Health Systems and New Careers

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Proponents of the new careers program, in which indigenous paraprofessionals are used to assist and supplement the work of traditional professionals have always found the health field to be the most complicated. Large-scale use of nonprofessional personnel is not new to the health scene, as was the case in education and, to a lesser extent, in social work. The "old nonprofessionals" (nurse's aides, attendants, and so forth), however, did not have the close connections with the populations to be served of the "indigenous" paraprofessionals; nor were there any notions of career advancement or reorganization of the health services themselves. In short, while tasks and roles were differentiated for the old nonprofessionals, plans for their career advancement and the reorganization of the delivery of health services were lacking.

Among the first health programs to use indigenous paraprofessionals were those concerned with migrants, maternal and child health, and family planning. Something more than a fifth of the personnel slots in the "Scheuer Amendment" program (initiated under the 1966 amendments to the Economic Opportunity Act) have been used in health programs. Also, of course, the neighborhood health centers (funded first by the Office of Economic Opportunity and later by the Public Health Service—Health Services and Mental Health Administration) have used paraprofessionals to a considerable extent.

Career development, however, has been much less of a reality. In fact, the most impressive efforts at career development in health have been in the old fields. One example is the program of New York City Local 37 of the American Federation of State, County, and Municipal Employees Union, in which training and education are built into jobs, allowing nurse's aides to become licensed practical nurses and allowing licensed practical nurses to become registered nurses. Another impressive effort in old fields, in the area of nondirect care, is the reorganization carried out by the California State Department of Public Health with its laboratory staff, technicians, and administrative personnel. I have outlined these various developments in another publication (*1*). Two publications of the National Institute for New Careers provide additional information on career development (*2,3*), and there is a burgeoning literature on allied health manpower (*4–8*).

Training nurses to be pediatric nurse practitioners and former military corpsmen to be physician's assistants can be viewed as limited examples of career development (*9–11*). These two activities, however, should not be given too much emphasis since they affect few people—by the end of 1971, a total of 152 physician's assistants had graduated

in the entire United States (*12*); they provide only very limited opportunities for advancement; and they are suspended in space with very restricted points of entry and no articulated paths for advancement. Further, they perpetuate the sex segregation of the health field. Physician's assistants have been hailed as a new panacea and have even inspired two new television series, but their contribution to a new design of services is likely to be small. And if the Indochina War ever ends, the main source for their recruitment will dry up!

Current Stage of New Careers

The goals incorporated into the new careers design are bold and diverse. The first of these broad goals has been to incorporate into jobs at the simplest level the training that will lead to careers. Some agencies, however, have reduced this "simplest level" below what appears to be the irreducible minimum and have sought merely to provide paraprofessional employment that offers little training and less opportunity for advancement. As William Lynch, Jr., president of the American Public Health Association's New Professionals Section, has noted, "All they are doing is stuffing people in at the bottom." The second broad goal relates to the delivery of health services—the reaching of "new" consumers and the provision of new and improved services to both "new" and "old" consumers. An intervening variable, also, has been affecting the health professions and changing their practice, organization, structure, mores, and membership.

What has been achieved to date in terms of the new careers goals? Large numbers of the poor and minorities have been employed in entry level positions, and there is general acceptance that such persons can provide at least certain health-related services. Traditional services have been provided to many persons heretofore not served.

Also, but to a considerably lesser extent, new services have been introduced and new roles have been identified. Much of this effort, it is true, has been more like pouring old wine into new bottles; a great many new titles have been added, but little new work. The facts about the capability and performance of paraprofessionals and about community needs, styles, and interests have, to a limited extent, penetrated the consciousness of professionals.

Some initial interaction has taken place between professionals and organizations of health personnel. More of this interaction has been with unions, but interaction with professional organizations has also been increasing (notably the American Public Health Association and the American Academy of Pediatrics, but also the American Medical Association, the American Nurses Association, and so forth).

