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THE HEALTH STATESMAN, THE POLITICIAN, AND THE PEOPLE

A STUDY OF HEALTH AFFAIRS IN THE

OKLAHOMA STATE LEGISLATURE

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PREFACE

The relationships between politics and such fields as agriculture, organized labor, transportation, and manufacturing are fairly well understood. Much study and research effort have over the years been devoted to such topics. More recently, scholarly work has been applied to the dynamic relationships between politicians and scientists, politicians and educators, and others. Considerable attention has been given to that super-triumverate, the so-called politico-military-industrial complex.

This study proposes to examine yet another relationship in our American democratic society - that of the politician and the health professional. Until recently the practice of health[1] has been essentially a private affair. Through a system of professional control the medical field was for years insulated from large scale involvement with the public collectively and with government. The organization of the "medical industry" along the lines of a large number of individual entrepreneurs further contributed to the laissez faire accorded this field. Moreover, the widespread ignorance and naivete of the public relative to medical affairs reinforced the relative isolation of medi-

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[1]The practice of "medicine" would be a more accurate term to describe the nature and structure of health care in the United States prior to the middle of the Twentieth Century.

cine from the mainstream of public attention.

There were, of course, some involvements between politics and medicine. Nostrum control was an issue on the national political scene for years. Establishment of a national secretary of health at the cabinet level was promoted continuously by the American Medical Association during the early decades of this century. Even a national health insurance program received some discussion during the depression years. There are other examples of interrelations between medicine and the public scene, but with respect to the total impact of the medical field and in comparison with other industries the degree of involvement was minimal. Prior to 1950 these involvements were not center-stage, dramatic issues entailing intense public interest on a continuing basis. With the arrival of mid-twentieth century and all its innovations, however, this situation changed radically.

Today we find that health affairs have become items of sustained high interest on the part of both politicians and the public. This melding of politics and medicine (or we might say collision of the two) triggers a need for much more research in this area.

A considerable amount of scholarly effort has been devoted to specific issues, e.g., the Medicare legislation, establishment of the National Institute of Health, etc. Also, scholarly studies have been made regarding the role of some institutions in health. For example, the role of the American Medical Association as a contending interest group is well-documented.

Little has been done, however, to explain the general functioning of our political system relative to health affairs. The extent of

our knowledge is remarkably shallow when it comes to these kinds of politico-health questions: How are political decisions made in health affairs? Are these made in just the same way as other political decisions are made in our democracy, or are there significant differences? What are politicians' underlying attitudes and philosophies toward health care? Does the very personal nature of health bring about philosophical inconsistencies? How is this reflected in voting behavior? How do politicians perceive health professionals? How dependent are they upon professional counsel in deciding how to vote on health legislation? What is the extent of politicians' knowledge in health affairs?

It is the purpose of this paper to deal with these questions at the state level of government. The general level of health of a population has much to do with the overall quality of life which a society has to offer. It is hoped that the study at hand will add to our knowledge of democracy and health care. Further, this study is done in hopes that it will be an addition to that body of knowledge which contributues to enrichment of life in the United States.

Customarily writers take advantage of the preface to pay tribute to those who helped in accomplishment of a project. In my case notice of this sort certainly does not do justice to the great amount of help extended me from a variety of quarters; nevertheless I do wish to acknowledge in at least this small way my gratitude to a number of people.

First, I wish to thank Dr. Charles M. Cameron, Jr., my major department chairman, for his great interest and guidance. At the outset the very feasibility of a study of this sort was much in doubt.

Without Dr. Cameron's timely encouragement, able counsel, and staunch support this project would not even have begun. Throughout the eighteen month period spanned by this study Dr. Cameron was a continuous source of strength and assistance.

The faculties of both the School of Health and the Department of Political Science of the University of Oklahoma gave to me invaluable assistance. Dr. Harry A. Holloway contributed numerous suggestions and observations. His expertise and knowledge in political science were most helpful. Dr. Paul S. Anderson provided indispensable guidance relative to initial sample selection and statistical design. Much assistance in instrumentation and interviewing technique was received from Dr. John G. Bruhn, Dr. Robert W. Ketner, and especially Dr. William R. Hood, all of the Department of Human Ecology.

Mr. Ronald Stewart, graduate student in the Department of Political Science, was helpful with initial encouragement and introduction to key persons working in the state capitol. I am indebted to Dr. James H. Johnson, Assistant Director of the Oklahoma Legislative Counsel, for sharing with me his keen knowledge of the legislature and Oklahoma state government in general. Dr. Johnson's numerous suggestions and informed comments were crucial to the successful completion of the study.

I wish to pay special tribute to a group of men and women who I find to be hard-working and earnest as they go about the serious business of making laws - the Oklahoma State Legislators. As a group I found the legislators to be warm, considerate persons of infinite goodwill. Their courtesy and hospitality are deeply appreciated. I have

endeavored to express to them my sincerest thanks by reporting accurately their attitudes and opinions.

A special thanks must go also to the legislators' ever-patient secretaries. It was they who often made it possible for me to gain access to their bosses and who kept me well-supplied with coffee during some of the long waits.

Most of all I wish to thank my wife, Helen, for her great diligence in typing and unequalled skill in deciphering my handwriting. But most of all I am indebted for her unceasing inspiration. Without this inspiration and practical influence I would fully expect to find myself permanently among the ranks of those who so often proclaim, "Oh, yes, I have completed practically all of the Ph.D. requirements - all I have to do is to write my dissertation".

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INTRODUCTION

Medical care has been traditionally a private affair in the United States. There were the early almshouses and public hospitals for care of indigents, but in the main the practice of medicine has taken place independent of government involvement. Up until mid-twentieth century the organization, delivery, regulation, and financing of medical care were left principally to the medical professions. These professions and their institutions tended to operate provincially behind cloistered walls. They were generally set apart from the more common-place aspects of American life such as labor, agriculture, transportation, "big business", etc.

Medical care has not, however, escaped the jolting impact of change upon the United States since World War II. Striking changes have erupted due to technologic advance, the knowledge explosion, proliferating specialization, civil rights legislation, the new consumerism, and other fundamental alterations in our social, economic, and political life. So spectacular have been these changes that even our terminology often becomes inadequate. In the medical field the originally inclusive term "medicine" became replaced by the broader term "medical care". Today the more generic term "health care" is used comprehensively to include all components of American activity which deal with health of the people.

Due to these great changes over the past three decades health care has been propelled from the sanctity of relative isolation into the mainstream of American public life. Each year government and the public become more a part of health care. Evidence of this abounds: the massive federal health legislation of the Kennedy-Johnson era; the growing sophistication of the general public in health; the intense interest of organized labor in health care; and the enormity of the health industry itself.[1]

As health care is impelled into the arena of public affairs, that body of knowledge called political science becomes relevant. Indeed the theory and methodology of political science become crucial to the understanding of where we are and where we are going in health care. Because of this the study at hand proposes to analyze the dynamics of health affairs from the perspective of political science.

A striking need challenges health professionals to speak meaningfully to the public and to exercise leadership in moving toward integrated national and regional goals. In attempting to meet this need health professionals should participate in the formulation of public policy in health. As the health statesman[2] thus moves into the world

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[1]In 1967, 3.7 million persons were engaged in the provision of health services and expenditures for health care totaled $51 billion or about 7 percent of the Gross National Product. $17.8 billion of this amount was public spending. These data are taken from the January issue of the "Social Security Bulletin" and the Bureau of Labor Statistics of the Department of Commerce as reported in Hospitals, J.A.H.A., Volume 43, No. 4, February 16, 1969, p. 104 and Volume 43, No. 13, July 1, 1969, p. 128.

[2]The concept of health statesmanship is discussed and explained in detail in Chapter II.

of the politician, he needs to know more about the politician, how he makes his judgments, and especially how he sees health professionals. Essentially this need for data is the research problem with which this study deals.[3]

The politician in the legislator role at the state level is the political figure selected for examination in this research effort. In an American federal system the states occupy a unique and in some ways contradictory position. The states are the seat of much governmental power, but the federal level has greatly outstripped them in capacity to raise funds. This condition has far-reaching implications in many fields, but especially so for health. Partnership programs in health among the levels of government are the primary accommodating mechanisms we see today. This study will examine the attitudes of state legislators toward these agreements and the political principles underlying them. The objective here is to provide health statesmen with information on which they may draw conclusions and make forecasts.

Being exploratory in nature, this study is broad in scope and its findings are necessarily tentative. The primary areas of investigation are as follows:

1. The manner in which legislators perceive health care generally and legislators' perceptions of health professionals, particularly health statesmen. The term "health statesmen" is a concept taken from current literature in Health Administration. Leaders in the field use this term to describe an expanded role of health administrators to

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[3]The research problem is discussed in more detail in the last section of Chapter I.

include participation in the formation of public policy in health.

2. The role of health statesmen in the American political process. Assuming that health care specialists become politicized in some degree as they attempt to influence health affairs, this study deals with just how they should relate themselves to the political system.

3. The manner in which legislators derive their knowledge in and concern for health care. Included here are not only the legislators' abstract knowledge of health, but also their awareness of health care problems and their reactions to such matters.

4. The underlying political philosophies which make up the legislators' mental set as he views health affairs. This "mental set" represents a characterization of the legislators' composite attitudes, opinions, and reactions to health issues.

5. Legislators' knowledge of health affairs in relation to their priority ranking of health. The phrase "knowledge of health affairs" in this statement refers to the degree of awareness of current health needs, understanding of contemporary health problems, and grasp for policies and principles which are widely accepted among health professionals. The phrase "priority ranking of health" refers to legislators' placement of health among other state programs in terms of need for additional funds and support.

6. Legislators' personal contact with health care in relation to their priority ranking of health. The legislators' personal contact with health care refers to the amount of association which the individual has had with health professionals, medical facilities, planning agencies,

etc. The concept here is determination of the degree of identification with health care through personal involvement or assessment of the psychological impact of legislators' past experience regarding the health of himself or his close relatives.

7. The determinants and variables of support or rejection of pending health legislation by legislators. The manner in which the decision-making process is carried out is central to this phase of the study.

8. Examination of actual voting records in light of attitudes expressed. The purpose of this phase of the study is to verify or contradict attitudes through corroboration by actual voting behavior. Legislative decision-making through the role of committees and legislative specialists is also examined.

Relative to research methodology the principal data collection effort is a cross-sectional study of the Oklahoma State Legislature. The universe studied is composed of members of the Thirty-Second Legislature. An attitudinal survey employing the non-schedule, semi-standardized interviewing technique is employed. The sample consists of about ninety percent of the total universe and is proportionate to the universe in terms of the principal variables involved, political party, geographic origin, etc. There being ninety-nine representatives and forty-eight senators, the sample consists of ninety-one and forty-three respectively, for a total of one hundred thirty-four subjects. The study encompasses both houses and both sessions (1969 and 1970) of the Thirty-Second Legislature. It spans an eighteen month period from November, 1968 to April, 1970. The interviews center on fifty questions

of a variety of types and are designed for forty-five minutes duration. In addition to the cross-sectional study actual voting records are examined and analyzed with the assistance of the State Legislative Council.

The process of government in the executive branch are no less relevant to health affairs than are those of the legislative branch. Perhaps a word is in order to explain why the executive component has been purposely excluded from the central thrust of this study. First, less is known about state legislatures in relation to health care as compared with the executive branches. Secondly, the legislature is the principal decision center in state government. And, lastly the relationship between health care and the executive element of state government is sufficiently complex as to justify study in its own right. Inclusion of this material in the study at hand would have broadened the scope inordinately.

Even while excluding the executive branch, the scope of the study is quite broad. This is by design as we are dealing with an area of inquiry which is relatively virgin. The main thrust of the study is to probe in an exploratory way a wide range of human phenomena in politico-health affairs. Thorough studies of a more specific and exacting nature will hopefully follow in the ground newly plowed by this study. Therefore, it is intended that the study shed some new light on a relatively obscure area while pointing the way to further research.

Being located in an interstitial area between the bodies of knowledge of health administration and political science, the study is

organized so as to present theory and methodology of both fields. The opening chapter deals with background material. This information is designed to orient the reader who is not familiar with the health care field. To aid in understanding for all readers some key terms are also defined in this section. The chapter closes with a summation of the research problem.

Chapter II describes the profession[4] of health administration (again, this is done for those unfamiliar with the field). A key section which establishes the concept of the health statesman also appears in this chapter. Pertinent literature is reviewed and a health statesmanship model is presented.

The next two chapters establish a thoeretical base in political science for later analysis of the data. The first of these chapters deals with relevant concepts such as elitist theory, pressure group theory, and decision-making in a democracy. The second concerns itself with the theoretical aspects of state government in the United States. Relevant literature is reviewed in both of these chapters.

Chapter V presents a description of the research setting. This section is designed to provide background information on Oklahoma and its state government so that the findings may be viewed in context.

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[4]If the reader is bothered by use of the term "profession" as applied to health administrators, he is invited to substitute occupation or avocation. The author does not wish in this study to become embroiled in the question of whether or not health administrators are indeed professionals. The term is used in a broad sense to reflect the growing professionalization of this group. Indicators are: increasing requirement for graduate preparatory schooling; establishment of ethical standards and self-regulation; and assumption of greater social responsibility.

This chapter also includes a summary statement of research objectives and limitations. The research design of the study is described in Chapter VI. Assumptions, hypotheses, instrumentation, pretesting, and conduct of the pilot study are all presented in some detail as methodologies are especially important in an exploratory study.

The attitudinal findings are shown in detail in Chapter VII. These findings are illustrated in aggregate form and are correlated in different ways so as to make the data more meaningful. Going further in this direction, Chapter VIII is devoted entirely to analysis of the findings. Special attention is given to testing of hypotheses through application of specific data uncovered during the study. The analyses in this chapter are of a more concrete type as hard evidence is used as a basis for discussion.

Analyses of a more impressionistic nature are presented in Chapter IX. General observation of the legislature over an eighteen month period and deductive argument serve as bases for commentary in Chapter IX. This section deals with the nature of legislative behavior in health affairs and the need for health statesmanship. Also, specific ways in which the health statesman might carry out his role are discussed.

The last chapter opens with a brief review of the entire study. A summary of findings and a resume of conclusions are also included in this chapter. A critique of the study appears in this section, and the report closes with suggestions relative to future research.

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CHAPTER I

HEALTH CARE

The health industry in the United States is totally amorphous. Its parameters are vague; it is without beginning and without end. There are components within the industry which are highly organized, but the total health care field has to be described as being disjointed, fragmented, unorganized, and ill-defined.

When confronted with such a state of affairs, one logically questions the value of this condition. Is this simply health's version of the free enterprise ethic of the larger society? Are there unique characteristics of health which render inoperable the concepts of Adam Smith, Keynesian theory, or the new economics? What are the implications for American life of establishment of a unified or otherwise organized health system?

These questions (and their ultimate answers) are fundamental to the health of the nation. As with all profound questions, one cannot really understand the issue without some knowledge of background data. He must know what has gone on before in order to appreciate even why

certain questions are being asked.

In order to bring about such understanding we shall now review some general descriptive material. This review will allow us later to focus on major issues from the bases of common background information. The section immediately following presents very briefly relevant historical information. The sections on definitions will aid in dispelling some of the ambiguity of health (at least for purposes of this study). We shall then examine rather closely the contemporary scene and the major health problems which we face in America. The chapter closes with a recapitulation of the research problem.

Background of Health Care

A long string of evolutionary developments contribute to the present-day form of health care in the United States. These developments span centuries and involve the three major components of health as it exists in the so-called "developed nations": the fields of medicine, hospitalization, and public health. We shall look briefly at the background of each of these in turn.

The Field of Medicine

Early man saw an interrelatedness between the physical and spiritual aspects of the human body. For this reason ancient physicians existed in the form of priest healers. This metaphysical view of health practitioners persists today among primitive cultures, the medicine man being the typical role developed by these societies. Vestiges of this view of physicians as father healers may also be seen in technologically

advanced societies.[1] Assumption by the physician of the father role in the patient-physician relationship,[2] the community view of the medical doctor as a "generalized wiseman",[3] and the guilt components of the sick role[4] all suggest modern hangovers of the historical priest healer. Moreover, the correlation between organic illness and the psyche is the basis for the notion of psychosomatic medicine and is central to the specialty of modern psychiatry. As with most aspects of medicine this reverent view of physicians is changing rapidly. The historical roots of this perception are deep, however, and they hold important implications for us in analysis of the conduct of health affairs in 1970.

The primary force in shaping the organization of medical care in the United States has been the medical doctors' professional society, the American Medical Association. It is necessary that we examine the historical development of this group in order to understand how health care evolved to its contemporary form.

The American Medical Association was organized about the middle of the nineteenth century. The nation is indebted to this organization for lifting the practice of medicine from the level of witchcraft and elixirs to a sound, scientific plane. The American Medical Association is also largely responsible for the establishment of ethics

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[1] This view of physicians is taken principally from Richard M. McGraw's Ferment in Medicine, Chapters 6 and 7 and from lectures by Dr. McGraw at the University of Minnesota during April, 1968.

[2] Talcott Parsons and Renee Fox, "Illness, Therapy, and the Modern Urban American Family", Journal of Social Issues, Vol. VIII, 1952.

[3] Talcott Parsons, The Social System, Chapter X.

[4] Henry D. Lederer, "How the Sick View Their World", E. Gartly Jaco, ed. Patients, Physicians and Illness, pp. 247-255.

and standards of medical practice in the United States. It is due primarily to this organization that the American people find its medical doctors among the most technically competent physicians in the world.[5]

Augmenting the earlier efforts of the American Medical Association, the celebrated Flexner Report of 1910[6] had enormous and lasting impact on the quality of medical education. The principal effect of this study was to upgrade permanently the quality of medical education through: (1) establishment of such education on the basis of science; (2) placement of all medical schools within the academic milieu of universities; and (3) drastic reduction in the number of both medical schools and medical students.

These actions by the American Medical Association, the Flexner Report, and medical educators were essential for improving medical education and were highly desirable for the American people. Not so desirable, however, is the fact that they set rational precedent for severely limiting the number of medical doctors which the nation could produce. As we shall see, the problem has become in the mid-twentieth century not so much one of quality as it is one of quantity and maldistribution of physicians.

The extremely fruitful scientific advances of this century have created many of the problems which beset medicine today. The

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[5]The historical data in this section are taken largely from Morris Fishbein's A History of the American Medical Association 1847 to 1947 and Oliver Garceau's The Political Life of the American Medical Association, passim.

[6]Abraham Flexner, "Medical Education in the United States and Canada", Bulletin No. 4, Carnegie Foundation for the Advancement of Teaching, New York, 1910.

development of the X-ray, anti-biotics, a battery of sophisticated anesthetics, and a host of other technologic innovations has altered fundamentally the practice of medicine. While the value system of physicians has remained unchanged (being inculcated through the intense indoctrinating atmosphere of medical schools),[7] the whole milieu of their medical practice has changed radically. The following are offered as being representative of these myriad changes: fragmentation of medicine into numerous specialities, virtual disappearance of the general practitioner, movement of practices from home visits to the clinic and thence to the hospital, merger of solo practices into group arrangements, decline or disappearance of the patient-physician relationship, and emergence of numerous other health professionals who openly challenge the pre-eminence of medical doctors in health.

As mentioned earlier, the American Medical Association has performed the necessary social function of policing and regulating the practice of medicine.[8] Moreover, an enormous volume of educational and scientific work is carried on by organized medicine. The official publication of the American Medical Association, "The Journal of the American Medical Association", is recognized as one of the world's leading medical publications. In addition, the American Medical Association

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[7] Several studies provide evidence of this indoctrinating process. Of these are: Oswald Hall, "The Informal Organization of the Medical Profession", The Canadian Journal of Economics and Political Science, Volume 12 (February, 1946) and Samuel W. Bloom, "Some Implications of Studies in the Professionalization of the Physician", E. Gartly Jaco, ed. Patients, Physicians and Illness, pp. 313-320.

[8] A principal reference in this section is James G. Burrow, AMA: Voice of American Medicine, passim.

publishes twelve journals devoted to the major medical specialties and there are over thirty state and regional medical journals. The American Medical Association holds annually two meetings which are oriented to scientific and educational developments. Over the years organized medicine has been the leading force in the battle to improve services in the area of mental health, maternal and child health, school health, and numerous others. It is widely accepted that the American Medical Association has made major contributions to the high quality of medical care which exists in America. By all counts the American Medical Association must be considered as an organization which is devoted to the advancement of science, medical practice, and professional ethics.

In its charter the American Medical Association states as its purpose the following: ".....to promote the science and art of medicine and the betterment of public health". Its goal is shown as, ".....better health for all people and service to the professional needs of the membership".[9] Although much of its income is used to support an impressive array of scientific and educational activities, more and more of its resources are devoted each year to political activity. "Over the past twenty years the American Medical Association has spent millions - more than any other single pressure group - for maintaining a highly effective Washington lobby. The American Medical Association's 1965 campaign against Medicare broke all recent records for expenditures by lobbyists. In the first quarter alone of 1965 it spent more than $950,000 on lobbying."[10]

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[9]Taken from "Constitution of the American Medical Association", Chicago, 1968.

[10]Elton Rayack, Professional Power and American Medicine: The Economics of the American Medical Association, p. 11.

This fleeting, historical review of medicine serves to orient the reader to three phenomena: namely, the aura of mystic with which the public has traditionally held the field of medicine; the extraordinary contribution which medical doctors have made to the health of a rapidly growing country; and the emergence of organized medicine as a potent political force during recent decades. The cogency of this pressure role to the politico-health study at hand is obvious. The full impact of this role will become apparent later in the study as the research findings are analyzed.

The Field of Hospitalization

The modern hospital in the United States grows out of the European medieval institutions of the same name, but with a different purpose. Pre-dating commercial inns, hospitals[11] were established as philanthropic lodging houses designed to provide shelter for wayfaring religious pilgrims during the Age of Faith. Initially, the stay was normally overnight and little consideration was given to anything other than "hotel-type" services. Inevitably, though, these hospitals found themselves the unintended hosts of the homeless, the infirm, and the elderly. Gradually, and quite naturally, nursing services were sought and eventually medical consultation came into the picture.

From this beginning, certain trends and practices became deeply rooted in the hospital system. Through a long and rigid conditioning process these practices became embedded in the hospital milieu. Much of the controversy today is simply a manifestation of basic conflicts

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[11]From the Latin hospes, meaning host.

between these old traditions and the demands of a rapidly changing world.

At the outset hospitals were humanitarian institutions, entirely charitable and supported by religious groups or generous individual philanthropists. These early establishments were known generally as "dying houses". This was only to be expected as most of the "patients" were either aged or suffering from terminal illnesses. The goal of these early hospitals was to make the dying as comfortable as possible; the personnel system amounted to using whomever felt benevolent to do whatever they could; the logistics revolved about consumption of resources as needed with only intermittent "rationing" identifiable as a crude counterpart to modern logistical methods; and the planning process was limited to consideration of food needs of tomorrow and perhaps the fuel requirements of next winter.

One other salient feature must be mentioned. Even as late as the sixteenth, seventeenth, and eighteenth centuries there was little cohesion between hospitals and physicians. The medicine of the time had little to offer the terminal or chronically ill patient. Doctors' services to hospital patients usually amounted to a gift of their time to the unfortunates. Only altruism could be cited as a motive for the doctor to give of himself in the hospital. Moreover, the early hospitals provided a wretched environment for the personnel, as well as the patients. Today it would be difficult to reconstruct sanitary and psychological conditions so poor and unsafe as those of the early hospital. It was noted in Paris in 1788 that those ward attendants living outside the hospital were usually much stronger and healthier than those who lived

inside.[12] The focus of medical practice in these early days was in the home. It was there that the physician found the resources and environment needed by his patients. So the composite picture one sees of the hospital up until the nineteenth century is one of a "dying place", occupied by the poverty-stricken, financed by wealthy philanthropists, staffed by benevolents, medically supervised as a side-effort by doctors, and completely without a management or administrative orientation.

Turning now to more recent developments, the past one hundred years have witnessed the emergence of the modern hospital as we know it today. This modern hospital is the result of "evolutionary adaptation rather than rational planning".[13] This is a key point as one of the current issues in health is the basic conflict between the momentum of evolutionary process and the braking and re-directing effect of the rational planners.

Through this evolutionary process and due to the imperatives of modern health needs the hospital has been completely transformed. It is now looked upon as the primary place where one goes to become well. Many persons knowledgeable in health care contend that the hospital has become the central institution in community health. Charity and philanthropy still play a part, but the colossal giants of health insurance and government intervention now dominate the world of medical economics. Hospitals as a group have assumed a distinct orientation to effective

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[12]S.S. Goldwater, "Concerning Hospital Origins", in The Hospital in Modern Society, edited by Arthur C. Bachmeyer and Gerhard Hartmen, p. 9.

[13]Temple Burling, Edith M. Lentz, and Robert N. Wilson, The Give and Take in Hospitals, p. 6.

management and long-range planning.

In large part the hospital is a reflection of the changes occurring in medical practice itself. For several reasons the hospital has become the center of the physicians' activity. "Yet the doctor is still not fully a part of the organization, despite the close relationship between the hospital and medical practice. He does not exercise direct control of it, nor is he in turn under effective control by the hospital administration. Because they share a strong concern for the care of the sick, the hospital and the doctor work together in close cooperation, but this is largely the result of mutual accommodation rather than formal organization. The doctor is still officially a guest of the institution."[14] An understanding of this very unusual and precariously balanced relationship is central to the purposes of this study.

The Field of Public Health

Historically, the interest of public health has centered on plagues and pestilences. This field consisted essentially of organized efforts by communities, states, or nations to reduce mortality from small pox, cholera, malaria, and the like. These efforts were frequently emergency measures.

Even from the days of Moses we observe governments as having been vested with some authority over the citizenry to reduce or eliminate the scourges of widespread epidemics. There is evidence that public health problems and programs received considerable attention in

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[14] Ibid, p. 6.

colonial America.[15]

It is noteworthy that no mention whatsoever is made of health at any point in the United States Constitution. Through modern interpretation of the welfare clause[16] considerable powers in health affairs have been accorded to the federal government. At the time of formation of the union, however, all such powers were vested in the states. This was done in line with the doctrine that all jurisdictions not specifically allocated to the national level by the constitution fell to the states. As the seat of original authority in health, the states could and did delegate authorities to local governments. The legal basis for city and county health departments is thus established.

Another legal authority important to the practice of public health is the legal basis of communicable disease control. A fundamental truism of public health administration is that "no health department, state or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring".[17] This truism forms the rationale for public health powers to require reporting. As infections may be transmitted from one person to another and since the unrestricted activities of an infected person may endanger many others, there must be some control by government to minimize the risk of spread. "Public health law, then, becomes an expression of the

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[15]John J. Hanlon, Principles of Public Health Administration, pp. 47-54.

[16]U. S. Constitution, Article I, Section 8.

[17]This statement formerly appeared at the head of the weekly listing of the current incidence of communicable disease published by the U. S. Public Health Service.

police power of the state. Police power (in this sense) means the right to regulate the conduct of the individual for the benefit of the many."[18]

It is perhaps this association of public health with regulatory powers and the close involvement of public health with government which have generally alienated from one another the public health worker and the privately practicing physician. Other differences undoubtedly contribute also to this schism of long standing between medicine and public health. The fiercely independent nature of most medical doctors has rendered full-time, salaried government service antithetical to their desires. For decades now the greatest prestige and social rewards have been accorded the specialists in medicine, next in line have come the general practitioners and lastly those engaged full-time in preventive medicine and public health. The glamour, power, and prestige have been weighted heavily in favor of the surgeon and other specialists within the medical pecking order. The existence of this informal hierarchal structure of medicine has been well-documented.[19] This in-group orientation has tended, until recently, to place public health on the periphery of medicine in the United States. There are now indications of this apparent schism beginning to close. Sartwell reports, for example, that "the barriers between the interests of clinical medicine and public

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[18]Gaylord W. Anderson, Margaret G. Arnstein, and Mary R. Lester, Communicable Disease Control, p. 91.

[19]The reader who wishes to pursue this topic further will find numerous studies in the literature which offer evidence in support of this phenomenon. See, for example Patricia L. Kendall and Robert K. Merton, "Medical Education as a Social Process" in E. Gartly Jaco, ed. Patients, Physicians and Illness; and Magraw, Ferment in Medicine, Chapter 11.

health, which were largely artificial, are fortunately disappearing".[20] But the dichotomy remains sufficiently present to have great impact on the organization of health in this country. This condition will become rapidly apparent as the findings are analyzed in later chapters.

In summary, then, we see public health as being originally oriented to epidemics and mortality. With the advent of the industrial revolution it came to be more concerned with the health needs of the destitute. More recently, the public health field has outgrown this concern solely with mortality. It still aims to keep people alive, but there is much greater emphasis today in preventing illness and in enriching life. Renewed interest by the public in general in environmental health, health education, illness prevention, and broad aspects of health care is elevating the status of public health and is breaking down the traditional barriers between it, clinical medicine, and hospitalization.

Definitions

The health field severely lacks terminology with which it may be described precisely. As with many fields, changes in health have far outstripped our development of adequate language. The inevitable result of this condition is widespread confusion and ambiguity. The misunderstandings are prevalent enough among those working in the health field; the situation is extremely acute relative to the public in general.

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[20] Kenneth F. Maxcy, Milton J. Rosenau, and Philip E. Sartwell, eds, Preventive Medicine and Public Health, 9th Edition, Sartwell's Preface, p. IX.

In view of these difficulties it is desirable for purposes of this study to strike some definitions of frequently used terms. This will allow us to view the findings and conclusions of the study within the context of common terminology. The following definitions are consistent with those given to legislators during interviews (when it was necessary to do so).

Terms Related to Components of Health

Health. This term is used in three senses: (1) the physiologic and psychologic state of an individual; (2) the state of man in harmony with his environment;[21] or (3) that portion of the nation's resources which is associated directly with health and its maintenance.

Hygiene. Those personal acts, school courses, and college curricula which are related to sanitary science and which are frequently referred to as health.

Health Field. That occupational category, academic content, or segment of social institutions which deal principally with the health of human beings.

Health Industry. This term is closely allied to "health field" and the two are sometimes used interchangeably. "Health industry" is distinguished by its economic connotation as it usually refers to the aggregate of all the factors of service: human resources, facilities, equipment, and capital which are devoted to human health.

Health Care. This is a term used broadly to include all of

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[21]To paraphrase the definition of health as set forth by the World Health Organization in its constitution in 1946.

health such as clinical medicine, dentistry, hospitalization, public health, preventive medicine, nursing home care, rehabilitative care, home visits, osteopathy, chiropractic, and paramedical services.

Medical Care. That portion of health care which is related to the delivery of medical services.

Medicine. The science and art which deals with the prevention, cure, or alleviation of disease and which has been institutionalized by the system of medical education in the United States. The term "organized medicine" refers to the association with which medical doctors have aligned themselves collectively.

Public Health. That portion of health which has come to be associated with governmental services through traditional practice of long standing. Central to this definition are services connected with epidemiology, environmental health, health education, public health nursing, immunology, and therapeutic services related to specific illnesses such as tuberculosis, veneral disease, and mental disorders.

Health Affairs. Those health matters which become involved in politics.

Public Health Affairs. Those public health matters which become involved in politics. Public health affairs are part of health affairs.

Terms Related to Health Roles

Health Administrator. An administrator of a health organization such as governmental agencies, planning agencies, voluntary health societies, professional associations, hospitals, nursing homes, institu-

tional associations, health insurance companies, group medical practices, and health plans.

Hospital Administrator. An administrator of an organization licensed as a hospital.

Medical Administrator. A medical doctor who is a health administrator or an administrator of a medical organization.

Health Statesman. A health administrator who participates actively in the formulation of public policy relating to health.[22]

The Contemporary Scene

Undoubtedly, the most salient feature of health care today is its inexorable susceptibility to change. The shock of great political, social, economic, and technologic change has health care reeling in attempts to adjust. The impact of change upon health during the past two decades was emphasized earlier. The pace of change is not diminishing at present. As a matter of fact, all indicators suggest continuing change at an increasing rate. The shock waves of urbanization, rising affluence, technology, consumerism, and demographic changes are increasing in intensity. Furthermore, it is these upheavals within our society which constitute the major force bringing health care more and more into the political process.

The flight of Americans from rural areas and small towns has wrought an appalling maldistribution of resources among the service industries. Health care is among the most acutely maldistributed. It is the urban area which typically offers the medical doctor and other

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[22]This term is described and defined in detail in Chapter II.

health professionals the greatest promise for career fulfillment. The opportunities for status, remuneration, peer association, and cultural activities have been greatest in the cities and their suburbs. As a result, health manpower has tended to concentrate in urban centers at the expense of that portion of the public which chooses to live elsewhere.

Concomitantly, the rush of ethnic groups and less advantaged people to the cities has created enormous health problems. Even though located within the shadow of great medical centers, the typical urban ghetto has lacked basic medical services. These developments have caused rural residents in general and the urban poor in particular to look more and more to government for help in meeting their health care needs.

As a companion development, technologic advances have encouraged consolidation of health resources into large, centrally located institutions. The high cost of complex equipment and facilities has made this necessary. It follows, too, that these medical centers and large community hospitals are often the places where a health specialist can apply the skills which his training and technology equip him to perform. Thus the voluntary health care system offers sophisticated operations and procedures to some while many lack access to acceptable, basic services. Again, these disadvantaged are looking increasingly to government at all levels for relief.

The rising level of general affluence brings about a better educated, more independent, and, in many ways, more demanding public. Much of the aura of medical practitioners as father-healers is falling

away. The blind trust accorded health professionals by society is giving way to a more discriminating, almost militant, wave of consumerism. Where the new demands of this affluent public are not being met voluntarily, government intervention is frequently being sought.

Also, the health care system is being severely tested due to changes in our nation's demography. The hourglass shape of our population by age (with growing numbers of youth and elderly and a smaller number of persons within the productive years) poses special problems. While the greater health needs of the young and the elderly are increasing, the number of employable persons to provide and pay for these services is decreasing proportionately. Again, the public is turning to government for assistance in meeting these relatively new problems. Passage of the recent Medicare and Medicaid legislation constitutes a prime illustration of this point.

Other major trends are apparent on the contemporary health care scene. For example, the watchword in health today is planning. All components of the health field are being urged - sometimes coerced - toward participation in planning. Planning is thought to be the only way to adjust effectively to change. It is considered to be the best way to close the gaps in health care in the United States. Indeed it is looked upon as the salvation of the private sector of health. The implication is that unless control of health resources is established voluntarily the federal government will assume total control; thus area-wide and regional health planning are being pursued vigorously. To date this planning has been mostly voluntary and only marginally successful. Government is already deeply involved. To the extent that

this planning is ineffectual, most authorities agree, the role of government will increase.

In line with area-wide planning there is a distinct contemporary trend for health organizations to merge, to affiliate, and to share services. Practitioners are joining group practices and health plans in unprecedented numbers. In short, the health industry is rapidly consolidating itself. It is trying to move in quick leaps from a posture akin to the corner store era to the age of supermarkets.

Notwithstanding the wide publicity given to organ transplantation and other exotic advances in medicine, there is evidence of shifts in emphasis away from acute health care. The favorable economics arising from preventive medicine, multi-phasic screening, outpatient care, and ambulatory care in contrast to the enormous costs of acute care are moving health institutions away from the latter and toward the former.

Since the infectious diseases have been virtually conquered, the stress in health has shifted to treatment of chronic illnesses and mental disorders. The aging of our population has accentuated the need for extended care, nursing homes, and domiciliary care on a grand scale.

The recent appearance on the scene of private hospital and nursing home corporate chains suggests a new shift to private enterprise in health. The overall picture, however, indicates that these are just minor movements against the current and that the net effect of these private ventures will be negligible.

