Commentary

Interest-Group Representation and the HSAs: Health Planning and Political Theory

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Abstract: Examination of the provisions of the National Health Planning and Resources Development Act, P.L. 93-641, concerning the composition of Health Systems Agencies, which are to be the primary building-blocks of local health planning, suggests that expectations of substantial change may be unrealistic. Specifically, in its provision for representation on the HSAs, Congress appears to have been accepting an implicit theory of pluralist interest-group representation that has long been prevalent in other sectors of public life in the United States, and long subject to significant criticism. Such forms of representation tend to lead to bargaining, log-rolling, and collusive competition among narrowly-defined special interests, with the interests of the broader general public less well-served. The application of this theory to health planning in P.L. 93-641 is examined, and predictions drawn about the implications of this analysis for health planning and health policy in the United States in general. (Am. J. Public Health 66:23–29, 1977)

Introduction

The passage and preliminary implementation of P.L. 93-641, the National Health Planning and Resources Development Act of 1974,[1] have engendered considerable controversy. On the one hand, it is argued that, for the first time, authoritative bodies free of provider control will be empowered to make crucial decisions about the allocation and development of health resources, the structure and volume of services provided in a given area, and the relative emphases to be accorded different modes of service delivery. The opportunity has thus been created, the argument goes, to bring order and coordination to the fragmented non-system of American health care.[2–5] That optimism is attacked by critics who find the law deficient in its provisions for implementation and enforcement,[6] or self-contradictory in its goals.[7] The most heated controversy has revolved around the role of governmental public health agencies, both state and local, under the new law.[8–13]

Yet one central characteristic of P.L. 93-641 that is quite likely to determine the conduct of local health planning has received too little attention. The statutory provisions for the governance of the Health Systems Agencies (HSAs), which will be the building blocks of the health planning process, have, it will be argued here, already established a pattern for the behavior of those agencies. In government, anatomy is destiny. The implicit theory of representation Congress appears to have followed in the enactment of P.L. 93-641, and the ways in which it has embodied that theory in the statute, narrowly constrain the future of health planning in the United States. Rather than creating a radically new force in the health-care arena, Congress has provided for the institutionalization of existing structures of power.

Above and apart from the size or smallness of the formal powers delegated to the HSAs, their impact is likely to be limited by their internal structures. The expectable result is change of only the most incremental, meliorist sort. Congress has not revised the rules of the health-care game, but merely added another player, one that can be expected to perform much like the others.

In order to make that argument, this paper will proceed as follows. First, the statutory provisions for HSA governance will be examined in some detail, followed by a consideration of the implicit theory of representation that underlies those provisions, and the implications, both practical and theoretical, of that theory. That discussion will provide the basis for conclusions about the likely behavior of HSAs under the new health planning system.

Governance of HSAs

Local Health Systems Agencies are to be the building blocks of the national health planning system established un-

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der P.L. 93-641. The functions and responsibilities of the HSAs, while still the subject of much dispute, have been widely discussed elsewhere,[2-13] and will be reviewed only briefly here. Within each of more than 200 "Health Services Areas", the HSAs, operating under federal monitoring and funding, will be charged with data collection and analysis, plan development and implementation, and review and comment on facilities certification. Their only actual yes/no authority over health institutions is the right to approve or disapprove of projects funded under the Public Health Service Act and related programs that, among them, comprise roughly ten per cent of federal health spending. But while the tools for implementation are limited, the mandate of the HSAs is large, and they can be expected to exert considerable influence as a result of, if nothing else, their singularly prominent position in local health planning.

It should be added in passing that P.L. 93-641 contains provisions for substantially strengthening state health planning agencies, now to be called "State Health Planning and Development Agencies." Aggressive governors and state health planning agencies will be aided and abetted by the federal government in exercising significant control, through licensure power, over existing facilities and institutions, as well as the planning of new ones.[11, 14] Nonetheless, the ultimate impact of P.L. 93-641 on health services depends to a large extent on the behavior of the Health Systems Agencies themselves. That behavior, in turn, will be a function of the governance of the agencies.

