

# Representing Consumer Interests: Imbalanced Markets, Health Planning, and the HSAs

THEODORE R. MARMOR and JAMES A. MORONE

**T**HE PASSAGE OF THE NATIONAL HEALTH PLANNING and Resources Development Act of 1974, PL93-641, set in motion the establishment of 205 health systems agencies (HSAs) across the country. The aims of the legislation were ambitious—to produce planning “with teeth,” to cut the costs of medical care, to rationalize access, and to do so with more attention to consumer interests than was the case under earlier health planning. Many commentators expected these efforts to produce little change. Yet in some state and local areas the tasks of health planning have been taken up with fervor. Our interest is the connection between consumer representation and these health planning institutions. Our focus is on the conceptual, legal, and administrative questions raised by efforts to create HSA boards dominated by actors “broadly representative” of the constituents of each local HSA. Our aim is to untangle some of the theoretical and political difficulties that have bedeviled PL93-641’s efforts to improve consumer representation.

We first set a broad theoretical background, and show why concentrated interests (such as medical-care providers) dominate the politics of most industries. Representing consumers is cast as an important attempt to break this recurring pattern in decision-making about public choices.

---

Earlier versions of the paper were presented at seminars at Yale, Harvard, and the University of Chicago; the penultimate draft was read at the American Political Science Association’s Convention, 1979. The topics here discussed are more fully dealt with in part of Morone’s dissertation on “Consumer Representation, Public Planning and Democratic Theory.”

The Milbank Quarterly, Vol. 83, No. 4, 2005 (pp. 1–38)

© 2005 Milbank Memorial Fund. Published by Blackwell Publishing.

Reprinted from The Milbank Memorial Fund Quarterly: Health and Society, Vol. 58, No. 1, 1980 (pp. 125–65). Style and usage are unchanged.

In the core of the paper we analyze the concept of representation and such associated notions as accountability and participation. Understanding these concepts is important in explaining why the law's clumsy efforts at representing consumers have fostered legal challenges and will almost certainly continue to fail. We describe a number of these failures and prescribe in brief outline a remedy that seems conceptually more defensible and legally more practical.

It would be naive, nonetheless, to expect the Health Planning Act to achieve a major reorientation in American medicine, even if consumer representation were successfully instituted. We suggest reasons why this should be so, emphasizing the wildly inflated expectations characterizing PL93-641 and its rhetorical promises about planning's high technology and regulatory "teeth."

Our effort throughout is to describe, illuminate, and appraise one widely discussed policy strategy for controlling contemporary medical care: local planning agencies dominated by consumer representatives. While we discuss consumer representation, its potential and limits, current pitfalls and proposed adjustments, we are keenly aware that the health planning law is in flux, that we are appraising, so to speak, a moving target. But, if our analysis is correct, the movements toward controlling medicine through planning and consumer control are crippled by flaws in both the statute and the regulations. Explaining why that is so constitutes this paper's aim.

## Representation and Imbalanced Political Markets

The puzzles of representation are exacerbated in circumstances that stimulate representation without explicitly structuring it—when there are no elections, no clearly defined channels of influence, or only murky conceptions of constituency. The politics of regulatory agencies or regional authorities provide examples. Though representatives of groups commonly press their interests within such contexts, there are no systematic canvasses of the relevant interests, such as geographically based elections provide. It is unclear who legitimately merits representation, how representation should be organized, or how it ought to operate.

Interest-group theorists address the problems of representation in precisely such political settings. In their view, interests that are harmed coalesce into groups and seek redress through the political system. Despite the absence of electoral mechanisms of representation, their conception of representation is systematic; every interest that is strongly felt can be represented by a group. At their most sanguine, group theorists suggest that “all legitimate groups can make themselves heard at some crucial stage in the decision-making process” (Dahl, 1964:137). Politics itself is characterized by legions of groups, bargaining on every level of government about policies that affect them. Government is viewed as the bargaining broker, policy choices as the consequences of mutual adjustments among the bargaining groups (Bentley, 1967; Truman, 1951; Dahl, 1961; and Greenstone, 1975:256).

The group model is now partially in eclipse among academic political scientists (McFarland, 1979; Salisbury, 1978). One criticism is significant here: groups that organize themselves for political action form a highly biased sample of affected interests. This argument recalls Schattschneider’s (1960:34) classic epigram: “The flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper-class accent. Probably about 90 percent of the people cannot get into the pressure system.” Furthermore, that bias is predictable and recurs on almost every level of the political process. We refer to it as a tendency toward imbalanced political markets.

Political markets are imbalanced in part because organizing for political action is difficult and costly. Even if considerable benefits are at stake, potential beneficiaries may choose not to pursue them. If collective goods are involved (that is, if they are shared among members of a group, regardless of the costs any one member paid to attain them, like clean air or a tariff), potential beneficiaries often let other members of the collectivity pay the costs, and simply enjoy the benefits—the classic “free-rider” problem.

Free riders aside, the probability of political action can be expected to vary with the incentives. If either the benefits or the costs of political action are concentrated, political action is more likely. A tax or a tariff on tea, for example, clearly and significantly affects the tea industry. To tea consumers, the tax is of marginal importance, a few dollars a year perhaps. Clearly those in the industry, with their livelihood at issue, are more likely to organize for political action. And even such concentrated

interests are not likely to act if the expected benefits do not significantly outweigh the costs. As Wilson (1973:318) has phrased it, "The clearer the material incentives of the organization's member, the more prompt, focused and vigorous the action." (See also Marmor and Wittman, 1976.) From de Toqueville to David Truman, observers of American politics have argued that threats to occupational status are the most common stimulants to political action. If the group model overstated the facility and extent of group organization, some of its proponents isolated the most significant element: narrow, concentrated, producer interests are more likely to pay the costs of political action than broad, diffuse, consumer interests.

Not only do concentrated interests have a larger incentive to engage in political action, but they also act with two significant advantages. First, they typically have ongoing organizations, with staff and other resources already in place. This dramatically lowers the marginal cost of political action. Second, most economic organizations have an expertise that rivals that of other political interests, even government agencies and regulators. Their superior grasp (and sometimes even monopoly) of relevant information easily translates into political influence. The more technical an area, the more powerful the advantage, but it is almost always present to some extent.

In sum, two phenomena work to imbalance political markets: unequal interests and disproportionate resources. The two are interrelated: groups with more at stake will invest more to secure an outcome. However, the distinction warrants emphasis for it has important policy implications. Attempts to stimulate countervailing powers, by making resources available to subordinate groups, are doomed to fail if they do not account for differing incentives to employ them. For example, even a resource such as equal access to policy makers—now the object of considerable political effort—is meaningless if the incentives to utilize it over time are grossly unequal. The reverse case—equal interests, unequal resources—is too obvious to require comment. But that clarity should not obscure the fact that imbalanced markets pose an even greater dilemma than the obvious inequality of group resources.

Naturally, diffuse interests are not always somnolent. There are purposive as well as material incentives to political action. A revolt against a sales tax might necessitate cuts in programs that benefit specific groups—scattered taxpayers defeating concentrated beneficiaries; tea drinkers may be swept into political action (even to the point of dumping

the tea into Boston harbor). Both are examples of diffuse interests uniting for political action. Such coalitions tend to be loosely organized and are characterized by a grass-roots style of politics. Since sustained, long-term political action requires careful organization, they tend to be temporary. With the end of a legislative deliberation, the group disbands or sets out in search of new issues. Concentrated interests, however, carry on, motivated by the same incentives that first prompted political action.

The conception of imbalanced political markets is relevant to any level of government, but it is particularly appropriate in considering administrative agencies and bureaus. The problem is less nettlesome for legislatures. On a practical level, lobbying legislators appears only marginally effective; analysts have generally found that politicians are more likely to follow their own opinions or the apparent desires of their constituency (Schattschneider, 1935; Bauer et al., 1963; Marmor, 1973; Eulau and Prewitt, 1973). More important, there is at least a formal representation of every citizen. Of course, this does not minimize the complexities of electoral representation. But elective systems do afford a systematic canvass of community sentiment, however vague a guide it may be to concrete policy.

The advantages of organized groups—whatever their extent in legislative politics—increase after a policy's inception. Such groups can be expected to pursue the policy through its implementation and administration. Administrative politics are far less visible; they are not bounded by clear, discrete decisions, and are cluttered with technical details rather than with the symbols that are more likely to arouse diffuse constituencies. The policy focus of program administration is dispersed—temporally, conceptually, even geographically. Only concentrated groups are likely to sustain the attention necessary to participate.

Furthermore, when a bureau deals with a group or an industry over time, symbiotic relationships tend to form. A considerable literature documents the range of these clientele relationships and offers the following account of their life cycle: The industry groups typically have information vital to governing; their cooperation is often necessary to program success; and, as a bureau loses public visibility, the groups with concentrated stakes form a major part of its environment, applying pressure, representing their interests, interacting regularly with the agency (Bernstein, 1955; Noll, 1971).

