COMMENTARIES

ISSUES OF HEALTH POLICY: LOCAL GOVERNMENT AND THE PUBLIC'S HEALTH

Perspective

Social endeavors can be programmed for failure as well as for success. In matters of health, a recent example of designed failure is illustrated by the legislation for public planning, P.L. 89-749, that exhorted for reform, but restrained interference with usual and customary practices. Many analysts of health policy hold to the view that an important part of the future of improved health for Americans requires a heightened responsibility on the part of local government in matters pertinent to health. In many areas the focus for this responsibility is the health department. In other areas, if it is not the health department as we know it today, then some worthy successor needs to be defined.

The great differences in the scope of the responsibility that has been assumed by local government in matters of health invite careful attention. Data on local health departments are incomplete and not altogether reliable, but enough is known to declare that some departments discharge extensive responsibilities very well while many others do very little or very badly. Why are there these wide differences? Programs for both failure and success have established substantial track records. Analysis of those records can provide useful insights for the future.

Many public agencies that are supported entirely from tax funds provide little opportunity for the public to participate in the process of setting policy and priorities, or allocating resources. A 1971 study of state boards of health and an analysis of their authorities, composition, and methods of appointment revealed that among 433 seats on state boards of health, only 12.5 per cent were held by consumers.[1] By far the commonest requirement for service on a board of health was licensure entitling the holder to engage in the practice of medicine; only rarely did a state require training, knowledge, or experience in public health as a prerequisite for service on the state board of health. In a number of states, the medical society either directly by appointment or indirectly by nomination was empowered to seat members on the board.

From the viewpoint of consumer participation, local health departments are even more important. They represent the tax-supported agencies concerned with health whose operations are closest to consumers. Unfortunately, data are incomplete: there is no available directory of local health departments or of their directors; there is no central repository of information concerning them, and they have not been the subject of any recent intensive published study. In 1968, Myers published a report on medical care as offered by local health departments.[2] That report was drawn from a survey sample taken from a registry then maintained by the Department of Health, Education, and Welfare. That registry was discontinued in 1971.

The Association of State and Territorial Health Officers recently completed a study of programs within the jurisdiction of state health departments.[3] A group at the University of North Carolina has established a registry of local health departments, and surveys are in progress on their funding, staffing, administrative authorities, legislative mandates, and relationship to other local and state interests. Surveys are also in progress at The University of Texas School of Public Health.

A Look at National Health Policy

Concern for the responsibilities of local government in matters of health properly begins with analysis of prevailing national health policy. Stripped to barest bones, health policy embraces an understanding of the way society distributes its political power and its economic resources in order to serve the health of its people. Duffy suggests that the first responsibility of public health workers and agencies, both official and voluntary, is to see that reasonable shares of available economic goods and political influence are allocated to the promotion of health.[4]

In mid-1974 the governments of Canada and the United States each issued a policy statement on health. Important differences, and even more important similarities, attach to these statements. The Canadian document, entitled *A New Perspective on the Health of Canadians: A Working Document*,[5] appeared with a sprightly flair that expressed itself in two languages and six colors. In contrast, their neighbors to the south first circulated their *Forward Plan for Health—FY 1976-1980*[6] in carefully protected copies printed by a faltering copy machine that did nothing to brighten language turgid with tradition.

The Canadian *Perspective* in 74 well written pages developed a "Health Field Concept" that acknowledged the influence of individual citizens, government, health professions, and institutions—but was not bound to the traditions of any of them. The Health Field Concept organized previously separate and unbalanced approaches toward improved health into two broad objectives, five main

---

Much of this material was presented as the James E. Perkins Lecture, International Conference on Lung Diseases, Montreal, Canada, May, 1975. Similar presentations were made by Dr. Miller in his official capacity as President of the American Public Health Association at a number of APHA Affiliate Meetings during the Spring and Summer of 1975.

strategies, and 74 specific proposals. The report rings with promise, such as this sample:

> "The federal role suggested by this paper constitutes a promising new departure. In the past the Federal Government has limited its activities in the health field to its traditional responsibilities such as quarantine medicine and the protection of the food supply, to product safety, to ensuring accessibility to personal health care through substantial financial assistance to provincial health insurance plans, and to financing research. The basis for concentrating its interests in these areas has been the belief that the improvement of personal health care was the principal means of raising the level of health of the Canadians . . . .
>
> The evidence uncovered by the analysis of underlying causes of sickness and death now indicates that improvement in the environment and an abatement in the level of risks imposed upon themselves by individuals, taken together, constitute the most promising ways by which further advances can be made."

