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"MEDICAL DEMOCRACY IN A HEALTH SYSTEMS AGENCY: THE ROLE OF STAFF"

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ABSTRACT

The performance of consumers or laypersons in government programs has been studied extensively, usually from the standpoint of the control exercised by providers or other professionals, or correlatively, what consumers need in order to be on an equal footing with the experts. At stake is lay control—i.e., democracy. This case study of one Health Systems Agency (HSA) in contrast, focuses attention on the crucial role of the HSA staff in the democratization of health care. Outcomes, such as cost-containment and allocation of resources, can be examined in terms of the staff's interests and the constraints of its multi-leveled environment. From this perspective, the recruitment, selection, socialization, promotion, training and control of consumers are seen as important factors in the decisions made by the HSA, and these factors are seen as being greatly influenced by staff members as they seek to achieve a balance of outcomes. The balance of outcomes may include certain material and professional interests of the staff itself. In this process, lay control becomes subordinated.

After a short life, Health Systems Agencies (HSAs) are apparently doomed. The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) mandated consumer majorities on the governing bodies and the substantive committees of Health Systems Agencies to carry out the purposes of the Act: viz., to improve the health of residents of the health service area, to increase the accessibility and quality of services and to restrain increases in health care costs, partly by preventing unnecessary duplication of health resources. Consumers are to be broadly representative of the health services area in terms of its geographical, social, economic, and ethnic characteristics.

The 1979 amendments to the Act broadened the definition of consumer to include, for example, those who served on hospital boards of trustees, formerly classified as "indirect providers" of health care. Even with this change, however, consumers have been expected to bring a lay perspective to deliberations involving local health planning and, armed with their certificate-of-need power and aided by a staff of professional health planners, to bring the escalation of costs under control.

The Reagan administration has announced plans to rapidly phase out the HSAs as part of its overall reduction of federal programs. Scholarly analysis

of the HSA program had hardly begun. With certain exceptions, little is known about the accomplishments and problems of the HSAs, and there will apparently be no opportunity to modify the program based on the accumulation of empirical data.

It might seem pointless to attempt an analysis of the program on its deathbed, so to speak. However, for those interested in the problem of democratic control over social institutions, such an analysis is quite worthwhile. The cornerstone of the HSA was (and still is, in its final hours) the consumer majority on its decision-making bodies, a majority which could prevail over the combined interests of health-care providers: physicians, hospital administrators, Blue Cross and other insurers, etc.

This paper is based on a study of an HSA in which the author has served as a member of the Project Review Committee (PRC) for three years. This committee's primary task is to review applications from hospitals for new construction and for the purchase of equipment costing in excess of $150,000, and to make a recommendation to the HSAs Governing Body. The Governing Body—also with a consumer majority—then reviews the application and submits ite recommendation to the appropriate body at the state level. Although the PRC receives reports and advisory recommendations from Sub-area Councils (SACs), it is the first unit to hold public hearings on the matter and where a vote is required. Since higher units seldom contravene its decisions, the PRC occupies a central position in the decision-making process.

Limiting the study to one HSA is unfortunate in many respects (even if unavoidable here). In some ways, the mid-state HSA (as it is called here) is quite "typical" when compared with other HSAs described in the evaluation literature: the high proportion of projects approved; a tendency to give priority to increased access to and quality of health care over cost-containment; the under representation of low-income consumers, etc. With respect to these findings see, for example, the findings of Salkever and Bice (1976) and the research conducted by Lewin and Associates, Inc. (1975). Of course, it would be far better to have more comparisons, even on a regional basis. However, given the paucity of HSA studies (as opposed to evaluations), perhaps the present one has at least something to offer. Moreover, it is always to be hoped, in studies of this kind, that certain gains in understanding partially offset the losses in comparability and generalization. It can even be argued that knowing what is typical and general is, in principle, no more instructive (or useful) than knowing what can happen under certain conditions.

