VILL ECONOMICS

CONTENTS

INTRODUCTION

Proposals to institutionalize small-scale political communities and associations have been common if not widespread over the past 15 to 20 years.[1] The popular belief is that small communities, called vills[2] here, best promote civic culture.[3] Beyond this general conviction, however, the reasons and ideological justifications for ensuring the legitimation and longevity—institutionalization—of grassroots citizen action or participation vary according to whether one is at the top of the social system looking down or at the bottom looking up. My ideological bias is bottom-up, a normative but somewhat descriptive perspective grounded in the idea that "the struggle for neighborhood identity" follows a predictable pattern:

> First, residents organize to maintain the integrity of their area against outside interests. Then, political mobilization of the neighborhood begins and there is an attempt to decentralize as much power as is possible from the city to the local unit. Finally, new institutions are established that will realize and reflect the kinds of economic, social, and personal relationships the neighborhood wants for itself.[4]

It is the last stage in this process that is least likely to be achieved. To survive, small-scale power-directed organizations require a human network that can link and mobilize the "inert majority," and they must have continuity and money.[5] The reality, however, has been quite different. Kitzmiller and Ottinger conclude that, "citizen groups are weak, underfinanced, uncoordinated and dispersed. There are few sustained citizen action organizations capable of continuous representation of and by the public."[6] (Original italicized.) Suttles' observations are similar: ". . . community organizations arise to meet a particular issue; they address their complaints or demands to one or a few service organizations; and with success or failure they all, except possibly their leaders, lapse into relative obscurity."[7] Although Perlman's 1976 nationwide in-person survey indicates that "the seventies are spawning a plethora of grassroots associations . . . ," she does not reach any certain conclusions about the survival potential or future impact of these organizations.[8]

The search for an institutional rubric to legitimate and lend permanence to vills is not new. Religious institutions played this role in Western cultures for centuries, certainly through the Middle Ages. Commercial institutions, among which Americans count the Massachusetts Bay Company and others, have also served to institutionalize small-scale political organizations.[9] Community development corporations are a more recent example in this vein.[10]

The use of government, that is, the *political* rubric for institutionalizing vills is of particu-

lar interest here.[11] For the past decade and a half, proposals have been made and decentralization experiments carried out as forerunners of small-scale political entities, with boundaries encompassing populations of approximately 5,000 to 25,000.[12] These proposals reflect a wide range of methodological and ideological points of view: the top-down perspective tends to see small-scale government as little more than an administrative outpost for existing municipalities, with nominal devolved powers; the bottom-up view advocates grassroots "bootstrap" organizing of independent political jurisdictions with authentic public powers, most notably taxing and spending.[13]

Other formal public powers that may potentially be claimed by small-scale political entities include control over the means of violence (police and militia), eminent domain authority, legislative power, and the power of "limitless credit" (to issue bonds).[14]

While there are substantial differences in decentralization schemes and their supporting ideologies, there is consensus on using a political rubric—whether administrative decentralization or neighborhood government—to institutionalize small-scale citizen action or participation in civic culture. But one of the most troubling criticisms leveled at proposals to use political institutions in this way is that they are economically inefficient. Taking this cue, the central concern of this paper is *the economic viability of small-scale political institutions*—vill economics.

While my bias for the introduction of such institutions is acknowledged, the research for this paper was begun without preset convictions about whether small-scale government would be found potentially "economical." In the following section, Economic Issues and Concepts, my objective has been to identify the main economic concepts related to small-scale public jurisdictions, and to determine their economic character, both benefits and burdens. The discussion ranges over public sector activity considered as a part of the broader "grants economy," the role of public sanctions in the production of collective goods and services, need-based versus demand-based processes for determining public good, economies of scale, problems and solutions related to externalities, and the threat of "political fragmentation."

The section on Precursory Experiments is an attempt to sharpen the focus on the issue of small-scale government economic viability through a review of several surveys of "decentralization experiments." These are surveys of cases in the literature and field studies of a wide inventory of decentralized community organizations, from block clubs and improvement associations through advisory boards and committees to little city halls and community development corporations. They reflect public and private, bottom-up and top-down conceptions; and all demonstrate, in varying degrees, the political-economic prospects for small-scale government.

The last major section, Vill-Sponsored Health Care, explores the potentials for small-scale government to play an economically useful role in providing neighborhood-based health care service delivery.

This is a working paper, admittedly broad in scope, sometimes almost exceeding my own interests and powers of concentration. Yet, the nature of the criticism—that small scale is inefficient—set the stage; and given the prevalence of this conventional wisdom, too often neighborhood organization may not be attempted. It was the need to examine the relevant literature and determine for myself the economic benefits and burdens of neighborhood-based government that accounts for the scope of this paper.

I have attempted at the end of each section to summarize the material and state my own conclusions. For the less intrepid reader, those conclusions can be broadly summarized: The literature, on balance, confirms that small-scale political jurisdictions which respect certain principles of economic theory and service delivery can play an economically efficient and possibly indispensable role in a mix of urban governments.

ECONOMIC ISSUES AND CONCEPTS

1. The Grants Economy

The political-economic framework for introduction of a new small-scale urban government, a vill, need not be limited to the traditional market conception. The implication of the market perspective is that government ". . . makes little or no direct, positive contribution to the nation's output or employment," considered implicitly to be the exclusive preserve of private, profit-seeking enterprise.[15] This conventional picture that defines government as a nonproductive, growth-restraining element does not fit with what Boulding describes as the "grants economy." He contends that the activities of government and nonprofit organizations play substantial roles in the market economy.[16] Examples include construction of the national highway system, the space program, and government sponsored medical research—all serve to potentiate private sector activity.[17] It is important, then, to consider the advent of vills as new elements in the grants economy.

The grants economy involves ". . . one-way transfers of exchangeables."[18] Grants require decisions by a donor and a recipient who agree to give and receive, motivated by "love and fear."[19] The foundation for this activity, according to Boulding, is the sympathetic bond linking individuals in cooperative community endeavors. Government expenditures funded by taxes are identified as "coerced grants," but grants nonetheless in a democratic society.[20]

Like the market economy, government granting activity redistributes resources. But contrary to common economic biases that grants create ". . . a distortion of the equilibrium produced by the unfettered operation of an exchange [market] economy," Boulding observes that the grants economy too can be an instrument to establish economic balance. The idea is that translating public preferences into political demands is a parallel to the price-profit mechanism, but as we shall see, a less than perfect one.[21] Grants supplement a number of prime functions in the market economy, including allocation of production resources to different industries, distribution of income, and direction of technical innovation and development. The subsidy and tax systems of the grants economy direct resources to various industries; grants are one of the centerpieces in income redistribution programs; and they are also a principal means to develop public works, research, and education.[22]

From one perspective, enterprises in the grants economy are in many ways similar to private business: they compete for market share, they bid for resources in competitive markets, and their survival depends on making a surplus.[23] Other views, however, dispute this picture. "Econ-

omizing" is said to be a problem in the grants economy because, unlike market reliance on the price-profit mechanism, ". . . nothing is given up directly for what is gained, and it is not recognized therefore that [given finite resources] what is gained for one party is frequently lost to another."[24]

Boulding warns that given the cooperative, even sympathetic community bond underpinning the grants economy, there is a danger that the sacrifices involved can become self-perpetuating. The problem is that ". . . once [we] start making sacrifices for anything . . . we find that we cannot admit to ourselves that the sacrifices have been in vein without a threat to our personal identity." As the U.S. involvement in Vietnam illustrates, however, overextending sacrifice eventually undermines the sanctity and support of the entire endeavor.[25]

Drucker is particularly pessimistic about prospects for economic efficiency in grants economy institutions, primarily because the service field is non-competitive and not focused on capital return. Service institutions receive their income through budget allocations, thus "'performance' is the ability to maintain or increase one's budget." (Original italicized.) Budget and staff size are the important motivators and create the stakes for organizational action. Public agencies chronically overspend and almost never underspend their budgets because "not to spend the budget to the hilt will only convince the budget-maker . . . that the budget for the next fiscal period can be safely cut."[26] Presumably, budget-based income undermines setting priorities and focusing efforts: the producer in the market economy focuses effort to expand market share, while the public organization tries ". . . to placate everyone by doing a little bit of everything . . . to ensure its budget allocation." Drucker also argues that budget-based institutions find it more difficult to abandon obsolete, unproductive efforts: "the temptation is great to double the budget, precisely *because* there is no performance." The problem, as Drucker sees it, is that budget-based institutions are paid for what they "deserve" rather than "earn."[27]

The foregoing discussion suggests that the introduction of new government units into the mixed market-grants economy may offer positive and negative potentials. Drucker's pessimism may be relevant but overdrawn for application to small-scale political institutions, insofar as it reflects observations of inefficiency in large, centralized governments. The bureaucratic bias to increased spending and indebtedness—the outcome of limited access to officeholders for citizens who have a contrary stake and open access for market interests that are congenial—is not a characteristic notably shared by existing small-scale public jurisdictions.[28] Drucker's view may better serve as a caution flag than an absolute prohibition. Boulding, on the other hand, conveys that while government may not be the ideal vehicle for solutions to critical social problems, it certain-

ly plays a constructive and indispensable role in the country's political economy.

2. Public Goods and Bads

Among the several functions of government is the production of goods and services. Setting aside momentarily the task of defining public goods (and "bads"), it is useful to consider justifications for their provision. Market economic explanations suggest that public goods are the result of the differential between what the public wants and what the private economy is motivated to provide. Public goods may also be provided because use is required, because private alternatives are not adequate, or because of a preferred distribution of benefits or costs under public sponsorship.[29] Government intervention in the market economy is also rationalized as necessary to correct market imperfections, such as ". . . monopoly power and insufficient consumer knowledge"; ensuring payment for collective-consumption goods; and externalities, ". . . where an economic action affects parties not directly involved in the transaction."[30] Goods may also become public because of "environmental" limitations, that is because ". . . national defense, law and order, and public health. . . . are a part of and condition the *environment* of the society."[31]

A less well-explored area in the provision of public goods is the transfer of granting authority from one sector (or public jurisdiction) of the grants economy to another, for example, from city to special district. The rule of transfer between market and grant sectors would appear to be applicable: once defined as a public sector activity, the provision of public goods by one jurisdictional level represents the failure of another level of government to provide those goods.[32]

Collective or public goods have a quality of "jointness," the satisfaction of a common interest, for a specific collectivity of citizens. With pure collective goods, more consumption by one person doesn't reduce the amount left to others.[33] Collective goods become public goods ". . . when the coordinating mechanism for providing a collective good invokes the powers of the state. . . ."[34] The transformation from collective to public goods is explained in part by "the logic of collective action."[35] Despite a common desire for a good, individual self-interest may preclude voluntary collective action to provide the good. The bind for the individual is that because the benefit is common to all, as in construction of a highway, no one can be excluded from enjoyment regardless of whether they pay their share of the cost. Thus it becomes necessary to provide ". . . some sanction or attraction, distinct from the public good itself, that will lead individuals to help bear the burdens. . . ."[36]

The logic of collective action is thought to differ for large and small organizations. One proposition is that small groups need not rely as heavily on sanctions to provide collective goods

because, since each member receives a large share of the total benefit, some individuals will be further ahead by paying a disproportionate share than if the good were not available. A counter proposition, however, is that in small organizations if a few members stop paying, costs will increase for others to the point they will refuse to pay and the good is lost.[37] O'Brien's thesis is that the failure of neighborhood-based community organizations is due primarily to the logic of collective action.[38] A fair conclusion may be that small-scale organizations, serving populations from 5,000 to 25,000, require sanctioning power or other compensatory mechanisms if they are to successfully distribute costs among all beneficiaries.

"Public bads" are the reciprocals of public goods. The idea here is that ". . . good for the individual, as a privately acting independent agent, may be bad for the same individual . . . as a part of a defined collectivity, and vice versa."[39] While the aim of contemporary large-scale urban government has been provision of public goods, increasing the *quantity* of facilities, Buchanan argues that it is at least equally important to eliminate public bads.[40] His thought is that, ". . . the current yield [of public goods] at the margin surely is greater from enforcing more effective usage of facilities than in enlarging the quantities of facilities. . . ."[41] Capital-intensive public goods and services particularly may require the funding capacity of larger jurisdictions, but elimination of public bads—". . . enacting and enforcing effective rules for personal and institutional behavior"[42]—may be better suited to vills.

3. Need-Based Versus Demand-Based Definitions of Public Good

Although it is one thing to state in general terms *what* a public good is, it is quite another to specifically define *how* such a determination is made. The traditional grants economy approach has been to define public goods in terms of *need*, derived from studies of government objectives, which in turn are based on professionally formulated standards created by engineers, librarians, physicians, etc. The standards are normative and designed to enhance the quality of life.[43] Defining public good through the concept of need, then, involves a benevolent but elitist top-down determination. Cost-benefit and utilization models and studies represent a further refinement of need as a vehicle for defining public good.[44] Cost-benefit analyses are used to establish the most efficient expenditure pattern within a previously established normative decision-making process that has identified public goods and services.

