doctors, insurance plans - and are free to help to seek the common good.
• **Simple but clear procedure/steps.** Although there are many different procedural approaches, a brief set of understandable and practical steps is the rule in successful cases. Health care leaders are using the experience of private industry but adapting to fit the uniqueness of health and medicine (such as shared governance).

• **Cross boundary collaboration.** Visioning moves across boundaries: of public and private, of governmental jurisdiction and of sector ownership (health care leaders do not dominate all health care discussion).

• **Power to effect change.** Change is generated by the positional power of key public officials and private sector executives, by the charismatic power of the outside facilitators and by the legitimate power of the community-wide effort.

• **Extensive public press coverage.** The media are used to report to the citizenry, contributing to inclusiveness and to educating the diverse stakeholders.

• **Follow up and commitment.** To make the future happen, leaders and followers must be committed at the start and support the project with regular progress assessment and with resources.

When we think of the Double Track approach, this community futures project is an example of macro level work, strategic in nature that must occur. It can be followed with improvement projects within subsystems such as health care. Whatever the level, the philosophy of an operating procedure is one of co-design, as noted by a community leader:

Although the task force contains some of the biggest local names in business and politics, Schankweiler stressed the summit gives virtually every resident an opportunity to participate on equal footing in setting the region's priorities.
This is not an elite group, it is a very grass-roots effort,” he said. “Anyone who comes, their voice will be heard. Most people probably already have thoughts about what they think should happen. We are not lacking thoughts. It will be interesting to see what is the consensus of all that thinking.\textsuperscript{86}

The underlying belief is that those who are engaged in co-designing the future will also be interested in co-producing it, insuring follow-up action and the realization of the desired future.

\textbf{Summary}

“Plan or be planned for”\textsuperscript{87} is both a call to action and the rationale for designing and enacting our desired future. Commentators find hope in reinvention,\textsuperscript{88} health care reform\textsuperscript{89} and reengineering.\textsuperscript{90} We can focus on health care as a start, ”backing" into a discussion of the containing supra systems (country or community). Or, we can begin with the larger whole and consider the function of the nested health system within the greater community and country. Building and realizing a vision of the future requires both the free flowing sketch of charcoal and the detailed attention of the oil painting. Visioning, reengineering and quality improvement are all contributing approaches to creating the future. Some communities and countries are already engaged. Should we not convert national rhetoric into a search for a vision of the most desired future and the means to take us there? Perhaps then we can answer the questions our children ask.
References


30. Drucker, D.P. *Managing in Turbulent Times*


44. Kennedy, C.  "Changing the Company Culture at Ciba-Geigy"  *Long Range Planning* 26(1); 1993; p. 19.


60. Below, P.J.; Morrissey, G.L.; Acomb, B.L. *The Executive Guide to Strategic Planning*. 
<table>
<thead>
<tr>
<th></th>
<th>Reference</th>
</tr>
</thead>
</table>


78. Ibid.


83. Capital Region Chamber of Commerce Report


90. Saxena, K.B.C. "Reengineering Public Administration in Developing Countries" *Long Range Planning* 29(5); Oct 1996; 703-711.