THE SHIFTING POWER STRUCTURE IN HEALTH

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This paper deals with a complex, difficult topic about which little is known. The paper considers social power in a general way; makes some observations on power changes internal to the health establishment, including observations on "the" physician's role and the university health center; examines the increasing role of government, particularly at the federal level; the changing role of lay community leaders; and the awakening, but as yet relatively inactive, consumer public. Following these considerations, the conclusion will present some thoughts on the central problem of the paper: the implications of power analysis for structuring the planning and administration of regionalized health services and facilities and the preparation of persons for this endeavor. To grasp these problems, a brief examination will first be made of social power and certain broad changes in the health systems of complex, technological societies.[1]

SOCIAL POWER

Social power is here defined as the ability to influence the orientation and behavior of others. How does an individual or group obtain social power in a social system? Individual and group power is given through the consent of others in the social system.[2] That consent is dependent upon certain recognized bases or sources of power that are described below. An individual may "hold" power or "exercise" influence, but he can do so only if others do his bidding. The power structure in health

(or any other sphere) changes, as does the control of different individuals and groups over the bases of power.

Some authors differentiate between power and influence on the basis of resistance versus acquiescence in the relationship. For example, friends are said to influence each other, while opponents wield power.[3] Since social interaction is always redefining some situation or reducing some ambiguity from a situation,[4] the above distinction between power and influence is rejected. For no matter how much in accord two persons or groups may be, if they engage in symbolic exchange, the resistance of prior definitions must be overcome. Thus the category of no resistance is essentially a null category in human intercourse and the problem of a substantive basis for distinguishing between power and influence is not a useful one.

If it is not important to make a distinction between power and influence on the basis of resistance being present or not (since it is always present to some degree), it may be more valid and useful to make a distinction on a temporal basis. Thus, one might suggest that power applies only to potential, or undemonstrated realization of an actor's influence.[5] Influence then is actualized power. Instances of influence are evidence that power existed and has been employed. Power is always present in a situation and will show itself as influence before a particular "scene" or other bit of interaction is completed.[6]

To more fully understand social power and have some way of assessing or "toting up" what Norton Long calls "the power budget"[7] of the health administrator or other persons and interest groups in the health system, the bases on which power rests must be studied. Some or all of the following bases of power may be involved in a given interaction between a staff physician and the hospital administrator, between a hospital and a planning agency and so on:

1. The interpretation of traditions, philosophies and history is one important tool by which men may be moved. The administrator who can remind board members of past traditions of delivering maternity care, when some members of the board were themselves born in the hospital, has considerable power in opposing a planning agency's moves to consolidate maternity services in another hospital.

2. The ability to generate believable myths, whether intentionally mythical or not, is another idea tool of some importance. Simply mentioning the Orson Wells-directed radio broadcast of the Inva-

sion from Mars, during which some people jumped into the Hudson River to save themselves, validates W. I. Thomas' aphorism, "When men define things as real, they are real in their consequences." The same phenomenon is seen in the health field (usually with less frightening results) when justification is sought in "magic numbers"—one public health nurse per 5,000 population, 4.5 general hospital beds per thousand population, and so on. Often such figures are justified very little in terms of function and need; yet plans are drawn, budgets passed and building programs launched in response to such calculations.

3. Reasoning ability or the power of logic seems clear enough not to need illustration.[8] However, it differs from "force of presentation" in the sense of personal style or other valued social characteristics. One can illustrate that distinction by "the brains of the outfit" (a person with knowledge as well as reasoning ability), who may act from a relatively hidden position of the state health department where some abrasive personal characteristics cannot do much harm, while his influence is felt through the actions and programs he suggests to others.

4. In most community (and other) power structures the expert who controls technical knowledge or skills fills an essential place. He may or may not constitute an initiating and perpetuating force, but he is essential at some point to certify the soundness of a program.

5. Control of economic resources is a major base of power. To Marx, this factor was important enough to base a theory of history on control over the means of economic production. Indeed, it may be that regional health services planning structures can have their major impact on coordination of services through control over the channeling of both operating and capital funds. But at least four conditions limit the power of the person or group who controls resources: those to be influenced may have resources the controller badly desires; they may obtain the same resources elsewhere; they may have power on other grounds to force relinquishment; they may resign themselves to do without.[9] Some of these limiting conditions reflect the operation of other bases of power.

6. The authority one has as a function of his office in a formal organization may be a source of far-reaching influence. This source

of power has increased in importance and to some extent changed hands as the administrative function in hospitals, health departments and other organizations has emerged as a special endeavor.

7. Apart from holding an office, control over an organization of men through formal or informal means is a familiar, but nonetheless important part of accomplishing tasks, especially large-scale ones. One or more nonelected power figures may control a political party, a government bureaucracy, even a health services planning agency from "behind the scenes." Such control may involve a formal office, as in the case of a large employer who is asked to head the United Fund drive; or it may not involve formal office, as in the case of the racketeer who moves into the nursing home field.