In extreme cases, groups with intense, concentrated stakes can use a friendly agency to recoup legislative defeats. Important decisions are

made in agencies and bureaus that define, qualify, even subvert original legislative intent. Administrative processes may even grow biased to the point that other affected parties are shut out from deliberations that concern them. For example, Congress included a consumer-participation provision in the Hill-Burton Act, but the implementing agency never wrote regulations for it. When consumers overcame the imbalance of interests and sued for participation, they were denied standing. Since the regulations had never been written, consumer representatives had no entry into the policy-making process (Rosenblatt, 1978).

As governmental administration becomes more important, the imperative of balancing political markets becomes more pronounced. The difficulties of doing so are intensified by the disaggregated character of the American political process. In contrast to the British case (McConnell, 1966; Lowi, 1969), congressional oversight of the regulatory and administrative agencies has in the past been uneven and often quite loose. This pattern illustrates imbalanced political markets and its extreme manifestation, agency “capture.” The notoriously weak and undisciplined political parties in America contribute to this centrifugal tendency of authority within national government (Burnham, 1978).

The issue we address is how to balance political markets in administrative politics. How do we represent broad, diffuse interests, when all the incentives point to domination by a minority of intensely interested producers? The following discussion analyzes the details of the effort to achieve this balance in local health planning according to the strictures of the 1974 law and subsequent regulation: agencies governed by representative boards ostensibly dominated by consumers. We suggest how clearly understanding and properly institutionalizing the concept of representation can help formulate measures to overcome the tendencies toward imbalance that would normally subvert such efforts.

## Consumer Representation and HSAs

The Health Planning Act addressed the issue of interest imbalance by mandating consumer majorities on HSA governing boards: between 51 and 60 percent of each board must be composed of “consumers of health care . . . broadly representative of the social, economic, linguistic, and racial populations” and of “the geographic areas” of the health service area.<sup>1</sup> The rest of the governing board is to be composed of health care

---

<sup>1</sup>PL93-641 §1512(b)(3)(C)(i).

providers. There was no means specified for conforming to this mandate in either the law or the regulations.

Administrators quickly discovered that achieving meaningful consumer representation requires considerably more than simply calling for it. Within two years of the law's enactment, a spate of lawsuits had been filed as various groups contended that they were not being represented; the law's ambiguity lent some plausibility to the claim of almost every group. Equally problematic was the question of who should count as representative of whom. And there were reports of public meetings attended only by providers, of consumers shut out of all meaningful deliberations, and of representatives overwhelmed by technical details (Clark, 1977). Such difficulties in the efforts to represent consumers were a major factor in the unexpected delays in certification ("full designation") of most agencies; confusion about or repudiation of consumer dominance has actually led to decertification in several instances. Not all the agencies have experienced such troubles, but where HSA success has been achieved, it occurs despite the federal law and its regulations.

Establishing representation requires making fundamental choices. Decisions must be made about the selection of representatives, what those representatives should be like, and the expectations that govern their behavior. Furthermore, the governmental structures within which representatives operate must be considered. Do they encourage or impede effective representation? Is the tendency toward political imbalance redressed? Finally, there is the issue of who is to be represented, a question particularly significant when geographic representation is supplemented or abandoned.

The character and success of consumer representation is contingent on how these questions get answered. Indeed, many of the difficulties that plague the Health Planning Act follow from a failure even to consider most of them.

### *Conceptual Puzzles and Consumer Representation*

Three factors, central to consumer involvement in PL93-641, have been conceptually muddled, both in the law itself and in the analysis and litigation surrounding it. They are accountability, participation, and representation.

*Accountability.* Put simply, accountability means “answering to” or, more precisely, “having to answer to.” One must answer to agents who control the scarce resources one desires. In the classic electoral example, officials are accountable to voters because they control the scarce resources officials desire. Public officials are accountable to legislatures, which control funds; to pressure groups, who can extend or withdraw support; or even to medical providers, who can choose whether to cooperate with an official’s program.

The crucial element in each case is that accountability stems from some resource valued by the accountable actor. Accountability is thus not merely an ideal—such as honesty—that public actors “ought” to strive toward. Rather, the resources one cares about hang in the balance, controllable by the relevant constituency.

We call the means by which actors are held to account “mechanisms of accountability.” These mechanisms can vary enormously in character and in the extent of control they impose on an actor. For example, voters can occasionally exert control with a “yes” or “no” decision, whereas work supervisors can regularly monitor a subordinate’s work, enforcing compliance with specific demands.

There is often, to be sure, a give-and-take process in which actors try to maximize their freedom of action within the constraints of the formal mechanisms and thus minimize accountability. And those indifferent to the scarce resources in question (e.g., an official who has no desire to be reelected) are not, strictly speaking, accountable. But this illustrates the crucial point: in speaking of accountability one must be able to point to specific scarce resources, particular mechanisms that hold representatives to account.

Many of the HSA requirements that are touted as increasing accountability to the public are, in fact, irrelevant to it: a public record of board proceedings;<sup>2</sup> open meetings, with the notice of meetings published in two newspapers and an address given where a proposed agenda may be obtained;<sup>3</sup> an opportunity to comment, either in writing or in a public meeting, about designation,<sup>4</sup> or health system plans (HSPs)<sup>5</sup> or annual implementation plans (AIPs).<sup>6</sup>

<sup>2</sup>41 Federal Register 12812 (March 26, 1976), §122.114.

<sup>3</sup>41 Federal Register 12812 (March 26, 1976), §§122.104(b)(1)(viii) and 122.109(e)(3).

<sup>4</sup>41 Federal Register 12812 (March 26, 1976), §§122.104(a)(8) and 122.104(b)(7).

<sup>5</sup>41 Federal Register 12812 (March 26, 1976), §122.107(c)(2).

<sup>6</sup>41 Federal Register 12812 (March 26, 1976), §122.107(c)(3).



These requirements might be said to facilitate public accounting, not accountability. Public participation and information can inform the exercise of accountability but, without formal mechanisms that force boards to answer to consumers, there is not what we call direct public accountability.

Well-defined mechanisms of accountability are central to the idea of holding leaders to account. Propositions that substitute such notions as “winning over” or “working with” the community for an identifiable mechanism are much weaker, conflating the common-language usage of accounting for action with accountability to a constituency, a distinction pointed out by our colleague, Douglas Yates.

Suggesting that health systems agencies would be ineffective without public support is an equally weak conception of accountability to consumers. Every agency of every government expresses these expectations and fears. What is unique about representative government is that the citizenry—not the government agencies—is given the final say. And that say is not expressed by “inhospitality” or “lack of trust” or “written protests” but by an authoritative decision. What we term mechanisms of accountability are the institutionalization of that authoritative decision.

Accountability can be to more than one constituency. As health planning is now structured, the Department of Health, Education, and Welfare (HEW), state governments, local governments, consumers, providers, and numerous other groups can all attempt to hold an HSA accountable. These competing agents introduce significant tensions. One especially difficult problem is the conflict between accountability to local and to national government. There are indications that precisely this conflict is asserting itself as HEW, for example, drafts guidelines, and local communities protest that they do not apply in their specific situations. (Rudolf Klein [1979] has elaborated this argument in the British context, with elegant insight on the question of consumer participation.)

The emphasis on community control rests on Jeffersonian traditions, and has been seized upon by opponents of big government and centralized bureaucracies. Local communities, according to this view, understand their own needs best and ought, therefore, to be responsible for the policies by which they are governed.

The opposing position draws from sources as disparate as Marx and Weber, Madison and Hamilton. National needs require national solutions. What is good for individual communities (e.g., the best hospitals) may not sum to what is best for the entire nation (lower medical costs).

This conception typically expresses egalitarian values—only a national policy can redistribute costs and benefits among states and regions.

Accountability in the Health Planning Act is only partially delineated, and is therefore geographically ambiguous. Since local communities establish their agency's *modus operandi*, the potential for local accountability is present. However, insofar as the law takes up the issue explicitly, it presses accountability to HEW.

HEW is responsible for reviewing the plans, the structure, and the operation of every designated agency at least once every twelve months (sec. 201515 [c] [1]). Presumably, renewal of designation (an important resource that HSA boards desire) is at stake. This is accountability in every important sense. But it can be traced to the public only through the long theoretical strand leading through the presidency. From this perspective, HSA boards are no more accountable to the public than is any other executive agency—certainly a far cry from the rhetoric that accompanied the enactment of PL93-641. As the law now stands, accountability to the public (either directly or through states and localities) is not prohibited or rendered impossible. But neither is accountability to the public instituted or even significantly facilitated.