The market approach to ascertaining collective good has been *demand*. Demand is defined as "participation, by which . . . all instances in which households act, voluntarily or under constraint, to *cause* a local public service to be performed."[45] (Emphasis added.) But estimating

demand for *public* goods is a problem because of the absence of a price-profit mechanism. In the public sector, politicians are the producers and voters are the consumers who pay through taxation.[46] Part of the difficulty is that the political decision-makers have no way of knowing when the benefits of an increment in output are greater than costs.[47] In effect:

> The *benefit* derived from the last dollar spent on a public service should be greater than or at least equal to the *cost*. Such a criterion would assume that every expenditure for a public service would yield a benefit at least equal to the value of the good foregone in the private sector. Also, it would ensure that such an expenditure would not prevent a more valuable expenditure in some other public service.[48]

It is also accepted as problematic that demand for public service cannot be analyzed in terms of existing expenditure levels. There is a ". . . problem of product definition": interpreting the meaning of an appropriation depends on how the service or good is defined, the value assigned to it, and its purpose.[49] "Fiscal profitability criteria" are also rejected as means to verify demand. The argument is that provision of public goods and services cannot be directed through analysis of projected costs and anticipated revenues. In other words, a decision about whether to build a new water works, thereby increasing water supply and lowering costs, cannot be made in terms of expectations for tax revenue flowing from new industry attracted by the availability of low-cost water.[50]

It seems that the political process itself is the only mechanism in a grants economy for assessing aggregated preferences. The prevailing economic view, however, is that ". . . an optimal political decision-making process has not yet been devised. . . ."[51] Steiner describes the related literature as "entirely theoretical."[52] Acknowledged deficiencies notwithstanding, there are several political models incorporated in economic constructs of demand. The classical model for economic demand in the public sector suggests:

> . . . that politicians present tax and expenditures options to voters so as to maximize the vote they receive. In this search for political support they will discover the preferences of consumers, innovations in service, and tax alternatives, and they will be motivated to maximize the sum of the fiscal surpluses (benefits minus costs) going to the citizenry.[53]

This model pictures government as a "quasi-market," with electoral activity assumed to be the linkage between individual preferences and the provision of services.[54] A second model wherein political process articulates and defines public good envisions the public jurisdiction as ". . . a coalition of . . . blocs that cooperate in order to provide public goods."[55] The Tiebout model for demand in the public sector, as described by Margolis, proposes that ". . . individuals

can move among government jurisdictions . . .” to press their demands.[56]

Several writers have commented on the shortcomings of these theoretical descriptions of political decision-making in relation to demand for public goods and services. It has been observed that “at-large elections, the absence of mass-controlled urban political parties and the failure to develop a social infrastructure usable for public action have greatly reduced the ability of residents to communicate more than the grossest preferences to elected officials.”[57] It is argued that “civic accountability” rests on a number of doubtful assumptions: that government representatives can be called to account via the electoral system for the conduct of public employees, that each jurisdiction has workable mechanisms for equitably resolving citizens’ complaints, and that public employees are generally responsive to the broad public interest. The issue of civic accountability is “… not only of responsiveness to *complaints about* service but to *demands for* service. . . .”[58] In the same critical vein are studies that conclude the relationship between electoral activity and public policy output is nil.[59]

A different but related criticism of political models for demand articulation is that political boundaries optimized for economic considerations may not the optimal for public representation.[60] Congressional constituencies now encompass populations of a half-million and urban local government districts typically range from 100,000 to more than a million. Warren's study of federally sponsored regional political and policy decision-making indicates that, “. . . the [large] scale of a district, determined by economic criteria, as well as its operating characteristics, create[s] high if not prohibitive [participation] costs for unemployed and minorities. Conversely, both relative and absolute access costs tend to be reduced for those who already are dominant and community influence—government officials and business and civic leaders.”[61]

Both need-based and demand-based processes present problems for determining public goods and services. The need construct, relying as it does on a top-down elitist expertise, tends inherently to produce inefficient outputs, a misallocation of resources redounding to the benefit of special interests. The demand construct suffers from the dilemma that, while public good is defined as commonality of individual preferences, there is no mechanism in a nonmarket system to determine the aggregated preferences except an inadequate political process.

Bish and Warren acknowledge the difficulty of assessing demand in the public sector, but they provide a substantive remedial proposal.[62] Their idea is that demands for public goods and services are “likely to be efficiently articulated only by political units of different sizes.” They trace demand inefficiency to public monopolization of demand-articulating *and* producing functions, a circumstance that undermines quickness and accuracy of political responses to citizen

demands. The result is a misdirection of resources. The remedy is for political jurisdictions of various sizes to buy and sell goods and services from one another, thereby introducing price competition in the public sector: ". . . the [public] producer must [then] measure and cost out his production and provide a price to the consumer, provide an amount and quality of goods determined by an *independently organized* consumer, and keep his costs and prices below that of potential competitors. . . ."[63] (Emphasis added.) Bish and Warren conclude that, ". . . a variety of sizes of [government] organizations, not necessarily with the same boundaries, is likely to be needed for the efficient production of goods and services in metropolitan areas."[64]

Process definitions for establishing a public good are limited to normative need types and political-economic demand types. The former may be rejected for inefficiency stemming from its top-down definition of need. The latter approach is plagued by the economic demand dilemma, an oblique commentary on the inadequacy of pluralistic models of political decision-making. One remedial strategy has been suggested which involves creating a range of demand-articulating public jurisdictions that would serve to separate demand from production (supply) functions and introduce price competition to the public sector. This political-economic remedy, whether suitable or not by other criteria, is congenial to proposals for establishing vills.

4. Economies of Scale

The economic issue most often raised about small-scale government is economy of scale. Scale economies are present ". . . when the unit cost of producing a commodity decreases as more units of that commodity are produced per period." Factors thought to be responsible for cost reductions include: indivisible production inputs, division and specialization of labor and capital, and bulk purchasing of inputs.[65] Internal scale economies are related to savings realized through technical innovations in large-scale production, usually the adoption of assembly lines and computers.[66] And economies are often linked directly to standardization.[67] Political-economic theory and "common sense" maintain that "small-unit governments are poorly equipped to take advantage of economies of scale and technological innovations. . . ."[68] Empirically grounded studies, however, lead to other conclusions.

Musgrave indirectly suggests a first principle of scale economy. He identifies three generic government budgeting aims: allocation, distribution, and stabilization. While stabilization and distribution efforts refer to government economic regulation and income transfer activities more suitable for state and federal jurisdictions, allocation of goods and services is an appropriate local function.[69] Hawkins pinpoints capital-intensive services and goods as the exception to "the gen-

eral finding of a number of studies using different methodologies . . . that there are few, if any, economies of scale in the production of local government services."[70] He also observes that while standardization reduces costs, it also diminishes consumer choices and options. Regardless of demand or development stage, every community is compelled to "enjoy" a higher or lower level of service—because of standardization—than its requirements or preferences would dictate.[71]

Emerson and Lamphear state that "numerous studies . . . have found public costs to be minimum somewhere between 10,000 and 250,000 population." While they do not in fact cite scale economy studies, they maintain that the range of constituents needed by public jurisdictions for "self-sustaining growth" is from a few thousand to more than a million.[72] Henderson and Ledebur claim that significant scale economies are associated with community growth from small to intermediate size. They note, additionally, little opportunity for scale economies in school expenditures, except for administration, and ". . . little, if any, economies of scale in the provision of conventional water supply and sewage operations. . . ."[73]

Hirsch provides a particularly useful general formulation of scale economy principles based on a distinction between horizontal, vertical, and circular integration of service. Horizontal services are those that provide coverage through plant replication, each unit producing the same service, as with fire protection or district health centers; vertical service integration exists when there are successive steps in service production, as with water or electric power production and distribution; and circular integration involves different units combining to provide complementary services under a unitary plan, for example, a multi-level transportation system. Hirsch reviews a wide sample of cost-benefit literature, focusing on scale economies, and concludes that the relationship between costs and scale are complex. Nonetheless, he indicates that economies of scale are not present or are at best "uncertain" or "very minor" in horizontally integrated services such as police, education, waste collection, fire, etc.[74]

To reiterate, Bish and Warren, and Heilbrun, contend that economies of scale are possible for small-scale governments when the demand-articulating jurisdiction and the producing (or supplying) jurisdiction are not the same. They propose, too, that smaller jurisdictions may purchase or contract services from larger public or private vendors, and can thereby ". . . remain small without sacrificing the possible advantages of economies of scale. . . ."[75, 76]

Relying on a review of professional standards, Hallman proposes minimum feasible scales for a range of public sector services. The standards reflect top-down conceptions of need as well as economic efficiency. A population of 7,500 to 10,000 can justify a police force of the "effec-

tive minimum size." A minimum urban fire district, serving one-story residential dwellings, is feasible with a population of 5,000; while inclusion of a ladder truck expands district size to 15,000 or 20,000. Minimum population for street maintenance is 10,000. *Full-service* neighborhood health centers should serve 25,000 to 35,000 people. Park programs are feasible for populations as small as two to three thousand, while library service minimums are about 12,000.[77]

General statements that categorically accept the principle of scale economies are misleading at best and mistaken at worst. The principle is not apt for horizontally integrated and labor-intensive services, and it ignores the potential for small units to enjoy scale economies by contracting for services. These conclusions are confirmed by studies of service delivery costs for special districts. Studies by the California Local Government Reform Task Force show no "significant" cost differences between small-scale special districts and other jurisdictions. Another study demonstrated ". . . consistent diseconomies of scale in school systems with student populations of over 2,500."[78] Hawkins concludes that "existing *evidence* warrants the assertion that the small-scale special districts are just as capable of realizing efficient operations as are [larger] units of general purpose government."[79] It is apparent that economies may be realized over a wide range of scales, given that certain principles are recognized and respected; and that rejection of neighborhood-level government because of scale inefficiencies is not justified.

5. Externalities and Spillovers

Externalities and spillovers comprise another problem-dimension for examining the economic viability of vills. The externality or spillover ". . . is an indirect side effect . . . which results from an allocation decision. Not typically considered a direct benefit or cost, externalities either inflict harm on someone without compensating him for it, or confer gain on someone without demanding payment."[80] Externalities are often related to population movement from one area to another. They also result from the technical service character of ". . . infrastructure, environmental control, and research and development activities. . . ."[81] The proposed Bay Bridge fare hike to subsidize BART is an example of a spillover burden; while the free use of locally financed roads may be seen as an unpaid-for benefit to out-of-state drivers. Technical services that are especially susceptible to spillovers include sewage treatment and disposal, air pollution control, transportation, water supply, and arterial streets. In human and social services, education is considered to have major spillovers, welfare is uncertain, and parks, libraries, and police have few or none.[82]

All public services have externalities. The issue is ". . . the ratio of external to internal

benefits. . . ."[83] Different public goods and services have different boundaries for spillovers. Water pollution control externalities follow boundaries related to "waterflows" and air pollution control to "airsheds."[84] Several writers posit a direct relationship between the ratio of internal to external benefits and the utility of local decision-making. When the ratio is high, that is, in cases of large benefit spillovers, ". . . expenditure decisions will clearly be inefficient unless made at the local level."[85] The principle is as follows:

> . . . if the boundaries of the political body are not roughly congruent with the boundaries over which the external benefits or costs prevail, decisions will be biased and inefficient. If the affected area is too small, important benefits or costs will be ignored. If the area is too large, excessive centralization and the associated inefficiencies will result.[86]

The structural solutions proposed to minimize externalities are centralization (via regional government) and decentralization (via neighborhood government). The centralizing strategy controls spillovers by an areawide government that can formulate special rules and tax policies.[87] The view is directly contradicted by writers who feel that government services should be allocated over a range of jurisdictional levels to minimize "unequal spillovers . . . done by a larger central government."[88] A middle ground approach is to shift upward both functional and fiscal responsibility while simultaneously providing "optimizing" grants to lower-level service-delivering entities. Netzer suggests that within this framework ". . . there is a theoretical case for the existence of a multiplicity of small governmental jurisdictions to provide and finance allocation branch activities without important externalities, even within such closely connected regions as metropolitan areas."[89]

The spillover solution strategy of special interest here is creation of independent small-scale governments. In this vein, Schultze suggests that the solution to varying boundaries may be the special district.[90] A criticism of special districts germane to the central theme of this paper is that they are economically inefficient. As already noted, however, recent studies confirm that a statistically significant correlation does not exist between the number of government jurisdictions and total costs of local government.[91]

It is clear that government goods and services of various kinds have differing spillover boundaries which require corresponding political jurisdictional lines to avoid externality inefficiencies. Remedies fall on a centralizing-decentralizing continuum. Decentralization proposals range from (1) creating multiple small-scale units *within* a regional entity to (2) establishing numerous separate small-scale jurisdictions. The main objection to small-scale government has

been grounded in "efficiency" arguments, but several recent cost studies do not confirm this view. Vills may be an appropriate response, then, to spillovers in the public sector provision of goods and services.

6. Political Fragmentation

The heart of criticism leveled at plans for introducing urban vills is conveyed by predictions of economic inefficiencies caused by "political fragmentation." A less biased characterization to denote decentralizing proposals is scale reduction (or scale expansion for centralizing proposals). The top-down-sponsored ideology of scale expansion acknowledges the value of local political control—"maximum citizen participation"—but argues that scale reduction undermines economies, resulting in ". . . an inadequate and expensive public service system. . . ."[92] Efficiency in this view is defined as coordination, consistency, and integration. The cornerstone is the idea that scale reduction in government has ". . . led to a separation of resources from needs."[93] Another perspective on the problem of separation between needs and resources is that the antidote is not eliminating small-scale jurisdictions but rather a selective upward shift of taxing and allocation functions for services subject to extensive spillovers. Current trends in this direction include state takeover of education costs through statewide property taxes and federal assumption of welfare costs.

Proponents of vills point out that small-scale units are often ". . . the direct result of inaction on the part of cities and counties following demands for public goods and services by smaller communities of citizens."[94] Efficiency in this ideological set is defined as direct but autonomous citizen engagement in the responsive exercise of public power. Scale expansion is seen as responsible for creating massive constituencies that block widespread access to and influence on political officeholders. The principal argument seems to be that proponents of scale expansion rely on ideologically biased policy *theory* rather than empirical studies, particularly the "reform theory" that so-called fragmentation is "inefficient, ineffective, unresponsive, unplanned, and uncoordinated."[95] As mentioned earlier, Hawkins presents persuasive evidence to the contrary.

7. Summary

The economic viability of vills has been considered from a number of viewpoints. The main theme in discussion of the economy is whether government, generally, can play a constructive role in the overall market economy. Positive and negative potentials are apparent, but the latter may be fairly interpreted as cautions rather than absolute disqualifications. The logic of

collective action suggests the need for government sanctioning power, probably taxation, or other compensatory devices to ensure full participation in sharing the costs for collective goods and services. And while capital-intensive goods and services require a larger tax base, eliminating public bads may be the forte of small-scale jurisdictions where face-to-face relations are dominant.

Several economic inefficiencies have been identified in relation to the *processes* for determining a public good. The only substantive remedy found in the literature is to separate demand from production functions by introducing a range of demand-articulating jurisdictions. Inefficiencies related to scale, when examined carefully, can be tied to a number of principles that allow for economies of large and small scale. Finally, it is suggested that externality inefficiencies may be amenable to a strategy that relies on small-scale governments to match spillover boundaries with political jurisdictional lines.

All of the foregoing discussion has aimed to identify economic issues related to the introduction of vills. Given opposing interests and thus the way in which the literature is cast, reduction versus expansion in government scale becomes the framework for analyses. The characteristic most common to reduction and expansion ideologies is the tendency to see categories of public service as indivisible totalities that must be the exclusive responsibility of a single level of government, fire and police to municipalities, transportation to regional authorities, health care to the federal government, and so on. The point is not that exclusive assignments actually exist in most cases, but that they are advocated, oftentimes by proponents of both scale reduction and expansion.