The mainstream of activity in health is oriented toward partnerships between public and private health resources, forming utility-

like health organizations. The cultural and political variations among these United States are numerous and extensive; thus it is dangerous to make sweeping generalizations. Even so, some features of the contemporary scene emerge as being broadly applicable. One of these trends is the greater participation of the public in medical care, or consumerism, if you will. Through labor organizations, health insurance plans, public corporations, and government the consumer of health services is making his will felt. This new consumer power amounts to a virtual revolt against the health establishment. The ultimate form of this new association of the public and the health field is uncertain, but the close relationship between the two in some form is clearly present.

The present and predicted growth rate of the health industry is another salient feature of the contemporary scene. At present, health care ranks third as an employment industry, after agriculture and the construction trades.[23] Since 1961, there has been a net increase of one million in the number of persons engaged in the provision of medical and health services, bringing the present total to 3.7 million. By 1975, it is projected that this number will grow to 5.3 million and that expenditures for health care will reach $94 billion, or about seven percent of the nation's Gross National Product. In terms of number of employees and expenditures health care will then become the nation's largest industry. All indicators point to a continual rising demand for health services. This condition holds major consequences for the topic

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[23]The data in this paragraph are taken from projections of the U. S. Department of Labor as reported by the Health Insurance Institute, New York City in Hospitals, J.A.H.A., Volume 43, No. 13, July 1, 1969, p. 128.

of health costs, as is discussed in the next section.

As a final comment on the contemporary scene, some mention must be made of the Nixon Administration. For purposes of this study two items are worthy of discussion. The first is the Nixon proposal to increase the role of state and local governments. This would be done according to President Nixon's proposal by pumping federal funds into state and local treasuries with few restrictions on expenditure. One question crucial to the ultimate form of the health care system in this country is whether or not the state will continue to be a viable political entity. This issue is discussed more in detail later. It is important to note here that contemporary events are suggesting revitalization of the political influence of the state governments. The full significance of this development will become apparent as one reviews the findings of this study and notes the sharp attitudinal differences between state legislators and national congressmen.

The other event of the Nixon Administration worthy of mention is the so-called Knowles Affair.[24] In January of 1969 the Secretary of the Department of Health, Education, and Welfare, Mr. Robert Finch, offered to Dr. John Knowles an appointment as Assistant Secretary of HEW for Health and Scientific Affairs. Dr. Knowles accepted immediately and it appeared at first that only the formalities remained before confirmation. A storm of protests quickly arose, however. There ensued a bitter controversy which lasted for months. The principals involved were Secretary Finch, Dr. Knowles, the President, the late Senator

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[24]The facts of this case reported here are taken from Newsweek, July 7, 1969, pp. 15-16.

Everett Dirksen of Illinois, Senator John Tower of Texas, the American Medical Association, the American Hospital Association, the AFL-CIO, the Blue Cross Insurance Association, and other interest groups. The upshot of this tempest was the eventual withdrawal of Dr. Knowles' name and the substitution of Dr. Roger O. Egeberg for the job. This issue is noteworthy on several counts including a near splitting of the Nixon cabinet. For purposes of this study it illustrates the political power of the American Medical Association and the growing role of other interest groups in health. But most of all it demonstrates the growing concern of the public with health affairs. In years past little national note has been given to the appointee to the highest medical post in the federal government. In the main John Q. Public just did not care who became the Surgeon General as this appointment had little impact on him. He might be concerned about foreign policy, agricultural subsidies, or, more recently, the military establishment. He would not likely have an interest in health because the government had little involvement in health. This condition has changed and the stormy Knowles affair offers evidence of the growing involvement of government in health and the increasing public interest in this involvement.

The Growing Crisis in Health Care

The rush of contemporary events just described in the previous section has brought about what most authorities in the field describe as constituting a crisis. This "crisis in health" appears repeatedly in the literature of the health field. The topic is a central theme of practically every contemporary health conference. Numerous committees

and commissions have been appointed at the national level to study pressing health problems. Both the Johnson and Nixon platforms included actions to deal with the health crisis. The AFL-CIO has organized a 100-member committee to study this problem and to push for legislation dealing with it. The UAW is taking similar action.[25] The crisis has many facets and is seen differently depending on the perspective of the viewer. A few conditions are paramount and are seen universally as contributing to the crisis.

Cost of Health Care

Perhaps the most serious health problem of the nation is the spiraling cost of health care. Considered from the viewpoint of macroeconomics the cost of health care rose from four percent of the GNP in 1958 to six percent in 1967[26]. As indicated earlier, the cost of health will soon reach seven percent of the GNP. Some authorities predict that during the 1970's these expenditures will skyrocket to $90 - $100 billion or ten percent of the GNP.[27] In comparison with other advanced nations of the world this amount appears to be excessive. Between 1950 and 1964

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[25]At the May 26, 1969 inaugural meeting of the Alliance for Labor Action, a coalition of the United Auto Workers and the International Brotherhood of Teamsters, Walter Reuther called for a "fundamental restructuring of the nation's health care system" and said the ALA would address itself to "the deep crisis in the health care field".

[26]Extracted from the "Report of the National Conference on Medical Costs", Washington, D.C., June 27-28, 1967 as published by the U. S. Department of Health, Education, and Welfare, U. S. Government Printing Office.

[27]Robert E. Toomey "Blue Cross and Hospitals Face the Future - Under Pressure", Hospitals, J.A.H.A., Vol. 43, No. 2, January 16, 1969, pp. 49-51.

health care costs in the United States rose by some 186 percent and total hospital costs arose 230 percent. The cost of a patient day in some hospitals has already exceeded $100.[28] According to the Hospitals, J. A. H. A. Guide Issue (Part 2, August 1, 1968) the 1967 expenses of community hospitals rose 17.6 percent over those of 1966. Although the increase in physician fees has been somewhat lower than that of hospitals, it has been well above the general cost-of-living increases. Another symptom of this problem is the serious financial difficulty in which state after state has found itself relative to costs of their Medicaid programs. Even the federal government is experiencing great problems with the galloping costs associated with Medicare/Medicaid. In short, the nation is pricing itself out of its own health care, both individually at the citizen level and collectively at the governmental level.

Health Manpower

The United States suffers from severe shortages of health personnel of a variety of types: dentists, nurses, physicians, medical technicians, health educators, etc. This is a complex problem involving much more than absolute numbers of trained health workers. The low ratio of physicians to population is worrisome enough in its own right, but compounding the problem are the factors of poor utilization, maldistribution, and over-specialization of the physicians who are available.

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[28]"Blue Cross Annual Report to the Nation", Blue Cross Association, Chicago, Illinois, June 1967.

Some of these same factors apply to the supply of registered nurses. Not only is the number of nurses registered in the United States small in relation to need, but also the available nurses tend to cluster in urban areas and are frequently under-utilized. Being comprised principally of females, this occupational group loses many of its ranks to child-rearing and home responsibilities. The rigid barriers between categories of nurses severely limit their upward occupational mobility.

This latter point applies to the whole spectrum of health workers. Practically every medical and paramedical field is a closed system which leads quickly to a dead-end unless the worker is willing and able to return to school for additional training. Both vertical and horizontal career mobility are virtually stifled.

The absolute shortage of health professionals and the stultifying organization of the health occupations are not the only problems associated with health manpower. Another relates to the rising expectations and demands for health care. Already the knowledge of medical science far exceeds our ability as a society to apply this knowledge. As discussed earlier, the affluent American public expects rapid application of advances in biomedical knowledge, surgical skills, and other medical procedures. This expectation places added demands on the already limited number of health workers.

As evidence of government concern with this problem a good deal of legislation has been inacted: The Health Manpower Act of 1968, the Health Personnel Training Act of 1966, and the Nurse Training Act of 1964. The evidence suggests that the health manpower problems will grow even more critical and that even more involvement by government

at some level will occur.

Organization and Delivery of Services

The health field is plagued with inordinantly high costs, acute manpower shortages, and woefully poor utilization of its physical and human resources. These conditions logically bespeak a need for improved organization, greater efficiency, and more effective planning. And this means bringing direction and control to a field which is fragmented, disjointed, and unorganized and which is deeply imbued with traditions of individualism and free enterprise.

This crisis, then, relates to our ability as a nation to preserve that of the past which is good while improving the organization and delivery of health services so as to achieve the added efficiency which is so sorely needed. To quote from a recent presidential commission the following summarizes this challenge: "The nation must now concentrate upon organizing health facilities and other health resources into effective, efficient, and economical community systems of comprehensive health care available to all."[29]

Health Care for the Poor

Probably the most important question asked in the legislative interviews of this research project is the one which asks if the legislators agree or disagree with the proposition that "Provision of high quality medical care is a right of citizenship for Americans". Implied

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[29]This quotation is taken from the major conclusion drawn from a study commissioned by President Johnson when he appointed a National Advisory Commission on Health Facilities to examine the structure of health care delivery.

in this proposition is the notion that all citizens may expect to receive high quality health care, the government guaranteeing these services for those not able economically to obtain such services for themselves.

The results of this question may be seen in Chapter VII. For our purposes in reviewing the national health scene here it is relevant to make the point that the past two Presidents, the Congress, the AMA, the AHA, and practically every other national health association have officially endorsed the concept of health care as a right. The fact is, however, that the United States is a long, long way from assuring each citizen high quality (or even adequate) health care. Study after study shows the sharp differences in quality of care, the great gaps in comprehensiveness of care, and the great differences in accessibility and acceptability of care between the poor of our society and the more economically able.

If indeed the United States adopts as a national goal the provision of high quality medical care to all citizens as a right of citizenship, then the present dichotomy in delivery of health services has to be viewed as a crisis. The colorful and straightforward language of the American Public Health Association is quoted to make the point succinctly:

> The anachronism -- and the scandal -- of anemic and undignified welfare medical programs for the inhabitants of our seething urban ghettos and for the often forgotten rural poor can no longer be continued. Title 19 or "Medicaid" gave initial promise of enlarging the health service horizons for the medically indigent, but the goal of equal health care for all segments of the community is still far from realized. The need is imperative to eliminate the two classes of medical care, to abolish the means test as the implement of segregated service, and to replace the whole concept of charity medicine with a single high standard and a single democratic frame-

work for health care.[30]

Summation of the Research Problem

Growing pressures are being exerted on government at all levels to solve the great social problems confronting the United States. This is especially true in the health field where private enterprise and voluntary organizations are hard-pressed to meet abruptly rising expectations for more and better health services.

Historically health has been a private affair in the United States. The various levels of government assumed early involvement in certain aspects of health, but these activities tended to be on the periphery. The bulk of medical services has been traditionally delivered and received in the United States with a minimum of government involvement.

This situation has changed a great deal over the past three to four decades principally through legislation at the federal level. The change began slowly with government involvement in meat inspection, nostrum control, and maternal and child health. The Social Security Act of 1935 and other legislation of the New Deal era had many long-term implications. During the postwar period there was other legislation adding medical assistance to the disabled, the blind, and certain aged groups. More recently PL 880 of 1956 and the Kerr-Mills Act of 1960 broadened government involvement with medical care to categorically needy groups. The early years of the Johnson Administration brought

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[30]Annual Report of the American Public Health Association published at the Section Council meeting in Miami Beach, Florida, August, 1967, p. 5.

forth a deluge of new legislation extending government intervention in health. Titles XVIII and XIX of the Social Security Amendments of 1965 (Medicare and Medicaid) and PL 89-749, Comprehensive Health Planning, are just two examples of the large amount of new federal legislation.

The transition of health from the private sector to a mixed private-public domain is having great impact on the field of Health Administration. Leaders in the field see a need for administrators to become "health statesmen". They see a need for such statesmen to be concerned with the larger issues of health care. They see a need for these statesmen to provide leadership in development of national public policy. The alternative is for all to be swept along with transitory and uneven demands of the public.

Concurrently, expanded federal involvement in health has had great impact on the states. Traditionally conservative in health affairs, the states are being drawn into the thick of it through inter-government contracts with the federal level. The state legislative bodies are paramount in this development because this is where laws are made and where funds are allocated. The long-term success of such partnership arrangements will likely hinge on the actions and attitudes of state legislators.

Thus we see state legislators and health statesmen being drawn together into a new, all-important relationship. The continued viability of state government in health may well turn on the effectiveness of this relationship. For his part the health statesman must know something about government and the people who comprise it. Particularly they must have information about the government officials who are clos-

est to and most responsive to the public - the legislators.

This brings us to the core of the research problem. More information is needed on the decision-making process in health affairs. As health care policy outputs come forth from government, we need to know more about the inputs which influence legislative action. In order to perform effectively health statesmen need to know the level of knowledge in health affairs which may be expected of legislators; the ways in which legislators perceive health professionals, particularly health statesmen; the manner in which legislators make voting decisions on health legislation; and the underlying political philosophies which make up the legislator's mental "set" as he views health affairs. Moreover, additional information is needed on how health statesmen are currently relating themselves to the political system and on how they might relate more effectively.

This study is designed to deal with the research problem in the following ways: First, it seeks to establish the manner in which one group of legislators perceive health professionals; it aims to identify the health statesmanship role as it actually exists in one political setting; it seeks to offer some evidence and argument as to how this role might be enhanced; it is designed to give some measure of legislators' knowledge in health affairs and their underlying political philosophy on health issues; and, lastly, the study aims to offer some evidence of how the decision-making process occurs within one legislative body. These are the things which the researcher is intending to do. Now we shall examine how it is intended that these research objectives be accomplished.

First, it is necessary that certain concepts be presented to form a theoretical base for consideration of the findings. This is done in the early chapters, drawing from the fields of Health Administration, Political Science, and other social sciences. Following this an orientation to the research setting is presented.

The research laboratory is the Thirty-Second Oklahoma State Legislature and the population being studied is comprised of the one hundred, forty-eight[31] legislators who make up this body. The primary methods of data gathering are personal interviews with the legislators and examination of voting records. Other methods employed less rigorously are observation of legislative committee meetings, general floor sessions, hearings, and contact with the Legislative Council.

Next, the findings are analyzed and conclusions are drawn from them. These conclusions return us to theories of the politics of health care, the health statesman, and political decision-making. The data serve as evidence and argument serves as rationale for dealing with the research objectives in latter portions of the report. Lastly, these objectives are capped with some final evaluating comments.

Being located in an interstitial area squarely between Health Administration and Political Science, this study relies heavily on the theory, techniques, and methodologies of the political scientist. Studies of politicians, political issues, legislation, pressure groups,

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[31]Actually the Thirty-Second Legislature was comprised of only 147 members (99 Representatives and 48 Senators), but one representative who was interviewed, subsequently expired during the course of the study and was replaced through special election by a new representative who was also interviewed. Thus the total population amounts to 148, comprised of the original 147 members plus the one replacement member.

elitism, etc. abound in the Political Science literature. There are some studies of this sort dealing with health affairs at the federal level. There are also numerous scholarly efforts directed toward state government, but very few of them deal with health affairs at this level.

Presumably the field of Health Administration has not sufficiently matured to prompt research interest in this area. The reasons why political scientists have left this ground unplowed are a mystery. Perhaps it has been due to the traditional cloistered nature of health and medical care; perhaps researchers have been preoccupied with items more central to the field of political science; or perhaps state health affairs lacked the dynamism and intrigue which often attract researchers.

In any event, little has been done in studying state legislative bodies from the unique perspective of health. The study at hand proposes to do just this, although no claim is made to either depth or comprehensiveness. These will have to come later. This study does propose to cast some early strands in bridging the gap between Health Care and Political Science, both of which are essential to studies of this sort.

CHAPTER II

HEALTH ADMINISTRATION AND STATESMANSHIP

"This nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector."[1] This foreboding observation by Mr. Finch and Dr. Egeberg makes explicit the crisis in health care. It also crystallizes the growing intensity of co-involvement between government and the private sector. This increasing interaction between politics and health care brings to the forefront a relatively new concept known as health statesmanship.[2]

The notion of health statesmanship has relevance to many groups and fields within health, but it is especially pertinent to health administration. By nature of their training health administrators are the best equipped among the health professionals to deal in public affairs. The principle thrust of schooling for many health careers is often directed toward technical esoteric material. Such is the case in this

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[1]The opening statement in "A Report on the Health of the Nation's Health Care System" by Robert H. Finch, Secretary of Health, Education, and Welfare and Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Washington, D.C., July 10, 1969.

[2]The concept itself may not be particularly new, but its application on the modern scene as envisioned by leaders in the health field during recent years is certainly innovative.

age of specialization. The trained hospital health administrator is the closest thing to a generalist which the health field has to offer. And there is ample evidence that the generalist is likely to be more successful in influencing public policy than is the specialist. The findings of the study at hand also support this contention.

Not only is the health administrator well-prepared academically for the health statesman role, but also the duties of his position orient him in this direction. Public relations has long been established as an integral component of the managerial function. In this "age of togetherness" in the United States the scope of public relations has broadened remarkably. No longer is the executive concerned simply with corporate image and customer satisfaction (although these are challenging enough in themselves). Public relations as conceived and practiced today involves broad social consciousness and a committment to the general welfare of the community or nation, depending on the sphere of influence of the organization. The field of management in general is being challenged to assume a statesmanship role. This point was well-made in an address delivered recently to the National Association of Manufacturers' Congress of American Industry:

> We have let crises pile upon us, and we must act with a degree of national committment which in our history we have shown only in time of major war. Historically, when the elite groups of societies continued to pursue their own interests in the face of mounting crisis, and failed to adapt to change, those societies did not survive. Business must provide the vanguard in the "war" against domestic ills, which are compounding and accelerating in gravity.[3]

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[3]Irwin Miller, "Business Has a War to Win", Harvard Business Review, Volume 49, Number 2, March-April, 1969, p. 4.

A broad social consciousness may be a newly acquired characteristic of corporate executives. Involvement in politics in shaping public policy, of course, is not new. In the case of health administrators both of these traits are relatively new. It is doubtful that one would seek a health career without a committment to social need, but the new dimension is the widened scope of social consciousness demanded of the health statesman. The role of health administrators in exercise of major influence in shaping public policy in health is indeed a new departure.

This research project is essentially a study of politicans for health statesmen. In order to view the findings in context it is necessary to establish certain theoretical bases. One of these concepts is the relationship between health administration and statesmanship. This chapter is devoted to examination of this relationship. The historical roots and present state of the art of health administration are discussed. A model of the health statesman is developed and the crucial function of this role to the health of the nation is emphasized.

An Emerging Profession

Health Administration is a relatively new discipline. In simpler times when hospitals were smaller and less complex, when physicians' practices were mostly solo operations, when health plans and health insurance had not yet appeared, and when public expectations of health care were less demanding, there was little need for health administrators.

Up until the 1930's (and much later for some sectors of health) the necessary administrative functions of health organizations were performed as sidelines by physicians, nurses, technicians, and others. The functions of management were accomplished incidental to one's primary calling. Rarely were these part-time managers prepared academically or psychologically for administration. Their career preparation and main interest naturally laid in their chosen field. Given the era in which they worked and the needs of the time, however, they performed their administrative duties in an exemplary manner. For example, "Florence Nightingale, truly the first hospital administrator, was a genius in organization".[4]

As health organizations became larger and more complex, the need for full-time, competent administrators became apparent. These early executives were typically persons who converted from one of the health fields or from a business occupation. In time, however, health administration emerged as a calling in its own right and health administrators began to professionalize themselves. Evidence of this may be seen in the formation of associations and in the establishment of professional codes of ethics.[5]

The spectacular technological advance deriving from World War II hastened and intensified the need for able administrators in the

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[4]Malcolm T. MacEachern, Hospital Organization and Management, p. 17.

[5]For example, the American College of Hospital Administrators, the Association of State and Territorial Health Officers, and the Medical Care Section of the American Public Health Association were established as associations primarily composed of health administrators.

health field. The job of management became enlarged from the purely business side of the operation to one of bridging "the gap between clinical services and medical administration. In this management must be equally attuned to the philosophy of physical and emotional care of patients, to the psychology of personnel relationships, and to the economic and cultural pattern of the community."[6]

Educational programs in health administration developed concomitantly with the emergence of this profession. In isolated instances these were undergraduate courses, but most usually they were graduate programs. For example, graduate programs in hospital administration began to appear in the 1930's. Today some thirty-three such programs are recognized by the Association of University Programs in Hospital Administration.[7] In addition, there are seventeen accredited School of (Public) Health in the nation which offer a formal curriculum in some form of health administration.[8]

Much controversy lingers even today as to whether health administration is a specialty within the field of health or within the broad discipline of administration. The final placement of health administration in the universal discourse of the arts and sciences remains an uncertainty. Evidence of this irresolution can be seen in the varying

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[6]John R. McGibony, Principles of Hospital Administration, p. 191.

[7]This information was obtained directly from the Executive Director of the A.U.P.H.A. in August, 1969.

[8]This information was obtained by mail from the American Public Health Association, 1740 Broadway, New York City in September, 1969. It must be noted that there is some overlap in counting the graduate health administration programs of the A.U.P.H.A. and those of the A.P.H.A.

location of graduate programs in health administration within universities. These programs are frequently located in schools of health and colleges of medical science. An almost equal number are located, however, in graduate schools of business administration or public administration.

A good deal of custom and practice supports the view of health administration as one of the occupational categories lying squarely within health. After all, the early health administrators (and many even today) were trained in technical fields such as medicine or nursing and assumed roles in administration as sidelights, as afterthoughts, or out of necessity. Thus health administration might be seen as a spin-off from the more traditional health disciplines. Also, sound arguments can be advanced showing that health administrators must be thoroughly trained in health. Many contend that primary training in health is desirable.

On the other hand, a growing number of educators and professionals are seeing administration as a discipline in its own right. Perhaps it is yet premature to refer to the "discipline of administration". One would obviously be on firmer ground by referring to the various administrative specialities like business administration, public administration, hospital administration, etc. But there is a growing tendency to view administration as a generic practice, learned through study and application of universal principles. This view sees the same concepts, theories, and processes underlying administration irrespective of the setting in which they occur. A solid grounding in health and a thorough knowledge of the setting are prerequisite, but from this point

of view the primary thrust of formal preparation by the health administrator should be in the broad discipline of administration. As the value and relevance of the social sciences continue to become apparent this view will probably be further reinforced.

Growth and Maturity

The increasing complexity and immensity of the health field have been equaled by growth of the health administration profession. It is difficult to determine whether or not this group has yet reached professional maturity. It appears, on the one hand, to be very much in the formative years. Health Administration has to be viewed as a loosely-knit group, comprised principally of more closely aligned sub-groups such as hospital administrators, health officers, health planners, health insurance executives, etc. Little beyond their common dedication to the needs of the patient serves to give these sub-groups cohesiveness. From this perspective health administration appears still to be an adolescent moving toward the unity of effort and integration of sub-groups which might signify maturity.

On the other hand, there are signs that the field is reaching adulthood in terms of what it is doing, i.e., the enlarged role of the health administrator. Over the years the health administrator has concerned himself with successively broader matters. From its relatively recent inception this field has advanced through a number of evolutionary changes. In the early days emphasis was upon the physical aspects of the health environment, principally housekeeping and maintenance activities. Then the emphasis was enlarged to include the all-important func-

tions of financial management, accounting, and other business services. As the field developed further, it came to concern itself with the responsibilities of total management. Again the emphasis was widened to encompass such prime administrative functions as goal-setting, integration of professional skills, long-range planning, and top level decision-making.

Today the major concerns of Health Administration are expanding in another dimension. This time the emphasis is on health affairs outside the physical environment of the organization. The contemporary health administrator is deeply involved with such widespread controversies as the rising costs of medical and hospital care, methods of organization for delivery of health services, areawide planning, comprehensive health planning, the citizens' right to health care, ghetto health problems, rural health problems, the role of government at all levels in health care, gaps in health care, determination and maintenance of high quality health services, and utilization of health personnel. Each of the foregoing is of crucial significance to the health administrator; each of them also involves the larger social, economic, and political world beyond the health organization's traditional posture of provincialism. When viewed from the perspective of these broad concerns of the field today, health administration appears to have the potential for early maturity. The crucial question centers on whether or not health administrators are rising to the occasion in meeting this challenge.

This study, then, deals with the extra-health organization concerns of administration within the health industry. Since the concept

of statesmanship among health professionals is central to the purposes of the study, it is important that we examine this concept and define who health statesmen are. For this we shall turn to a review of relevant and recent literature on the subject.

The Health Statesmanship Concept - Literature Review

Review of relevant literature reveals that the notion of health statesmanship is not an altogether new concept. For example, Owen commented in 1962 that the health administrator is becoming increasingly subject to public scrutiny and that he has joined "the statesmen of health".[9] The statesmen of health here refers principally to medical doctors and their professional organizations. The role of physicians in influencing public policy over the years is well-established. In commenting on the statesmanship activities of medical doctors in Canada Taylor observes that "medical leaders appear keenly aware of the new responsibility now devolving upon the profession, individually and collectively, of sharing in the administration of major public programs; and the medical profession as an interest group has major influences on public policy and, in Canada at least, no other group is as deeply involved in public administration".[10]

In the past few years a good deal of attention has been given to this topic in the Hospital/Health Administration literature in this

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[9]Joseph K. Owen, ed, Modern Concepts of Hospital Administration, p. 5.

[10]Malcolm G. Taylor, "The Role of the Medical Profession in the Formulation and Execution of Public Policy", The Canadian Journal of Economics and Political Science, Volume XXVI, February 1960, pp. 109 and 125.

country. One finds these papers principally in professional journals where leaders in the respective health fields are urging their colleagues to assume broader roles. Dr. Edwards emphasized this expanding role as early as 1965.[11] Another of the early authors on this topic is Professor Dornblaser who discussed specifically the term "Statesmanship in Administration" and described its nature.[12]

More recently John R. Griffith has this to say on the subject:

> The good administrator of a community hospital will do better if he understands these (the major issues in public affairs of health) and can to some extent predict their impact. For many these will be new skills, insights into collective bargaining and the process of government at both administrative and legislative levels. A few in the profession must become masters in these arenas, men whose primary job is the identification, mastery, and negotiation of the health care issues that will be settled collectively rather than individually. We will be served well if these men are among our best, and if in addition they have accurate insights to the community hospital.[13]

Walter J. McNerney has referred to administrators of this type as "health care statesmen". He specifies as prerequisites for such a group thorough knowledge of the political process, and he emphasizes the need for many more of them than we presently have.[14] Weil, Holm,

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[11]Sam A. Edwards, "The Contemporary Hospital and Social Control", Hospital Administration, Fall, 1965, pp. 95-121.

[12]Bright M. Dornblaser, "The Hospital Administrator - His Emerging Role", Hospital Administration, Fall, 1966, pp. 6-16.

[13]John R. Griffith, "An Educational Challenge for the Programs and the Practitioners: The New Role of the Administrator", Hospital Administration, Fall, 1967, pp. 128-129.

[14]Walter J. McNerney, speech before the American Public Health Association, October 31, 1966, San Francisco, California.

and Parrish emphasize the need for educational programs which will produce administrators "capble of addressing the medical care statesman role".[15] Thompson and Filerman mark their concern on the subject in this way: "A knowledge of the concept of the medical system as an instrument of social policy and the role of government in shaping and directing this policy has become crucial to understanding the role of the hospital within the system."[16]

From a theoretical point of view, Dr. Schaefer[17] stresses the shortcomings of administrative theory in providing solutions to health problems facing our nation. This is so, Dr. Schaefer contends, because the emerging issues of the day go beyond the issues with which conventional administrative theory has been concerned. "What is striking about these problems is that they are not so much administrative in character as they are political. They have to do with the structuring of authority and power."[18]

In a recent paper Douglas R. Brown describes a new administrative model for hospitals which "views the professional hospital administrator largely as a policy-maker, an innovator, and an initi-

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[15]Thomas P. Weil, Donald S. Holm, and Henry M. Parrish, "An Approach to Training Health Managers: The University of Missouri Program", Hospital Administration, Fall, 1967, p. 116.

[16]John D. Thompson and Gary L. Filerman, "Trends and Developments in Education for Hospital Administration", Hospital Administration, Fall, 1967, p. 17.

[17]Morris Schaefer, "Current Issues in Health Organization", American Journal of Public Health and the Nation's Health, July, 1968, pp. 1192-1199.

[18]Ibid, p. 1198.

ator of medical care programs to meet health needs. He is a program-planner and program-developer with a broad social role in the total community."[19]

Robert Toomey[20] observes that changes in public policy cannot take effect without some interference with existing patterns of private professional practice. He sees change as inevitable and feels that the big problem is the decision as to who the "changers" are to be. Mr. Toomey contends that the health field itself should effect such changes and that it is the primary responsibility of "health care administrators" to provide leadership in this process.

In his recent article Dr. Crosby emphasizes the physician's role in Health Care Administration. He "speaks out in favor of physician participation in management decisions at the board level of hospital responsibility - but he emphasizes that those decisions must be made by persons acting as representatives of the community, not of the medical staff itself".[21]

Dr. Magraw also speaks effectively to this point relative to the statesmanship responsibilities of physicians as well as trustees and administrators.[22]

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[19]Douglas R. Brown, "A New Administrative Model for Hospitals", Hospital Administration, Winter, 1967, p. 13.

[20]Robert E. Toomey, "Blue Cross and Hospitals Face the Future - Under Pressure", Hospitals, J.A.H.A., January 16, 1969, pp. 49-51, 118.

[21]Edwin L. Crosby, "The Physician's Place in Health Care Administration", Hospitals, J.A.H.A., August 1, 1968, Part I, pp. 47-49, 121.

[22]Richard M. Magraw, Ferment in Medicine, pp. 254-257.

Donald M. Rosenberger presents an incisive description of the "Health Statesman" in his recent paper.[23] Although he uses the term "professionalism", much of what Dr. Duce[24] says of the health administrator is relevant to the model of a health statesman which is rapidly beginning to form. Dr. LeTourneau[25] notes the great responsibility of the hospital administrator to public service. He emphasizes that unselfishness and freedom from purely personal considerations are essential. "Dedication to public service demands subordination of personal interest of the individual. In some instances, dedication may entail a tremendous sacrifice in the personal life of the professional hospital administrator, but it is a sacrifice that every professional expects when he makes that public profession of availability for public service."[26]

As an informed observed in the public affairs of medicine, Elliot Richardson[27] highlights the need for changes in medical education. He maintains that courses in the social sciences must be included in medical education to enable physicians to perform more effectively the health statesmen role. There is a forbidding note in his summary

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[23]Donald M. Rosenberger, "Hospitals, Focus of the Search for Better Health Care", Hospitals, J.A.H.A., June 12, 1968, p. 55

[24]Leonard A. Duce, "The Administrator: Today and Tomorrow", Hospital Administration, pp. 7-24.

[25]Charles U. LeTourneau, "Hospital Administration: A True Profession", Hospital Administration, Winter, 1968, pp. 51-67.

[26]Ibid, p. 65.

[27]The Honorable Elliot L. Richardson, Lieutenant Governor, Commonwealth of Massachusetts, "The Politician Views Medical Education in the Social Context of Medicine", as this writing appears in John H. Knowles, ed., Views of Medical Education and Medical Care.

comment: "Life is short and the art long, but in the decades ahead not the least of the art will be the preservation of it."[28]

In the closing pages of his recent book Dr. DeGroot[29] laments that the role of the general physician in developing and formulating public policy in health is "almost nil". He calls for a tack of leadership, not of adjustment as in the past, in public affairs by organized medicine. And DeGroot looks for this leadership to come from new sources within medicine - the deans and faculties of medical schools and the professional societies, as opposed to the traditional "Voice of American Medicine",[30] the American Medical Association.

One finds recurring mention of the Health Statesman concept in the periodic newsletter of the American College of Hospital Administrators. For example, Donald W. Cordes, 1968 President of the A.C.H.A., has this to say on the subject:

> We need hospital administrators who are truly community health leaders: people with a large view of the leadership assignment. Most administrators are tending the machinery of the existing hospital and doing it very well, but they are not thereby translating into reality the vision of what society needs in health services. Tending the machinery of a modern hospital does not help one develop a strategy for wielding community action to accomplish the goals that

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[28]The Honorable Elliot L. Richardson, Lieutenant Governor, Commonwealth of Massachusetts, "The Politician Views Medical Education in the Social Context of Medicine", as this writing appears in John H. Knowles, ed., Views of Medical Education and Medical Care. p. 115.

[29]Leslie J. DeGroot, ed., Medical Care Social and Organizational Aspects, pp. 522-530.

[30]One of the earliest and most authoritative descriptions of the A.M.A. as the "Voice of American Medicine" is contained in Oliver Garceau's, The Political Life of the American Medical Association.

involve all of the health resources of the community.[31]

To put the issue another way and with specific reference to public health planning Kaufman recently wrote that "politically sophisticated groups outside the field have come to assert new claims and to voice new expectations concerning public health services. If public health planners are any less sophisticated about the political process than their competitors, they will soon find that others have taken over the field.[32]

Albert W. Snoke sees an immediate and compelling need for "the recruitment, education, training, and retention of competent, qualified, career professionals in health administration. As the federal government plays an increasing role in the financing and in the determination of policy for health care in this country." Dr. Snoke continues, "the career professional in health administration, both in and out of government, will determine in substantial measure (directly or through advice to political or community bodies) the nature of our health care system."[33]

A Health Statesmanship Model

Recently Theodore Chester seemed to differentiate between

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[31]Donald W. Cordes, "A Point of View", News, A.C.H.A. Volume XXXII, Number 5, July, 1968, p. 2.

[32]Herbert Kaufman, "The Politics of Health Planning", American Journal of Public Health and The Nation's Health, Volume 59, Number 5, May, 1969, p. 796.

[33]Albert W. Snoke, "The Unsolved Problem of the Career Professional in the Establishment of National Health Policy", American Journal of Public Health and The Nation's Health, Volume 59, Number 9, September, 1969, p. 1576.

health administrators and health statesmen when he wrote, "Obviously an effective and efficient health service needs to have both first class hospital (health) administrators, and also health care statesmen".[34]

Regardless of the precise definition of a "Health Statesman" and irrespective of the origin and evolution of the term, there appears from the literature to be a distinct health statesman model. The current informed thought on the subject paints a general, but clear picture of this model. A brief composite of what the literature envisions as a "Health Statesman" might appear like this.

He (or she) is a person trained and skilled in the art of administration in health. He is an accomplished administrator, an effective executive. But his orientation is as much to the total environment of his organization as it is to the organization itself. He is a concerned, active participant in the formation of public policy in health. He is sufficiently knowledgeable and broadly informed as to formulate convictions on how to best meet society's health needs, whether on a local, state or national level. He exercises leadership and administrative expertise in attempting to implement his convictions into public policy.

He may function in a hospital, planning agency, voluntary agency, group medical plan, prepaid health insurance concern, university, labor organization, or government. Although it is not central to the model, he may well be a medical doctor or any other health professional. His

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[34]Theodore E. Chester, Graduate Education for Hospital Administration in the United States: Trends, A Monograph published by the American College of Hospital Administrators, Chicago, Illinois, January, 1969, p. 21.

health statesmanship might manifest itself on the local, state, or national level or combinations of these. He possesses distinguishing marks of integrity, professional ethics, and an overriding concern for the best manner in which the community health needs may be met. His judgment in health affairs is valued by the public.

Compared with the politician he may be handicapped by lack of political savvy. This seeming weakness, however, is a principle strength in the health statesman role. Being free of the vicissitudes of political life which beset the politician, the health statesman may assert his independence to a greater extent and seek to provide true leadership to worthy but sometimes unpopular goals.

It is apparent that the literature envisions in the health statesman role both practicing physicians and career administrators. The primary thrust as a major career activity is aimed at the latter, however. It is beside the point of this study to explore the arguments as to which of these two professions is best suited to fill the role. For purposes of a theoretical construct it seems more relevant to make the point that one or the other - or perhaps both - ought to perform this role. Consequently the study at hand considers whether or not either group is performing effectively as health statesmen in the eyes of state legislators.

The physician statesman utilizes his background in medicine to good advantage. The non-physician statesman understands his limitations relative to the practice of medicine and makes no pretense to competence in the specific diagnosis and treatment of illness. At the same time, though, he knows that he represents one of the health profes-

sions and that he has specialized knowledge in health and medical care. He recognizes his broad preparation in the social sciences, his expertise in dealing with large numbers of people, and his special capabilities for the role of integrator, coordinator, planner, and manager. These skills and this role summarize the idealized model of the health statesman.