Each HSA is to be run by a "governing body." The governing body is to have no fewer than 10 nor more than 30 members, except in those cases where there are more than 30, in which case there must be an executive committee of the governing body of 25 or fewer members.[15] In general, most of the governing bodies will indeed have more than 30 members, and thus have executive committees as well. Of the 12 HSAs receiving conditional designation in HEW Region II (New York, New Jersey, Puerto Rico, and the Virgin Islands), for example, eight have governing bodies of more than 30 members, extending upwards to over 100; each of the other four has exactly 30.* There is no reason to believe that this pattern will not be generally characteristic of the whole country.

Of those members, of both the governing body and the executive committee, the majority, but not more than 60 per cent, are to be consumers who are not providers of health care. What is a consumer? A consumer is not a provider and has not recently been a provider, is not married to a provider, nor has a fiduciary interest in a provider. What is a provider? That will be discussed below; first it is necessary to say some more things about consumers. The consumers on the governing body and the executive committee must, in the language of statute, be "broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care."[15]

Providers, by subtraction, are to constitute between 40 and 49 per cent of the governing body and the executive committee. The statute defines five classes of providers: 1) physicians, nurses, dentists, and other professionals engaged in the actual delivery of care; 2) representatives of health care institutions, specifically hospitals, long-term care facilities, and HMOs; 3) health insurers; 4) those involved in health professions education; and 5) members of the allied health professions. The first two classes—physicians, dentists, nurses, other professionals, and representatives of health care institutions—are called "direct providers", and must comprise at least one-third of the provider membership; that is, at a minimum, between 12 and 17 per cent of the total membership.

There are other representational requirements for the governing body and the executive committee. All members must be residents of the health services area. Public officials involved in providing or paying for care must be represented. If there is a Veterans Administration medical facility in the health service area, there is to be a representative from the VA on the governing body ex officio. If there is a qualified HMO in the area, at least one representative is to be on the governing body. And on both boards, the proportion of individuals from non-metropolitan areas must parallel the non-metropolitan proportion of the population in the health services area. Roughly one-half of the health service areas in the country are mixed metropolitan/non-metropolitan.[16]

Concretely, one can posit a hypothetical, or not so hypothetical, Health Systems Agency, with a large governing body, as many will have, and an executive committee of 25. There will be between 13 and 15 consumers on the executive committee, who are to be broadly representative of the ethnic, racial, religious, social, and geographical composition of the area; and between 10 and 12 providers in five categories, but at least four of them direct providers. Powerful public officials will be included on either the provider or consumer side.

Meeting these specifications will take some doing. The applications for conditional designation as HSAs seen by this author proposed very elaborate procedures for selecting members of the boards, because it will be necessary to guarantee conformance to all the representational requirements. Should a board member die or resign, for instance, it will generally not be possible to simply pick another name out of a hat; it will instead be necessary to find individuals with the appropriate designated characteristics.

These explicit constraints on membership are, moreover, only the beginning. Continuing the hypothetical exercise, one can predict who, in terms of role and position, many of the board members will be, regardless of the specific HSA involved. On the consumer side, members will certainly include government officials in the area who are involved in paying for the consumption of health care or in funding facilities for health care delivery. It would be a rare Health Systems Agency that lacked representatives of major labor unions in the area, especially those that, through collective bargaining, are major purchasers of health care. Major

*Hyman, H. H. HSA Governing Body Composition: Analysis of Region II. U.S. Public Health Service, DHEW, Region II. May 1976. Mimeo.

employers who are major purchasers of care are also likely to be represented. So will major charitable organizations, especially those with denominational bases that have long been active in the provision of health services.

There will also be representatives from a number of what might be called categorical special-interest groups. Health-care policy in the United States has long been characterized by the predominance of categorical grant-in-aid programs for relatively narrowly-defined populations;[17, 18] some of the sources of that tradition will be described below. Each of those programs creates, or is created by, a constituency, and one can expect that those constituencies will be seeking representation, as consumers, on HSAs. Thus many boards will have representatives of the local mental health association, the local organization of parents of retarded children, senior citizens' organizations, alcohol control groups, and particular disease-related foundations or organizations, such as those focusing on kidney disease, respiratory disease, heart disease, and the like.

An alternative style of representation, which will appear very different but have very similar effects, may prevail in those HSAs which adopt formal sub-regional organization, as encouraged by the statute. In geographically large, multicounty HSAs, sub-regional organization will probably be on a county basis; in urban areas, smaller subdivisions may serve as the basis of organization. In either event, governing body and executive board members will have to meet geographical distribution requirements as well as all the others.