*Participation.* In classical political thought, self-government meant direct participation by the citizenry in public decisions. In this context, Plato envisioned a republic small enough for an orator to address; Aristotle, one in which each citizen could know every other. Rousseau argued that democracy ended when participation did. For obvious reasons, such formulations are generally considered anachronisms in modern industrial societies. Representation has replaced direct participation as the institutionalization of the idea that “every man has the right to have a say in what happens to him” (Pitkin, 1967:3). From a theoretical perspective, it is surprising that a law as concerned with consumer representation as PL93-641 articulates so few guidelines regarding representation, and so many regarding direct public participation.

The earlier discussion of imbalanced political markets suggests why direct participation provisions tend to favor providers over consumers. First, their interest in health planning is far more concentrated and obvious. Planning decisions can directly affect their livelihood. Hospital administrators, officials of state medical associations, and other employed medical-care personnel are far more likely to pay the costs of participating in open HSA meetings. The general public—“the consumers”—are

not likely to do so. After all, their stake in the proceedings is much smaller; planning does not usually affect their livelihood in as obvious a way.

Furthermore, the difficulties of fostering direct consumer participation are aggravated by the nature of health issues. Health concerns, though important, are intermittent for most people. They are not as clearly or regularly salient as the condition of housing or children's schools—situations that citizens confront daily. Consequently, it is far more difficult to establish public participation in HSAs than in renter's associations or school districts (Marmor, 1977).

We are not suggesting that provisions for participation are objectionable or should be stricken from PL93-641. Rather, without being carefully tied to some mechanism of accountability or broader view of representation, the provisions are, at best, marginally useful to consumers. They are most likely to be utilized by aroused provider institutions.

*Representation.* Representation is necessitated by the impossibility of direct, participatory democracy in modern society. The entire population cannot be present to make decisions. Hence, institutions must be designed to "represent"—literally, "to make present again" or to "make present in some sense something which is nevertheless not present literally or in fact" (Pitkin, 1967:8).

Three aspects of representation are usually considered in the appraisal of representative institutions: formal, descriptive, and substantive features, a formulation originated by Griffiths (1960), and refined and popularized by Pitkin (1967).

By *formal representation* we mean the institutionalization of representation—the specific mechanisms by which representatives are selected and controlled. The mechanisms need have nothing to do with what representatives should be like (descriptive), or the way in which they should act (substantive). Yet they are crucial in defining the process of representation. They are the structure through which representation is established and carried on; they define constituencies and link representatives to them. Institutionalizing accountability rests in large measure on formal requirements.

One commonsense definition of representation is purely formal. Birch (1971:20), for example, suggests that "the essential character of political representatives is the manner of their selection, not their behavior or characteristics or symbolic value." To him, elections equal representation. Few theorists would agree to so starkly formal a view. More commonly,

elections must not merely be held but must offer significant “choice”—they must be “free” (Swabey, 1969; Friedrich, 1950:266 ff.). Although empirical referents are often noted (elections in the UK, not in the USSR), theorists have had difficulty in specifying precisely what constitutes “free” elections.

The most important issue of formal representation relevant to PL93-641 is whether representatives should be selected in general elections, by organized groups, by officials, or by self-selection. Though in many cases accountability to the community is increased by general elections, we do not believe that is the case for HSAs.

The Health Planning Act leaves most formal representational questions to be answered on the local level. This is not necessarily unfortunate, as long as the applications for designation are carefully reviewed regarding the issues of formal representation. These issues can be stated in broad terms by asking what constituency a representative is tied to, and by what institutional arrangements.

*Descriptive representation* refers to the characteristics of representatives. Early formulations of representation held that, since constituencies could not be present themselves to make public choices, they should be “represented” by a “body which [is] an exact portrait, in miniature, of the people at large.” The reasoning is straightforward. Since not all the people can be present to make decisions, representative bodies ought to be miniature versions or microcosms of the public, mirroring the populations they represent. The similarity of composition is expected to result in similarity of outcomes; the assembly will “think, feel, reason (and, therefore) act” as the public would have (John Quincy Adams, cited in Pitkin, 1967:60).

A number of difficulties confront this formulation. First, “the public” is a broad entity. What aspect of it ought to be reflected in an assembly? The map metaphor is telling in this regard. Do we want the kind of map that shows rainfall, or altitudes? Topography? Trade regions? Dialects?

John Stuart Mill argued that opinions should be represented; Bentham and James Mill emphasized subjective interests; Sterne, more ambiguously, “opinions, aspirations and wishes”; Burke, broad fixed interests. Swabey suggested that citizens were equivalent units, that if all had roughly equal political opportunities, representatives would be a proper random selection and, consequently, would be descriptively representative. Whichever the case, a failure to specify precisely what characteristics are mirrored reduces microcosm or mirror theories to incoherence.

Even when the relevant criterion for selecting representatives is properly specified, mirroring an entire nation is chimerical. Mill's "every shade of opinion," for example, cannot possibly be reconstructed in the assembly hall on one issue, much less on all. One cannot mirror a million consumers, no matter which sixteen or eighteen consumers are representing them on the HSA governing board. Competing opinions or interests can of course be represented. But the chief aim of microcosmic representation is mirroring the full spectrum of constituencies. Pitkin notes that the language in which these theories is presented indicates the difficulty of actually implementing them. The theorists constantly resort to metaphor—the assembly as map, mirror, portrait. They are all unrealistic in more practical terms.

Mirroring the populace may be as undesirable as it is infeasible. Many opinions are idiotic. The merriment that followed Senator Hruska's proposal that the mediocre deserved representation on the U.S. Supreme Court suggests a common understanding of the foolishness of baldly descriptive views.<sup>7</sup>

Furthermore, if representatives are asked merely to reflect the populace, they have no standards regarding their behavior as representatives. Descriptive representation tells us only what representatives are, not what they do. Opinion polls would be more appropriate mechanisms for identifying public views.

Though microcosm theories are neither realistic nor achievable, descriptive (if not precisely mirror) views are relevant to the operation of modern legislatures. Legislators are commonly criticized for not mirroring their constituents' views or interests. In fact, Adams's formulation might be recast as one guideline to selecting representatives—members of the public vote, essentially, for candidates who appear to "think, feel, reason, and act" as they do. Thus, descriptive qualities inform the operation of formal mechanisms. But surely such very generally conceived descriptive representing is entirely different from the utopian endeavor of forming a microcosm of the populace in the assembly hall.

One contemporary manifestation of microcosm views is what Greenstone and Peterson (1973) refer to as "socially descriptive representation." Rather than mirroring opinions or interests, this conception proposes mirroring the social and demographic characteristics of a

---

<sup>7</sup>For notable formulations of this common idea, see Edmund Burke, "The English Constitutional System," in Pitkin (1969); or James Madison, "The Problem of Faction in a Republic," in *The Federalist*, Modern Library edition, 1937.

community's population. A precarious link is added to Adams's already rickety syllogism: If people a) share demographic characteristics, b) they will "think, feel, and reason" like one another and, consequently, c) act like one another. This is both bad logic and pernicious to the substantive representation of consumer interests.

The problems with mirror views, enumerated above, are all relevant to this version. Demographically mirroring a populace in an assembly is even more unlikely than mirroring their opinions. Obviously, not all social characteristics can (or ought to) be represented; the problem of discriminating among them is particularly vexing. Common sense rebels at representing left-handers or redheads. What of Lithuanians? Italians? Jews? The uneducated? Mirror views provide no guidelines for drawing such distinctions. Their central conception—the microcosm—is flawed, impossible. It is necessary to look beyond the logic of descriptive representation to choose the social groups that ought to be represented.

Even when the categories to be mirrored are specified, problems remain. Not all individual members of a social group will, in fact, "think, feel, and reason" alike; and they will not act with equal efficacy. Yet, in itself, mirror representation does not distinguish among members of a population group—one low-income representative, for example, is interchangeable with any other. As long as the requisite number of a population group is seated, the society is represented—mirrored—in the appropriate aspect. Such actors are not truly representatives but are mere instances of population groups.

Socially descriptive representation is pernicious because it removes the necessity of recourse to the constituency. The need for formal selection mechanisms and accountability is obviated. Skin color or income, for example, marks a representative as acceptable or not acceptable, regardless of what the constituency thinks. The result is that any member of the group is as qualified a representative as any other. This is a situation that almost begs for "tokenism." If the only requirement is that a fixed percentage of the board must be drawn from a certain group, there is nothing to recommend blacks, elected by fellow blacks or selected by NAACP, or women, elected by women or selected by NOW, over blacks and women "drafted" onto a board because they will "not rock the boat." Precisely this logic operated in New York litigation (*Aladmuy v. Pirro*, discussed below), where the judge found that, as long as the "quota" of minorities and poor was filled, there was nothing for him to do. He would not distinguish among them.