Before leaving this section it is important to analyze critically the health statesman model just developed through literature review. By urging their peers to rise to the call of statesmanship the leaders in health have constructed a social role almost too idealistic for relevance in the world of reality. It is one thing to deal in the abstract with behavioral goals designed to challenge men to greater service. It is quite another to expect great change in short order on a grand scale. The health professionals for whom the admonitions for statesmanship are intended find themselves burdened with massive problems well within the confines of their working environments. Regardless of the urgency of the call to statesmanship, the press of daily events seem to keep the typical health professional firmly embedded in his present role. Some of the most skillful and the heartiest will respond to the call with competence. (Indeed this study by implication urges them to do so). But it is important to acknowledge that the health statesmanship model does not envision a sort of philosopher-king with super-human powers. The concept is aimed at real men who function well-within constraints of the real world.

A more serious criticism of the health statesmanship model relates to its failure to describe how such a role might be effectively

assumed and carried out. As abundantly illustrated in the literature review, many writers describe vividly what health administrators should do. The goal is assumption of influence and leadership in health affairs. The problem is that little is known on just how this should be done. Interestingly enough, many of the advocates for health statesmanship seem themselves to be health statesmen; nevertheless the literature contains little on how they became such.

As indicated earlier, one of the main objectives of this study is to identify health statesmen as they exist in the eyes of the politician. The emphasis is on those actions, characteristics, or skills which are associated with health statesmanship. Once this is known we should be able to deduce, or at least posit, the ways in which the role can be assumed and carried out. Much more will be said about this in later chapters.

CHAPTER III

POLITICAL SCIENCE AND HEALTH CARE

The health statesman executes his statesmanship role in the world of the politician. Although the health professional's values and knowledge have a bearing, it is essentially the politician's game which is being played. The rules of this game are not set by the health worker. To the contrary, they are often antithetical to professional values and methodologies. Thus the health statesman must not only learn well the rules of the politician's game, but also he must alter his basic attitudes to accommodate these rules. He must develop skills in playing this game, much as the politician himself has done.

The politician does not set these rules either. He has simply learned to play by them. The rules of the game are determined by the larger society and the political system which it employs. In order to understand the world in which the health statesman functions, then, it is necessary that we examine the findings of scholars in political theory.

Some knowledge of political science is especially relevant to the health statesman for two reasons. First, it enables him to understand how things are in politics and how they came to be that way. Second, and more importantly, some knowledge of political science allows the health statesman to see how things really happen in a democracy, to

understand the principles which are operative, and to become more effective himself in affecting the decision-making process.

A thorough review of political science literature pertinent to health statesmanship is beyond the scope of this report. There are, however, a few key concepts which are particularly relevant and which may be summarized. These concepts are presented here as being representative of the total. By this means a theoretical basis for certain political processes may be developed as a backdrop for analysis of the formation of public policy in health.

Pressure Group Theory

"The role of the politician and the political party in our mass democracy is to act as a broker of interests."[1] Monsen and Cannon go on to explain that it is inherent in the political process for a politician to seek compromise and concensus among the various conflicting pressures which impinge upon him. Politicians and political parties tend to avoid extreme positions, to blur sharp issues, to bring protagonists together on middle ground. This is so because political success in a democracy depends on pleasing as many of the people as much of the time as possible. This feature of political life often serves as a basis for the criticism of politicians for fence-straddling, inconsistent ideology, and lack of conviction.

The consequences of neglect of this political fact of life may be disastrous. For example, the extreme approach and dogged purism of

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[1]R. Joseph Monsen, Jr., and Mark W. Cannon, The Makers of Public Policy: American Power Groups and Their Ideologies, p. 331.

Senator Goldwater in the 1964 Presidential Campaign contributed in good part to the lop-sidedness of his defeat in the judgment of some political theorists.[2] This is not to say that all successful politicians are or must be unprincipled - it is to say that by the nature of their role, their ethics and principles are expressed in a unique way. It is important that health statesmen understand this characteristic of the politician.

It is also important to lay the theoretical foundation for the phenomenon of pressure groups in American democracy. As health professionals play a statesmanship role, they will probably do this as part of a pressure group. They must understand, therefore, the highly desirable and important functions served by interest groups. To look upon these groups as being nonproductive or deleterious to the democratic process would be unjust and inaccurate. One must exercise due discrimination in differentiating between the registered lobbyist representing the legitimate interests of an organized pressure group and the gangster-type extortionist who forces political favors through threat, illegal coercion, and direct payment to politicians of large sums of money. H. R. Mahood's recent book serves as an excellent general reference for a discussion of the theory of pressure groups and it provides a succinct statement regarding the valuable role of these groups:

> Political pluralism has contributed to America's greatness. Our progress in economic, social, technological and

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[2] Nelson W. Polsby and Aaron B. Wildavsky describe this phenomenon in detail and use the 1964 Goldwater-Johnson election as a prime example in Chapter 4 of their recent book, Presidential Elections, Strategies of American Electoral Politics, pp. 169-217.

> cultural fields has been stimulated and expanded by pressure groups. Their operation is sometimes chaotic and sometimes selfish, but by the very fact that groups may pursue their interests so freely and openly is a sign that our political processes are in a healthy state.[3]

The theory of groupness from social psychology and the concept of contending interests from political science combine to form the theoretical basis for pressure groups. Early in American political life individuals with common interests joined forces in efforts to sway governmental policy to their benefit. As time passed these groups became better organized and more influential. Traditional pressure group models are found in the fields of business, agriculture, labor, transportation, etc. As American society became more complex, the quantity of pressure groups proliferated at various governmental levels. Today there are powerful pressure groups among even such unlikely groups as military officers, scientists, and government workers themselves.

"A striking feature of American politics is the extent to which political parties are supplemented by private associations formed to influence public policy. These organizations, commonly called pressure groups, promote their interests by attempting to influence government rather than by nominating candidates and seeking responsibility for the management of government."[4] A leading theory of the nature of interest groups suggest that such groups rest on shared attitudes. The activities of the group, then, center on promulgation of these attitudes relative to society as a whole or to preservation of the shared attitudes

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[3]H. R. Mahood, Pressure Groups in American Politics, p. 303.

[4]V. O. Key, Jr., Politics, Parties, and Pressure Groups, p. 23.

within the group. A flurry of pressure group activity is a predictable response to external threat to shared attitudes.

One must be careful to avoid the convenient notion that Americans have neatly sub-divided their political interests into discrete pressure groups and that all decisions arise uniformly from organized pressure group activity. Interest groups do play an important role in American politics, as will be emphasized in this report. Even so, it is important to acknowledge that there are major elements of the decision-making process at work in addition to the organized interest groups. The political parties themselves represent major decision-making centers in our political system. There are two other elements in the political process in the United States that are of crucial significance and that require special mention. "These are, first, the notion of multiple or overlapping group membership and, second, the function of unorganized interests, or potential interest groups."[5] The remainder of our discussion shall center on the highly organized pressure group, particularly the professional association. The author wishes, though, to acknowledge in a general way the significant roles played by other elements of our political structure. As a matter of fact, much of the controversy in our system derives from the inevitable conflicts between organized pressure groups and the larger elements of society.

In summary, the following composite view of nonparty associations and groups is offered:

> In the give and take between government and governed,

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[5]David B. Truman, The Governmental Process, p. 508.

> formal apparatus of government may be supplemented by a system of private association, which, in the United States, are called pressure groups. These associations may perform a representative function by communicating the wishes of their members to public authorities; or they may bring 'pressure' to bear upon the government. The same groups may be consulted by the government. They may even exercise forms of private authority which differ little from governmental authority. At times their influence on the actions of formal government may be so potent that they in fact control the exercise of public authority. In other instances they may perform creative functions in the contrivance of proposals for public policy. Pressure groups may be in alliance with a political party and they often seek to influence the outcome of elections.[6]

Elitist Theory

Contrary to the democratic ideal there is growing evidence that many top-level political decisions in the United States are actually made by a small number of persons who constitute a power elite. Central to this theory is the notion that power becomes concentrated in the hands of a few through the amassing of economic fortunes. In our capitalistic system, this theory holds, wealth leads to greater wealth and further control over the elements of production. Centralization of economic power, in turn, leads to more frequent and more effective access to the political decision-making process. Also, a power elite typically gains inordinate control over information media. Moreover, this concept holds that an elite is able to shape public opinion and actually create consumer demand through control of the fantastically effective means of Madison Avenue advertising and public relations firms.

C. Wright Mills,[7] for example, contends that the United States

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[6]Key, Politics, Parties, and Pressure Groups, pp. 13-14.

[7]C. Wright Mills, The Power Elite, passim.

is no longer comprised of scattered, loosely-held states, but that it now has a highly centralized government, increasingly concentrated industrial corporations, and a huge military component, all of which are becoming more and more interrelated. It is Mills' view that major national power lies in the big three components of our society: economic enterprises, government, and the military. He sees these three as forming sort of an interlocking military-industrial-political complex which towers over other elements of the society. Institutions such as the family and the church simply adapt themselves to the dominance of this military-industrial complex. The complex, in turn, is dominated by a few hundred corporate executives, key members of the military establishment, and influential persons high in government. Mills sees this elite group as being self-perpetuating and as creating the mobility of its members to move freely from one phase of the complex to another.

Floyd Hunter provides additional evidence of this phenomenon of power in a democracy in his analysis of the concentration of national political power in the hands of a relatively small number of economically and socially elite persons.[8] In still another study Hunter examines the operation of a power elite at the regional and community levels.[9] Here he finds local societies clearly gradated into strata with the top layer composed of a small number of key decision-makers. The primary thrust of Hunter's findings is confirmation of the theme

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[8]Floyd Hunter, Top Leadership, U. S. A., passim.

[9]Floyd Hunter, Community Power Structure, passim.

that business interests dominate the regional and local scenes.

In illustration of yet another dimension of elitist theory Don K. Price finds other manifestations of elitism among scientists of national prominence.[10] The source of power for the scientific estate is not economic wealth, but rather is technical and esoteric knowledge. Our technology has advanced so far and so quickly, contends Dr. Price, that the traditional decision-makers are simply not able to understand the vital considerations inherent in an issue. Being a generalist, this theory holds, the politician does not comprehend scientific issues and allows the decision-making to pass by default to the scientist.

Unanimity does not exist relative to the existence of a highly dominant power elite in the United States. A number of scholars[11] hold to the pluralist view which envisions a general distribution of power among many people and numerous elements of our political system. This school of thought contends that the appropriate method for studying the exercise of power is to examine closely political decisions one by one, rather than employing the reputational methodology of the elitist. Each approach seems to have some validity and both are employed in this study.

Still another perspective of the exercise of power in a democracy is suggested by Galbraith[12] who describes a range of national

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[10]Don K. Price, The Scientific Estate, pp. 213-229.

[11]To mention a few of the more prominent pluralists the following names are offered: Nelson W. Polsby, Robert A. Dahl, and Delbert C. Miller.

[12]John K. Galbraith, American Capitalism, the Concept of Countervailing Power, pp. 1-11, passim.

balance which derives from the conflicts of contending interest groups. He calls this a condition of "countervailing power". "The neutralization of one position of power by another" is the essence of the concept. Some herald this concept as being particularly insightful. Other political scientists are highly critical of Galbraith's theory on the grounds that it implies an unrealistic state of equilibrium and that it overlooks the dominance of economic elites. Also, it should be noted that Galbraith himself has now shifted somewhat from his earlier pluralist position of counter-vailing power.

Regardless of how one feels about the outcome of contention by rival interest groups, there seems to be agreement in the fact that important roles are played by these groups. The following quotation seems to aptly summarize this point:

> Interest-group leaders are an important category of unusually active participants in the policy-making process who, with some exceptions, are without legal or extra-legal authority to make proximate decisions on policy. They are therefore heavily dependent on the other major method of exerting power or influence: persuasion through the practice of partisan analysis.
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> So diligent and skilled are many of them that they become powerful indeed. They come to serve as major sources of information and analysis for those proximate policy makers who do have authority.[13]

The Health Care Elites

All of these theories and concepts are relevant to health affairs because the dynamics of pressure group theory are the same whether we are dealing with industry, labor, firearms control, or medicine. In-

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[13]Charles E. Lindblom, The Policy-Making Process, p. 117.

deed the American Medical Association with its constituent state and local societies is recognized as one of the most active pressure groups in the nation. Furthermore, there is considerable evidence that medical doctors as a group through their professional societies exercise the authority of a power elite in health affairs of the United States.

Other pressure groups also operate within the health field and there are indications that the prestige of organized medicine is diminishing on the national scene.[14] Nevertheless the American Medical Association remains far and away the most influential, the wealthiest, and the most powerful health organization in America. For these reasons the American Medical Association represents the most meaningful model for examination of political power in health. This examination will center on the national scene for it is at this level where the greatest amount of activity has taken place and where much documentation has been done. Unfortunately, the literature is remarkably scanty relative to power politics of state medical societies. (As stated in the introduction, it is one of the purposes of this study to add to the meager data on health affairs at the state level).

The American Medical Association was established initially in 1847, but it did not achieve a thoroughgoing formal organization until after the turn of the century. From this point forward it has had tremendous impact on health affairs. "With the increase in Federal appropriations for public health purposes after World War I and with the efforts of various groups largely made up of laymen to use the powers of national government to foster changes in the organization

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[14]McGraw, Ferment in Medicine, Chapters 9 and 10 passim, especially p. 255.

and financing of medical practice through some form of social insurance, the American Medical Association has become increasingly active in trying to influence national government policy."[15]

The American Medical Association was a remarkably effective pressure group during the thirty years between 1935 and 1965. Beginning with the depression times of the mid-thirties it successfully thwarted the efforts of formidable forces who aggressively sought a national health system. Almost single-handedly it staved off the efforts of the Roosevelt, Truman, and Kennedy administrations to bring about federally financed general medical programs, especially for the aged. Most authorities agree that the United States would have experienced expanded federal medical care programs years ago had it not been for the efforts of organized medicine.

Another singularly successful strategy was that of severely restricting the number of medical graduates throughout this thirty year period. This policy became a principle factor in the American Medical Association's prestige decline of the sixties; nevertheless organized medicine was able to limit enrollment for decades in the face of growing public opposition and ever-widening gaps in medical care. Not only were the absolute numbers restricted, but also minority and low socio-economic groups were effectively denied admission to medical schools in many cases. Jaco discusses at length the sociological history of medical education in his sourcebook in behavioral science and medicine.[16]

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[15]Truman, The Governmental Process, p. 94.

[16]E. Gartly Jaco, ed, Patients, Physicians and Illness, Section V.

During the period 1952-1960, the American Medical Association enjoyed a period of relative calm. Under the umbrella of two Republican administrations it was little-tested on the great issues. It looked fondly upon the Eisenhower era as a period of successful maintenance of the status quo. Pleasant though this period may have been, the conservative 1950's reaped bitter harvest for the American Medical Association as the harsh problems of the 1960's rushed in. Owing to the absence of dynamic health leadership for the nation, medicine found itself in serious difficulty. Striking advances in technology and medical science and rapid social change buffeted the medical world. Among the far-reaching effects of these forces were new trends in group practice, contract procurement of medical service, group hospitalization, and increased governmental activity in health. The American Medical Association had done little to develop a constructive approach to the massive health problems which came to face the nation. And "in the absence of professional leadership in advancing broad and effective programs of medical care, great social pressures swelling behind the dams of governmental inertia (began to move) the nation in directions that presented formidable dangers to the profession".[17]

More than forty pieces of federal health legislation were enacted during the period 1964-1968, but the biggest political battleground was the historic Medicare/Medicaid legislation, i.e., Titles XVIII and XIX of the Social Security Amendments of 1965. The role of the American Medical Association in battling against these bills serves

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[17] James G. Burrow, AMA, Voice of American Medicine, p. 186.

as an ideal model for examining the influence of a power elite. Before so doing, however, it is relevant to review the reasons for steadfast opposition by organized medicine to any form of government health insurance.

This opposition is forged on a few basic issues. First, the American Medical Association considers the "fee-for-service" method of payment as being absolutely essential. Although it finally relented in its resistance to private, voluntary insurance programs, the American Medical Association has insisted over the years that the physician be paid a fee for his services by the patient. The arrangement toward which the American Medical Association is most hostile is one whereby the doctor is paid by a governmental agency or an organization such as a hospital or group medical practice.

Secondly, organized medicine has steadfastly fought for the patient's right to freely select his own physician. It is felt that the quality of services rendered will inevitably suffer if the patient does not always have the prerogative of selecting his personal doctor.

The third traditional stand of the American Medical Association involves the sanctity of the patient-physician relationship. It is maintained that if any organization, government, hospital, etc. becomes a party to the patient-physician relationship then the patient's right to confidentiality and his expectation of total committment by the physician are destroyed. For his part the physician sees intrusion into the patient-doctor relationship as one which reduces his professional status and impedes him in delivery of appropriate medical services.

In short, organized medicine sees government involvement in medicine as a profound threat to the quality of services and the health of the nation. Some informed observers posit that American Medical Association's resistance to Medicare, group practice, etc. has also been due to the threats of personal economic loss and reduced professional prerogatives.

Proponents of government intervention in medical care have traditionally cited the wide gaps in adequate medical services to all Americans and the absence of a fundamental financial base underpinning the health industry. In effect, these supporters were challenging the established role of organized medicine to determine the method by which health services would be rendered. The "Medicare" position maintained that traditional American Medical Association approaches were out of phase with the needs of a modern, technologic society.

These brief explanations over-simplify both the "Medicare" position and the American Medical Association position. Nevertheless this short discussion puts before us the issues central to the Medicare legislation and allows us to turn our attention to the actions and strategies of the protagonists.

The Presidential Campaign of 1960 was the first in which a government-sponsored health program for the aged was a major issue. John F. Kennedy proposed such a program under the existing Social Security system and delivered to Congress the first presidential address on this subject. Bills to implement the President's proposals were introduced by Senator Anderson of New Mexico and Representative King of California. The famous King-Anderson bill was thus formed and was subjected

over the next five years to denouncement, revision, modification, and general political combat characteristic of the fate of controversial proposals.

The American Medical Association's reaction to the King-Anderson bill was right in line with its strategy of past success in stalling off similar legislation during the earlier administrations of Roosevelt and Truman. The opening battle cry was one of "Socialized Medicine". The rationale was that this was just another step toward full government control of medicine. Organized medicine did recognize the gaps in medical care and the need for an improved financial structure in health, but its solution was antithetical to the King-Anderson bill. In its widely noted twelve point program the American Medical Association cited the local community and the individual physician as the only groups able to cope with and solve the nation's health programs. It did acknowledge that the needs of special groups such as crippled children, medically indigent, etc. were so great that federal programs were appropriate. But even here administration of these programs was delegated entirely to state and local groups. By this means the American Medical Association supported greater implementation of the Kerr-Mills Law.

Some of the flavor of the American Medical Association's argument may be seen in the following quotation in description of its position in 1962:

> I call attention to it (American Medical Association's past leadership in health legislation) specifically in view of the current controversy concerning the American Medical Association and the Federal government's desire to pass the King-Anderson bill into law. We, of course, support greater

> implementation of the Kerr-Mills Law. Our concern in this matter harkens once more to the American Medical Association Constitution; we shall continue to support sound medical legislation and oppose any measures that will retard the overall advancement of medicine, impair the quality of medical care or tend to destroy the free practice of medicine in this country that has given so much to the public health and well being.[18]

For four more years and into another presidential administration the American Medical Association was able to forestall enactment of major health legislation, but the opposition was growing. The pressures of the times were recruiting many new supporters for some form of insurance under social security.[19] Liberal Republicans such as then Congressman John V. Lindsay and Governor Rockefeller swung over.

Eight Republican senators revised their earlier stands on the issue and several key officials in the Eisenhower administration also publicly endorsed a social security program. Some of the nation's major publications followed suit, including "The New York Times", "The Washington Post", and "Business Week". Gallup and other polls began to consistently show public opinion two to one in favor of increased social security taxes to pay for old age medical insurance. Moreover, the American Medical Association found itself abandoned by fellow professional groups as Medicare was eventually endorsed by the American Public Health Association, the American Nurses Association, the American Hospital Association, and others.

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[18]N. A. Welch and D. F. Ward, "The A.M.A.", in Medical Care, Social and Organization Aspects, ed. by Leslie J. DeGroot, pp. 445-446.

[19]Herman Miles Somers and Anne Ramsay Somers, Medicare and the Hospitals, Issues and Prospects, p. 10.

Thus we see organized medicine beginning to sound as a single voice crying out against "socialized medicine". Through its great power, influence, and authority it was single-handedly holding the line.

Also taking place, though, were other major trends which had profound effect on this issue. The entire spirit of the "New Frontier" and the "Great Society" was conducive to social legislation. The state governments, the constitutional sovereign for health affairs, were proving themselves to be singularly incapable of coping with extensive health problems. Some authorities argue that the very dominance of state medical societies over state legislatures in health issues is one of the major factors in the sudden surge of the federal government into health affairs.

Technology and specialization in medicine were virtually eliminating the general practitioner and were upending solo practice itself. Moreover, the "medical imperialism"[20] of the physician in the health field was toppling, causing his historic unchallenged leadership to become tenuous within medicine as well as out of it.

The King-Anderson bill barely missed passage during the 1964 session, and, in so doing, set the stage for its being the first order of business in the next Congress. Moreover, the overwhelming Democratic victories of the 1964 elections were decisive for Medicare.

The American Medical Association then launched a crash program to put across an alternative plan called "Eldercare". This package was but a modest liberalization of the existing Kerr-Mills Law and the

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[20]Rayack, Professional Power and American Medicine, Chapter 6.

Association was soundly criticized (even by its Congressional sponsor) for exaggerating the benefits of "Eldercare" in its propaganda.[21] It is at this point where we see most clearly the singular power of the American Medical Association. Here the key legislative groups, the major interested lobbies (except the American Medical Association), and the majority of the electorate are all concerned with the specific provisions of Medicare, while the American Medical Association is able to forestall the whole bill through promotion of a radically different alternative.

The "Eldercare" program did serve a useful national purpose, but not the one intended by the American Medical Association. There were serious weaknesses in the King-Anderson Bill and Congressman Wilbur Mills used the "Eldercare" proposal to pull off his famous "Tour de Force". Mr. Mills was then Chairman of the Committee on Ways and Means, and he was very cautious in recommending legislation until he was assured that passage was imminent.

In this situation he saw considerable criticism of the King-Anderson Bill because its benefits were limited. He saw considerable support for the Republican version of Medicare, the Byrnes Bill, as proposed by Representative John W. Byrnes of Wisconsin (even the Republican Congressmen did not support Eldercare). And, finally, Mr. Mills recognized that implementation of Medicare would be vastly strengthened if some support by organized medicine could be achieved - if some elements of their "Eldercare" could be used.

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[21]Somers and Somers, Medicare and the Hospitals, Issues and Prospects, p. 14.

Thus Mills saw three alternatives to the need for health legislation: the King-Anderson Bill, the Byrnes Bill, and "Eldercare". He felt that somehow he needed to consolidate this three-way split in order to pass quickly and implement effectively an act. As a result the stage was set for his "Tour de Force". Chairman Mills came up with an ingenious surprise by combining all three alternative plans into one comprehensive package.

The resulting bill called for two new titles to the Social Security Act. Title XVIII, Part A was substantially the King-Anderson Bill while Part B of this same title was substantially the Byrnes Bill. Title XIX provided the third component of the legislation and encompassed the main provisions of the "Eldercare" and Title XIX "Medicaid". Others called the entire package, "Mills' three-layer cake".

Mills' stroke of genius caught everyone by surprise. Also, it increased enthusiasm for the law and made it more difficult to oppose. The House passed the bill by a vote of 313 to 115; the Senate passed it by a margin of 68 to 21; and President Johnson's signature on July 30, 1965 brought Medicare into law as a part of PL 89-97.

In a sense passage of this legislation represents defeat for the American Medical Association and reflects a waning of influence. On the other hand, the characteristics of power elitism are clearly present in a situation where a group of some 200,000 with a much smaller number of key leaders is able to delay considerably and alter extensively a law which affects greatly the lives of over two hundred million people.

Other evidence of American Medical Association power and influence abounds. Without going into great detail brief mention should

be made of the Knowles Affair.[22] As it represents one of the more contemporary examples of American Medical Association influence. Upon the election of the Republican party in November, 1968, to the White House the appointment of Dr. John H. Knowles as the Assistant Secretary for Health and Scientific Affairs appeared to be a certainty. Dr. Knowles had worked assiduously for Mr. Nixon and the party. He was imminently qualified for the post and had sought it eagerly. The only barrier to Dr. Knowles' nomination was dislike by the American Medical Association for his views on delivery of medical care to the public, and, in the end, this obstacle proved to be enough to block his appointment. Perhaps the most telling description of American Medical Association power in health may be summarized in this observation of the Knowles Affair by the Wall Street Journal:

> The really surprising thing is that Mr. Nixon considered appointing a doctor at odds with the American Medical Association in the first place. Can anyone imagine a liberal administration even thinking about appointing a Secretary of Labor who doesn't get along with the labor bosses?[23]

What are the sources of power of organized medicine? Obviously, one great source of power of the American Medical Association is its economic wealth. As already mentioned it is the highest spending pressure group in the nation. It appears as though the continued affluence of the Association is well-founded in the increasing resources

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[22]A complete report and commentary on this affair appears by Charles U. LeTourneau, "The Knowles Affair, Political Lobbying", in Hospital Management, September, 1969, Volume 108, Number 3, pp. 64-66.

[23]Wall Street Journal editorial (Review and Outlook), July 2, 1969.

of its members. Between 1947 and 1964 the median net income of non-salaried physicians rose some 225 percent to a level of $28,380.[24] Considerable power accrues, too, from block membership in the Republican party. Opinion surveys clearly indicate that American doctors, in their party identification and choices of candidates, share and even exceed the Republican preferences typical of the upper class (see Table 1).

But beyond wealth, education, and party affiliation, there is a much more subtle and pervasive source of power accorded medical doctors, this being the professional authority deriving from consumer ignorance. It is argued by Truman,[25] Key,[26] and Klarman[27] and others that the patient is relatively helpless in the medical market place as compared with his role in other types of markets. Whereas the consumer may exercise his authority through evaluation of most of the services and products he buys, he is in no position to evaluate the quality of the medical care which he receives. In recognition of this fact society has granted considerable power to organized medicine to maintain quality standards and to police the profession. And it is exactly this delegation which has allowed the American Medical Association over the years to exercise control over the number of doctors who will be trained, the methods of financing medical care, the functioning of

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[24]Rayack, Professional Power and American Medicine, Table 3, p. 32.

[25]Truman, The Governmental Process, Chapter 4, passim.

[26]Key, Politics, Parties, and Pressure Groups, Chapter 5, passim.

[27]Herbert E. Klarman, The Economics of Health, (New York: Columbia University Press, 1965), passim.

TABLE 1

PARTISAN PREFERENCES OF MEDICAL DOCTORS AND OTHER ELITES* (Percent)

Party Identification	Physicians	Professional and Executives		College Graduates	Economic Level A
Republican	56	49		45	55
Democrat	21	36		33	20
Other	3	--		--	--
Independent	20	15		22	25
Number of Respondents	About 2,000	126		252	44
Presidential Preference in November, 1955	**Physicians**	**Professionals**	**Business Executives**	**College Graduates**	**Economic Level A (Sept. 1956)**
Eisenhower	70	59	59	51	69
Stevenson	16	33	35	43	26
Others; none	14	8	6	6	5
Number of Respondents	About 2,000	94	104	67	38

*The doctors were interviewed in the national survey reported in "The Doctor as a Citizen", Medical Economics, XXXIII (May, 1956), 141-142. The other respondents are upper status men taken from representative national samples. Party identification was asked in Roper Commercial Survey 63, June, 1956. Pre-election presidential choices by professionals, business executives, and college graduates were secured in Gallup Survey 556, November, 1955. Presidential preferences by mean on economic level A (upper level) were taken from Roper Commercial Survey 64, September, 1956. These unpublished data were supplied by the Roper Public Opinion Research Center.

Source: William A. Glaser, "Doctors and Politics", The American Journal of Sociology, November 1960, p. 241, Table 3, and as illustrated in Elton Rayack, Professional Power and American Medicine: The Economics of the American Medical Association.

hospitals, the kinds of health personnel who will be permitted to practice, and numerous other integral parts of the medical care industry.

One other major source of power will be mentioned briefly. Organized medicine has traditionally insisted that the authority to license medical practitioners be vested in the state. It has at the same time, though, insured that only its members occupied seats on the licensing boards. This is an inevitable product of the fact that in about half the states the medical society recommends appointees to the state board, in others the society nominates candidates for the office, and in one the State Medical Society Board of Censors itself constitutes the State Board of Medicine Examiners.[28]

After hitting a low ebb in public opinion during the Mid-sixties there are indications that the American Medical Association is now embarking on a new course and that public reaction is becoming more favorable. Recently the American Medical Association Board of Trustees urged that the Association and the federal government study carefully the many advantages of a health income tax credit program. At its annual meeting in Miami, Florida in December, 1968 the American Medical Association House of Delegates moved to support the expansion of medical schools, the establishment of additional schools of medicine, and the assimilation of osteopathy into organized medicine.

The Republican victory in the recent Presidential election certainly pushed the pendulum of support in the American Medical Associ-

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[28]David R. Hyde, Payson Wolff, Anne Gross, and Elliott Lee Hoffman, "The American Medical Association: Power, Purpose and Politics in Organized Medicine", Yale Law Journal, LXIII (May 1954), p. 942.

ation direction. "The American Medical Association News" reported recently: "With responsible leadership in the Presidency (the Nixon Administration) we look forward to having the health care needs of our people directed by the professional judgment of the experts in this area, the medical profession. We look forward to a creative partnership with government agencies dedicated to making our outstanding health care system even better, and to helping bring it increasingly to those who do not yet fully benefit from it."[29]

On the other hand, there remain formidable forces in opposition to the American Medical Association. Just recently Walter P. Reuther, President of the United Automobile Workers announced the establishment of a Committee for National Health Insurance which will be based in Washington and will press for enactment of such a program by Congress. One of the key members of this committee is none other than the prestigious surgeon, Dr. Michael DeBakey. Continued public unrest regarding rising medical costs, unclosed gaps in medical care, shortcomings of the Medicare and Medicaid programs, etc. brings much discontent to bear on the "establishment".

As V. O. Key so aptly observes, the greatest danger to the authority and autonomy of a professional group is that its interests will begin to run counter to the desires of major segments of society. In this connection many see the American Medical Association as being either a professional society or a political organization. The evidence

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[29]A statement by Dwight L. Wilbur, President of A.M.A. as reported by "The A.M.A. News, The Newspaper of American Medicine", November 11, 1968, p. 1.

available argues formidably that it is both. Rayack states succinctly how this comes about. "Perhaps in no other area are the internal contradictions inherent in the concept of professionalism so acute as in the field of medicine. On the one hand, the maintenance of professionally established quality standards is generally accepted as a socially desirable function of professional organizations; this is particularly true of medical care, where the quality of services provided may mean the differences between life and death. On the other hand, the professional organization is inevitably concerned with protecting and advancing the economic interests of its members. Since it is inherently difficult to translate 'quality' into objectively quantifiable terms, there arises the possibility of an internal contradiction in the dual role of the professional organization as protector of society's welfare through the regulation of quality and as defender of the economic interests of the members of the organization."[30]

The American Medical Association has a long history as not only a professional society but also a power elite. The influence and leadership capability of this group reached a peak during the 1940's and 1950's and has been declining in recent years. This dramatic diminution of power is due to a number of interrelated factors: rapid technologic advances, both within medicine itself and the American economy in general; massive social upheavals; rising expectations emanating from ever-growing economic affluence; increased education and awareness in

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[30]Elton Rayack, Professional Power and American Medicine: The Economics of the American Medical Association, p. XIV, Introduction.

the population; growing public pressures; and political developments.

Reflection of the past and analysis of the present indicate that organized medicine is changing in response to social needs. To this extent it appears that it will regain some of the recently lost influence in health affairs. There are many indications that the organization is reacting with a total change in policy - that it is discarding its rigid adherence to traditional shibboleths - that it is beginning to respond to society's needs in a new and different way.[31] But holding sway as a power elite in the form it existed in the 1930's, 1940's, and 1950's is very unlikely. The effects of massive social, political, economic, and technologic change over recent years are irreversible. These developments impose the imperatives of change on an organization imbued with the status quo.

A resurgence to the former lofty position of total power elitism in health affairs is unlikely; nevertheless the American Medical Association will play a major role in the future in this sector of our national life. Perhaps this role shall be one of leaders among other leaders in health akin to the pluralistic view of elitism as envisioned by Polsby, Dahl, and others.

Decline in the power of organized medicine is giving rise to new sources of influence within the field. Medical educators, health administrators, and others are rising to positions of leadership in health. They are making their voices heard and their influence felt through their professional roles in government, prepayment plans, universities,

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[31] "The Doctors Show Symptoms of Change", Professions Section, Business Week, July 19, 1969, pp. 39-40.

and health organizations. Accordingly, other associations (in addition to the American Medical Association) are beginning to have impact on the national scene. The association of American Medical Colleges has become much more vocal nationally; the Medical Care Section of the American Public Health Association is making strong bids to influence national health policy; and the traditionally apolitical American College of Hospital Administrators is beginning to speak out with growing authority. Though lacking the great power of the American Medical Association, the American Hospital Association seems to be growing in influence and resources. The increasing number of non-medical health professionals who are appointed to national advisory commissions and Presidential study groups represents further indication of a new corps of power elites in health.

As other health professional join the medical doctor in influence of health affairs, the question becomes not one of who will be the health care elites, but rather one of what these elites will do. Will they exercise influence primarily toward selfish ends or will they keep uppermost the health needs of society? The latter is, of course, the answer when taken within the concept of the health statesmanship model as presented in the previous chapter.

Public Administration

In addition to the study of pressure groups and the phenomenon of elitism, Political Science provides other information pertinent to this study. As health administration in our modern government continues to become more complex the sub-discipline of Public Administration with-

in Political Science will become ever more important to us. Indeed the number of health professionals engaged in government will continued to grow.[32] Health administrators in particular are now found in the executive arms of national, state, and local governments; independent boards and commissions set up by Congress and state legislatures; and government corporations. Besides this, voluntary hospitals themselves are increasingly assuming a public service role.

When we talk about public policy in health, then, we must give some consideration to the public administrator who is engaged in health programs. In noting that the increase in governmental agencies has been the most significant legal development of the twentieth century, Justice Jackson of the United States Supreme Court asserted that "perhaps more values today are affected by their decisions than by all the courts".[33] Arthur T. Vanderbilt, another noted jurist, re-emphasized this point when he declared that agency legislation had already exceeded in quantity "by many times the corresponding additions to the statute books".[34] Thus the health administrator in government is in a particularly suitable position for achievement of the health statesman role.

Public Administration brings together the theory of administra-

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[32]This idea is expressed and well-defined by Senator Edmund S. Muskie in his contribution to "Health Services at all Levels of Government: Desirable Structure and Relationship," American Journal of Public Health and the Nation's Health, Volume 58, No. 12, December, 1968, pp. 2198-2201.

[33]Federal Trade Commission vs. Ruberoid, 343 U. S. Supreme Court 470, 486 cited by William W. Bayer, "Policy-Making by Government Agencies" in Robert T. Golembiewski, Frank Gibson, and Geoffrey Y. Cornog, eds, Public Administration: Readings in Institutions, Processes, Behavior, p. 58.