An alternative approach leads to accommodation between reductionists and expansionists by projecting logical divisions in categories of urban services, separation related to various levels of government. This approach can be formulated in general and specific terms. A number of general situations can be specified where small-scale jurisdictions are especially appropriate. These include instances where problem boundaries do not match boundaries of general purpose jurisdictions; where important communities of interest do not correspond to local government boundaries; where general purpose government does not meet citizen preferences for service; where new and complex government functions involve large quantities of decision-making information to ensure good results; where neighborhoods within large urban areas do not receive the kind or quantities of service from large bureaucracies that are attempting to satisfy the most common denominator in massive constituencies; where smaller districts offer access to fiscal resources; and more.[96]

Goodman proposes some parallel principles for scale expansion. Central authority is considered appropriate "where there are no district limits and something positive must be done, as in epidemic control or smog control; or when an arbitrary decision is required and there is no time for reflection, as in traffic control; or when we have to set arbitrary standards for a whole field, but the particular standard is indifferent, e.g., weights and measures or money." For Goodman, centralization of authority may also be necessary to deal with emergencies.[97]

Divisibility of *particular* services may be considered within this general framework. It has been suggested, for example, that the urban police function may be divided into logical, feasible categories related to different levels of government. Specifically, the division proposed is between maintaining order (traffic control, mediating domestic disputes, etc.) and fighting crime, the first undertaken by neighborhood-level governments and the second by regional authorities.[98] Benefits would accrue in the form of neighborhood foot-patrol beats and freeing up highly trained personnel for more specialized or dangerous duties.[99] It is difficult upon reflection not to agree that sound arguments for service divisibility, realized in part through the introduction of vills, can also be made for education, judicial administration, social service, transportation, and other areas.[100]

It is difficult also to avoid the conclusion that there are sufficient theoretical indications that vills are not inherently inefficient means for institutionalizing small-scale political communities and associations.

PRECURSORY EXPERIMENTS

1. Introduction

It may not be unreasonable to conclude that small-scale government is, in the abstract, a viable economic proposition. Yet, it is another matter entirely to practically demonstrate that conclusion without actually creating such governments. In lieu of such an ideal demonstration, this section presents findings from several studies by two investigative teams that surveyed a wide range of "decentralization experiments." The observations, analyses, and conclusions presented by Hallman[101] and Yin and Yates[102] are cited to shed additional light on the *economics* of vills.[103]

The various organizational experiments reviewed are not replicas of an ideal type of vill. They are at best precursory examples of programs and problems, characteristic situations that may be associated with small-scale government; at worst they are simply irrelevant. They cannot be held as definitive precursors. Thus while it may be argued that their successes are not a certain prospectus for neighborhood-level government, the same argument must carry for their problems and failures. It may be more useful to think of them as a common class of locality-based endeavors, among which are the institutional antecedents for vills. These experiments are the seedbeds.

2. Field Studies

Hallman observed 30 community organizations that had various degrees of autonomy and power. These projects did not have grassroots origins; they were the result of "socially concerned, progressive leadership. ..." Governance was typically via a "coalition board," with political, agency, and grassroots organization representatives. Neighborhood representation, often not required, was token in many cases.[104] The range of organizations surveyed went from ECCO (East Central Citizens Organization of Columbus, Ohio), serving a neighborhood of 6,500, to New York City community corporations with service area populations of 75,000 to 300,000.

The New York corporations, functioning as planning-coordinating entities, are said to have ". . . produced mixed results." While unity and competent staff are factors linked with success, the corporations were problem-ridden in their roles as funding agencies.[105] Neighborhood centers operated by the corporations are poorly rated, ostensibly a reflection of ". . . the precarious position of the corporations in the institutional structure [which] has made them weak instruments for coordinating the work of other agencies.[106]

"Unlike the New York corporations, ECCO governance is by direct assembly, open to all residents over the age of 16. The first ECCO project was the operation of a settlement house. The organization was able to obtain outside funding for a "youth civic center" and multipurpose neighborhood center offering educational, social, medical, legal, employment, recreational, and welfare services. By 1968, three years after formation, the organization began to develop a strategy for achieving economic self-sufficiency in response to financial pressures. A profit-making stock corporation was formed in anticipation of the purchase and operation of two grocery stores. Hallman rates the ECCO service programs as "average," but the demise of several service activities no doubt prompted his statement, "I am skeptical of . . . [ECCO's] ability to gain complete self-sufficiency for enterprises it runs or controls.[107]

Hallman concludes that these decentralization experiments have achieved significant results. He adds that projects controlled by neighborhood residents ". . . with one or two exceptions . . . are doing no worse than related decentralized operations without resident control.[108]

3. Enclave Cities

In a second major publication, Hallman writes that "enclave cities" (with populations from 6,000 to 35,000) are able to finance and manage police and fire services and a range of public works activities.[109] Safety services, however, are supplemented by mutual assistance pacts with nearby jurisdictions. All of the enclave cities studied operated waste collection, street maintenance, and parks and recreation services. These small-scale municipalities were limited in their capacities to undertake specialized police services (crime laboratory, training, sophisticated investigation, etc.), refuse disposal, sewage treatment, hospitals, and comprehensive public health services. Hallman concludes that, "different aspects of neighborhood government are practicable because they are now being accomplished." He also notes that ". . . it is possible for an urban administrative unit serving 5,000 people to conduct several kinds of activities. However, a population of approximately 10,000 might be a more desirable minimum because it would widen the range of services."[110]

4. Case Studies

The combined works of Yin and Yates encompass surveys of several hundred decentralization-experiment cases in the literature.[111] Yates identifies some of the political-economic foundations for scale reduction demands: the failure to integrate public schools, development of community organizations and protest groups, decay of urban political machines, failure local

government representation, centralization and fragmentation of urban government, and the character of urban public services.[112] Yates also identifies nine different forms of decentralization: self-help groups, advisory boards, agency field offices and little city halls, ombudsmen, multi-service centers, Model Cities programs, community corporations, neighborhood health corporations, and community school boards.[113]

Yin and Yates characterize the two main dimensions of decentralization as (1) devolution (top-down transfer) of responsibility and power to citizen groups and (2) expansion of government resource allocations to small geographic areas.[114] Within this framework, six decentralization strategies—from weak to strong—are recognized: "community relations," "physical redeployment," "administrative decentralization," "employment of neighborhood residents," "new neighborhood institutions" (federally-funded health centers), and "political decentralization."[114, 115] Decentralization outcomes were evaluated by four criteria: improvements in communication, attitudes of servers, attitudes of citizens, and citizen control. Two-thirds of the studies reported a positive relationship between scale reduction and better service and information flow. Agency and client attitude improvements were observed respectively in only 12.6 and 24.7 percent of the studies.[116]

In relating decentralization strategies to outcomes, Yin and Yates found that ". . . there is a tendency . . . for the first four /or weaker/ strategies to be associated with higher frequencies of increased information, and for the last three [or stronger] strategies to be associated with higher frequencies of both improved services and increased control."[117] The explanation offered is that stronger strategies gave citizens and service deliverers more political and economic resources, enabling them to reshape their relationships.[118]

Decentralization outcomes are related to two other factors. Yin and Yates point out that "smaller-sized populations [under 10,000] are associated with the highest frequency of increased citizen control, whereas moderate-sized populations [10,000 to 50,000] are associated with the highest frequency of improved services.[119] Service improvements following decentralization are related to "degree of professionalism" and "scope, of bureaucratic control" inherent in the service. These characteristics are negatively correlated with openness to client influence.[120]

Several other findings and conclusions from the Yin and Yates surveys are noteworthy for the purposes of this paper. Block associations, the best examples of face-to-face direct-democracy surveyed, demonstrate more flexible agenda, increased options in selecting winnable issues and tasks, and thus are rated as better mechanisms of demand-articulation. The smaller-scale experiments generally exhibited economies in that fewer ". . . conflicts and cleavages are

likely to arise. . . .”[121] Decentralization, then, “... increases pluralism in urban democracy. In promoting 'local solutions’ to neighborhood problems, decentralization permits the articulation of more diverse preferences and interests and thus enhances local self-determination.”[122] The Yin and Yates surveys show that decentralization impact on “responsiveness” problems is high and on “resource” problems, nil.[123, 124] The caveat is that while decentralization experiments improve citizen capacity to articulate demands, they apparently do so by “. . . strengthening of existing interests [which] constrains the development of under-represented and unrepresented interests.”[125]

5. Decentralization Dilemmas

Possibly of greatest concern are two dilemmas suggested by the surveys of decentralization experiments. First is the conflict between “equal treatment and social justice.” The problem can be illustrated by imagining an urban landscape overlaid with vills. The difficulty is that if resources are equally accessible to and divided among all jurisdictions, “. . . the goal of equal treatment is advanced, but the desire for social justice which recognizes the special needs of poor nonwhite neighborhoods is not furthered.” The second dilemma is that decentralization experiments may also potentiate the tension between “quest for community and the desire for racial integration.”[126]

6. Summary

Hallman's research indicates that small-scale, neighborhood-based services meet average standards and can be operated successfully under resident control. His review of small municipalities suggests that public services may be provided efficiently to populations as small as 5,000 to 10,000.

Yin and Yates conclude that scale reduction improves services and communications between servers and served. The improvements are most closely connected to the decentralization strategy employed: stronger strategies, forms of “political decentralization,” resulted in greater citizen control and service improvements. Their overall findings show that decentralization enhances government responsiveness but has little effect on limited or maldistributed resources.

Yin and Yates identify two fundamental dilemmas inherent in proposals for a new layer of small-scale urban government: the conflicts between equal treatment and social justice, and between quest for community and desire for racial integration.

The surveys of decentralization experiments do not provide certain answers about the

economic viability of vills. They do, however, tend to confirm the general economic principles discussed in relation to scale economies, demand articulation, and the need for government sanctioning power to overcome the logic of collective action. The decentralization experiments implicitly confirm the service divisibility approach to scale reduction: The experiments rarely aim to provide comprehensive service packages. As locality-based organizations, their practice is to provide gap-filling, supplemental services that have, in part, been identified and given high priority by local citizens.

The two dilemmas identified by Yin and Yates must be admitted as the most troubling byproducts of attempts to engage citizens directly in the exercise of public power through neighborhood-based organizations. Of less concern but still troubling is the finding that decentralization experiments had little or no effect on resource problems. While it is not possible to treat these issues in any depth here, their importance is recognized and directions for further consideration are outlined.

In respect to the two dilemmas, the legal structure of urban vills vis-à-vis other levels of government is an appropriate focus for additional study. The aim would be to identify the potential for intervening legal sanctions and grants by higher levels of government that would offset the destructive provincial effects of small scale. The failure of decentralization experiments to remedy resource problems indicates the absence of a power lever, a *compelling* strategic device, such as the labor strike. While the potential of tax resistance has been identified and exercised in recent decades, it has been viewed as a tactic for individuals of conscience rather than a lever for organized neighborhoods to deal with higher levels of government. An area for future exploration, then, one with crucial political-economic implications for small-scale urban government, is the feasibility of incorporating the tax resistance power lever in the vill.

VILL-SPONSORED HEALTH CARE

1. Introduction

To this point we have identified and considered the main economic concepts related to small-scale political institutions, and reviewed findings from surveys of precursory experiments in "neighborhood government." The aim of this final section is to consider whether vills can play an economically useful role in meeting a critical service need for health care. By way of introduction, the section begins with some perspectives on what is wrong with the U.S. health care system, why, and how it can be improved.

Following the discussion of U.S. health care service delivery problems, a conceptual framework for their solution, and some reform strategies that have already been proposed, brief case histories are presented of three past efforts in this country to reduce the scale of health care. The cases cited are the Cincinnati Social Unit Organization, the National Maritime Union-United Seaman's Service project, and the federally funded Neighborhood Health Centers. The main issues of political economy that emerge from these demonstrations are intimately linked to employment of citizens in policymaking and as treatment agents in the health care system. The experience of Neighborhood Health Centers is considered in some detail as an example of citizen policy-making in top-down sponsored and funded public agencies; and current practices as well as future prospects for greater use of paraprofessionals and allied professionals are considered. The discussion of vill-sponsored health care is concluded with an overview of the health care system in the People's Republic of China, which has many characteristics that might be incorporated in a U.S. neighborhood-based system.

The need for reform necessarily follows a specification of the problems to be remedied. In the U.S. health care system several can be readily identified: high cost in general, but particularly for hospital-based care; lack of accessibility to care (primarily for political-economic reasons) for low-income populations; inadequate growth of service delivery capacity; nearly exclusive allocation of resources for crisis management at the expense of large-scale prevention efforts; increasing demands on physicians for "non-medical" services and a parallel lack of citizen participation in their own health care; and lack of screening-referral mechanisms using low-cost, non-hospital-based organizations on the input side of the system.[127]

2. Conceptual Framework

Beyond specifying specific problems, theoretical and analytical frameworks are useful to conceptualize complex systems. Alford's study of twenty investigative reports on the New York City health care system, from 1950 to 1971, provides a coherent overview of the need for and obstructions to health care system reform. He identifies "market" and "bureaucratic" reformers, ". . . each pointing to the other as the cause [of health care service delivery problems] and itself as the solution." The market viewpoint places culpability on "bureaucratic interference," while the bureaucratic perspective blames market competition. The market reform program is to have the public sector assume the cost of ". . . expand[ing] the diversity of facilities available, the number of physicians. . . ." They want more competition (read less bureaucratic regulation) and better private insurance programs. Fee-for-service and physician control of hospitals and practice would remain unchanged. The bureaucratic reform program puts physicians under the control of hospital-based boards and administrators. The goals are coordination, planning, and public funding.[128]

Alford argues that the so-called health care crisis (now at least two decades old) does not result from pluralist competition or bureaucratic inefficiency. His position is that the failure of health care planning ". . . sustains the unresponsiveness of the separate market-oriented units." His point is that, "powerful interests benefit from the health care system precisely as it is . . ."; and that planners and providers, bureaucratic and market reformers, have a cozy arrangement because none of the reform proposals ". . . challenge any of the institutional roots from which the power of *structural* interests derives."[129] (Emphasis added.)

