Standards—A Model for the Nation

Who could be against standards for public health? We are proud of our lofty goals, and we do a lot of talking about them. The professional equivalent of “putting our money where our mouths are” is to force ourselves to be rigorous and specific where now our platitudes and generalizations prevail. This is part of the commitment of every profession. In order to live up to such a commitment we must first agree on just what the standards are and then develop some clear ground rules about how to ensure them. That is what the article appearing in this issue of the Journal is all about. It describes California’s experience in negotiating model standards for local health departments.

Somehow, what should be an “undisputed good”—clear, realistic, feasible, understandable, and useful standards by which our profession will be known and by which the people for whom we care will be able to hold us accountable—has been a source of controversy over the years. Would-be advocates damn meager efforts because they are meager. Would-be utopians condemn standards which aim at equitable distributions within the status quo as an invitation to reductions in excellent programs. Sanitarians complain about medical standards, and physicians complain about nursing standards. Everyone is upset when someone else sets standards for his or her corner of the world, yet in the next breath the complainant articulates still another uncoordinated fragment. The generalist takes issue with all standards for fragments; and the pragmatist is offended by the lofty idealism of anything which addresses how things should be, knowing full well how far short we fall of achieving even minimal standards in many parts of our country.

All of this makes the California trials of model standards for community preventive health services something of a landmark in our profession. The standards themselves were developed jointly by leaders in the field at the state, federal, and local levels—from town and gown and from public and private sectors; they were extensively reviewed by professionals in the field and by national organizations interested in the issues. The process was elaborate and careful.

The perspective of the standards represents a major departure from previously prevailing approaches. Rather than creating a monolith, punishing the productive while setting unachievable goals for the fledgling, these model standards are flexible. Indeed, the reader of the standards document—unless one also reads the preamble—is at once puzzled by the peculiar open-ended format which permits the articulation at regular periodic intervals of the next level of expectation; at the same time, it provides a comprehensive outline so that the decision to emphasize one area or another is based upon conscious priority setting rather than ignorance of default. In other words, the standards are inseparable from the structured “fill-in-the-blanks” negotiation instrument.

Furthermore the standards include something more than the usual “process measures” which so often offend people who know too well the shallow proof of efficacy of many public health practices. They place firm emphasis upon achievement of improved health status (referred to in the article as “outcome indicators”)—the proof of our public health pudding.
Finally, the developers of the standards coined the acronym AGPALL—because they couldn’t think of another word for the phenomenon of “a governmental presence at the local level.” The premise is that the standards represent what the citizen has the right to expect from his/her community. It then makes the role of local government—the local health department in many cases—not a series of explicit activities, categories or programs, but rather that of an overseer, assuring that the community has either the needed service level in all areas or a rigorous strategy to achieve at least minimum necessary services. The exact contribution which the four walls of a public health department might make to any of these objectives would then vary according to community need, alternative delivery approaches, and the negotiated reasonable expectation up to or exceeding the minimum.

Equally as important as this new conceptualization of what is meant by “standard” is the establishment and testing of a process which translates these standards into a reality for local community health programs. The California experience carves out the ground rules for the decade of revenue sharing (block grants) in which federal categories (the old method of “protecting” selected health agendas) give way to agreed upon inventories of necessary community health services. The process by which each community sets its priorities is based upon negotiation rather than some sort of lockstep federal reporting of activity and compliance. The California experience suggests that negotiation provides a process which is satisfactory to local and state authorities—each with its own commitment to achieving better health for the public—and at the same time furnishes a forum in which unmet needs and incompletely pursued obligations can be responsibly arrayed and addressed.

Dr. Weiler’s report indicates that standards can be agreed upon and that a process works by which communities may hold themselves accountable and reach satisfactory accommodation with one responsible state health agency (which receives block grant funding from federal government). Several challenges and opportunities seem unavoidable if and when this process moves forward:

- Community health advocates, concerned that one interest will be compromised in the name of expediency, will have a frame of reference to argue for their cause against clearly defined competing priorities. As cut-backs come, we will want to permit and encourage such rationality.
- Responsible public officials, concerned that in the blush of enthusiasm over “no strings” granting funds will simply “disappear” at the local level, now have a framework for documenting responsible management and cost-effective achievements.
- A responsible Congress and Administration, wishing to cut unnecessary federal bureaucracy and reduce burdensome reporting requirements on the one hand without losing touch with necessary health priorities and vital federal roles on the other, can understand what the resources are doing without mandating an inappropriate homogeneity and a burdensome plethora of reporting systems.

It is paradoxical that such a process is reaching fruition at this time in the evolution of our nation’s public health policy. The model standards were developed with the notion that they would be used as a tool for the allocation of new resources against competing priorities, as Dr. Weiler suggests; they may be equally useful when the question of reductions in the face of crying needs on many fronts must be addressed, but with a different approach. It is also paradoxical that a mechanism to establish relative uniformity across the nation (in the light of the wonderful uniqueness of each local public health endeavor) should emerge at a time when the federal mentality seeks to dismantle critical national roles in the name of “new federalism.”

The role of national uniform data bases, derived from important public health outputs and the processes which go into achieving them, is well known to every public health professional who has ever called the Centers for Disease Control or used the National Public Health Program Reporting System; yet critical epidemiologic intelligence and other essential data bases may be allowed to wither away. The role of the federal government in providing leadership, guidance, and catalysis is of crucial importance, yet such a role seems passé. The rhetoric of “cutting administrative overhead” (however small in relation to other federal outlays) is invoked as an excuse for cutting our very lifeline.

Let us be sure, then, that the work which has gone into the development and testing of model standards for community preventive health services is harnessed to the goal of health advocates nationwide: first, to establish local priorities so that the most important programs can be salvaged under current fiscal realities; and then to build from there to the level of service every community has the right to expect.

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REFERENCE


Medical Care in China: Equity vs Modernization

The article by Gail Henderson and Myron Cohen in this issue of the Journal1 is an important contribution to two different but closely-related literatures. The first is the extraordinary output over the past decade—not only in China and the United States but in many other countries as well—on medical and health care in the People’s Republic of