effect, as that of an agent for social change, with a subsidiary obligation to fill the gaps that may exist in the delivery of personal health services.

This is not a shift in priorities—only an affirmation. Nor is it to imply that creative contributions to the delivery of primary health care are unimportant.

It is rather to suggest that asking local health departments to take on primary health care responsibilities is urging the assumption of a set of very consuming tasks. Such a decision ought to be made only after very careful assessment of the implications for the department's essential responsibilities—and the program alternatives.

After the local health department's obligation as a change agent through the major prevention programs, comes a secondary responsibility for the provision of "linkage" services—those services which utilize nurses, nurse practitioners, and other health workers to reach out to the particularly vulnerable and ensure that their needs are met. That is, those services which ensure that, at a *minimum*, the very young get off to a good start and the very old are provided a comfortable finish.

So I would caveat this discussion of the "new public health" with a plea that as functions of direct primary care services are assumed, directors of local health departments ought to treat them as *tertiary* responsibilities, behind responsibilities which are often less stylish, attractive, and attention getting, but which are of overwhelming importance to the health of Americans.

A State View of Local Health Departments

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When it comes to the provision of personal health services, it is apparent that some people are uninsured for all services and all peoplee are uninsured for some services; and when they are poor or disadvantaged in some other way they will, of necessity, have to depend upon the local community for care and support. This has been a tradition since 1601 and the passage of the Elizabethan Poor Law which required the most local government to respond to needs for care and support.

The fundamental problem is dependency—when an individual is unusually dependent for physical, mental, or social reasons upon others, then the community which has that problem can and should produce the solutions, even though it may need to call upon a larger community for some of the resources needed.

Dependency creates vulnerability. When people are vulnerable, they are subject to exploitation and government must protect them.

That is part of the unique difference between the public and the private sectors. The public interest is served by reducing dependency. The private sector prospers from dependency—its income is earned by producing the necessary services. Public organizations, in their attempts to alleviate dependency, must not only produce or purchase the services, but must spend the necessary money to do so. It is often difficult for physicians and hospital administrators who have worked in the private sector to understand the thought processes of the public sector. For example, cardiologists, working in public hospitals, insist that we should expand our X-ray capabilities to incorporate cardiac catheterization procedures, since such procedures are fully reimbursed and, in fact, may be "money makers" for the hospital. They seem not to understand explanations that the money they are "earning" is money that we and they provide as taxpayers. Buying the service at another hospital may be less costly.

Because of the need to protect the vulnerable and the dependent, and because the public sector must use its resources to do so, there is and always will be a need for a governmental presence at the local level.

The question is how to satisfy that need—and the suggestion is that we should do so by developing the capacity of communities and by encouraging and facilitating community "experiments" in problem solving. We can use national or even global goals in terms of outcomes, but we need to support local strategies for achieving those goals. We tend to spend too much time at the national and even the state level, wrestling with strategies and methods rather than end results. It would be better if we could turn the federal-state-local governmental structure upside down and understand that the purpose of state government is to support local communities in their efforts to solve problems, and the purpose of federal government (insofar as human services are concerned) is to support that process. Instead, we find communities forced to conform to state organizational patterns which, in turn, are forced to conform to national organizational standards and needs, all of which are designed to satisfy a uniform law and regulations and not the needs of dependency in a community setting.

Why insist upon local leadership? Arden Miller* has pointed out that there are many striking examples of local public health organizations which have proven to be emi-

*See p. 15.

nently successful in reducing dependency and solving human problems. His information is at variance with that of Dr. Chang,** but we need to recognize that both have asked different questions from a different population of respondents. Dr. Miller found that the creative and innovative health departments indicated they had achieved their success almost in spite of state health departments and received their principal support from federal agencies. This is not surprising. The federal government cannot directly implement its health and social service initiatives but must do so through state and local governments. This means that they have to be more accepting of local community strategies in order to accomplish their purposes. States can and sometimes do ignore such local idiosyncracies.

Gary Clarke*** has made a good case that the federal government has been unable to handle the certificate-of-need process directly, and that their efforts to curb health costs have been unsuccessful to date, while many states have developed creative and effective procedures. The same is true for efforts to control public health insurance programs such as Medicaid. Most of the creative innovations in health insurance management in the public sector have occurred in Medicaid, which is administered by the states, rather than in Medicare, which is administered by the federal government through intermediates.

In addition, economists support the thesis that decision making in a complex market is more powerful and effective when the buy and sell decisions take place in a decentralized market. That thesis can be extended to the kinds of planning and decisions which occur in developing health programs. The state of the art of health planning is still so very primitive and the systems so complex that decentralization is likely to lead to more efficient planning and solutions. One of the most articulate spokesmen for this thesis is Rudolf Klein, the British economist.[1] In his paper for the Royal Commission, he has described diversity as a virtue rather than a defect and has urged that we continue to encourage local experimentation and innovation as the only way to learn more about the complex issues in health care delivery. Professor Klein acknowledges that localism can lead to inequities, but he contrasts the drive for democratization on one hand with the thirst for equity on the other. I would suggest that the price of universal equity is maximal imperfection, and that the present legal and administrative structure developed in the United States gives us sufficient protection against blatant inequity while allowing us to experiment creatively at the local level.

While much of the past criticism of local government and federalism has been justified, our experiences with revenue sharing, manpower development programs, and other initiatives involving cash transfers from federal to state and local governments have given us a great deal of useful experience in federal goal setting and local program development.

In our work, we find it desirable not to deal with private groups on behalf of a community, but rather to work directly with real representatives of that community, whether elected or appointed for that purpose. This pushes us more and more in the direction of urging that the governance of health delivery organizations or systems, at the local level, be placed in public hands, although the public body, through its representatives, may contract with private individuals or organizations to produce the needed services.

We are seeking ways to bring together mental health, public health, and primary care programs so that they can share the same physician staff, the same laboratory base, the same administrative structure, and often the same facilities, outreach workers, social workers, nutritionists, and other health and administrative personnel. The process is one of coalition building at the local level, and is similar to the techniques and strategies of economic development as carried out by some of the more progressive state governments in this country. Our major goal is to develop a dependable and secure base of support at the community level to serve as the main backstop to whatever kinds of health systems we now have or will develop in the future. In doing that, we find it necessary to negotiate with official community representatives and to take each community on *its* own terms, not ours. We try to avoid process standards and work more toward outcome expectations. Ultimately, our ideal would be to develop a block-grant mechanism wherein all monies spent for health could be allocated to a responsible community organization with sufficient background and experience to make the crucial decisions about how much of what kind of service is necessary to support the needs of that community.

**See p. 31.
***See p. 59.

REFERENCE

1. Klein R: Evidence to the Royal Commission on the National Health Service. Journal of Health Politics, Policy and Law 1978; 3:11-19.