It has been suggested that socially descriptive representation might be effective if the representatives were tied to the groups they represented by some kind of pressure, some sort of oversight. Such representation then moves beyond mere socially descriptive representation. The selected agent is then a representative, not merely as an instance of a group's features, but because he or she is acceptable to that group. Thus, we return to a formal conception of representation—the constituency selecting a representative who “thinks, feels, reasons, and acts” as it does.

PL93-641, as it currently stands and has been interpreted in the New York and Texas district-court cases, does not provide for this. It requires only that the composition of the board be a statistical microcosm of the constituency's racial, sexual, and income distribution. The Health Planning Act does attempt to expand the health role of often overlooked groups. But, to be successful, it must mandate more than proportional representation on the HSA board; it must require that groups select and monitor their representatives.

Still, for all its difficulties, there is a kernel of truth (as Birch points out) within the theory of socially descriptive representation. Often social categories are related to interests; and, as we will argue in the following section, interests are what ought to be represented. Thus, religious affiliation bespeaks definite interests in Northern Ireland, race affects interests in America, poverty defines specific interests everywhere. And although the actual representation of interests may be subtle and complicated to evaluate, the social categories that are attached to them are almost correspondingly easy.

The choices regarding formal and descriptive representation must be made with the objective of furthering genuinely representative behavior, or *substantive representation*. This is an analytic category by which representatives can be guided and evaluated.

The central question about representative behavior is whether it is in the interest of the constituency. This raises the hoary problem of defining “interest” (Barry, 1965; Balbus, 1972; Flatham, 1966). Is it to be understood as objective fact or subjective choice? The answer determines whether representatives should be considered “messengers,” simply conveying constituent desires and acting on constituent requests, or “guardians,” doing what the representatives consider to be in the constituents' interest, without consulting them. Substantive representation fits neither of these extremes. Though certain choices are surely

in a constituency's objective interest, regardless of their opinions, liberal institutions are ultimately structured on consent. Representatives may pursue their own understanding of constituent interest, but at some point the constituency must make a judgment. The directness of the judgment depends on the formal representation mechanisms, but that there is judgment is crucial.

There is always a danger of drift from substantive representation to simply a guardian or messenger role. In PL93-641, the former can occur, for example, when an organized group selects a representative and exerts too much control over his or her behavior. But drifting toward the guardian role is the greatest danger for consumer representatives.

Health issues are often viewed as technically complex; PL93-641 encourages that view in its emphasis on expert scientific planning. If consumer representatives are to be successful, they will need to develop expertise regarding health and planning issues, either through interaction with the HSA staff or by other means. However, as consumer representatives become sophisticated, their tendency may be to drift toward a guardian role, defending a consumer interest that is thought to be incomprehensible to the consumer constituency. This development may be aggravated when the perception of crisis gives representatives more latitude, at the expense of representational ideals such as accountability.

A related issue is the identity of the constituency. Should governing board representatives be working for the good of the community as a whole? Of the consumers as taxpayers? Of all black (female, poor) consumers? Some answers may be implicit in the formal mechanisms. The general model underlying HSA boards implicitly follows the liberal ideal of getting all the narrow, self-interested parties together and making them thrash out policy choices among themselves. Each representative works for his narrow interest group; yet, through the compromise and bargaining necessary to get his group anything, answers acceptable to all will emerge. If this is the model, then it is important that all groups be in on the bargaining process.

When, for example, lawyers for one HSA emphasize the importance of getting a board that is not segmented, they are incorrect. Ironically, the model calls for a highly segmented, even contentious, board, for a board on which every health interest is vigorously represented will be more contentious than one that is captured or dominated by a single interest.



It is also important that representatives affect policy outcomes. All representatives have some symbolic function; but insofar as they have no other, they are not substantively representative, for they give the public they represent no say over policy (Edelman, 1967; Pitkin, 1969: n.10, chapter 10).

By this logic it is clear how some representatives can represent their constituency better than others: they not only perceive what is good for—in the interest of—their constituency, but also have the ability to act successfully on that perception. An eloquent speaker, a successful operator, a person who is not easily duped, an individual with important contacts or serving on important committees, therefore provides more substantive representation than one with the same opinions but without the same capacities. There are many relevant examples from the community action programs (CAPs) of precisely this phenomenon—boards that were relatively more successful because of the political skills, experience, and intelligence of some of their members (Greenstone and Peterson, 1973).

A representative's effectiveness, then, generally flows from a mixture of position and ability. An able person may affect policy, even from a relatively weak position. An incompetent one may fail to do so, even in a position of authority. The point is that substantive representation necessitates both knowing and successfully pursuing the constituents' interests.

*Conceptual Puzzles Reconsidered.* Substantive representation is the effective pursuit of the interests of the constituency. Ultimately it is the goal of all democratic representation. However, the final judge of representation must be the represented; either directly or indirectly the represented must control some scarce resource their representative wants (e.g., votes). Only then can we properly speak of a governing board as accountable to its constituency.

The Health Planning Act gives these issues little consideration. There is no systematically mandated accountability and little evidence of it as a concern. A representative's orientation is considered only in terms of socially descriptive representation. This approach patronizes the relevant groups. It will ineffectively advance consumer representation unless it is linked to effective mechanisms of accountability by which the members of those groups can evaluate the substantive quality of the representation received.

### *Effective Consumer Representation*

This section suggests ways in which adequate consumer representation can be facilitated and effective mechanisms of accountability created. The task, as pointed out earlier, is balancing the health-planning political market, rather than just getting consumers on boards.

The HSA staffs are one resource that could help consumers achieve political parity. Staffs generally have considerable expertise in issues of medical care and health. Occupying full-time positions in health planning, they have a concentrated interest in the industry. Is there any reason to believe that they will typically support consumers when there are conflicts of interest?

The evidence thus far shows wide variation in staffs' views. In New England, some play an outspoken proconsumer role (Codman, 1977). In many other areas they have allied with providers, often seriously undermining consumer representatives who cannot match the combined expertise of providers and staff (Clark, 1977:55). Generally the support of the staff appears to be essential to an active consumer role on HSA boards. The problem is systematically harnessing the staffs' market-balancing potential to consumer interests.

The most direct approach is to restructure the health systems agencies so that part of the professional staff is placed under consumer control—to be selected by and accountable to them. The staff's tasks could be specified in any number of ways, but its critical function would be providing professional (i.e., expert, full-time) support to the consumer effort.

Another potential for balancing the health planning market lies in organizations that already exist within the consumer population. Political scientists generally agree that the "basic units . . . of polity or political process are groups formed around interests" (Schmitter, 1975). The very existence of these groups attests to a commitment to improve the life circumstances of some part of the population. Furthermore, they have already paid the costs of organizing. We can expect their attention to issues to be high and relatively sustained. They can often overcome lack of expertise by redeploying their staff (Berry, 1977; Nadel, 1971; McFarland, 1976).

Organizations can meet a problem with more resources and in a more sustained way than isolated individuals. It is telling that much of the litigation challenging HSA boards comes from organizations formed

to further the rights or general circumstances of certain disadvantaged groups within the consumer population. Existing “reform” organizations have potential, then, for balancing the health-care political market; we believe that they can play an effective role in selecting and monitoring consumer representatives.

The experience of the community action program (CAP) provides some support for this claim. Selection by groups tended to produce the most independent and competent boards. Moreover, where more than one organization wanted to select representatives for the same population or interest, elections were held among the groups. Organizations representing the poor in parts of New York City, for example, competed fiercely to gain support of the community—a far cry from the apathy that greeted general elections, and the alienation and cynicism that accompanied selection of representatives by officials (Greenstone and Peterson, 1973).

We recommend, therefore, that those charged with selecting members of consumer boards select not the members themselves, but groups organized around health-care interests. If more than one group seeks to select a representative for the same interest, a special election would be called. It is crucial that the interests themselves (e.g., poverty, race) be specified by HEW. Competition among groups representing an interest is acceptable, even desirable; competition among interests to be represented is not. (The logic of choosing what interests merit representation on HSA boards will be discussed below.)

A potential gap always exists between an interest felt and a group’s articulation of that interest; however, groups that have overcome the obstacles to organization are the most likely promoters of a particular interest. Representatives from these groups will have clearly defined constituencies, experience in organizational politics, and resources at their disposal. These attributes will help them both in identifying group interests and in pursuing them, regardless of their other characteristics. (Even minorities suing for representation in Texas were willing to accept whites to represent blacks, for example, if the NAACP selected them.)

The experience of the CAPs indicates that representatives selected in this way tend to be the most able, show a universalistic orientation, and are least likely to be co-opted.

A group can be expected to monitor its representatives more carefully than will the general public. Thus, as long as the representatives are chosen for a fixed term, accountability is increased. Representatives

should be allowed to serve out their term (without recall) so as not to bind them too tightly to the selecting organization (Lipsky and Lounds, 1976:107); they should be permitted reelection so that they are not bound too loosely.