The main thesis, then, is that entrenched structural interests are the principal barriers to reform. They are classified into three categories: dominant, those that need not continuously organize to protect themselves because their institutional agents act on their behalf;[130] challenging; and repressed. The professional medical monopoly is cited as the dominant structural interest.[131]

> Physicians have extracted an arbitrary subset from the array of skills and knowledge relevant to the maintenance of health in a population, have successfully defined these as their property to be sold for a price, and have managed to create legal mechanisms which enforce that monopoly and the social beliefs which have mystified the population about the appropriateness and desirability of that monopoly. The result of this professional monopoly by physicians has been the definition of most health problems as "illness" requiring specific and immediate diagnosis and treatment.[132]

Challenging interests, the "corporate rationalizers," seek to shape the system so as to maximize profits. The health care system is described by the Ehrenreichs as a multibillion-dollar business.[133] They note that, "the drug, hospital supply, and hospital equipment industries have already begun to blur into a single 'health products' industry. Profit-making hospital chains are creating vertical chains including construction and supplies and equipment." The suppliers have a heavy stake in a centralized health care delivery system because larger service populations sustain the market for complex, sophisticated, and expensive hardware. They shape the system by developing hardware and software packages that are hospital-linked, thus promoting large-scale service over non-institutionalized health care. Writing at the end of the 1960s, the Ehrenreichs observe the development of health industry lobbying and other efforts to affect government policy. Industry representatives—insurance company officers, health corporation officials, computer manufacturer executives, etc.—continue to obtain key appointments on government panels and commissions. The industry is also able to influence public policy by employing hospital and medical school professionals as consultants.[134]

Repressed structural interests are said to include neighborhoods and communities that are medically indigent or simply need more or better services. Their problem, however, is that they must marshal ". . . enormous political and organizational energies . . . to offset the intrinsic disadvantages of their situation."[135]

The role of government in this context of structural interests ". . . is not an independent power standing above and beyond the competing interest groups, but represents changing coalitions of elements drawn from various *structural* interests."[136] (Emphasis added.) Government action has served to reinforce rather than disrupt private health care interests, a contradiction to the popular ideology that ". . . the private sector contracts when the public sector expands. . . ."[137] Increasing federal assistance has improved care for low-income and older people, but left in its wake a compounding of systemic dysfunctions.[138] Alford concludes that while conflict between structural interests may lead to internal efficiencies in the health care delivery system, ". . . the larger issues of preventive care, neighborhood outpatient clinics, and so forth, which cannot easily be organized in a humane way by corporate structures in a market society, will be ignored."[139]

To summarize, then, the market-based antidote to problems in the health care system is a strong free-market approach underpinned by government-sponsored insurance subsidies and maintenance of the institutional status quo. The bureaucratic prescription is for new forms of government-financed care, in addition to fee-for-service, all planned and coordinated by the pub-

lic bureaucracy. A third, community-based reform strategy, initiated by repressed structural interests, rejects piecemeal reforms and the view of health care as a marketable commodity; and aims instead for institutional reconstruction.[140] These reform strategies reflect two basically different assumptions: ". . . that America is a wealthy, democratic, egalitarian society . . . [or, alternatively, that] its democratic political institutions conceal a fundamental lack of access to decision-making power by a large fraction of the population."[141]

Many other writers provide useful if less comprehensive commentaries on the U.S. health care system. Fox suggests the notion of "medicalization," the tendency to overdependence on professional treatment of pain, sickness, and disease.[142] He contends the result is that behavior once considered sinful or criminal is now socially defined as sickness, appropriate grist for an already overburdened medical mill. For Fox, the medicalization process is closely tied to the professional monopoly on health and sickness, as well as biotechnical advances and the scale of expenditures for health and medical services. He also argues that medicalization is being offset in impact by growing trends to demedicalization.

3. Reform Strategies

Analyses of the health care system often produce quite different reform strategies. Ginzberg concludes that because health care is labor-intensive; improvements will require major increases in expenditure levels and thus "cost constraint is not a realistic goal."[143] Reinhardt points out, however, that additional funding for medical care would increase demand and ". . . place an added burden on the nation's already strained health care provider system."[144] Anderson, on another tack, points to group practice, comprehensive preventive care, and prepayment as prerequisites for meaningful reform.[145] And Mechanic, like Reinhardt, argues against additional funding per se, and likewise rejects group practice, health centers, and prepaid care as solutions.[146]

Mechanic proposes that models for the future must develop ". . . entirely new types of workers, whose prime concerns will be the continuity of health care, the health education of the patient, and the coordination of the technical and social aspects of health care service."[147] The goal is to substantively improve health care through much greater utilization of paraprofessionals and allied health professionals. Reinhardt reaches a similar conclusion by a different route. His inquiries are directed to finding means of increasing system productivity. He states that, notwithstanding existing legal and professional restrictions, major productivity increases—from 40 to 75 percent—are possible by optimizing use of physician aides, nurse practitioners, technicians, assistants, and other health and medical workers.[148] Reinhardt's rationale for more efficient utiliza-

tion of non-physician health workers is not prevention oriented. To show their potential as primary treatment agents, he cites testimony to the U.S. Senate Health Subcommittee by Professor William B. Schwartz, Chief of Medicine at the Tufts University medical school:

> . . . if we undertake a rigorous analysis of what the doctor does, we will almost certainly find that a substantial number of his tasks, now considered sacrosanct, could be done instead by skilled technicians who could be quickly trained for single specialized tasks: for example, to diagnose and treat simple fractures, remove an appendix, strip varicose veins, carry out therapeutic abortions, or perform needle biopsies on the kidney and liver.[149]

Views vary widely about the efficacy of preventive health care programs. Lewis argues that preventive medicine offers little prospect for more than minor improvements in health care.[150] Knowles, however, makes a more persuasive case for the contrary position—that "we have developed an acute, curative, hospital-based system that favors older people. . . . made all the more serious by the lack of emphasis on the detection and prevention of disease."[151] He identifies a strong anti-prevention bias among medical educators and teaching hospitals.[152]

Knowles sees a wide range of possibilities for preventive health care: Heart disease, cancer, and strokes, the chronic diseases of middle and old age, are prime candidates for preventive programs.[153] Immunization levels in the U.S. are, in many cases, dangerously low. Officially reported cases of gonorrhea and syphilis totaled nearly one million in 1974, and unofficially the Public Health Service places the number at nearly three times that figure. There were nearly 600,000 "unplanned and unwanted" births to teenagers in 1974. Preventive mental health care potentials exist through genetic counseling for Tay-Sachs disease, Down's syndrome, and PKU (phenylketonuria). Knowles states that "30 percent of severe forms of mental retardation could be avoided in the United States if all currently available scientific information were utilized, namely, identification of parents carrying recessive genes, birth control, amniocentesis and induced abortion, screening and treatment at birth. . . ."[154]

In another brief for preventive health care, Somers maintains that "lifestyle" is one of the country's major problems; that is, drug addiction, car accidents, venereal disease, heart disease, alcoholism, and other problems are mainly the result of ". . . living conditions, ignorance, or irresponsibility of the patient—not susceptible to additional expenditures for medical service delivery or reorganization of the delivery system."[155] Somers suggests a two-part solution strategy: first, nationwide health education and preventive care programs. She recognizes that this proposal may be difficult to implement, however, because of opposition from certain industries,

such as tobacco and alcohol. Secondly, Somers proposes that new allied professionals may make it possible ". . . to shift . . . primary attention from crisis intervention to lifetime prevention of disease and health maintenance."[156]

4. Past Scale-Reduction Reform Programs

Top-down-sponsored efforts to decentralize or reduce the scale of health system delivery units are not new. Both public and private sector interests initiated plans for neighborhood-based health care in the past; and probably without exception, they have shared the goal of increasing citizen action or participation in policy-making and treatment activities. These attempts at health care reform also share a commitment to expanded employment of paraprofessionals.

An early private sector attempt to enhance citizen participation in government activity and provide neighborhood-based health care was begun under the auspices of the Cincinnati Social Unit Organization (CSUO). The social unit plan that served as the base for the organization was drafted in 1914-15. The origins of the plan were in the experiences of Wilbur and Elsie Phillips' neighborhood work in Milwaukee. They developed a child health center and district medical-nursing committee. According to Shaffer,

> they became convinced that developing programs in a single district and then expanding district by district was the soundest approach to introducing new services. . . . As they saw neighborhood residents identifying with the health center as a "part of their neighborhood," they became convinced that the notion of a "cooperative commonwealth" was indeed feasible.[157]

The Phillips believed that genuine democracy must be based on nonpartisan government, ". . . with the block as the basic political unit." Their plan was to ". . . introduce democratic social units, on a neighborhood basis, focusing on block development, coordination of expert resources, and a community council."[158]

The National Social Unit Organization (NSUO) was launched with approximately $100,000 in contributions from prominent philanthropists. The national organization was to provide funding and technical assistance to the first local affiliate, in Cincinnati, which was to be an independent, democratically organized entity for self-help and service coordination. The CSUO was initiated at the beginning of 1917. The first objective was to organize 31 block councils. Each council would elect a block worker to the citizens' council which would be responsible for ". . . uncovering the needs of the total district and guaranteeing that plans and programs were developed to meet these needs."[159] "Occupational councils," comprised of workers from different

occupational groups, were also organized, each with a representative on the district council. Both councils meeting together made up the "general council" that was responsible for overall policy-making and budgeting.[160]

A child health center offering medical and preventive health care services was the first CSUO project. Shaffer describes the center's accomplishments:

> The health center, with only four nurses, provided nursing care to one-half of the district population, gave complete medical examinations to 90 percent of the children under six years of age, provided nursing care to all the infants and preschool children found to be in poor health, achieved a fourfold increase in tuberculosis supervision and a fivefold increase in the care of sick children and adults, gave prenatal services to 45 percent of the expectant mothers, established the first special clinic for examination and treatment of persons convalescing from influenza, and provided information on symptoms and treatment of influenza within twenty-four hours of receiving such requests from public health officials.[161]

The beginning of CSUO's demise came in March of 1919 when Cincinnati's mayor attacked the program as "socialist," the first chink in what had been uniform local support. Next, the city's Council of Social Agencies withdrew its support in response to threats from its own prominent contributors. By 1921 the CSUO was defunct and the NSUO had been placed in receivership, victims of antagonism from influential members of the community. Shaffer concludes that, despite the vulnerability of the organizations to powerful community interests, ". . . the social unit approach [was] tested and shown workable. . . ."[162] Presumably, his reference is not to top-down sponsorship but the prospect for operational efficiency in decentralized health care service delivery.

Reynolds chronicles a small-scale cooperative social services undertaking between the National Maritime Union and the United Seaman's Service (a USO-type organization). In part, the aim of this wartime project (circa 1943) was to use contract private agency services ". . . to see how a group employed in one industry would respond to a social agency which was not public, but which they could think of as their own." The seamen who used the service in this arrangement were themselves the sponsors, and it was located in their union hall. This fact had several implications: Caseworkers were responsible to the union membership, which represented both policy-making authority and consumer interests. For the union members, "not only do . . . [they] belong in the agency when they first come, without having to be selected for its benefits, but the relationship is a continuing one."[163]

Reynolds suggests that the character of the Maritime Union project accounts for its success in overcoming common consumer resistance to accepting services from traditional social

work agencies. Union members had an important role in policy-making and thus a genuine sense of program "ownership." The practice of offering service within the union hall itself significantly diminished the social work tendencies to deny clients' adult status and dismiss their judgment and honesty out of hand. The organization of the project also served to eliminate "the criterion of having a recognized capacity to pay . . ." and was able to convey in practice the principle "that help must be what it looks to be."[164]

The development of Neighborhood Health Centers (NHCs), financed by the federal government in the 1960s, is thought to have been a response to the medical indigence of low-income populations, mainly urban and Black. Declining municipal hospitals and fewer doctors practicing in inner-city neighborhoods compounded their medical problems. At the outset of the program, the Office of Economic Opportunity (OEO) received "scores of applications" to allocate funds for "fragmentary" health services. They rejected the majority of these proposals in favor of supporting comprehensive projects.[165] About 100 neighborhood health centers and other comprehensive health services projects were begun with OEO support between 1965 and 1971. Approximately $400 million was expended to provide service to about three million people. Most of the projects have been "free-standing" health care centers.[166]

NHC service populations range from 6,000 to 50,000.[167] Typically, one-half of the NHC employees are neighborhood residents.[168] While the model incorporates a prevention component, preventive efforts appear to be limited to minor attempts at early case-finding rather than large-scale education designed to promote lifestyle changes.[169] A case in point, the Montefiore Medical Group demonstration was designed to encompass immunizations, annual physical exams, "emotional support," and health education. The expectation of professional staff was that "presumably, the very existence of a health team would encourage the early use of its members for problems and difficulties, and therefore act as a preventive measure."[170] The demonstration also included a lifestyle-change component. This was an office-based program, extended for the most part to patients being seen for other reasons. It included attempts to modify family childrearing practices (from autocratic to democratic) and eating habits. Most of the instruction took place in small group meetings, in which attendance is described as "limited and rather selective."[171]

Staff analysis of low participation in prevention programs focused on other activities and interests that might compete for an urban resident's time and energy, plus economic factors such as babysitter costs, two-job parents, etc.[172] It was also noted that the demonstration did not draw together people with a common basis for action:

> Our families had no community relationship with each other and did not depend on one another for guidance or leadership or diffusion of ideas. The influence structure and community power network that determine use of a community service like the Demonstration could not be tapped.[173]

The Montefiore group used two approaches to prevention, early case-finding and health education to promote lifestyle changes, but neither with much success. While successful early case-finding holds out the hope of improving individual care by early intervention that limits the course of disease, it also presents the promise of increasing the demand for service and thus the burden on the delivery system. On the other hand, large-scale health education aimed to produce lifestyle changes must—as the Montefiore experience shows—engage substantial citizen participation in the actual prevention activity.