8. Position in the social structure (aside from prestige as discussed below) can be an important determinant of power. It is not impossible, but very much less likely, that the "lower-class" patient will have as great access to or control over any of the sources of power as will the health professional who seeks to influence his behavior. The health organization that is primarily "plugged in" to the "lower class" will be similarly short in its power budget.[10]

9. Prestige can be thought of as the combined impression of a person or organization due to valued social characteristics. Whatever causal role these characteristics play in the generation of power, considerable evidence may be found of their association with those identified as powerful. This has been regularly noted among community leaders.[11] It has also been noted for high-prestige occupational roles such as that of the physician. Outwardly, given some native intelligence, training makes the physician. But this is not all, for he is expected to have certain of what Everett Hughes terms "auxiliary characteristics."[12] In the United States, these expectations operate to exclude many women, Negroes and others from these roles.[13] That condition may change, however, in the face of manpower shortages and public demands.

10. Direct popular or political support is an important power base to which public health professionals have given inadequate attention while attempting to justify their programs to political figures on economic grounds. Within certain limits, the costs do not matter if the people in general are sophisticated enough about health prob-

lems and services to vigorously demand adequate care as a basic human right.

11. The "miraculous cure" lends charisma to the one seen by the patient as responsible, for the event breaks all expectations of disaster. Charisma is not a mystical source of power. It can be empirically indexed by behavior that violates rules or expectations with good results. Some community health leaders acquire charisma as they demonstrate ability to ignore various bureaucratic labyrinths while achieving results for their followers.

12. The power of violence is gone as soon as it is unleashed. Only in the potential of its use are men moved out of fear to do the bidding of its wielder. To a considerable degree, the potential of violence on the mental patient's part structures the whole mental hospital, even to some of the fine points of architecture. In some institutions this is seen as the ultimate problem. Even if the threat of violence achieves negative results, it can influence the behavior of others.

13. But even violence, to have its effect, requires, as Simmel pointed out, the reciprocity of the threatened person.[14] The narcotized patient has no ability to influence the surgeon, but we could not say that social power is involved in this relationship. The matter of hypnosis is an interesting and problematic relationship from this point of view.

To distinguish these several foundations upon which social power rests may be arbitrary and no doubt overlaps occur, which a better categorization might eliminate. Nevertheless, an inventory of these sources of power for a given health administrator or planner and his organization, as compared with the same assessment for those to be influenced, would yield a reasonably adequate estimate of the "power budget" available to develop and institute plans.

Plans, of course, have their own definitional power when developed throughout the system to be affected. Further, the various sources of power may be differentially weighted and these weightings may vary with the context of opposition or encouragement faced by the planning organization. Clearly, the power budget is no static entity granted within some fiscal period. The total budget may increase or decrease and its component parts shift depending on changing definitions, new enthusiasms, crises and other events.

The relevance of the size and complexity of a social system will be seen if certain broad shifts in the health system are considered that have altered access to and control over the bases of power and have thus changed its power relationships.

First, in recent years a vast proliferation of new health specialties has taken place. By way of illustration, Dochez examined the records of two cases of heart disease in the same hospital, one in 1908 and the second in 1938. The first case developed a written record of two and one-half pages reflecting the observations of three professionals—an attending physician and a house officer, with consultation from a pathologist-bacteriologist. In the later case, the record occupied 29 pages reflecting the contributions of 32 professionals, more than ten times the number involved in the first case. These included three attending men, two residents, three interns, ten specialists, and 14 technicians.[15]

New groups continue to enter the field. "The trend toward new careers is yet to be fully appreciated. Among the 200 plus careers listed by title in the *Health Careers Guide Book,* the majority represented but a small segment of total health manpower prior to World War II. Many careers, e.g., inhalation therapist, nuclear medical technologist, radiologic health technician, cytotechnologist and medical engineering technician, did not exist."[16]

Within the once relatively unified, single profession of medicine, numerous specialties now operate in effect as independent occupational groups.[17] Whereas, in 1931, five general practitioners were found for every full-time specialist in active private practice, 30 years later one-half were specialists. "Between 1931 and 1959 the number of full-time specialists more than tripled, increasing from 22,158 to 78,635. On the other hand, the number of general practitioners (including part-time specialists) decreased from 112,116 to 81,957."[18]

Increased complexity is also evident for health organizations. In his book, published in 1945, covering 95 national health agencies of the nongovernmental, promotional type (National Tuberculosis Association, American Child Health Association, etc.), Cavins noted that no attempt was made to deal with all national voluntary health organizations. Further, none of the organizations dealt with was formed before 1904. In the following two decades they sprang up "mushroom-like."[19]

In 1961, a report for the Rockefeller Foundation by an ad hoc citizen's committee counted, aside from hospitals, over 100,000 national,

regional and local voluntary health and welfare agencies that solicit contributions from the general public.[20] The growing complexity of governmental organizations in the health field is not much, if any, less striking. For example, in recent federal legislation granting 256 million dollars in addition to matching state and local monies for activities in the field of mental retardation, Congress provided for no less than 12 federal agencies to disburse these funds.[21]

In 1950, Roemer and Wilson examined this problem from a new perspective. In the words of Joseph W. Mountin, they "Attempted to set down systematically the structure and function of all organized health services having an impact on the people of one county."[22] In this semi-rural county of what is now identified as "Appalachia," they found no less than 604 agencies involved in organized health service that had some impact on health care in that county. Locally based health-relevant organizations numbered 155.[23]

