Toward Rationalization and Integration of Urban Health Bureaucracies

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The urban health crisis derives in part from the widening gap between urban fiscal resources and needs. That gap reflects massive changes in the urban tax base as industries and high income (white) populations move out of central city jurisdictions in large numbers (*1*). These changes seriously impair the ability of the central cities to bear the maintenance costs of the rapidly disintegrating social infrastructure or to finance a broad

array of new social services. As large numbers of poor people have moved into urban areas, bringing with them the health problems associated with poverty, the demand for health services in the cities has increased dramatically (*2*). Increased demand has taxed already burdened private-voluntary and public health systems.

Despite new Federal programs to ease the burden and to provide basic health care to the medically needy, accessibility remains a critical problem, both for newcomers and for long-term residents. Modest increases in the numbers of physicians and hospital beds have been induced by new governmental efforts, but these are largely cancelled out as suppliers raise their fees, confident that nearly limitless Federal funds are available. The net effect of programs like Medicare and Medicaid has been to push health costs upward at a higher rate than relative improvements in personal incomes, resulting in the systematic pricing of ever larger numbers of people out of the health care market.

Historically, Federal health policy has emphasized indirect intervention in the health care market in an attempt to influence costs (for example, Hill-Burton hospital construction funds). There has been the tacit assumption that the institutional structures comprising the health care market could adequately service the population if the financing problem were solved. This assumption, we would argue, is erroneous. Indeed, it can be demonstrated that failure to deal directly with the structural-institutional aspects of the health care system stymies any efforts to control costs or improve services. Our thesis is that Federal attempts to solve urban health problems actually encourage the steady fragmentation of urban health bureaucracies, limiting their capacities to cope with growing health-welfare problems.

The following analysis of the destruction wrought by increasing Federal involvement in the urban health arena emphasizes the immediacy of the need for control. In the past decade, the nation has witnessed the creation of agency after agency, each charged with solving massive social problems whose enormity seemingly increases with the number of agencies. Surely the evidence of the 1960's indicates that we must introduce some control mechanism into urban health systems if they are to serve anyone or to solve anything. We contend that recent history itself is the strongest evidence for the need to restore the power of action to fragmented and impotent urban health systems. The Federal Government's involvement in health has been massive, but misguided, and we propose that the trend be reversed.

Federal Involvement and Fragmentation

Direct Federal involvement in community affairs had expanded dramatically by the late 1960's. Federal grants to States and local communities quintupled between 1958 and 1970; these grants also increased as a proportion of Federal expenditures and of State and local revenues (*3a*). Increased Federal funding accompanied a radical departure from traditional intergovernmental relations. Before 1960, Federal involvement in local affairs was seen primarily as a means to help States and communities realize their unique policy objectives. Under the Federal grants-in-aid programs of the 1960's, however, local agencies were conceived as executors of the determined objectives of the Federal Government. Sundquist has pointed out that "The program remains a *federal* program; as a matter of administrative convenience, the federal government executes the program through state or local governments rather than through its own field offices, but the motive force is federal, with the states and communities assisting—rather than the other way around" (*3b*). In fact most programs introduced since 1960 to implement Federal health goals were developed under the aegis of the Department of Health, Education, and Welfare (HEW) rather than by local agencies. Table 1 illustrates how pervasive the Federal administrative process has become. The concurrent formation of local client agencies to administer various programs supports Sundquist's notion of a motive Federal force at the local program level.

National objectives dictated close monitoring of all phases of program planning and implementation at the local level. National policy planners believed that local governments could not be entrusted with responsibility for attaining those objectives. First, local governments suffer under the yoke of unsympathetic, rurally oriented State legislatures, which often retain many fiscal controls over cities, such as local tax structures, bonding ceilings, and school district organization. Second, rigid civil service systems make the creation of new jobs and the elimination of old ones exceedingly difficult. Third, city service agencies control few of the major health resources generated and distributed in their areas, since the pri-

