Establishing National Health Goals and Standards

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SYNOPSIS ....

Four statements of national health goals and standards were proclaimed from the U.S. Department of Health and Human Services during the 1970s. Two were based on statutory mandates—the National Guidelines for Health Planning and the Model Standards for Community Preventive Health Services. Two were the results of administrative initiatives—the Forward Plans for Health and the complementary publications "Healthy People" and "Promoting Health/Preventing Disease." These efforts present a variety of approaches and experiences and can provide direction and lessons for future endeavors along these lines.

The four issuances include guidance on national priorities, resource standards, and accessibility to care. They also offer goals and objectives for local services and health status. They address a multiplicity of issues, ranging from hospital bed supply and recommended uses of specialized medical equipment to infant mortality and proposed reductions in death and disability. Almost all urge further actions to prevent illness and promote health.

The development of statements of national health goals and standards has been advocated by some experts and questioned by others. Advocates believe that these materials can help clarify purposes and priorities for health programs, resulting in more effective and efficient uses of resources and greater accountability. Critics are particularly concerned about deleterious impacts on creativity and local initiatives.

Among the major lessons identifiable from these undertakings is the importance of committed leadership, broad-based consultation, and reliable data. Implementation inevitably encounters the complexities of the health system and depends upon available resources. In influencing the agenda of deliberation and debate, the symbolic value of these statements may often be more significant than the specific details. The continuing interest in these approaches suggests that future efforts along these lines are likely.

NATIONAL HEALTH GOALS AND STANDARDS for the United States have been proclaimed in four statements in recent years. The Department of Health and Human Services (DHHS) and many other public and private agencies throughout the country have invested substantial effort in their development and dissemination. It is too early to determine the long-term impact of this work, but the broad scope and frequency of these endeavors—and the prospect of similar activities in the future—indicate widespread interest in these approaches.

Two of the statements resulted from statutory mandates. One of these mandates, the National Health Planning and Resources Development Act of 1974, called for the formulation of national guidelines for health planning, based on a set of specified national health priorities. The other, the Health Programs Extension Act of 1977, required the establishment of model standards for community preventive health services.

The other two statements resulted from administrative initiatives. In the early 1970s, a series of Forward Plans for Health were issued by the Public Health Service (PHS). In the latter part of the decade, health goals and related objectives were set forth in two DHHS publications, "Healthy People" and "Promoting Health/Preventing Disease" (*1, 2*).

In this paper, I review the four efforts, considering first their purposes and problems. Finally, I discuss common experiences and issues to identify lessons for the future.

Purposes and Problems

Statements of national health goals and standards are aimed at clarifying the purposes and priorities for

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health programs. They seek to stimulate and reenforce the consideration and endorsement of desired ends and of the appropriate actions needed to achieve them. Such declarations, their advocates hope, will result in the formulation and adoption of related policies, strategies, and implementation actions that will give direction to health activities. Supporters anticipate that these efforts will contribute to more effective health care and more efficient use of health resources.

Many critics have bemoaned the lack of coherent national health policies, believing that this failing has led to contradictions in Federal and other health programs and to unnecessary controversies and costs. They argue that in both the public and private sectors, wasteful duplication and lost opportunities have resulted from failure to rationalize health goals and to set standards for health services.

Advocates of national statements suggest that many important purposes can be served by clarifying national health goals and standards, including the following:

- Help ensure consistency among Federal health programs;
- Improve relationships and coordination among national, State, and local agencies;
- Focus the attention of public and professional groups on the services deserving higher priority;
- Further an understanding of neglected opportunities; and
- Improve accountability and efficiency in the use of costly resources.

For example, the lack of consistency among Federal health programs has been of serious concern to many health experts. Differences between Federal health care financing programs (for example, Medicare and Medicaid) and other Federal health programs have been deplored. Federal health care financing programs have emphasized the support of institutional care, whereas other Federal programs have focused on ambulatory care and prevention.

Similarly, many administrators and analysts have pointed out the need for better coordination of national, State, and local activities. These issues become more serious as budgetary shortages become more common among both public and private sponsors. A principal role of the national government under the "New Federalism," it has been argued, is to offer policy leadership.