In addition to increasing complexity, the health system shows striking evidence of increased size, change in relative size of different components and change in position in society generally. As regards occupational groups, "It is estimated that the health professions requiring college education or professional preparation accounted for approximately 200,000 persons in 1900. The number of individuals in these same categories increased to 409,000 in 1920; 692,000 in 1940; and 1,140,000 in 1960. . . . Individuals in the health occupations accounted for 1.2 per cent of the experienced civilian labor force at the turn of the century. This proportion increased to 2.1 per cent by 1940; 2.4 per cent by 1950; and 3.0 per cent by 1960."[24] Relative to other groups, physicians have lost dominance simply in terms of numbers. "Whereas at the turn of the century, three out of five health professionals were physicians, by 1960 rapid growth in other disciplines reduced the proportion of physicians to one out of five professional health workers. A continued decline is to be anticipated as other disciplines experience more rapid rates of growth and new categories of personnel emerge."[24] According to another estimate, the present ratio of physicians to all health personnel is less than one to ten.[25]

From fear-inspiring, segmental units serving only the displaced and disinherited of society, some of the most essential health organizations, such as clinics and hospitals, following the development of scientific secular medicine, became more effective, highly desired and generally used.[26] The rate of admissions to general hospitals, for example, rose from about one in every 18 persons in 1931, to approximately one in

seven in 1962. Modern health care has come to be regarded as a basic human right.[27] Health institutions have moved squarely into the community. They have become community institutions.

CHANGING POWER RELATIONS

General

It is not possible to detail the impacts on power relations in the health system of the increased complexity, size, change in relative size of certain components (e.g., physicians relative to other health workers) and overall shift in the place of the health services industry in society. Yet several observations seem evident. First, with the rate of technological and social change in this field the power structure is certainly very fluid. That is not news. But perhaps it is this very fluidity throughout modern society that seems to accentuate the striving of occupational groups and organizations to protect or increase their autonomy, gain greater support and generally hold or improve their "place in the sun." Perhaps, too, this complexity and fluidity of power relations is what makes the problem of planning health services so important, yet at once frustrating and fascinating. In any case, it is not anything that could be characterized as a stable structure; the power budget is fluid. Thus, rather than carrying the assigned title, this paper should have "power relations" in its title.

Second, some growth has taken place in the power of the total health system. In these perilous, warring times, health has not achieved, and may never approach, the concentration of power C. Wright Mills found combined in the "defense" establishment as it serves the interests of "Big Business," "Big Labor," Government and The Military.[28] But with the generally high regard in which health services have come to be held, increased utilization and greater proportions of personnel and funds, health now occupies a more substantial place in society. For this, and other reasons to follow, health affairs have become matters of important public concern and political action. For example, see the conflicts between groups of elderly voters, the American Medical Association and other interest groups as detailed in Richard Harris' series on the legislative process involved in the development of Medicare.[29]

Third, although the system overall may be more powerful (at least when overwhelming budgets for international conflict do not intervene), power is more dispersed, shared as it is among a myriad of health occupations and organizations in different public and private

jurisdictions. That entails unnecessary inefficiency, expense and suspected lower effectiveness. Certain reactions have occurred to the dispersal of power within the health system. Government has begun to play a larger part as have various quasi-governmental health bodies. Consumers too, particularly in poverty areas have begun to insist on a role in determining the character of health services delivered to them.

In the Health System

Although the position of "the" physician in society may have remained relatively constant and high in the view of the general public,[30] insiders are beginning to realize that "the" physician is a myth. Not only do medical schools differ in their emphases in the two, four or five years their programs run, but differentiation within specialties has progressed to such an extent that when someone collapses in a gathering it no longer makes sense to shout, "Is there a doctor in the house?" Doctors in a range of specialties who really treat patients might answer the call (if they are not afraid of a malpractice suit as a consequence of treating someone outside their usual, well-equipped work setting). But what of the administrator, the researcher, specialists in "thing-oriented" fields such as radiology. What of epidemiologists? Or psychiatrists who have only *talked* to patients for years? Could they do much more for the victim than the nurse or even the lay person trained in first-aid?

The specialization and development of new health occupations is not limited to physicians.

What are the consequences of specialization for the power of a given occupational group or representative thereof? On the one hand is a tremendous increase in esoteric, technical knowledge and, in situations where it is relevant, it affords tremendous power. On the other hand, the monopoly the physician once had in the health field is gone.[31] Not only is his own house often divided against itself, with different specialties having different associations and making different representations, but many newcomers are on the scene. Often the newcomers are as vital as any particular type of physician in the provision of care. For example, a radiologist recently complained that he was leaving his practice in a community hospital in part because he was no longer in complete control of therapy—a physicist now determines the use of the cobalt unit. It is this "functional equality" that is beginning to make one member of the health team as vital as another.

Although the colleague rather than leader-follower relationship

among health workers has not been given wide recognition, to some extent it is a fact and it makes some health workers uneasy. After imperialistically referring to "sub-professionals" for years and recently modifying this to "ancillary professionals," the vogue among physicians now is to speak of "allied professionals."

Of course, prestige and income differentials suggest that the label may only be a sop. The left-hand column of Table 1 shows a ranking of several listed groups according to "how professional" their members are judged to be by a general sample of public health workers (members of the American Public Health Association or one of its state or regional affiliates).[32] In the right-hand column are the median incomes determined from reports by members of these occupational groups in the same mailed questionnaire. Although new words like "allied professionals" may only be a cover for continued exploitation, they probably reflect change in power relations.