Ideally, then, the imbalanced political market in health planning will be tempered by two mechanisms, one internal to the health systems agency (staff assigned to the consumer representatives), the other external (selection of representatives by groups). We expect the former to facilitate organization and expertise among the consumer representatives, the latter to improve representation and heighten their accountability.

Of course, in some locations and for some interests it will be impossible to find appropriate groups. In these cases, another, less desirable, mode of selection (or formal representation) will be necessary. We evaluate two others: general election, and selection by officials.

*General Elections.* Various reform groups have called for election of consumer representatives in a model roughly based on that for the selection of school boards. The surface plausibility of the proposal should not be permitted to obscure its difficulties. One problem with direct election of representatives to HSA boards stems from the failure of most Americans to consider themselves part of an ongoing health-care community. They typically seek care sporadically, and do not conceive of health care in terms of local systems. Both factors distinguish health planning from education or housing issues, where specific elections may be more effective.

Evidence from the CAP poverty programs supports the view that elections are problematic; fewer than 3 percent of the eligible population voted for local CAP boards in Philadelphia, fewer than 1 percent voted in Los Angeles. Those who did vote were moved to do so by personal, not policy, considerations. Overwhelmingly, they voted for their neighbors and, presumably, personal acquaintances. The consequent policy formulated by these representatives was, predictably, overwhelmingly particularistic. It helped their friends, not the community or the interests they ostensibly represented. Representatives generated little community interest or support. They tended to be ineffective advocates and operators.

Since the public chooses its health planning representatives directly, the representatives can theoretically be held accountable with relative ease. However, in practice, low incentives and marginal visibility will undermine elections.

It is important to note that “antiparticipation” city officials, who could not control the selection of CAP boards, preferred elections as the alternative. They apparently felt that this formal mechanism would not threaten their interests by generating energetic, aggressive representation of the interests of poor people—an outcome they feared from selection by groups.

*Selection by Local Officials.* This mechanism leaves accountability to the public very tenuous. The constituency is left with no direct control over its representatives, but must hold the selector of the representatives to account. In the worst cases, the selector is not directly accountable to the public either. Boards selected by local officials are accountable to, and presumably controlled by, local government; they will be as accountable as any other local agency. Yet they operate within a program that promises direct consumer participation. When a health planning issue becomes highly visible, we expect this mismatch of rhetoric and reality to cause public frustration and alienation.

Since officials can choose whichever member of a group they desire, many will choose ones that “make no trouble.” Thus descriptive representation (what representatives “think, feel, and reason”) will probably be low even when socially descriptive representation is high.

Substantive representation will generally be low. The HSA, over time, will become indistinguishable from other agencies in the local health-care bureaucracy.

### *Who Should Be Represented?*

We now turn from the means of securing effective consumer representation to the issue of who should be represented. Which elements of the consumer population merit health representation?

The notion of dividing up the consumer population for the purpose of representation implies that there are subgroups of the consumer population with distinctive health care interests that ought to be represented.

Only one subcategory has been precisely delineated in PL93-641—those individuals who live in nonmetropolitan areas. Their representation on the board must reflect the proportion of nonmetropolitan residents in the health service area.<sup>8</sup> As for the rest, PL93-641 says only that

---

<sup>8</sup>PL93-641, §1512(b)(3)(C)(iii)(II).

consumers should be “broadly representative of the social, economic, linguistic, and racial population” of the area.<sup>9</sup>

Unscrambling the present confusion about representation requires an assessment of what consumer involvement is intended to accomplish. Presumably, the goal is to facilitate the articulation and satisfaction of the health care needs in American communities. If so, what is required is substantive representation, not hollow tokenism. Different health care interests in the area must be identified and selected for special attention through representation. The reason for including such groups as minorities, low-income persons, and women on the board should not be to mirror the community’s population on the boards; that, we have argued, is foolish and impossible. Rather, certain groups—minorities, low-income people, and women—should be included insofar as they have different and important health interests that the political system ought to consider. The argument is most compelling when it refers to interests that are often overlooked in local political processes. Moving from mirror representation to the effort to improve representation of specified interests requires changing the language of the law requiring that consumer representatives be “broadly representative of the . . . populations” of the health service area, to language requiring them to be “representative of consumer health interests” of the health service area.

The obvious question, then, is what specific consumer health interests should be represented? The answer is not easy because interests vary by issue. Regarding questions of access to health care, the current debate has identified various groups with legitimate claims. For example, access problems are different for rural and for urban populations, or for the chronically as opposed to the intermittently ill. At the same time, there are groups that, while part of the population (and therefore potentially included on a board constituted on the microcosm principle), do not genuinely have health care interests peculiar to their own group. For example, it is not clear that those with little formal education have specific health care needs or interests in the same way as the low-income or the aged populations.

As issues change, so do the interests that claim the right to a spokesman. The infirm could claim a representative for every type of disease, when the issue of new facilities arises; so could every ethnic group with specific genetic diseases that disproportionately or exclusively

---

<sup>9</sup>PL93-641, §1512(b)(3)(C)(i).

afflict them (blacks, Jews, Italians, for instance). The possible list is very long. However, to avoid an infinite round of litigation, HEW must make the difficult choices and specify the various consumer subgroups with recognizable health care interests that ought to be represented on the HSA boards. In this way, the present, almost infinitely broad, mandate would be replaced by one that is highly specific.

To illustrate, HEW could specify that groups reflecting the following interests be provided representation on the HSA board in approximate proportion to their number in the health service area: a) the poor; b) women; c) the aged; d) racial or linguistic groups comprising significant portions of the population; e) area of residence (the Codman Report [1977] breaks health service areas into hospital service areas—essentially, these are large catchment areas corresponding to the distribution of hospitals within a health service area. We suggest such a division of all health service areas, getting representatives from each subdivision in approximate proportion to its percentage of the total population of the health service area); f) groups that pay for medical care, such as insurance companies or unions; g) other identifiable groups that the secretary of HEW recognizes as having a health care interest and forming a significant segment of the population. Examples are migrant workers, black-lung victims, persons exposed to occupational hazards. These groups should be specified by the secretary either on the recommendation of the state or by appeal of that group.<sup>10</sup>

The specification of interest we propose will not only curtail the stream of litigation that has sprung from the microcosm view, but will also help insure the representation of important interests. As the law stands, a great deal of discretion regarding who is represented is left to state and local political games. And while it is appropriate to maximize the competition among groups on the board regarding health care issues, it is important to minimize the competition over which interests get on the board in the first place to compete over these issues. The danger is that groups will try to take over the boards, shutting out other legitimate interests. The vagueness of the current law and regulations as to who is to be represented increases the possibility of

---

<sup>10</sup>For a similar list, see Georgia Legal Services Program, "Proposed Amendments to PL93-641," Dec. 9, 1977, #3. To avoid litigation, regulations should make clear that this is a residual category to be filled at the discretion of the secretary, not a sweeping general provision mandating representation slots for all identifiable groups having significant health care interests.

conflict—and some of the litigation indicates that fear of further conflict is not groundless.

While the preceding discussion resolves a practical problem, it introduces a theoretical one: there is no systematic rationale by which HEW can make those “difficult choices” among affected interests. No matter which interests are selected, not all individuals are equally represented, or even equally enfranchised. How, under such conditions, can HSAs claim legitimacy as authoritative community decision-makers?

The answer is clear when there is a macrotheory of objective interests spanning the entire citizenry, such as class analyses include. However, liberal theory offers no comparable vision of fixed systematic interests. Pluralism brilliantly avoided the issue by assuming the link between subjective interest felt and group formed. Bentley is clear and adamant on this issue: “To state the raw materials of political life [—] the groups directly insisting on [a policy] . . . those directly opposing it, and those more directly concerned in it—is much more complete than any statement in terms of self-interest, theories or ideals” (Greenstone, 1975:244). Market conceptions provide little help. Although the populace is, theoretically, divisible into consumers and providers, regarding any functional area, those labels press a horde of often competing interests under a single label. As shown earlier, seating “consumer” representatives is a difficult mandate, regardless of the infelicitous mandate that boards be “broadly representative.” Finally, the choices we have urged HEW to make are plausible, not Platonic ones.

This does not mean that we are without a rationale for selecting interests. Emerging groups can be legitimated or strengthened as political actors by this type of quasi-corporatist program. The most important of these may be advocacy groups speaking for broad consumer constituencies and organizations such as unions and industrial associations. They are organized and have a clear, relatively concentrated interest in the politics of medical care. Such groups are promising market balancers. Other interests (minority groups, poverty groups) can be included for similar reasons, or because it is reasonable, necessary, or prudent to include them, given the objectives of the program. Anderson’s (1977) elaboration of this argument helps clarify the problem of the legitimacy of the HSA boards.