The other side of the coin is that few paraprofessionals have moved beyond their entry positions, health services have not been significantly increased or improved, the main features of the service systems are unchanged, and the monopoly of professionals is largely undiminished. Clearly more than could have been achieved in half a decade was attempted. Perhaps the greatest failure has been that even the proponents of paraprofessionals have failed to understand the relationship between the concepts of new careers and the reorganization of the delivery of health services. For example, the new proposals of Garfield at Kaiser-Permanente, the rural design at New Mexico, the proposals of Creditor and others, as well as the specific proposals and assumptions incorporated into national health insurance models (Kennedy-Griffiths' included), all posit the use of paraprofessionals (*13–18*). Yet none incorporate any notions of new careers; nor do they relate such factors to their systemic designs.

Whatever the gains in the first stage of new careers—and I have purposefully downplayed them—the present seems to call for new work unless we are to become mired in the real but limited gains made to date. Among the areas ripe for new developments, one can identify the building of career ladders (including jobs, training, education, certification, and licensure) that reach to full professional status as to role, pay, and recognition; the effect of new career designs upon service design and productivity; and the impact of new career designs upon the professional.

Jobs Versus Services

The nature of the new careers achievement and its limits, of course, relate in no small part to the structural situation in which the programs began. The "Scheuer programs," as part of the Economic Opportunity Act, and particularly as administered by the Labor Department, have focused on jobs for the poor, while holding to the minimum the issues of training, education, and impact on the service system. Programs for the employment of new careerists funded under legislation with a service focus (namely, family planning, maternal and child health, migrant health, and neighbor-

hood health centers) have faced other problems. These problems have included community pressure to provide jobs regardless of what opportunities the jobs offered for training and advancement, the difficulties of breaking into new fields and of formulating effective training designs, and the greater interest shown by grant-giving agencies in the employment of community people than in training and upgrading them.

An obstacle in the way of new careers that is more fundamental to the larger health scene is the failure of the traditional health leadership to regard the work which paraprofessionals perform as central to the tasks which they conceive of a health system performing. Driving this point home is the nonreimbursable nature of most paraprofessional work under third-party payment schemes.

The experience of current programs with new workers illustrates the difficulty. OEO centers in Chicago, for example, have nine levels of aides, but a person at the top level is not yet a recognized professional. This pattern of jobs hovering around the bottom is not unique to Chicago or to the OEO centers. Patterns elsewhere are no more encouraging. In some instances, paraprofessionals, such as family health workers, are being removed from their jobs and sent to school full time. This approach, of course, is not encompassed in the new careers design. It has led to difficulties in delivering services, as well as in maintaining general staff morale, since with limited resources only a few persons can be favored with the opportunity for full-time schooling.

In some career ladders, paraprofessionals have been able to move up to supervising other paraprofessionals but can never transfer into the mainstream of agency work. Even when neighborhood health centers are operated by, or as a part of, hospitals, there has been little articulation between the two systems, a lack which no doubt is in part at least an expression of the limited articulation between the two service systems.

What has occurred, in many instances, is that the paraprofessionals are encapsulated at the bottom to serve the angry, critical poor, who hitherto have not been well served. This arrangement has functioned to reduce the pressure from the community on the professional; the aides serve as buffers, a fact that accounts, in part, for the rapid acceptance of the paraprofessional without any reorganization of services or change in professional leadership.

Comparison with developments in the area of mental health suggest a way, however, through which new workers can be introduced to do work that is actually new. As mental health agencies moved to a mode of service delivery which emphasized the community and preventive approaches in place of following a primarily custodial model, the "old" staff was found to be inadequate. Thus, in Illinois, as a different service model was being adopted—with greater concern for "well care" in contrast to exclusive focus upon "sick care"—a new manpower resource was required. A major reorganization was initiated August 1, 1971, with the establishment of the new Patient Care Generalist Series. This series included more than 8,000 workers who had been in dead-ended specialized positions. These positions were transferred into a career ladder system that moves from entry positions to some top level posts. Progression is based upon job-based training, regardless of formal education, and upon satisfactory job performance.