A significant influence on the course of federally funded health centers is that they have been sponsored as demonstrations.[174] Writing in 1972, Howard observed, NHCs are on notice ". . . that they must . . . find ways of becoming self-financing."[175] One explanation for this situation is that Congress intended that the health initiatives of the 1960s "not impinge on the practice of medicine. . . . [but] buy care from the private sector without interfering with it."[176] A less compelling explanation for declining federal support is that NHCs are not economically efficient. Klarman's view is that they are generally competitive with other delivery systems; however, their use of "registered" rather than "enrolled" population counts, and certain allocation-of-overhead practices, tend to understate per capita costs.[177] Sparer and Anderson conducted a two-year study of six OEO-funded NHCs and concluded they are competitive with other providers.[178]

Wildavsky describes the transition of federal funding from NHCs to Health Maintenance Organizations (HMOs):

> As neighborhood health centers phased out, the health-maintenance organizations phased in. If the idea behind the NHCs was to bring service to the people, the idea behind the HMOs is to bring the people to the services. If a rationale for NHCs was to exert lay control over doctors, the rationale for HMOs is to exert medical control over costs.[179]

HMOs are a market approach to health care service delivery. Like NHCs, they too are designed to provide a total package of health and medical care, short of satisfying inpatient and major surgical needs directly. They provide comprehensive services under contract for a fixed premium. They may be proprietary or nonprofit, and organizationally structured as a group practice, medical foundation (association of solo practitioners), or in some other form. Their claim to bring about competition seems mainly rhetorical given the "exclusivity of franchise" granted to each

individual HMO.[180]

5. Citizens as Co-Directors

A number of questions have been raised about citizen engagement in neighborhood-based health services, not as patients or clients, bus as co-directors of administration and treatment activities: Should patients or funding agencies determine needs? Should community programs be accountable to government agencies or the public at large? Should government agencies or community groups determine program priorities? Who speaks for the community and how is that determined? Can community participation be meaningful without control?[181] Two related issues emerge from these questions: the role of citizens in policy-making and their employment as staff.

As top-down-sponsored enterprises, NHCs are the ". . . focus of a number of [professional] reform ideas in health care. . . ."[182] They are operationally controlled by agencies and organizations not primarily based in the community served, such as public health departments, medical schools and associations, and *citywide* antipoverty agencies.[183] Zwick states that health agency professionals organized most NHC projects.[184]

Citizen participation on NHC advisory and governing boards is estimated to range from a low of one percent to just over 30 percent ". . . in a few cases where massive efforts were made to turn out service populations. . . ."[185] Participation has been described as an "energizing force" or "related to the selection of key staff," but these characterizations nearly always include oblique references to conflicts between citizen-controlled boards and administrators ". . . as to appropriate divisions of power."[186] One observer suggests that while citizen boards frequently want program control, they have neither ". . . the mandate nor the machinery to carry out this important function."[187]

The experience of the Lincoln Community Mental Health Center in the Bronx, New York, is an example of how a top-down- sponsored health care organization accommodates consumer demands for citizen engagement in policy-making. Community protests had resulted in a ". . . complete stoppage of services" when the center's management decided to establish a "central community board," an advisory group comprised of elected representatives from three of the main community organizations in the area. The advisory board is credited by the center's managers with having played a praiseworthy role in staff selection, programming, and budgeting, but it is noted that the citizen board ". . . recently decided to convene only when the need arises."[188]

Tischler outlines the experience of the Hill-West Haven Division of the Connecticut Mental Health Center. The center's organizational model initially specified its mission as repre-

senting a "working alliance between consumer and provider."[189] [Original italicized.] After three years of "community development" activities, the center formalized citizen participation by recognizing community-designated consumer advisory boards to which the center "was to be accountable." Dreams of accountability notwithstanding, the effect of citizen participation is pictured as being limited to sensitizing administrative decision-makers to community-perceived priorities for services to children and the elderly. Also, community residents were hired to fill staff positions.[190]

In reviewing NHCs developed under OEO and later sponsored by the Department of Health, Education, and Welfare, Howard contends that participatory conflict is closely related to the direction of sponsorship, whether top-down or bottom-up.[191] By the early 1970s, government sponsorship of decentralized health care service delivery and accompanying participation ideology had begun to wane,[192] a circumstance intimately related to the conflicts engendered by these programs, which often eventuated into attacks on the government sponsor.[193]

6. Utilization of Non-Physician Health Workers

The second major theme to emerge from questions about citizen engagement in NHCs regards broader utilization of indigenous paraprofessionals and allied professionals in treatment activities, particularly as (1) intermediaries between patients and physicians, (2) educators, and (3) primary treatment agents. Reiff and Reissman spell out those tasks related to mental health services that are appropriate for "nonprofessionals." These include community action (canvassing and organizing), homemaking, childcare, parent education, interpreting (mediating between professional and lay people), negotiation and advocacy, public education, companionship, and counseling.[194] Adding primary treatment functions can expand the list. It seems that most jobs for NHC employees, however, are limited to aides, advocates, and intermediaries.[195]

The use of indigenous workers as lay-professional intermediaries involves the lowest degree of autonomy and independent responsibility. The Mount Carmel Guild Mental Health Center in Newark, New Jersey, for example, developed an ombudsman program. The success of the program has been credited to the use of nonprofessional personnel with close communication links to the community, making the center's caseload ". . . more representative of the community's racial and ethnic population. . . ."[196] Pittsburgh's Mercy Hospital "health care expediter program" was designed as a ". . . liaison between . . . consumers and suppliers of health care." Mercy Hospital is located in a low-income urban area and relies on indigenous outreach workers. Tasks include follow-up on patients who have missed appointments, initiating contacts with

community organizations and other agencies, and providing social service referrals. Expediters also share the responsibility for explaining test results to patients, interpreting staff instructions to them, and occasionally taking a low-key advocacy role on their behalf. They receive 15 weeks of training, combining classroom instruction and field experience.[197]

The most common role for indigenous workers falls under the rubric of education. Although one program of "neighborhood representatives" is described as a vehicle for professionals to close the distance between themselves and low-income populations, the representatives act—without direct supervision— to organize and conduct neighborhood health care information meetings. Training consists of a two-day orientation followed by ". . .a continuous problem-oriented process . . . , not a structured program terminated at a certain point." The program is deemed successful in its "preventive" health care projects for expectant mothers and mothers with newborn infants.[198]

The Contra Costa project was started in North Richmond, California, a minority community with the lowest family income in the county. The program goal was ". . . raising the level of knowledge and concern about immunization." Indigenous residents were employed as "health aides." They were recruited for their ". . . maturity, poise, and participation in community activities . . . ," rather than their educational achievements. Formal training classes were held daily, five days a week in four-hour sessions, for 17 days. The aides made door-to-door house-visits, collecting and disseminating immunization information. Tasks were incrementally expanded to include surveillance of families with non-acute health problems for which public health service nurses had been unable to make headway. In time, the aides assumed advocacy roles on behalf of these families. The Contra Costa project is thought to be successful on two counts: Twelve of 30 families being supervised took definite steps to alleviate their problems. And in a special measles inoculation program, the aides found 64 families with children susceptible to measles and eligible for a new vaccine being given. Of those identified, one-quarter appeared at the next scheduled clinic.[199]

The Harlem Rehabilitation Center program created a ". . . primary therapeutic agent role for community residents recruited from and indigenous to the community." New careerists at the Harlem center provide therapeutic counseling. Trainees do not meet formal educational requirements but must show ". . . potential for constructive self-criticism and personal growth, for helping relationships and communication with others, and for learning the principles and skills necessary. . . ." The program provides a career ladder with four grades: trainee, worker, senior worker, and technician; and four specialties: social health, socio-therapeutics, and vocational and educa-

tional services. Training includes basic and advanced on-site experiences, plus formal classes at local colleges and universities.[200]

7. Potential for Greater Reliance on Non-Physician Health Care Workers

As already suggested, the economic viability of health care service delivery through decentralized organizations is linked to utilization of non-physician health care workers. Thus, potentials for greater reliance these categories of workers are explored here.

In 17th century Russia, feldshers—middle-grade medical workers (MMWs)—emerged as military medics because of a paucity of doctors. They continued to be the medical mainstays of the Russian army into the 19th century. During this period, former military feldshers began to provide medical care for peasants in rural areas. Feldshers were originally trained through preceptorship, but in 1864 five two-year schools were opened to provide formal training. By the turn of the century there were 32 schools, and by 1913 there were 30,000 feldshers. For a time the new Soviet government tried to end feldsherism, but the effort was abandoned by the late 1920s in the face of growing medical care needs.[201]

As middle or medium grade medical workers, feldshers are below physicians, who are university or institute graduates, and above personnel who receive only practical training.[202] The profession is divided into four specialties: "general practitioners," sanitarians, laboratory technicians, and a few midwives. Today's feldshers are primarily *urban* health workers. Approximately 30,000 are graduated annually (compared to 28,000 physicians). Victor Sidel observed feldshers in urban settings, working ". . . directly under a physician's supervision, often within a medical team." He also notes, however, references in the Soviet literature that describe the feldshers ". . . as practicing relatively independently of the physician in rural areas."[203] Practicing in a feldshers-midwife station, MMW services include:

> epidemic control measures; reduction of childhood morbidity and mortality; early case-finding, observation and medical service ("under the guidance and in accordance with the instructions of a doctor") for tuberculosis, malignant tumors, and other diseases; "timely provision of pre-doctor medical aid to the adults, women, and children, and the carrying out of therapeutic procedures described by the doctor"; "sanitary and hygienic measures to improve the living and working conditions of the people engaged in farm production"; and health education. . . .[204]

The most serious criticism of feldsher practice by Soviet medical authorities revolves around diagnostic inadequacies, attributed in part to ". . . the lack of indispensable diagnostic apparatus and the absence of day-to-day control of the feldsher's work." In some cases, careless-

ness and negligence are thought to be at fault. On the plus side, feldshers are singularly credited for disease prevention in rural areas, providing immunizations, health education, and accident prevention programs.[205]

Nurse practitioners and physician assistants are the closest U.S. parallels to Soviet middle-grade medical workers. Pediatric nurse practitioners work mainly as associates of physicians in private practice. They provide medical evaluation and management of healthy children, as well as those with acute and chronic problems. They are often responsible for *total* well-child care, plus child-related health education and counseling. Pediatric nurse practitioners are not tied to office-based practice but also work from field stations. Physicians may be on-premises or may make station visits once or twice a week. The nurse practitioner, however, is always technically under the supervision of a physician, and a physician regularly sees all children. The nurses also make home visits to see newborn infants, a service not practicable for physicians.[206]

Tighe cites a 1967-68 survey, conducted under the auspices of the American Academy of Pediatrics, that concludes, ". . . nurses might naturally assume many of the traditional tasks of the pediatrician." She refers to other studies that show nurse practitioners ". . . could care for about 75% of pediatric needs in a routine population" and that "82% of all children who came to a health station which was removed from any physician or medical facility were cared for by the nurse. . . ." Tighe also notes that high proportions of patients express satisfaction with nurse practitioner-pediatrician teams, more than half feeling the care was superior to that received from the pediatrician alone.[207]

In addition to pediatric nurse practitioners, family nurse practitioners, nurse midwives, and nurse anesthetists are assuming broader roles and receiving more intensive training and recognition.[208] It appears there are not any insurmountable legal obstacles to broadening nurse practitioner roles. Legislative acts ". . . are conveniently vague with the particular functions which a nurse may perform not specifically delineated." The transfer of responsibility from doctors to nurses is expected to continue incrementally, at a slow but steady pace.[209]

Physician assistants represent a relatively new middle grade medical worker. A 1971 conference report defined the assistant's role to encompass tasks previously performed by a doctor but now carried out by ". . . a skilled person . . . under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."[210] The Illinois guidelines for physician assistants specify the following tasks as appropriate: taking medical histories; providing individual and group health education, office- or clinic- and community-based; administering immunizations, prophylactic dental care, and therapeutic dietetics; symptomatic therapy for mi-

nor and chronic conditions; taking throat cultures, or ordering blood counts, urinalysis, x-ray, or electrocardiogram; and ongoing responsibility for managing selected clinic categories, such as well-baby, normal prenatal, etc.[211]

The so-called exception statutes that permit physicians to delegate tasks to assistants working under their supervision generally do not require the "personal presence" of the doctor. It is normally considered sufficient if some "immediate method" of communication—usually telephone—is available between physician and assistant. Three types of supervision are allowed: "over-the-shoulder," "on-the-premises," and "remote with regular monitoring and review." It is well understood that ". . . physician assistants or nurse practitioners can work at substantial distance from the physician but still be legally 'dependent' because their actions are subject to continuous medical review and direction."[212]

California regulations require physicians to consult with their assistants "before and after the rendering of routine laboratory, screening, and therapeutic procedures."[213] Physician assistant regulation in California, however, is in flux. Current committee deliberations in the Legislature include provision for physician supervisory overview on the basis of a "sampling of conditions." Autonomy may be further extended by allowing assistants to work under protocol: "if the assistant has done this step and this step and this step, then he can apply preset standards for diagnostic studies and treatment modalities." While the assistant is prohibited from writing prescriptions, it is permissible to issue a prescription under the physician's protocol.[214]

Nearly 50 physician assistant-type training programs were operating in more than two-dozen states as of 1972.[215] The Duke University program began in 1966. It is a two-year curriculum, 1,111 classroom hours. Formal instruction is followed by 14 months of supervised clinical experience, including two months each in inpatient, outpatient, and emergency departments. One month is spent in an intensive care unit and one in a health clinic, with the final two months of practicum under the supervision of a community-based physician. The Medical Services Associates Program of the Brooklyn-Cumberland Medical Center and Long Island University was started in 1970 and offers a two-year course. The University of Colorado Child Health Associate program is a three-year baccalaureate degree sequence.[216]

In all cases of physician assistants and nurse practitioners, the doctor remains legally responsible for the patient's care. The consensus of conferees at the 1971 conference on physician assistants was that the growing utilization of these allied professionals would not aggravate medical malpractice insurance problems. It was thought, to the contrary, that as more assistants enter practice the basis for malpractice actions—communications breakdowns between patients and

doctors—would be reduced.[217] It is assumed that assistants will free up physicians for tasks only they can manage, the assistants will be able to devote more time for routine care, and communications with patients will be improved. The widely accepted view is that physician assistants do not create malpractice issues not already raised by the employment of nurses and other allied health professionals.[218]

8. Health Care in the People's Republic of China

The argument most frequently heard for neighborhood-based health service is that ". . . one's state of health is only in small part related to medical care and that it is significantly linked to behavior. . . ."[219] Thus, the Chinese health care system is of particular interest in considering vill-sponsored health care. Integration of health work with mass social movement was one of four principles adopted by the Chinese National Health Congress in Peking in the early 1950s. The goal was to involve people in their own care. The outcome was that

> during the first decade and a half of Communist rule. . . . cholera, plague, smallpox, and most nutritional illnesses disappeared; opium addiction was eliminated, largely through community-based efforts; venereal disease took somewhat longer, but through a combination of social and medical techniques was reportedly almost completely wiped out in most of China by the early 1960's.[220]

The Chinese health care system rests on a nationally articulated ideological foundation: mutual help, self-reliance, and learning by doing are widely encouraged; health care must primarily serve working people, workers, peasants, and soldiers; preventive medicine has priority over curative medicine; traditional Chinese medicine must be united with Western practices; and, again, health work must be integrated with mass movements.[221] It is also clear to observers that the valuation of practical experience and performance over education and degrees is an integral part of China's health care transformation of the past three decades.[222]

In an economic analysis of Chinese health care delivery, Teh-wei Hu describes the system as ". . . not centralized" and ". . . even less socialized than the Canadian system." He notes that neither the central ministry (our federal level) or district bureaus (our state authorities) are responsible for direct management of local hospitals or ambulatory health care: ". . . the major tasks of health care delivery and health services financing are left to the local political units."[223] Ruth Sidel confirms that although central bureaus establish "broad principles" of planning and programming, local committees develop unique service patterns and payment plans to meet their own needs.[224] Dr. Joshua Horn, a long-time practicing physician in China, relates that

> . . . the policy of the Chinese Communist Party is that . . . unless the persons actually concerned have had an opportunity to debate problems *and formulate policy*,

> decisions handed down from above are likely to be wrong. Moreover, unless those who have to operate a policy are convinced of its correctness, it is likely to remain a policy on paper only. In the long run, the key to high working efficiency is to make correct decisions on the basis of unity of purpose, after a detailed examination of all the facts and a full democratic consultation of those involved, and to ensure that everyone understands and supports these decisions.[225] [Emphasis added.]