The greatest redeeming feature of the *Forward Plan for Health—FY 1976–1980* is its acknowledgment that national policy is in a transitional stage of development. Emphasis was placed on the importance of prevention, yet no program of prevention was offered. " . . . A fundamental component of our emphasis on prevention is a full commitment to research, evaluation, and the generation of new knowledge." And no plan was proposed for expanding successful elements of DHEW demonstrations of how to apply existing knowledge as derived from projects of maternal and infant care, children and youth, family planning, and comprehensive neighborhood health centers. Practically no mention was made of maternity care, children's health, or environmental protection. Local and state health departments were not involved in the *Forward Plan for Health;* their traditional roles as well as their potential for new ones were ignored. No substitutes for health departments were proposed. The *Forward Plan for Health* dealt most comfortably with DHEW's intentions to regulate and subsidize private medical care. Worthy as these endeavors are, they bring limited benefits for the preservation of health, as Canadian neighbors affirm. With the exception of such activities as fluoridation, immunization, and VD control, little community or public health emphasis was proposed in the *Forward Plan for Health.**

Clearly, the Canadian experience has previously plowed the same health ground now being worked in the United States. In time both countries may achieve a fuller understanding of the implications expressed in the Canadian policy statement to the effect that the achievement of health requires community action. Unfortunately, neither policy statement clarified just *how* that community action will be effected.

It is the writer's view that attainment of health for a people requires an agency committed to that purpose, operative at the local level, and empowered with the force of democratic governance. Such agencies are called local health departments. In the United States these departments are widely neglected, ignored, and misunderstood. With a few important exceptions, they are understaffed, underbudgeted, and kept weak both by popular indifference and by the emasculating efforts of special interest groups. Many of them are programmed for failure.

* A revised version of the *Forward Plan* (FY 1977–1981) presents many possible strategies for a preventive emphasis but makes no commitment to their implementation.

The New York City Experience

A useful beginning for analysis of a public health agency programmed for success is provided in Duffy's recent book, *A History of Public Health in New York City, 1866–1966.*[4]

Some background will be helpful. The New York City Department of Health was founded out of three major concerns. First was the fear of recurrent epidemics of cholera and typhus, which were regularly introduced into the city by a flood of immigrants. During the 1860s about a quarter of a million immigrants arrived in New York City each year, bringing with them great talents, high hopes, and nearly every pestilence known to man. Latent infections reached full flower during long and crowded ocean crossings.

The second concern was dismay over the thick layer of filth that threatened to sink the city. Streets had become nearly impassible because of the accumulation of garbage, manure, and dead beasts. The third concern stemmed from the desperate circumstances of many impoverished people, living and dying all too quickly in the city. As forcible as all these concerns were, they were not sufficient to establish a health department. In 1859 a reform movement began, led by the Association for Improving the Conditions of the Poor and by the New York Academy of Medicine. Repeatedly, their proposals for a health department went down to defeat under the opposition of city officals.

A dramatic change was forced in 1863 by upheavals that have come to be known as the draft riots. Although opposition to the draft appeared to be an initiating factor, rioting quickly moved to other issues and became, in essence, a revolt of the poor against privilege and property. In the course of the riots, 2000 people were killed and more than 50 buildings in central Manhattan were totally destroyed. For the first time, middle and upper class New Yorkers became aware of the bitter frustrations of poor people and began efforts to improve their plight. A health department became a top priority and it was quickly authorized.

An account of the work of the department of health over the next 100 years leaves a number of strong impressions:

1. An awareness of the wide ranging concerns of the health departments. In addition to its responsibility for street cleaning and general sanitation, the department became responsible for working conditions. Work certificates for children under 16 years of age could be obtained only from the health department. The purity and availability of water were departmental concerns, leading to the planning and development of the first major reservoirs and aqueducts for New York City. Housing, garbage collection, sewage, and epidemic control all came under the department's purview.

Later, with passage of the Emergency Maternity and Infant Care Act of 1943, the department moved vigorously

into the arena of personal health services. At the outset, these services were confined to maternity and child health, but later, under the leadership of Drs. Leona Baumgartner and George James, all personal health services to the poor were included. The philosophy of the department was rooted in the belief that the poor qualified for expert medical care, and that it was the responsibility of the health department to render it.