Whether sub-regional organization is important in the HSA or not, the central point is that the individuals sitting on the governing body and the executive committee will attain their positions, not as individuals, but as representatives of defined constituencies, constituencies that, by and large, already exist. The consumers on the board may be named Mr. Smith, Mrs. Jones, and Ms. Brown, but they will be chosen, perceived, and constrained to act, as Mr. Labor Union, Ms. United Fund, and Mrs. Mental Health Association.

Much the same can be said of the provider side. No one is going to take a list of all local physicians provided by the state medical society and then randomly choose five for membership on the board. Instead, there will be representatives of the local hospital association, the local medical school if there is one, and so forth. Certainly, the law almost says in so many words that one of the provider representatives must be from the local Blue Cross-Blue Shield.

To make matters still more complex, in very large Health Systems Agencies—and most will be large—the selection of members from the governing body to serve on the executive committee will involve selecting the representative of representatives. In practice, for instance, a seat will be assigned to local charities, and the local Catholic diocese will rotate, or draw straws, with local Protestant and Jewish agencies for the slot (assuming no further denominational complications). The medical societies of each county in the HSA will have one seat or two or three, and they similarly will draw straws or choose among themselves. The individuals chosen for these executive committee seats will, however, feel a sense of accountability and responsibility to all the organizations in the defined constituency they are representing. When the member is attached to a sub-regional council or agency, he or she will feel responsible not only to his own area, but to the needs and requirements of the sub-regional organizations as a group.

The result, then, is a kind of council of elders, or what the French might call a council of notables, which is to be vested with management of the HSA. If that sounds familiar, it should—indeed, that is the central argument of this paper. On the one hand, it means that there will be a lot of familiar faces sitting on the governing body and the executive committee of the HSA. On the other hand, it resembles, in principle and in form, many other quasi-governmental or quasi-public bodies that exercise public authority in this country. There is almost a rote formula, although Congress has modified it slightly to meet the exigencies of the health sector: a labor representative and a management representative, an urban representative and a rural representative, a Black and a Hispanic, at least two women, and so forth.

The Implicit Theory of Representation in P.L. 93-641

The philosophy Congress appears to have followed in this case, and in so many others, is under severe attack in other sectors just as it is gaining ascendancy in health planning. It might appropriately be called the theory of pluralist representation; Theodore Lowi, in *The End of Liberalism*, called it "the public philosophy, interest-group liberalism."[19] The basic assumption of the theory is that society is composed of a number of groups defined by shared economic, cultural, ethnic, or geographical interests, and that those are the legitimate interests in public policy and policy formation.[19-24] An exhaustive list of actual and potential interest groups constitutes an exhaustive list of the legitimate interests in society, and those are the interests which merit representation in the political process. Thus, in practice, if one wished to adequately represent, for purposes of policy-making, the population of a health service area, one begins by dividing the population into the two dominant economic groupings—consumers and providers. One then defines the groups comprising the provider and consumer sides, and arranges for their representation. The resulting board, or governing body, can then be said to be fairly representative of the population as a whole.

One important corollary of this theory, about which more will be said later, is that in its terms government officials are just one interest group among many. Nothing in the recent history of health planning has caused quite as much controversy as the status of local public officials under P.L. 93-641,[8-13] but the Congressional intent is quite clear. Government officials are an interest group, and if they can do relatively well at getting more seats on the HSA governing body than other interest groups, more power to them. They are, however, given only one advantage relative to other groups: they can be classified as *either* providers or consumers.[25]

Those with a taste for historical irony can take pleasure from the application of this theory to the contemporary

health system in the United States. In an earlier, but not radically dissimilar, incarnation, the theory of interest-group liberalism was called "functional representation". The intellectual acme of functional representation was reached in the early part of this century, in the work of the Fabian socialists, most notably Beatrice and Sidney Webb and G.D.H. Cole.[26-29] The Webbs, indeed, even proferred a *Constitution for the Socialist Commonwealth of Great Britain* as the core of their party platform.[30] It detailed, in very great specificity, exactly who was going to sit in the Parliament of Producers that would be the new upper house of the British Parliament. The lower house would be a Parliament of Consumers. The Fabian movement was, of course, the forerunner of the modern British Labor Party. Since the time of the Beveridge Report, however, British socialists have largely abandoned such representational theory, and gone ahead with the National Health Service. The irony is that Americans, generally thought to be more pragmatic and atheoretical, have gotten stuck with the representational hocus-pocus without the substance of significant change in the health-care system.

