# THE PUBLIC INTEREST

by

Irving J. Lewis
Professor of Public Policy and Community Health
Albert Einstein College of Medicine

National Conference of Coordinators
and Advisory Group Chairmen
Regional Medical Programs
Arlington, Virginia
March 19, 1974

I sincerely appreciate the honor that Regional Medical Program has done me by asking me to speak this morning. Some among you may recall that I emerged from the anonymity of the old Budget Bureau by addressing a Conference/Workshop in January, 1968 — only 6 years ago. In that address, "A Non-Professional Looks at RMP," I advanced the cause of rational planning for the organization of all human resources programs and identified the future worth of RMP as lying within that domain rather than the area of research which had given birth to this new program.

In six short years all sorts of illnesses have afflicted the body politic. You all know what I mean — it is summed up in today's phraseology of "survival" and "hunkering down". Unlike some, I would not attribute the root cause of our illness to the present Administration, though there is ample for which we can fault it. Rather, I see the crumbling of Camelot and the vanishing of our dreams of a Great Society as a consequence of our own loss of the concept of the public interest.

To relearn this concept and to select those programs or tasks which are in the public interest represents, I think, the new effort in public service for RMP or other fields. The public interest never was and never can be the sum of special interests, individual or group, for which political bargains are struck. In the 1960's "the best and the brightest" of us said that the public interest in health was to be identified with furthering the interests of a host of special groups or organizations — mothers and children, aged, black, poor, handicapped, migrant, medical schools, hospitals, health professionals, to cite but a few. But we rarely, if ever considered the

impact upon groups not being favored by governmental action.

I must repeat that although our political system depends upon compromise, the public interest is not just the sum of the interests of special groups. Pressures and tensions created by such political process can be accommodated so long as the economy is growing, i.e. the size of the pie for everyone to share was increasing in the last decade. But with the inevitable slowdown in growth counter-actions have set in on many fronts. What we are essentially left with is today's phenomena of groups and individuals fighting for their "piece of the action," and no group inquiring into the public interest.

For the determination of the public interest involves quint-essentially the ordering of priorities for the greater good — in the use of our energies, our resources, and our legislative authorities. When we have used the phraseology of priority-setting, we have really followed a public policy of thinking that we could accomplish in a romantic sort of way the selection of matters to be done, and matters to be deferred. In our flight to romance, we have also fled from the tough political decisions precedent to creating orderly institutions and structure by which priorities could be ordered. It is the absence of this structure, given the philosophy of our times, that so distresses me.

So we set the boat of CHP and the ship of RMP adrift on the sea of romance. We took care of the narrow interest of the public sector in planning health care (not medical care) and the special interest of the private sector in planning medical care (not health care). We were just as romantic in our approach to community

organization for health as we were with ideas of "maximum feasible participation" in OEO or community involvement in model cities.

In our reliance upon romance we openly stress the virtues of the diversity of our health care system by calling it pluralistic. As a political philosophy, pluralism once described a state of society in which members of diverse ethnic, racial, religious or social groups maintain an autonomous participation in and development of their traditional culture or special interest within the confines of a common civilization. That is what Harold Laski meant when he coined the word some 50 years ago. He conceived of society operating towards a common goal on the basis of group consensus rather hierarchical commands. We say that health care is pluralistic, but what we truly have are independent and independent-minded, multiple power centers, some public, some private, some professional, some non-professional, some State and local, some Federal, some private insurance companies, some Federal financial mechanisms, some medical schools, some hospitals, etc. — need I further characterize the multiple power centers? What is obviously lacking is any consensus on the "common civilization" in the definition of pluralism, an agreement on what their common goals is, or if you will, on the ordering of priorities that defines the public interest at any point of time. Instead of action by group consensus, the health care system is characterized by group inaction.

As part of the convential wisdom of five or six years ago, I wrote that the real test of our ability to make a health partnership work would come in the communities and in the professions. By now it surely is clear to all who seek the public interest that they have

failed the test, or better put, they are unable, precisely because of their own territorial imperatives, to develop lasting institutions that can order the differing claim on resources.

In this complicated public/private world framed by public policy, when we look at health manpower I see two sets of questions. The first relates to substance, the second to organization for decision. As to the first, the issues are not too difficult to set forth, and in truth, they are not very different from what they have been for years. Among them are:

1. Whether to maintain or increase the production of physicians and other health personnel, and if so, by what financing means;

2. How to increase the productivity of physicians, especially by changing their roles and the use of allied and other health personnel;

3. How to deal with the maldistribution of physicians by specialty and by geographic areas;

4. How to fit together, in our communities, training resources with job needs and job opportunities.

But manpower is like money or facilities — it is only a resource. So the basic substantive questions in manpower are really questions of service. Here I would say that if we really mean to address manpower issues, then we should clearly focus our efforts and energies on service needs. Not the needs of the people for health care generally but for that level of care which repeatedly appears to be most in the public interest, namely, primary care or family medicine. We must also determine what are the best tools and organizational instruments to achieve the movement of manpower into this branch of health care. We may be sure of one thing — if the public interest

requires a major shift of resources to primary care, that shift will not come about by serendipity or by small scale incentives.

The tools or organization are clearly reorganized models of care involving physicians, nurses, health workers, and social workers. More than that, we had better decide whether we can achieve a redistribution by specialty and geography through subsidies or special projects to medical schools or whether, as I think studies show, we do not have to achieve this by concentrating on residency programs — those we want and those we do not. Obviously, given the new role for medical schools on residencies, this means government must press the medical school and its affiliated hospitals very hard to assume a forthright and positive role on the issue of maldistribution. For one, I think it is time that we recognized that the issue is not so much the role of the medical school in the delivery of care or the medical school being drowned in service obligations. The issue really is the relationship of the medical school and its hospitals to the public interest in primary care.

I am not quite sure where specialty boards fit into all this. But it seems inescapable to me that we must come to a decision-making process, of which they are an essential part, that establishes the quantitative aspects of post-graduate training, and thus limits the number of residencies not only to those which "by hook or by crook" can be financed but can reasonably relate to service needs, the dominant need in the years ahead to be residents trained in primary care and family medicine.

Part of the decision on the tools to do the job includes the future of Regional Medical Programs, Comprehensive Health Planning,

and Hill/Burton. It was clear to me years ago, and it is increasingly clear to me, that neither the Federal nor State nor local government represents a political structure that can with confidence effectuate systematic ordering of priorities of service, manpower and facilities at a local level. The key question ahead of us is whether the Federal Government will mandate a system of effective regional health authorities responsible for this function. I totally agree that the multitude of manpower transactions, analyses of need, relation to demand, etc., cannot be done except in a bona fide relation to the local operation of health care. But I am equally convinced that we will not arrive at the future which we hope to find in organization for health care by major reliance upon the initiatives of the legitimate but self-interested elements in our communities. As the traveler to Los Angeles said, "I have seen the future and it won't work" -- and that's mu judgment about the capacity of the professions and the elements of community to see and seek the public interest.

A final personal note, I have been teaching a course at City College on the role of government and the public interest in health and medicine. My friend and mentor, Paul Ward, has a great article in the Cater and Lee book, "The Politics of Health," wherein he discusses the role of health lobbies and their assistance to legislators. When you apply Paul's lessons to help the Congressman seeking aid and wisdom, I hope that Regional Medical Programs will first tell the Congressman not the answer but the question, "What does the public interest require?"