Over the years, the health department gave up administrative control over many public services such as street cleaning, sanitation, water supply, and sewage—yet never surrendered its authority over these services insofar as they affected the health of the population served.

2. The persistent antagonism of organized medicine toward the work of the health department. From time to time this antagonism was tempered by interventions of the New York Academy of Medicine and by various voluntary associations, particularly the Tuberculosis Association. These agencies repeatedly came to the rescue of the health department when it was under attack from organized medicine. Interestingly enough, the early Boards of Health were constituted largely of members who were laymen, in the belief that a board dominated by doctors would be unable to agree on actions responsive to the full scope of the health department's concerns. From time to time the Chairman of the Board was a layman.

Instances of the medical profession's opposition to the work of the board are abundant:

- In 1897 the Board passed an ordinance requiring physicians to report cases of tuberculosis, which was then a leading cause of death. This measure was denounced by the profession as interference with patient/doctor relationships. The medical society sought legal action to strip the Board of its powers, but its powers were upheld by the courts;
- The Medical Society, at one time, sponsored legislation that would forbid the health department from dispensing vaccines and antitoxins in the belief that this practice was unfair to private, competitive interests. The authority of the health department again prevailed;
- In 1914 after two accidental deaths in elevators, Dr. Sigismund S. Goldwater, then Commissioner of Health, urged installation of standard safety automatic closing devices on all elevators in the city. The Society of Medical Jurisprudence attacked this recommendation as committing the city to "a policy of socialism";
- In 1929 the Queens County Medical Society opposed examination of school children for visual defects by health department physicians on the grounds that this practice "tended towards state medicine." The charge was made in spite of abundant evidence that widespread visual loss among school children went undetected, unreported, and untreated by private physicians.

3. The constant battle the health department waged to balance personal privilege against public well-being. The second annual report of the Board of Health dealt with this matter in the following way: "The health department of a great commercial district which encounters no obstacles and meets with no opposition may safely be declared unworthy of public confidence; for no sanitary measure, however simple, can be enforced without compelling individuals to yield something of pecuniary interest or of personal convenience to the general welfare." Throughout its long history, the health department never wavered from this strong position, even when some closely defended privileges needed to be sacrificed. Early in its history the Board asserted that it preferred voluntary cooperation, but stated that it would "exert its powers to the utmost, for the law the Board has to enforce is founded on the theory that individuals have no right to peril the lives of thousands; that the poor have a right to protection against avarice and inhumanity."

The Board early attacked the problem of slum dwellers, by arbitrarily moving them, and overrode the sacred property rights of many businessmen by depriving them of rental income.

At one time, the Board became greatly concerned with the foul conditions existing in public markets and ordered the removal of all booths and stalls around Washington Square market. This decision was so unpopular that the police department refused to implement it. Dr. Charles F. Chandler, then Commissioner of Health, personally recruited an army of 150 carpenters and marched on the market one evening, dismantling every illegal structure. The courts upheld this assault on private property.

In 1885 the Board requested and was granted authority to require the vaccination of anyone designated by the Board, including school janitors and their families. In 1896 the Board made a further courageous assault on private property when it required the inspection of cattle and the subsequent destruction of any that were found to be infected with tuberculosis. In 1901 the Board passed an ordinance against spitting in public places and enforced it with hundreds of plainclothesmen. During one 45-day period in 1920 the Board brought 1358 convictions for spitting in public places.

The Board vigorously followed a policy of forcible isolation of infected individuals in order to prevent epidemics. In 1938 Mary Mallone, better known as "Typhoid Mary," died. She had been forcibly isolated in Riverside Hospital for 20 years. On one occasion it required five policemen to obtain from her a specimen that had been requested by the New York Health Department. She was known to carry typhoid bacilli, and she insisted on working as a food handler. Her personal rights of free choice were declared void against the larger rights of society to be protected from epidemic.

4. Throughout the Board's history, the courts proved to be a strong and unfailing ally. From time to time medical societies, real estate boards, property owners, and outraged politicians attempted to strip the Board of Health of its

powers. Repeatedly, the courts upheld its efforts to protect the public health. The close working relationship between the Board and the courts has continued up to the present day. Beginning in 1958, the courts supported the Board's programs in its vigorous efforts to make family planning and abortion services available to anyone who wanted them. And in 1965 the courts ruled that the Board acted within its authority in fluoridating the city's water.