Literature

The literature on the problem of consumer participation (versus control) is fairly extensive, much of it based on earlier programs such as the Model Cities and the Comprehensive Health Planning (CHP) programs. The effectiveness of consumer participation in decision-making has been shown to vary with a number of factors. Moguloff (1969) for example, has pointed to "previous participatory experience" as one factor that influences the consumer's effectiveness. Daniels (1973) has proposed that consumers without an identifiable

constituency are unlikely to be effective. Graves (1970) relates effectivenes to the consumer's access to resources that balance the power and influence of health-care providers. The importance of clarifying program goals is stressed by Partridge (1973); failure in this task was found to be associated with a concentration on procedural rather than substantive tasks, and with consumers dropping out because of a lack of impact on the program. Parker (1970) has focused on the need for training consumers in planning skills and providing them with substantive knowledge.

Most of the literature either states explicitly or implies that failure to deal with the problems discussed above leaves the consumer open to domination by the better organized and more powerful providers such as physicians and hospital administrators. Douglass (1973) found that providers were more influential than consumers in the planning of Model Cities health programs. Salber (1970) found that physician-providers often find it difficult to view (and accept) the consumer as citizen rather than as a patient, and that sharing decision-making with consumers runs counter to the content of professional education. Metsch and Veney (1980) also observe that "provider attitudes toward consumer participation are a critical determinant of the impact of consumer participation on the delivery of health care services."

Metsch and Veney (1980) argue that government legislation has reduced consumer demand on the health care system by creating participatory structures such as HSAs, but has not re-allocated the resources which the consumer sector needs in order to be effective within the structures. Until this occurs, the outlook is for incremental rather than fundamental changes. Marmor and Morone (1980) are equally critical of the failure of the legislation to address and resolve certain crucial problems:

> "Logic rebels at the peculiar idea that a planning agency without sufficient authority can scheme, scold and cajole a dynamic system into compliance with plans that run contrary to all that system's incentives."

Not only do HSAs lack the necessary authority and resources, but the legislation has not dealt with the problems of whom the consumers should represent, how they should be chosen so as to be representative, and providing adequate structures of accountability.

The problem of interest here is not the lack of authority of HSAs. Rather, it is: what do they do with the authority they have? Lack of authority can always be cited all the way up to a centrally-planned state (where different problems become salient). Within the context of available authority and the use of it, the interest is centered on the HSA staff as the recruiter of consumers and as a counterweight to the expertise of providers. The staff is, if not an adversary of providers, at least presumptively committed to the goals embodied in the legislation and is at the service of consumers as the majority. The staff of the HSA (and similar programs) may be the key to the success of democratic processes in sectors dominated by strong professions and high technology. This can only be suggested here, though it is seemingly supported by the literature previously discussed.

The PRC at Work

Three dimensions of the PRC's activity were of interest and some attempt was made to gauge them: (1) effectiveness in cost containment; (2) dependence of consumers on the staff; and (3) the degree of unanimity on the committee.

The dollar value of the proposals presented to the PRC in a recent one-year period was used to assess the cost-control effectiveness of the staff-recruited committee (with its consumer majority). The value of the approvals was nearly $30 million and the value of the disapprovals only about $2.8 million—a 91% approved-dollar rate (or a 9% rejection rate). The number of proposals approved was 28 (out of 31 submitted).

The dependence of committee members on staff analyses and recommendations can be suggested by looking at the decisions made by the Project Review Committee over a one-year period. Of the 31 proposals presented to the committee for a decision, the committee adhered to the staff's recommendation on 30 of the proposals. Furthermore, the committee's vote was unanimous on 26 of the proposals. There were no more than two negative votes (either opposed or abstaining) on the five remaining proposals.

Some understanding of this conformity to staff recommendations can be gained from looking at the process of committee meetings. Consumers on the Project Review Committee are required to make decisions about matters involving high technical knowledge and tend to be more dependent on staff than providers are. At one meeting of this committee, the kind of remarks made by consumers and providers were classified and counted. Remarks were classified according to whether they represented positive statements about the proposal, clarifying questions about the finer points of a proposal, or "educational" questions reflecting rather clearly ignorance of the purpose of the equipment sought or some other matter. Consumers asked three "educational questions" and providers asked none. Consumers made two "statements" and providers made nine.

