THE HEALTH AGENDA FOR THE FUTURE

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Two clear ideological lines seem to run through discussions concerning public policy with regard to health and welfare. These arguments are based on assumptions that are broader and more general than those that pertain only to the health field. The old moral order consisted of a major concern with integrity and wholeness. Now, however, one can see a new morality developing, in which the concern is with honesty and antihypocrisy. But much public policy still reflects the old morality, based on compassion and on a concern for quality in the evolution of public policy regarding health and social insurance.

More and more, society is being exhorted to adapt to the new morality, with its great emphasis on not promising what cannot be delivered, and on developing programs to meet broad-based demands rather than just professionally drawn goals. In a sense, a new type of politician has become the prophet of the new morality, and the "true church" tends to be bedded in a public policy. While the old values—the old morality —have been the justification for the development of social policy in the past, it is doubtful that they can continue to be the basis for future policy in the face of the new wave of public insistence.

Dealing with that problem would seem to call for something that sounds as odd as "the constructive manipulation of hypocrisy." It will not be possible to implement public policy without a full professional commitment of support, and to get that kind of support the behavior of the politicians must be such as to attract it.

The second ideological line relates to the productive qualities in human organization. As a culture, the United States is moving into a

situation where group autonomy is considered to be essential to the effective productivity of a societal unit. The reason why this is so is not fully understood, but it is clear that up and down the line a massive attack is being mounted on conventional hierarchical organization. Perhaps, having rejected a conventional Satan, society has seized on human organization as a substitute. The feeling is that an orderly establishment creates a premature closure on creativity—that it necessarily thwarts the individual. Progress must be antiauthoritarian; responsibility must be exercised in role, not in rule.

Both of these ideological lines—the new morality overturning the old and the growing disaffection with orderly organization—are crucial in considering the politics and practice in the delivery of health services in society. To use New York City as an example (and reasons may be found not to), evidence is plain of the public concern for meeting people's immediate needs in an honest and straightforward way, rather than worrying about organizational integrity and hypothetical standards of quality.

A central development that has received too little attention is that of new technologies that complement the new morality. One can ask whether radical social change can be accomplished through new technologies. The evidence is that not very much technology of any kind has been introduced into the delivery of health services. That refers mainly to "hardware" developments such as educational television and the computer. On the other hand, such "hardware" may have a much more profound effect than is expected on how people decide to get their health care. It has been demonstrated, for example, that commercial television has profoundly altered the way in which young children develop vocabulary recognition, so how about concept recognition? It seems entirely likely that a generation is growing up with thought processes that are quite different from those developed in a culture limited to the spoken and written language for communications.

An outgrowth of the new morality is the growing conviction that the availability of services to the community is more important than the quality of those services. It is a public imperative and if it is recognized, strategy considerations become simplified. The maintenance of quality standards in the health field will continue to be important, of course, and will continue to be tended to in quasipublic ways. But the demands for broad availability, coupled with the drive for group autonomy in social units and in production units, will inevitably produce a large toleration of variances in quality for some time to come.

Major unresolved dilemmas are encountered in the matter of maintaining quality standards. For example, the question of conflicts of interest should be examined, as when professionals who are engaged to provide one kind of service in fact spend their energies in other kinds of activity. One could cite teachers or administrators who spend their time in consulting, clinicians who spend their time in research and so on.

By and large, the American system has delegated to private agencies the responsibility of minimizing conflicts of interest and of maximizing quality. In the immediate years to come it will continue to be the public policy to assume that the private sector is maintaining quality and that governmental agencies will be concentrated upon assuring wider accessibility and availability of services.

It is deplorable that this nation really has no coherent and systematic public policy on health and social services. It is all the more deplorable since substantial movement is taking place in the form of new and altered programs without substantial guidelines based on public policy. (The one exception to this generalization is the seemingly consistent policy regarding the economic impact of government spending as it relates to fiscal and monetary results.)

Turning to planning, regionalization and the development of leadership, it is clear that much needs to be done. Currently the situation could be described as a vacuum. The United States Public Health Service seems to be the most likely agency in which substantial changes can take place and where forthright action can be stimulated to fill this vacuum. The Public Health Service has the logical role to play in taking the leadership in planning and regionalization.

The United States is not without experience in regionalized health planning. In New York state, for example, hospital and health planning has been tied to governmental approval of hospital capital proposals, which affect the hospitals through dynamic "selective deprivation." That is, of course, based on the old morality and therefore must be considered dead. This approach is one of making austerity a virtue in the presence of affluence, similar to community chests around the country, which are consistently dispensing philanthropic funds on criteria drawn up without any reasonable concern for social priorities. (Leading, for example, to support for suburban Boy Scout troops in communities with problems of squalor and poverty.)

It also seems doubtful that the "house of intellect" will be able to provide effective leadership in regionalization and health planning. Most medical schools and universities have nothing more than an intel-

lectual interest in the delivery of health services. The medical schools actually have specific educational and research purposes that are quite inconsistent with the recommendations of the Coggeshall Report. Besides, even if one were to charge the educational establishment with a leadership role, the fact is that the medical schools and universities move with glacial speed. The medical school—indeed the institution of higher learning—is designed for stability and for slow adaptation. As such, it simply cannot be expected to serve as a central source of leadership in this fast-moving era of social change.