In any event, there are, and there have always been, at least two major things wrong with the theory of interest-group liberalism as an intellectual concept. Each, again, has important implications for health planning. The first involves what might be called the dynamics of interest-group bargaining.

Naively, one might think, the definition of providers and consumers as mutually-exclusive groups would insure that, when they are put together in a governing structure, their interests would be mutually incompatible, and that they would thus keep each other honest. In fact, both logically and empirically, assemblies or councils characterized by interest-group representation tend to behave very differently.

Neither providers nor consumers are homogenous or monolithic, certainly not as they are defined in P.L. 93-641. Quite to the contrary, it can reasonably be expected that the 15 consumers on an executive committee will represent 15 quite different constituencies—geographical, economic, ethnic, and so on. Much the same will be true of providers. The executive committee will not have two major interest groups, but 25. There is no a priori reason to believe that either broad grouping will spontaneously coalesce into a single bloc just because they all are described by the same term in the statute. There are no majorities in such a system, only a series of fragmented and largely autonomous minorities.[21] Under those conditions the only way in which the institution can function at all is to develop very strong norms of reciprocity and log-rolling. I get mine if you get yours; that is and must be the general rule.[19-21]

Institutional processes of this kind work most smoothly when resources are abundant, or at least not especially constrained. Everyone can get a piece of the pie, and be satisfied, and the intellectually and practically impossible task of finding a single solution to satisfy 20 or 25 diverse interests is no longer a problem. But under certain conditions, such as those established by P.L. 93-641, they will prevail even when resources are constrained. The underlying intellectual rationale of health planning is to do more with less, to constrain resources, to use them more effectively. But, as noted above, the only funds over which HSAs are to have any real authority involve federal grant programs, and there are more than 200 HSAs in the country. Even when those funds are limited, then there will still be an incentive for reciprocity and log-rolling within any one HSA, because the decisions will involve the choice between accepting "free money" for their area or allowing it to be spent in another area.[14] Whatever the conflict of interest may be between consumers and providers in Northern Manhattan, for example, it will be easy for them to ally against the combined consumers and providers in Westchester County, or Bergen County, New Jersey. Consumer members of the HSA in Los Angeles will prefer to see funds spent in their area than in San Francisco, and those in San Francisco will certainly prefer cooperating with local providers to seeing funds flow to Oakland. The incentives for what economists would call collusive competition are thus very great even in a situation of apparent resource limitations.

From a structural perspective, therefore, it is hard to see how HSAs will be able to act effectively in any way contrary to the desires of powerful interest groups, both consumer or provider, in their areas. "Compromises" in which there is something for everyone are more likely. The only plausible alternative is stalemate and total breakdown. The "ins" will all be protected, and the "outs"—except for those local interest groups too unaware or inept to have gained representation—will be those on the other side of the HSA boundary.

It should be noted that this logic suggests another reason for believing that state agencies will be far more aggressive in controlling facilities and services growth than local HSAs. Especially when State Health Departments have both planning and Medicaid-administration functions, those hierarchical agencies will have a direct and substantial stake in controlling health-care expenditures on a statewide basis. There will be no one for them to collude with. Whether they will be able to overcome the united fronts presented by HSAs with strong norms of internal reciprocity and log-rolling is another question, especially since nothing is more likely to strengthen those norms than external opposition.

That reciprocity and log-rolling among numerous small groups tends to predominate over polarized, bimodal conflict is illustrated by the best analogy for this whole process, the House of Representatives of the United States. Madison's basic plan was to put 435 people, each defining his interests primarily in narrow geographic or economic terms, together in one body, and then demand that a majority of them agree in order to enact policy. The expectation, reasonably enough, was that very little would happen.[31] That grand design works well on some things, but whenever policy affects what political scientists would call disaggregable benefits, those in which a little something can be given to everyone, Madison's plan is frustrated. Congress works quite effectively, particularly in periods of resource abundance, at devising programs that distribute benefits to each of the 435 Congressional districts.[32-34] Discontinuing programs is always more difficult, because every program is somebody's, and the norms of Congress are that the interests of one's constituency are to be protected.[35] Those norms developed, again,

because without them Congress would never have been able to do anything at all. Extending the Congressional analogy back to health planning, one can expect local health plans with long lists of approved "needs" and services—encompassing all the major interests on the HSA board—and recommendations for closing of only those institutions that constitute an embarrassment—or threat—to provider representatives.