The lowest level of urban Chinese government—run by "street committees"—serves populations of 40,000 to 70,000. These areas represent subdivisions of municipalities and districts, and they are, in turn, subdivided into "lanes," the lowest level of administrative decentralization and polity. Lane organizations provide health, department store, and grocery services to populations of 1,000 to 8,000. Each lane has a "revolutionary committee" mandated to organize and operate social services and study groups, and to mediate disputes.[226] The urban health care delivery system operates on four levels: lane and neighborhood health stations, district hospitals, and municipal or specialized hospitals.

The lane health station specializes in health education and prevention programs, treatment of minor and chronic illness, and sanitation.[227] Services include childcare, medical treatments, visiting nurse and homemaker assistance, foster care for orphaned children, and assistance to patients recently released from psychiatric hospitals.[228] The most important *economic* function of the lane health station is as a low-cost portal of entry into the total health care system. The stations are staffed by low- to middle-grade medical workers, trained for about a month at neighborhood hospitals. A doctor from the neighborhood hospital may visit the station three times a week. The station may be open six hours a day and at other times health workers can be contacted at home.[229]

The prevention activities of the lane health station are based on citizen and paraprofessional involvement. Part-time health workers, two to five or ten for each block, canvass monthly to survey residents on birth control practices and to provide education. These health workers are neighborhood residents; some are homemakers or retired, but most hold other jobs.[230]

Since the cultural revolution, paraprofessionals have been trained in large numbers to provide health education and treatment of minor illness. The rural "barefoot doctors" and their "Red Guard" urban counterparts receive formal training for three to six months. They divide their time between agricultural or industrial work and health care service. "Worker doctors" receive training for one to three months and give unsupervised minor medical treatment. The health workers, who are the first-line agents for health information, immunizations, and minor treatments, are trained by and responsible to barefoot doctors or Red Guard doctors.[231] Ruth

Sidel observes that

> Human services are provided at the lowest level of organization largely by non-professionals recruited from the communities in which they live. Social health workers are trained for brief periods of time in the hope of eliminating the alienation that occurs during extended educational experiences and in the hope of decreasing the distance between the helper and the helped.[232]

The "cooperative medical services" concept of decentralized health care financing was adopted in China to relieve from the central government the financial burden of national health care. Participation in the program is voluntary. Charges vary among communes and are based on expenditures for the previous year. The cost averages 1.5 percent of a family's disposable income, which is comparable to median expenditures in the U.S. and Western Europe. Each commune production team also makes a contribution for service to its members who subscribe to the program. In addition to subscription fees, there is a small charge (co-payment) for visits to the health station. When local treatment is not sufficient, the patient is referred to the next level in the system and the cooperative assumes part of the costs for x-rays, hospital care, or whatever is required. The patient's contribution varies according to the particular plan and a lay peer group reviews requests. Teh-wei Hu states that, "free medical services or unlimited amounts of medical finance are not feasible even in a socialized country." Financing by the national government is directed mainly to capital projects, hospitals and clinics.[233]

In considering the relevance of China's health care system for Western countries, Teh-wei Hu acknowledges that the Chinese are able to rely on unique political circumstances and social incentives, and an almost complete absence of licensing regulation of medical professionals. Nonetheless, he concludes that ". . . what other countries can learn from the PRC [People's Republic of China] experience is not necessarily the effectiveness of the Chinese *total* health care system, but some of the experiences they have revealed." He notes the following points: ". . . decentralization is an effective and economical approach to carrying out the health care plan"; an effective, economical delivery system requires a low-cost screening and referral mechanism, and organized local infrastructure is a ". . . ready-made link-up system for medical referral"; co-payment is an appropriate means to limit over-utilization; and paramedical practitioners can be used successfully on a large scale.[234]

Victor Sidel "disputes" observers who say ". . . the Chinese experience is unique to China. . . ." He lists as important lessons for the U.S.

> increased emphasis on preventive medicine, particularly for "social illnesses" such as venereal disease and drug addiction, and for degenerative diseases such as lung cancer; decentralization of services to the most basic possible level, with in-

> creased accessibility to appropriate treatment for common and minor illnesses; standardized referral patterns for specialized care, so as to make optimal use of expensive and scarce resources; and involvement of people in the provision of their own services through community health education and community health work.[235]

Ruth Sidel describes the use of indigenous paraprofessionals in China as "astonishing" from a social work perspective. She observes that Chinese paraprofessionals maintain their original work roles and tend not to be isolated from those they serve. Sidel contends that bureaucratized, institutionalized social service may, on balance, contribute to rather than relieve individual and social dysfunction.[236] She suggests that in the U.S.

> much of the social services performed by professionals in agencies might be accomplished far more effectively by neighborhood people helping each other. Perhaps rather than taking over services, the social work profession needs to activate local people to take over these functions themselves on a broader and more systematic scale than was tried during the War on Poverty.[237]

9. Summary

This inquiry into prospects for economically efficient vill-sponsored health care has identified a number of problems in the U.S. health care system. Some of these are related to inadequate resources for production of services, while others—for example, inappropriate utilization of hospital-based services—suggest a failure to eliminate public bads.

Alford's conceptual framework gives an overview of the character of obstructions to reform. The perspective, adopted here, is that entrenched structural interests have a stake in the maintenance of a large number of market-oriented service units coupled with a centralized hospital-based service delivery system. Conflicts between dominant and challenging structural interests lead to internal efficiencies, but ignore systemic dysfunctions that price health care out of reach for the majority of low- and middle-income U.S. families.[238] The government role has been to reinforce private health care interests and provide nominal improvements in care for low-income and older people while avoiding institutional reform. Reform strategies that extend beyond increased government funding, prepayment, or some form of group practice, rely on comprehensive preventive care aimed at promoting lifestyle changes and much greater use of non-physician health workers, neither of which has much appeal to market-oriented structural interests.

Past demonstration efforts to reduce the scale of health service delivery have produced a

number of tentative findings relevant to vill-sponsored health care: The Cincinnati Social Unit Organization, while demonstrating the practical efficiency and usefulness of neighborhood-based health care, was ultimately vulnerable to withdrawal of top-down sponsorship and funding. The National Maritime Union-United Seaman's Service project suggests that approaches to scale-reduction that rely on bottom-up funding and sponsorship—integrating policy-making and consumer functions—are likely to produce greater demand-articulation efficiency and less misallocation of resources. The federally-funded Neighborhood Health Center demonstrations (and Community Mental Health Centers) point up two critical and related aspects of all attempts to reduce the scale of health care service delivery: engagement of citizens in policymaking and treatment activities. The NHCs are not examples, however, of well-founded or successful lifestyle-changing prevention programs. Also, the failure of continued NHC program growth appears not to be an indication of underutilization or economic inefficiency but vulnerability to the political and bureaucratic vagaries of top-down sponsorship. Citizen participation in the top-down funded and sponsored NHCs did not extend to control but rather was limited to providing "input." NHCs, however, typically employ large numbers of indigenous residents in paraprofessional staff positions, usually as "interpreters," health educators, and rarely, as primary treatment agents, often with marked success.

The potential for increasing utilization of allied health professionals as primary treatment agents seems assured by present trends to incrementally expand nurse practitioner roles and the scope of training facilities for physician assistants. Although professional medical licensing and "exception" statutes place restrictions on the independent actions of non-physician health professionals and on the supervisory reach of physician-assistant working relationships, the allied professionals are not prohibited from providing treatment services while not in the presence of a physician.

The health care system of the People's Republic of China, although founded on an ideological consensus that is national in scope, is a largely decentralized system, both in service delivery and financing. It is, then, in some respects, a model for vill-sponsored health care. The Chinese system enjoys the cost-saving benefits of neighborhood-based outpatient clinics that serve as screening-referral portals of entry to more specialized (and expensive) hospital-based services. The lane health station is also the center of intensive lifestyle-changing prevention programs and direct treatment for minor and chronic problems, and relies almost exclusively on paraprofessionals and engagement of indigenous citizens. Western observers of the Chinese system generally agree that it provides several instructive lessons for U.S. health care reform, par-

ticularly in regard to decentralized screening-referral and minor treatment, emphasis on prevention, greater utilization of non-physician health care workers, and involvement of citizens in their own treatment and care.

This discussion began with the question of whether vills can play an economically useful role in responding to the critical U.S. deficiencies in health care. It is not a matter of whether every neighborhood can or should develop its own health care system, or whether the country's health care problems can be resolved by vill-sponsored health care adopted on a national scale. The issue is if one community that identifies a local need for improved health care can generate an efficient and useful response to that need.

Four main innovations or strategies have been associated with overdue health care reform: a decentralized screening-referral mechanism that provides for non-hospital-based portals of entry into the system; expanded use of non-physician health workers in treatment and prevention activities; community-based lifestyle-changing prevention programs; and engagement of citizens—as policy-makers and treatment agents—in their own health care.

The prospect for top-down adoption of these innovations on a large scale is uneven at best and unlikely at worst. Alford's framework suggests that powerful vested interests have stakes in the present system of market-oriented service units, both hospital-based and fee-for-service solo practitioners. The paradox for the medical profession to support prevention programs on a national scale is that doctors and hospitals would not be the principal beneficiaries of the resources expended, presumably an unacceptable outcome in their view and a plausible explanation for the absence of such programs. The likelihood also seems dim that "professional monopolists" and "corporate rationalizers" will initiate or support appropriation of resources for the development of local infrastructure to bring about widespread citizen action in health care delivery. It may be reasonable, however, to be hopeful that non-physician health care workers will continue to grow in number and responsibilities.

The implicit suggestion made throughout much of the discussion here has been that improvement in health care is mainly a political problem rather than a professional one. As Howard puts it, "health is an interest around which communities or neighborhoods can organize to achieve larger political objectives."[239] And certainly, vills—small-scale neighborhood institutions of political infrastructure—are congenial to the reform innovations that have been identified in this review.

The Chinese health care system may be a model for the urban U.S. vill. It is almost within the bounds of present California law and regulations for physicians to operate neighborhood

clinics staffed by a nurse practitioner or physician assistant. Vill-sponsorship of such clinics would create wider latitude for employment of practitioners and assistants. It is estimated that one full-time physician assistant in vill-sponsored health care service could handle approximately 80 percent of the presenting problems of 3,000 patients. In addition to direct treatment, the assistant's responsibilities would include designing and organizing prevention programs.[240] Finally, although the fiscal implications of a plan for neighborhood-based health care service delivery require extensive independent consideration, vill sponsorship would open access to user-taxes and revenue-sharing funds to underwrite service costs.

CONCLUSIONS

Conclusions? No doubt the reader who has come this far has already reached the most important one—whether or not vills are economically efficient. My own conclusions are these: There are endless lists of services and enterprises that small-scale governments may efficiently undertake if certain political-economic principles are respected. Neighborhood institutions may be neither the perfect nor even best platforms for providing public services, but they are unquestionably suitable and even advantageous in some respects. Lastly, there are cautions, dilemmas, even dangers that must be continuously acknowledged, explored, and compensated for.

NOTES

[1] For recent examples, see Charles McC. Mathias, Jr., "A Way to End the Remoteness of Government," *Los Angeles Times*, January 22, 1974; _____, "Bill Would Give Power to the People—Hatfield," *Los Angeles Times*, November 25, 1973. The idea, however, is not new to this country. In his letter of July 12, 1816, to Samuel Kercheval, Jefferson wrote, "divide the counties into wards of such size as that every citizen can attend, when called on, and act in person." See Merrill D. Peterson (ed.), *The Portable Thomas Jefferson* (New York: Viking Press, 1975), p.556.

[2] See George A. Hillary, *Communal Organizations, A Study of Local Societies* (Chicago: University of Chicago Press, 1968), pp. 64-72. The vill is a town or village, a small urban or rural community. Hillary proposes that, "the vill is a localized system integrated by means of families and cooperation" (p. 65). [Original italicized.] Cooperation in the vill may be through mutual aid (folk villages) or contracts (cities) (p. 66).

[3] See Ada W. Finifter and Paul R. Abramson, "City Size and Feelings of Political Competence," *Public Opinion Quarterly*, 39(2):189-198 (Summer 1975); Robert A. Dahl, *After the Revolution? Authority in a Good Society* (New Haven: Yale University Press, 1970); Alex Inkeles, "Participant Citizenship in Six Developing Countries," *American Political Science Review*, 63:1120-41 (1969), p. 1138.

[4] Gerald D. Suttles, *The Social Construction of Communities* (Chicago: University of Chicago Press, c. 1972, 1973), p. 78.

[5] Nicholas von Hoffman, *Finding and Making Leaders* (New York: Students for a Democratic Society, mimeograph, n.d.), p. 10.

[6] William Michael Kitzmiller and Richard Ottinger, *Citizen Action, Vital Force for Change* (Washington, D.C.: Center for a Voluntary Society, 1971), pp. 62-3.

[7] Suttles, pp. 60-1.

[8] Janice E. Perlman, "Grassrooting the System," *Social Policy*, 7(2):4-20 (September/October 1976), p. 4.

[9] For a brief history of the transformation of the Massachusetts Bay Company corporate charter to colonial government, see Milton Kotler, *Community Foundation Memorandum #3, From Colonial Company to Community Foundation; The Corporate Basis of Government* (Washington, D.C.: Institute for Policy Studies, mimeograph, n. d.).