Reform, rather than efficiency, is the primary interest of some supporters of efforts to extend national leadership. They desire higher priority and added resources for particular programs and hope that clearer national goals can contribute to fulfilling these desires. The proponents of public health programs are often among these groups.

Goals and standards can provide benchmarks against which to measure progress and to extend accountability in the use of available resources. The evaluation of performance has frequently been confounded by lack of clarity and specificity in the definition of aims. Guidance on the effective and efficient use of scarce and expensive resources can encourage more careful examination of existing and proposed practices.

Numerous problems, however, complicate efforts to establish national health goals and standards. The many interests involved in providing health services present a wide variety of aspirations and perspectives. Advances in knowledge and technology, economic pressures, and different public and professional concerns create continually changing conditions. As a result, some observers conclude that the health system is so diffuse, complex, and uncertain that effective and useful statements of national goals and standards are not possible (*3*).

"If health policies are fragmentary, tentative and halting," one expert has commented, "so are economic policies, labor policies and welfare policies. Those who would function in a democratic society must learn to live with inconsistency and compromise" (*4*). Others argue that disorder and pluralistic approaches foster creativity and growth and that decisions about goals, standards, and resource allocation are best made in the private marketplace. They view efforts to order national goals and priorities as likely to be an unproductive enterprise, mischievous at best and dangerous at worst.

Other problems have also been identified, such as the following.

- Formal adoption of a given set of goals and standards can make innovation more difficult.
- Too simplistic approaches may ignore or underestimate the great variations in conditions and practices throughout the country.
- National statements may encumber or divert local and State efforts.
- Goals may be too general and ambiguous to be useful.
- Inadequate data can result in excessive attention to items that are measurable but of lesser importance than other issues.
- Setting goals and standards can become an end in itself and divert attention from needed action.

Further, the process of setting goals and standards can create conflict and tension. One observer has pointed out: "The difficulty of national goals is that they too quickly become standards by which to judge not the future but the present. They institutionalize the creation of discontent. The setting of future goals, no matter how distant, drains legitimacy from present conditions. Once it is established and agreed upon that the future will be very different from the present, it is absurd to be content with the present" (*5*).

Despite the actual and potential problems, attempts to establish national goals and standards have been undertaken frequently. Private commissions as well as public agencies have joined in such endeavors (*6*). As high expectations and demands strain limited health resources in the future, the interest in efforts to set clearer choices and greater order may increase even more. A review of four efforts in the 1970s to set goals and standards can provide lessons for subsequent undertakings of this nature.

National Guidelines for Health Planning

The first section of the National Health Planning and Resources Development Act of 1974 (Public Law 93–641) calls for the Secretary of Health, Education, and Welfare to issue national guidelines for health planning. These guidelines are to include a statement of national health planning goals and standards respecting the appropriate supply, distribution, and organization of health resources. To the maximum extent practicable, the goals are to be expressed in quantitative terms. In formulating them, the Secretary is required to consult with local and State agencies, associations, and specialty societies representing medical and other health care providers, the National Council on Health Planning and Development, and other interested groups.

A principal purpose of the national guidelines is to inform and assist local and State health planning agencies in formulating their plans and their review criteria. In an evaluation of earlier health planning efforts, "the deliberate posture adopted by the federal government of refraining from formulating a national health planning policy or anything that might resemble one and from furnishing guidelines to local health planners" (*7*) had been criticized.

The act itself sets forth an overall goal for the health system of "equal access to quality health care at a reasonable cost." The act also includes a number of national health priorities for consideration in the development of both national guidelines and local plans. Ten such priorities were specified originally, and seven more were added in later amendments to the act. As the following list of the national health priorities (each identified by the statutory number) shows, seven are concerned with the delivery of health services, six with the organization of these services, and four with cost containment.

Delivery of health services

1 Primary care to underserved populations
6 Quality of care
8 Prevention of disease
10 Education of public concerning personal health care and health services use
14 Hospital care for mental patients
15 Outpatient mental health services
16 Emotional and psychological aspects of prevention and treatment.