These results, especially those regarding the unanimity of votes and the high approval rate on proposals, are somewhat paradoxical when seen in the context of consumer attitudes toward providers. Farris (1980) surveyed the consumer members of Mid-State HSA's Project Review Committee. Although the sample was small and the response rate rather low (about 50%), some information is available on this topic. Consumer members of the PRC were asked if health costs in general were too high; then which specific kinds of costs (such as doctors' fees, hospital room rates and medicine) were too high; finally, why those costs were too high, in their opinion. Only one respondent believed that health costs in general were not too high, and even that one said that they were too high but that she understood the reason for it. The respondents also believed that all the specific costs listed were too high, although there was some variation among these. Three (of eight) respondents, for example, said that doctors' fees were not too high, while only one (of six) said that the cost of hospital emergency-room services was not too high. Half the respondents (four) attributed the problem of high costs to provider greed: "greedy doctors" and/or companies, profiteering, overcharging, etc. Another two identified poor hospital management as the culprit.

This sounds like a situation in which a low rate of unanimity would be expected. However, there were, evidently, cross-currents at work. The same consumers surveyed by Farris also tended to identify providers as being most influential for them in making decisions. When asked whose opinions and ideas carried the most weight for them in decision-making, the majority (4 of 7) mentioned providers only or specific providers along with specific other consumers. Only two identified other consumers exclusively. The expertise and experiences of providers was often cited as a reason for their influence. This can be more fully appreciated by looking at some of the forces at work on the consumer.

Ambushing the Consumer

To be a consumer on the PRC means having to cope with at least four potent forces, all tending to predetermine decision. These can be called (1) the technology bind; (2) the me-too principle; (3) medical revivalism; and (4) the levitation factor.

The "technology bind" comes into play when a hospital proposes to replace an existing piece of equipment such as a computer, an x-ray machine or a laboratory analyzer. Usually, the equipment is still working but is technologically obsolete. That is, the manufacturer has a better machine available that he must sell. The best sales tool, apparently, is to reduce or withdraw maintenance and repair services on the older equipment. The hospital is thus the first to feel the technology bind. Downtime is inversely proportional to the availability of spare parts and maintenance service. When the hospital administrator presents his case to the PRC he, in turn, binds its members. Rejection of the proposal is tantamount to surgery by candlelight, administrative chaos, leaving the sick and wounded in the halls waiting for diagnosis. Because of the technology bind, these proposals really represent entitlement programs for hospitals. Replacements for "obsolete" CAT scanners will undoubtedly be leveraged in by the technology bind in the near future.

The "me-too principle" is based on the composition of the HSA region and on the existence of certain leading hospitals which are usually out in front of the crowd with respect to the latest technology and services. The Mid-State HSA region is made up of eight counties. Each county has villages and towns of varying sizes—some of which have their own hospitals. The "center" of the region, in terms of population and health-care institutions, is a city of a little over 300,000 population. A proposal for new construction or new equipment by a hospital in the central city can be (and often is) justified because the leading hospital—a teaching hospital—has it. Since the leading hospital does not serve the entire community, other hospitals, and their patients, have a right to the same level of service. Hospitals in outlying counties and towns use the central-city facilities as the basis of their claims. Why should their patients have to travel all the way to the city for a CAT scan? The structure of an HSA region, made up as it is of independent and competitive institutions and political jurisdictions, makes the me-too principle an ever-present factor. When we consider also that one of the objectives of the HSA legislation is to improve "access" to health care, we can see that it is not an easy problem to deal with.

"Medical revivalism" is often combined with the "me-too principle." It is seen in the testimony of physicians brought to the PRC meeting to describe the new equipment or service desired, and to tell how it will save lives or reduce inconvenience. Every physician called to testify can recall a number of cases appropriate for the occasion. "But even if it only saves one life..." is the clincher. The sin of failing to save one life is pounded home—in professional language, but with the fires of damnation dancing on the ceiling. Would-be sinners on the PRC come forward and are saved—i.e., vote for the proposal.