[34]Arthur T. Vanderbilt in George Warren, ed, The Federal Administrative Agencies, p. iii.

tion and the mechanics and legalism of government. It emphasizes the vital relationship in a democracy between politics and administration. The health administrator in public service is viewed in this study within the theoretical context of a basic works in this area by Simon, Smithburg, and Thompson.[35]

Decision-Making in a Democracy

The theory of Political Science is also useful to us in that if offers analysis and explanation of the dynamics of the political decision-making process. Indeed much has been written on how such decisions are made. And authorities in the field admit openly that much is yet to be uncovered. For our purposes Lindblom offers an excellent summary statement which is quoted below:

> Political parties, proximate policy makers, interest-group leaders, and other leaders, do not simply respond to citizen preferences; in various ways they inform, persuade, and indoctrinate the citizen. The policy-making process, therefore, becomes circular. It can also be conceived of as a ladder with chief executive on top, ordinary citizens at the bottom, and other participants ranged on the intermediate rungs. Citizens send upward their opinions and preferences; but at each rung of the ladder a more informed, active, or responsible participant in policy making is sending downward some information, analysis, and advice that help a participant on a lower rung to clarify and amend his policy position, and that eventually reach down to help citizens understand and better express their own wishes and needs. It follows that there is great scope in policy making for political leaders who appreciate the possibilities of reconstructing the preferences both of citizens and of other participants in policy making, and who skillfully alter the position of the range of alternatives within which policy decisions must fall.[36]

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[35]Herbert A. Simon, Donald W. Smithburg, and Victor A. Thompson, Public Administration.

[36]Lindblom, The Policy-Making Process, p. 118.

In a free, democratic society the decision-making process sometimes becomes so intricate as to virtually defy analysis. In this connection the following is a succinct description of the process: "The United States political policy-making process has largely become a complex process of conflict and concensus-building in which groups of participants debate, maneuver, and influence."[37]

From the perspective of public administration the setting of policy may be viewed as a distinct process with phases which are clearly discernible. "Thus agency policy making may be considered a cyclical process with five sequential stages: initiating, preliminary drafting, public participation, final drafting, reviewing."[38] As review of policy takes place, the need for initiation of new or altered programs becomes apparent and the process begins anew.

Viewed in a different context Galbraith sees a danger in the modern, industrial society of key decisions actually being made by specialists and super-technicians who comprise the "corporate technostructure". According to this concept the nature of the enterprise becomes so esoteric as to go beyond managers and the public, having "technocrats" as the crucial goal setters for the system.[39] Although Galbraith's technostructure model is designed to fit industrial corporations, there are obvious implications for the field of medicine and

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[37]Nelson W. Polsby, Robert A. Dentler, and Paul A. Smith, Politics and Social Life, an Introduction to Political Behavior, p. 488.

[38]Bayer, "Policy-Making By Government Agencies" in Golembiewski, Gibson, and Cornog, eds, Public Administration, p. 58.

[39]The concept described here very briefly is one of the principal themes of John Kenneth Galbraith's, The New Industrial State.

growing, merging health organizations.

Finally, there is the theoretical construct, also suggested by Galbraith, where American industry gains the power not only to control production and distribution but also to create demand. This comes about through the unbelievably effective capabilities of the "Madison Avenue hucksters". Through relentless advertising public opinion and wants are created and shifted. In adjusting to public opinion politicians are thus rendering decisions and policies which emanate initially from industry's desire to create demand. Galbraith laments continued growth of this trend because it results in tragic misallocation of national resources.[40] Without intending to draw a value judgment, the author submits the tobacco industry as a prime example of Galbraith's theory and as an illustration of the application of this theory to public policy in health.

As a resume of the report to this point, these first chapters have attempted to bridge the gap between the fields of Health Administration and Political Science. Establishing a relationship between these disciplines is essential because the research study itself is located in the interstitial area between them.

The research problem and objectives have been defined. It has been emphasized that health professionals must know something about government and the people who comprise it, if they expect to participate directly in the formation of public policy in health affairs. Essenti-

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[40]This theory is discussed at length by Galbraith in The Affluent Society.

ally this is a study of state legislators for health statesmen.

The concept of health statesmanship has been discussed and defined through the medium of literature review. An idealized model was constructed to reflect the composite picture of a health statesman envisioned by the literature.

In establishing the relevance of politics to health affairs references were taken from Sociology, Economics, and mainly from Political Science. The primary purpose of these opening chapters has been to lay a general theoretical framework for the research study. Before proceeding on to the study itself, though, it is necessary that we examine briefly the nature of state government in the American federal system. For this and for finalizing of the research problem we shall turn our attention to the next chapter.

CHAPTER IV

STATE GOVERNMENT

As a political entity in the United States the state is sovereign in health affairs; yet the national government has assumed vast "de facto" powers in health. On the surface this development is perplexing and contradictory. Moreover, such an enigma has untold implications for health professionals.

As we try to unravel such complexities as federal-state relationships in health, it is requisite that the nature of state government itself be understood. Thus to evaluate accurately the findings of this study it is important that we understand the roles of state government, in general, and the state legislative system, in particular, as they exist in the United States.

General Considerations

"As every American college student knows, the United States has a federal type of government, with power divided between the nation and the states."[1] The Constitution sets forth this division of power in general terms. The underlying legal assumption is that all powers origi-

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[1]James A. Burkhart and Raymond L. Lee, Guide to American Government, p. 17.

nate from autonomous states; that in choosing to form a federal government the states elected to give up permanently some of their power; and that the central, federal government becomes the repository for these "enumerated powers" and their concomitant "implied powers". Thus the powers of the national government are either enumerated or implied by the Constitution. All other powers then fall to the province of the states, which may retain all of them or delegate portions to local governments. This brief review of American government is oversimplified, but should be sufficient for our purposes.[2]

Health is not mentioned at any point in the United States Constitution; therefore all powers related to health affairs fall to the states. This rationale forms the basis for the contention that the states are sovereign in health affairs, at least theoretically. There is a crucial "de facto" consideration, however. It is true that the powers of the Congress to legislate are limited to those outlined in the Constitution, but the legal interpretation of implied powers is notable. By this means the welfare clause of the Constitution[3] has been interpreted through judicial review as including health and thus implied powers are granted to the national government in health affairs.

This raises the question as to which powers belong constitutionally to which level of government. The question is not easily

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[2]Detailed discussions of this fundamental doctrine may be found in any number of authoritative sources. One good source is James MacGregor Burns and Jack Walter Peltason, Government by the People, pp. 81-106.

[3]U. S. Constitution, Article I, Section 8 which states in part that "The Congress shall have power ... to provide for ... the general welfare of the United States ...".

answered, for "this division of power is an endless source of conflict, and at best a federal system of government is a good deal more complicated than one in which most power is centralized or decentralized".[4] There seems to be a more or less continuous tension between the national and state governments in exercise of powers which are not clearly and traditionally accorded to one or the other. Many informed observers make effective arguments that expansion of the national government is frequently an admission that state governments have not solved contemporary problems. Some of the proponents of this point of view assert that the state has become a political anachronism in modern American society. The opposition to this notion staunchly defends the states' political role and accuses the national government of encroaching on the states and usurping their rights.

Political Anachronism or "Puissant de Nouveau"

The principle underlying this dispute is decisive to the health field. Indeed the outcome of this question may well determine whether or not state government continues to play a significant role in major health affairs. For this reason let us digress long enough to explore the arguments underlying each side of this issue.

Those asserting obsolescence of state government point to impotence of the state level to deal effectively with major problems, to the inability to raise funds in adequate amounts, and to the outmoded organization patterns of state government. Chronic waste, mismanagement and corruption in state government are frequently cited. The fact that

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[4]Burkhart and Lee, Guide to American Government, p. 14.

metropolitan governments now effectively bypass the states and deal directly with the national level adds more fuel to the argument. This trend constitutes a constant challenge to each state's role as an important source of meaningful political action. Recognition of these problems prompted V. O. Key to surmise that the states might well become "vestigial remnants left by the process of unification of separate entities into nationhood".[5] Bulky, inappropriate constitutions further impede the states in many cases. And, finally, the slogan "states rights" has become a meaningless and empty retort to efforts by the national government toward positive action. In short there is behind the "states rights" mask a philosophy of "do nothing".[6]

Reichley summarizes the case well:

> If the states should fail to meet the challenges that are being put to them during the seventh decade of the twentieth century, the only alternatives, short of chaos, would be enormous expansion of the resources and authority of local government or acceleration of the present trend toward complete assumption of governmental responsibility by the national government. The former, while offering some promise in such fields as urban development and regional planning, would hardly provide adequate means to cope with the more fundamental political and economic realities of the age of automation, mass culture, and population explosion. The latter, while to some degree a military and economic necessity, would, carried to its logical extreme, almost surely undermine if not destroy the political freedom, regional diversity, and social and economic flexibility which have thus far characterized the American system.[7]

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[5]V. O. Key, Jr., American State Politics, p. 4.

[6]The whole question of obsolescence of state government is treated in detail in James Reichley, States in Crisis, (Chapel Hill: The University of North Carolina Press, 1964), passim.

[7]Reichley, States in Crisis, pp. 256-257.

On the other hand, it is maintained that "in spite of improvements in communication and transportation, the United States is still a diverse land which is governed best when there is a great deal of regional autonomy. The federal system is thus a happy compromise that provides both unity and diversity".[8] Advocates of the continued viability and essentiality of state government point to the many areas of public affairs which are decided principally at the state level. Mention is made of the 35,000 laws enacted during state legislative sessions and the nearly 8,000 lawmakers throughout fifty states who make decisions which profoundly affect the lives of constituencies thus represented[9]. One scholar in the political science of state government puts it this way:

> That the states have lost prestige during recent decades there can be no doubt. But they are firmly imbedded in our constitutional system and still perform sufficient essential functions to justify their retention.[10]

The domestic aims of the Nixon Administration also give promise of the states assuming "puissant de nouveau". This new power would accrue to the states from Mr. Nixon's proposals to decentralize management of programs that have piled up in Washington through the periods of the New Deal, Fair Deal, New Frontier, and Great Society. Many of the developments of these political eras involved health programs. As indicated in his television report to the nation of August, 1969, President Nixon intends "to make state government more effective and more impor-

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[8]Burkhart and Lee, Guide to American Government, p. 17.

[9]Taken from G. Theodore Mitau, State and Local Government: Politics and Processes, p. 3.

[10]Clyde F. Snider, American State and Local Government, p. 53.

tant in the life of the country than it has been since the 1920's".[11] The principal means by which this will be brought about, according to the Presidential plan is to channel many more federal funds to state governments with few "strings attached". This redistribution of tax revenues with minimal restrictions on expenditure will presumably enhance greatly the powers of the states. Block grants are expected to be the primary mechanism by which these federal revenues will flow to the states.

The President's proposal will undoubtedly meet much opposition in the Congress. Key federal legislators such as Wilbur Mills have already expressed resolute dislike for the plan. Moreover there are many who doubt the capability of the states to make this proposal work even if the President is successful in implementing it. Nevertheless, it must be admitted that the changing political climate does represent a new opportunity for the states to revitalize themselves and to regain a portion of their former luster and power.

From the foregoing discussion we may conclude that the state governments are indeed in a "crisis"; that they are being hard-pressed to meet the enormous public needs of their citizens; and that they are struggling to maintain their status between powerful, active metropolitan administrations and the ever-expanding federal bureaucracy. We may also conclude, however, that the states are still a central repository of much constitutional authority and that the prerogative of how they wish to be governed still lies with the people. For this reason a

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[11]This quotation and the Nixon proposal in detail appear in Business Week, "Washington Outlook", August 2, 1969, pp. 37-38.

study of state legislators has much relevance to health affairs in general. We shall now turn to the literature on state legislatures.

Characteristics of State Legislatures[12]

All of the American state legislatures are bicameral in structure except one.[13] They range in size from 43 in Nebraska to 424 in New Hampshire. The official name of the state legislative bodies varies with "Legislature", "General Assembly", and "General Court" being most prevalent. The upper houses are uniformly called the "Senate" and the lower houses variously referred to as "House of Representatives", "Assembly", and General Assembly".

The legislatures of 23 states meet annually; the remaining 27 hold regular biennial sessions, most of which occur in odd-numbered years. The characteristic pattern is for the session to begin in January and to be limited in length from 60 to 120 days, although some states exceed this range. In about one-half of the states special sessions may be called in addition to the regular sessions. There are usually constitutional limits on the length of any such special sessions as well as the regular sessions. "Originally these constitutional restrictions were imposed to guard against legislative irresponsibility resulting in excessive legislation, in 'riotous' living at public expense, or to prevent an unnecessarily prolonged session from

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[12]Except as otherwise noted the factual data contained in this section is taken from The Book of the States, 1968-1969, as prepared by the Council of State Governments, Section II, pp. 35-100.

[13]Nebraska has a unicameral legislative body.

interference with the harvest."[14]

The compensation paid to legislators varies widely among the states and between the two houses within states. The salary range varies from the highest in California of $16,000 per year to the slight $200 for the biennium which the unusually large number of legislators in New Hampshire receive. The majority of states are found in the category of $4,000 to $7,000 biennially. In addition some states provide travel and per diem allowances.

For complex reasons the long-term trend of the nineteenth and twentieth centuries is toward a decline in the status of the legislature compared to other agencies of governmental power.[15] This decline "is like, and related to, the alleged decline in the power of the states in their relationship with the national government. Although the great increase in the power of the national government attracts most attention, the states are performing more services and employing more people than ever before. In the last twenty years the rate of state spending has far exceeded the rate of increase in national government spending. To the extent that state legislators make decisions concerning these increased functions of government, they have become much more important than they were a century ago, when state functions were minimal".[16]

The legislative characteristics of party composition, committee

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[14]Mitau, State and Local Government, p. 65.

[15]The interested reader will find a full discussion of this topic in Wilder Crane, Jr. and Meredith W. Watts, Jr., State Legislative Systems, passim.

[16]Crane and Watts, State Legislative Systems, p. 6.

structure, turnover rate, procedural rules, and legislative services are all of concern in understanding the legislative process. Whether there exists one-party dominance of some degree or two-party competition is of paramount importance. Although changes do occur, one recent study describes ten legislatures as having one-party control (all Democratic), thirteen with one-party dominant (seven Republican and six Democratic), and the remainder are classified as having two-party competition. A full discussion of party composition as well as the other characteristics mentioned above may be found in Jewell's study of state legislatures.[17]

The literature contains a number of good studies regarding the sociologic and psychologic characteristics of American legislators. All of these studies indicate that they come from socioeconomic backgrounds higher than those of the majority of the population.[18] The occupations of the legislators indicate that they are upwardly mobile and that they over-represent higher status occupations.

According to a study by Wahlke[19] et al., the occupations of lawyers, businessmen, and farmers are found most frequently among legislators. "Of the business occupations represented, a large number are real estate dealers, insurance agents, and others who may be described as bargainers and negotiators, occupationally trained to represent other persons and to compromise interests in order to reach agree-

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[17]Malcolm Jewell, The State Legislature: Politics and Practice, pp. 9-105.

[18]Crane and Watts, State Legislative Systems, p. 45.

[19]John C. Wahlke, Heinz Eulau, William Buchanan, and LeRoy C. Ferguson, The Legislative System, p. 489.

ment with others."[20] This same study indicates that the legislators represent higher educational achievement than the population in general, the majority of them having attended college.

In another study of American legislators Barber[21] sought out the psychological orientation of the individual. Although his study deals with Connecticut alone, Barber constructs four typologies which would appear to have wide application. In his study of the Pennsylvania Legislature, Sorauf[22] finds that status and occupation are important in being elected in the first place and that candidates must fill certain image requirements of the constituency in order to be successful. Although there is some evidence that this may be changing, some students of state legislatures maintain that women and minority groups are considerably under-represented.[23]

The State in Health Affairs

Interest by state governments in health affairs over the past century has been concentrated in three areas: (1) the exercise of police power in health; (2) the provision of traditional preventive medicine and public health services; and (3) the operation of hospitals for the men-

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[20] John C. Wahlke, Heinz Eulau, William Buchanan, and LeRoy C. Ferguson, The Legislative System, p. 243.

[21] James D. Barber, The Lawmakers: Recruitment and Adaptation to Legislative Life, (New Haven, Conn: Yale University Press, 1965), pp. 101-106.

[22] Frank K. Sorauf, Party and Representation, (New York: Atherton Press, 1963), passim.

[23] For the reader who wishes more detailed information on this topic reference is made to Crane and Watts, State Legislative Systems, Chapter III.

tally ill. This pattern is clearly evident in the literature. In their review of medical-legal history in Texas, for example, Overton and Stone[24] show that since 1837 medical legislation in this state has dealt exclusively with these three components of the health industry. This same pattern is apparent in the writings of recognized authorities in public health.[25]

There are explanations as to why states have universally concerned themselves with these areas almost to the exclusion of other aspects of health care. "For the most part, subject to some limitations imposed by the United States Constitution, the states' police power, especially in regard to health and safety, is virtually unlimited."[26] The states have exercised this right extensively in meeting public needs for licensure of practitioners and institutions and for control of communicable disease.

Early in the development of this country that portion of health dealing with domestic quarantine, vital statistics, sanitation, food inspection, and the like were grouped into a category called public health and allocated to state government. Over the course of time this role was gradually broadened to include some services to indigents and

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[24]Philip R. Overton and Sam V. Stone, "Medical-Legal History of Texas", Texas Medicine, March, 1967, pp. 117-122.

[25]Two examples of what such authorities have to say on this subject are offered as being typical: Harry S. Mustard and Ernest L. Stebbins, An Introduction to Public Health, Chapters 3 and 15; and John J. Hanlon, Principles of Public Health Administration, pp. 1-35 and 157-366.

[26]Nathan Hershey, "The State's Right to Police Health", American Journal of Nursing, Volume 67, Number 3, March, 1967, pp. 557-558.

other needy groups. During the past three to four decades the national government has fostered this trend through legislation at that level.

The states' deep involvement in mental health over the years may be described as the accommodation of choice by American society to an unwanted and historically unattended problem. This development also accounts for the traditional separation of Mental Health and Public Health programs within state governments.

A review of state involvement in health would be incomplete without some mention of public welfare, for the two have become deeply interrelated over the years. While health and welfare programs are combined at the national level, the typical pattern is for them to be located in separate departments in state government.

One might reasonably ask, why have the states not expanded beyond their traditional three areas of health in view of the rising expectations for health services across the nation? The answer to this question is complex. One of the purposes of this study is to shed light on this very question. It is suggested by the literature that the following factors have a hand in this condition: (1) general conservatism at the state level; (2) chronic inadequacy of funds and lack of broad bases for taxation; (3) general lack of sophistication in health affairs and awareness of health needs in state legislatures; (4) confidence by the legislature in organized medicine to meet adequately the health needs of the people; (5) effective lobbies by state medical societies at the state level in influencing legislation and limiting government involvement in health; and (6) an apparent reluctance by the electorate to demand and pay for broadened health services by the states.

"Expenditures for public health services totaling $944 million were reported for the fiscal year 1966 by state health departments and other state agencies administering programs for mental health, hospital and medical facilities construction, water pollution control, and crippled children's services."[27] This amounts to about 1.3 percent of the total portion of the Gross National Product which is devoted to health.

Before leaving this section on the state in health affairs two further points must be mentioned. First, a major and direct involvement in provision of direct medical services by state government is usually overlooked because state medical centers are classified under higher education. Typically, these centers include schools for the various health professionals and state-operated, general, acute-care hospitals. Organizationally, these centers and hospitals are usually located within the structure of a university. This accounts for the lack of visibility of these institutions as major state programs in direct delivery of health care. And with the advent of the historic Medicare legislation of the Eighty-ninth United States Congress, these medical centers and hospitals are addressing themselves to wider segments of the general population.[28]

Secondly, the great amount of health legislation enacted by Congress since 1965 is having an extraordinary impact on state govern-

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[27]The Council of State Governments, The Book of the States, 1968-1969, pp. 338-339.

[28]Philip D. Bonnet, "The Impact of Medicare and Other Federal Health Legislation on U. S. Teaching Hospitals", The Journal of Medical Education, Volume 42, Number 5, May, 1967, pp. 387 and 391.

ment. Title XIX of the Social Security Amendments of 1965 (Medicaid) alone has brought about political, economic, and administrative turmoil on an unparalleled scale in state health and welfare activities. Legislation of this type also infuses new impetus into state government and offers rich opportunity for states to participate decisively in health affairs of the people.

Also, "even a casual reading of Public Law 89-749, the enabling legislation for comprehensive health planning, makes clear that state government is the critical element in achieving the goals of national health policy. Congress has clearly put most of its eggs for health planning in the basket of state government".[29]

Although the states traditionally played a limited role in health affairs, it is now apparent that this is changing. Pressures within our society are bringing government into health in a big way. Consequently it appears that the states have at this point an option as to what extent they will participate. The views, attitudes, and values of state legislators will in good measure shape the extent of future involvement of the states in health affairs.

Statement of the Research Problem

In summary the research problem deals with our need for more information about state legislators as their attitudes and behavior relate to health care. With greater knowledge about legislators and

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[29]Herman E. Hilleboe and Morris Schaefer, "Administrative Requirements for Comprehensive Health Planning at the State Level", American Journal of Public Health and The Nation's Health, Volume 58, Number 6, June, 1968, p. 1039.

political processes at the state level health statesmen should be able to more effectively participate in formulation of public policy in health affairs. Presumably, then, this will lead to improved health of the population and will ultimately aid in accomplishment of national goals.

This area of research is essentially interstitial between health administration and political science with some relevance to economics, sociology, and social psychology. The research problem is approached within the theoretical context of the "health statesmen" concept, pressure group theory, political decision-making processes, and the operation of state government, especially in health affairs.

Specifically, this study attempts to improve on methodology and knowledge of the following: (1) the role of the legislator's knowledge vis-a-vis the influence of counsel by health professionals; (2) the manner in which legislators perceive health professionals, particularly hospital and health administrators, practicing physicians, and nurses; (3) the manner in which legislative decisions are made in state health affairs; and (4) the impact of legislators' general political attitudes and values on state public policy in health.

It has been shown that legislators at the state level occupy today a crucial position in adjustment to the pressure of change. Our need for knowledge in this area is extensive and immediate. It appears, however, that relatively little research effort has been devoted to this aspect of human dynamics. There being a dearth of empirical data on which to build, an exploratory study is in order. Special emphasis is needed for instrumentation and methodology.

The limitations of such a study as this are readily apparent.

Tendencies may be observed and tentative judgments drawn, but definite conclusions are not possible. In line with scientific method, hypotheses are proposed and examined in light of the data; however, this study is better suited to development of hypotheses than to testing of them. It is desirable that the findings of this study be replicable and generalizable to legislators across the nation. Obviously, though, there are marked regional, cultural, and political differences among the fifty states.

CHAPTER V

THE OKLAHOMA LEGISLATURE

Oklahoma is a young state with a colorful past. It was settled almost overnight by large numbers of people who forsook ordered societies in favor of opportunity and adventure in the new territory. These hardy souls rooted Oklahoma's heritage in strong feelings of conservatism, individualism, and protestantism. From the beginning the preferred role of government has been decidedly laissez faire. This heritage influences greatly the state legislature of today. Furthermore many of the prevailing attitudes and practices in health are traceable to this heritage. Thus it is relevant to this study to examine briefly the Oklahoma legislature and its background.

Historical Setting

Late in the last century the epical land runs triggered a rapid transition of the Territory of Oklahoma from a land of Indian reservations to an area of predominantly white settlers from other sections of the United States. Some historians assert that the youth, vigor, and aggressiveness of the early day "Sooners"[1] set the tone of Oklahoma's

[1]The term "Sooner" was originally coined to label those land-seekers who illegally entered the settlement zone before the scheduled land opening and "staked out" a claim in advance. Common usage today has broadened the term to include all persons who participated in the early land runs and subsequently settled the territory.

development over the ensuing eighty years.[2] By 1906 the population of the Territory had risen to 700,000, a tenfold increase over Oklahoma's first census in 1890 of 60,000. In 1907 Oklahoma became the forty-sixth state to enter the union.

The legacy of Oklahoma is deeply embedded in rural and agrarian life. It is important to note, however, that industrialization and urbanization have had tremendous impact on state and regional uniqueness. It is apparent that a sort of nationalizing of state cultures is taking place.[3] This trend manifests itself conspicuously in the attitudes and values of the people - and thus also in the state legislature.

Oklahoma's founding fathers produced a constitution which contains more than 36,000 words, one of the longest of the state constitutions. "The most powerful branch of the state government, deliberately so placed because the delegates regarded its members closer to the people, was the legislature."[4] Even so, the basic suspicion of the people toward government is clearly evidenced by severe restrictions on the legislature in its power to tax and create debt. The legislature was established as a bicameral body, the house members serving two-year

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[2]This theme is developed in full in Edward E. Dale and Morris L. Wardell, History of Oklahoma, Chapter I, especially pp. 10-11.

[3]Rationale and evidence for this position are presented by Arrell M. Gibson, Oklahoma A History of Five Centuries, Chapters 1, 19, and 20.

[4]Ibid, p. 333.

terms, members of the senate four-year terms.[5]

Today the population of Oklahoma is about 2.5 million.[6] The majority of Oklahoma people live outside urban areas, though, as in most other states, the ratio of urban to rural is steadily increasing. According to standard population density criteria for designation as Metropolitan Statistical Areas, the state has three urban centers. These are Oklahoma City SMSA with a population of 609,000, Tulsa SMSA with 450,000, and Lawton SMSA with 108,000. There are eight other cities with a population of 25,000 or more. Most citizens of the state are native-born Americans, less than one percent being of foreign birth. "The peculiar manner of settlement, however, brought in people from virtually every section of the country, each group bringing its own customs, ideas, and ideals."[7] A little more than seven percent of the total population of the state is of Negro blood; about two and one-half percent are Indians. The Negro population is concentrated in the cities and towns. Although Indians are slowly migrating to the urban centers, a large majority still reside in rural areas.

Oklahoma's economic activity centers on agriculture, retail and wholesale trade, light industry, petroleum, and several large

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[5]Constitution of the State of Oklahoma as amended to January 1, 1969, Article V, Sections 9A and 10A.

[6]The demographic data in this paragraph represent 1968 estimates and are taken from Rand McNally Commercial Atlas, Ninety-ninth Edition, pp. 55, 384-391. (SMSA - Standard Metropolitan Statistical Area).

[7]Dale and Wardell, History of Oklahoma, p. 3.

Federal activities.[8] In recent years major efforts have been put forth to attract new industries and businesses to the state. Oklahoma ranks thirty-fifth among the states with a per capita income of $2,860.[9]

Politically, Oklahoma is classified as having two-party competition with the Democratic Party distinctly dominant.[10] Of the 1,200,000 persons eligible to vote in 1966 about 80 percent registered as Democrats and 20 percent as Republicans.[11] It is interesting to note, however, that the state has had a Republican governor for two terms in succession; it has recently sent its first Republican senator to Washington; and Mr. Nixon carried the state in the last presidential election.

An Overview of Oklahoma State Government

With a system of checks and balances high in mind the state founders provided for three branches of government, executive, judicial, and legislative, much in the same manner as does the United States Constitution. As a means of making the government more responsive to the will of the people an unusually large number of officials gain office through popular election. As a result there are in addition to the governor some fourteen members of the executive branch who are elected state-wide. Moreover, these persons, including the lieutenant governor,

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[8] R. A. Hunter, Publication Director, Public Affairs Guide of Oklahoma An Almanac of Government, Politics, and Business, pp. 7-15.

[9] U.S. Department of Commerce, Pocket Data Book USA 1968, p. 189, (as supplied by the Office of Business Economics, Department of Commerce).

[10] Crane and Watts, State Legislative Systems, p. 41.

[11] Hunter, Public Affairs Guide of Oklahoma, p. 43

are not responsible to the governor in carrying out their executive duties; each is directly accountable to the voters who elected him. One scholar of Oklahoma State Government has referred to this type of organizational arrangement as a "Headless Administration".[12]

By virtue of a state-wide election in 1967 to amend the state constitution, the voters completely reorganized the judiciary branch. The supreme judicial power now rests with the Senate as it may sit as a Court of Impeachment. The judiciary itself is divided into two broad categories: (1) the Supreme Court and its subordinate courts; and (2) the Court of Criminal Appeals and its counterparts at the appellate and district levels.[13]

Financing of the state government in Oklahoma is rapidly becoming a billion dollar business. Expenditures by state agencies for the fiscal year ending June 30, 1969 amounted to well over nine hundred million dollars.[14] This represents an increase of three hundred million dollars over the amount of expenditures recorded for fiscal year 1965. At the current rate of expansion, then, it becomes obvious that the billion dollar mark will be reached shortly. To evaluate accurately the research findings of this study it is helpful to know generally how the state receives and spends its money. A useful way to analyze state financing is through examination of its three major components:

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[12]Jack W. Strain, An Outline of Oklahoma Government, p. 71.

[13]Ibid, Chapter V.

[14]This information, as well as the financial data which follow, was obtained directly from the Division of the Budget, Executive Department, State of Oklahoma.

revenues, appropriations, and expenditures.

The sources of state revenue for a recent fiscal year appear in Table 2. As indicated, the leading source of state income is taxation.

TABLE 2

STATE OF OKLAHOMA REVENUE COLLECTIONS BY SOURCE
FOR THE FISCAL YEAR ENDED JUNE 30, 1969*

Source	Collections	Percent of Total
Taxes	$404,148,500	42.25
Revenue from other Agencies	348,392,700	36.48
Licenses, Permits, and Fees	71,738,200	7.49
Non-Revenue Receipts	58,638,100	6.12
Sales and Services	27,780,600	2.90
Higher Education Student Fees	25,920,600	2.71
Use of Money and Property	19,319,000	2.02
Fines, Forfeits, and Penalties	252,400	.03
Total	$956,190,100	100.00

*Rounded to the nearest one hundred dollars.

Source: Division of the Budget, Executive Department, State of Oklahoma.

The primary taxes in order of relative income are: sales, gasoline and fuel excise, income and withholding, gross production, cigarette, motor vehicle excise, and alcoholic beverage tax. The second major source of state revenue is that which derives from other agencies,

principally the Federal government. The great bulk of this three hundred, forty-eight million dollars comes to Oklahoma through Federal grants-in-aid and Federal reimbursements for state participation in Federal programs. A much smaller but still substantial amount of revenue accrues to the state through licenses, permits, and fees. The principal revenue producers here are automobile licenses and commercial vehicle licenses.

Table 3 indicates the manner in which the legislature appropriated that portion of total revenues which were legally allocable by it during a recent fiscal year. As can be noted in the table, well over one-half of all appropriations went to education. Education and highways together received over seventy-five percent of all funds appropriated by the legislature during fiscal year 1969.

In many ways analysis of expenditures is a better measure of state operations than is a study of appropriations. For one thing expenditures include the large amount of Federal funds which are allocated to the states. For another, expenditures reflect utilization of the so-called "dedicated revenues". These are revenues which are constitutionally earmarked for specific uses and which are not subject to appropriation by the legislature. Oklahoma's substantial program in social services is an example of such dedicated funds. Thus Table 3 shows state appropriations for social services as being less than one percent of total appropriations, while Table 4 indicates state expenditures for social services as being about thirty-two percent of total expenditures. As a final reason for being a more accurate gauge of state operations than other measures, expenditures reflect the integrated

TABLE 3

APPROPRIATIONS MADE BY THE FIRST SESSION OF THE THIRTY-SECOND OKLAHOMA LEGISLATURE*

Function or Activity	Appropriation	Percent of Total
Public School Education	$108,284,800	36.48
Higher Education	59,730,900	20.12
Highways	57,969,900	19.53
General Government	20,874,000	7.03
Mental Health	14,161,100	4.77
Public Safety and Defense	12,031,900	4.05
Natural Resources	8,904,800	3.00
Public Health and Medical Assistance	4,326,500	1.46
Regulatory Services	4,076,900	1.37
Social Services	2,346,500	.79
Other	2,103,200	.71
Supplemental Appropriations	2,052,000	.69
Total	$296,862,500	100.00

*Rounded to the nearest one hundred dollars.

Source: Division of the Budget, Executive Department, State of Oklahoma.

TABLE 4

EXPENDITURES BY OKLAHOMA STATE AGENCIES FOR THE FISCAL YEAR ENDED JUNE 30, 1969*

Function or Activity	Expenditures	Percent of Total
Social Services	$293,134,100	31.98
Public School Education	176,275,500	19.22
Higher Education	168,579,800	18.40
Highways	166,429,900	18.16
General Government	25,422,200	2.77
Mental Health	18,137,400	1.98
Natural Resources	17,589,300	1.92
Public Safety and Defense	16,082,800	1.75
Public Health and Medical Assistance	12,903,400	1.41
Regulatory Services	11,928,500	1.30
Other	10,187,000	1.11
Total	$916,669,900	100.00

*Rounded to the nearest one hundred dollars.

Source: Division of the Budget, Executive Department, State of Oklahoma.

priority of programs by including the total funds, regardless of source, expended on each.

One final comment relative to expenditures is necessary. Table 4 shows only 1.41 percent and 1.98 percent as having been spent on Public Health and Mental Health, respectively. Based on this, one might deduce that the state of Oklahoma devoted only three and one-half percent of its total expenditures to the health of its citizens. This is not true. The data in Table 4 are misleading to the extent that sizeable health expenditures are buried in the functional category of social services. Indeed these funds are managed and controlled within the Department of Public Welfare and may be properly classified as social services in a budgetary sense. In a practical sense, however, some of these social services funds are used to procure health services. The money so-utilized amounts to about one hundred and two million dollars. Moreover, a portion of the funds shown under higher education might be conceived as a health expenditure (at least insofar as this report is concerned). The latter point refers to the $21,500,000 expended in fiscal year 1969 at the University of Oklahoma Medical Center. This includes the University Hospitals, the state's single medical school, and other health/educational organizations.

By adding together those expenditures for health described above, we may arrive at an estimate of the total amount of money spent by the State of Oklahoma on health. This arithmetic is shown graphically in Table 5.

The total amount of state expenditures on health shown constitutes about 16.8 percent of all state expenditures during fiscal

TABLE 5

SUMMATION BY CATEGORY OF OKLAHOMA
STATE EXPENDITURES ON HEALTH

Function or Activity	Expenditures
Public Health and Medical Assistance	$ 12,903,400
Mental Health	18,137,400
Social Services Devoted to Health Care (Medicaid, Medical Assistance to Aged, etc.)	102,042,200
University of Oklahoma Medical Center	21,452,500
Total	$154,535,500

Source: Extracted and interpreted by data obtained directly from the Division of the Budget, Executive Department, State of Oklahoma.

year 1969. In closing out this section on state financing it is important to highlight the spread of control of these health monies. The State Commissioner of Health controls only a small portion of the $154.5 million, the Director of Mental Health a bit larger portion, the Vice-President of the Oklahoma University Medical Center a bit larger portion yet, and the bulk of the sum is controlled and administered by the Director of the Department of Public Welfare.

Structure and Composition of the Legislature

The legislature now meets once in regular session every year as a result of a recent constitutional amendment. These sessions commence on Tuesday following the first Monday in January and adjournment customarily takes place in early May. There is no legal restriction on the length of sessions, and the Governor may call special sessions.

Legislative reapportionment has taken place in Oklahoma in recent years just as it has in many states across the nation. Currently there are forty-four senators and ninety-nine representatives. Each of these legislators has an office with a secretary in the Capitol. (Offices and secretarial services are frequently shared).

The officers of the two houses hold important responsibilities and authorities. The Speaker of the House is one of the most powerful figures in state government. Other prominent positions in the House are the Speaker Pro Tempore, the Majority Leader, and the Minority Leader. The Lieutenant Governor is the presiding officer over the Senate, but senators themselves play the key roles of President Pro Tempore, Majority Leader, Majority Whip, and Minority Leader.

The work done by Legislative Committees is crucial to the whole law-making process. "Ordinarily, more than a thousand bills and resolutions will be introduced in the two houses during a single session. In order to give even passing consideration to such a large number of measures, the standing committees are essential."[15] The first session of the Thirty-Second Legislature organized fifteen committees in each house. Public Health Committees in both houses are included among these standing committees. In addition, special committees and task force committees may be set up. The committees of various types are surprisingly active during the interim period between legislative sessions. Committee membership varies from seven to twenty-four. The parties are usually represented on committees in the same proportion as they exist in the legislature at large. As with the national Congress, committee chairmanships are power-laden positions and are much sought after.