It is possible to take another tack at examining the political dynamics of interest-group bargaining. One can begin by saying, as a theoretical concept, that what has been wrong with the health care system, assuming that anything has been wrong—and Congress clearly seems to think so—is that it has been dominated by an elite group—call them "providers"—who have run the system pretty much in their own interest. It is therefore necessary to control that elite in some way so that they will be more responsive to the general public interest, which Congress thinks is out there but can't quite put its finger on. There is obviously some truth to this whole idea. By its very elaborate definition of providers, the Congress seems to agree, sounding at times like a Marxist, or at least Millsian, sociologist in defining the ruling class and then separating them out from the rest of us.

But if that is the general theory of health planning, the question immediately becomes: How does one go about controlling an elite group? In general, there are three ways to do so. The first is to guarantee that conflicts of interests are built into the elite. If the providers are the elite, creating conflict among them is one way to insure that they will control one another. Assigning them a fixed pool of money or patients and then leaving them to split it up among themselves is one possible approach.

The second way is to internalize within the elite, through education or acculturation, the values that are to be promoted. One can teach physicians Community Medicine, for example, and then hope that over 20 or 30 years their outlooks will come to be more in conformance with the public interest.

The third strategy is to make the elites accountable. In theory, they can be made accountable to the public through some kind of electoral mechanism. Or they can be made accountable to a hierarchical authority, say the state, through a system of legal regulation that defines, with the force of law, what they may do and what they mayn't, and what will happen to them if they fail to obey. Despite the assumption of elite control in its definition of "providers", however, P.L. 93-641 employs none of these mechanisms. It creates no structural conflicts of interests within the elite, contains no mechanism for "raising their consciousness," and certainly creates no accountability to anyone.[8] Instead, it incorporates the elite into a governing body, and hopes that, since they're outnumbered, they will be outvoted.

The flaw in this strategy is that the non-elites who are supposed to outvote them are themselves, by law, representative of special interest groups. There is not only, therefore, an incentive for providers to collude among themselves because they're outnumbered, but also an incentive for consumers to collude with providers to win approval of policies they desire. Assuming that people want health services, as they tend to do, and as interest groups in particular tend to do, then the likely outcome is collusive competition to obtain more and more for everyone's constituency.

This chain of argument leads immediately to the second general historical stream of criticism of interest-group representation. As far back as 1923, Paul Douglas made the argument,[36] since echoed by everyone from Ralph Nader[37] to radical theorists like Robert Paul Wolff,[24] that those who lose out in the process of interest-group representation and interest-group bargaining—whether in the case of economic policy, agricultural policy, or industrial regulation—are, to use the traditional term, "consumers". It is perhaps inappropriate to use that term in this context; instead, it can be said that the losers are: the general public. No one represents them. The consumers on the HSA boards certainly do not; instead, they represent "social, economic, linguistic, and racial populations, geographic areas of the health services area, and the major purchasers of health care." They are in no way accountable to the public at large.

The only numbers of the HSA boards who are accountable to the public at large are elected public officials, and their role has been very carefully circumscribed by the statute. They have been defined as just another interest group. And even in those instances in which the HSA itself is a unit of local government or part of a multi-functional regional planning council with governmental authority, it must have a separate governing body which is elaborately defined, in both the statute and the implementing regulations, to insure that public elected officials can not control it.[1, 25]

Conclusions

The primary conclusion to be drawn from this analysis is that, if the behavior of the HSAs results from their actual composition as well as their legal functions, the likelihood that they will generate radical changes in the health care system is small. Rather than conforming to the inspiring exhortations of the preamble to P.L. 93-641, they are more likely to provide an institutional forum for legitimizing existing patterns of power distribution, and to accede as slowly as they can to those irresistible exogenous forces that would have produced major change in any event.