The "levitation factor" refers partly to the props that are part of the act that hospital administrators present in defense of their proposals, and partly to the world of appearances that they create. Any act needs props. Here, they include color slides, architect's drawings, handouts, testimonial letters, flip charts, etc. It is usually a class act. No one can fail to be impressed by the amount of thought and effort that go into the presentation, by the sincerity of the proponent, by the progress that will surely follow from the plans. Committee members are treated respectfully, somewhat like military commanders. "Yes, sir" is heard quite often in response to questions. No one wants to stand in the way of progress—or in the way of sincere, hard-working, important but respectful men. The stage is thus set for the act's finale. Not only is the proposal desirable—but it will cost nothing or at most a trivial amount will be added to the cost per patient-day. The metaphysics of accounting create this illusion. Funded depreciation, for example,—the free lunch of hospital accounting—will be used to pay for the equipment desired. Since few on the committee understand funded depreciation and there is no follow-up mechanism to analyze the real cost impact, the act ends impressively. The magical effect is appreciated more fully when the consumer realizes that health-care costs continue to rise but nothing adds to the costs.

This impressionistic account of life on the PRC is meant to suggest that certain forces operate on consumer members in such a way as to make simple, rational decisions difficult. However, the expertise and the recruitment power of the staff have the potential of redressing this imbalance of forces—either by training consumer members, or by recruiting more militant consumers and at least occasionally siding with them, drawing on their own expertise. The staff seemed to give these functions a low priority. This can be seen in the recruitment of consumers.

Criteria for Consumer Recruitment

Consumers do not simply flow to the agency. They are recruited. And the kinds of consumers recruited are important to all concerned, including the HSA's professional staff. The evidence suggests that key staff members play an important role in the recruitment of consumers, and that they have fairly well-defined criteria of acceptable consumers. These favored consumers have characteristics that lend themselves to the achievement of certain staff objectives.

Primary responsibility for consumer recruitment in the Mid-state HSA was assigned to the Assistant Director for Community Involvement. According to

this official, 40 percent of the consumer members are directly recruited by the staff. Others come in as a result of the work of the Speakers Bureau, brochures left in physicians' waiting rooms, and other publicity activities.

It will be helpful at this point to identify some of the important factors comprising the agency's situation so that they can be related to the criteria for consumer recruitment. These factors are:

1. There is a time limit (90 days) for acting on applications;
2. Providers bring the greatest prestige and influence to the decision-making process;
3. The legitimacy of the HSA's decisions in the community cannot be taken for granted; and
4. Local interests are strong and are always a potential threat to the attainment of regional plans.

In this situation, the staff has certain practical interests. These are identified in Table 1. The table also relates the four situational factors (above) and consumer characteristics to the staff interests. The consumer characteristics were obtained from interviews with staff members and from analysis of the occupations and incomes of consumers.

Table 1: AGENCY SITUATION FACTORS, STAFF INTERESTS, AND CONSUMER CHARACTERISTICS DESIRED

Agency Situation	Staff Interest	Characteristic Desired in Consumer
1. Time limit on processing applications	Transacting business with dispatch	"Interest"
2. Provider prestige and influence	(a) Obtain hearing for staff recommendations	(a) "Objectivity"
	(b) Avoidance of "adversarial position" or overt conflict with providers	(b) Ideology of common goals: all "working towards the same thing"
	(c) Favorable consumer decisions	(c) Ability to "say no" to providers
3. Questionable legitimacy of decisions	(a) Securing formidable allies and supporters	(a) Professional or managerial status and/or representing a "constituency"
	(b) Firm commitment of allies; acceptance of professional planning	(b) "Pro-HSA attotude"
4. Localism	Collectivism; developing acceptable regional plans	"Regional View"

Information about the desired consumer characteristics was obtained from interviews with the Assistant Director of Community Involvement, the official

who is primarily responsible for consumer recruitment, and with the Assistant Director for Project Review. The most important characteristics identified in the interviews were (1) interest, (2) recognition of common goals, (3) representativeness, (4) a "regional view," and (5) an ability "to say no to providers" on occasion.