Several variables in the legislature such as party affiliation and urban/rural origin are important to the study and are discussed in more detail in Chapter VI under sample selection for the pilot study. An overview of these variables is sufficient for our purposes here. The Thirty-Second Oklahoma Legislature is 78 percent Democratic and 22 percent Republican with the Senate slightly more one-sided than the House. About 61 percent of all these legislators reside in rural districts; the remaining 39 percent coming from urban areas. The House is two percent more rural than is the Senate. Reflecting the relative stability of the Oklahoma Legislature, only 17 percent of the members

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[15]Strain, Outline of Oklahoma Government, p. 37.

of the Thirty-Second Legislature are freshman law-makers. The Senate experiences a much lower turnover rate than the House, the percentages of new members being 12 percent and 20 percent, respectively.

Two other elements of the legislature deserve brief comment. In response to growing needs for their own fact-finding agencies and professional research assistance the legislature established in 1947 a Legislative Council. The legislators themselves comprise the council membership which is organized into committees. These committees meet during months when the legislature is out of session and hold hearings on major questions and problems of public interest. For our purposes it is important to note the role of the full-time research staff of the Legislative Council. It is the duty of these persons to research the statutes, gather general data, provide technical assistance in bill drafting, and offer non-partisan counsel on proposed legislation. The entree of this group to major influence in the decision-making process is obvious. As a practical matter it appears that the staff eschews policy stands, and is dedicated to factual research and gathering of information.[16]

The "Invisible" Legislature is a term accorded to the pressure groups who operate behind the scenes and who bear no official responsibility for governmental action.[17] The legislature requires that all lobbyists register themselves by submitting information on their organi-

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[16]The basis for this appraisal is discussed by John W. Wood in "The Oklahoma Legislature" as it appears in Alex B. Lacy, Jr., ed., Power in American State Legislatures, pp. 138-139.

[17]H. V. Thornton, Corbitt Rushing, and John Wood, Problems in Oklahoma State Government, p. 20.

zations and by requesting a permit to lobby. During a recent session there were one hundred twenty-two such lobbyists registered with the House and ninety-two in the Senate. The types of associations primarily represented were business, farm, labor, professional, and governmental.[18] As indicated in Chapter III, these pressure groups are deeply interwoven into the fabric of American political life and form a natural base of activity for health statesmen.

A Composite View of Oklahoma Legislators

Earlier we considered some characteristics of legislators across the nation; now we shall focus on those in Oklahoma in particular. "The profile of the Oklahoma legislator reveals that he is usually a middle-aged, male, white Protestant, Democrat, lawyer or farmer, college-trained, businessman with prior legislative experience. This profile emerges from the study of background characteristics of the legislators over the period, 1945 to 1967."[19] A survey of the members of the Thirty-Second Legislature[20] reveals that the median age is 47.8 years with the youngest being 24 and the oldest 79 at the beginning of the first session. Slightly over fifty percent of the legislators are

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[18] Taken from Wood, "The Oklahoma Legislature", as it appears in Alex B. Lacy, Jr., ed., Power in American State Legislatures, p. 141, Table 2.

[19] Ibid, p. 143.

[20] The ages of 139 legislators were taken from "Who is Who in the Oklahoma Legislature" as published by the Oklahoma Department of Libraries, Oklahoma City, Oklahoma for the year 1969. The ages of eight legislators are not shown in this document and are not included in the data above.

between the ages of 35 and 50. Analysis of these data with that of the period 1945 to 1967 reveals a trend toward slightly older legislators.

The Senate is all-male and has been since 1921. Currently there are four women in the House. After reapportionment increased the metropolitan representation Negroes began to appear in the Legislature. There are four in the House and one in the Senate in the current session. Survey of the last four legislative sessions reveals that the religious preferences are overwhelmingly Protestant. About 90 percent indicate Protestant religious preference, some three percent Catholic, and none Jewish.[21]

Occupational background data for legislators over the period 1945-1969 reveal that businessmen (46 percent), lawyers (26 percent), and farmers (18 percent) have dominated the membership.[22] Among the businessmen one finds most often those engaged in real estate, insurance, retail trade, and petroleum activities.

Educational data on Oklahoma legislators for the period 1963 to 1969[23] show that some 58 percent of them are college graduates and over 85 percent of them have attended college to some extent. As might be expected the educational profile shows a distinct rise over the years.

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[21]These data were obtained from "Who is Who in the Oklahoma Legislature" for the years 1963, 1965, 1967, and 1969. The seven percent unaccounted for above expressed no religious preference.

[22]Taken from Wood, "The Oklahoma State Legislature" as updated by the author with data from "Who is Who in the 32nd Oklahoma Legislature", 1969, p. 145.

[23]Taken from Wood, "The Oklahoma State Legislature" as updated by the author with data from "Who is Who in the 32nd Oklahoma Legislature", 1969, p. 146.

It appears that the turnover rate in the House is about 20 percent each two years and about 15 percent in the Senate. This variable as well as party affiliation and urban/rural residence are discussed in some detail in the next chapter.

In summary, the purpose of this chapter has been to give the reader some background information on the state, its people, and its legislators. Presumably, the research findings may be evaluated more accurately if we understand something of the total milieu in which they occur. Indeed the cultural and political values of today seem to stem from an odd mixture of traditional beliefs and new, changing emphases as imposed by an urbanizing society.

Historically, the tone of human affairs in the state has been pervaded with pioneer spirit and rugged individualism. The so-called Protestant Ethics seems to have influenced much of the political and moral thinking over the years.

Reflecting a basic distrust of government by the people, the state government is characterized by marked limitations and an unusually wide dispersion of that power which is permitted state officials. The structure and composition of the legislature are prescribed by the state constitution. Notable trends in this connection are longer and more frequent sessions, elevated pay and status of legislators, and periodic reapportionment of legislative districts.

Accompanying these trends are indications of rising qualifications of the legislators. It appears that they are becoming increasingly better educated and more experienced. Relatively stable characteristics of the legislators are their occupational backgrounds and

their religious preferences. Some changing features are the increasing numbers of women and Negroes in the legislature in recent years and the tendency toward slightly older legislators.

Several contrasts between the legislators and the general Oklahoma population stand out sharply. For one thing the occupational range of the legislators is much more narrow than that of the general population. The occupations of businessman, farmer-rancher, attorney, and educator include all but a very few of the legislators. A much wider range of occupations exists in the population at large, of course. Being only part-time politicians, the legislators need a primary source of income. By the same token, their principal occupation must be one which allows legally and practically the time for legislative duties.

Another contrast is seen in the much higher educational level of legislators as compared with the general population. Concomitant with the higher educational level, one observes an economic status among legislators somewhat above that typical within the general population. As compared with their non-political counterparts of their own socio-economic class, the legislators are much less mobile. Typically, the legislators have lived in their present communities for long periods of time, frequently throughout their adult life. This relative immobility suggests a strong orientation to the local scene and a tendency toward conservatism. This suggestion will be discussed at some length in later chapters.

CHAPTER VI

DESIGN OF THE STUDY

In the study of state legislators one finds a number of options open to him. One of the initial decisions to be made deals with the scope of the study. The ideal is to set one's scope at a level sufficiently inclusive to justify research effort while not so broad as to make the study unmanageable. The study at hand tends to be broader than is normally desirable. This enlarged scope is not by chance. As stated earlier, two of the research objectives are to test methodologies and to uncover appropriate topics for more detailed study. In a sense this study attempts to probe a broad topic in order to uncover fruitful areas for closer investigation. A third objective is, of course, to gain knowledge and examine variables. Undoubtedly, the selection of a wider scope in favor of the first two objectives is at the expense of the third. Nevertheless this study seeks to arrive at tentative explanations of human phenomena through the classical approach of establishing assumptions, proposing hypotheses, and then testing these hypotheses.

Assumptions

There are a number of assumptions on which this study is predicated. Those of major importance to us are shown below:

1. Constitutionally the state (as a government entity in the

United States) is sovereign regarding health affairs. Even so the federal government has assumed vast "de facto" powers through its great fiscal resources.

2. The state legislatures enact a significant number of laws each year in the health field. In addition, opportunity presently exists for state legislatures to play an expanded role in health through federal legislation such as the Comprehensive Health Planning Act, PL 89-749.

3. The state legislatures appropriate significant sums of money each year for the operation of health programs within the executive branches.

4. Even though it is repository of constitutional power in health affairs, the state level seems to have exercised this power with much restraint. It is currently being squeezed between massive legislation and bureaucracy at the federal level and very active urban programs from metropolitan areas.

5. State legislatures occupy a crucial position in health affairs within the United States. Moreover, we do not know enough of how the legislators perceive health professionals, the extent of their understanding of health issues, and the manner in which they make decisions in public policy as it relates to health.

6. There is a relationship between the extent of knowledge of the health field by the legislator and the way in which he makes decisions.

7. From the standpoint of the health administrator who is attempting to participate in shaping health legislation, there is valu-

able information to be gained through assessment of the legislator's need for and receptibility to professional interest group salesmanship.

Hypotheses

The primary areas of investigation are discussed in the Introduction. A proposition is hypothesized around each of these areas of research interest. The hypotheses below are suggested as tentative explanations for the manner in which health affairs take place in state government:

Hypothesis 1 - Legislators' priority ranking of health is directly related to the extent of their knowledge of the health field. It is proposed that the dependent variable in this proposition is the position of priority in which the legislator sees health as related to other programs. The independent variable is suggested as being the extent of knowledge by legislators in health affairs. This hypothesis was formulated on the view that legislators who are well-informed in health affairs tend to rank the field higher in relation to other programs than do other legislators who are not so well-informed. If this opinion were found to be true (in terms of probability truth), health statesmen could then reasonably hope to further health interests by actively educating politicians in health affairs. Possible intervening variables in this hypothesis are pre-existing attitudes, values, and beliefs of both the respondents and the researcher. The extent of a legislator's personal contact with hospitalization and/or medical care might also be an intervening variable.

Hypothesis 2 - State legislators are prone to give priority to

state programs other than health, i.e., highways, education, etc.

Hypothesis 3 - Though a matter of increasing concern in state government, health affairs are still not popular issues in Oklahoma politics which generate widespread public and legislative interest.

Hypothesis 4 - State legislators perceive health professionals in a way contradictory to the way these professionals see themselves.

Hypothesis 5 - Specific to health/hospital administrators, state legislators do not perceive these profressionals as health statesmen.

Hypothesis 6 - State legislators are inclined to associate health and medical education with health services rather than state education.

Hypothesis 7 - State legislators are not sufficiently knowledgeable in health affairs to render independent judgment on pending health bills.

Hypothesis 8 - State legislators are therefore especially dependent on health professionals for counsel and vulnerable to pressure groups in their promotion of vested interest.

Hypothesis 9 - Hospital/health administrators, as a group, are fulfilling a role of health statesmanship relative to the Oklahoma State Legislature.

Hypothesis 10 - In the process of becoming politicized the hospital/health administrator executes the role of health statesmanship in a way quite similar to spokesmen of other interest groups.

Hypothesis 11 - Legislators' priority ranking of health is directly related to the extent of their personal contact with hospitaliza-

tion and/or medical care.

Hypothesis 12 - State legislators tend to be politically conservative relative to health affairs.

Hypothesis 13 - The majority of state legislators disagree with the concept of health care as a right of American citizenship.

Hypothesis 14 - State legislators are predominantly concerned with rural health needs.

Hypothesis 15 - The voting behavior of Oklahoma State Legislators is generally consistent with their expressed attitudes in health affairs.

Research Methodology

Review of the literature concerning studies of politicians and political processes reveals two broad approaches. One is the longitudinal method where one item is singled out and thoroughly investigated. This case study approach is characterized by exhaustive research of all factors related to a particular event, issue, or legislation. The other method is a cross-sectional study of a number of politicians. Usually this approach involves an attitudinal survey of some form. Analysis of voting behavior may accompany either method. The literature offers a number of examples of each method. Let us consider first the longitudinal approach.

A study of the historic Medicare/Medicaid Legislation (Titles XVIII and XIX of the Social Security Amendments of 1965) is typical of the case studies.[1] Another example of this type of research methodology

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[1]This legislation and the approach are treated by Herman Miles Somers and Anne Ramsey Somers in Medicare and the Hospitals, Issues and Prospects, especially Chapter I.

is the work of E. C. Banfield who put together a series of such studies in his study of political influence within the city of Chicago.[2] Concentrating on the dimensions of voting behavior of members of the 1959 session of the Oklahoma House of Representatives Samuel Patterson analyzed roll call votes on specific bills.[3] With a view toward determination of the overall political leanings of a group of state legislators Richard Marvel also analyzed particular legislation.[4]

Contrasting with the methodologies just mentioned are those which deal with determination of politicians' attitudes and perceptions at a particular point in time. An example of this is the attitudinal survey of legislators relative to pressure groups by Wahlke, et al.[5] Barber's psychological study of legislators is concerned with the primary orientation of the legislator.[6] Moving back to the field of Health Administration Victor McGowan recently carried out an attitudinal survey of governmental and non-governmental leaders in the health field.[7]

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[2]Edward C. Banfield, Political Influence, passim.

[3]Samuel C. Patterson, "Dimensions of Voting Behavior in a One-Party State Legislature", The Public Opinion Quarterly, No. XXVI, Summer, 1962, pp. 185-200.

[4]Richard D. Marvel, "Decision-Making in the Nebraska Unicameral Legislature".

[5]John C. Wahlke, William Buchanan, Heinz Eulau, and LeRoy C. Ferguson, "American State Legislators' Role Orientation Toward Pressure Groups", in Frank Munger, ed., American State Politics, pp. 420-441.

[6]James D. Barber, The Lawmakers: Recruitment and Adaptation to Legislative Life, passim.

[7]Victor B. McGowan, "Comprehensive Health Planning: A Survey of the Attitudes of Governmental and Non-Governmental Health Leaders".

As one might gather from this brief literature review the longitudinal approach is most appropriate when there is a substantial body of knowledge on which to build. Moving from a pre-established base of theory an investigator may concentrate on a particular item in depth. On the other hand, a broader approach is more fitting when the area of investigation is less well-established. This is precisely why the exploratory study in the form of an attitudinal survey has been selected as the methodology of choice in this instance. This is why the scope of the study is broad and the findings are necessarily tentative. Oliver Garceau expresses the point best when he says:

> Very little is known about members of the state legislature: Who they are, where they come from, and what they suppose to be the nature of their job ... Interviews could profitably extend to kinds of awareness or perceptions of the political process among present legislators. By asking questions about the factors involved in deciding issues of the current session, it is possible to discover a good deal about a respondent's level of information, the interest groups and lobbyists he can identify, what techniques he sees, and what he thinks are (the primary) issues.[8]

Having decided to conduct an attitudinal survey, one must next select a means of gathering the data. There are two general techniques available for recording the verbal behavior of respondents: questionnaires and interviews.[9] Moreover, there are several variations on each of these techniques. In the terminology of Richardson, et al.,[10] the

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[8]Oliver Garceau, "Research in State Politics" in Frank Munger, ed., American State Politics, pp. 6-7.

[9]These techniques and the advantages and disadvantages of each are discussed in Bernard S. Phillips, Social Research Strategy and Tactics, Chapter 6. This book serves as the general research reference for this thesis.

[10]Stephan A. Richardson, Barbara Snell Dohrenwend, and David Klein, Interviewing, Its Forms and Functions, passim. This book serves as the specific reference on interviewing for this study.

nonschedule semi-standardized interview[11] is used as the principle data-gathering technique. The rationale for this choice is that: (1) legislators respond infrequently to questionnaires; (2) when they do respond, the questionnaire is often completed by an assistant; (3) legislators are usually cooperative in granting interviews for research purposes; (4) after rapport has been established and anonymity guaranteed during interviews, legislators tend to be fluent in discussion of issues and questions; and (5) the nature of the information being sought is best served by the balance in consistency and flexibility achieved in the nonschedule semi-standardized interview.

A major shortcoming of this technique is the reduced reliability which it affords. The ideal objectivity of the scientific method bespeaks total reliability of the data-gathering instrument. Yet it appears that deviation is warranted in this situation. By following a scheduled and rigidly standardized procedure much greater reliability would be achieved, but validity would be virtually destroyed. Achievement of validity is paramount in this study. In addition the legislators must be interested in the interview in order to be fully cooperative. Under rigid questioning and without the opportunity to expound, legislators will not be so cooperative as they are otherwise. It is quite likely that such an approach would be self-defeating. The nonschedule semi-standardized interview is designed to achieve maximum validity while retaining a reduced but acceptable level of reliability.

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[11]Stephan A. Richardson, Barbara Snell Dohrenwend, and David Klein, Interviewing, Its Forms and Functions, passim. This book serves as the specific reference on interviewing for this study. pp. 45-55.

Instrumentation

The instrument for the nonschedule semi-standardized interview is designed to yield data on legislators in four areas: (1) priority ranking of health and knowledge of health; (2) attitudes toward health professionals; (3) decision-making in public policy of health; and (4) general political attitudes and values. There are ten to fifteen questions grouped about each of these topics for a total of fifty-one questions.

A copy of the Interview Plan appears in Appendix A. This plan sets forth the introduction to the interview, the rationale for the sequence of questions, the techniques used in questioning, and a listing of the questions themselves. The usual sequence of the questions during interviewing is shown in the next chapter. On occasion this usual order of questions would be altered to follow a "rich vein" of discussion by a confident.

There are five types of questions. The open-ended questions are designed to disclose the general level of awareness of understanding on a topic. The true-false questions are intended to measure specific knowledge, although some of them also have an attitudinal component. The question with "Likert Scale"[12] responses are intended to obtain summated ratings on specific topics. Multiple-choice questions are designed to gain insight into legislators' perceptions and behavior in decision-making. And finally there are ranking questions which are designed to measure legislators' priorities.

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[12]G. Murphy and R. Likert, Public Opinion and the Individual, as discussed by Phillips, Social Research, pp. 184-185, 203-205.

The source of topics covered by the questions deserves brief comment. In general, the current literature in the health field was surveyed to identify some of the principle controversies of the day. Many of the questions are designed to measure legislators' attitudes toward these issues. Other questions deal with concepts generally shared by health professionals, but not necessarily by the public at large. The knowledge questions in Category A are intended to measure the legislators' grasp of principles and facts which are well-established in the field.

The Universe and the Sample

The universe was described in detail in the previous chapter. One hundred representatives and forty-eight senators comprise the total population of one hundred forty-eight. A sample of one hundred thirty-four was actually studied. The sample was proportionately divided between the two houses, there being ninety-one from the House and forty-three from the Senate. The sample represents approximately ninety percent of the total universe. It is conceivable that the remaining ten percent could have been interviewed, too. But the time and effort involved in interviewing these "difficult-to-see" legislators was felt to be disproportionate to their worth to the study. Moreover, it is felt that the ninety percent interviewed represents accurately the total population. Care has been taken to insure that the sample contains several major variable characteristics in the same general proportion as these variables are found in the universe. The variables in question are described more in detail in the discussion of the pilot study below.

Pretesting and Pilot Study

In an effort to refine the measuring instrument it was pretested on a variety of persons. First, it was administered to graduate students in health administration; then to faculty members in a School of Health. Also, trial run interviews were performed with two former legislators. The primary concerns of this pretesting were the presence of ambiguity, the efficiency of the question to elicit an attitude on the topic sought, determination of the proper sequence of questions, and development of appropriate timing.

Following this the schedule was examined by a senior staff member of the Oklahoma Legislative Council. By this means the terminology of the questions was tested for meaningfulness to legislators, and some adjustments were made. A number of questions were identified as likely to require clarification during interviews. These were marked for special emphasis by the investigator. Also, some terms taken from legislative jargon were added.

The questions of Category "A" were administered to a group of five hospital administrators in order to set standard knowledge scores against which those of the legislators could be compared. These same hospital administrators were given the questions of Category "B" in order to determine their perception of themselves and other health professionals. These rather limited efforts with hospital administrators were superficial and by no means achieved standardization of the instrument. Some confirmation was attained, however, and this appears to be sufficient for the purposes of this study.

Due to the exploratory nature of this research project it was

deemed advisable to conduct an extensive pilot study. The purposes of the pilot study were to test the feasibility of the research design and to refine the instrument.

The sample size of the pilot study amounted to 20.2 percent of the universe. A stratified random sampling was selected as the technique of choice for selection of confidents. This approach was taken to insure that the sample be as representative as possible of the total population. Only in this way could there be assurance of tapping the variety of psychological sets posed by the legislators. Thus it was necessary that the sample contain several major variable characteristics in the same proportion as they exist in the universe. These variables are membership in the House or Senate, political party affiliation, representation of urban or rural districts, freshman or veteran status in the legislature, and assignment as a legislative or health committee leader or no such assignment.

Random sampling by use of a table of random numbers was employed within each stratum. First, proportionate strata were set up; then selection began with the rarest combination of variables and progressed to the most frequently occurring combination of variables. By this means the research group was structured to contain randomly selected legislative or health committee leaders and non-leaders in proportion, freshmen and veterans in proportion, etc. Appendix B illustrates the composition and characteristics of the pilot study sample.

Other variables are also felt to be important, i.e., regional origin, education, age, sex, and race; however, these items were not considered in sampling. An excessive number of variables renders the

process too complex and totally unmanageable. Fortunately, it appears that a fair distribution of these variables "fell out" of the sampling process by chance.

The pilot study served the purposes for which it was planned. First, it confirmed the feasibility of the research design and paved the way for accomplishment of the major study. Secondly, it allowed for refinement of interviewing technique and instrumentation. Based upon the experiences and findings of the pilot study several questions were deleted from the interview schedule. Some changes in wording were made to other questions. Fortunately, these changes were not so radical as to preclude use of the data of the pilot study in the overall findings of the major study. Some adjustments were necessary and where modifications were made, qualifying remarks are included in the report.

As a closing note on actions prerequisite to conduct of this study, brief comment is directed to the matter of establishing rapport with the legislature. Three conditions are vital to the successful conduct of research interviews in a legislature in the opinion of the writer. First, the researcher must gain for his project the blessings of the power structure of each House. It is highly desirable to gain the support of top leadership in both parties. With such support it appears that many doors open. The project may well flounder without it.

Secondly, a base of contact and information within the Capitol is highly desirable. With such a base the researcher may be advised of appropriate timing and techniques, may remain appraised of the tone of the legislature, and may become aware of factors with bearing on his project, but not generally known to the public. Being research-oriented

itself, the State Legislative Council is suggested as a good point of contact for continuous legislative rapport throughout the project.

And, lastly, the interviews must be interesting and stimulating to most of the respondents. In the main legislators are willing and cooperative people but they are also quite busy. Their calendars are usually crowded, their minds are often cluttered, and their attention span is short if not effectively captured and retained.

Collection of Data

The data concerning legislators' attitudes were obtained by means of personal interviews. These interviews were conducted in a variety of places: the legislators' offices in the Capitol, the House or Senate Chamber, committee rooms, the legislators' offices, work sites, or homes in their hometown, etc. About two-thirds of the interviews took place in the Capitol with the remainder done in the legislators' hometowns. Practically all of the interviews were arranged by appointment. The shortest of the interviews lasted just thirty-one minutes, the longest an hour and forty-five minutes. Eighty percent of them fell within the range of forty to fifty-five minutes. The data were tabulated and aggregated in code throughout the data-gathering period. The most relevant data were placed on key punch cards and counting was accomplished by means of electrical card sorters and counters. Computations were made with the aid of electrical calculating machines. The data-gathering phase took place over a sixty week period with an average of 2.21 interviews per week. It is estimated that four to five man-hours were required on an average for each interview. This estimate includes time

devoted to telephone conservations, letters, travel, waiting, and actual interviewing.

The data on voting behavior were taken directly from the Legislative Journal of the First Session of the Thirty-Second Legislature. These data were gathered at the Capitol with the assistance of the Legislative Council. The information relevant to floor sessions and committee activity was taken from both sessions and the interim period of the Thirty-Second Legislature. Most of the committee hearings were conducted at the Capitol, although a few were held elsewhere.

This completes the explanatory material concerning research design and conduct of the study. In the next chapter we shall turn our attention to the findings. Before doing so, however, let us recapitulate briefly. Early in the report it was established that government in the United States is playing a large and growing role in health affairs. We identified that health professionals, in adjusting to the massive intervention of government, need to participate more effectively in the formulation of public policy relating to health. How do they do this? By becoming and functioning as health statesmen according to leaders in the field.

Having established the theoretical construct of a "Health Statesman", we turn our attention to the key figure in formulation of all public policy in a democracy - the politician. In order to perform his role effectively the health statesman must know a good deal about the politician, his attitudes, his values, and his methods of making judgments. With the aid of literature from political science and other social sciences we established the ways in which the study of politics

is relevant to health administration.

As this study deals with politicians in the role of state legislators, we then digressed long enough to survey the theory and practice of state government. Sharp expansion of state involvement in health was noted through partnership arrangements with the federal government. The strengths and weaknesses of state government in this growing role were reviewed.

To gain perspective with which research findings could be viewed we next looked at the setting and composition of the Oklahoma State Legislature. Characteristics of the legislators themselves were examined. This set the stage for the study.

The chapter just closing carried us through design of the study with emphasis on assumptions and hypotheses. Thus we are now ready to inspect the findings.

CHAPTER VII

ATTITUDINAL FINDINGS

Preliminary Comments on the Data

The responses of legislators are aggregated in this section in raw form. Questions are listed in the same order in which they were asked during interviews. Moreover, the questions are identified by lettered and numbered designations for use should the reader care to cross-reference them with Appendix A.

The responses are aggregated in terms of absolute numbers and as percentages of the total in all cases except ranking questions. Mathematical precision is unnecessary for purposes of this study; therefore all percentage figures have been rounded to the nearest whole percent. This is done to facilitate quick and easy grasp of the findings. Because of this procedure percentages may sometimes add to 99 or 101 rather than 100, indicating that fractional parts of one percent are evenly distributed among the responses.

Another technique is necessary for showing aggregate responses to ranking questions. Here the quantitative rank positions assigned each response item are totaled and divided by the number of confidents. The quotient indicates the composite ranking of the choices. This technique allows us to see not only the aggregate ordering of the ques-

tion items, but also the relative methematical value of each item.

In some cases, brief phrases in quotation of the respondents are included. This is done to capture some of the feeling and tone of responses in legislators' own words. Indeed there are hazards in employment of this technique. Quoting out of original context is always risky. Too, there is danger of introducing investigator bias through the process of selecting which quotations to include. Yet these respondent comments are material to our purpose for they bring flavor and added dimension to the attitudes expressed. For this reason a few germane quotations are stated relative to certain questions. Special effort has been made to report these in context. Also, the author has attempted to minimize bias in the selection process by using consistently the same criterion for selection. This criterion relates to clarity and depth of whatever attitude is expressed, rather than regard for the value judgment which underlies the comment.

The Raw Data

Opening Questions

A - 1. What do you see as being the greatest needs in development of Oklahoma's human resources over the coming ten years?

(Note: This is an open-ended question; thus no alternative answers are given to the respondents).

By categories the responses are as follows:

a.	Public School Education	83	28%
b.	Higher Education	82	27%
c.	Industrial Development/Employment	37	12%
d.	Vocational Training	32	11%
e.	Health	9	3%
f.	Highways and Transportation	6	2%
g.	Other	48	16%

A - 13. Assume that $1,000,000 in new state revenue becomes available for appropriation by the legislature. Given that the entire amount must go to only one program, rank the following state programs in the order in which you feel these new funds would be needed: (Ordered by aggregate ranking).

	Total[1]	Mean	Aggregate Ranking
Public Schools	239.5	1.79	1
Higher Education	323.5	2.41	2
Health	642.0	4.79	3
Highways and Roads	648.5	4.84	4
Economic/Industrial Development	724.0	5.40	5
Public Safety	789.0	5.89	6
Penal and Correction	872.0	6.51	7
Parks and Recreation	1,007.0	7.51	8
Conservation and Wildlife	1,040.5	7.76	9
Welfare	1,056.5	7.88	10

A - 2 Do you see Oklahoma as having any major health needs? If so, what are they?

(Note: This is an open-ended question; thus no alternative answers are given to the respondents).

By categories the responses are as follows:

a.	More Medical Doctors	27	13%
b.	Pollution and Environmental Health	26	12%
c.	Mental Health	19	9%
d.	Reduced Costs of Health Care	14	7%
e.	Health Education	8	4%
f.	Improved County Health Departments	8	4%
g.	Better Organization for Health Care Delivery	7	3%
h.	Other	100	48%

Selected Quotations:

(1) "More tax dollars are needed for health."
(2) "More allied health professionals are needed."
(3) "Better medical care in poor, rural areas is needed."
(4) "More and better family planning is needed."
(5) "Better preventive medicine, especially mass screening is needed."

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[1]It might be helpful to explain further this "Total" column: If, for example all 134 legislators ranked "Public Schools" as number one, the "Total" for "Public Schools" would be 134; if all 134 legislators ranked it tenth, the "Total" would be 1,340.

(6) "Nothing more is needed; Oklahoma is a healthy state."

B - 1. What meaning for you has the term "Health Statesman"?

(Note: This is an open-ended question; thus no alternative answers were given to the respondents.)

a.	Health politician	40	26%
b.	Health professional	37	25%
c.	Health lobbyist	9	7%
d.	No meaning	64	43%

Selected Quotations:

(1) "Not a politician because health holds no glamour - not much public interest involved."
(2) "One who sees no other facet to government than taking care of the people - an extreme liberal."
(3) "One who is dedicated to health."
(4) "One who is interested in promulgating laws in health."
(5) "A Medical doctor."
(6) "Someone from the state, county, or city health department."
(7) "A spokesman for health."
(8) "One who pictures the needs and provides real leadership."
(9) "A legislator who takes an interest in health."
(10) "A man who is willing to stand up for what he believes."
(11) "The president of the state medical association."
(12) "There is a great need for health statesmen."

D - 10. Do you see a greater need for improvement of health in urban or rural areas in Oklahoma?

a.	Rural	40	30%
b.	Urban	45	34%
c.	Equal	42	31%
d.	No answer or don't know	7	5%

Likert Scale Questions

D - 2. Provision of high quality medical care is a right of citizenship of Americans.

a.	Strongly agree	45	34%)	
b.	Mildly agree	37	28%)	--- 62%
c.	Undecided	10	7%	
d.	Mildly disagree	19	14%)	
e.	Strongly disagree	23	17%)	--- 31%

Selected Quotations:

(1) "I agree in the broadest sense only - we have a duty only to indigents."
(2) "This leads to socialized medicine."
(3) "To say that this is not a right is like being against motherhood, but I won't say it is a right either."
(4) "This can't be because others have to pay for it and this violates their rights."
(5) "Can't do because MD's are raising their prices too high."
(6) "Morally and ethically a 'right', but not legally."
(7) "The world owes each of us nothing. All it takes to make it is will power, intelligence, hard work, and individual effort."
(8) "Would have to know how this is to be done before deciding."
(9) "I have compassion, but not everyone is entitled to this simply because they are here."
(10) "I strongly agree because we should treat all on an equal basis regardless of whether they are rich or poor; strep throat hurts everyone the same."
(11) "This is a non-government function; we cannot afford it anyhow."

C - 8. A legislator is usually not sufficiently informed on pending health legislation; therefore he should seek the counsel of health professionals in deciding how to vote on health bills.

a.	Strongly agree	67	50%)	---78%
b.	Mildly agree	37	28%)	
c.	Undecided	1	1%	
d.	Mildly disagree	16	12%)	---21%
e.	Strongly disagree	13	9%)	

Selected Quotations:

(1) "Expert advice is necessary in this area."
(2) "Disagree; legislators are closer to the people."
(3) "I prefer to rely upon other legislators who are well-informed."
(4) "Yes, professional counsel in medical matters is essential."
(5) "No, because I don't go for these scare deals by the medical groups."
(6) "Health experts are the prime cause of the problem."
(7) "No, because these are not professional problems; they are social problems."
(8) "No, definitely, because MD's live in a vacuum and have selfish motives."

B - 3. Charitable Immunity should be maintained for hospitals in Oklahoma.

a.	Strongly agree	38	28%)	---49%
b.	Mildly agree	28	21%)	
c.	Undecided	16	12%	
d.	Mildly disagree	15	11%)	---39%
e.	Strongly disagree	37	28%)	

D - 1. STATEMENT OF FACT: Constitutionally the state (as a governmental level in the U. S.) is sovereign in health affairs; yet the federal government has assumed vast "de facto" powers in health.

PROPOSITION: This is fitting and appropriate as it is the best way the health needs of our nation may met.

a.	Strongly agree	21	16%)	---44%
b.	Mildly agree	37	28%)	
c.	Undecided	3	2%	
d.	Mildly disagree	29	22%)	---54%
e.	Strongly disagree	44	32%)	

Selected Quotations:

(1) "We can't afford at state level, as the Fed has usurped the tax dollars."
(2) "State's rights are usurped."
(3) "Must be because per capita income is higher elsewhere."
(4) "Fed role is essential, but creates dilemma."
(5) "Would prefer otherwise, but states are incapable of this."
(6) "Has to be this way, because states are too close to heavy lobbyists."
(7) "No, because the Fed is too involved now."
(8) "Strongly disagree; New York or Maryland is different; Oklahoma is doing better."
(9) "I resent this, but there's not a damn thing we can do about it; they have the dollars."
(10) "This is the best way with present attitude of state legislators; also technology demands this."

B - 7. In principle, licensure by the state should be required of hospital administrators.

a.	Strongly agree	64	48%)	---67%
b.	Mildly agree	25	19%)	
c.	Undecided	9	7%	
d.	Mildly disagree	12	9%)	---27%
e.	Strongly disagree	24	18%)	

Selected Quotations:

(1) "No, too many boards and commissions not good - too restrictive and we must not have a super-certified society."
(2) "Strongly agree, to protect the people and ward off corruption."
(3) "No, the boards will pick good men irrespective of licensure."
(4) "Licensure not needed because they only collect bills."
(5) "No, because the doctors and nurses on the hospital board will select someone good."
(6) "No, because hospital administrators can be trained in only six weeks beyond a B.A.".

D - 12. The State of Oklahoma is doing all that it ought to do in providing health services to its citizens.

a.	Strongly agree	8	6%)	---21%
b.	Mildly agree	20	15%)	
c.	Undecided	15	11%	
d.	Mildly disagree	35	26%)	---68%
e.	Strongly disagree	56	42%)	

D - 11. Establishment of Program "A" will bring matching federal dollars to Oklahoma. Program "B" will not. It is best for a legislator to vote state dollars to "A" in order to get the federal dollars, even though he favors "B" over "A".

a.	Strongly agree	45	34%)	---55%
b.	Mildly agree	28	21%)	
c.	Undecided	6	5%	
d.	Mildly disagree	20	15%)	---38%
e.	Strongly disagree	31	23%)	
f.	No answer	4	3%	

Selected Quotations:

(1) "Partnership agreements are good."
(2) "Agree, because this is the way the game is played."
(3) "No, because this sacrifices principle."
(4) "OK, because states get dollars under "B", but use for "A".
(5) "More truth than poetry in this."
(6) "This is the only practical thing to do - it's our tax dollars coming back."
(7) "No, this infers that legislators vote against their conscience; they vote in best interests of the state."
(8) "Definitely, this allows us to have best policy to take care of children, old folks, indigents, etc. I won't allow my politics to choke me to death - I may be country, but I'm not stupid."

(9) "Hate to do this, but we must - we're coerced. We have three choices: get Fed matching, raise taxes, or do nothing."

(10) "This is the great dilemma between principle and practice. This is expedient, but I hate it - we must reverse the trend."

B - 6. A pharmacist is more a businessman than he is a professional.

a.	Strongly agree	26	19%)	---32%
b.	Mildly agree	18	13%)	
c.	Undecided	9	7%	
d.	Mildly disagree	22	16%)	---60%
e.	Strongly disagree	59	44%)	

B - 8. It is appropriate that doctors who work full time in hospitals be paid by the hospitals as opposed to the charging of separate fees to each patient. (Excludes interns and residents.)

a.	Strongly agree	31	23%)	---37%
b.	Mildly agree	19	14%)	
c.	Undecided	24	18%	
d.	Mildly disagree	21	16%)	---45%
e.	Strongly disagree	39	29%)	

Selected Quotations:

(1) "Disagree, because this would destroy individuality of MD's."