Organization of health services

2 Multi-institutional systems for coordinating and consolidating institutional services
3 Medical group practices, health maintenance organizations, and other organized systems of care
4 Physician assistants, including nurse clinicians
5 Multi-institutional arrangements for sharing support services
7 Geographically integrated systems of care
17 Competition and consumer choice

Cost containment

9 Cost accounting and reporting and cost-saving technology

11 Energy conservation
12 Duplicative or unneeded services and facilities
13 Appropriate use of services and system efficiency

After a series of public solicitations and conferences, the DHHS staff drafted statements of potential national health planning goals, which were endorsed by the National Council on Health Planning and Development but not formally issued (*8*). The goals concerned health status, health promotion and disease prevention, and access to services. The priorities were to reduce infant mortality, increase immunization rates, prevent communicable diseases, extend organized systems of care, strengthen preventive services, reduce the incidence of alcoholism, and assure the effectiveness and safety of clinical procedures. The process of preparing these materials was complicated by changing leadership, program uncertainties, and budgetary constraints. Some Federal officials feared that official publication of such statements would encourage unrealistic expectations of additional Federal fiscal support to help attain the articulated goals.

In March 1978, the Department of Health and Human Services issued a series of resource standards relating to bed supply and specialized facilities in general hospitals (*9*). Following is a summary of these standards.

General hospitals: Less than 4 short-stay beds for each 1,000 persons and an average annual occupancy rate of at least 80 percent

Obstetrical services: Regional linkages with hospitals caring for complicated cases having at least 1,500 births annually and an average annual occupancy rate of at least 75 percent

Neonatal special care units: Regional linkages with intensive and intermediate care beds not to exceed 4 per 1,000 live births per year and a minimum of 15 beds in special care units

Pediatric inpatient services: Minimum of 20 beds in urban areas and an average annual occupancy rate of at least 65 percent

Open heart surgery: Minimum of 200 procedures annually for adult units and 75 for pediatric units

Cardiac catherization: Minimum of 300 procedures annually for adult units and 150 for pediatric units

Radiation therapy (megavoltage): Minimum of 300 cancer cases annually

Computed tomographic scanners: Minimum of 2,500 procedures per year

End-stage renal disease services: Consistent with Medicare requirements

An earlier version of the proposed regulations had engendered substantial controversy (*8*). The revision emphasized local and State discretion and flexibility in the application of standards, the special needs and circumstances of rural areas and health maintenance organizations, and the importance of regionalization of services.

Implementation of the established standards entails detailed analyses by local agencies to determine the appropriate application in the light of local conditions. Local agencies are expected to carry out studies and to adjust individual quantitative standards in line with documented needs. This approach assumes substantial local resources to carry out these tasks. The avowed aim is "a careful balance between the federal role in providing national health planning leadership and guidance and the needs of local and state agencies to take account of local health conditions and requirements."

Forward Plans for Health

Between 1973 and 1976, the Assistant Secretary for Health in the then Department of Health, Education, and Welfare issued a series of Forward Plans for Health. Although the plans were prepared to guide internal planning, they were based on a comprehensive consideration of health issues and were published and disseminated for widespread examination. More than 150 consumer and provider groups contributed to the development of the last issuance, which was published in August 1976 and covered the period 1978 through 1982 (*10*). The plans were designed to provide a more rational basis for the decisions and recommendations that are made as part of the annual Federal budgetary and legislative process and to present the Assistant Secretary's views of the health world "in order to stimulate and raise the quality of public debate."

Within the broad goal of "improving the health of the American people," two general objectives are presented in the 1976 document, namely, to assure access to quality health care at a reasonable cost and to prevent illness, disease, and accidents. The following priorities for "structural reform"' are identi-

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fied as "needed, doable, and enforceable": containing the quality of health care, assuring essential resources, and strengthening PHS policymaking, priority-setting, and policy implementation.

In addition, the 1978–82 Forward Plan presents these seven planning themes: preparing for national health insurance, improving the health care system, assuring the quality of health care, prevention, knowledge development, tracking and evaluation, and PHS management. Following is an example of one theme in the 1978–82 Forward Plan for Health—improving the health care system—showing the specific strategies and activities presented with respect to this theme.