In the struggle for position, now with particular reference to occupational groups, various strategies and means are employed.[33] But one that comes under myth making should be examined briefly as it is so pervasive, ubiquitous and consequential for the question of health manpower. That is the master myth of "professionalization." If a group can become known as "professional," as seen in Table 1, it is more likely (though the rank-order correlation is only .57) to enjoy a better income. Other conditions lending prestige and power to the group are also correlated with this appelation. Indeed, after a careful analysis of available studies and theoretical discussions, Becker has concluded that "professional" is only a term of approbation, and does not clearly distinguish one work group from another except possibly in terms of power and prestige.[34] Yet, a great deal is made of the term with extensive ideologies and much effort is invested in "becoming professional." Aside from a certain assurance of quality to the public, the net result may be a narrowness of outlook, special jargon, restricted supply, higher costs, sloughing off of necessary but "dirty" tasks, divorce from those most in need of service (such as poverty, "lower-class" and certain ethnic groups)[35] and expensive machinery to license, accredit, lobby and otherwise protect secrets and domains. In short, as has been seen in various parts of the world, "when the chips are down," doctors and nurses are not so different from other work groups; they make use of the ultimate labor weapon like anyone else; that is, the strike, though it may be called "mass sick leave" or "a professional holiday."[36]

Control of the health organization, too, is changing. In the hospital,

TABLE I. PROFESSIONAL RANK AND 1964 INCOMES OF SELECTED OCCUPATIONAL GROUPS IN PUBLIC HEALTH, BY SELF IDENTITY, DEGREE AND SELF-IDENTIFIED BASIC DISCIPLINE*

Work Group	*Professional Rank***	*Under $5,000* N	%	*5,000–9,999* N	%	*10,000–14,999* N	%	*15,000 and Over* N	%	*Total* N	%	*No Resp.*	*Not Appl.*	*Median Income*	*Income Ranking*
Physicians†	1	37	8.0	40	8.6	80	17.2	308	66.2	465	100	39	10	17,850	1
Public health dentists	2	4	6.8	22	37.3	25	42.3	8	13.6	59	100	3	3	10,700	4
Veterinarians	3	2	2.8	28	37.8	28	37.8	16	21.6	74	100	5	4	11,250	3
Laboratory scientists	4	47	13.0	207	57.3	84	23.3	23	6.4	361	100	14	24	8,200	9
Health officers	5	9	3.7	52	21.5	104	43.0	77	31.8	242	100	14	18	12,850	2
Public health engineers	6	6	2.0	154	52.1	111	37.5	25	8.4	296	100	10	15	9,550	6
Biostatisticians	7	36	28.6	63	50.0	21	16.7	6	4.7	126	100	4	14	7,100	11–13
Public health nurses	8	760	58.9	513	39.7	18	1.4			1,291	100	59	174	4,200	16
Other nurses	9	77	56.7	55	40.4	4	2.9			136	100	4	15	4,400	15
Hospital administrators	10	27	6.1	181	40.8	133	30.1	102	23.0	443	100	26	37	10,500	5
Other public health administrators	11	69	13.4	240	46.4	109	21.1	99	19.1	517	100	25	13	8,900	8
Health educators	12	42	21.8	128	66.7	18	9.4	4	2.1	192	100	7	19	7,100	11–13
Nutritionists	13	23	20.5	77	68.8	9	8.0	3	2.7	112	100	4	12	7,100	11–13
Public health social workers	14	12	10.7	84	75.0	14	12.5	2	1.8	112	100	1	3	7,600	10
Sanitarians	15	273	48.8	279	49.8	7	1.2	1	.2	560	100	25	29	5,100	14
Occupational hygienists	16	5	2.4	121	57.3	65	30.8	20	9.5	211	100	6	3	9,150	7
Other††	unranked	964	27.6	1,194	34.2	595	17.0	741	21.2	3,494	100	184	363	8,250	unranked
Total		2,393		3,438		1,425		1,435		8,691		430	756		

* Exact means of delimiting groups furnished on request.

** See reference 32 for derivation of this ranking.

† These are largely clinical physicians in public health, epidemiologists, specialists in preventive medicine and occupational health physicians. Excludes M.D.s who identified themselves in other categories, such as health officer, hospital administrator, etc.

†† Includes a number of "professional" categories with only a few members as well as secretaries, clerks and certain other "nonprofessional" categories plus those unemployed or not in the labor force.

particularly, a new breed of non-medical administrators has entered upon the scene in the past 30 years.

Sharply prepared in quantitative aspects of management, personnel relations and organization theory and other aspects of the social sciences, they are in a better position to respond to the problems of the complex health organization than is the case-oriented, biologically prepared physician, however much he enjoyed (or did not) his preventive medicine and public health courses. Over the years, the administrator has also learned the value of having the board in his corner. Through his board, if it has the right composition, the administrator has access to the community leadership—the industrial, financial, legal people. Physicians and other health professionals listen when and if these men become interested in "a new wing," "a new professorship in surgery," "a hospital planning agency" and so on.

Public health organizations are also showing signs of change, even at the very top of the structure. A blue-ribbon committee composed largely of public health physicians concluded the following:[37]

> To say, however, that the departments of health are the logical agencies to take on major responsibility for the planning and coordination of the delivery of these [personal health] services is not to say that they are now ideally equipped for the job. A responsibility of this breadth will of course require special personnel to meet it, and this brings us back again to the problems of education for public health, especially in the schools of public health. The simple fact is that very few people are being prepared in schools of public health today, or anywhere else, who could justifiably be presented to a community as qualified for this task. . . .
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> The schools of public health should give immediate attention to establishing a doctoral curriculum which would blend the contributions of economics, political science, sociology, the health sciences, certain of the physical sciences and other fields of study.