[10] See Charles Hampden-Turner, *From Poverty to Dignity* (Garden City, New York: Anchor, 1975); Milton Kotler, *Community Foundation Memorandum #7, Community Organization in a Clientele Society*, Prepared for Washington Conference on the Returned Peace Corps Volunteers, State Department, March 6, 1965; mimeograph, n.d.

[11] For examples, see Richard P. Appelbaum, "Community Control in Isla Vista," *Working Papers*, l(2):16-28 (Summer 1973); Alan A. Altshuler, *Community Control: The Black Demand for Participation in Large American Cities* (Indianapolis: Pegasus, 1970); Milton Kotler, "Neighborhood Government," *Liberation*, 19(8/9): 119-125 (Spring 1976); David Morris and Karl Hess, *Neighborhood Power, The New Localism* (Boston: Beacon Press, c. 1975).

[12] See Appelbaum; Robert B. Hawkins, Jr., "Special Districts and Urban Services," in (Elinor Ostrom, ed.) *The Delivery of Urban Services, Outcomes of Change*, Vol. 10, Urban Affairs Annual Reviews (Beverly Hills, Calif.: Sage, 1976), p. 172. For proposals on a larger scale, see State Study Commission for New York City, *The Neighborhoods, The City, and The Region: Working Papers on Jurisdiction and Structure* (New York: The Commission, 1973); New York/ State Study Commission for New York City, *Re-Structuring the Government of New York City* (New York: The Commission, 1972).

[13] Michael Parenti, *Democracy for the Few* (New York: St. Martin's Press, 1974), p. 4. Taxing and spending are identified as the two most important functions of government, the prerequisites for all other activities. In discussing the New York City decentralization plan to create districts of several hundred thousand population each, Moynihan suggests that, "if no taxing powers and responsibilities are to be given to the proposed local districts, decentralization will only accentuate the present irresponsibility of municipal government." See Daniel Patrick Moynihan, "Comments on Restructuring the Government of New York City," in State Study Commission for New York City, p. 13.

[14] Parenti, p. 280.

[15] Eli Ginsberg, Dale L. Hiestand, and Beatrice G. Reubens, *The Pluralistic Economy* (New York: McGraw-Hill, 1965), pp. 5-6.

[16] Grants rose from three to 13 percent of the G.N.P. between 1910 and 1969. See Kenneth E. Boulding, "The Grants Economy," in *Collected Papers, Volume Two: Economics* (Boulder, Colorado: Colorado Associated University Press, 1971), p. 477. In *The Economy of Love and Fear* (Belmont, Calif.: Wadsworth, 1973), Boulding estimates that 20 to 50 percent of the U.S. economy is organized by grants rather than exchange (pp. 1-2).

[17] Ginzberg, Hiestand, and Reubens, pp. 8-9.

[18] The definition does not preclude reciprocation with intangibles.

[19] Boulding, *The Economy of Love and Fear*, p. 15.

[20] Boulding, "The Grants Economy," pp. 478-9.

[21] Boulding, *The Economy of Love and Fear*, p. 8.

[22] Boulding, "The Grants Economy," pp. 480-1.

[23] Ginzberg, Hiestand, and Reubens, p. 197.

[24] Boulding, "The Grants Economy," pp. 482-4.

[25] Ibid., p. 479.

[26] Peter F. Drucker, "On Managing the Public Service Institution," *The Public Interest*, 33:43-60 (Fall 1973), pp. 46-50

[27] Ibid., pp. 51-2.

[28] For firsthand descriptions of contemporary New England town meetings, see Jane J. Mansbridge, "Town Meeting Democracy," *Working Papers*, 1(2):5-15 (Summer 1973); "Conflict in a New England Town Meeting," *The Massachusetts Review*, 17(4):631-63 (Winter 1976).

[29] Herbert E. Klarman, "Syphilis Control Programs," in (Robert Dorfman, ed.) *Measuring Benefits of Government Investments* (Washington, D.C.: Brookings Institution, 1965), pp. 23, 26.

[30] M. Jarvin Emerson and F. Charles Lamphear, *Urban and Regional Economics* (Boston: Allyn and Bacon, 1975), pp. 210-11.

[31] Peter 0. Steiner, "The Public Sector and the Public Interest," in (Robert H. Haveman and Julius Margolis, eds.) *Public Expenditures and Policy Analysis* (Chicago: Markham, 1970), p. 31.

[32] See Hawkins, p. 173; Stanley Scott and John C. Bollens, *Governing a Metropolitan Region: The San Francisco Bay Area* (Berkeley: Institute of Governmental Studies, University of California, 1968), pp. 72-3.

[33] Mancur Olson, Jr., *The Logic of Collective Action, Public Goods and the Theory of Groups* (Cambridge: Harvard University Press, 1965), p. 14n.

[34] Steiner, p. 25.

[35] Olson.

[36] Ibid., pp. 15-16.

[37] Ibid., pp. 22-36, 43.

[38] David J. O'Brien, "The Public Goods Dilemma and the 'Apathy' of the Poor Toward Neighborhood Organization," *Social Service Review*, 48(2):229-44 (June 1974). O'Brien, however, rejects small-scale government as a remedy.

[39] James M. Buchanan, "Public Goods and Public Bads," in (John R. Crecine, ed.) *Financing the Metropolis, Public Policy in Urban Economics*, Vol. 4, Urban Affairs Annual Reviews (Beverly Hills, Calif.: Sage, 1970), p. 51.

[40] Ibid., p. 52.

[41] Ibid., p. 69.

[42] Ibid., p. 52.

[43] Julius Margolis, "The Demand for Urban Public Services," in (Harvey S. Perloff and Lowdon Wingo, Jr., eds.) *Issues in Urban Economics* (Baltimore: Resources for the Future, Johns Hopkins, 1968), pp. 536-7.

[44] For a review of health-oriented models, see Nancy W. Veeder, "Health Services Utilization

Models for Human Services Planning," *Journal of the American Institute of Planners*, : 101-9 (March 1975).

[45] Charles S. Benson and Peter B. Lund, *Neighborhood Distribution of Local Public Services* (Berkeley: Institute of Governmental Studies, University of California, 1969), p. 10.

[46] Margolis, p. 536.

[47] Ibid., p. 539.

[48] Emerson and Lamphear, p. 215.

[49] Margolis, p. 531.

[50] Ibid., p. 549.

[51] Ibid., p. 537.

[52] Steiner, p. 44.

[53] Margolis, p. 553.

[54] Steiner, pp. 46-8.

[55] Ibid., p. 49.

[56] Margolis, p. 548.

[57] Robert L. Bish and Robert Warren, "Scale and Monopoly Problems in Urban Government Services," *Urban Affairs Quarterly*, 8(1):97-122 (September 1972), p. 106.

[58] Albert J. Reiss, Jr., "Servers and Served in Service," in (John P. Crecine, ed.) *Financing the Metropolis, Public Policy in Urban Economics*, Vol. 4, Urban Affairs Annual Reviews (Beverly Hills, Calif.: Sage, 1970), pp. 570-1.

[59] Robert R. Alford and Roger Friedland, "Political Participation and Public Policy," *Annual Review of Sociology*, 1 (1975), p. 19.

[60] Robert Warren, "Federal-Local Development Planning: Scale Effects in Representation and Policy Making," *Public Administration Review*, 30(6):584-95 (November/December 1970), p. 586.

[61] Ibid., p. 594.

[62] For a similar point of view, see James Heilbrun, *Urban Economics and Public Policy* (New York: St. Martin's Press, 1974), p. 348.

[63] Bish and Warren cite as examples of efficiency in intergovernmental negotiation of services—separating demand from production—contract educational, fire, and police services (pp. 110-17).

[64] Ibid., pp. 102-9.

[65] Uwe E. Reinhardt, "Proposed Changes in the Organization of Health-Care Delivery: An Overview and Critique," *Milbank Memorial Fund Quarterly*, 51(2):169-222 (Spring 1973), p. 184.

[66] Emerson and Lamphear, p. 108.

[67] Hawkins, p. 108.

[68] Committee for Economic Development, "Reshaping Government in Metropolitan Areas," in (Sandor Halebsky, ed.) *The Sociology of the City* (New York: Charles Scribner's Sons, 1973), p. 653.

[69] Heilbrun, p. 322.

[70] Hawkins, p. 176.

[71] Ibid., p. 178.

[72] Emerson and Lamphear, pp. 332-3.

[73] William L. Henderson and Larry C. Ledebur, *Urban Economics: Processes and Problems* (New York: John Wiley & Sons, 1972) pp. 94-5.

[74] Werner Z. Hirsch, *Urban Economic Analysis* (New York: McGraw-Hill, 1973), pp. 327-34. Part of the explanation is that few near-term changes can be made that will effect economies among a large number of replicated units. Given an existing stock of capital facilities, substantive changes must occur through a long-term attrition-replacement process (p. 332).

[75] Heilbrun, p. 348.

[76] Marvin Karno and William Knipe, "Contracting for the Delivery of Public Mental Health Services," *California Medicine* (Western Journal of Medicine), 114:52-4 (January 1971), pp. 52-3. Los Angeles County since 1962 has been contracting with private nonprofit agencies for mental health services. These contracts have been for inpatient, day care, specialized services such as hotlines and suicide prevention. It has been observed that ". . . some agencies are very responsive to regulations and standards established under contract, others are not." The contracting government does not automatically hold the upper hand by virtue of not renewing its option because of the effect on the agency's patients and because of the political clout of the agency's board of directors.

[77] Scott and Bollens, pp. 22-3.

[78] Hawkins, p. 177.

[79] Loc. cit. Hawkins cites several recent national studies that show no statistically significant correlation between the number of government jurisdictions and the total costs of local government (p. 179).

[80] Robert H. Haveman, "Public Expenditures and Policy Analysis," in (Haveman and Julius Margolis, eds.) *Public Expenditures and Policy Analysis* (Chicago: Markham, 1970), p. 9.

[81] Dick Netzer, "State-Local Finance and Intergovernmental Fiscal Relations," in *The Economics of Public Finance* (Washington, D.C.: Brookings Institution, 1974), p. 367.

[82] Margolis, p. 534.

[83] Netzer, p. 367.

[84] Charles L. Schultze, *The Politics and Economics of Public Spending* (Washington, D.C.: Brookings Institution, 1968), p. 128.

[85] Netzer, p. 384.

[86] Schultze, p. 128.

[87] Margolis, p. 534.

[88] Henderson and Ledebur, p. 98.

[89] Netzer, pp. 371-2. Notwithstanding the weakness of this proposal given the questionable assumption that communities of residence are selected because of their tax rate-service package, Netzer may still have a point in arguing that ". . . if the local jurisdictions actually did correspond to 'natural' service areas for the provision of most local services, and if the financing devices were specific cost-based user charges, most of the advantages of the Tiebout solution [citizens shopping for communities of residence] could be realized" (pp. 372-3).

[90] Schultze, p. 129. He injects the disclaimer that special districts ". . . often acquire semi-autonomous, self-perpetuating status, and become political eunuchs, with only a tenuous connection to the electorate." Hawkins contends, however, that special districts are not unresponsive per se, and may in fact be more responsive than other public jurisdictions. He identifies state enabling statutory schemes as antecedents of unresponsiveness because they often ". . . fail to guarantee that significant communities of interest are involved, that decision-making rules and regulations do not reflect the interests of these communities, and/or that state authorizations do not allow these communities adequate leeway to determine governing structures that meet their particular circumstances." Special districts may be more responsive because they typically represent homogeneous communities; their scale makes elected officeholders more accessible; and (as already suggested) districts provide alternative institutional vehicles for public goods and services, a form of competition to general-purpose governments. Hawkins' main point is that perspective on unresponsiveness rests on the empirical issue of ". . . whether citizens perceive a fragmented system as more confusing than a more centralized, consolidated one." He cites several studies indicating that where substantially larger numbers of special districts exist, and government can be described as more fragmented, citizens used and were more satisfied with government. (Pp. 177-85.)

[91] Hawkins, pp. 177-9.

[92] Emerson and Lamphear, pp. 217, 277.

[93] Ibid., p. 278.

[94] Hawkins, p. 173.

[95] Ibid., 174-5.

[96] Hawkins, p. 186.

[97] Paul Goodman, *People or Personnel and Like a Conquered Province* (New York: Vintage, 1968), p. 9. His misgiving is that, ". . . the central organization tends to outlive the emergency, and then its very existence creates a chronic emergency; people soon become helpless unless they are told what to do."

[98] The similarity to two-tier conceptions is more apparent than real. The present discussion anticipates a mix of independent, variously sized government jurisdictions, each with powers to levy taxes, make appropriations, issue bonds, and exercise eminent domain, with small-scale entities serving populations from 5,000 to 25,000. Two-tier conceptions are strategies for administrative decentralization, with neighborhoods encompassing megalopolis populations of 50,000 to 300,000. For examples, see State Study Commission for New York City, Committee for Economic Development, p. 655.

[99] Michael Lipsky, "Street Level Bureaucracy and the Analysis of Urban Reform," in (George Frederickson, ed.) *Neighborhood Control in the 1970s* (New York: Chandler, 1973), p. 111.

[100] For examples, see Milton Kotler, *Community Foundation Memorandum #8, Action Projects for Neighborhood Community Foundations* (Washington, D.C: Institute for Policy Studies, mimeograph, April 30, 1965), *Community Foundation Memorandum #5, Community Law Through Community Foundation* (Washington, D.C: Institute for Policy Studies, mimeograph, n.d.); Morris and Hess; _____, "Police Walk Beats, Meet the People," *Los Angeles Times*, March 13, 1977; Lee Mitgang, "Citizen Patrol Cuts Down Crime Rate," UI, February 13, 1977; Neil Seldman, "Neighborhood Planning Council," *Communities*, 25:22-6 (March-April 1977).

[101] Howard W. Hallman, *Government by Neighborhoods* (Washington, D.C: Center for Governmental Studies, 1973); and *Neighborhood Control of Public Programs, Case Studies of Community Corporations and Neighborhood Boards* (New York: Praeger, 1970).

[102] Douglas Yates, *Neighborhood Democracy: the Politics and Impacts of Decentralization* (Lexington, Mass.: Lexington Books, 1973); Robert K. Yin and Douglas Yates, *Street-Level Governments, Assessing Decentralization and Urban Services* (Lexington, Mass.: Lexington Books, 1975).

