mation must be made. But just as they understand the interdependence of all life systems, environmentalists must come to understand the interdependence of scientific and social or political decisions. In the case of lead additives, significant reduction in environmental lead may be accomplished by replacing lead with organic manganese, or by replacing autos with mass transportation. The former solution is largely a technical one which inevitably has its technical consequences. The latter solution is primarily social and political with social and political consequences. Utimately, there are no scientific answers to political questions. Perhaps the most important help scientists interested in the environment can offer will be to provide the background material to make unpopular social or political decisions; decisions which may require sacrifices we would otherwise not be willing to make.

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Limitations of Community Control of Health Facilities and Services

Within the last ten years a considerable literature has emerged on the subject of community participation in the control of the operations of health care services and facilities in the United States. A great deal of this literature has concerned experiences arising from the Neighborhood Health Center movement, which received its principal stimulus from the Federal Office of Economic Opportunity. In this issue of the Journal, Warren Paap has drawn upon that literature as well as his own experience to present us with some of the "structural problems" consumer-based boards of health centers have "in achieving effective control" of them.[1] Among the major problems observed by Dr. Paap are the following:

- Institutional structuring of information and the problems of health care delivery system language for nonprofessionals;
- Institutional structuring of time, and the limitations that time constraints impose upon consumer participation;
- Structural basis of contacts and careers which give many professionals inherent advantages in decision-making powers over consumers, especially working-class ones;
- The lack of political power bases in the community for most community representatives; and,
- "Organizational imperatives" which may make significant consumer involvement dysfunctional to program operations.

Dr. Paap concludes that it may not be possible to overcome these problems and produce more "consumer control" by educating consumers either about their roles or about the health care delivery system. He proposes instead to stress the building up of the influence of consumers at all levels of the health care delivery system rather than just at the local level as has been stressed to date. This development would serve to create consumer information, communication, and influence networks, distinct from the professional networks which, in Dr. Paap's view, provide professionals with so much of their power.

Some time ago, I took a look at the problems of "community control" in health services facilities.[2] I concluded then, and still believe, that the principal obstacle to community control in the health care delivery system is the fact that control over the system's basic *building blocks* (expense budget, capital budget, and quantity and quality of staff) does not lie within the realm of a local community board or of a local program administrator. Because of the nature of the medical licensing and fee-for-service private entrepreneurial medical practice systems, a great deal of the medical program decision-making in the system is undertaken by one group—the physicians—who are essentially beyond the control of anyone.

The health care delivery system in the United States, more properly called the disease care delivery system, is oriented toward the diagnosis and treatment of acute illness. Because prevention is generally ignored, diagnosis and treatment are in fact the system's centerpieces. The medical license gives the physician essential control over diagnosis and treatment, and thus over the system's centerpiece. One could, of course, reason the other way: that because the license gives the physician the powers of diagnosis and treatment, *they become* the system's centerpiece. The functional outcome is the same. Physicians independently make the decisions concerning the allocation of 60 to 70 per cent of the resources expended by the system, a powerful position indeed. About 80 per cent of all physicians in active practice, other than house-staff, are in private fee-for-service practice.[3] Control of the system's centerpiece is thus exercised

by a group of about 200,000 private entrepreneurs, earning their income on a piece-work basis.

Do these facts mean, then, that one should give up all hope of providing any kind of useful consumer input to health care delivery system decision-making, whether at the institutional or planning levels? In my view, the answer to that question is no. The facts do mean, however, that one must have some realistic expectations about what changes can be accomplished in an economy in which production is primarily for profit rather than for use. One must also be realistic about what can be done in a health care delivery system in which a significant portion of the corporate participators (the commercial insurance industry, the proprietary hospital and nursing home industries, and the drug and hospital supply industries) also operate principally to make a profit, and in which the main front-line decision-makers are private entrepreneurs. In this milieu, an *ideal* health care delivery system cannot even be approached, much less be created. However, there *are* some achievable reforms which consumers can play a role in achieving. Here are some suggested guidelines for effective consumer/community-participation/control:

• The objectives for creating or strengthening consumer input must be clearly defined. Often it has appeared to me that some advocates of "community control" view control as an end in itself. On the basis of performance to date, it is obvious that providers/professionals have not had all of the answers concerning the health care delivery system. However, consumers will not necessarily have all of the answers either. Focusing solely on the process seems to draw attention away from the social objective—improvements in health services delivery. The rationale for consumer involvement should be clearly stated, along with an explanation of how consumer input will help achieve stated program objectives. Once the function is clearly defined, the form the activity should take should become self-evident.