Although the power of formal position and control over an organization have accrued to the administrator's balance to an ever increasing degree as the hospital has taken on greater central importance in the health system, important counter trends have appeared. With the increasing size of the health system (in terms of overall budget, personnel and other matters) and complexity of modern care and consequent rising costs, no health organization is an island unto itself. If, as Martin Cherkasky has indicated, the hospital must become "a sharpened instrument" used in the right way for the right case at the right time, it must be integrally tied in to preventive services, ambulatory care, domiciliary care and diagnostic services, home care, nursing homes

and other extended care and rehabilitation units. That means a sharing of power and the likelihood of numerous interorganizational problems.[38] In any case, it is no longer fruitful to look at the hospital as an autonomous unit with definite boundaries outlined by its walls. Instead, it has become a kind of point of intersection for several functions that must be carried out by the community or regional health system as a whole.

The development of organizational networks, as well as other conditions that will be discussed presently, has turned the organization outward. The Surgeon General, William Stewart, has reflected on this trend as it affects medical schools by pointing out that after developing two faculties, the so-called "basic" science faculty and the clinical faculty, medical schools have begun to develop a third faculty—a community medicine faculty. Growing community awareness is in no way limited to or particularly characteristic of medical faculties. Other patient care professionals, the administrators and board members of the university-based health center are becoming community conscious. Since the Flexner report, the medical school particularly, but other schools of the health professions as well, have served increasingly as the establishers of new knowledge and legitimators of values in the health system. In addition, the university-based health center has gathered, in most cases, the most elaborate and effective armamentarium of personnel, equipment and facilities of any organization in the immediate vicinity. To the extent of these occurrences, the university health center has become the power center of the local health system. Now, in addition, the Regional Medical Care Program, even if it is interpreted as primarily educational in character, may add major impetus to the abilities of the centers to reach into the surrounding networks of health organizations and occupational groups.

Changes in the Environment

Four general developments seem noteworthy: the efforts of organized occupation groups; the increasingly political nature of health issues; the increasing interest of lay community leadership in health planning; and a slowly awakening desire of consumers of health services to determine policy with regard to local service institutions.

As mentioned in the previous section, occupational groups, of which numbers are increasing in the health field, are on the move toward establishment. Their efforts are sometimes carried out within the health organization and could have been treated as part of the internal an-

alysis as one examination of the "negotiated order" suggests.[39] But many of these efforts are frank moves in the larger body politic to gain legislative support for higher salaries, a different more advantageous system of payment, higher stipends to aid recruitment and stricter licensure to maintain better control over a domain of work.

That health issues have achieved political status indicates a reaction to rising costs, fractionation, inefficiency, impersonality, suspected ineffectiveness and the dispersal of power among the units of the complex health system. The engagement of political power in the determination of health policy has of necessity held in view the action of government, particularly the federal government.[40] The state, after all, is, at any level of government, the only institution of society that covers or intends to cover all elements of the society no matter how disparate and diverse. The larger part that government plays in health policy is not only a matter of payment and decisions as to criteria and standards for these expenditures. Government is also an adjudicator, a guardian of the public interest as regards licensure of individual practitioners and health organizations. The hearings conducted by Commissioner Smith of Pennsylvania on Blue Cross rates demonstrated that even where a private insurance organization is concerned, the state may inquire into the public interest.

As effective and desirable as modern health care has become, the public has an ambivalent attitude. On the one hand is the possibility of saving life, preventing disability, even realizing and enhancing human potential. On the other hand are fantastically rising costs,[41] and impersonality and disjointedness in a family's care, which is difficult for even the most sophisticated to tolerate.[42] Thus, health services have become matters of public concern, particularly to large, so-called "third-party" payers (Government, labor, industry, insurance organizations), but also to community leaders, philanthropic interests and consumers. As a result, health issues have become key political issues with government at all levels entering the health care picture to an increasing degree.

Since Bismarck's time, politicians have seen that they can protect their power or obtain election in part by making adequate health services more available. Although the determination of health policy has always been to some degree external to the health system because the actions of health agencies and professionals require the support and acceptance of the surrounding society. Such determination is currently moving into the conscious scrutiny of mass politics and

could easily mean the setting of goals and priorities that "professionals" would not choose. The bulk of the voters are not health professionals, although the sizable interest group, particularly the large "third-party" is likely to have the expertise of health workers at its command.

Sometimes a lack of correspondence is noted between the general public mandate for action to improve health services as expressed in the election of officials and legislators and the specifics of health legislation and administration of such legislation. No exact correspondence exists, for example, between the Debakey Report, representing an expression of broad public interest in the receipt of "the latest" medical care, and the Regional Medical Program Legislation. On the one hand, the pressures of public demand and political promise build up relevant to very general health goals. On the other, the expertise of health officials is applied to specific measures in a context of what is possible in Congress and the political arena generally.