Such a system incorporates the shortcomings and advantages of the parallel professional system. Nevertheless, by its very existence (and, more important, by its successful operation), such a system acts as a goad to, and stands as an alternative for, the traditional one. Yet without ties to formal educational systems or credit-and-degree-granting structures, it limits the mobility of persons who may seek to go outside of it. But a system with as many as 8,000 employees operating statewide cannot be dismissed as an isolated experiment. Apparently the key question, as for any alternative institution, is the institution's ability to affect (or even to become) the main institution. In terms of the workers, the question arises as to mobility between the two systems. The established order, in protecting itself, has often found it effective to encourage, to allow, or to permit to develop alternative patterns, which may drain off energy from the main health arena.

Other areas for comparison are within the health field but not in the area of patient care. These include positions in mechanical and technical occupations, laboratory services, vector control, administration, and so forth. Another similar cluster of work is in urban public health and relates to roles in urban and environmental extension. Still another area of opportunity is the trauma networks being set up under the Department of Transportation as part of State plans.

Yet another set of comparisons can be made between the new careers' experience and that of

the free clinics and physician's assistant programs. Each of these efforts, as Sidney Wolfe of the Health Research Corporation, a Nader project, has argued, in their own way have made their peace with the health structure as it exists and, thus, have failed to produce significant change. They all share the additional common feature of failing to involve significantly health consumers. Such involvement should include the sharing of information with consumers, the development of quality control measures incorporating measurable "health outcomes," and an assessment of the degree of benefit resulting from the encounter between "consumer" and "server." The use of devices for peer accountability and of fiscal controls, which then move to consider service quality, also deserve attention.

An example of changes which can be made is illustrated by the experience at Pittsburgh's Mercy Hospital. This hospital established a comprehensive community-based care system in which new workers were used extensively, emphasis was placed on prevention, and the self-care of patients was fostered. Key factors favoring the changes included the critical and continuing pressure from the community, which was directed not against the institution, but in behalf of a particular care system; the flexible funding enjoyed by a private institution, which was able to shift its own money; a key insider who was able to overpower the forces of resistance within and respond to the pressures from without; the institution's focus on service rather than on manpower—a focus which was not wed to any set of preestablished abstract models; and finally, the hospital's tactical use of evaluative results, both to affirm success and to lever for further action.

The flexibility of Mercy Hospital's operation contrasts with the rigidity of other systems. In other institutions, prepaid insurance systems, because of their policy of reimbursement for specific treatments, discourage preventive approaches and tend to encourage discrete medical services.

Another model is presented in the work of a Johns Hopkins team in Maryland, in East Baltimore and Columbia (*19,20*). In both communities, prototype Health Maintenance Organizations are being set up. Task analysis is used as the basis both for the training content and for measuring performance. Central to the delivery of services is a planned nonphysician family health team with a three-step sequence consisting of health advocate, health assistant, and health associate. The development of this design—and it is interesting that it is planned for both an inner-city poverty area and an upper middle-class suburb—is related to the establishment of a new school at Johns Hopkins (*21,22*).

Efforts such as these at Johns Hopkins and others in which new roles are proposed for new workers will, of course, affect the roles of present workers. In effect, new roles for some is bound to mean changed roles for all others with whom they interact. Issues which Rolf Lynton and his colleagues at the University of North Carolina have found worth addressing include the necessary shifts on the part of traditional health workers in perception of their roles and role performance, the identification of the key clusters of persons concerned with the delivery of health services, and the administrative environment in which service teams are to operate.

An approach with a different focus is being taken by Wilbur Hoff in California (*23*). At a neighborhood health center and a community mental health center, he is demonstrating the development of coherent manpower systems based upon task analysis. Using, as a basis, a systems analysis of all the operations necessary for the provision of health care to consumers, he will develop, try out, modify, and evaluate behavioral objectives, tasks, job descriptions, performance standards, and training requirements in respect to their effect upon training, trainees, health and education agencies, and the delivery of health services to consumers.

Whatever the analysis, credentials for these new workers becomes a key issue. The two traditional routes to obtain them in the health field have been for a new area to stake itself out as unique—and therefore outside of the purview of an already existing field and learning structure—or for a new area to be regarded as a subpart of an older area and to have its definition, regulations, and standards established by the "senior" discipline, as for example, licensed practical nurses in respect to registered nurses (*24–26*).