• Consumers, as the recipients of services, should be primarily concerned with the evaluation of program results, not administrative process. In New York City's so-called "Ghetto Medicine" program, in which voluntary hospitals received state and city money to maintain their outpatient services under lump-sum contracts with the New York City Health Department, the particular mode of consumer participation was a very important factor in the positive outcome of the program.[4] The roles of the participants were clearly defined. The hospitals were the program-operators; the Health Department was the contractor and enforcer of the contract-specified standards; the community boards were the program evaluators, contributing to the design of the standards and the measurement of the degree to which they were met. The consumers had a clearly defined role. "Who's in charge here?" was not an issue in the hospitals. The Health Department, relying heavily on consumer input, enforced the performance standards of the contracts; toward the end of the program, compliance was tied to payment levels. Services improved significantly over a five-year period.

• It should be understood that many community board-administration conflicts are in essence no different from those which take place between boards of directors and program operators in voluntary hospitals, or in private industry. In the case of programs in which the working class is represented on the board, conflict can easily be exacerbated by class, race, and language differences. "Who's in charge here?", if it is not clearly spelled out at the beginning, can become the question tying up in knots *any* enterprise having a board of directors.

• A corollary is the administrative principle of responsibility/authority consonance. The separation of the loci of authority and responsibility in any enterprise almost guarantees continued internal conflict and what usually appears on the surface as "poor administration." The proper role of administration is to administer; the proper role of a board is to set policy, choose its administrators and evaluate program results. If previously agreed-to program objectives are not met, the board should require administration to change course to meet them. If program objectives still are not met after the passage of some time, the board should get a new administration. These thoughts are hardly original, and they certainly are not new. They are basic principles, usually taught in Management 101 courses. However, in the health care field, relatively few professionals and still fewer board members, regardless of social class, seem to be familiar with them, often leading to situations in which responsibility and authority are widely separated and a state of internal war exists with disastrous results for program.

• A great mistake is made when all professionals and consumers are cast into separate groups, with each group considered by the other as "the enemy." Some current proposals for a "community-controlled" National Health Service refer to professionals in such punitive and distrustful tones that one wonders how such a program, if enacted, would ever attract any professional to work in it at all. This monolithic vision of the generally evil, selfish provider is both harmful and distorted. Every major reform in the health services system that has taken place in the last century has had health professionals in its leadership: sanitary reform, health professions licensing, health sciences education reform, voluntary health insurance, group practice, the neighborhood health center movement, and the 60-year campaign for national health insurance. A professional degree does not guarantee the ability to produce a program beneficial to the people it serves. Many professionals are trapped in a provider-centered system which offers few good role-models for the altruist. But some health professionals certainly are patient-centered. By the same token, being a consumer does not guarantee that one will be patient-centered in his/her approach. Some consumers certainly are. Others certainly are not. The guaranteed amateurism featured by some current "community-controlled" National Health Service proposals can serve the needs of no one.

In summary, health care programs which will truly meet the needs of the people they are designed to serve require both dedicated professionals and dedicated consumers. Policy-making boards should have consumer majorities. After all, voluntary hospital boards in the private sector, and local school boards in the public sector, have always had consumer majorities, and many have functioned very well. The working class has been inadequately represented on these

boards, a matter which must be corrected, but they have been consumer-dominated. As we move toward increasing public involvement in the health care delivery system, the health care delivery system might do well to critically examine and learn both the positive and negative lessons the long history of local school boards in this country has to teach. Boards should make policy; professionals should administer programs. Boards should set and monitor performance in terms of program results and hold the professionals responsible for their work. The special, dominant position of the physician, referable principally to the medical license and the disease orientation of our "health" care delivery system, should be understood. Whether professional or consumer, board members should be chosen to work in the health care delivery system on the basis of their demonstrated ability to meet the needs of the people, not on the basis of one label or another. The realistic limits of "community control" in our society must be recognized. Artificial solutions to problems created by a class-based, profit-oriented society do no one any good.

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International Nutrition Congress to Meet in Rio de Janiero

The XI International Congress of Nutrition, sponsored by the International Union of Nutritional Sciences (IUNS), will be held August 27–September 1, 1978 at the Riotur International Center, Rio de Janeiro, Brazil. The main objective of the Congress will be to discuss the practical utilization of available multisectorial technical and scientific knowledge to solve food and nutritional problems. Discussions will be conducted on a multi-disciplinary basis, covering specific problems of basic and applied nutrition as well as their socioeconomic, cultural, and political implications. The Congress is open to all interested persons. Registration fees for the Congress are: $150, active IUNS members; $100, affiliate members. Deadline for pre-registering at this rate is July 31, 1978.

Brochures describing the Congress and details on travel arrangements are available from: Ann M. Crowley, RD, PhD, USA Liaison for the XI Intl. Congress of Nutrition, Health Care Services Ltd., 125 Mt. Vernon Drive South, Iowa City, IA 52240. Tel. 319/338-2711.

Those wishing to present free communication papers or participate in poster sessions should contact the Congress secretariat as follows:

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The official languages of the Congress will be Portuguese and English.