(2) "MD's are money mad - hospital couldn't afford to pay."

(3) "Should be paid by hospital and everyone get equal care."

(4) "Undecided, but know we need uniform fees for MD's in hospitals - ridiculously high fees now for poor people."

(5) "I trust the doctor and his judgment more than I do the hospital, administrator and board. We must keep authority in hands of an individual, a professional with ethics."

(6) "Yes, if MD's are given adequate salary."

(7) "No, this would be bad for MD's".

(8) "Yes, definitely, and the patient-physician relationship is a bunch of bunk; patients are just nameless faces to modern MD's."

B - 16. The health care resources in Oklahoma meet adequately the health needs of the people.

a.	Strongly agree	7	5%)	---15%
b.	Mildly agree	13	10%)	
c.	Undecided	9	7%	
d.	Mildly disagree	34	25%)	---77%
e.	Strongly disagree	70	52%)	
f.	No answer	1	1%	

D - 6. The United States ought to have a universal Federal Government Health Insurance Program available for all citizens.

a.	Strongly agree	16	12%)	---30%
b.	Mildly agree	24	18%)	
c.	Undecided	8	6%	
d.	Mildly disagree	18	13%)	---64%
e.	Strongly disagree	68	51%)	

Selected Quotations:

(1) "No, this should be done with private insurance."
(2) "No, this can't happen - it's unconstitutional."
(3) "Yes, if it's good for those over 65, it's good for those under 65."
(4) "No, I'm definitely opposed to socialized medicine."
(5) "I disagree philosophically, but would accept this to meet health needs."
(6) "This is probably the only way."
(7) "Yes, employee health plans offer a big advantage; so why shouldn't all have a plan?"

D - 4. What is your attitude toward the new concept of specific health services as a right through application of the social insurance principle (Title XVIII, Part A) as opposed to the concept of various categories of needy people provided health care on a means test basis?

a.	Strongly favor	19	14%)	---27%
b.	Mildly favor	18	13%)	
c.	Undecided	9	7%	
d.	Mildly disfavor	37	28%)	---66%
e.	Strongly disfavor	51	38%)	

Selected Quotations:

(1) "The individual is responsible - must keep means test - must not penalize initiative - must leave rewards for those who look after themselves."
(2) "Oppose this principle, but am all for Medicare as elderly need it."
(3) "Strongly favor - very important to people of my district because we have little industry and low incomes."
(4) "OK to help people who can't work, but if one is able he ought to work. Work is good for work's sake" America was built on hard work."
(5) "The means test is good, but we must revise our criteria."
(6) "Strongly oppose, because we should have levels of care."
(7) "Strongly favor, should apply to others who are needy as well."

D - 5. What is your attitude toward comprehensive health care to needy groups as opposed to item-by-item care to these groups?

a.	Strongly favor	36	27%)	---55%
b.	Mildly favor	37	28%)	
c.	Undecided	25	19%	
d.	Mildly disfavor	21	16%)	---26%
e.	Strongly disfavor	13	10%)	
f.	No answer	2	1%	

B - 2. What is your attitude toward group medical practice as opposed to solo practice?

a.	Strongly favor	53	40%)	---67%
b.	Mildly favor	36	27%)	
c.	Undecided	27	20%	
d.	Mildly disfavor	3	2%)	---13%
e.	Strongly disfavor	15	11%)	

Selected Quotations:

(1) "Strongly oppose - the MD oath requires house calls."
(2) "We trusted the old family MD; today they're removing too many organs."
(3) "Many advantages of this for MD's and patients - should be kept small to retain personal interest."
(4) "Yes, definitely, this is the only way."
(5) "This question doesn't apply to the rural situation in Oklahoma."

D - 7. Some persons see a need to consolidate/organize the many components of the American Health Industry into an integrated system. Do you agree with this proposal?

a.	Strongly agree	25	19%)	---38%
b.	Mildly agree	25	19%)	
c.	Undecided	21	16%	
d.	Mildly disagree	18	13%)	---44%
e.	Strongly disagree	42	31%)	
f.	No answer	3	2%	

D - 8. If you agree with the preceding question, who should take the lead in this?

a.	Blue Cross and other insurance companies with health plans	3	3%
b.	Health administrators	19	23%
c.	State government	21	24%
d.	Hospitals	9	10%
e.	Medical doctors	19	21%
f.	Federal government	11	12%
g.	Local government	7	7%

True-False Questions

A - 4. The cost of staying in a hospital should be about the same as the cost of staying in a motel plus the cost of meals.

True	16	12%
False	113	84%
No answer	5	4%

A - 6. The administrator in the majority of Oklahoma hospitals is a medical doctor.

True	18	13%
False	113	84%
No answer	3	2%

A - 7. We have ways to measure accurately the quality of medical care in Oklahoma.

True	54	40%
False	77	58%
No answer	3	2%

A - 8. Health statistics show that the United States has the best medical care of all nations in the world.

True	99	74%
False	32	24%
No answer	3	2%

A - 9. Physicians in private practice engage primarily in preventive medicine.

True	42	31%
False	86	64%
No answer	6	5%

A - 10. The state agency responsible for making Medicaid payments to hospitals and doctors in Oklahoma is the State Health Department.

True	27	20%
False	104	78%
No answer	3	2%

A - 5. Even though it is a non-profit enterprise, the community hospital should strive to have its revenues exceed its operating costs during each year.

True	97	72%
False	33	25%
No answer	4	3%

Yes-No Questions

C - 9. Have you or a close relative of yours suffered recently a prolonged or tragic need for medical care?

Yes	59	44%
No	75	56%

(Note: This question is used for correlative purposes on an individual level only; thus it has little aggregate significance).

D - 3. It is maintained that United States citizenship affords a right to health care. Can we afford provision of such a right in the case of $30,000 kidney transplants? $100/day hospitalization? Rising physician fees?

Yes	29	22%	Yes	52	39%	Yes	51	38%
No	93	69%	No	72	54%	No	72	54%
No answer	12	9%	No answer	10	7%	No answer	11	8%

Selected Quotations:

(1) "Yes, because we can't place a dollar value on this."
(2) "No, it would bankrupt the system."
(3) "No, because resources should be devoted to the young."
(4) "Yes, if we can go to the moon, we can do this."
(5) "Yes, but don't know how we'll pay for it."

Multiple Choice Questions

C - 1. By which, if any, of the following are you influenced in deciding how to vote on health legislation?

a.	Desires of constituents	59	20%
b.	Personal knowledge	75	25%
c.	Counsel of your family physician	68	23%
d.	Counsel of other health professionals	84	28%
e.	Other	7	2%
f.	No answer	5	2%

Selected Quotations:

(1) "Not constituents because they know nothing on general health matters."
(2) "All of these because legislators are as independent when it comes to voting as is a hog on ice."
(3) "I value especially the counsel of pharmacists because they are an informed listening post; they know the health

problems community-wide while the MD is individual-oriented."

B - 4. Who is legally responsible for the general quality of medical care in a community hospital? (Select One)

a.	County Health Officer	3	2%
b.	Hospital Nursing Staff	1	1%
c.	Hospital Governing Board	53	40%
d.	County Board of Health	11	8%
e.	Hospital Medical Staff	44	33%
f.	Hospital Administrator	9	7%
g.	No answer	13	10%

Selected Quotations:

(1) "The Board and Medical Staff because they are interlocking."
(2) "The Board mainly, but also the Health Department."
(3) "The Board because it is composed of part of the Medical Staff."

B - 5. With which of the following do you primarily associate the Oklahoma Medical Center?

a.	Research in Health Sciences	25	19%
b.	Health services to patients	14	11%
c.	Education of health professionals	47	35%
d.	All of the above	44	33%
	(No answer)	4	3%

B - 9. What should be the degree of influence by medical doctors in state public policies relating to health?

a.	Actually make the important decisions	14	11%
b.	Very influential	74	55%
c.	Fairly influential	34	25%
d.	Small degree of influence	12	9%
e.	Not influential at all	0	0%

Selected Quotations:

(1) "MD's haven't done anything up 'til now except sit out there and make all the money - still I think they ought to be very influential."
(2) "I differentiate between OMA (Okla. Med. Assn.) and other lobbying groups - the others are out only for the money."
(3) "The doctors should dominate."
(4) "The medical profession has failed throughout the country in offering the proper services and in properly disciplining their members; so only little influence is appropriate."

(5) "The actual decision must be left ultimately to the people and their elected representatives."
(6) "MD's are very influential if knowledgeable in health affairs, but most of them aren't."
(7) "The MD's have the skill and knowledge - legislators have no other way than to listen to them."
(8) "Only small influence for having much influence would be like asking a utility if it wanted a rate raise."

B - 10. What should be the degree of influence by hospital/health administrators in state public policies relating to health?

a.	Actually make the important decisions	6	5%
b.	Very influential	36	27%
c.	Fairly influential	59	44%
d.	Small degree of influence	29	22%
e.	Not influential at all	4	3%

Selected Quotations:

(1) "Should come just below the doctors."
(2) "They deal only with dollars - nothing more - are not fit to influence public policy."
(3) "These people have much to contribute."
(4) "Very influential if knowledgeable in health affairs."
(5) "Little influence because they are limited to operation of the hospital, costs, and accounting."
(6) "Very influential because MD's are not the only ones who know health needs in the state."

B - 11. What should be the degree of influence by registered nurses in state public policies relating to health?

a.	Actually make the important decisions	3	2%
b.	Very influential	23	17%
c.	Fairly influential	58	43%
d.	Small degree of influence	36	27%
e.	Not influential at all	9	7%
	(No answer)	5	4%

Selected Quotations:

(1) "Nurses ought to be concerned solely with patient care - not be involved in public affairs."
(2) "Nurses should have a voice in what happens."
(3) "Nurses make no decisions - they just carry out the doctor's orders."
(4) "Nurses are like lawyers' secretaries; so they should have some influence."

(5) "Not too much because nurses are subordinate to MD's and beholden to MD's."
(6) "Very influential because I trust the nurses - they're the only ones with a raw deal."

A - 3. In terms of dollars spent and persons employed, the health industry ranks in which of the following levels among other industries in the United States?

a.	1st to 5th	49	37%
b.	6th to 10th	31	23%
c.	11th to 20th	9	7%
d.	21st to 30th	13	10%
	(No answer)	30	22%

C - 3. What is your opinion of the effectiveness of the Oklahoma Medical Association relative to other lobbying groups?

a.	Much more effective	32	24%
b.	Somewhat more effective	27	20%
c.	About the same amount of effectiveness	34	25%
d.	Somewhat less effective	20	15%
e.	Much less effective	15	11%
	(No answer)	6	5%

Selected Quotations:

(1) "AMA/OMA: the real determinant of all health policy."
(2) "Very effective; a good source; high class; can rely upon; employs good people; does a good job."
(3) "Too damned effective; controlled by insurance companies."
(4) "Much less effective; MD's are poorly coordinated as a group; usually can't agree."
(5) "Not effective because they have nothing to lobby about."
(6) "When mobilized they are effective; otherwise ineffective."
(7) "Great PR and very effective; maybe not too active because don't have to be; nothing threatening at state level."
(8) "I never see them."
(9) "Their presence is unknown to me."
(10) "They do an excellent job because they have integrity and their staff relate well with legislators."

A - 12. Which of the following would you say are good health goals for the state?

a.	More mental health clinics	75	34%
b.	More tuberculosis facilities	5	2%
c.	Development of areawide planning	95	43%
d.	A complete hospital in each community	33	15%

e.	Gradual phasing out of nursing homes by provision of more hospital beds	4	2%
	(No answer)	7	3%

D - 9. Relative to the organization of state health and welfare services which of the following do you think is best?

a.	Organized into two separate agencies	85	63%
b.	Combined in one agency on an equal basis	33	25%
c.	Welfare as part of a health agency	5	4%
d.	Health as part of a welfare agency	7	5%
	(No answer)	4	3%

Selected Quotations:

(1) "I prefer welfare as part of a health department so that we would have less welfare."
(2) "Should be separate because the health program would become too dependent on DPW."
(3) "They should be consolidated so we could gain many efficiencies and savings."
(4) "Yes, they should be combined; Public Health and Mental Health should also be combined."
(5) "Should be combined so we could have benefit of the superior management and administration in the DPW."

B - 12. Which of the following best describes the role in <u>health affairs</u> of medical doctors as a group?

a.	The group in ultimate authority - plays a dominant role in shaping public policy.	37	28%
b.	A very effective group which influences health affairs greatly.	48	36%
c.	A leadership group among other equal leadership groups in the health profession.	22	16%
d.	A group which is mildly influential in health affairs.	11	8%
e.	A group of professionals who have little influence in health affairs.	11	8%
	(No answer)	5	4%

Selected Quotations:

(1) "A few MD's are (a); most are (e)."
(2) "The MD's will cause socialized medicine if they don't put a lid on fees."

(3) "You don't fool around with MD's; they have the authority - there are three people you listen to: doctors, lawyers and bankers."
(4) "Only mildly influential because they are afraid to participate."
(5) "There's a big difference between OMA and practicing MD's; I polled the MD's at home and they don't care."

B - 13. Which of the following best describes the role in <u>health</u> <u>affairs</u> of the typical, individual medical doctor?

a.	A very active and effective participant in public affairs related to health.	9	9%
b.	An active participant in shaping health affairs.	18	17%
c.	About average among professionals in interest and effectiveness in public affairs.	23	22%
d.	Mildly active and influential.	17	16%
e.	Preoccupied with the demands of medical practice - not active outside medical practice.	32	31%
	(No answer).	5	5%

A - 11. Which of the following would you say represent acute health problems in the State of Oklahoma?

a.	Shortage of medical doctors	100	26%
b.	Shortage of hospital beds.	41	11%
c.	Medical and hospital costs.	90	23%
d.	The need for "family physicians".	56	15%
e.	The incidence of communicable diseases.	10	3%
f.	Duplication of services by hospitals in the same community.	17	4%
g.	The maldistribution of medical docters.	51	13%
h.	The amount of mental illness.	20	5%

D - 13. Who should oversee the ethics of medical practice in the area of organ transplants, euthanasia, and new definitions of death? (One or more).

a.	Attorneys	22	11%
b.	Government	49	24%
c.	Laymen	21	10%
d.	Medical doctors	103	50%
e.	Other	7	3%
	(No answer)	6	3%

Selected Quotations:

(1) "Government - should be limited to elected officials to insure responsiveness to the people."
(2) "The doctors are the only authorities in this - I don't know why we would want to involve anyone else."
(3) "It's got to be the doctors because they are the only ones who know anything about it."
(4) "The government is the only agency in our society with the authority to do this."
(5) "It won't be the MD's - I can tell you that. Because they will not get after one another. But somebody has to do it and I don't know who!"
(6) "Medical doctors only; professional ethics lie clearly within the domain of the profession."
(7) "Others are needed, too - especially the clergy."
(8) "Essentially professions should establish ethics - this is a hallmark of professions; but legislation is also needed in this area."
(9) "Government must set safeguards."

C - 2. In general, how do you make voting decisions on health bills?

a.	Legislative committee recommendations	78	27%
b.	Counsel of health administrators	86	29%
c.	Counsel of legislative colleagues	36	12%
d.	Counsel of legislative representatives	66	23%
e.	Other	19	7%
	(No answer)	7	2%

B - 15. How do you see the relationship between the community hospital and the medical doctor?

a.	The governing board is in complete control	7	5%
b.	The medical doctors are in complete control	11	8%
c.	Authority is shared but the board dominates	46	34%
d.	Authority is shared but the MD's dominate	33	25%
e.	There is shared and equal authority.	23	17%
	(No answer)	14	11%

C - 10. Describe the extent of your contact with medical care or hospitalization as a result of the health of yourself or your family.

a.	A great deal	31	23%
b.	A more than average amount	29	22%
c.	An average amount	26	19%
d.	A less than average amount	22	16%
e.	Very little	26	19%

Ranking Questions

B - 14. Rank in order of prestige the following occupational groups. (Note: Responses have been ordered by aggregate ranking.)

	Total	Mean	Aggregate Ranking
Medical Doctors	260.5	1.96	1
Ministers	370.5	2.79	2
School Teachers	554.5	4.17	3
Attorneys	564.5	4.24	4
Registered Nurses	681.5	5.12	5
Health/Hospital Administrators	802.5	6.03	6
Medical Social Workers	889.5	6.69	7
Laboratory Technologists	896.5	6.74	8
Practical Nurses	944.0	7.10	9

Selected Quotations:

(1) "When I was a child and needed help, I was told to turn to the minister and to the MD; these two are close to God."
(2) "The MD, the LLD, and the minister; these are professionals."
(3) "Who is a Health/Hospital Administrator?"
(4) "School teachers are high because they are responsible for getting all of us started."
(5) "Your MD is kinda like your barber - you've got to listen to him and have respect for him."
(6) "The RN's are now bookkeepers; the LPN's are the Florence Nightingales."

C - 4. Assume that there is before the legislature a bill dealing broadly with MEDICAL CARE and HEALTH PLANNING. Rank in order of relative importance those of the following to whom you would turn in getting advice as to how to vote.

	Total	Mean	Aggregate Ranking
Administrator of the State Health Department.	478.5	3.60	1
Oklahoma Medical Association	508.5	3.82	2
Your family physician	520.0	3.91	3

	Total	Mean	Aggregate Ranking
Legislative Committee Recommendations	616.0	4.63	4
Your electorate in general	736.0	5.53	5
Oklahoma Hospital Association	755.5	5.68	6
A group of Oklahoma hospital administrators	771.5	5.80	7
Close associates and friends	773.0	5.81	8
Influential members of the electorate	823.0	6.19	9

C - 5.

C - 6.

C - 7. These questions are the same as C - 4 above, except that each of them deals with a different type of health legislation. The responses to these three questions are omitted as there are no important differences between any of them and the responses shown above for C - 4. The significance of this finding is discussed in the next chapter. These questions were dropped upon completion of the pilot study. If the reader is interested in seeing the wording of these questions, reference is made to Appendix A.

CHAPTER VIII

ANALYSIS OF ATTITUDINAL FINDINGS

The analysis of attitudinal findings is organized along the same lines as the principle areas of investigation discussed in Chapter VI. Consideration is given first to the working hypotheses. Following this, discussion is devoted to the other hypotheses in each of the areas of investigation: legislators' perceptions of health professionals; decision-making behavior, and underlying political values.

These hypotheses have been suggested as tentative explanations for the manner in which health affairs take place in state government. The data gathered in this study and just presented in the preceding chapter will now serve to test the validity of these propositions. For purposes of reference and clarity the hypotheses are numbered here in the same order as presented in Chapter VI.

The Working Hypotheses

Hypothesis number one posits that legislators' priority ranking of health among other state programs is directly related to the extent of their knowledge of the health field. Stated in another way, the postulate suggests that legislators become more sympathetic with health needs as they gain greater understanding of problems in health. Speaking of government in particular, they become more supportive of health

agencies in government as their comprehension of health affairs increases. The dependent variable is the priority ranking of health and the independent variable is knowledge in health.

This hypothesis is important to health statesmen as its soundness or invalidity, whichever the case may be, should guide health spokesmen in developing their statesmanship strategy. If the hypothesis were found to be valid, statesmen might well devote major effort to educating and orienting politicians. Since health affairs seem to be less understood by legislators than other more popular issues, the health statesman might reasonably expect to achieve some success in his lobbying efforts simply by contributing to greater understanding and awareness of health problems in the minds of legislators. If the hypothesis were found to be invalid, the health statesman might do better to design his statesmanship strategies along other lines.

Upon first glance it might seem a truism that one's priority ranking of a program rises as his awareness and understanding of the issues increase. Upon closer examination it becomes evident that this behavior may not necessarily occur at all. Familiarity with the problem alone may not enlist support for health as a program in competition with other programs. The health care field brims with enigmatic issues, and decision-makers may encounter dilemmas when dealing with these issues irrespective of their knowledge of the topic.

The thirteen questions of Category A in the interview schedule are designed to assay the working hypothesis. Questions A - 1 and A - 2 are intended to measure the degree of the legislators' awareness of health and its needs. Questions A - 3 through A - 12 are included on

the basis that most informed health professionals will answer them the same way, that legislators will not answer them the same way, and that we can thereby discriminate among the respondents according to their knowledge in health affairs. Question A - 13 is designed to establish the dependent variable, i.e., priority ranking of health among government agencies.

Values have been assigned to Questions A - 1 through A - 12 on a scale of 0-100 according to the scheme shown in Appendix C. These score values are aggregated and shown in Table 6 in an array of score ranges. For correlative purposes the mean priority ranking of health (taken from Question A - 13) is also shown in this table.

By plotting these data (see Figure 1) the degree of correlation between the scores and the priority rankings is more clearly seen. If full positive correlation existed between these two variables the graph line would rise evenly from the lower left (score of 0 and priority ranking of 10) to the upper right (score of 100 and priority ranking of 1). Generally, the graph line does do this. It rises from the lower left where both the scores and priority rankings are low to the upper right where both variables are high. This indicates a general positive correlation between knowledge of health and priority ranking of health among other state programs. These data and the correlation graph, then, provide some evidence that hypothesis number one does hold forth.

Several counterpoints limit firm conclusions, however. First, the health knowledge scores must be accepted as only a gross indicator of knowledge. The respondents' answers were necessarily evaluated in an arbitrary fashion. Little allowance is made for qualification of answers

TABLE 6

HEALTH KNOWLEDGE SCORES AND PRIORITY RANKING OF HEALTH BY OKLAHOMA STATE LEGISLATORS, 32ND SESSION, 1969 AND 1970

Score Ranges (0-100)	Number of Legislators	Mean Priority Ranking of Health (0-10)*
90-99	2	4.0
80-89	3	3.0
70-79	24	4.7
60-69	42	4.3
50-59	27	4.8
40-49	20	5.4
30-39	7	6.0
20-29	3	6.3
10-19	2	8.0
Not Included	4	---
	Total 134	Overal Mean 4.8

*The reader is reminded that the highest ranking is 1 and the lowest ranking is 10.

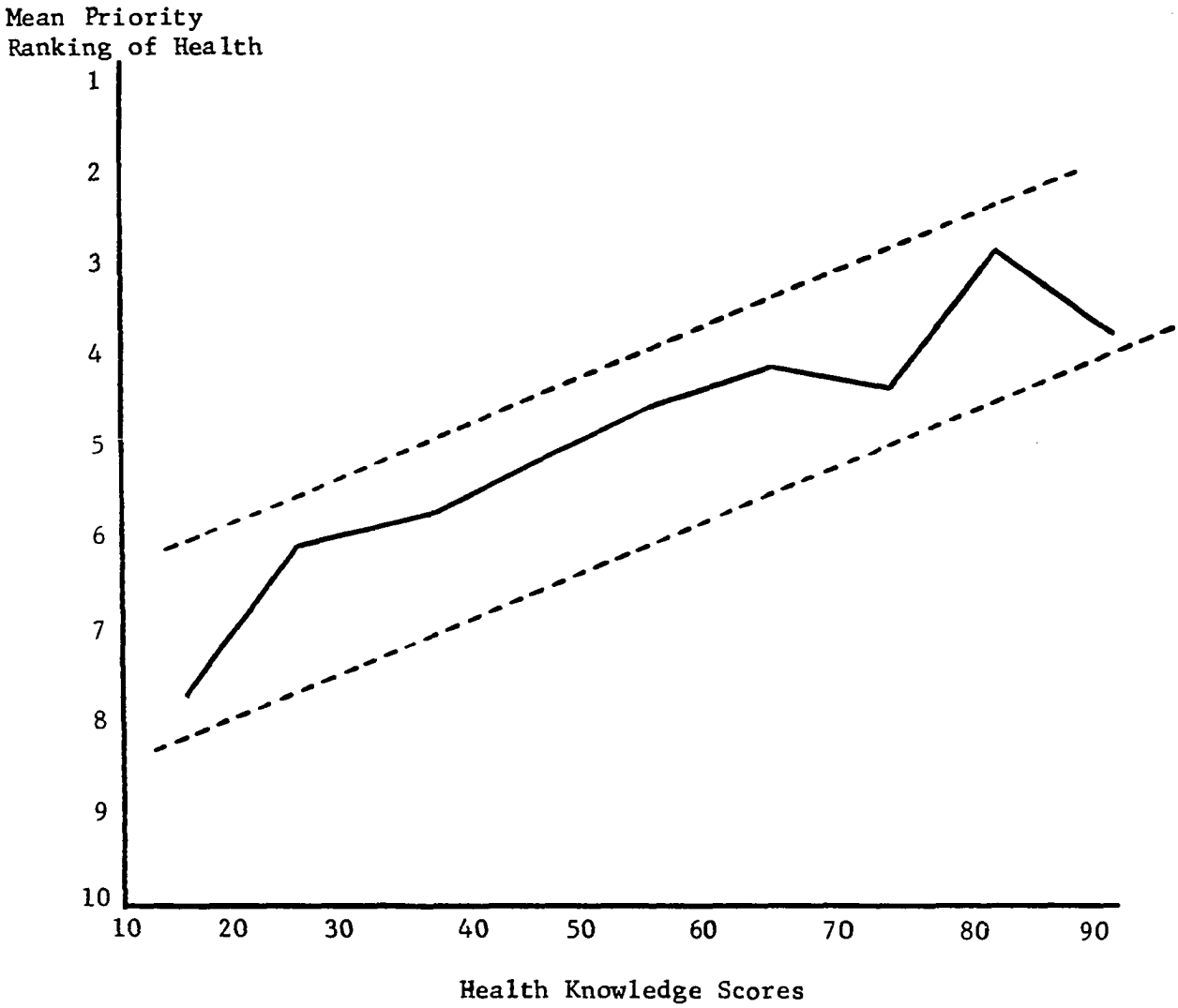

Figure 1. A graph depicting correlation between legislators' priority ranking of health and their knowledge of health. Note: On this scale the one represents the top or highest ranking and then value decreases to the least or lowest ranking of ten.

and for misinterpreting questions. Secondly, the priority rankings must also be viewed with necessary qualifications. These rankings do not reflect emphases other than those afforded by the one through ten scale. Moreover, the research strategy calls for a ranking based on need for added funds at a specific point in time. And, lastly, the mid-range of scores (40-80) do indeed reflect small differences in priority ranking. Figure 2 reveals that the bulk of the scores do fall within this range. As indicated in Table 6, the difference in priority ranking from the bottom of this mid-range to the top is only .7. This means that slight changes in priority ranking accompany large changes in scores among this group.

Clearly, a need for verification of this hypothesis exists. For example, the clear identification of which variable plays a dependent role and which is independent in nature will require research of a much more exacting nature than has been done here. In spite of their inconclusiveness though, the data do provide some early evidence of positive correlation between these two variables. This correlation is sufficient to justify tentative acceptance of the hypothesis. More will be said of the implications of this for the health statesman in the next chapter.

There may be intervening variables in determination of legislators' priority ranking of health. This study seeks to shed light on one of these - the notion that legislators' experiences with personal health problems affect their political position in health affairs. Questions C - 9 and C - 10 were imbedded at different points in the interview schedule in an attempt to determine the degree of personal contact

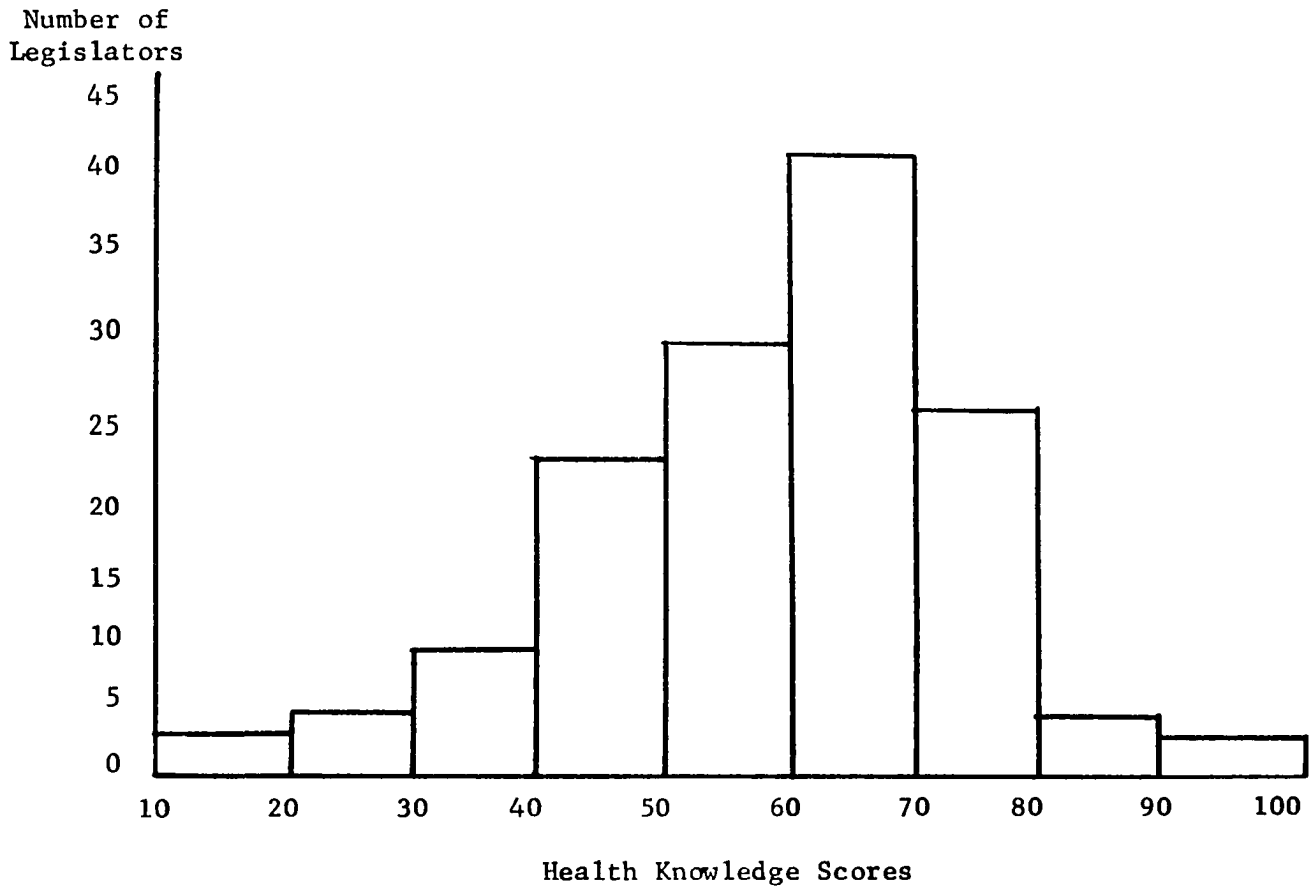

Figure 2. A graph depicting frequency distribution of the health knowledge scores of Oklahoma State legislators, 32nd session, 1969 and 1970.

with health care. The responses to these questions have been aggregated and polarized. They appear in Table 7 and are shown in relation to the priority rankings of health by those legislators in either group.

If personal contact with health care tended to produce a high degree of sympathy for health in public affairs by legislators, the mean priority ranking shown on the first line of Table 7 would be high (close to 1.0). Conversely, the ranking of those legislators with no contact would be low (close to 10.0). The findings do not support this hypothesis. The seventy legislators who felt they had experienced a high degree of personal contact with health care ranked health on an average of 4.81 among nine other state programs. Those with a small extent of contact ranked it at a slightly higher level. Actually, the difference in priority ranking between the two groups is so small as to make it totally insignificant. This finding infers that in general there is no relationship between extent of personal experience with health care and priority ranking of health. Again, this posit is highly tentative and requires much more research for verification.

In this connection two criticisms of the research design are in order. First, the questions included for measure of this single intervening variable actually measure two different things. Question C - 9 measures the emotional impact of acute illness. Question C - 10 measures the extent of contact with medical and health care over time. Another major consideration not included in the research design but certainly exerting a contaminating influence is the respondent's contact with health care resulting from professional and civic activities.

TABLE 7

EXTENT OF PERSONAL EXPERIENCE WITH HEALTH CARE IN RELATION TO PRIORITY RANKING OF HEALTH BY OKLAHOMA STATE LEGISLATORS, 32ND SESSION, 1969 AND 1970

	Number of Legislators	Mean Priority Ranking of Health
Personal Experience - Yes	70	4.81
Personal Experience - No	60	4.83
Incomplete Data	4	----
	Total 134	Overall Mean 4.82

Although the data show this intervening variable to be a neuter in relation to the total picture, the author hastens to add evidence of strong operation of this variable, both positively and negatively, on an individual basis. The interviews clearly reflect in a number of ways the influence on priority ranking of health of the legislator's personal experiences in health. It appears that the positive and negative influences are in balance. In spite of the offsetting effect involved the nature of personal experience seems to operate as an important factor on an individual basis in health affairs. This variable shows great potential for wielding of influence in attitudes of individual legislators toward health care, even though it balances out in the aggregate.

Hypothesis number two suggests that state legislators are prone to give priority to state programs other than health. Analysis of the responses to Question A - 13 suggests that legislators far and away favor education as the top priority program in state government. Health and highways and roads follow at a considerable scale distance and are closely situated to each other. The next grouping some scale distance below is composed of economic/industrial development, public safety, and penal and correction. These data indicate that only education (public schools and higher education) are favored over health. In this connection, though, attention is invited to the relatively small amount of state funds appropriated to health.[2] Also, the very low regard for health suggested by responses to Question A - 1 is relevant.

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[2]These data are shown on Page 115.

In the research design hypothesis number three is stated in this way. Though a matter of increasing concern in state government, health affairs are still not popular issues in Oklahoma politics which generate widespread public and legislative interest. Or, stated in the form of a question this proposition might be phrased, "How is health seen by legislators and why is it a neglected area?"

Several elements of data from the previous chapter support the notion that health is a neglected area in Oklahoma politics. The overall priority ranking of health by the legislature at the mid-point among state programs (Question A - 13) certainly reflects the absence of great concern in health affairs. This is incongruous in view of the broad, national concensus that the United States is in the throes of an appalling health care crisis (as discussed fully in Chapter I). The relatively meager appropriations to health mentioned earlier serve as another indication of only moderate concern by the legislature with health affairs. And the dearth of health legislation proposed during the Thirty-Second Oklahoma State Legislature provides further evidence. This matter is discussed more at length in Chapter IX.

Perhaps the most pertinent and revealing data on this hypothesis derives from the expressions of the legislators themselves during the interviews. There follows a distillation of these views as summarized by the author from quotations and notes made during the interviews.

Yes, health is a neglected area in Oklahoma politics and necessarily so for several reasons. First, the legislators are only part-time politicians and are amateurs in public affairs. They are not a wealthy group and have to devote much of their time to their profes-

sions, businesses, or trades. The legislators have special problems in studying and understanding issues because they lack adequate staff and other resources to do so thoroughly.

There appear to be in Oklahoma politics many more demanding, more pressing problems than health, e.g., education, commerce and industry, roads and highways, welfare, etc. These issues are far more tangible and visible. Moreover, such programs are supported by strong interest groups which maintain active lobbies. The legislators are forced into making decisions between competing demands. Realistically, they can satisfy only some of the needs and "somebody" will be shorted. That "somebody" is often health. There are other factors accounting for this phenomenon, too.

The practice of medicine and medical care have historically taken place exclusive of government involvement in Oklahoma. The legislators have an orientation to this tradition of long-standing. They tend to dichotomize the health care alternatives in terms of no government involvement at all versus socialized medicine. The role of the state medical society in this matter is subtle but effective. This statement is supported by the data of Questions B - 9, C - 3, and B - 12.

Another important factor in explaining why health affairs are not popular issues in Oklahoma politics is the fact that health lacks a constituency. People do not have health on their minds unless they experience illness and this occurs infrequently - especially among those most influential politically, the affluent, the productive portion of society, the middle class. While health is not high in the minds of the voting public as a state issue, schools are because many people have

children in school on a daily basis; roads are because people drive on them daily; etc. These programs relate historically to state government. Health and medical care do not. When people do become interested in health their natural inclination is to look to the medical profession or the federal government for action.