Interest ranked high on the list of the Community Involvement official's priorities—higher than "filling the categories" such as age, sex, and ethnic group requirements. "You can always find somebody to fill the categories," he stated. Interest, however, signified that the person would be more likely to attend meetings so that necessary decisions would not be postponed or delayed for a lack of a quorum. We might note that schedules were made in advance for the various levels of the organization—SAC, HSA Committee and Governing Body—and deferred decisions caused problems up the line. Also, the 90-day time limit for acting on applications presented to the Project Review Committee was a legal requirement. Finally, it appeared that "interest" (and attendance) is necessary to balance the more regular attendance of providers at meetings.

The ideology of the consumer was said to be not a factor in recruitment. "We don't care what their views are, although it would be preferable if you had somebody who was pro-HSA." Despite this disavowal of ideological criteria, however, there was an unofficial ideology of "centralism," a recognition of common goals:

> "I think in the beginning there was a feeling that there had to be two different points of view—a provider point of view and a consumer point of view. But I think somehow the two have to work together and if there are two opposing points of view, somehow they're going to have to come towards the middle. If it's this sort of thing—us against them—its not going to work, because they're always going to be fighting each other. There's going to have to be some give and take on both sides. But the bottom line is going to have to be there's one point of view, more or less, a central point of view—i.e., a commitment to improve the health-care system."

The desirability of having consumers represent a known constituency was also mentioned. Although an "adversarial position" vis a vis providers is to be avoided, consumers should nevertheless represent a constituency of some kind, perhaps because this would increase the legitimacy of the HSA's actions. The one complaint that the Assistant Director for Project Review had with regard to the consumers participating in the HSA was that they usually "represent only themselves" and have "no constituency."

Farris' (1980) survey of the PRC consumers showed that they do not see themselves as representing an organized constituency of any kind. The consumers were asked what group or constituency they represented or considered themselves to represent. The constituencies identified were broad categories such as general public, consumers, low-income people, and minority groups. Ultimately, this problem reflected one of the many dilemmas found in the agency: if every consumer represented an organized or self-conscious constituency of some kind, the control of staff over the process and its own professional vision of health

planning could be compromised. The relative absence of constituencies, however, left the staff groping for community sentiments and left the legitimacy of decisions open to question.

When asked what were the significant decisions made by the Project Review Committee (PRC) since she had been assigned responsibility for the committee, the Assistant Director replied: "The x county's application for a scanner. That was the first time the committee said no to a provider." The ability (and willingness) to say "no" on occasion to provider applications appeared to be an important characteristic desired in consumers. The rejection of applications should not be carried to the extreme, however; rejecting too many applications would falsify the ideology of common cause with providers. "In the end," she said, "we are all working towards the same thing," and an "adversarial position" with respect to providers was not desirable.

Finally, desirable consumers should have a regional view rather than a purely local view, able to transcend the strictly local interests of their own communities. The Community Involvement Director asserted that "most younger people (18-34) tend to get involved in things right in their own communities; they don't normally get involved in regional-type activities—and we have to go out and recruit them if we want them."

Control

The kinds of consumers actually recruited might make it appear that the staff's control and its ability to achieve certain objectives would be weakened. The consumers ranked high on interest, occupational prestige, income, and education. The PRC had eight consumer members (out of 15). One of these was a retired hospital administrator who, after one year in retirement, technically became a consumer member. Of the remaining seven consumers, four were associated with the professions of teaching and educational administration (one was the wife of a college teacher), one was an engineer, one an attorney, and one was a small business owner (about 20 workers). There were no ordinary workers on the committee. Although income data is not highly reliable in this case (no verification is required), four consumers had a family income in excess of $25,000 per year; the other three reported $10-25,000 annually; none had family incomes of less than $10,000.