Political parties as such have not as yet engaged themselves in the health sphere to any great degree at any level. True, the major parties have included health concerns in their platforms and presidential candidates have included issues such as Medicare in their campaigns. But good health care is an amazingly nonpartisan issue and detailed questions of financing and organizing are generally too complex to make good public issues. Although it is difficult for political parties as such to develop and take positions on health questions, they can be expected to do so increasingly as good health care is more and more regarded as a fundamental human right. Furthermore, politicians, as individual campaigners and as policy makers, can be expected to take greater interest in the details of health issues in the future. Men like Hill and Fogarty have already become expert guides to their congressional colleagues on health policy.

At the local level, health questions—especially when they involve the determination of the location for a new hospital or other facility, or the expenditure of public funds for programs and improvements—often become points for political action; sometimes rather acrimonious as Banfield's analysis of the Cook County Hospital expansion plans indicates.[43] But, again, these are seldom developed into party issues with one party vigorously supporting one side and so on. Instead the local party leader is called upon to meet the demands of various organized interests that do not fall along strict party lines. Of course, when a hospital rests under the control of the party in power, a con-

tinuing struggle occurs between patronage and appointment and promotion for merit. But, again, the Cook County case is instructive. Although the hospital administrator, Meyer, had built up "an organization" it was not for party politics.[44]

On occasion a local party will adopt a program of economy, perhaps even focusing on welfare and indigent care. The mayoral candidate may run on that issue with success (the case of Newburg, New York, comes to mind). Or the issue may be improvement of services in city or county health institutions, a situation that may be developing now in New York, where state legislators and others have made tours of Bellevue and other public hospitals and found appalling conditions. These developments obviously have important implications for retaining personnel and for general ability to deliver services. Usually the issues depend less on party competition than on other organized interest groups (welfare association, medical or dental society, trade unions) or civic leadership. By common consent political parties tend to avoid "stirring up fights" on religion, schools and hospitals.

Another reaction in the environment of the health system has been the establishment of new, sometimes quasi-governmental systems of planning and control that cut across health occupations, organizations and even communities where "area-wide" or regional planning is envisioned. Lay community leaders have begun to assume an increasing role in these endeavors. One official of a powerful planning agency, composed of nonelected financial and industrial leaders (and two ministers to lend a sense of contact with the populace), was asked from where his board derived its authority. His answer: "They asserted it."

With the colossal capital and operating expenses required by the modern hospital in an urban region, the men who control the large economic and organizational resources that are likely to be financially bled to death, have begun to band together to seek economies. So far the emphasis of community leaders has been on the costs of bricks and mortar rather than on sophistication about people and service programs. They have also concentrated their interests on those organizations requiring the most private capital (hospitals) with little awareness of the total community health system.[45] But one can expect community leaders to expand their interests to other organizations, supply of manpower and concern for services, including their quality

and controls, in a continuing and expanding search for an answer to the question, "Are we getting our money's worth?"

With the activities of the Office of Economic Opportunity, particularly the Community Action Programs that arose in response to the poverty-civil rights revolution now in progress, a larger voice is demanded by consumer groups. These are mainly "lower-class," neighborhood-based groups with social structural characteristics similar to those Gans described for the once vibrant West End of Boston.[46] It is evident that on the local scene where a direct confrontation can take place between health professionals and those they serve, or should serve (a confrontation even the political system or some vast and distant bureaucracy of the state does not provide), "the forgotten" may develop a contribution to determine the policy for operating a given network of health service agencies. New forms of nonbureaucratic organization may evolve in which these populations will exercise control and learn to seek health care before it is too late. The present wilderness of outpatient clinics may be particularly anachronistic in this context.[47]

In summary, thus far, to assess the power budget available to the health planner, one must realize how the bases of power have come to be distributed through complex changes, internal and external, to the health system. These have entailed fluidity in power relations; a more prominent place for health concerns generally in society, but dispersal of power among occupational groups and organizations in the system, including a less exclusive and dominant role for "the" physician and a more prominent role for administrators and planners; the development of organizational networks in which hospitals and university health centers play key roles; and certain public reactions including a vast politicalization of health policy issues, sometimes with political party involvement and greater involvement of "third-party" payers, community leaders and the consumer generally.

IMPLICATIONS

Research

From this brief and necessarily abstract overview of a complex topic, one thing is clear: knowledge, even an adequate framework, is lacking in the field. This is not the place to specifiy a long list of research opportunities and needs, but a few examples are called for.

What is the relative contribution of each of the bases of power to the outcome of various issues in the health field? Is "professional magic" (myth making), scientific knowledge, tradition, economic and organizational resources, official authority, charisma or some other source of power the dominant factor in resolving various issues?

How do power relationships alter with changes in organizational complexity, size and arrangement?

What is the relative contribution of various types of health experts and lay leaders to decisions at the policy-planning level in the local community and at regional, state and national levels?

How do lay leaders' connections with and understandings of the health system and its component organizations differ according to the socioeconomic composition of the community and the structure of the leadership itself? What places do health and particular health endeavors hold in the value hierarchies of lay leaders such that the position of health in the priorities of public policy is affected?

Must the "value" of health be expressed in economic terms or is a potent political force that is desirous of better and more health services enough to assure health a high priority in public policy?

If the health system is to be regionalized, how does "community power structure" relate to "regional power structure" (if such exists) and what effect does crossing local and state jurisdictions have on regionalization?