For various reasons, HSAs are structured to improve public accountability and representation. However, that structure is not relevant to the legitimacy of these agencies qua governmental units. HSAs must



be viewed as a supplement to, rather than a substitute for, geographic representation. As administrative agencies, their legitimacy flows not from representational schemes, but from a legislative mandate—from Congress.

### *Litigation and Representation*

PL93-641 was enacted in January 1975. By December 1977, it was the subject of eighteen lawsuits, five of which included the issue of consumer representation. These five cases are analyzed below in light of the preceding discussion of representation and accountability.

*Aladmy, et al. v Pirro, et al.*, C.A. No. 76-CV-204 (N.D., N.Y., April 7, 1977). The plaintiffs were dissatisfied with the minority representation on the Syracuse-Onandaga County (N.Y.) Planning Agency. The court ruled against plaintiffs because the representation of minorities was numerically adequate. With respect to the selection of certain minority members over others, the court stated that it would not find an abuse of discretion by the secretary of HEW except where the secretary's action was "so arbitrary as to be clearly wrong."

The case is an illustration of the application of the view of mirror representation. The court found no criterion in either the law or the regulations by which to judge representatives except for descriptive characteristics (in this case, "minority" status). Since both the representatives selected for the HSA board and their challengers satisfied that criterion, there was no way to choose between them. It was not possible to select one minority group member as any better, or more "representative," than any other. Since PL93-641 and its regulations say nothing about formal representation, challengers have no recourse and courts have no reason to insist on accountability if the criterion of socially descriptive representation is minimally satisfied.

Three companion cases can be considered together:

*The Louisiana Association of Community Organizations for Reform Now (ACORN), et al. v New Orleans Area/Bayou Rivers Health Systems Agency, et al.*, C.A. No. 17-361 (E.D. La., filed March 15, 1977). ACORN is an association of low- to moderate-income citizens claiming that the New Orleans HSA is not "socially or economically" representative of the area. ACORN states that of thirty-nine consumer members of the board, only four have incomes under \$10,000.

*Rakestraw, et al. v Califano, et al.*, C.A. No. C77-635A (N.D. Ga., Atlanta Div., filed April 22, 1977). Plaintiffs assert that there is inadequate representation of low-income individuals and families as well as of the handicapped and women.

Califano is cited, not only for conditionally designating a board with inadequate representation of the above-mentioned groups, but for failing to “propose and promulgate regulations dealing with the composition . . . and selection process” of HSA boards. The court is asked to require Califano to devise a method of selecting consumer representatives that renders them accountable to the public.

*Texas ACORN, et al. v Texas Area V Health Systems Agency, et. al.*, C.A. No. S-76-102-CA (E.D. Texas, Sherman Div., March 1, 1977). The plaintiffs argued that only three of the forty-one consumer representatives have incomes below the median for the area (\$10,000). They argued that if people with income above the median are to represent lower-income consumers (“under specific circumstances”), then the burden of proof is on the defendant HSA to indicate how some or all of the board members with over \$10,000 incomes would represent the poor.

They contend that representatives of the “public at large” do not count as representatives of the poor; this is a consequence of the model underlying their notion of HSAs, one of pluralistic bargaining among interests.

The federal defendants replied that it is not necessary to be poor to represent the poor; but they conceded that the federal regulations were inadequate, with regard both to the selection of the consumer representatives and to the representation of consumers on the board. (Note that these are precisely the charges in *Rakestraw*.)

The district court a) enjoined the defendant HSA from acting as an HSA or expending HSA funds, and b) ruled that between sixteen and twenty-five of the forty-one representatives must have incomes below the mean. Thus a strictly mathematical delineation was made, with a little “give” in it to make it “broadly” rather than “precisely” representative.

Defendant HEW has asked for a stay in the case until regulations can be developed; it will then be determined whether the Texas HSA conforms to the regulations.

Once again we find HEW mired in attempts to enforce socially descriptive representation. In bringing suit, the ACORN organizations use the mirror conception of representation to their advantage. But they recognize that it alone will not suffice to produce adequate representation of consumer interests over the long run. This realization—although present

in all three cases—is most explicit in *Rakestraw*. There, HEW is sued not only regarding the “composition” but also regarding the “selection” of boards. The suit asks HEW to consider what we describe as the formal aspect of representation. Furthermore, plaintiffs demand not mere specification of a formal mechanism, but a mechanism that guarantees accountability to the public. They are, to some extent, willing to waive socially descriptive requirements in favor of accountability engendered by the selection process. The trade-off is illustrated in the Texas ACORN brief, with the suggestion that a white selected by the NAACP would be acceptable from the perspective of black interests.

*Texas ACORN et al. v Texas Area Health Service Area, et al.*, 559 F2d 1019 (U.S. Court of Appeals, 5th Cir., Sept. 23, 1977). On appeal, a broader view of the case was taken. The district court’s undifferentiated mirror view was rejected and a full evidentiary hearing, in which HEW demonstrated precisely how board members were representative of the low-income or demographic population, was mandated. The view that one must be a member of those groups was explicitly rejected.

This ruling shows a far greater sensitivity to the issues of representation. There is cognizance of questions regarding the representatives’ relations to their constituencies and the necessity of various skills relevant to achieving substantive representation. In sum, there is awareness that a mindless adherence to the mirroring ideal can undermine the effective (or—in our terms—substantive) representation of a constituency’s interests.

*Amos, et al. v Central California Health Systems Agency, et al.* C.A. No. 76-174 ci (E.D. Calif., filed Sept. 10, 1976). Plaintiffs charged that whites were underrepresented on the board because Fresno and Kern counties were underrepresented. HEW has sent the defendant agency a letter, noting that its governing board is not composed in conformity with the requirements of PL93-641, so this case will probably not be settled in court. The race issue was not directly dealt with by HEW but subsumed under the criticism that the representation of metropolitan and nonmetropolitan areas was not fixed in exact proportion to the population. About race, HEW said only: “The ethnic representation on your board can be reasonably readjusted when you correct its composition in terms of nonmetropolitan/metropolitan distribution.”

The *Amos* case illustrates two other difficulties. First, the charge that minorities “captured” this HSA board, as the plaintiffs claimed, points out the distinction between a) giving contending groups a place on the board to dispute policy questions, and b) letting groups contend for the places on—or control over—the board. The latter defeats the purpose of representative boards: to allow local consumer interests to thrash out local health issues with each other as well as with providers.

A second difficulty follows directly from the first. Precisely who is being represented is not made clear by a law and regulations that merely mandate broad representation of the “social, economic, linguistic, and racial populations” of the health service area. Who is to determine what is “broadly representative”? We have argued that the concept of “broadly representing” (i.e., mirroring) a community is a meaningless guide to consumer representation. Instead, the interests or groups that merit representation must be specified precisely. That specification must be made with a fuller understanding of representation than is at present evident in PL93-641.

## Health Policy, Health Plans, and the HSAs

HSAs face insurmountable problems completely apart from that of representing consumers. The Health Planning Act has generated expectations for reshaping American medicine that no HSA can meet. The health systems agencies are simply not equipped to control inflation, solve problems of inadequate access, or rationalize the health services of a community. In discussing why, we shall point particularly to the factors that were expected to distinguish this planning effort from previous ones—“teeth” and sophisticated technology.

### *Authority and Health Planning*

Serious planning involves choosing goals for the future and the ways of arriving at them. One must distinguish between this sense of planning—manipulating a system toward particular goals in a specified fashion—and the writing of (often unreadable) documents termed “plans.” The former requires the capacity for authoritative decisions about the allocation of resources.

How nations in fact plan for health—that is, make allocative decisions regarding future goals—is not exhaustively illuminated (indeed,

sometimes not seriously touched on) by studies of how official planning bodies operate. Put another way, we have two subjects: the process of operational health planning, and the process of health planning organizations (Marmor and Bridges, 1980). The key element is the connection between choosing goals and the capacity to pursue or “implement” them. When the connection is loose—when plans are isolated from the process of resource allocation and, more generally, from authority—planning can become a smokescreen, a symbol, or simply frustrated wheelspinning.

At the same time, *de facto* plans will be either the choices of those who in fact allocate resources (the connection between authoritative choices based on financing arrangements and system control holds true under most conditions—including *laissez-faire*), or a result of the incentives operating within ongoing arrangements. The latter may be termed “change without choice” (Marmor, 1976), but it ought not be confused with the “change without influence” that is implicit in homeostatic—antiplanning—market conceptions. Such arrangements tend to be characterized, not by the theory’s self-regulating market, but by the domination of identifiable actors—hospitals, nursing homes, physicians—with an unrelentingly clear incentive: “more.” Thus, the well-known incentives of an American hospital are more high technology, more modernization, a fuller range of services and, therefore, more prestige, more first-class physicians, and so on. The consequences of this system are impressive technologies, rising costs, and a frustrating lack of corresponding change in health status indicators (Sidel and Sidel, 1977; Marmor and Morone, 1979). An HSA that overcomes some of the problems described above and plans for “less,” will need more than its “plan” to deflect that hospital from the incentives that ideology, financing, and provider expectations have generated.