5. *And finally, an understanding of the circumstances which caused the work of the Board of Health to flourish.* The 100-year history is not one of sustained progress. There were dark years and unsavory episodes—such as a time when burial permits were sold to enable murderers to conceal their crimes. Generally speaking, the work of the Board flourished when it had strong leadership. But that strong leadership worked effectively only when the city was administered free of graft by politicians who manifested a concern for people. Several strong Commissioners of Health lost their jobs by advocating the public's health too vigorously in an administration concerned with other priorities. In New York City public health flourished not just when there was strong public health leadership, but when there was a congruence of such leadership with honesty in government and with enlightened political commitment to human values over property values.

Lessons to be Learned

An effort to generalize about public health from the history of New York City holds many pitfalls. All of public health is not fairly represented by local health departments, and not all local health departments are fairly represented by the example of New York City. And yet there are lessons to be learned here. New York City was a leader after which many of the best health departments in the country patterned themselves. And a case can be made that the health of no population has been well served, no matter how enlightened and innovative the private market systems, and no matter how vigorous the work of voluntary agencies, without the existence of an agency of government committed to the healthful well-being of its constituents as the core of the endeavor.

Drawing inspiration from the record of New York City, perhaps some generalizations about public health and its impact on public policy at least in years past can be set forth:

1. For the 100 years spanning the late 19th and early 20th century, public health at its best and strongest was a movement deriving strength, leadership, and support not from *national* sources but from *local* ones. Toward the end of the century, public health became increasingly dependent on federal funding, a reflection of the much greater taxing potential of federal as opposed to local government. For this reason, the generalizations which follow require a continuum of responsibility and a consonance of health policy beginning at the local level and extending through state and federal governments.

2. Public health cannot be strong except as it is strongly represented in local government. It is hard to see how the commitments and responsibilities of public health can be fulfilled except through the exercise of the power of government. Voluntary organizations have been and will continue to be exceedingly influential in public health. They serve best as adjuncts and sometimes gadflies to official public health agencies, but not as their substitutes. Today there is a role for voluntary associations: to help public health departments see and execute their duty, and to help them by protecting them from abuse, neglect, and special interests.

Questions are raised at once about how effectively the newly fashionable private nonprofit corporations can assume public health functions. Such corporations are now authorized for planning and for regulating health services at local levels. The question is: Can they share both the public accountability and the authority of government? Consumers have cause to be apprehensive about delegating such *authority* without assurance of *accountability*. Democratic governance comes considerably closer than private corporate structure to keeping together authority and public accountability. Private corporate structure in health services has a checkered past—look at Blue Cross as reported by Sylvia Law.[7]

3. There is need to examine agencies of public health for conflicts of interest; if any are found, they need to be eliminated. History suggests that insofar as these agencies are influenced by private interests, whether they be private medical, industrial, or property interests, the public interest will be compromised. One thinks at once of the major polluters of the environment, who are universally represented on commissions charged to monitor the environment; or of medical providers who are expected to regulate the quality of their own services.

4. Public health workers should seek ways to broaden their scope of influence over aspects of public service that affect health, but which owe operational allegiance to some other interest. Public health need not claim operational responsibility for housing, highways, industrial expansion, or communications—but public well-being can be protected by insisting that a voice knowledgeable about health be influential in these fields. Public health was strong when it had that voice, and the public's health may have been better protected. Over the years, the scope of responsibility of public health has tended to be narrowed as mental health, environmental protection, consumer advocacy, and personal health services have all been siphoned away to other agencies with other priorities. For public health to regain influence in public policy it needs to regain its voice in the lost fields. Environmental impact studies are now required on any endeavor that spends federal dollars. Should not health impact studies also be required on any endeavor that spends tax dollars or enjoys tax exemptions?

5. Public health agencies should reexamine influences that can be exercised through juridical process, an avenue which upheld their strength to a great degree. More recently, it is an avenue that in two decades has brought about a revolution in civil rights. Perhaps it can help

promote a renaissance in public health as well. Are there legal mandates and authorizations in public health that are not sufficiently tested and not kept strong by enforcement? Can the courts once again become the powerful ally of public health to reestablish lost influence?