Table 1. Federal administration of local health programs

Program	Year established	Federal administrative agency
Medical assistance for the aged	1960	HEW
Community health services (chronically ill and aged excluding patients with heart disease and cancer)	1961	HEW
Radiological health and institutional training	1962	HEW
Air pollution control and prevention [1]	1963	HEW
Communicable disease activities	1964	HEW
Community action programs [1]	1964	OEO
Administration on aging	1965	HEW
Medical assistance	1965	HEW
Dental services and resources	1965	HEW
Health manpower	....	HEW
Disease prevention and environmental control	....	HEW
Health services	....	HEW
Mental health [1]	....	HEW
Comprehensive health planning and services [1]	....	HEW
Comprehensive neighborhood health centers [1]	1966	HEW OEO
Regional medical programs [1]	1966	HEW
Model neighborhood health programs [1]	1967	HEW HUD

[1] Denotes formation of local client agency.
SOURCE: Reference 3c.

vate-voluntary sector is independent of local public control.

In recent years the Federal perspective has broadened to encompass a more comprehensive view of health problems (comprehensive health planning, regional medical programs, model cities programs, and so forth), but a corresponding awareness of the complexities of local institutional environments has not been forthcoming. Thus, the Federal Government's decision not to vest new program responsibilities in old city health agencies was not surprising. Lacking confidence in the ability of these old agencies to pursue innovative objectives, the Federal Government created new local client agencies to insure the faithful execution of national policy. In Detroit, for example, neighborhood health clinics run centrally by the city health department co-exist with health clinics in close proximity run by the Mayor's Committee for Human Resources Development (OEO) with little or no concern about service overlap. The Federal Government did not consider that the institutional incapacity inherent in the urban environment itself was a major impediment to the realization of any urban health objectives. What was required was not agency creation, but institutional reform.

Federal control over local politics and local administration, however, has been historically attenuated by the American system of checks and balances. Precisely because the American system retains much of its historic federalism, Federal creation of new local agencies does not lead to more effective and coordinated administration. Rather, the many new agencies are absorbed into an already fragmented federalized structure. Attempts at administrative coordination at the national level (HEW, HUD, OEO) have not been paralleled locally. Sundquist has perceptively noted this trend. He stated that "The 'coordinator of the month' at the Washington level created his counterpart 'coordinating structure of the month' at the community level" (*3d*). Table 2 illustrates the lack of true coordination in most urban areas.

In short, the creation of new local health agencies has not solved difficult social problems but has promoted greater institutional dysfunction. Most city agencies, whether locally or federally oriented, are powerless to combat the nation's urban health crisis. The emerging pattern is one of rapidly pyramiding bureaucracies—deliberately isolated from each other, short-lived, and generally dysfunctional. Their built-in propensity for

Table 2. Competing local and Federal "coordinating agencies"

Local coordinating agency	Federal coordinating agency
Community action agencies	OEO
City demonstration agencies (model neighborhoods)	HUD
Economic development districts	Commerce
Overall economic development program	Commerce
Cooperative area manpower planning system	Labor
Concentrated employment program	CEP
Comprehensive health planning agencies	HEW
Neighborhood service centers	OEO HUD Labor HEW

failure is reinforced by their subsequent performance. Failure initiates the formation of still newer agencies. Subsequent resource-allocation decisions gradually exclude existing health institutions, and dysfunction is perpetuated ad infinitum.

Bureaucracies and Social Change

The foregoing model of destructive bureaucratic competition is a gloomy diagnosis of the condition of urban health care systems. We would suggest two analytical yardsticks with which to begin monitoring the identified bureaucratic process and initiating a condition of rational control. The first yardstick is to measure the bureaucratic proliferation at local levels (that is, the balkanization effect). Because the American political ethic dictates the rapid institutionalization of new policies into resource-allocating agencies, this measurement would identify the current bureaucratic chaos as a function of alternative strategies developed to solve health and welfare problems. The second yardstick is to gauge the relative social profitability of investing money in new local agencies as opposed to spending it to revitalize existing ones.

Three hypotheses to use in investigating the balkanization of urban health bureaucracies complement the aforementioned analysis. All three are relevant to evaluating the impact of Federal health programing both on the local health infrastructure and on federally supported progams.

HYPOTHESIS *1*. The amounts of municipal health appropriations and of Federal health expenditures for new programs in the same urban area are inversely related.

COROLLARY: The increasing presence of federally supported programs acts as a deterrent to higher investments in health by local entities.

