Toward A Local Solution

Recent congressional and Administration actions directed toward consolidation and decentralization of federally financed health programs have been greeted with considerable skepticism and anguish by many national health leaders. Aside from concerns about decreased overall funding, limited local ability to administer these programs, and the possibility of State and local political problems, there is a strong underlying sentiment in much of such criticism that centrally operated or rigidly controlled programs are "better," that is, more effective and responsive. This feeling runs counter to more than 25 years of experience in the delivery of health services to American Indians and Alaska Native communities.

Addressing the health problems of America's most underserved populations over these past 25 years has taught us that there are no universal solutions. American Indians and Alaska Natives by and large are economically deprived, geographically isolated, rural populations who exist in small, scattered, remote locations. Although great strides have been made during this time, their health status continues to lag behind that of the general population.

At first glance it would appear that the problems of the various Indian tribes and Alaska Native communities—over 500 in all—are probably common, and the solutions no doubt similar. Nothing could be more deceiving. What works in community X will be a dismal failure in community Y. The standardized government model or solution is an impediment to health progress in such tribes and communities. Progress has only begun to emerge in the last few decades when ingrained paternalism has slowly begun to give way to local planning and self-determination. Such a process is uncomfortable, desultory, agonizing, and demanding.

It is not neat and it defies a PERT chart. It is not uniform in scope, dimension, or timing. It is the antithesis of the uniformity and standardization demanded by Washington administrators and bureaucrats. It only has one thing going for it—IT WORKS.

The solutions to the health status and health care access problems of American Indians and Alaska Natives—who on the surface appear a homogeneous group as regards many health care factors—vary greatly. When such observations are expanded to the United States as a whole, and such differences as rural versus urban, economic access, race, environmental exposure, culture, and geography are considered, simple logic dictates that the solutions must be even more varied and diverse. Yet, until recently, many programs designed to improve access and health status have displayed a frightening quality of standardization and universality. The strategy has been for academia or bureaucracy to design the "model," mass produce it, and transport it to diverse communities for implementation. It is a neat process that can be stated effectively and efficiently. It is a quantifiable, easily described product that can readily be reduced to numbers and tracked diligently by administrators. It has only one major flaw—it usually does not work. If health problems are to be solved, local planning, priority setting, decision making, implementation, and evaluation are imperative.

Resources are limited, and it is foolish to believe that over the next decade we can expect a significant growth in resources dedicated to improving health status. The Federal Government's role will not cease; rather it will change. No longer will the detailed uniform blueprints from the banks of the Potomac flow to the Bronx, Biloxi, Peoria, and Broken Bow, Okla., for standardized implementation. Funds and technical assistance will still be supplied—perhaps in more limited amounts—but local communities will decide how to assemble such raw materials. The onus for making tough decisions will rest on local communities—the only locus where such decisions can be made in an enlightened fashion. Categorical programs designed for all communities despite their vast differences will give way to block grant assistance, and detailed requirements will be replaced with general guidelines.

Will there be mistakes and unmet needs? Of course. The process of community maturation is not that different from the tumultuous emergence of the adolescent into adulthood. Responsibility is not easily acquired but necessitates a process of trial and error, give and take. However, such hard-earned maturity results in stability, enlightenment, and benevolence, essential ingredients of a healthy community.

The process will be circuitous, at times disappointing and confusing, but ultimately it will work.

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