The American suspicion of centralized authority is well documented (Hartz, 1955; Shonfield, 1965). Even the sweeping expansion of government legitimacy in the 1930s included only fleeting relaxation of this resistance. Intellectually, the hostility has been expressed in two major ways: in arguments that authoritative planning or control is tyrannous (Friedman, 1962; Hayek, 1944; von Mises, 1962), and that it is not realistic (Lindblom, 1959). The Health Planning Act and its HSAs fit obviously into this tradition. Their mission is overstated, their role ambiguous, their authority and political capacity highly circumscribed. They are certainly no match for the grandiosity of their plans. Most of what occurs in local health markets is beyond their jurisdiction: the

terms of reimbursement, the closing of facilities, the positive choices of places to expand. The powers they are given are widely qualified: they review certificates of need, but can only make recommendations; they are supposed to conduct “appropriateness review,” but the sanctions of inappropriateness are unclear (indeed, the regulations guiding this task remain unpublished).

In sum, HSAs do not have the authority—“teeth” is the current metaphor—necessary for the tasks, such as taming medical inflation, that have been assigned to them.

The difficulties of limited authority are compounded by the uncertain relation between HSAs and the rest of government. Indeed, the brief history of the law reads like a catalogue of contemporary confusions in American federalism: local governments are spurned for the—partially new, partially redundant—HSA structures; states and counties fight for influence within the framework of the law (Iglehart, 1973). Federal guidelines are promulgated with little clarity about how seriously they will (or indeed ought to) be taken in the communities. To the confusion of the now traditional “marble cake” metaphor (M. Grodzins, cited by Sundquist and Davis, 1969:7) we can add the impermeability of “picket-fence federalism” (Hudson, 1979). Unclearly stated regulations, interagency jealousies, lack of hierarchical support, and a growing, bureaucratic, self-generating political sector (Beer, 1978) lead to confusion, and ineffective governance and planning. Within the confusion, both governmental accountability and authority are dissipated.

We are not sanguine about the HSA successes that have been reported. Logic rebels at the peculiar idea that a planning agency without sufficient authority can scheme, scold, and cajole a dynamic system into compliance with plans that run contrary to all that system’s incentives. On their own terms, HSAs will achieve varying levels of success. But they will not achieve the foolish expectations that have been thrust upon them. They simply do not have the authority or the resources.

### *The Technological Fix*

The present health planning effort promised more “teeth” than its failed predecessor (comprehensive health planning), but added few. Another well-publicized innovation was scientific planning. The Health

Planning Act was presented as the marriage of community participation and scientific planning. The success of the law was seen to hinge to a large extent on the latter.<sup>11</sup>

The reliance on the technology of planning is the most recent manifestation of a recurring alchemy in American politics: the effort to derive objective solutions from political choices. This impulse was very much a part of the Progressives' search for the "public interest"; relatedly, the "best way" was a kind of grail for scientific managers preoccupied with achieving measurable efficiency (McConnell, 1966; Taylor, 1971).

There are of course legitimate—perhaps pressing—data needs in health delivery. Indeed, data are notoriously poor, and tend to be monopolized by provider institutions, which are predictably reluctant to share them with regulators. And, clear data sometimes have clear policy implications. For example, one Philadelphia study showed that people admitted on Fridays have longer hospital stays than those admitted on Mondays and Tuesdays with the same ailment. Furthermore, a quarter of the hospital days in the same sample were taken up by patients suffering from alcoholic and nervous disorders, both more effectively (and economically) treated on an outpatient basis (*Business Week*, 1979).

The policy implications of such findings are relatively clear, but difficult to implement. Furthermore, there generally remains the policy leap between facts and political choices—where to build a hospital, how to allocate limited resources, or, more dramatically, "who shall live." Even problems that seem objectively solvable (where to close down hospital beds) are intensely political. Ignoring the realities of political interests and value choices without some fundamental—and unlikely, undesirable—system changes is a naiveté that will result in irrelevant plans and frustrated planners.

The difference between data analysis and political choices is reflected in the odd disjunction of commentary on health planning: from Washington and academia flows an apparently steady stream of methodologies, simulations, and data processing advice. At the same time, reports

---

<sup>11</sup>See, for example, the report by the Committee on Interstate Commerce and Foreign Commerce on the National Health Policy, Planning and Resources Development Act of 1974. Report No. 93-1382, Washington, D.C.: Government Printing Office, Nov. 26, 1974.

from the HSAs deal with the different world of power struggles, influence peddling, and political choices. The language of science seems strikingly distant from the realities of local health planners.

There are some fundamental political and philosophical conflicts that the language of technology obscures. Two such conflicts are apparent in the Health Planning Act.

*Federalism.* The conflict between national demands and local desires was referred to earlier. When a national program invites local participation, the community will generally want to make alterations. Local residents see a different set of needs, for their perspective is different, and community politics—to recall a classic variant—involves a different cast of political actors. The conflict is resolved neatly when de facto responsibility for each part of the program is fixed at one level of government, however much the symbols or rhetoric of the program may distract attention from the outcome.

The structure of the Health Planning Act exacerbates this tension rather than resolving it. The law stimulated wide-ranging community participation, local discretion in agency design, and goals and purposes so vague that they appeared to promise significant local autonomy. However, set expectations, fixed goals, and stringent guidelines followed. With it came a furor that reflected the conflict between local participation and national goals.

Scientific planning cannot relieve this tension. Selecting problems requires choosing between values, as does the series of increasingly narrow decisions that follow. And participants on various levels of government must hammer out agreement about what those choices are. The vision of objective solutions, replicable from place to place (in the manner of scientific experimentation) is, in this context, a vacuous one.

*Efficiency.* A second formidable conflict lies between representing community interests and program efficiency. The constant juxtaposition of representation and scientific planning reiterates the hope that representative boards can somehow be made efficient with an infusion of “science.” In reality, the phrase is an oxymoron—the juxtaposition of opposites.

The point is illustrated nicely by the Common Cause official (cited by McFarland, 1978) who was told that his organization was not sufficiently democratic and participatory. He responded that if it were any more so



its efficiency at achieving policy objectives would be hampered. He was correct for a number of reasons.

First, inducing wider representation introduces conflict. This may be desirable, indicating the articulation of various interests and perspectives, but it is not administratively efficient. And much of the conflict is irrelevant to the agency's tasks, often reflecting longstanding community animosities, personal agendas, and the like.

Second, the essence of administrative superiority is the skillful gathering, use, and even monopolization of information. The resulting expertise and technical skills are complicated—often undermined—by the introduction of nonprofessional participants, particularly when they are accountable to outside constituencies rather than to agency superiors. The logic of representation emphasizes a principle directly contrary to the logic of efficient organizational management on this point.

Third, administration will be more time-consuming. Representatives reexamine first questions and basic values; they may need to consult with constituencies, delaying the decision-making process. Such problems particularly complicate long-term planning where objectives must remain fixed over time. The starts and stops of a volunteer-governed agency can make the planning process considerably rougher than one run by professional staff.

The result is that representative institutions are inherently less efficient than bureaucratic ones, even when they are properly institutionalized. In the case of HSAs, the inefficiency is more apparent because amateurs are asked to plan and regulate a technical system that has been highly resistant to almost every sort of government intervention. The litany about marrying representation and science is useless in this regard. And it even undermines the HSA effort. For each argument against the efficiency of representation is a hurdle that must be overcome if representation is to survive. And insofar as the myth of science distracts from serious consideration of a proper volunteer role, it contributes to the antirepresentational impulse grounded in the exigencies of efficient administration and planning.

Though expanded interest-representation makes administration less efficient, it is worth pursuing. There are numerous reasons for this choice, though all finally point to the permeability of policy-making institutions by the public.

First, Weber's efficient bureaucracy may not be desirable for policy bodies. The reevaluation of fundamental values, the limitations on technical vocabularies, the brakes on routinization and standard operating procedures, all make such agencies more accessible to public groups.

Furthermore, when limits to bureaucratization are removed, imbalance is facilitated. Bureaucratic agencies tend to tug issues out of politics and resolve them administratively. The bargaining process remains, but entry qualifications grow so high that only concentrated interests are likely to meet them. Administrators, with their expertise and their specialized vocabulary, grow inscrutable to any but provider (expert) groups. Public accountability is difficult, legislative scrutiny unlikely.

Finally, an open process makes it less likely that groups will be completely shut out—like the consumers suing by participation in Hill-Burton. A market open to all health system actors is more difficult to manage because conflict is introduced; the planning process grows more complicated and time-consuming. However, in a time of dwindling resources, forging a consensus among all health system actors is important to planning success.