HYPOTHESIS *2*. Health management, planning, and administrative resources are perfectly substitutable. As new resources create new bureaucracies, career options for health professionals expand.

COROLLARY: Since the ability of new social programs to recruit personnel from relevant disciplines is controlled by external factors, "new" bureaucracies depend upon the mobility of "old" bureaucrats whose aggregate sum of skill and experience is partially conditioned by previous failures. The outcome is an increased probability of failure of the "new" program.

HYPOTHESIS *3*. Each stage in the bureaucratic cycle or movement along the bureaucratic frontier is attainable at relatively higher overhead costs.

COROLLARY: The capacity of new health bureaucracies to produce direct health services is progressively smaller as more of their resources are used for overhead costs. Recruiting costs, duplicating costs, and fixed costs are higher for the new agencies, and fewer economies of scale are possible since their operations are characterized by small outputs and short institutional lives.

These hypotheses can be tested with such descriptive-qualitative data as patterns of historical funding, of linkages between "old" and "new" bureaucracies, and of professional career shifts and opportunities. Research of this type would be a valuable instrument for policy planners trying to decide whether to rejuvenate old agencies or to build new ones. For example, research ought to determine whether the Model Cities agencies or central city OEO bureaucracies have been distributing health services more effectively to target populations than city health departments. It may be that given equivalent resources, city health departments could do the job as effectively and at far less cost. Certainly the particular institutional histories of each urban area deserve careful analysis in order to ascertain the most appropriate Federal investment strategy.

The accelerated creation of new urban health agencies has had three immediate effects which cast doubt on the wisdom of the "new agency" approach. First, Federal intervention has encouraged the flow of scarce health resources from old to new agencies at the expense of the old and not necessarily to the advantage of the new. New methods have not always accompanied the birth of new agencies. The continuous movement of old professionals, with old ideas and unchanged abilities, along the bureaucratic frontier often renders new agencies obsolescent even at inception. Second, this "scavenging" drains older health agencies of any problem-solving capability they may have developed and virtually eliminates them from effective competition for new resources. The condition is aggravated by the unwillingness of local governments to support older health bureaucracies when they know that Federal dollars flow more readily to newer agencies. Third, bureaucratic fragmentation creates its own analog among newly activated constituent-consumers. Citizen participants, for example, emerged within the poverty program; another group arose to participate in the Model Cities program, and a third within the Comprehensive Neighborhood Health Centers' programs. Some of the participants no

doubt belong to more than one group, but the net effect on the poor has been to fragment their growing political activity, dissipating their potential strength within the competitive bureaucratic infrastructures. Indeed, having prevented the emergence of a monolithic, politically potent group of consumers, the new bureaucracies have co-opted central city residents, in effect creating "participatory elites" by providing some constituents with semiprofessional training in the workshops of a given service agency. The great test for emergent consumer participation in urban health care, therefore, is whether these consumer elites can overcome their natural competitive political instincts and pressure urban health bureaucracies to coordinate and consolidate their efforts.

Integrating the Health Delivery System

No alternative to the existing situation can be implemented without first building a consensus for structural reform among urban health actors. All must place the consumers' need for critical health services above petty political infighting if the goals of rational decision making and equitable health services delivery are to be realized and sustained. Internally oriented bureaucratic priorities must be exchanged for ones that are consumer oriented, whether this exchange is accomplished voluntarily or through a system of incentives (perhaps applied by the Federal Government by means of strategic channeling of funds) and regulations.

With three innovations, we could begin to build a health service system oriented to the consumer. The first innovation would be the establishment of autonomous organizations of health constituents at the community level which have strong links to the allocators of health resources. Currently, in most urban settings, few distinctions are made between distribution of resources and delivery of services. The result is multiple bureaucracy and redundant rather than complementary service activities. Moreover, health bureaucracies tend to ignore citizens' demands or to accept citizens' participation but keep it peripheral and subordinate. Citizen groups must be given the power and the resources to plan meaningful, substantive health service programs for implementation in their own communities. With the support of regional resource-allocating institutions and the health professions, new and dynamic programs could be fashioned and implemented. Furthermore, community-level health organizations should be geographically coordinated to avoid duplication of effort and fratricidal political quarrels.