This is not to argue that the early years of the HSAs will be without innovation or excitement, nor that all will conform all of the time to the broad outlines of this analysis. There is a life-cycle to every organization, especially those organizations delegated government authority to regulate the conduct of powerful private-sector actors.[38–40] It can be expected that many HSAs will, in their early years, attempt to build political coalitions of consumers and elected officials to restrain the natural tendencies of providers. Particularly when they are able to attract aggressive and innovative staff, those HSAs may effect some substantial change. But before too long the natural restlessness and aging of staff will blunt these tendencies, and the genetic endowments of the HSAs will come to the fore. Providers and consumers will break bread together on the governing bodies, and distribute some of the crumbs to each of their members. Health planning will

increasingly constitute an institutionalization and rigidification of what is, rather than a thrust towards what could be.

Four subsidiary concluding points should also be made. The first is the importance of geographical structure in governance, and the consequences of the continued attachment of American policymakers and the American political system to "grass roots" government. As has been discussed, the delegation of health planning functions to, if not the grass roots, then at least the grass tops (the smallest HSAs will encompass populations of several hundred thousand) creates considerable difficulty in rationalizing resource allocation on a national or even broader regional basis. In technical terms, it creates a classic problem of sub-optimization. Under the existing law, there is every incentive for HSAs to compete against one another, thus removing the prospect of the kind of internal conflict that could lead to a true balancing of provider and consumer interests, and encouraging precisely the sort of fragmentation and over-investment that health planning is supposed to cure. Conversely, the likelihood that state governments may take a much more direct hand in resource limitation suggests that the smallest governmental unit is not always the best for specific purposes.

The second point is closely related; it is the interconnectedness of financing and planning. If health planning is to be more than an intellectual exercise, it must come equipped with sanctions, yet it is clear that the only sanctions available to the HSAs for implementing their plans are unlikely to be used, because of the way in which health services are financed. If, on the contrary, the 10 or 15 percent of federal health funds over which the HSAs were to have jurisdiction included Part B of Medicare, and if each Health Service Area were allotted a fixed annual pot of Part B funds, the prospect for real consumer-provider and provider-provider conflict within the HSA, leading to significant changes in health care delivery, would be substantially greater.

The third point is that this entire process would be considerably less troublesome if Congress, or anyone else, had a clearer idea of what health planning really was. Like the dog who didn't bark, the most significant clue in analyzing P.L. 93-641 is that there is no detailed specification of the kinds of activities HSAs are to conduct. Attention therefore necessarily turns to specifying the individuals who are to be involved in the process. If the "technology" of health planning were substantially more advanced, it would make far less difference who sat on the governing body. All that would matter would be the technical competence of the planners. In the absence of such an advanced technology, however, the planning process is inescapably political, and political consideration thus come to the forefront.

Finally, it is perhaps alarming that, especially at this point in history, both Congress and health professionals appear to be so reluctant to trust the general public. If the notion of popular government has any meaning, it is that officials vested with public authority must be accountable to the public. But in specifying the composition of HSA governing bodies, Congress has removed any such accountability. It has defined a class of "consumers" and then blithely assumed that they will be accountable to consumers—which is to say, all of us—as a whole, when in fact they are far more likely to be accountable only to much more narrowly-based interest groups. And it has treated the only class of HSA members who are accountable, elected public officials, as untouchables.

There may be good reasons for skepticism about the capabilities, integrity, and willingness to oppose vested interests of state and local elected officials. There are, no doubt, reasons to be dubious about the abilities of ordinary citizens to make informed judgments on highly technical biomedical questions. But in a society that styles itself democratic, there is really no other alternative. The choice is between accepting the evils inherent in democratic government and imposing a different, less democratic set of evils. It is only regrettable that a popularly-elected Congress has chosen the latter course.

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ACKNOWLEDGMENTS

The author is grateful to Florence Fiori, Irving Lewis, Sumner Rosen, Robert Weiss, and Jack Yager for their comments.

Problems in Preventive Medicine

Many of our most important health problems lie in the field of preventive medicine, and it is here that measures of established value and information of possible usefulness are not being fully employed. The most pressing challenges are accidents, water pollution, air contamination, cigarette smoking, the population explosion, immunization programs for adults, newly-acquired venereal disease, prevention of rheumatic fever and bacterial endocarditis, coronary heart disease, and rehabilitation after accidents and illnesses.

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Ed. Note: Contributed by Dr. Fred B. Rogers