The general paraprofessionals, those in the categories of family health worker or with similar titles in neighborhood health centers and the like, do not have a discrete function; rather, their jobs are a hodgepodge of leftovers from social work, public health nursing, health education, field "doctoring," and so forth. The desire of the new workers for a credential stems partly from a desire to establish what it is they do and who they are.

A first step, then, toward providing these new workers with credentials is the definition of their discrete functions and body of skills—functions and skills appropriate to the delivery of mainstream health care to the rich and poor alike. The credential ought to be quickly obtainable, particularly for those who have had extensive work experience and inservice training. Finally, as a way of expressing the concerns of the new professionals for a different relationship between service providers and consumers, consumers should get involved in the credentialing process. Moreover, setting up credentials for paraprofessionals in this manner might act as a goad for similar action in other areas.

As we have learned in other areas, the very tools that are used for analysis have an impact upon the nature of the analysis and the type of programs proposed. The question is whether to examine the work of individuals or, to use Rolf Lynton's term, "health service units," that is, whether to focus upon the individual giver of services or the full delivery team. Similarly, there is the question of whether the analysis is to be in terms of the effect of either of these service units upon individual patients, upon families, or upon communities. A similar area at issue is whether the thrust for generalist job series or generalist classifications, which encourage horizontal mobility and staffing flexibility, may be (or may be perceived as) a way to manipulate workers. An intermediate position is that it may be possible to establish specific tasks within the context of a generic classification system. Another possibility is to describe specifically the series of tasks to be performed by a care delivery team. Unfortunately, however, so-called teamwork between professionals and nonprofessionals has too often been akin to the partnership of horse and rider.

New Careers and Productivity

The basic impact that the various new careers concepts, including authentic career ladders and the whole approach to work and study, can have on the character of the human service in question has to be spelled out explicitly. New careers has many connotations and extra meanings. Essentially, it implies the building of a new orientation to providing human services in any field. The movement is critical of the character and efficiency of professional practice. New careers proponents argue from the assumption that a good deal of the institutional and normative structure that surrounds a profession impedes its efficiency and development and that the profession frequently serves the server rather than the client. A major objective of the new careers movement is to produce a more powerful consumer ethos that will affect every aspect of service and every service giver. To realize this objective, the roles and leadership in the profession will have to be basically reorganized. The aim is to build a new profession and a new professional (*27*).

The new careers strategy is to try to produce a disequilibrium in the system. (But if the paraprofessional is segregated from the main structure, little tension and disequilibrium will occur.) Fulfillment of the demand for authentic career ladders that move beyond the credentials barrier will upset and disequilibrate the system, requiring to some extent a rethinking of traditional roles and the paths to them. The training hoax is exposed, because people start to raise questions about whether a prolonged period is necessary to achieve professional skill. This questioning leads to the study of the specific types of skills and knowledge required for given tasks and the methods of training and education which can best impart the skills and knowledge. What rapidly becomes obvious is that the traditional ways of doing things are exactly that; they are traditional and institutional, rather than functional. They are not based on an analysis of the work to be done and the requisite skills and knowledge to perform the tasks (*28*).

The new careers program attempts to break the professionals' monopolistic leadership in a variety of ways:

- through demands to repattern education and to relate field training to academic courses (*29*)
- through calls for new training models that build upon cross-socialization and cross-training so that the new worker can affect the old, as well as vice versa (*30*)
- through consumers' acquiring a great deal of inside-the-system knowledge by working in the system—provided they are not cut off from advanced knowledge in that system (*31*).

To the extent that performance evaluation evolves and genuine analysis of tasks takes place, these procedures can have an impact on changing the health system and the professional leadership in it.

We are not suggesting that the demand for new careers and the related mechanisms for achieving them will necessarily, or immediately, result in reorganization of professional roles and produce

more services, but the demand is an element, a pressure, which if consciously understood and united with other trends, may lead to some real change in productivity.