Assure access to quality health care

1. Direct project support
2. Assistance to State and local governments
3. Comprehensive health insurance benefits
4. Modification of existing delivery systems

Reduce unnecessary institutional care

1. Health maintenance organizations
2. Ambulatory care centers and home health
3. Professional standards review organizations
4. Health planning agencies

Provide for primary care services, especially for residents of rural or medically underserved areas

1. Maternal and child care
2. Indian Health Service
3. Rural Health Initiative
4. Urban health strategy

Assure appropriate, effective, and efficient facilities and services

1. Health planning
2. Manpower development

Other strategies

1. Consumer involvement
2. Patients' rights
3. Medical malpractice

A series of initiatives in the plan also reflect "substantive priorities" with respect to special populations (for example, children, women, minorities, and the aged), environmental and occupational health, nutrition, health education and promotion, dental health, and international health.

Model Standards

The Health Programs Extension Act of 1977 (Public Law 95–83) required the Secretary of Health, Education, and Welfare to "establish model standards with respect to preventive health services in communities." These standards are to identify populations in need of preventive and protective services and to help maintain community-oriented preventive health programs. The Congressional report concerning the act emphasizes a "commitment to the continuing need for such programs and services and to the benefits which accrue to the entire population."

Interest in setting such standards was stimulated by concerns that public health programs might not be adequately maintained in an era dominated by expansion in the delivery of personal health services. The great demands of health care financing programs, some feared, threatened to reduce the resources being made available for basic community-wide services (*11*). The establishment of model standards, it was hoped, would provide a countervailing force.

The model standards were developed by a voluntary collaborative effort (*12*). Members of the American Public Health Association, the Association of State and Territorial Health Officers, the National Association of County Health Officials, and the U.S. Conference of City Health Officers were active participants, as well as PHS staff. A report was issued in August 1979 (*13*).

The model standards for community preventive health services cover 28 program areas. As the following table indicates, about half are concerned with

health care services and half with environmental services. For each program area, one or more program goals and objectives are identified; in some areas, both outcome objectives and process objectives are presented. Altogether, 41 goals, 67 outcome objectives, and 221 process objectives are specified.

Program area	*Goals*	*Outcome standards*	*Process standards*
Health care services:			
Chronic disease control	1	4	5
Communicable disease control	3	4	21
Dental health	1	4	9
Emergency medical services	1	1	5
Family planning	1	3	4
Genetic disease control	2	2	7
Home health services	1	2	7
Maternal and child health	7	11	23
Nutritional services	1	1	6
Primary care	1	..	10
School health	1	..	19
Environmental services:			
Air quality	1	1	6
Food protection	1	1	5
Housing	1	1	4
Injury control	1	2	4
Institutional services	1	3	3
Noise control	1	1	4
Occupational health	1	6	9
Radiological health	1	1	2
Safe drinking water	1	4	6
Sanitation	5	7	18
Solid waste management	1	3	6
Vector and animal control	1	3	7
Wastewater management	1	2	6
Support services:			
Administration	1	..	15
Health education	1	..	5
Public health laboratory	1	..	1
Surveillance / epidemiology	1	..	4

The model standards are designed as a framework to encourage the establishment and quantification of objectives in local communities. No national quantitative levels are set. Rather, as illustrated in the following example of model standards for communicable disease control, a series of blanks are part of the objective statements. It is expected that "filling in the blanks" will result from negotiations involving interested persons from responsible local and State agencies.

Goal

1. Tuberculosis will be eradicated from the community.

Outcome objective

1. By 19—, the new tuberculosis case rate will not exceed ————.
2. By 19—, at least 95 percent of new positive sputum tuberculosis cases reported will convert their sputum to negative within 6 months.