These characteristics suggest a consumer majority that might easily go its own way—oblivious of certain interests of the staff, such as the achievement of harmonious relations between providers and consumers, the acceptance of the HSA within the community, and the ability of the staff to have significant input into the process. Some of the findings already presented—e.g. the frequency with which the staff's recommendations were followed—suggest that the PRC consumer majority does not act independently to any great degree. But to understand why this was so, we need to look at some of the control mechanisms that appeared to be operating.

If the consumers ranked relatively high on education, interest, etc., it will also be recalled that they ranked low (or possessed little) "representativeness" and technological knowledge. Maintaining the isolation and ignorance of the consumers were important objectives for the staff, objectives that were

accomplished through the recruitment-promotion process, and through the encouragement of ambiguity and ad hoc decisions. By "isolation," it is meant detachment from organized constituencies. There is, of course, no evidence that these objectives and control mechanisms were consciously pursued and activated. They are inferred (quite tentatively) from what is known about the situation the staff finds itself in, the characteristics of the consumer, and observations of the decision-making process.

Ambiguity: The Health Systems Plan (HSP) developed by the Mid-State HSA is required by the legislation. The plan was proposed by the agency's Plan Development Committee, with the guidance of the staff, and accepted by the Governing Body. Here, the HSP is of interest because it serves as the framework for much of the PRC's activity—expenditure proposals, for example, are subjected to the test of whether they are consistent with the plan—and because in the crucial area of cost containment, the plan is non-specific, having almost nothing to say.

Of the 29 goals in the most recent plan, 15 are aimed at improved health, nine are accessibility goals, two focus on the quality of health services and three addressed to the problem of cost containment and duplication. "Improved health" covers such things as immunization programs, health education in public schools, reducing infant mortality rates, and family planning services. "Accessibility" in this plan is addressed in the form of goals aimed at adding hospital beds in certain outlying areas, lowering the physician-patient ratio in some counties, and providing an "optimum level of long-term institutional care" for residents of the region. The thorny problem of cost containment is dealt with primarily by means of studies proposed—e.g., studying the feasibility of an HMO, and a study of "ways to utilize surplus or duplicative facilities.

In the context of the HSA's overall commitment to cost-containment, this reflects an ambiguity toward an important objective. The plan provides little guidance to the PRC in this area. More important, some clearer definition of cost-containment plans (including the development of standards) would free consumers to pursue these. Ambiguity has the effect of tieing cost-containment to specific proposals, and of strengthening dependence on the staff for analyses and recommendations. This tendency was, of course, reinforced by the consumer's generally low level of expertise and by the absence of a concerted training program for consumers. Under these conditions, ad hoc decisions and dependence are almost inevitable. Again, the reader is reminded that this is not necessarily (or even probably) pursued consciously by the staff. It is only argued that consumer ignorance and dependence are consistent with the overall interests of the staff and that this being so, it must be manifested in some way.

Isolation: The sub-area Advisory Councils (SACs) play an important role in the recruitment and socialization of consumers. The Director of the agency estimated that about 50% of the HSA's Governing Body and committees previously served on one of the three SACs. The SACs then constitute a pool of potential candidates for committee or Governing Body positions, with the usual path apparently leading first to a committee position, then possibly to a position on the Governing Body of 30 members (plus one mandated representative from the local VA hospital).

The staff member assigned to the SACs is the Assistant Director for Community Involvement. He attends all meetings of the SACs and is the only staff member with extensive knowledge of the consumers serving on the SACs, and his recommendations on new committee members coming from one of the SACs carry considerable weight.

The interest of consumers serving on a SAC can be gauged by observation. Those who pass the test can be recommended for committee or Governing Body vacancies as they occur.

The Assistant Director noted that the SACs are "strictly advisory"; their recommendations and decisions are not legally required in the planning and review activities of the agency. As such, they are an ideal mechanism for taking in new consumers, sizing them up, sorting them out, and selectively promoting them.