The Organization of Regional Health Planning

The accomplishment of efficient, effective delivery of health services to all segments of the population within a specific geographical region will require special personnel and special organization to accomplish the task. The concluding section will discuss the preparation of community-wide health services administrators and planners. All aspects of the organizational question will not be considered, for that involves a determination of 1. the potential of the population, given adequate health care; 2. the relative place of health in the overall endeavors of the region and the investment that can be made in health; 3. sociocultural variations in the population; 4. the available resources including manpower; 5. the setting of priorities among health activities; 6. delegation of responsibility and authority for assigned, functionally interrelated tasks; 7. two-way (center—periphery—center) flow of communication, patients, staff; 8. evaluation, and so forth. Here, interest is limited to power relationships.

Much discussion has centered around the "locus" of the health planning effort in the future. Will it be the hospital? Will it be the Health and Welfare Association? Will it be the Health Department? Will it be the university-based health center? Will it be public or private? These questions cannot be answered in any final sense at this time. In fact, the problems should be treated in experimental fashion across different regions. Nevertheless, if the foregoing analysis is at all accurate, and since the effective power is now dispersed throughout many organizations and occupational groups in the local system, no present single component will be adequate to carry out planning.

Some new organization will be required that, above all, will have to bring to bear the effective power structure of the region. The "power budget" must be adequate to the task. Where the power structure is fractionated and uninformed as to the overall health system, planning will be little more than several unheeded staff functions located where they cannot become an embarrassment. Where the power structure is united in the achievement of well-understood specific goals, the planning process will be integral to the total endeavor of the system. Under these ideal conditions, planning would not be exclusively assigned to a given unit. Instead, the development and institution of plans would go on throughout the system to be affected.

Major contributors to the power structure as regards health are: 1. government and legal authority; 2. lay community leaders, particularly financial and industrial figures, depending somewhat on the composition of the community;[48] 3. increasingly, consumer groups who may have an impact through local government, health organization boards or neighborhood groups; 4. the university-based health center; 5. large "third-party" payers; 6. particular organizations, such as dominant hospitals that are well connected with lay community leaders; 7. particularly well-organized occupational groups.

Although the pattern of regional health planning for the future cannot be envisioned, it is possible to suggest that this become a problem for the design and evaluation of planned change. With a legal mandate and the engagement of the effective power system, along with health planners, health service personnel, social scientists and other researchers to aid in the design and evaluation, various health planning systems can be tried out in different regions. Careful research methods involving before-after and cross-regional comparisons will be necessary. In some settings, nothing should be under-

taken other than the before-after measurement of the efficiency and effectiveness of the local health system. The most sophisticated theory will be required to develop the design, with deliberate variation on key points to "test" the impact of crucial factors on the operation of various regional health planning structures. Under this plan the region will become a laboratory for the design, institution and evaluation of planned change.

Preparation of Regional Health Administrators and Planners

It was of major concern to the Joint Committee on Education for Public Health that nowhere in this country today is an adequate effort consciously being put forth to provide the kind of persons required for the above task.[37] What would such preparation involve?

Several components of the university would be required to carry out a program at the doctoral level in regional health services administration and planning. It would be necessary for the student to become acquainted with the subculture of the health world, its occupations, its organizations, its traditions and patterns generally. That could be done in part through reading and class work, but more through varied field experiences. The student would need to have social science theories and methods at his command, the tools of quantitative management, an understanding of the place of science in society, knowledge of political and economic systems and an understanding of, if not expertise in, epidemiological research. He would give special attention to the planning process and to the design and evaluation of planned change.

For the student to develop ability in practice, teaching and research, the school or health center that prepares him would ideally have responsibility for the planning and delivery of health services in the surrounding region. As suggested above, community leaders and consumers might play determining policy-making roles to assure that the health center carry out its responsibilities to the public. Through this means, students could be assigned in such a manner that the teaching would be beneficially focussed, and in turn the teaching would be altered to confront realities seldom imagined in the insulated classroom.

It is not necessary that students in such a program be of any particular health discipline or profession. Excellence in a liberal arts and sciences background should be adequate. Nor should a certain amount of experience be required, since practice in regional health services

administration and planning would be gained in the program itself. It should be clear that persons of any health discipline or profession and any amount of experience would also be admitted on grounds of ability and interest in pursuing such a program.

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[1] By a system is meant a collection of identifiable units interrelated in their effects on some outcome. The many health agencies, occupational groups and individuals involved in them make up the health system of a community or region (some geographically bounded place containing a human population) for these units act to affect for good or ill the level of disability in the population.

[2] Bierstedt, Robert, An Analysis of Social Power, *American Sociological Review,* 15, 730–738, December, 1959.

[3] Weber, Max, THE THEORY OF SOCIAL AND ECONOMIC ORGANIZATION (Trans. A. M. Henderson and T. Parsons), New York, Oxford University Press, 1947, p. 152. Most modern sociologists accept the essentials of Weber's definition and have only slightly qualified it—e.g. Schermerhorn, R. A., SOCIETY AND POWER, New York, Random House, Inc., 1961, pp. 9–10. Blau also excludes power from "intrinsically rewarding" relationships and reserves its applicability to relationships that are unilateral (as opposed to reciprocal) and involve extrinsic elements, i.e. those which can be detached from the persons supplying them. Blau, Peter M., EXCHANGE AND POWER IN SOCIAL LIFE, New York, John Wiley & Sons, Inc., 1964, pp. 312–313. But this seems unnecessarily complicated. It implies (as the author recognizes) a static theory of social life and structure, and good theoretical grounds in the symbolic interaction school of thought indicate that some ambiguity or "resistance" must be overcome in any human interaction. Thus, some "extrinsic" or general social element is always in the relationship, almost by definition, so long as one remains at the human, social level and is not concerned simply with any unsymbolized biological aspects that probably are involved in the most ideal reciprocal, love relationship.