Process objectives

1. By 19—, each community will be served by an agency responsible for overall tuberculosis prevention and control activities.
2. By 19—, outpatient tuberculosis care services will be accessible to the community, and acute and long-term care facilities will be identified, accessible, and available.
3. By 19—, at least 90 percent of all patients for whom two or more drugs are recommended will complete their prescribed therapy.
4. By 19—, at least 90 percent of infected close contacts and other high-risk tuberculin-positive individuals will be placed on preventive therapy and will complete the recommended course of therapy.
5. By 19—, for close contacts of infectious cases, at least — percent of those under 15 years of age will be placed on preventive therapy, regardless of tuberculin status, and will complete the recommended course of therapy.

"Healthy People"

In July 1979, the Department of Health and Human Services issued "Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention" (*1*) and about a year later released a related document, "Promoting Health/Preventing Disease, Objectives for the Nation" (*2*). These statements of health goals and objectives resulted from initiatives of the Secretary and the Assistant Secretary for Health.

"Healthy People" presents health goals for five age groups—infants, children, adolescents and young adults, adults, and older adults (see table, page 423). Some goals are general; others specify quantitative targets to be attained by 1990, such as reductions in mortality for the four groups under 65 years of age. Ten subgoals are identified, 2 for each major goal.

According to "Healthy People," "it is the controllability of many risks—and often, the significance of controlling only a few—that lies at the heart of disease prevention and health promotion." Three major risk categories are reviewed—inherited biological, environmental, and behavioral factors. The report

emphasizes that at least 7 of the 10 leading causes of death could be substantially reduced if persons at risk improved 5 habits—diet, smoking, exercise, alcohol abuse, and use of antihypertensive medication.

"Promoting Health/Preventing Disease" sets forth objectives for 15 priority areas. These objectives, which are set for 1990 or earlier, are designed to facilitate progress toward the broader goals set forth in "Healthy People" by specifying quantifiable targets (*14*). As the following table shows, altogether, 226 objectives are set forth for 15 program areas in 3 categories. The first category includes services of providers; the second includes measures by government, industry, and other agencies; and the third includes activities of individuals and communities.

Program area	*Number of objectives*
Preventive health services:	
High blood pressure control	9
Family planning	10
Pregnancy and infant health	19
Immunization	21
Sexually transmitted diseases	11
Health protection:	
Toxic agent control	20
Occupational safety and health	20
Accident prevention and injury control	17
Fluoridation and dental health	12
Surveillance and control of infectious diseases	12
Health promotion:	
Smoking and health	17
Misuse of alcohol and drugs	19
Nutrition	17
Physical fitness and exercise	11
Control of stress and violent behavior	14

The largest number of objectives are concerned with improving health status—58—and with improving health services and health protection—51; 47 are focused on reducing risk factors, 38 on increasing public and professional awareness, and 32 on improving surveillance and evaluation systems. In addition to specification of objectives, "Promoting Health/Preventing Disease" presents information for each program area on the nature and extent of the problem and the principal assumptions. Potential program measures are also discussed. Further, data sources at national, State, and local levels are reviewed for use in profiling current status and tracking progress toward the established objectives.

The formulation of these goals and objectives was based on studies and conferences sponsored by the DHHS and the Institute of Medicine, National Academy of Sciences (*15*). Many private individuals and organizations contributed to the effort, including representatives of consumer and provider groups, academic centers, State and local health agencies, and voluntary health associations.

Discussion

The four efforts during the 1970s to establish national health goals and standards present a variety of approaches and experiences. In different ways, each attempted to clarify and extend information and understanding concerning the aims and potentialities of health activities. There is evidence of continuity and consistency in these efforts, especially with respect to the emphasis on prevention. All of them resulted in products that have been widely disseminated.

Despite the differences in approach and style, these endeavors have involved a number of significant common experiences and issues. I will attempt to identify some of the major commonalities and noteworthy lessons. I hope others will be stimulated to extend this discussion from their own perspectives.

The development of these issuances highlights once again the importance of committed leadership. In two cases, the Assistant Secretary for Health took the lead, and these initiatives were productive even in the absence of specific statutory authorization or requirement. On the other hand, only limited progress was made in preparing National Guidelines for Health Planning even though there was specific legislative provision for their formulation. (The critical role of personal leadership is also seen in the development of recent statements of national health policy in Canada and England.)