The potentialities of leadership developing through the political organization of consumers is a new enough social phenomenon to seem to have momentum at present. The current apparatus of the phenomenon may be too fragile to have a national impact at this time, but regionally, and in New York City in particular, it could be most useful.

In any event, with leadership unlikely to come from the medical schools or from the organized consumer, it is up to the federal government to develop its capacities. What is needed now is a new and innovative drive within the United States Public Health Service itself.

Much discussion has centered on the meaning of leadership. It may be defined as a means of inventing ways for innovative ideas to become public practice, to connect people with change, to let conservative strictures be relaxed so that the doers in the field can do. Specifically, leadership will require the imagination to give away money with very few strings attached regarding program, though without abandoning strict scrupulousness about malfeasance in spending.

The Public Health Service must make continuing attempts to enunciate public policy in health care, but in doing so it must draw heavily on the collective innformed intellect of the professional health field. It must do so, however, without developing a dependence upon them for participation. The federal government is the logical candidate for the leadership role because the problems and challenges are too immense for any smaller entity to grasp.

It is appropriate to digress for a moment to discuss patronage as a tool of progress. Patronage is the substitute for violence in a humane society and is needed if a program is to work. It is difficult for the new morality to cope with the necessity for patronage—it can cope best when the political power is being wielded in a sheltered situation by a trusted institution such as the Public Health Service.

The professional field must protect the Public Health Service from gross errors in professional judgment. The Public Health Service can

return the favor by building institutional protections for the field from patronage traps. In that sense the federal government can at once support and protect localized regional planning bodies.

America has established a clear pattern of delegating, for better or worse, the main responsibility for delivering health services to provider institutions and especially to hospitals. Unfortunately, it may be pure fantasy to think of today's hospital as having the capacity to be a community health center. But in any event, it certainly has an extraordinarily important role and is the key asset in the organization of services.

The central challenge is now to connect the hospitals with their new social setting. Would it be practical or feasible to create a new institution to be responsible for the delivery of health services? Not a health center in the conventional sense of the term, but a new institution with heavy local representation to take primary responsibilities in assuring the population of the delivery of services. The new institution might have to include a facility, but not nesessarily so. It could well be a kind of referral system without its own care resources. Certainly improved delivery systems are needed, and some of the country's most inventive people must be put to work in developing proposals along that line.

The health institutions should be heavily consumer dominated for several reasons, but at least because it is becoming necessary politically. If its clientele are not satisfied with the delivery of services, the institution will be in a continuing crisis. "Quality" is too elusive to use as a criterion. In the political sense it is accessibility and availability that count. In any event, the old notions about the nature of quality in medical care are changing. Although nostalgic memories and some solid virtues remain in the idea of the personal physician, he represents an obsolete idea for the urban community.

The health care system must be organized on a basis broader than individual hospitals. The assumption must be removed that the individual in the community should adapt to the hospital-based delivery system. Instead, satisfactory health care must be produced with random contacts between people and the system.

On the subject of manpower, since the availability of health services has become a matter of public commitment, it becomes the responsibility of the federal establishment to see that sufficient manpower is made available to produce on the promise. A formal responsibility for the development of health manpower can no longer be avoided.

As to the form of the federal commitment to manpower development, the military model seems promising. Professional health academies

should be created that are related to the needed deployment of manpower and to the employment system. A great deal of flexibility should be permitted in the organizational relationships of the national academies and they should be made strong and autonomous centers.

There is little hope that the existing educational institutions will be able to adapt to the health manpower demands of the country. Certainly it is inappropriate to ask a medical school, for example, to train health planners. New educational forms are needed, and are needed rapidly. As a part of that the national manpower commitment will logically lead toward systems of national licensure for health personnel. If severe handicaps of distribution are to be overcome, health personnel must be universally interchangeable. Moreover, ways must be explored to solve manpower shortages that do not require the training of new personnel. People with existing skills may be hired without training them anew. An example would be the feldschers who are functional in other countries.

On the subject of community development, the power of novelty is strong in social change. As function is at least partly the result of structure, and as structure is often accidental in its final form, an atmosphere is needed in which novel structures can be devised and implemented. In short, if a community shows sufficient agreement that health care has a high priority, the government should be willing to support innovative ideas simply because they are there.

It all depends on whether people really are concerned about health care, and that is doubtful at times. It is worth looking at carefully, for the health producers may be trapped in a fantasy about the high priority of health services in people's minds. The available evidence would seem to indicate that health ranks below such other community concerns as jobs, votes and perhaps even education. But if evidence can be adduced that health has a high priority in the community, that health care provides a key motivating force, then let us lay hold of this and capitalize on it.

In conclusion, a thought on the value of capitalizing on the initiative power of minority groups within the society. Society is well past the notion that consensus produces sound policy. The challenge is to learn to use minority positions creatively to improve public policy. It is the passion of minority concerns that can provoke rational solutions. Society must learn how to manipulate minority interests creatively for the sake of the majority. Action, finally, is where change is. If the change can be identified, progress has been made toward developing public policy.