In an increasingly bureaucratic age, representation is a more fragile value than efficiency. If the Health Planning Act accomplishes nothing more than introducing and legitimating potential market balancers on an ongoing basis, it will have achieved considerable success.

## Conclusion

The vision of representation in the National Health Planning and Resources Development Act is impossibly flawed, but not irretrievably so. We have suggested one plan for achieving reasonably effective consumer representation and balancing provider dominance. But representing consumers, overcoming imbalance, even discerning the public interest on HSAs will not alter the American health system in any profound fashion. The HSA mandate—limiting costs, expanding access, and improving the quality of health—reaches far beyond the agency's capabilities. Measured by these standards, the act's program is trivial, more symbols and rhetoric than significant improvement.

Rather, the law's significance lies in its stimulation of a broad range of consumer interests. Viewed as an effort to organize communities into

caring for their own health systems, it is the largest program of its kind. And one that could influence health politics long after its particular institutional manifestations—HSA planning boards—have been forgotten.

## References

- Anderson, C. 1977. Political Design and the Representation of Interests. *Comparative Political Studies* 10 (April):127–152.
- Balbus, I. 1972. The Concept of Interest in Pluralist and Marxian Analysis. In Katznelson, I., et al., eds., *The Politics and Society Reader*. New York: David McKay.
- Barry, B. 1965. *Political Argument*, chapter 10. London: Routledge and Kegan Paul.
- Bauer, R.A., Pool, I., and Dexter, L.A. 1963. *American Business and Public Policy*. New York: Atherton Press.
- Beer, S. 1978. Federalism, Nationalism and Democracy in America. *American Political Science Review* 72 (March):9–21.
- Bentley, A. 1967. *The Process of Government*. Cambridge, Mass.: Harvard University Press.
- Bernstein, M. 1955. *Regulating Business by Independent Commission*. Princeton, N.J.: Princeton University Press.
- Berry, J.M. 1977. *Lobbying for the People*. Princeton, N.J.: Princeton University Press.
- Birch, A. 1971. *Representation*. New York: Praeger.
- Business Week*. 1979. August 6:54.
- Burnham, W.D. 1978. American Politics in the 1970s: Beyond Party? In Fishel, J., ed., *Parties and Elections in an Anti-Party Age*. Bloomington, Ind.: Indiana University Press.
- Clark, W. 1977. Placebo or Cure? State and Local Health Planning Agencies in the South. Southern Governmental Monitoring Project, Southern Regional Council, Atlanta.
- Codman Research Group. 1977. The Impact of Health Planning and Regulation on the Patterns of Hospital Utilization in New England. Executive Summary, DHEW Contract 291-76-0003. Final Report, Year 1, September.
- Dahl, R. 1961. *Who Governs?* New Haven: Yale University Press.
- Dahl, R. 1964. *A Preface to Democratic Theory*. Chicago: University of Chicago Press.
- Edelman, M. 1967. *The Symbolic Use of Politics*. Urbana: University of Illinois Press.

- Eulau, H., and Prewitt, K. 1973. *Labyrinths of Democracy*. Indianapolis: Bobbs-Merrill.
- Flatham, R. 1966. *The Public Interest*. New York: Wiley.
- Friedman, M. 1962. *Capitalism and Freedom*. Chicago: University of Chicago Press.
- Friedrich, C.J. 1950. *Constitutional Government and Democracy*, 266 ff. New York: Blaisdell.
- Greenstone, J.D. 1975. Group Theories. In Greenstein, F., and Polsby, N., eds., *The Handbook of Political Science*, vol. II. Reading, Mass.: Addison-Wesley.
- Greenstone, J.D., and Peterson, P.E. 1973. *Race and Authority in Urban Politics: Consumer Participation and the War on Poverty*, chapter 6. Chicago: University of Chicago Press.
- Griffiths, A.P. 1960. How Can One Person Represent Another? *Aristotelian Society*, supplementary vol. 34 (6):187–208.
- Hartz, L. 1955. *The Liberal Tradition in America*. New York: Harcourt, Brace, and World.
- Hayek, F. 1944. *The Road to Serfdom*. Chicago: University of Chicago Press.
- Hudson, R. 1979. *A Bloc Grant to the States for Long Term Care*. Waltham, Mass.: University Health Policy Consortium, February 2.
- Iglehart, J. 1973. Health Report: State, County Governments Win Key Roles in New Program. *National Journal*, November 8.
- Klein, R. 1979. Control, Participation, and the British National Health Service. *Milbank Memorial Fund Quarterly/Health and Society* 57 (1, Winter):70–94.
- Lindblom, C.E. 1959. The Science of Muddling Through. *Public Administration Review* 19 (Spring):79–88.
- Lipsky, M., and Lounds, M. 1976. Citizen Participation and Health Care: Problems of Government Induced Participation. *Journal of Health Politics, Policy, and Law* 1 (Spring):106–109.
- Lowi, T. 1969. *The End of Liberalism*. New York: Norton.
- Marmor, T.R. 1973. *The Politics of Medicare*. Chicago: Aldine Press.
- Marmor, T.R. 1976. Welfare Medicine: How Success Can Be a Failure. *Yale Law Journal* 85 (July):1149–1159.
- Marmor, T.R. 1977. Consumer Representation: Beneath the Consensus, Many Difficulties. *Trustee* 30 (4):37–40.
- Marmor, T.R., and Bridges, A. 1980. Comparative Policy Analysis and Health Planning Processes Internationally. Prepared for the director of the Bureau of Health Planning and Resources Development, DHEW, May 1977. Revised for *Journal of Health Politics, Policy, and Law*.

- Marmor, T.R., and Morone, J.A. 1979. Innovation and the Health Service Sector: Notes on the U.S. In Altenstetter, C., ed., *Innovation in Public Services*. Berlin: Internationales Institut für Management und Verwaltung.
- Marmor, T.R., and Wittman, D. 1976. Politics of Medical Inflation. *Journal of Health Politics, Policy, and Law* 1 (Spring):69–83.
- McConnell, G. 1966. *Private Power and American Democracy*. New York: Knopf.
- McFarland, A. 1976. *Public Interest Lobbies*. Washington, D.C.: American Enterprise Institute.
- McFarland, A. 1978. "Third Forces" in American Politics: The Case of Common Cause. In Fishel, J., ed., *Parties and Elections in an Anti-Party Age*. Bloomington, Ind.: University of Indiana Press.
- McFarland, A. 1979. Recent Social Movements and Theories of Power in America. Paper delivered at the American Political Science Convention, August. Washington, D.C.
- Nadel, M.U. 1971. *The Politics of Consumer Protection*. Indianapolis: Bobbs-Merrill.
- Noll, R. 1971. *Reforming Regulation*. Washington, D.C.: Brookings Institution.
- Pitkin, H.F. 1967. *The Concept of Representation*. Berkeley: University of California Press.
- Pitkin, H.F., ed. 1969. *Representation*. New York: Atherton Press.
- Rosenblatt, R. 1978. Health Care Reform and Administrative Law: A Structural Approach. *Yale Law Journal* part 2:264–286.
- Salisbury, R. 1978. On Centrifugal Tendencies in Interest Systems: The Case of the U.S. Paper delivered at the International Sociological Association, Uppsala. August 17.
- Schattschneider, E.E. 1935. *Politics, Pressures and Tariffs*. Englewood Cliffs, N.J.: Prentice-Hall.
- Schattschneider, E.E. 1960. *The Semisovereign People*, 34. Hinsdale, Ill.: Dryden Press.
- Schmitter, P.C. 1975. An Inventory of Analytical Pluralist Propositions. Unpublished monograph. University of Chicago.
- Shonfield, A. 1965. *Modern Capitalism*. New York: Oxford University Press.
- Sidel, V., and Sidel, R. 1977. *A Healthy State*. New York: Pantheon Press.
- Sundquist, J., and Davis, D. 1969. *Making Federalism Work*. Washington, D.C.: Brookings Institution.
- Swabey, M.C. 1969. The Representative Sample. In Pitkin, H.F., ed., *Representation*. New York: Atherton Press.

- Taylor, F. 1971. *Scientific Management*. In Pugh, D.J., ed., *Organizational Theory*. New York: Penguin Books.
- Truman, D. 1951. *The Governmental Process*. New York: Knopf.
- Von Mises, L. 1962. *Liberalism and Socio-Economic Exposition*. Kansas City: Sheed, Andrews, and McMeel.
- Wilson, J.Q. 1973. *Political Organizations*. New York: Basic Books.

---

*Acknowledgments:* We want to thank Brian Barry particularly for his careful reading and constructive criticisms. Various other colleagues at the Institution for Social and Policy Studies, Yale University, and the Center for Health Administration Studies, University of Chicago, have been challenging, and helpful. And our thinking was advanced, particularly at the outset, by the writings and comments of Rudolf Klein and Charles Anderson. Julie Greenberg deserves great credit for improving the successive drafts of this article.