As reflected by the data of Questions D - 1 and D - 11, the legislators themselves are highly dependent on the federal level for action and innovation in health affairs. They disagree strenuously and almost unanimously with the philosophical aspects of this dependency. But they agree almost to the man with the practical necessity of it under the constraints of the relative revenue raising capabilities of the two levels. They do not like having to look to the federal government for solutions to health problems, but they do it because they have to. Given these circumstances it is only reasonable that health affairs would not be a major concern in Oklahoma state government.

In this connection the following impressions derived from the interviews are relevant. People do not like to think of illness, pain, surgery, injury, and death unless it is forced upon them. These are unpleasant topics. The public in Oklahoma would rather think of positive things - those which improve and enhance daily living. The bulk of the electorate would rather concern itself with something other than health. Penalogy is similar to health in this respect: it represents great social and economic problems, but few want to talk about it. Politicians show greatest concern with those issues which are high in the minds of voters - they must do this to survive politically. If felt needs in health care do not become visible among the general elec-

torate, it is only natural that state legislators devote their limited time and resources to more popular matters.

On the other hand, growing pressures for improvements in health care may arouse greater public concern. The issues of health costs and shortages of health personnel are becoming especially controversial in Oklahoma. In this connection the news media play a major role. But, by and large, hypothesis number three is supported by the data of this study at this point in time. The legislators, it seems, simply reflect the psychology of the people as a whole. They represent an aggregation of individual attitudes and they, as does the Oklahoma public in general, tend to take health for granted, to rely on the medical profession, or to rely on the federal government. At least, these are the attitudes derived from a synthesis of expressions taken from the 134 interviews of this study.

Legislators' Perceptions of Health Professionals

This section explores the data pertinent to hypothesis four: state legislators perceive health professionals in a way contradictory to the way these professionals see themselves. Implied in this postulate is the assumption that we know how health professionals see themselves. Considerable research has been done in the self-perception of health professionals, but much more is needed. Do we know, for example, that most hospital/health administrators do indeed see themselves as health statesmen? For purposes of this study a few broad generalizations are assumed, thus allowing us to cut through to the heart of the matter relative to legislators' perceptions. For example, it seems reasonable

to assume that pharmacists see themselves as professionals, not as businessmen; that physicians see themselves as the dominant professional group in health; and that the leaders in Health Administration see a need for health statesmen.

The questions of Category B probe a broad range of legislators' perceptions of the health field. In Question B - 1, for instance, only twenty-five percent of the respondents visualized a health professional when asked what meaning for them had the term health statesman. Nearly one-half of them responded that it had no meaning at all. The responses and selected quotations to this question intimate that a few legislators conceptualize the idealized model of health statesmanship,[3] but some three-fourths of them do not.

If the health statesman role is to be performed in Oklahoma in a way visible to state legislators, which professional group is best suited to do this? Physicians are, in the eyes of state legislators; or, at least, the findings of Questions B - 9 through B - 11 suggest this. Some sixty-six percent of the respondents feel that medical doctors should be very influential in formulation of state public policies relating to health. Thirty-two percent see hospital/health administrators in this role; nineteen percent view registered nurses this way.

Questions B - 12 and B - 13 shed further light on legislators' perceptions of physicians in health affairs. Some sixty-four percent of the lawmakers see medical doctors as either the group in ultimate authority, playing a dominant role in shaping public policy or as a very

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[3]This statement refers to the health statesmanship model as developed in Chapter II.

effective group which influences health affairs greatly. In contrast with this, the legislators perceive individual physicians in an entirely different way. Only twenty-six percent of the respondents see the typical medical doctor as an active participant in shaping health affairs. This distinction in view of physicians as a group and as individuals reinforces the role of the professional association in public affairs as described in Chapter III. It also infers the operation of elites within medical societies as suggested by Garceau, Knowles, and others.

Item B - 2 shows that a two-third majority of the legislators surveyed favor group medical practice. Only thirteen percent of them prefer solo practice. Also, thirty-seven percent of the respondents favor the proposition that medical doctors who work full-time in hospitals be paid salaries by the hospitals as opposed to the charging of separate fees to each patient (Item B - 8). These findings are somewhat surprising in view of other more conservative attitudes held by the legislators. For example, only thirty-eight percent agree with a proposal to organize and further coordinate the American Health industry; and thirty-nine percent favor abolition of charitable immunity for hospitals in Oklahoma.

Contrary to the current trends and the legal precedent set by the Darling Case,[4] only forty percent of the respondents believe that the hospital governing board is legally responsible for the general

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[4]Darling vs. Charleston Community Memorial Hospital, 211 N.E. 2d, 1965. This Illinois court case and its implications are discussed in Problems in Hospital Law as prepared by the Health Law Center, Pittsburgy, Penn.: The Aspen Corporation, 1968. p. 84.

quality of medical care in a community hospital.

Of those surveyed sixty-seven percent favor state licensure of hospital administrators. This finding is somewhat surprising since a bill requiring such licensure of medical technologists was defeated in committee during the legislative session in which this survey was conducted. Another seeming inconsistency is suggested by the following data. Some seventy-seven percent of the respondents feel that the health care resources in Oklahoma do not meet adequately the health needs of the people. And the aggregate ranking of health is second only to education in priority of need for funds. Even so the actual appropriation of funds for state health programs is relatively low.

Item B - 13 provides some data on legislators' perceptions of the relative prestige of professional/occupational groups. Several items stand out here as noteworthy in view of findings from other occupational prestige studies. First, the scale distance between medical doctors and the other health professionals is greater than might be expected. Also notable is the aggregate ranking of school teachers well above all health professionals except medical doctors. The position of registered nurses well above that of both health/hospital administrators and medical social workers is unexpected. A number of explanations for these seemingly anomalous findings are possible, but more extensive research must be done before explanation can be made. Some attention is given in the next chapter to implications of these data for the health statesman.

Relative to hypothesis number five it is apparent from the data presented above that the legislators by and large do not perceive

health/hospital administrators as health statesmen in the sense described in Chapter II. More will be said of this, too, in the next chapter.

The last hypothesis relevant to this section is number six: state legislators are inclined to associate health and medical education with health services rather than with state education. The responses to Question B - 5 suggest that this proposition is tenuous. Only eleven percent of the respondents associated the Oklahoma Medical Center primarily with health services. Thirty-three percent of them selected the answer choice which includes all three of the traditional functions of medical centers. When pressed by the investigator to choose one of the three, most of the thirty-three percent chose education with research next in line.

Decision-Making Behavior

The questions of this section are designed to probe the behavior of legislators as they approach pending health legislation. The processes by which they make judgments and the ways in which they represent their constituencies in health policies are the primary concerns here.

Hypothesis seven posits that state legislators are not sufficiently knowledgeable in health affairs to render independent judgment on pending health legislation. Item C - 8 deals directly with this question and provides response data in support of the postulate. Some seventy-eight percent of the legislators surveyed agreed that they are not sufficiently informed on pending legislation and that they should seek the counsel of health professionals in deciding how to vote (hypothesis eight).

To whom, then, does the legislator turn in getting such counsel? Items C - 1 and C - 2 are designed to explore this question. In general the response data indicate that legislators pursue all useful sources of information. These findings are augmented by investigator notes and impressions. While elaborating on the subject the legislators, as a whole, assert that they listen to any interested party or group who wish to be heard and who voice their position in a lawful and socially acceptable way. These findings are not particularly useful to us, but they do fit the theoretical role of the politician as established in Chapter I.

The data yielded in Item C - 4 provides better information on decision-making influences as it calls upon respondents to rank the groups which are influential with them. Here a surprising response is noted - the administrator of the State Health Department is decidedly the number one choice in terms of aggregate ranking. Closely clustered behind this state official are the Oklahoma Medical Association, the legislators' family physicians, and Legislative Committee Recommendations. The next grouping contains the electorates in general, the Oklahoma Hospital Association, and hospital administrators. Notably the legislators' close friends and associates and influential members of their electorates are ranked among the choices given as the least important group to whom the legislators would turn in getting advice as to how to vote. The administrator of the Department of Public Welfare was a popular "write-in" choice of this question.

Since the respondents ranked the administrator of the State Health Department quite high in Question C - 4, it is likely that the

choice "Health Administrators" in Question C - 2 was interpreted by the confidents as referring to medical doctor administrators within state government. Otherwise the high ranking of "Health Administrators" in C - 2 is inconsistent with the generally lower regard for "Hospital/ Health Administrators" in responses to other questions in the study.

Questions C - 4, C - 5, and C - 6 were designed to see if the respondents materially altered their ranking of sources of voting advice as the subject matter of pending health legislation was altered. The findings of the pilot study show little such differentiation. It is important to add, however, that these findings are likely to be invalid. These were the last questions asked during the interviews, and respondents seemed not to give the thoughtful consideration to these questions as was generally accorded the others. In short, the point of diminishing returns in attention span of respondents was often reached as Question C - 4 was asked. Because of this Questions C - 4, C - 5, and C - 6 were dropped upon completion of the pilot study.

Hypothesis nine posits that hospital/health administrators, as a group, are fulfilling a role of health statesmanship relative to the Oklahoma State Legislature. The data of several questions in the study provide an abundance of evidence with which to evaluate this proposition: Questions B - 1, B - 4, B - 9, B - 10, B - 12, B - 14, C - 1, C - 2, and C - 4 are all relevant. Analyses of these data strongly suggest that hypothesis number nine is invalid. Neither hospital administrators, staff and members ot the Oklahoma Hospital Association, executives of the Blue Cross/Blue Shield Association, nor Oklahoma Hospital and Health Planners are visible to state legislators as health statesmen. Moreover

it would appear that these groups are only nominally effective in influencing state public policies in health affairs.

Of those health professionals identified by the legislators as being health statesmen, the administrators of the State Health Department, the State Mental Health Department, and the State Medical Center were mentioned most frequently by the respondents. These officials along with members and staff of the State Medical Association, and legislators' private physicians were found to be far and away more influential in state health affairs than any other health professionals.

The data are somewhat confusing because the term "hospital/health administrator" does not have a clear and uniform meaning for legislators. Some ambiguity may be dispelled by defining terms as seen by the legislators. Generally, they perceive a "health administrator" as being a professional trained in medicine and heading a state health program or institution. They see "hospital administrators" as being sub-professional business managers. They identify Blue Cross/Blue Shield staff members with the insurance/commerce industry - not health. The legislators do not seem to have any image at all of those persons who work in the health planning groups in Oklahoma.

Since hypothesis nine is invalid according to the findings, hypothesis ten becomes irrelevant. Number ten suggests that the process of becoming politicized the hospital/health administrator executes the role of health statesmanship in a way quite similar to spokesman of other interest groups. The data indicate overwhelmingly that hospital administrators, individually and as a group, have not become politicized relative to the state legislature. Analysis of the data reveals only

two items concerning hypothesis number ten: (1) to the extent that hospital administrators do become political they are seen much as any other lobbying group and their interests are viewed as being narrowly oriented to hospital operations, not broadly oriented to general health needs and problems; and (2) those health professionals who are found as being influential in state health affairs, medical doctors in the executive branch, executives of the state medical association, and legislators' family physicians, probably influence in a way quite different from other interest groups. (Confirmation or refutation of this posit would take a full study in itself).

Hypothesis eleven proposes that legislators' priority ranking of health is directly related to the extent of their personal contact with medical care. This proposition is closely related to an intervening variable of the working hypothesis, i.e., the psychological impact of care for acute illness. In other words, we are discussing here two closely linked but distinct variables: attitudes arising from extent of contact with medical care over time versus attitudes arising from the intensity of traumatic experience in acute care. Because of the close connection between these variables the data relative to hypothesis eleven are presented with discussion of the working hypothesis early in this chapter, pages 162-175. It is clear from this discussion and the information shown in Table 7 that legislators' priority ranking of health is not directly related to the extent of their personal contact with medical care. At least the data show the net effect of this variable to be negligible on an aggregate basis. As discussed, the extent of contact does seem to have a definite effect on health attitudes on an

individual basis. This effect seems to be both positive and negative with the opposing influences virtually offsetting one another.

Underlying Political Values

This section is designed to investigate some of the legislators' political philosophies and predilections which are relevant to health affairs. The future role of state government in health affairs is uncertain. In order to achieve some early insight into what this future role might be more information is needed on the fundamental values of legislators in health affairs. So this section is designed to provide some early data on this question.

Hypothesis twelve posits that state legislators tend to be politically conservative relative to health affairs. Ten questions are included in the study for testing of this hypothesis: Questions D - 1, D - 2, D - 3 (two parts), D - 4, D - 5, D - 6, D - 7, D - 11, and D - 12. Each of these questions sets forth a politically liberal or conservative proposition and offers Likert scale responses. The responses are quantified according to values shown in Table 8.

A value of four is considered to be fully liberal, a zero fully conservative, and a two neutral. Any score between two and four represents degrees of liberalism; likewise values between two and zero signify degrees of conservatism. Table 9 shows the aggregate values for the ten items in question.

As shown in Table 9 the mean aggregated value of all 1,340 responses is 1.97. This indicates that the respondents are found to be slightly conservative based on ten questions in this study and a

TABLE 8

SCHEME FOR ASSIGNING LIKERT VALUES TO RESPONSE OF QUESTIONS D-1, D-2, D-3, D-4, D-5, D-6, D-7, D-11, AND D-12

Response	Value
a. Strongly agree	4
b. Mildly agree	3
c. Undecided	2
d. Mildly disagree	1
e. Strongly disagree	0

TABLE 9

Aggregate Likert Values of Ten Interview Items
on a Conservative - Liberal Scale

Question Number	Topic	Aggregated Value of Responses
D - 1	Larger Federal Role in Health	1.71
D - 2	Health Care as a Right	2.46
D - 3 (1)	Organ Transplants for Indigents-Costs	1.54
D - 3 (2)	General Medical Care to Indigents-Costs	1.87
D - 4	Social Insurance Principle	1.38
D - 5	Comprehensive Care for Indigents	2.46
D - 6	Federal Government Health Insurance	1.30
D - 7	Greater Organization of Health	1.81
D - 11	Altering Priorities to Get Fed Funds	2.31
D - 12	Expansion of State Health Services	2.87
	Mean of Aggregated Value of Responses	1.97

Likert scheme of quantifying responses. Viewed from another perspective, some seventy-one respondents score on the conservative side as a result of individual responses; fifty-four are categorized as liberals; and nine scores are recorded on the neutral point of 2.0. The percentages are fifty-two percent, forty-one percent, and seven percent, respectively. These data provide some foundation for hypothesis twelve, but the support is so meager as to make the hypothesis tenuous. The proposition really suggested by these data is that Oklahoma state legislators as a group stand at about mid-ground in their philosophical/political views of health care. Even this must be viewed as being highly tentative since the ten Likert scale propositions have not been standardized.

Table 9 provides much more concrete information relative to legislators' predilections as a group relative to specific issues. For example, they tend to be moderately liberal in viewing health care as a right, in favoring expansion of state health services, and in altering local priorities in order to get matching federal funds. Though favoring health care as a right, the legislators feel that our society lacks the resources to make good the guarantee thus implied. With some tendency toward conservatism the legislators disfavor greater organization of health care and feel that the federal government role in health should be reduced. The issue with which the legislators exhibit greatest conservatism is their opposition to federal government health insurance. This information on the attitudes of legislators on major issues should be valuable to the health statesman as he goes about developing a statesmanship strategy. More will be said of this in the next chapter.

Hypothesis thirteen proposes that the majority of state legislators disagree with the concept of health care as a right of American citizenship. The findings of Item D - 2 suggest rejection of this postulate. About two-thirds of the legislators registered agreement with the concept that recipiency of high quality medical care is a right of citizenship. Only one-third disagrees with the concept.

Before accepting these data at face value, though, more analysis is necessary because other findings firmly contradict those of Item D - 2. For instance, Item D - 3 discloses that the respondents feel overwhelmingly that the government cannot afford to provide specific health services to those unable to provide for themselves. Item D - 4 deals with a practical application of the health care right concept, i.e., the social insurance principle as embodied in the Medicare Program. Only twenty-seven percent of the legislators favor application of this principle in even the case of the aged.

This conflict in attitudes toward principles versus those of practice bears some analysis. For one thing, it is likely that the legislators agree with the concept of health care as a right in an ideal, abstract sense, but cannot agree that actual application of the concept is economically feasible. Another explanation of this conflict lies in the fact that many respondents seemed to overlook the implications of the proposition in Item D - 2. The proposition infers, of course, that, being a fundamental right, health care will be furnished by the government to those who cannot get it on their own. The government thus assumes responsibility for the personal health care of the citizenry. Another implication of Item D - 2 sometimes missed by respondents is that

a uniform, high quality medical care will be rendered to all. In other phases of the interviews legislators who previously agreed with D - 2 would espouse varying levels of health care based on ability to pay. Again, the cultural and traditional orientation to the Protestant ethic, laissez faire, etc. comes to play.

The basic structure of the research strategy in this study renders the data on hypothesis thirteen inconclusive. Nevertheless, there are some indicators. It is likely that most of the legislators agree with the ideal that high quality health care should be a right of citizenship. Even more of them, it would appear, agree that society in general, not government, is obligated to see to the health needs of the poor. In this sense provision of adequate health care is seen as a moral obligation of society rather than as a legal right of the individual. It is likely, further, that most of the legislators feel actual operation of either concept, moral or legal, to be totally unfeasible.

In the words of one legislator, "The expectation that one shall be provided high quality health care simply because he is alive must end in disillusionment. There is no more substance to an actual moral or legal right to health than there is to peace of mind - even though both are good". In aggregate, the legislators reflect that health care as a right is not popularly recognized as such by the public in general. Even though every major health organization in the nation has adopted this principle as basic policy, the public at large (at least in Oklahoma) does not manifest awareness of, or need for, this concept. This poses problems for the health statesmen. Although many may agree philosophically with health care as a right, it takes the belief and concur-

rence of the people to make a right meaningful.

Hypothesis fourteen suggests that state legislators are predominantly concerned with rural health needs. This idea is based on the rationale that a state with strong rural, agrarian heritage will continue to concern itself inordinately with rural needs long after the majority of its population is relocated to urban centers. The findings in Item D - 10 tend to invalidate this hypothesis and its rationale. It is interesting to note that more rural legislators were interviewed than urban, but urban health needs were viewed as being slightly greater.

This completes analysis of the data in light of fourteen of the fifteen hypotheses in the research design. The last hypothesis deals with legislative behavior in health affairs. This proposition along with its implications for the health statesman will be discussed in the next chapter.

CHAPTER IX

POLITICS AND THE HEALTH STATESMAN

Fundamental to all research is the quest for truth and knowledge. So one contribution of this study, it is hoped, would be the adding of some specific data to what is known about the relationship between politicians and health professionals, the attitudes and values of politicians toward health issues, and the operation of health affairs in the political world. But more than this, it is hoped that the study could have something useful to say to the health statesmen who earnestly strive to improve the health of our society.

In this connection Chapter IX seeks to relate the theory and findings of the study to the pragmatic world of the health statesman. In earlier chapters the theoretical bases for the operation of health affairs in politics were established. Also, the findings were presented and analysed. Now come the questions: So what? What does all this mean? How does the study contribute to the health care field? This chapter deals with such questions as attention is given first to general legislative behavior in health affairs, then to the need for health statesmenship, and finally to specific ways in which a health statesman might assert influence at the state level.

Some specific data support the first discussion on legislative behavior. The findings presented earlier underlie by inference much of

the discussion throughout the chapter. However, most of the concepts presented here are based on impressions derived generally from the study. Although impressionistic, these generalizations seem plausible enough for posit of some theoretical constructs.

Legislative Behavior in Health Affairs

Hypothesis fifteen posits that the voting behavior of Oklahoma State Legislators is generally consistent with their expressed attitudes in health affairs. The original research design calls for testing of this hypothesis through comparison of actual voting records with attitudes uncovered through interviews with legislators. This strategy presumes that bills involving major health issues do reach the floor sessions in roll call vote so that the voting position of each legislator may be ascertained. This assumption appears to be incorrect.

Examination of House and Senate Journals[1] and weekly legislative reports,[2] attendance at legislative committee hearings, and observation of floor sessions reveal that few major health bills arrive at the point of roll call vote. Of those which do, the issue seems to have been settled in advance, for the voting is typically unanimous. In short, there appeared during the span of this study no issue comfrontations at the point of roll call vote; thus no basis exists for rela-

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[1] Journal of the Senate, First Regular Session, Thirty-Second Legislature, 1969, published by the State of Oklahoma, 1969; and Journal of the House of Representatives of the Thirty-Second Legislature, First Regular Session, 1969, compiled by Louise Stockton and Allen Owens, and published by the State of Oklahoma, 1969.

[2] Oklahoma Legislative Reporter, Leroy A. Ritter, ed., published weekly by the Oklahoma Business News Company, Oklahoma City, Oklahoma.

ting voting behavior to expressed attitudes.

To elaborate, those bills dealing with health care, public health, mental health, hospitals, physicians, medicine, etc. which reached roll call vote were, at best, only tangential to the big issues in health today. As one compares the import of health legislation introduced at the national level with that considered by the Oklahoma Legislature, the contrast is stunning.

Those bills which did reach the voting phase during this study may be divided roughly into three categories: (1) those dealing with licensure and qualification of health professionals and facilities; (2) those dealing with appropriations for health programs and institutions; and (3) a miscellaneous grouping which includes child immunization, safety standards, air pollution, etc. The genesis for much of this legislation seem to emanate from vested interests, jurisdictional disagreements, and professional disputes. The principals to such legislation are usually opposing interest groups. Rarely is the general public involved. Most of the legislation studied during the Thirty-Second Regular Session dealt with matters well within the more narrow confines of the traditional state role in preventive medicine and public health.

The appropriations bills do offer some prospect for major issue involvement. Expansion of the state medical center, for example, became controversial. But the controversy relates to competing demands for limited resources, not to whether or not the medical center should be expanded. Typically, such appropriations issues are a response to obvious needs and follow previously established trends in both govern-

ment and medicine. The killing blow to use of appropriations bills for voting analysis derives from the fact that when these bills do arrive at the voting stage, they are usually passed by unanimous vote.

Notably absent are proposals which deal broadly with the organization, delivery, and control of health and medical services. And it is in these areas where the major issues lie - where the roots of the health care crisis are embedded. Bills reaching the roll call stage by and large do not deal with correction of these fundamental and growing problems.

Some evidence is emerging that broader health legislation is in the offering. One proposal dealing with hospital staff privileges of physicians[3] and one dealing with incentives for rural medical practice[4] were introduced into the Second Session of the Thirty-Second Legislature. Certainly, there is ample evidence of a surge of legislation to strengthen regulatory powers over hospitals and medical care by state legislatures across the nation.[5] At this point in time, however, the necessary legislative confrontations on health issues are not sufficiently present in the Oklahoma State Legislature to offer opportunity for in depth analysis of voting behavior. As a result the testing of hypothesis fifteen becomes impractical.

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[3]Senate Bill Number 468 introduced by Senator Stansberry into the Senate Public Health Committee to broaden eligibility for hospital staff privileges in publicly supported institutions.

[4]House Bill Number 1797 introduced by Representative Conner into the House Public Health Committee to lend funds to medical students who, after graduation, have the option of practicing medicine in rural areas as repayment.

[5]Hospital Week, Volume 6, Number 7, February 13, 1970.

The search for data on legislative behavior is not totally barren, however. Looking behind the absence of issue confrontation at the point of roll call vote, one does discover some useful information relative to legislative behavior in general. The real meat of the matter lies in the political process preceding advancement of a bill to the House or Senate floor. At least, this seems to be the case relative to health issues in the Oklahoma Legislature.

What forces are at work and what processes take place which mitigate against passage of broad health proposals in the Oklahoma State Legislature? And why are these forces and processes so effective even though the legislators themselves complain bitterly about the critical problems present in health care? Several likely possibilities emerge from the study in answer to these questions.

First, there is the subtle but effective influence of organized medicine. Major changes in the organization, delivery, and financing of health services are inimical to the values of private medicine. Although there are indications of a decline in prestige and influence of medical doctors, the results of the study still show the presence of considerable political power.

Secondly, the limited resources available to the legislature mitigate forcefulfully against new programs or major changes in existing policy. The intense competition for state resources was described in the previous chapter. This factor coupled with the absence of a health constituency certainly works against meaningful legislation in health.

A syndrome of "Let Uncle Sam do it" is at work in the legislature. The typical feeling is that the federal government has usurped

the state's tax powers, that the federal level has commandeered the lion's share of resources, and that it should therefore legislate and pay for large scale social programs. The data suggest that this is the strongest force inhibiting more vigorous activity by the state in health affairs.

There are still other factors which may contribute to the dearth of major health legislation in Oklahoma. The notion that the legislators are basically conservative - that they inherently and philosophically resist change bears close examination.

Data of the previous chapter reveal that the legislators in aggregate stand clearly at mid-ground on a conservative/liberal spectrum in health care. The question arises, then: Are there special groups or elites within the legislature which are distinctly conservative and which are exerting disproportionate influence? The data offer some insight into this question as certain variable traits of the legislators may be cross-correlated with political attitudes. These cross-correlations allow one to see if there are significant differences in political position between sub-groups within the legislature. By this means we may tease out, for example, the attitudes of the leadership in the legislature and health committees to see if it is markedly different from the legislators as a whole. The three variables selected for closer examination are: political party, origin, and leadership status.

Table 10 shows political position of the legislators on health issues by political party. The reader is reminded that the Likert scale system is used to establish political position as described in the preceding chapter. Thus a quantity of 4.0 represents extreme liberalism, a quantity of 0.0 represents extreme conservatism, and a 2.0 rating

denotes the mid-position.

TABLE 10

POLITICAL POSITION OF OKLAHOMA STATE LEGISLATORS IN HEALTH AFFAIRS BY POLITICAL PARTY

	Number of Legislators	Percentage of Total	Political Position
Democrats	103	77%	2.10
Republicans	31	23%	1.53
Total	134	100%	1.97

These data show that there is indeed a difference in political position of legislators according to political party. The Republicans are decidedly conservative and the Democrats are slightly liberal. The position of the total group is insignificantly conservative, as indicated earlier. This information comes as no surprise as one would expect to find those in the Republican Party somewhat to the right of center. The data do not aid either in identifying a group which might inhibit the introduction of broad proposals into the legislature. Naturally the Republicans, by virtue of their 1.53 position, would be expected to behave in this manner. Though certainly exerting an inhibiting influence, the Republicans number too few (only 23 percent) to be decisive. This minority might prove to be effective in case of legislative battles, veto struggles and the like, but the question being tested is proposal of liberal legislation, not final passage of it.

Table 11 shows the same information on legislators by origin, i.e., rural legislative districts versus urban legislative districts.

TABLE 11

POLITICAL POSITION OF OKLAHOMA STATE LEGISLATORS IN HEALTH AFFAIRS BY ORIGIN

	Number of Legislators	Percentage of Total	Political Position
Rural	81	60%	1.95
Urban	53	40%	2.00
Total	134	100%	1.97

As might be expected the rural legislators are slighly more conservative than are their urban counterparts. The differences are slight, however. Again no evidence of a strong restraining force emerges.

The leadership of the two houses and the respective health committees constitutes a logical place to look for presence of disproportionate influence because these are positions of great power in the legislature. Table 12 reflects the conservative/liberal tendencies of the leadership sub-groups and the group as a whole in the legislature.

These data indicate that the leadership in the two houses, in aggregate, tend to be markedly conservative in health affairs, while the leadership of the health committees leans somewhat to the left. For purposes of this study the health committee leadership is identified as the chairman and vice-chairman of the public health committees and sub-committees of each house. Seven of the eight legislators in these

TABLE 12

POLITICAL POSITION OF OKLAHOMA STATE LEGISLATORS
IN HEALTH AFFAIRS BY LEADERSHIP STATUS

	Number of Legislators	Percentage of Total	Political Position
Senate Leadership	4	3%	1.25
House Leadership	4	3%	1.68
Health Committees Leadership	8	6%	2.31
Total	16	12%	1.89
Non-Leaders	118	88%	1.98
Grand Total	134	100%	1.97

positions registered liberal scores. As noted in Table 12 the aggregate rating is 2.31; thus it is difficult to see why, for reasons of political philosophy, the committee leadership would work against broad health proposals.

The data on the leadership of the two houses do suggest a possible power locus with a conservative orientation. The senate leadership is defined as the President Pro Tempore, the Majority Leader, the Assistant Majority Leader, and the Minority Leader. This group scores a Likert scale rating of 1.25. The house leadership is defined as the Speaker of the House, the Speaker Pro Tempore, the Majority Leader, and the Minority Leader. This group scores 1.68 on the scale with the composite score for the leadership of both houses rated at 1.46. This is the most conservative rating of any group measured - even more conservative than the Republicans as a group (1.53). This finding is revealing and suggestive, but caution is in order. For one thing not enough is known, nor does this study examine, the specific role of these leaders in health legislation. In addition, the research design is not exacting enough to be conclusive. The data are noteworthy, though, and connote a fertile area for future research.

The overriding implication appearing from all these analyses of political position is that conservatism is not really the causal factor in the dearth of major constructive legislation at this state level. The legislators are just not that conservative. Moreover, there is no evidence to indicate that constructive legislation to combat health care problems must be liberal simply because new approaches imply change. Solutions could lie in conservative proposals which innovate

new ways to stimulate or capitalize on old institutions, e.g., private medical practice, private enterprise, and the protestant ethic.

Unfortunately creative proposals, either conservative or liberal, require considerable skill, knowledge, and effort. And this brings us back to another force which mitigates strongly against major health legislation in Oklahoma. The legislators lack the resources to develop innovative legislation. They lack the necessary information and expertise in health care. They generally recognize that something must be done to correct problems, but they are uncertain as to what it should be. Traditionally, the politicians have relied on the medical profession for such counsel and guidance. Private physicians are less able to do this today, however, due to growing pressures of their own practice, i.e., technology, super-specialization, overwhelming patient loads, etc. In addition the legislators have become increasingly suspect of vested interest groups. As they see it, each group has "his own ax to grind": physicians, hospitals, nursing homes, nurses, medical education, public health, etc. Each sees health needs from only the narrow view of his own perspective. What is really needed here is a health statesman with a broad, conceptual view.

The Need for Health Statesmanship

Constitutional government in the Anglo-Saxon model is very slow to move and change because of many safeguards. Recognition of a problem is simply the first step in a long process. Much time and effort are involved in moving from the point of recognition to the point of action. Problems are readily identified, but it takes a long time for

a specific need to become recognized as a pressing public problem of high priority. A crucial phase in this process is the point where a problem is selected out among many problems and where a decision is made to do something.

Health care seems to be in this crucial phase in Oklahoma. The problems are fairly well-recognized by those knowledgeable in health affairs. A concensus has not yet developed to the point that health care should be picked out as a high priority item which demands early action. Even if there were a broad-based concensus to do something about the crisis in health, the evidence of this study suggests that there would be considerable doubt as to what should be done. A need stands out, then, for strong leadership in building concensus and in developing effective proposals.

The legislators themselves make it clear that they have a great need for information and expertise in health care. They do not need more counsel from the perspective of vested interest, however. They feel that they encounter enough of this. The call is for some degree of objectivity with benefit of the public uppermost, not the interests of health professionals or institutions. Counsel of this sort is rare and perhaps idealistic, but this is the stuff that professionalism is made of. Characteristically, a profession is given the authority and responsibility by society for meeting one of its needs. Implicit in this understanding is the trust that the profession will keep society's needs ahead of its own interests, that it will exercise authority only to meet its responsibility. So what is being called for here is statesmanship of high quality, not only in terms of skill but

also in terms of motive.

In order to meet problems inherent in the health care crisis described in Chapter I, innovative programs and policies are essential. As established in Chapter III, the medical profession has played the role of a health care elite in determining the organization of medical care for the nation. This degree of influence is becoming increasingly tenuous for reasons also stated in Chapter III. John Knowles sums it up well when he says, "When authority becomes complete and final with doctors ... on what is or isn't going to be done, inevitably you will find the decisions frequently are made in favor of the doctors and not necessarily the patients. Harold Laski said that the 'expert sacrifices wisdom to the intensity of his experience'. In other words, the expert, by virtue of the intensity of his experience, loses perspective; he can't play the role of the statesman; he can't stand off and look objectively at what is good for whom".[6]

The administration, organization, and management of health care have simply become too complex for the practicing physician to cope with, especially so as the already huge demands of practice are continuing to mount. The propulsion of health care into government was also established in the early chapters. This new political dimension to health care has further reduced the influence of practicing physicians in health affairs. Expertise in political science and other social sciences now becomes as relevant to health affairs as is knowledge of medicine.

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[6]John Knowles, "The Physician in the Decade Ahead", Hospitals, J.A.H.A., Volume 44, Number 1, January 1, 1970, pp. 58-59.

The data of the study show clearly that neither hospital administrators, registered nurses, health planners, or health insurance executives are fulfilling the statesmanship role. Those coming closest to it according to the data are non-practicing physicians who head elements of state government and even in these cases the role is circumscribed by the functional mission of the department or institution headed. So what emerges is the fact that there is a large leadership vacuum in health affairs in Oklahoma. And this is occurring even while health is becoming more and more a public issue.

The principle implication of this situation relates to the future role of Oklahoma State government in health affairs. Continued laissez faire and timidity in this area will inevitably leave the state to simply follow along and react to programs and policies developed at the national level. The need for health statesmanship has much to do with whether or not Oklahoma chooses and is capable of retaining some degree of self-determination in health affairs.

Some experts maintain that by its very nature health programs must be legislated at the federal level. Some sound arguments support this position and the proposition bears consideration. But there are also strong points favoring extensive involvement by the states. From the perspective of the states the most important element of this controversy is that the states participate in the decision as to the extent of their involvement in health programs. It is one thing for a state to think through and purposefully relate its programs to those of the federal government, but it is quite another for a state to simply tag along with the federal government out of abdication of its constitutional powers.

From the viewpoint of the states a bright opportunity looms on the horizon - the proposal of the Nixon Administration to share revenues with the states and to push authority downward in the levels of government. Mr. Nixon emphasized this approach to government during his campaign for the presidency in 1968. Since assuming office, he has continued to move in this direction. His State of the Union message of January, 1970 re-emphasized this approach, especially with reference to environmental health.

The central theme of President Nixon's proposal is a change in the basic relationship between levels of government. The states and local governments would regain some powers now residing at the federal level; they would have greater opportunity to participate in the shape of public programs; and, most important of all, they would enjoy a larger share of federal revenues with fewer built-in requirements. Mr. Nixon's proposal also has an orientation to involvement of private groups in resolution of public problems. Experimentation and trial programs are to be encouraged.

This whole approach has direct application to health care and offers the states great opportunity for meaningful involvement in setting national and state policies in health. Should Mr. Nixon's proposal be implemented a steady flow of power, authority, and revenue should move to the various state governments. Thus one of the major roadblocks to meaningful involvement by state government in the health crisis would be moved aside.

One ingredient prerequisite to successful implementation of Mr. Nixon's proposal is evidence that the state governments do indeed

have the competence and wherewithal to handle effectively massive new powers and resources. This is particularly important in health care. If there is indeed a health care crisis in Oklahoma, then positive leadership in planning and action must begin to show the way in resolution of these problems. If the Oklahoma state government would embrace the Nixon proposal fully (and it is assumed that it would inasmuch as the legislators almost to a man decry federal intervention and the state has a Republican administration), then much work should be in progress now to gear up for new powers and revenues. Extensive spade work and planning necessarily preceed major legislation. Some of this is going on in health matters, but not nearly enough - and it is fulfillment of this crucial need for leadership and guidance that cries out for more health statesmen in Oklahoma.