"Regionalism" is one ticket out of the SAC for those who are interested. The SACs also play an important role in the socialization of consumers into a "regional view" of health-care needs and in their selective promotion. The Community Involvement Director explained:

> "If you involve people on the subarea level, the chances are they can relate to what goes on in the subarea a little bit easier than what goes on at the regional level...Then later on, once they understand what regional planning is all about, if they're interested enough that they feel they can make a contribution in a larger group—then they might move up from the subarea to, say, the Project Review Committee."

Another ticket, we might infer, is "volunteerism"—meaning here the detachment from organized interest groups and constituencies. We must note two things in this connection. The first is that while the regulations do not require that consumers represent some organized constituency, neither do they discourage or prevent it. We have seen that at least one official in the HSA lamented the fact that the consumers represented no one but themselves. Second, however, the Assistant Director in charge of recruiting did not mention the constituency factor in the list of traits sought in consumers. This could have been simply an oversight. But it seems more likely that it was consistent with his and the agency's general emphasis on the development of common goals, consensus, and "civic mindedness." Conflict and adversarial relations were clearly unwanted.

There is no way of saying whether "representatives" are even recruited at the SAC level, and if so, whether those who fail to adopt the "common goals" ideology are left in the SAC. The SACs themselves were not studied. We can only say that if they were recruited at that level, they were not promoted without the requisite socialization—as the voting patterns show—and that this serves the overall objectives and views identified by the officials interviewed.

Staff Control and Environments

These practices may not be entirely local in nature. To some extent they are built into the structure of HSAs. The HSA and its staff operate within both a national environment and a local environment. The former includes certain

national purposes and values; more concretely, these are expressed in the form of P.L. 93-641 and other legislation, and more concretely still, the national environment is represented by the Department of Health and Human Services (formerly DHEW). The national scene also includes the professional health-planning community. Locally, the environment is characterized by political "conservatism" and provider prestige and power. Here, conservatism refers to a strong belief in regionalism and local autonomy; it is anti-bureaucratic. Within the region, of course, there is the familiar problem of rural vs. urban interests and perspectives as well as the problem of local autonomy for the various counties and municipalities involved. This is another way of saying that the HSA region is an artificial community at the present time and that while autonomy for the region is strongly preferred over central control, consumer identification with their home towns and counties is a potential threat to a regional spirit and the achievement of regional objectives if some sacrifice is required in the allocation of health services. That is, in a world of real communities, the staff has the difficult task of integrating an artificial one. Operating within these environments, staff members at Mid-State HSA have three major sets of goals: professional, material, and political.

Professional goals have to do with health planning for a community and all that this entails: the use of professional techniques to identify problems, the setting of objectives and priorities, and the mobilization of resources to achieve the objectives. Planning is precisely what these health professionals have been trained and hired to do. The central documents embodying the professional goals are the Health Systems Plan (HSP) and the Annual Implementation Plan (AIP); all else is tested for "consistency with the plan." The essential requirement for doing health planning is the availability of resources—in this case, support staff, salaries, consumer and provider bodies, etc.

However, maintaining these resources—especially salaries—comprises the material goals of staff. Job maintenance is an important objective at Mid-State HSA just as it is in any organization. This objective is achieved primarily by satisfying as many of the demands for accountability imposed by HHS as can be satisfied without jeopardizing other important objectives. Some cost containment, for example, must be demonstrated. But aggressive cost-containment programs might require taking an adversarial position vis a vis providers, exposing the health-planning efforts to dangerous attack and withdrawal of support from this potent sector. Thus cost containment cannot be the major objective, although some results must be shown to satisfy the funding agency (and ultimately the Congress). The more immediate goals appeared to be the acceptance of health planning within the local environment and the legitimacy of the HSA's decisions. These were apparently the political goals of the Mid-State staff. These goals appeared to be extremely important to staff members—so much so that "militant" consumers were seen as not helpful in the overall effort. Ultimately, the political goals were attached to professional and material ones: one staff member envisioned the day when local funds would take the place of federal funds in health planning. In that case, local support would be indispensable for the maintenance of jobs and professional activities.