[103] I have not referred to the bulk of their work, which centers on political implications.

[104] Hallman, *Neighborhood Control of Public Programs*, p. 4.

[105] Ibid., pp. 38-43.

[106] Ibid., p. 209.

[107] Ibid., pp. 65-73.

[108] Ibid., p. 210.

[109] Hallman, *Government by Neighborhoods*.

[110] Ibid., pp. 17-25.

[111] Yates; Yin and Yates.

[112] Yates, pp. 4-5.

[113] Ibid., p. 28.

[114] Yin and Yates, pp. 24-5, 60.

[114, 115] The authors observe that ". . . existing decentralization experiments either constitute the form of strict hierarchy or, at most, shared power. . . . Central government . . . has given up almost no power to any general purpose form of neighborhood government that might be viewed as a real alternative to central government" (p. 30).

[116] Robert K. Yin and Douglas Yates, "Street-Level Governments: Assessing Decentralization and Urban Services," *Nation's Cities*, 12(11):33-48 (November 1974), pp. 33-37.

[117] Yin and Yates, *Street-Leve1 Governments*, p. 58.

[118] Yin and Yates, "Street-Level Governments," p. 41.

[119] Yin and Yates, *Street-Leve1 Governments*," p. 168.

[120] Yin and Yates, "Street-Level Governments," p. 41.

[121] Yates, p. 116.

[122] Ibid., p. 159.

[123] Ibid., pp. 149-50.

[124] In regard to experiments aimed at community control of schools, Yates suggests the problems and failures were predictable: ". . . in a climate of racial conflict, a formal neighborhood-wide experiment that dealt with an intractable urban problem, that was closely and confusingly entangled with city government, that was politically controversial, and that lacked resources, had enough costs and conflicts built into its basic structure to guarantee failure." (Pp. 126-7.)

[125] Ibid., p. 159.

[126] Ibid., pp. 160-1.

[127] The chief problem is that families without insurance or access to private physicians frequently enter the system—for minor complaints—at its most expensive stage, the hospital.

[128] Robert R. Alford, *Health Care Politics: Ideological and Interest Group Barriers to Reform* (Chicago: University of Chicago Press, 1975), pp. 1-2. Alford suggests that the main weakness of the market strategy—giving consumers the money to shop for services—is the presumption that consumers have the necessary information to make choices, that agencies will emerge in response to their demands, and that this is superior to an elite-generated plan (p. 5). An important weakness in the bureaucratic view is the idea that reform requires only a break in the professional monopoly of doctors (p. 263).

[129] Ibid., p. 6.

[130] Alford describes reform commissions and investigative bodies as ". . . direct expressions of inter-organizational relationships. . . . [and] the formation of such committees is evidence of a breakdown or challenge of the basic agreement concerning the division of powers, resources, and functions among the various [structural] interest groups comprising an inter-organizational system" (p. 25).

[131] Ibid., p. 14.

[132] Ibid., p. 195.

[133] Barbara Ehrenreich and John Ehrenreich, "The Medical-Industrial Complex," in (David M. Gordon, ed.) *Problems in Political Economy, An Urban Perspective* (Lexington, Mass.: D.C. Heath & Co., 1971), pp. 336-46.

[134] Ibid., p. 346.

[135] Alford, pp. 15-16.

[136] Ibid., p. 251.

[137] Ibid., p. 13.

[138] Ibid., p. 8.

[139] Ibid., p. 217.

[140] Alford is pessimistic about community-based reform strategies. His fear is that they will be coopted by other, more powerful structural interests and used as self-legitimation by them. Alford seems to implicitly assume that all community groups are top-down initiated and sponsored. (P. 219.)

[141] Ibid., pp. 265-6.

[142] Renee C. Fox, "The Medicalization and Demedicalization of American Society," *Daedalus*, 106(1):9-22 (Winter 1977), pp. 10-18.

[143] Eli Ginzberg, "Health Services, Power Centers, and Decision-Making Mechanisms," *Daedalus*, 106(1):203-13 (Winter 1977), p. 211.

[144] Reinhardt, p. 169.

[145] Fred Anderson, "The Growing Pains of Medical Care," in (David M. Gordon, ed.) *Problems in Political Economy, An Urban Perspective* (Lexington, Mass.: D.C. Heath & Co., 1971), p. 332.

[146] David Mechanic, "Human Problems and the Organization of Health Care," *Annals of the American Academy of Political and Social Sciences*, 399:1-11 (January 1972), pp. 4-5.

[147] Ibid., p. 10.

[148] Reinhardt, pp. 196-7.

[149] Ibid., p. 195.

[150] Thomas Lewis, "On the Science and Technology of Medicine," *Daedalus*, 106(1):35-46 (Winter 1977), p. 45.

[151] John Knowles, "Introduction" *Daedalus*, 106(1):l-7 (Winter 1977), p. 2.

[152] John Knowles, "The Responsibility of the Individual," *Daedalus*, 106(1):57-80 (Winter 1977), p. 76.

[153] Knowles cites Belloc and Breslow. Findings from their studies at U.C.L.A. show that activities related to styles of daily living—sleeping, eating, drinking, exercise, and smoking habits—are as much responsible for physical health status as professional medical care. See Nedra B. Belloc and Lester Breslow, "Relationship of Physical Health Status and Health Practices," *Preventive Medicine*, 1(3):409-21 (August 1972).

[154] Knowles, "The Responsibility of the Individual," pp. 68-75.

[155] Anne R. Somers, "The Nation's Health: Issues for the Future," *Annals of the American Academy of Political and Social Sciences*, 399:160-75 (January 1972), p. 161.

[156] Ibid., pp. 162-65.

[157] Anatole Shaffer, "The Cincinnati Social Unit Experiment: 1917-19," *Social Service Review*, 45(2):159-72 (June 1971).

[158] Ibid., p. 161.

[159] Ibid., p. 164.

[160] Ibid., p. 165.

[161] Ibid., p. 166. Definitive economic evaluation of the health center is not possible because Shaffer does not provide demographic data on the CSUO service population or cost data for center services.

[162] Ibid., pp. 168-70.

[163] Bertha Capen Reynolds, *Social Work and Social Living* (New York: Citadel Press, 1951), pp. 52-67.

[164] Ibid., pp. 28-30.

[165] Robert M. Hollister, Bernard M. Kramer, and Seymour S. Bellin, (eds.), "Neighborhood Health Centers as a Social Movement," in *Neighborhood Health Centers* (Lexington, Mass.: Lexington Books, 1974), pp. 14-18.

[166] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," *Milbank Memorial Fund Quarterly*, 50(4):387-420 (October 1972), p. 392.

[167] Program standards call for a patient-physician ratio of 1:1500 (registered, not enrolled) and a patient-dentist ratio of 1:2500.

[168] Robert M. Hollister, "Neighborhood Health Centers as Demonstrations," in *Neighborhood Health Centers*, p. 2.

[169] Community aides and other paraprofessionals are most often described in the NHC literature as intermediaries between patients and physicians rather than as health educators in full-scale prevention programs. For example, see Zwick, p. 78.

[170] George A. Silver, *Family Medical Care: A Design for Health Maintenance* (Cambridge, Mass.: Ballinger, 1974), p. 130.

[171] Ibid., pp. 136-9.

[172] Ibid., p. 140.

[173] Ibid., p. 143.

[174] Hollister, p. 1.

[175] Lawrence C. Howard, "Decentralization and Citizen Participation in Health Services," *Public Administration Review*, 32:701-17 (October 1972), p. 709.

[176] Herbert E. Klarman, "Major Initiatives in Health Care," *The Public Interest*, 34:106-23 (Winter 1974), p. 107.

[177] Ibid., p. 120.

[178] Gerald Sparer and Arne Anderson, "Cost of Services at Neighborhood Health Centers," *New England Journal of Medicine*, 286(23):1241-5 (June 8, 1972), p. 1241. The authors acknowledge that their findings cannot be replicated with smaller centers ". . . because of a ". . . clear cost advantage to the larger scale center" (p. 1245).

[179] Aaron Wildavsky, "Doing Better and Feeling Worse: the Political Pathology of Health Policy," *Daedalus*, 106(1):105-23 (Winter 1977), p. 112.

[180] Klarman, "Major Initiatives in Health Care," pp. 122-3.

[181] Pedro Ruiz, "Consumer Participation in Mental Health Programs," *Hospital & Community Psychiatry*, 24:38-40 (January 1973), pp. 39-40.

[182] Hollister, p. 7.

[183] Ibid., p. 8.

[184] Zwick, p. 395.

[185] Hollister, p. 10.

[186] Zwick, pp. 396-7.

[187] Paul R. Torrens, "Administrative Problems of Neighborhood Health Centers," *Medical Care*, 9(6):487-97 (November-December 1971), p. 489.

[188] Ruiz, p. 39.

[189] Gary L. Tischler, "The Effects of Consumer Control on the Delivery of Services," *American Journal of Orthopsychiatry*, 41(3):501-5 (April 1971), p. 501-5 (April 1971), p. 502.

[190] Ibid., p. 503.

[191] Howard, pp. 707-8.

[192] See Anatole Shaffer, *Maximum Feasible Participation of the Poor: An Experience in Uncertainty* (unpublished, 1968).

[193] See Warren C. Haggstrom, "On Eliminating Poverty, What We Have Learned," in (Warner Bloomberg, Jr. and Henry J. Schmandt, eds.), *Power, Poverty, and Urban Policy* (Beverly Hills, Calif.: Sage, 1968).

[194] Robert Reiff and Frank Reissman, *The Indigenous Nonprofessional*, Community Mental Health Journal Monograph Series, No. 1 (New York: Behavioral Publications, 1965), pp. 11-12.

[195] Zwick, p. 82.

[196] Herbert Rusalem, "Ombudsmen for Patients at a Mental Health Center," *Hospital & Community Psychiatry*, 24:680-1 (October 1973), p. 681.

[197] Eugene C. Wood, "Indigenous Workers as Expediters," *Hospital Progress*, 49:64-8 (September 1968).

[198] James A. Kent and C. Harvey Smith, "Involving the Urban Poor in Health Services Through Accommodation—the Employment of Neighborhood Representatives," *American Journal of Public Health*, 57:997-1003 (June 1967), pp. 998-1001.

[199] Jane Luckham and David W. Swift, "Community Health Aides in the Ghetto: the Contra Costa Project," *Medical Care*, 7:332-9 (July-August 1969), pp. 332-7.

[200] Hilda Richards and June Christmas, "New Careerists in Mental Health," *American Journal of Nursing*, 72:1640-4 (September 1972), pp. 1640-3.

[201] Victor W. Sidel, "Feldshers and Feldsherism," *New England Journal of Medicine*, 278(17):934-9 (April 25, 1968), pp. 934-5.

[202] Ibid., p. 934.

[203] Ibid., pp. 934-6.

[204] Ibid., p. 937.

[205] Ibid., pp. 937-8.

[206] Henry K. Silver, Loretta C. Ford, and Lewis R. Day, "The Pediatric Nurse Practitioner Program," *Journal of the American Medical Association*, 204(4):298-302 (April 22, 1968), pp. 298-300.

[207] Bridget Tighe, *Review of Training Programs and Utilization of Paraprofessionals in Medicine and Dentistry* (Washington, D.C.: Institute for Study of Health and Society, 1972), pp. 27-8.

[208] Ibid., pp. 32-5.

[209] Ibid., p. 48.

[210] _____, *The Physician's Assistant* (New York: Brooklyn-Cumberland Medical Center and Long Island University, 1971), p. 9.

[211] Ad Hoc Committee, *Guidelines for Physician's Assistant Programs in Illinois* (Chicago: State Inter-Agency Task Force on Health Manpower and the Interim Organization for Chicago Area Allied Health Manpower, 1971), pp. 6-8.

[212] Alfred M. Sadler, Blair L. Sadler, and Ann A. Bliss, *The Physician's Assistant—Today and Tomorrow* (New Haven, Conn.: Yale University School of Medicine, 1972), pp. 99-100.

[213] Ibid., p. 102.

[214] Personal communication with Jess Bromley, M.D., February 26, 1977: Bromley was one of the first physicians in Alameda County to employ a physician assistant, and he was willing to speculate on the prospects for bottom-up initiated decentralized health care.

[215] Sadler, Sadler, and Bliss, pp. 177-80.

[216] *The Physician's Assistant*, pp. 10-13.

[217] Ibid., pp. 27-31.

[218] Sadler, Sadler, and Bliss, pp. 81-2.

[219] Ernest W. Saward, "Institutional Organization, Incentives, and Change," *Daedalus*, 106(1):193-202 (Winter 1977), p. 194.

[220] Ruth Sidel, *Families of Fensheng* (Baltimore: Penguin Books, 1974), p. 84.

[221] Ruth Sidel, "Social Services in China," *Social Work*, 17(6):5-13 (November 1972), p. 6; Victor W. Sidel, "Health Services in the People's Republic of China," in (John Z. Bowers and Elizabeth F. Purcell, eds.) *Medicine and Society in China* (New York: Josiah Macy, Jr. Foundation, 1974), p. 106; Joshua S. Horn, *Away With All Pests* (New York: Monthly Review Press, 1969), p. 40.

[222] Ruth Sidel, "Social Services in China," pp. 6-7.

[223] Teh-wei Hu, *An Economic Analysis of Cooperative Medical Services in the People's Republic of China* (Washington, D.C.: John E. Fogarty International Center for Advanced Study in the Health Sciences and U.S. Department of Health, Education, and Welfare, 1975), p. 3.

[224] Sidel, "Social Services in China," p. 5.

[225] Horn, p. 31.

[226] Sidel, "Social Services in China," pp. 7-8.

[227] Ruth Sidel, *Families of Fensheng*, p. 85.

[228] Sidel, "Social Services in China," p. 8.

[229] Sidel, *Families of Fensheng*, pp. 85-7.

[230] Sidel, "Social Services in China," p. 10.

[231] Loc. cit.

[232] Sidel, *Families of Fensheng*, p. 151.

[233] Teh-wei Hu, pp. 19-23.

[234] Ibid., pp. 36-7.

[235] Victor W. Sidel, "Health Services in the People's Republic of China," p. 124.

[236] Ruth Sidel, "Social Services in China," p. 13.

[237] Loc. cit.

[238] See _____, "Health Insurance Umbrella: Half of U.S Unprotected," S.F. *Sunday Examiner & Chronicle*, January 30, 1977.

[239] Howard, p. 702.

[240] Personal communication with Jess Bromley, M.D., February 26, 1977