It will be necessary, however, to arrive at a clearer understanding of the nature of future models for health service delivery so that we can envision what the new training and education might be. Achieving such an understanding is an extremely important dimension of the strategic thrust of new careers. To simply talk, as many professionals do, about the need for restructuring the delivery of service without specifying the character of that service leaves us largely at the rhetorical level. And, thus far, professionals have largely resisted a goal-oriented analysis of tasks, an analysis that might result in changing their systems of work (*32*).

Strategy

In working out a strategy, account needs to be taken of basic contextual factors of the health system. There is a health system—despite analyses which, in focusing upon the system's inadequacies, lead to the belief that no system in fact exists. Sumner Rosen, Institute of Public Administration, New York City, has cogently noted that its existence is felt when one tries to change it. But the system is in trouble and, at least equally important, it is also seen as being in trouble. This is a time that is generally hostile to major social and institutional changes. Yet the skyrocketing costs of health care, if nothing else, demand some form of public intervention. Also, a number of forces are at least tending toward an increased, but as yet unclear, role for health consumers.

The problem facing the developers of strategy for new careers is how to convert tendencies which are operating in the direction of change into desirable and real changes, how to set a timetable for change and its parameters, and how to identify allies and enemies so as to marshal the allies and at least mute the enemies.

To work out a strategy requires some clarity as to goals and an identification of the tactics available for use at a given time. In addition to the contextual issues just noted, a better understanding is needed of the exact nature of the health crisis. What is its shape? Whom is it hurting? Whom is it benefiting? How do various groups perceive it? What are the proximate and deeper forces which produced it? Who will get what and at what costs to whom in the various proposed "solutions"?

To an extent, clarity can be gained from comparing the special character of the health system with other systems of human services. In such a cross-sectoral analysis, consideration would have to be given to the meaning of technical proficiency and the technological apparatus, the fragmentation of care, the mystique of the medical field, the power of the medical caste, the role of licensure and other forms of control of supply, the difficulty of maintaining the participation of health consumers (in contrast to the situation in welfare and education), the special difficulties of measurement and assessment of quality and productivity, the lack of a systematic preventive approach, the broadening areas of concern outside of direct service, the patterns of funding, and the extended and elite process of physician training.

In formulating a strategic design, planners need to consider carefully the constituencies involved. While the inadequate care of the poor seems to be a given quantity, their involvement in changing the health care system seems at present to be more potential than actual. The unions, whose health fringe benefits have been eroded by cost escalation, are central players. Of course, unions of health workers are of key importance, particularly with their growing membership of blacks and other minority groups. Another potential force is the women's movement, as well as consumer groups (note Nader's move into the health field with the establishment of the Health Research Group). Those health professionals who are liberals, reformers, or radicals have been, and will continue to be, key figures; this group, it would seem, will be augmented by the new student groups. There even seems to be some stirring in the American Medical Association and the American Public Health Association, organizations which have apparently decided that the new professionals give them a new face.

The tax and cost crisis in the public sector is an ever-present factor. Health care costs are enormous and growing. There is little in the way of increased productivity, although the allocation of ever-increasing amounts of money for health continues (7.4 percent of the GNP in 1970). And the health system competes with other social systems in the society, such as education and welfare.

In many ways this is a period of ebb, restriction, contraction, and counter-attack—a time of assault upon egalitarian ideas and on notions about redistribution of wealth and power (*33*). And yet,

simultaneously, other broad forces seem also to be at work. There is a continuing growth of, and interest in, public service employment, new concepts of rights and entitlements are being developed, community participation is increasing, women and youth movements are becoming more active, and many professionals are seeking new forms of work and new kinds of relationships. The dangers are not only from the "enemy;" they include the nihilism of some and the enchantment of others with the diversions of alternative systems.

For the advocates of new careers, this is a period to join with the new professionals and supporters of new systems of service delivery and to set priorities; to establish both long- and short-range objectives; to work out direct and indirect approaches; to identify, isolate, or neutralize opponents; and to mobilize, consolidate, and expand supporters.

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