Moving away from the local arena, additional avenues suggest themselves as leading to a stronger national influence upon matters of public health. The strength of property interests and their lack of identification with local government, the great mobility of our population, and the great taxing authority of federal government all point up the need for new federal roles. The next major phase of public health development may well require no less local commitment, but much stronger federal enforcement. A case can be found in the experience of revenue sharing. This 5-year, $30 billion program has funneled money from federal to local government, very little of which has found its way into social services.[8] Very little, indeed, has gone for health services. It has been used in large part to reduce local taxes, to fund projects of priority too low for local financing, and to reduce the local backlog of capital investments. This suggests the importance to public health of reforms in the tax structure, and measures designed to control the power which vested economic interests exert in the formation of public policy.

A reasonable quid pro quo for continued sharing of revenues to state and local governments could be that shared revenues be used to meet specified standards of health services. Performance standards are in the offing for private medical care; performance standards are similarly required in education and in nearly every sector of public service. Should there not be established a required performance standard in public health? Is it a reasonable part of the public health perspective to allow a local option for services known to be essential to human life and well-being? Perhaps now is an appropriate time, if public health desires to exercise greater influence on public policy, to enter an era of self-discipline. What do public health agencies expect of themselves; what do they wish society to expect of them? Can public health establish minimum standards of performance and accept enforcement of standards at the local level, while also accepting a role for state and federal governments as monitors and guarantors of such enforcement? To answer these questions in one way is to suggest that public health will experience a further decline of influence over national policies that affect matters essential to good health. To answer another way is to suggest a willingness for public health to assume a future for itself.

If public health would have a larger voice in national policies, and if it would have greater support from the economic and political power of the country—in the interests of good health—then efforts to set standards must begin. Both personal and community services require enforcement of standards at every local jurisdiction. Public health cannot have it both ways. It cannot completely endorse local option, as now practiced in many states, and expect to exert great influence on this nation's health policies. It cannot reasonably be programmed for success in some areas, and for failure in others. If one believes in a take-it-or-leave-it attitude toward public health, it will continue to be left out when meaningful support is distributed.

Finally, a word needs to be said about the climate in which public health strives to give greater emphasis to human values. The climate is by no means a promising one. Over three decades ago our nation committed itself at a time of crisis to an economy of war. We have never moved away from that economy. For 30 years our nation has committed a major share of its capital and its labor to the production of war materiel. Perhaps at no time since the prolonged series of conflicts between France and England known as the 100 Years War has a society committed so much of its wealth over such a prolonged period of time for purposes that are essentially nonproductive. That commitment supposedly provides for national defense and protects security. Some may feel that it does, but others begin to inquire whether the protectors of security have in fact themselves become a threat. What security do we find in providing arms for any conflict in any part of the world? Are we driven by a search for security or a search for markets in which to unload military goods? What security does the nation find in sometimes arming both sides of the same conflict? What sense is there in fostering foreign policy that urges friend and foe to preserve an unstable peace by not using the military might our nation provides them? What long range futures do we jeopardize by trading off nuclear capabilities as bargaining items for short term diplomatic advantage?

The world may be more threatened than protected by our 30-year commitment to a war economy. Until that commitment is altered, public health probably can exercise less influence than is needed for distributing the country's economic resources and its political influence to promote the health and well-being of its people. Public health suffers, nutrition suffers, housing suffers, education suffers, and people suffer. The nation needs advocates of public health; it also needs advocates for the circumstances that will allow public health to flourish. Public health capabilities *may be* on trial; our nation's social values *are* on trial.

C. Arden Miller, MD
Professor of Maternal and Child Health
University of North Carolina
School of Public Health
Chapel Hill, NC

REFERENCES

1. Gossert, D. J., and Miller, C. A. State Boards of Health, Their Members and Commitments. Am. J. Public Health 63:486, 1973.
2. Myers, B. A., Steinhardt, B. J., Mosley, M. L., and Cashman, J. W. The Medical Care Activities of Local Health Units. Am. J. Public Health 83:757, 1968.
3. Initial Report on Programs and Expenditures of State and Territorial Health Agencies, FY 74. Association of State and Territorial Health Officers, Washington, DC, 1975.
4. Duffy, J. A History of Public Health in New York City, 1866–1966. Russell Sage Foundation, New York, 1974.
5. A New Perspective on the Health of Canadians: A Working

Document. Ministry of Health, Ottawa, Canada, 1974.
6. Forward Plan for Health—FY 1976-1980. DHEW, U.S. Government Printing Office, Washington, DC, June, 1974.
7. Law, S. A. Blue Cross, What Went Wrong. Yale University Press, New Haven, 1974.
8. Blair, P. A. General Revenue Sharing in American Cities: First Impressions. National Clearinghouse on Revenue Sharing, Washington, DC, 1974.