The point to be made is that the staff is at the intersection of several "environments," each of which has its own demands. To serve each—and thus to serve its own interests—required a balancing act by the staff. This balancing act involved the subordination of consumer control—more specifically by means of maintaining the isolation and ignorance of consumers.

Health care in general appears to be a tangle of shared interests and conflicting interests. Better health care, reduction of mortality rates, etc. can be presumed to be among the interests of providers as well as consumers (though perhaps for different reasons). The problem is that the provider version of health care tends on the whole to prevail. Whatever conflicting interests there are, and there are many involved in cost-containment, are swept aside.

There is, of course, an alternative explanation. People want better health care and are willing to accept and pay for the provider definition of "better." This cannot be clearly refuted here, although we can note that the consumers surveyed do not tend to support such a statement with respect to costs. We can only say that consumers in the Mid-State HSA were selectively recruited, socialized, and promoted in such a way as to minimize the possibility of purely consumer interests being on the agenda.

Making consumers representatives of organized constituencies would probably be an improvement. But even this step would not deal with underlying structural problems—independent political jurisdictions and hospitals, the market forces involved in pushing technological advances, and others. Nor would this step deal with the problem of staff as an interest group very well, barring any other changes. Consumer representatives might well intensify the conflict, but without any other basis for remedies, that might be the extent of it.

In the absence of any fundamental changes in the organizations and control of health care in the U.S., it may be that stabilizing the situation of the staff would accomplish as much as anything else. The staff of the Mid-State HSA was preoccupied with the legitimacy of the agency and its survival beyond the immediate future. From this perspective, it appears that the American tendency to experiment with programs and then discard them when the short-term results are disappointing almost guarantees program failures. Staff members can hardly avoid becoming preoccupied with security issues, which necessarily entails placating powerful groups. In the existing scheme of things the staff is seen here as a key to the success of democratic control over health-care and other institutions. Only the staff could offset the ignorance of the consumer and see that consumer interests were placed on the agenda through its recruitment practice. That the staff did not do so is seen as more of a reflection of its own precarious position than anything else.

Summary

The perspective adopted was that staff is one more group of professional experts confronting the consumer directly, the others being the various categories of providers. Staff members have their own professional identity (health planners), ideology, and objectives. Consumers are instrumental in the achievement of these objectives and need to be carefully recruited, socialized, and controlled.

The recruitment of consumer members in the Mid-State HSA was largely in the hands of the staff, who had formulated fairly clear criteria for the purpose. Consumers should be interested and pro-HSA; they should be able to say no to providers on occasion, and represent some kind of constituency, yet recognize their common purpose with providers; and they should have a regional view of health care rather than a strictly local view. The consumers' level of knowledge of the technical matters involved should be low, promoting dependence on the staff. The kind of consumer recruited is of considerable importance to the staff, and the consumer characteristics sought were related to certain practical and professional interests of the staff (see Table 1).

On the surface, it would appear that at least some of the traits desired in consumers were inconsistent with each other. For example, representing a constituency would seem to be opposed to the goal of common purposes to be pursued with provider "colleagues." There is some inconsistency; however, it was argued that the staff is consistently attempting to manage and control the diverse forces that impinge on the agency and its employees through the process of consumer recruitment, and that the management of these forces is perceived to require a careful and subtle balancing act.

The strategy of the staff, taking all things together, appeared to be one of selective recruitment of consumers so as to reduce overt conflict and to increase the acceptance and legitimacy of the agency. An important part of the strategy was to secure provider acceptance of and cooperation with the HSA mechanism, so that some planning and some cost containment could be achieved. The informal criteria adopted for consumer recruitment had as their focus the simultaneous pursuit of professional, material, and political goals within a multi-dimensional environment. Only when we see consumer recruitment in this or some similar way do the often conflicting requirements make sense.

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