[4] A classic experiment identifying the element of ambiguity and some factors associated with its removal in one direction or another is given *in* Sherif, Muzafer, Group Influences Upon the Formation of Norms and Attitudes, *in* Maccoby, E., Newcomb, T. and Hartley, E. (Editors), READINGS IN SOCIAL PSYCHOLOGY, Third edition, New York, Henry Holt and Company, 1960, pp. 219–232.

[5] To Bierstedt, power is always potential, Bierstedt, *op. cit.* Weber's use of the term "probabilities" suggests the same. A different kind of distinction that may be useful reserves power for intentional effects on another's behavior while influence is broader, including unintended effects. Van Houten, Donald R., Opportunity and Influence: A Study of Medical Leadership in Community Hospitals, Ph.D. thesis, University of Pittsburgh, 1967.

[6] It may be on this basis that a basic unit of social interaction could be identified; something comparable to the atom, various subparticles, or "quanta" (whatever is current in physics these days). Various frameworks have been suggested for the social sciences with the recognition of this problem in view. For example, Foote, Nelson N., Anachronism and Synchronism in Sociology, *Sociometry,* 21, 17–29, March, 1958.

[7] "The lifeblood of administration is power. Its attainment, maintenance, increase, dissipation, and loss are subjects the practitioner and student can ill afford to neglect. Loss of realism and failure are almost certain consequences. . . . Power is only one of the considerations that must be weighed in administration, but of all it is the most overlooked in theory and the most dangerous to overlook in practice. . . . Analysis of the sources from which power is derived and the limitations they impose is as much a dictate of prudent administration as sound budgetary procedure. The bankruptcy that comes from an unbalanced power budget has consequences far more disastrous than the necessity of seeking a deficiency appropriation." Long, Norton E., Power and Administration, *in* THE POLITY, Chicago, Rand McNally & Co., 1962, pp. 51–52.

[8] These may be the formal rules of logic recognized in disciplined intercourse or the "folk logic" of everyday interchange. *See* Rose, Arnold M., Popular Logic in the Study of Covert Culture, *in* THEORY AND METHOD IN THE SOCIAL SCIENCES, Minneapolis, University of Minnesota Press, 1954, pp. 320–326.

[9] Blau, *op. cit.*, pp. 118–119.

[10] The author and co-workers suggested that different relations to the class structure would explain the lower support received by local governmental hospitals as compared with voluntary hospitals. Elling, R. and Halebsky, S., Organizational Differentiation and Support, A Conceptual Framework, *in* Scott, W. R., and Volkart, E. (Editors), MEDICAL CARE—READINGS IN THE SOCIOLOGY OF MEDICAL INSTITUTIONS, New York, John Wiley & Sons, Inc., 1966, pp. 543–557. The paper by Robb Burlage included in this volume analyzes the working of a program in New York City designed to upgrade the public hospitals by affiliating them with voluntary hospitals.

[11] For example, Freeman, Linton, *et al.*, LOCAL COMMUNITY LEADERSHIP, Syracuse, University College, 1960. A recent study in Pittsburgh also found a great predominance of male, white, Anglo-Saxon, Protestants among those reputed to be leaders of the community. Elling, R. H. and Lee, O. J., Formal Connections of Community Leadership to the Health System, *Milbank Memorial Fund Quarterly,* 44, 294–306, July, 1966.

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[21] These funds and organizational arrangements were provided by the Mills-Ribicoff Act (Public Law 88-156) and the Mental Retardation and Community Health Centers Construction Act (Public Law 88-164). A study of coordination resulting from planning for mental retardation activities in several states has been funded and carried out by Conrad Seipp, Edward Suchman, Ray H. Elling and research associates Edmund Ricci and Malcolm MacNair.

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[23] *Ibid.,* p. 77 and Table I, p. 78.

[24] Kissick, *op. cit.,* p. 4.

[25] Somers, Anne R., Some Basic Determinants of Medical Care and Health Policy: An Overview of Trends and Issues, in this volume.

[26] Sigerist, H. E., An Outline of the Development of the Hospital, *in* Roemer, M. I. (Editor), HENRY E. SIGERIST ON THE SOCIOLOGY OF MEDICINE, New York, M.D. Publications, 1960.

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[28] Mills, C. Wright, THE POWER ELITE, New York, Oxford University Press, 1959. For a sharpened, even if disturbing version of Mills' analysis, see THE CAUSES OF WORLD WAR III, New York, Simon and Schuster, Inc., 1958. In this connection, recall also President Eisenhower's parting speech in which he identified the combination of business and military as almost overwhelming of civilian control in government. Senator Fullbright has recently issued similar warnings.

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scored. On the average, 234 cases responded "don't know" to the question of professional ranking. Since other ways of manipulating the scoring system are possible and since different samples might give different results, this ranking cannot be viewed as final. Further, it is supposed here that change may occur in the position of any of these groups over time.

For other methodological details of the study *see* Shepard, Elling and Grimes, *op. cit.*

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