TOWARD A NATIONAL HEALTH POLICY—VALUES IN CONFLICT

From time to time the Congress and the President of the United States have agreed on something akin to a National Health Policy. These agreements have been reached through compromise and they bear the signs of compromise. The first real national effort at health planning (P.L. 89-749), in 1966, contained words about national purpose, healthful living, and assuring the highest level of health attainable for every person, but it also declared that nothing was to be done which might change the traditional practices of medicine, dentistry, and related healing arts. The copayment and coinsurance features of Medicare were a form of compromise between ideals and ideology. This particular compromise is both *intra-* and *inter*personal: that is, everyone should have the *right* of access, but the *means* of access should be tempered by some degree of personal sacrifice, sometimes an unreasonable one. We are a compassionate people, but the social Darwinism of our American frontier fantasy persists. It may be useful.

Compromise, in American politics, has undergone a subtle change in process as we have moved from a confederation to a nation. The pork barrel has changed to a stew pot. Once upon a time a legislator with a particular goal could gain the votes needed by agreeing to support another legislator's goal in another unrelated bill. Laws were more regional and less national a century ago. But the process has become more national and more pragmatic. The legislator's desired objective is described accurately and then, through head counting, the contents of the bill are selectively modified to gain the number of votes needed. From *inter*-bill compromising we have shifted more toward *intra*-bill compromising. The process is, in some respects, faster, and our general societal acceleration has demanded this, but it is more difficult to find a clear sense of policy in the final law since the resulting bills reflect the ambivalence inherent in compromising values. The result is often left to administrative determination of national policy (which is less responsive to the electorate than is the political process) and to occasional judicial surprises.

That values can conflict with surprising results is apparent in some recent remarks by former DHEW Secretary Caspar W. Weinberger. Appearing before the American Pharmaceutical Association on April 23, 1975, he spoke about the problem of drug prices and urged new rules which would allow substitution of the lowest priced version of the drug available. He was quoted as saying: "No one is more opposed to unwarranted federal intrusions than I; but any time the federal government invests, as we do, over $2.5 billion for drugs provided to other Americans, then any proposal that is designed to bring about a real savings at no cost to quality has to be the government's business."[1]

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) is a result of the stewing process—somewhat of a Mulligan stew at that. The original author of the progenitor of the final bill had a fairly clear sense of what he was trying to do. He attempted to improve a much heralded but largely ignored 1966 effort at health planning by putting teeth in the process and shifting control from communities to the Secretary of Health, Education, and Welfare. Considering the generally weak acclaim earned by Comprehensive Health Planning between 1966 and 1974, the heat of the cooking process in the last few months of 1974 was probably unexpected. The battle, of course, was over control, and others, in addition to the directors of Comprehensive Health Planning Agencies and Regional Medical Programs, had something to gain or lose. Hospital associations saw the significance of the Act, as did some state and local government officials, but physicians, who really don't want the sort of planning needed, were caught napping. Now the frenzy over boundaries and agency control is intense because the potential for controlling or being controlled is evident. But what is it all to accomplish?

The 1974 Act contains 10 priorities which are to be considered in formulating national health planning goals. (It is not clear whether these are priorities for the planning process or part of the health goals themselves, but it is useful to assume the latter.) The priorities can be grouped as follows:

- Primary care services should be available to those populations presently underserved;
- Comprehensive "systems" should be developed, to include all services. These should include sharing agreements between institutions and subsystems, the formation of group practices as parts of the systems rather than as independent entities, and consolidation of high cost, low volume services and functions;
- More physician assistants and nurse practitioners should be trained and used;
- Quality should be improved;
- Costs should be studied, compared, and, presumably, at least contained; and
- More emphasis should be given to disease prevention, particularly through better understanding of nutrition and environmental factors and by better education of consumers in how to appropriately use available services and protect their health.

There are a number of potential value conflicts inher-

This commentary was prepared for presentation at the meeting "Toward a National Health Policy," sponsored by the National Association of Regional Medical Programs, Atlanta, Georgia, May 6, 1975.