Another common ingredient of these four efforts was consultation with a large number of private and public groups. For example, the drafting of the objectives for "Promoting Health/Preventing Disease" involved more than 500 people and organizations from both private and governmental agencies. In other cases, preliminary proposals were distributed widely for review and comment, and conferences and meetings served as forums for discussion and recommendations. Efforts were made to include representatives of many consumer and professional groups in these activities.

In the consultation process, professional groups tend to assume major roles. The indepth knowledge, sustained interests, and committed staffs of these groups supply not only critical information and expertise but also needed and willing staff resources.

Goals and subgoals for various age groups in "Healthy People" (1)

General goals and subgoals	Specific 1990 goals
INFANTS	
Continue to improve infant health. Reduce the number of low-birth-weight infants. Reduce the number of birth defects.	Reduce infant mortality by at least 35 percent—to fewer than 9 deaths per 1,000 live births.
CHILDREN 1 TO 14 YEARS	
Improve child health and foster optimum childhood development. Enhance childhood growth and development. Reduce childhood accidents and injuries.	Reduce deaths by at least 20 percent—to fewer than 34 deaths per 100,000.
ADOLESCENTS AND YOUNG ADULTS 15 TO 24 YEARS	
Improve the health and health habits of adolescents and young adults. Reduce fatal motor vehicle accidents. Reduce alcohol and drug misuse.	Reduce deaths by at least 20 percent—to fewer than 93 deaths per 100,000.
ADULTS 25 TO 64 YEARS	
Improve the health of adults. Reduce heart attacks and strokes. Reduce deaths from cancer.	Reduce deaths by at least 25 percent—to fewer than 400 deaths per 100,000.
OLDER ADULTS 65 YEARS AND OVER	
Improve the health and quality of life for older adults. Increase the number of older adults who can function independently. Reduce premature death from influenza and pneumonia.	Reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent—to fewer than 30 days per year.

For example, the resource standards issued as part of the National Guidelines for Health Planning were largely based on studies by medical specialty societies. A continuing challenge is to ensure a balance of perspectives and values other than those of professionals and to focus on the broader public interest.

Standards for health resources must be based on sound data and careful judgments if they are to be acceptable and influential. Consideration must be given in analyses both to clinical information on effectiveness and to economic information on efficiency. Relatively little effort has been devoted to such studies in the past, and more resources for these types of analyses by a variety of interested agencies will be necessary in the future. This work should be closely linked to the assessment of new technologies.

The complexities of the health system are inevitably reflected in the formulation of national health goals and standards. Many parties demand recognition, many issues claim consideration, many technicalities require attention, and many uncertainties induce caution. These conditions conflict with the desire for relatively straightforward and readily understandable statements. An approach to solving this dilemma is presented in the complementary publications "Healthy People" and "Promoting Health/ Preventing Disease"; the former presents 5 broad goals whereas the latter specifies more than 200 related objectives. There is a danger, however, that in attempting to accommodate many demanding pressures, the focus on major goals and priorities may be lost.

Efforts to articulate national purposes raise questions about the responsibilities for achieving the established ends. Views differ as to the appropriate role of the Federal Government, and there are continuing concerns about the relationships between national aspirations and local conditions. In addition, opinions differ on the nature and extent of the activities that the public and private sectors should sponsor and conduct. Furthermore, people with established commitments to ongoing programs are likely to question the direction and rate of changes that may be proposed. Reconcilation of these diverse

forces will generally require a high degree of sensitivity and considerable patience and time.

Movement toward specified goals and standards usually requires broad participation. For example, as is pointed out in "Promoting Health/Preventing Disease," "while the objectives . . . are consistent with Federal policies, they are far wider in purpose and scope. They are intended to be National—not Federal—objectives. To realize the potential for reducing the rates of premature death and disability . . . requires a truly national commitment, including, but going far beyond, that of government." An even broader view is expressed in "Healthy People": "To reach these goals will require a national effort and commitment of people extending far beyond what we traditionally consider the health sector. No single segment of society can accomplish them alone. . . ." Attracting and maintaining such broad attention and commitment, in competition with the many other demands and pressures of contemporary life, calls for a great deal of continuity and persistence.