Second, research and development must be made an integral part of the health planning process. Data about consumer needs and demands are indispensable if patient care is to reassume its position as the primary concern of the health service system. Data and information that are properly integrated into decision-making processes could facilitate the emergence of equitable urban health services oriented to the patient.

Third, the entire health service system must become visible to the public and accountable for its actions. Current revenue-sharing proposals must allow States and localities to control significant allocations of public health resources. Both categorical assistance and grant-in-aid programs, for example, should be placed under the control of reorganized health service organizations responsive to patients.

Selection of Health Care Coordinator

Potentially, any of several actors in the urban health environment might become the coordinator of regional health care activities. Each alternative agency has its advantages, although none is without certain drawbacks.

City or county health departments. City and county health departments have the advantage of being well established on the urban scene and being in close contact with city executives. The introduction of research and development components and the expansion of these departments' political power would be substantially cheaper than starting new organizations from scratch. Certainly placing central city health departments in a position of preeminence assures that the city will have a voice in emerging regional health systems, a matter of some importance to city populations suspicious of regionalization. For precisely these reasons, however, city health departments have a strong vested interest in the status quo and may be loath to part with traditional methods, particularly in terms of granting real power to health care constituents. The need for specific Federal subsidization of research and development in urban health departments derives from the fact that if the new dollars given to those departments have not been secured from outside line-service budgets, they will flow into existing service systems.

These suggestions are not new. Nevertheless, most proposals for health reorganization fail to

emphasize the mechanisms which are available to health reformers, who must work with existing political and economic instruments. Some of these instruments may be applied to the elimination of duplication and dysfunction in the urban health environment. Spheres of authority must be established among nonredundant health actors in urban space and one actor chosen to coordinate the distribution of resources, to apply research results to patient care, and to translate citizens' grievances into effective political action. Health revenues could then be consolidated and the money applied in concentrated doses to improve the quality of health care and the delivery mechanisms and to create more feedback linkages between consumers and information. The powerful effects of large amounts of cash would no longer be diluted by dividing them among dozens of ineffectual and self-serving health actors.

Comprehensive health planning agencies. Comprehensive health planning agencies were mandated by Congress under the Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89–749) and the Partnership for Health Amendments of 1967 (Public Law 90–174), which provided funds for establishing State and regional health planning agencies and created a mechanism whereby consumers, public and private health providers, and the Government would plan the reorganization of health care systems. Unfortunately the Congress neglected to provide the agencies with much political power, and few regional organizations have reached the operational stage. Without regulatory powers, these agencies are finding it difficult to persuade private health care establishments to accept partnership with health consumers. Nevertheless, among the alternative actors, these agencies have the greatest chance to attain authority over the disbursal of Medicaid funds, which constitute the largest package of Federal health dollars spent in States and localities. With authority to set standards for the disbursal of noncategorical Federal dollars, comprehensive health planning agencies could gain an effective political foothold in the health services environment.

Health planning research and training programs. There is a considerable body of literature describing information systems at the hospital level which supports the notion that data and information are essential for the maintenance of an effective health services system (*4*). The strategic use of planning and data collection activities might also serve as political instruments for moving immobilized health systems. Health planning programs at universities could be of critical importance in providing the initial analytical and political stimuli to move rigid agencies in more progressive directions, because they have access to facilities for gathering data and for systems analysis which could enhance the problem-solving capabilities of health agencies throughout a given region. The consolidation and analysis of health care data by an objective third party free of political or bureaucratic bias could pinpoint specific problems on which agencies might collaborate effectively. Most university programs, however, would need greater financial resources if they are to build regional data centers for health care information.

Which of these alternatives could best fulfill the requirements and lay the groundwork for rationalized health care systems? The answer may vary from one metropolitan region to another, depending upon the relative strength of new comprehensive agencies and the relative fossilization of old specialized ones. Indeed, in some areas other alternatives may exist. The available options must be explored, and each region must make a decision based on its particular needs and resources. The necessary first step toward rational metropolitan health care systems, however, is for fragmented health bureaucracies to stop fighting and start talking, subordinating their own profit and prestige to the true purpose of urban health care —the prevention and cure of illness.

REFERENCES

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