Because national goals and standards do not always apply readily to all communities throughout the country, adaptations are often essential to meet particular local needs and circumstances. For example, the "Model Standards for Community Preventive Health Services" assume an extensive process of discussion and negotiation to "fill in the blanks" in line with local resources and priorities. With respect to the National Guidelines for Health Planning and the National Health Priorities, the law indicates that they should be given "appropriate consideration" in local plans, and the regulations regarding the resource standards emphasize that these guidelines and priorities should be adjusted "upward or downward" to meet local circumstances. Such negotiations and adjustments can produce constructive and creative interactions among the various participants. However, they require substantial local capacities that may not always be available, and there is also the risk that some modifications may result in largely abandoning the original thrusts.

A similar concern for balancing local and national perspectives was considered in a recent analysis of the National Health Service in England (*16*). With respect to the usefulness of national standards, the conclusion of the study was that "they would seem to be helpful if they are used with discretion. There is some evidence that [local] authorities consider them to be convenient, albeit imprecise, yardsticks. . . . Interpreted sensibly, they may provide a useful barometer of under- and over-provision which [local] authorities need to probe in taking a strategic look at their services." It was noted that such guidelines have often been most valuable in directing attention to relatively neglected services, such as home health care.

Goals and standards do not, of course, determine policy or program outcomes. They must compete in the marketplace of ideas, and many other factors demand the attention of decision-makers. The implementation of national statements depends on the actions and resources that are set in motion in particular cases to accomplish the goals, as well as on the pervading circumstances and environment.

A full consideration of the many issues of implementation is beyond the scope of this review. Generally, though, the multiplicity of factors affecting the establishment of health programs makes it difficult, and often impossible, to be certain of the impact of individual influences, especially those of a rhetorical nature. Thus, a good deal of caution and humility with respect to claims and expectations is usually appropriate.

Implementation of goals and standards would be greatly facilitated if they were linked to payments under health care financing programs such as Medicare and Medicaid (*17*). Currently, only an indirect and limited linkage exists through the provisions for the review of capital expenditures. Broader agreement on particular goals and standards is probably necessary before such mechanisms are greatly extended. Although additional linkages are likely in the future in the light of the increasing interest in having more effective guidance of the large public outlays for health care, these steps are likely to be incremental and modest.

The implications of the articulated goals and standards in terms of costs have received relatively little attention. Such analyses have seldom been done either because of lack of concern or lack of resources. Apparently it is assumed that in the light of the extraordinary increases in outlays for health services in recent years, the impact of new goals and standards would not be more expensive—and even might be less costly—than past practices have been. Although such an assumption seems reasonable, it deserves more scrutiny.

In considering the influence of goals, a reverse approach may also be useful. Rather than trying to determine the influence of articulated goals on programs, the goals that are implicit in ongoing programs might be analyzed. One health expert has observed that "national health policy is explicitly expressed by allocation of resources, not by exhortation (*18*)." For example, national health expendi-

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tures appear to have been largely devoted to four purposes: (*a*) extending the availability of health care services, (*b*) advancing biomedical knowledge, (*c*) providing a basic structure of public health protection, and (*d*) maintaining a pluralistic system.

As noted at the beginning of this paper, a principal aim of statements of national goals and standards is to influence the agenda of deliberation and debate on health issues. The goals and standards are designed to educate, affect attitudes, and influence subsequent actions. In these three processes, their symbolic value may be more important than the specific details; a call for "more" or "less" can be clear and understandable even though there is much uncertainty about exact targets. For example, the national health priorities call for more primary health care, and the promulgated resource standards urge less beds. The need for public health services is emphasized in the "Model Standards," and the importance of health promotion is highlighted in "Healthy People." These general themes may be heard through the common cacophony and may be influential.

Future efforts to clarify and articulate national health goals and standards are likely. The expanding share of the national wealth being devoted to health activities will probably create further interest in the formulation of coherent national health policies and strategies to enhance the impact of these activities and reduce inefficiencies. The four efforts of the 1970s can provide useful directions and lessons for those who will be participating in the continuing process of considering and establishing national health goals and standards.

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