As the health statesman addresses himself to the political system, he should be aware that state government is becoming generally more competent. Some developments are occurring which favor continued viability of state governments in health affairs. The evidence which follows relates to the Oklahoma Legislature in particular, but similar things are happening in state governments across the nation. In the past few years the Oklahoma Legislature moved from biennial to annual sessions. Compensation for legislators has improved consistently and the trend is distinctly toward full-time legislative service. There have been in recent years major improvements in facilities and staffs of legislators. Further progress in resources and personnel is promising and should enable legislators to be much better informed and discerning in evaluating the credibility of data. Full health committees

have been established in both houses of the legislature. The work of the legislature during the interim session has been expanded greatly. This allows for the tedium of detailed committee work to take place in an orderly, purposeful fashion. And, lastly, there is concrete evidence of major revision of the state's bulky constitution either by constitutional convention or by committee revision. In either case there is promise for more effective government in general. All of these things make the legislators more capable of responding to needs. So there is some evidence that state government is gearing up to develop competence and capacity.

Congress, on the other hand, seems to be moving somewhat in the opposite direction toward reduced capacity for response. The great complexity and very nature of politics at the national level are impeding influences. Burning issues like the Viet Nam War, Civil Rights, appointments to the Supreme Court, missile defense systems, etc. tend to tie the Congress in knots and impede its functioning for prolonged periods. The very size of the Congress relative to state legislatures renders it cumbersome. The intense competition and demand to be heard by many interest groups causes many delays. As evidence of this, the Congress did not complete its appropriations for fiscal year 1970 until almost one-half of the year had expired. Demographic trends and cultural differences cause many difficulties for Congress. A relatively small number of states now hold a majority of the voters. There are wide cultural, political, economic, and social differences among the states. These conditions create for Congress special problems in "targeting" legislation, i.e., tailoring the appropriate programs and

policies to the diverse needs of widely varying groups. This last point applies especially to health care - in this area the state legislatures are closer to the people and have a much better feel for the needs, problems, and values of the citizens of a particular section of the country.

Many authorities claim that state government is dying and soon to become extinct in health affairs. This may happen, but the indicators for the near future suggest some movement in the opposite direction. Perhaps the greatest opportunity for state government to remain a viable force in health care lies in its central role in comprehensive health planning. This also represents great opportunity to the health statesman. It gives him access to key decision centers and it provides him with a medium for application of his forte, planning and design of health care programs and health services delivery systems.

As our society has become more affluent, planning activities have grown in public favor. It is now and will continue to be possible to make more money and manpower available to gather data and to analyze alternatives. In his decision-making model Lindblom[7] seems to take into account the increasing role of planning. Some discussion of the Lindblom model appears in Chapter III. Further treatment cannot be made here, although the interested reader may refer to the literature cited.

The important point to be made for our purposes is the growing role of planning in the decision-making process. The nature of this

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[7]Charles E. Lindblom, The Intelligence of Democracy, Chapter 9, and "The Science of Muddling Through", Public Administration Review, Volume XIX, Spring 1959, p. 79.

planning is both rational and political. The successful planner is likely to be skilled technically in health care but also highly capable in politicking, lobbying, negotiating, bargaining, and dealing with people. This planning process constitutes an ideal opportunity for marriage of the states' efforts to have a hand in health affairs and the health statesman's desire to influence public policy in health. And the public can be the beneficiary of these efforts.

Now, more specific to the health statesman, he may come to the planning table from a position as a hospital administrator, health care administrator, educator, government official, physician administrator, or as a full-time planner. Regardless of his origin the health statesman has to accept the fact that planning and subsequent decision-making must have community acceptance. This is true idealistically in a democratic society, but more pragmatically, any plan not widely accepted in an American community is doomed from the outset.

Full concensus may not always be possible, but it should always be taken into account and sought. Communities are especially dependent on health professionals; thus there is great responsibility and challenge associated with health planning. As described in Chapter II a statesman is needed to meet this challenge, to open himself up to the community, to lead through association, not to be autocratic and aloof. He needs to have sensitivity to consumer concerns and to assist them, while also imputing his own proposals and influencing the final outcome.

The public has authorized and accepted comprehensive health planning. Although there is much difference of opinion as to its effectiveness thus far, a concensus is growing that rational health

planning is essential. This poses singular opportunity for the health statesman to apply his expertise in health planning and his executive leadership.

Influence in Health Affairs

A model of the health statesman was presented in Chapter II. This model was taken from a review of current literature and it represents the role in health affairs which leaders in the field suggest for hospital and health care administrators. The qualities necessary for the health statesman were described in detail. Also, the objective of health statesmanship was presented; we see clearly what it is that the health statesman is supposed to do. In short, he is to exert influence in the political arena (national, state, or local) so as to bring about a healthier society.

The crucial point absent in the literature on health statesmanship, however, is the matter of precisely how the hospital/health care administrator is to carry out this role of health statesmanship. Just how should this administrator relate himself to political issues and politicians? Assuming that the health administrator needs to become politicized and assuming that he has the will and time to do this, the crucial question stands out: how can he become effective in influencing health affairs in a democracy?

As stated in the introduction, one of the primary purposes of this study is to offer some early indications in answer to this question. These indications are based on theory gleaned from both the fields of political science and health administration. And the theore-

tical concepts are backed up by specific data gathered through an examination of the operation of health affairs in state government. Emphasis is placed on the attitudes and behavior of legislators, specifically the Oklahoma State Legislature. These data have been presented and analyzed. The time has now come for translating these analyses of data and the underlying theoretical concepts into practical suggestions which have meaning and relevance to the everyday world of the practicing administrator who wishes to become a health statesman.

Two approaches offer opportunity for influence in health affairs. In reality, these two methods are overlapping and interrelated. For sake of clarity, however, it is useful to discuss them separately. The first approach involves deliberate actions over time designed to bring about formal or informal decision-making through the political system. This approach is planned and carried out by the health statesman. The initiative for what happens and when it happens lies in good measure with him.

The second approach applies in those rare instances when great public interest becomes focused on a health issue or problem. Such a condition usually occurs as a result of circumstance, events, or trends. Public concern of great magnitude may be precipitated by special calamity or by a single notorious incident. The news media are obviously much involved. Since this approach takes place in such a highly charged atmosphere, the health statesman's control of the situation is minimal. In this instance he is principally a reactor and an opportunist. For purposes of identification the first will be referred to as the initiative method, the second as the opportunist method.

Neither method offers a high probability for total success. Enough is known of the American political system to support the notion that hardly anyone gets all that he wants. The key word in our system of contending interests - in our inglorious bargaining associated with carving up of the political pie - is compromise. Thus a statesman wise in the ways of public affairs may set his goals based on idealism, but he measures accomplishment in terms of reality and that which is feasible. Within this frame of reference the initiative method offers the greater chance for success. This is so because the health statesman is more in control when pursuing the initiative method. The final outcome is more related to what he does and does not do than in the case of the opportunist approach. More needs to be said in comparison of the merits and pitfalls of the two approaches, but first the processes themselves bear explanation.

As stated earlier and as evidenced by the empirical data of this research project, health affairs rarely offer issues of high public interest. The public is not involved in most of the decision-making in health affairs at the state level. Accordingly, the principals to these decisions are the legislators, key persons in the executive branch of state government, professionals, lobbyists, and public-spirited citizens with influence (an elite, if you will). The task of the health statesmen, then, becomes a matter of constituency building within this relatively small group.

In approaching this task, the health statesman first identifies that aspect of health affairs which bears influencing. In other words, he determines that decision which needs to be made and/or that action

which should be taken. This is the objective. It is assumed for purposes of this discussion that the health statesman's goal is one based on his informed perception of society's health care needs. This assumption is in keeping with the health statesmanship model developed in Chapter II. It is further assumed that in adopting a goal the health statesman thinks through the all-important considerations of relevance, significance, feasibility, and probability of acceptance of his proposal. Moreover, it is essential that he carefully weigh the resource expenditures inherent in promoting his proposal in light of the anticipated benefit to derive from it. Only if the cost/benefit ratio is favorable should the project be undertaken.

The next phase of action is essentially one of planning. By cognitive process the health statesman plans a strategy aimed at ultimate achievement of the objective. Alternate tactics are examined and gamed. Barriers, constraints, and points of resistance are anticipated. In addition, possible compromises and trade-offs are developed. A control mechanism for review and evaluation of project status at various phases is established.

Following the planning phase, actions are executed step-by-step. Depending on the presence or absence of favorable conditions, the project moves ahead rapidly, slows, or is held in abeyance. The review process at various points suggests acceleration or deceleration. If evaluation discloses only meager progress and dismal prospects for success, the project may well be aborted in favor of other proposals with more favorable expectations.

The health statesman centers his efforts on a specific target group. This group is comprised of the key decision-makers in the area of concern. Obviously, the statesman must be able to identify at the outset the decision centers wherein lies the real power sufficient to effect the proposal in question. His efforts are ultimately aimed at the target group, although the strategy may call for circuitous approach. In a positive sense the health statesman may use others to the extent that they have access or can provide access to decision centers.

The data of this study strongly suggest that decision-makers are influenced by those persons that they know well; those with whom they can identify; those with whom they have good rapport; those whose knowledge and judgment are respected; those who inspire confidence; and, lastly, those who know, respect, and play well the political game of give-and-take. If the health statesman wishes to carry out his role along the initiative approach, he can do it by fitting himself to this model. The role could be executed personally and directly, or it could be carried out through an intermediary (ies).

Powers of personality and persuasion, competence, bearing, stature as a citizen, concern, interest, enthusiasm, and credentials all seem to be centrally involved in executing well the health statesman role. Wide variation in the presence and application of these factors is natural. Success may be achieved even though a number of them are absent. The importance and usefulness of these traits vary widely in relation to geography, time, cultures, and trends. As a generalization, though, these factors are crucial to the initiative approach and should be high in the mind of a health statesman.

More must be said on this point. Application of these health statesmanship qualities on a "flash-in-the-pan" basis is not what is being said here. To the contrary, the relating of these traits to decision-makers over time is the intent. Other things being equal, this study suggests that the degree of influence will grow as the time during which a health statesman relates himself to decision-makers lengthens.

The essence and essential ingredient of the initiative approach is contact with the key decision-makers. This contact may be formal and official through career roles, institutions, organizations, committees, boards, or community activities. Or the contact may be informal and social. Club memberships, social events, sports activities, recreational activities, and general friendship encounters represent contact possibilities. A mixture of official and social contact is likely. Even so, one method or the other would probably be predominant.

During such contact the health statesman may relate himself to decision-makers in a variety of ways. His role may vary from time to time depending on the occasion. He may be alternately a friend, a lobbyist, a professional, a constituent, a consultant, or a number of other roles.

Also, the health statesman varies his technique with the occasion. Timing and appropriateness are important considerations. He may, at times, pursue a "hard sell" of his proposal, hammering away with forcefulness in presenting the logic and desirability of his proposal. Other situations and personalities may call for a "soft sell". Or an encounter may be devoted to simply establishing rapport and gaining the

decision-maker's confidence, with the "selling" to come later. The important thing is that the health statesman recognize early the nature of the decision-maker, that he be sensitive to the techniques which are appropriate, and that he then employ these techniques with adroitness. In a sense the health statesman accommodates himself to the decision-maker on a level which is mature, dignified, and consistent with the health professional's ethics.

The matter of ethics must be included in this discussion. The ethical considerations for the health professional deeply involved in politics are ambiguous and troublesome. The values held in practical political life in a democracy are often at odds with the values of professionalism, especially health professionalism. Pork-barreling, for example, is an accepted practice of long-standing among politicians and modern statesmen. Such a practice is indeed antithetical to health professionals. It must be remembered, however, that the health statesman is playing the politician's game on the politician's home field. And pork-barreling is a fundamental practice in politics. A quotation from one of the leading legislators interviewed is appropo: "I may be country, but I'm not stupid - I won't let my politics (principles) stand in the way of getting for the people the best I can."

If this whole approach is offensive to the reader who deplores the notion the ends justify means, then it is relevant to assert that this notion is to some extent part and parcel of the democratic decision-making process. Means justified through ends is not the key question; it is a practical necessity in politics. The crucial ethical question relates to the nature of the means, i.e., the moral and legal rightness

of the means. This is, of course, a very gray area which entails constant individual and social review in determining the ethical standards which are appropriate at any given point in time.

This is an issue which the health professional cannot ignore if he aspires to become a statesman. He must face it head-on. As the author observes the democratic process in this study, a hard and fast, unyielding line by the health statesman will probably leave him outside the decision-making core and render him ultimately ineffective. Or said another way, the idealist will not long last in the world of practical politics. This does not mean that the health statesman is unprincipled. The term statesman connotes wisdom, dignity, self-sacrifice, and social concern. In the American political system the term also involves a skill in and willingness to scrap politically, to maneuver, to devise strategies, to bargain, and to compromise. To be successful the health statesman must approach his tasks with the latter as well as the former characteristics of statesmanship in mind.

If this analysis implies a cold and calculating motivation by the health statesman, such is not intended. Behavior based on this motivation would be impractical and unsuccessful. It is doubtful that a health professional could politicize himself (herself) unless he felt natural, sincere, and comfortable in the role. Barring this condition, a better route would be for the health professional to work through another who was closer to being the natural political man.

Let us turn now from ethical considerations back to the initiative approach itself. The great obstacles to the health statesman are inertia, competing demands, ideologic and cultural conflicts, vested

interest, and power politics. These are formidable foes and must not be taken lightly. Conquering them through the initiator method seems to be a long, tedious process. The slowness of progress is often in sharp contrast with the rapidity of change and need for action. This approach is also frightfully expensive. The costs of attitude change are enormous. Also, constituency-building over time seems to be a fluid, obscure process. Progress is measured in small advances and is sometimes not measurable at all. The health statesman alternately moves rapidly, slows, does nothing, and then moves out again. Regardless of rate of activity, uppermost in the mind of the health statesman is the fact that he is a catalyst, a stimulator. If anything is to happen, it will be because he stirs the activity. This initiative approach is difficult and often impractical for harried practitioners. Perhaps this is one reason why more do not carry it out. It does, however, offer the important advantages of: (1) a greater likelihood of success; and (2) a higher degree of control by the health statesman.

The second approach involves opportunism. This term, too, may be objectionable to the purist; nevertheless opportunism is precisely what is involved. The health statesman exploits circumstance to influence actions and decisions favorable to health care. The name chosen for this approach may be a poor selection because of the negative connotation usually associated with the term. There is, however, a positive side to this phenomenon equally as powerful and useful as is the negative view.

Although it occurs infrequently, great public interest does rise up on specific health issues. The clamor for nostrum control

early in this century illustrates such concern on the national level. The growing pressures of the mid-sixties for improved health care for the elderly present another example. Popular concern with regional and local health issues also occur. A crisis-type situation is typical. These occasions of great public interest in health constitute rare opportunities for the health statesman to have immediate impact on health affairs.

If the health statesman has been following the initiative method over time prior to the crisis, his capability for influence in a crisis is further enhanced. But even if he has not previously played a statesman's role, he may, by forceful and direct leadership at a crucial time, render considerable influence. Crisis-like situations present two conditions which are important. First, there is an overall, general attitude of need for action or change by the public. Second, public opinion is consolidated with a great intensity. This mobilizes public interest sufficient to provide for the follow-through to insure that quick action does take place. In other words, the public has recognized a problem, is intent on taking action to solve the problem, and in this process, at this time, is especially in need of and vulnerable to the expert leadership of the health statesman.

Great public interest in an issue represents tremendous power over the short run. This power may be looked upon by the health statesman as a potentially valuable asset, particularly if power of this sort is needed for implementation of the statesman's program. It is very difficult and costly to generate public interest and to mobilize public opinion. Development of such interest might take years of effort and

expense, or it may never take place. Thus the very fact that such a situation has come to exist amounts to special opportunity.

The health statesman, then, can seize the opportunity during crises to move for retaining that which is socially good and to exploit public interest to bring about change for that which ought to be changed. In this way the practicing health administrator responds to crises by shifting his energies to public affairs at times when public interest in health has heightened. He alters his usual allocation of time to devote special effort to health statesmanship during such periods. Many of the techniques of the initiative method are employed, but in a much more concentrated way.

In comparing the two approaches to health statesmanship several advantages and disadvantages stand out. The initiative method offers a greater probability of success, takes more time, is more expensive, and presents more opportunity for control of the situation. The opportunist approach, on the other hand, offers some chance for success quickly, is less costly and time consuming, is highly volatile and less subject to control, represents greater danger, and is highly political in nature. The two methods do not compete for selection. One is appropriate to one set of circumstances, the other to another set. The health statesman's decision is simply to determine which approach is appropriate to existing circumstances.

In summary, this discussion has attempted to analyze the health statesman's role. Some early explanations have been offered as to how precisely the health statesman does what it is that he sets out to do. These explanations are based on impressions derived from empirical data

uncovered during the study. The two methodologies analyzed have not been seen as being mutually exclusive. They are presented separately for sake of analysis but merge and overlap in reality. The discussion was not intended to be exhaustive in stating how the health statesman might perform his role. It was explicit, though, in offering explanations on two specific ways in which this role might be carried out within the American social and political milieu.

CHAPTER X

SUMMARY AND CONCLUSIONS

This chapter is a crucial part of the report because it is at this point that theory established in the early chapters is coupled with findings of the later chapters. This is done in order to arrive at the major conclusions suggested by the study. Since this study concerns itself particularly with methodology, there is also included a critique of the research methods and techniques. The chapter and the paper conclude with suggestions relative to future research in this area of investigation.

Before moving to conclusions and critique, though, a brief review is in order.

A Brief Review

The first portions of the report served to introduce the study. Some background information on health care was provided and several often-used terms were defined. The contemporary scene in health was described and the so-called health care crisis was explored. Also, a summation of the research problem was presented at this point. In a word, the research problem was stated as a need for more information about the roles, attitudes, and relationships between politicians and health statesmen. The health of the Oklahoma public and the continued

viability of state government in health may turn in good part on the effectiveness of this relationship.

Chapters II and III presented information from the literature of health administration and political science. This material forms a theoretical framework for the study. The background and values of the field of health administration were stated. A health statesmanship model was established in detail. Relative to concepts in political science, pressure group theory and elitist theory were presented and related to health care. The historical and contemporary influences of the health care elites were assessed. Concepts related to decision-making in a democracy being central to this study, some discussion on this topic was presented in Chapter III with emphasis on the writings of Lindblom.

From another dimension of political science theories of state government were analyzed in Chapter IV. The role of the state in health affairs also received some attention. Chapter V set the stage for the study by describing the setting of the Oklahoma Legislature. In Chapter VI the design of the study was discussed in some detail. Then our attention turned to the findings, first a presentation of the raw data (Chapter VII), and, then, an analysis of the findings with emphasis on testing of the research hypotheses (Chapter VIII).

Chapter IX relates the theory and findings of the study to the pragmatic worlds of the politician and the health statesman. Here commentary is devoted to legislative behavior, an outlook for the role of state government in health affairs, the pivotal position of planning, the need for health statesmanship, and finally two conceptual approaches

for ways in which the health statesman role might actually be carried out. The theories posited in Chapter IX are based on inferences drawn from the findings and overall impressions derived from the study.

Summary of Findings

Relative to priority ranking of health in relation to knowledge of health, the summarized findings reveal some indications that:

1. Oklahoma State legislators' priority ranking of health increases with greater knowledge of health, especially among those legislators in the lower range of health awareness. Among those legislators whose knowledge of health affairs is minimal sharp increases in priority ranking accompany moderate increases in knowledge. The correlation continues to hold for the mid-range of health awareness where the bulk of the legislators are found. At this level, however, the increases in priority ranking are small in relation to large increases in health knowledge. At the upper scale of health awareness the correlation of the two variables itself becomes doubtful.

2. Oklahoma State legislators' priority ranking of health, in aggregate, is independent of the amount of their personal experiences with health care. On an individual basis, though, both the quantity and intensity of such contact were found to be causative variables in priority ranking of health.

3. Oklahoma State legislators rank health in a high position relative to other state programs (second only to education), but this high ranking is not reflected in the amount of resources appropriated to health.

The summarized findings of number three above are consistent with the theoretical construct of the politician as a broker of interests.[1] According to this theory the politician responds to some degree to pressure, seeks compromise between contending interests, and does not always exhibit voting behavior consistent with his personal convictions. While ranking health with a high priority, it appears inductively that Oklahoma State legislators respond to: (a) pressures from organized medicine for limiting state health programs to those health activities traditionally performed by state government; and (b) pressures for funds by non-health groups which are more influential than those groups seeking funds for health programs.

4. Though a matter of increasing concerns in state government, health affairs are still not popular issues in Oklahoma politics which generate widespread public and legislative interest. In light of the health care crisis and the vigor of legislative activity in health at the national level, health may be portrayed as a neglected area in Oklahoma.

Relative to attitudes of legislators toward health professionals, the summarized findings of this section suggest that:

1. Oklahoma State legislators do not, as a group, clearly visualize the health statesmen role as formulated by leaders in the health field. To the extent that the role is visualized it is seen as being fulfilled by the administrators of the State Health Department, the State Mental Health Department, the State Medical Center, and

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[1]This concept was established and discussed in Chapter III.

the State Department of Public Welfare. These groups are not associated with health statesmanship in the eyes of legislators: hospital administrators, hospital association members and executives, health insurance executives, and health planners.

2. Oklahoma State legislators see medical doctors, as a group, as diminishing in power and influence. Nevertheless the legislators still see the medical doctor as the dominant and forceful voice of health in the state while hospital administrators are viewed as being strongly associated with and having expertise limited to financial and housekeeping aspects of hospitalization.

Relative to political decision-making in health affairs, the preliminary findings on this topic provide some early evidence that:

1. Oklahoma State legislators recognize that they are particularly in need of advice in deciding how to vote on pending health legislation.

2. Oklahoma State legislators tend to listen to and consult with a variety of sources relative to pending health legislation.

3. In deciding how to vote on health bills Oklahoma State legislators favor in order of preference the counsel of state government health administrators, the Oklahoma Medical Association, their family physicians, and recommendations of their own legislative committees.

These findings fit the theoretical roles of pressure groups and public administrators in the decision-making process as discussed in Chapter III.

Relative to legislators' underlying political philosophies in

health affairs, the findings suggest that:

1. Oklahoma State legislators, as a group, are neither conservative nor liberal in political philosophy relative to health affairs. In aggregate, they position themselves at about mid-point. If there are aggregate predilections in either direction, the data sugges slight leanings to the right, even though over eighty percent of the legislators are members of the ordinarily more liberal Democratic Party.

2. Rural legislators are slightly more conservative in health affairs than are their urban counterparts; Republic legislators are decidedly more conservative than Democrats; the health committee leadership is more liberal than are legislators in general; and the legislative leadership is markedly more conservative in health affairs than are legislators in general.

3. Oklahoma State legislators agree in principle, but disagree in practice with the concept that recipiency of high quality medical care is a right of citizenship for Americans.

4. Oklahoma State legislators tend to dislike and disagree with the massive intervention of the federal government in health, but they nevertheless accept this development pragmatically.

5. Oklahoma State legislators recognize about equally the health needs of rural and urban areas.

Relative to legislative behavior in health affairs, the findings suggest that:

1. Confrontations on major health issues at the stage of role call vote in the Oklahoma State legislature are rare. Debate and controversy take place in the legislative process prior to roll call

voting during regular sessions.

2. The import of health legislation which does reach the voting state is inconsistent with the magnitude of health problems in the state. Such legislation typically deals with matters tangential to major health issues.

Conclusions

Decisive conclusions are not within the province of exploratory studies; thus conclusions of this study are viewed as being only tentative. On the other hand, some inferences stand out prominently from the data and merit comment. Moreover, it is useful to deduce preliminary conclusions from even limited data as these deductions may lead the way to hypotheses which are suitable for further research. On this basis the following major conclusions suggested by the findings of this study are offered:

1. Health statesmen may hope to achieve some success in causing state legislators to be more sympathetic to health programs if they employ efforts to better inform the legislators. The primary target group in this connection is first those who have the least understanding of health affairs, then those who are better informed, and on up the scale to those who are well-informed. Additional support is probable through efforts of health statesmen to acquaint uninformed legislators with health affairs, while other strategies would be more effective with those who are well-informed on health issues.

2. Non-medical administrators are not presently performing the

health statesmen role in Oklahoma, at least not in a way which is cognitively visualized by state legislators. To the extent that the health statesmen role is being done, it seems to be fulfilled by medical doctors in the more traditional role of the "generalized wise man".[2]

To elaborate briefly, it appears that some legislators do not discriminate between the practicing physician's knowledge and expertise in the area of disease diagnosis and treatment and that portion of health care which deals with matters not included in the science of medicine. The latter include the social, economic, and political aspects of health - the organization of health resources, the various methods of delivery of care, the mechanisms for financing care, long-range planning in health, the maximizing of efficiency and effectiveness in health care, and general administration in health. There seems to be little awareness of: (1) the typical orientation of practicing physicians to individual patients, not to groups; (2) the small amount of schooling in the social sciences found typically in the background of practicing medical doctors; and (3) the training and experience of a new breed of hospital/health administrators specifically in the social aspects of health care.

Either health statesmen of the idealized typology are not present in significant quantity in Oklahoma; if present, have made little visible impression on the consciousness of state legislators; or

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[2]This term and its appropriateness to medical doctors in certain sections of the U.S. are discussed in Temple Burling, Edith M. Lentz, and Robert N. Wilson, The Give and Take in Hospitals, Chapter 2, pp. 11-25, passim with further reference to Talcott Parsons, The Social System, Chapter X. The concept was discussed in this report in Chapter I.

they are medical doctor administrators and thus not differentiated from practicing physicians.

From the foregoing it may be concluded tentatively that a health statesman (in the form of a health administrator as established in Chapter II) is a pioneer, a trail blazer in the state of Oklahoma. This professional will not be automatically accorded respect, trust, and confidence in his judgment by virtue of his profession. These qualities of health statesmanship will have to be won; they will have to be established through the tedious process of attitude change.

3. In the area of political decision-making the findings suggest that two phenomena are at work: the well-established part of pressure groups in formulation of public policies; and the role of public administrators in the decision-making process. With regard to the former the Oklahoma Medical Association seems to be the primary pressure group. The findings of this study and the theory of pressure groups combine to suggest that the effectiveness of organized medicine is much greater at the state level than it is at the national level. This difference accounts, in part, for the more extensive involvement of government in health at the federal level. Another factor, it appears, is the greater presence of aggressive pro-government lobbying groups at the national level than at the state level.

Concerning the second of the two phenomena in decision-making, it appears that health administrators in Oklahoma state government are participating in policy formulation in the way described in the public administration literature cited in Chapter III. The findings lead to conclusion that the judgment of these administrators is frequently

sought and valued. In the eyes of legislators these state executives are health statesmen.

This report contains only cursory findings and no theory relevant to the decision-making role of politicians' private physicians; thus no conclusions are offered. It is important, however, to stress the high regard with which the legislators surveyed hold advice of their family physicians and to suggest the obvious impact of this relationship on voting behavior.

4. Relative to underlying political philosophies it is reasonable to conclude that state government in health affairs has been and continues to be primarily conservative. This relates not so much to political predilections of the legislators as it does to historical and contemporary circumstance.

Historically the state has concerned itself with only its traditional activities in public health and preventive medicine, leaving the balance of responsibility for health of the citizenry to private medicine and philanthropy. The strong heritage of the state in rugged individualism, the pioneer spirit, and the Protestant ethic has reinforced this pervasive political position in health. More recently the state has come to look to the federal government for meeting health needs. The net effect of these circumstances is that the legislature has produced little in the way of broad, progressive health legislation.

What does the future hold for state government in health? It appears that Oklahoma is at the crossroads, with some indicators pointing to even less involvement in health affairs and other pointing to much greater involvement. The direction of movement along one or the

other of these two roads is likely to be determined in the near future.

It seems reasonable to conclude that state legislatures must alter their traditional conservatism toward health and look for innovative ways to meet pressing health problems or they will become increasingly dominated by the federal government. In this latter case the states will play a less and less important role and will eventually relinquish totally their constitutional authority in health.

Some conditions favor greater involvement in health affairs by state government. The state legislatures are closer to the people and are better able to respond appropriately to differing regional needs. If implemented, the Nixon proposal for revenue-sharing between levels of government offers singular opportunity to the states. The fact that comprehensive health planning has been established under the auspices of state government coupled with the great potential of such planning suggests a central position of the states in health care.

Due to the rapid pace of change in the United States and the urgency of present health problems this issue is likely to be settled conclusively in the next five to ten years. It is further suggested that the health statesmen role in this matter is crucial. The whole outcome may well turn on the effectiveness of such statesmenship at the state level, because the states must prove to the public their capability to meet pressing health needs. The medical doctor and his professional society appear to be in a favorable position in Oklahoma to perform the role of active statesmanship with an eye to relevant and timely solutions to immediate problems. Because of the central role of planning, health planners have a unique opportunity for contri-

bution. But there is also an imperative need for hospital/health administrators to emerge as health statesmen. The extent of the current leadership vacuum calls out for greater participation by these administrators in meeting comprehensively the health needs of Oklahomans.

Critique of Research Methodology

This study has sought to identify those research techniques which are appropriate and those questions of an interview schedule which yield useful data. The nonschedule, semi-standardized interview technique does appear to be the most desirable, perhaps the only practical approach to attitudinal survey of state legislators. The data yielded by this method appear to be useful; however, there are weaknesses.

First, conduct of interviews of this sort is time-consuming. Arranging appointments, rearranging canceled appointments, and outer-office waiting time are all real difficulties inherent to this method. Gaining access to legislators at an appropriate time when they can devote careful attention to the interview for forty-five minutes can be very difficult. A high degree of success was achieved in gaining such access, but this was accomplished at a high cost.

There is constant danger of contaminated data because over time confidents come to associate the interviewer with health care and alter responses accordingly. This danger became especially troublesome during the latter stages of the study when the researcher and the study became familiar to legislators in general. This familiarity was helpful in gaining access, but was paid for through the liability of demand responses.

The interview schedule of this study contains too many questions and covers too many topics for explanatory research. Any one of the four broad areas considered in this study would appear to be appropriate scope for a study in depth. In some cases just one aspect of these areas would be sufficient. An interview plan designed for thirty minutes duration would seem to be more appropriate than the forty-five minute interviews of this study. As mentioned earlier the last few questions exceeded the legislators' span of attention.

The technique of quantifying knowledge scores seems to be useful, but much refinement is needed. For example, Questions A - 4, A - 6, and A - 10 contributed little in differentiating health knowledge among legislators; Questions A - 5, A - 7, A - 8, and A - 11 seem to have been effective in this regard. The relative value given each question needs to be re-examined and the whole test ought to be standardized in order to establish norms and expected ranges of scores.

The Likert scale technique also needs to be standardized. For example, the degree of liberalism contained in each proposition ought to be determined so as to give appropriate weight to each question. In this study each Likert question was given equal weight even though some propositions are obviously more liberal than others, e.g., the question on attitudes toward a National Health Insurance Program is more liberal than the one dealing with comprehensive care to needy groups.

Only a few questions in the schedule were open-ended; therefore respondents usually gave answers which were limited to choices predetermined by the investigator. The possibility of introduction of investigator bias and demand factors thus becomes apparent. Also, the

limited range of choices ruled out meaningful responses in some cases. For instance, many respondents volunteered high regard for the advice of the legislative council research staff in their decision-making process, but this group was not offered as an answer choice anywhere in the study.

It is hoped that the findings relative to Oklahoma legislators can be generalized to other states. Perhaps some of these findings are generalizable; undoubtedly some are not. Striking regional contrasts exist in the United States due to cultural, economic, and demographic differences. It will remain for other research in other sections of the country to identify those findings which are replicable elsewhere and those which are regionally unique.

Another troublesome area in the course of the study was in the area of semantics. The research design did not sufficiently discriminate among these very different components of health care: public health, mental health, welfare health, and private medical care. An example of such difficulty is manifest in Item A - 13 where the legislators are asked simply to rank "health" among other state programs.

As a final criticism a general statement on the limitations of an attitudinal survey of this sort is offered. Such an exploratory study gives some clues on voting proclivities, but mainly it provides opinions of legislators as indications of their immediate state of mind on issues in general. It furnishes data on legislators' attitudes, in principle, and an indication of prevailing values among their electorates. It offers some evidence of the nature of legislative behavior in health affairs and on how the health statesman role might be carried out. Such a study cannot offer complete evidence; therefore it does

not serve as a basis for predicting behavior precisely or for explaining the role of variables conclusively. These things must come with future research.

Recommendations for Future Research

As emphasized throughout this report, health care is becoming more and more political. The whole social atmosphere surrounding health dictates that this trend will continue at an accelerating pace. Perhaps a plateau representing a new relationship between society and the health field will be reached at some point. In the meantime, however, much research is needed in order to explain what is happening and why it is happening.

First, there needs to be a research study of the executive branch of Oklahoma state government in health affairs. Enough has been discovered in this study to demonstrate a potential for great power in health affairs in the executive branch. The positions of executive department heads show evidence of being decision centers. Legislative function through public administration is an established phenomenon and bears further study. Through its coordinating role planning elements of the executive branch could become loci for decision-making. And, of course, the governor's office itself could become a power in health affairs. In any event the role of the executive branch seems to be a fertile area for future research.

Studies of health affairs in other state legislatures are indicated. Such studies could confirm or refute the findings of this research project; the role of variables could be more clearly defined;

and significant differences in health affairs among the states could be identified.

In addition, a need exists for research comparing state legislators with Congressmen. There are indications of increasing coordination between state legislators and their national counterparts, but wide differences in attitudes, values, and priorities still seem to be present. This study offers some suggestion that there are greater differences in political philosophy between state and national representatives regardless of party than there are between such politicians of opposing parties but at the same governmental level. The whole question of what appears to be a dichotomy in health affairs between the state and federal levels deserves investigation.

There is another aspect of state government which merits research. It is suggested that state legislatures are concerned with issues other than health to an extent that belies the number two ranking given health in comparison with other state programs in this study. It is suggested that legislators do not really see health with this high a priority, but for some reason they do respond this way during interview questioning. The answer may be obtainable, if at all, only through the use of psychological instrumentation. Moreover, it appears that the situation may well demand that legislators be primarily concerned with non-health affairs. For example, the management of state government itself seems to occupy a great deal of the legislature's time. The inherent weaknesses of the executive branch (as discussed in Chapter III) contribute to this burden.

Other hypotheses and area of investigation are also suggested.

Research into specific aspects of the decision-making process are needed. The role of legislative leaders and health committee members needs to be identified. The roles and relative effectiveness of the American Medical Association at the national level and the constituent state societies at the state level need to be identified and explained. The relationship of such findings to the aggressiveness of the federal government in health affairs and the restraint of the states in health needs to be established. In this same connection the roles of the American Hospital Association and the state hospital groups bear investigation. Although it appears to be politically inactive at this point, the American College of Hospital Administrators might justify examination to determine its manner of participation, if any, in the formulation of public policy in health.

The role of lawmakers in health affairs at the local level bears some scrutiny, especially in major urban areas. The attitudes and predilections of city councilmen and other officials of city municipal government may in some instances have greater impact on health care than those of politicians at the state level.

Finally, it is suggested that studies within the health professions themselves be undertaken to clarify the status of the health statesmen role. Much more needs to be known about how this role is actually carried on and how it might be improved. The influence of health statesmen in various settings deserves some study. Both the state and local settings merit further study. Health statesmanship at the national level appears especially inviting for research. Perhaps the setting in which the health statesman may make his greatest

contribution and perhaps the one most in need of research, however, is the voluntary sector of health care.

APPENDIX A

INTERVIEW PLAN

Appointments for the interviews are made in advance by the student with the legislator's secretary or the legislator himself. The appointments are made for forty-five minutes and are intended to take place in the legislator's office, although interviews may be conducted at any place of the legislator's choosing.

Upon gaining access to the legislator the student briefly introduces himself and his project. The legislator is told the following in general:

> "This study is part of graduate work at the University of Oklahoma. The purpose of the study is to improve our knowledge of state legislators and the operation of state government.
>
> Through a sampling process you have been selected to provide information from the point of view of a state legislator. Your cooperation is greatly appreciated. You will be asked about fifty questions over the next forty-five minutes. Some questions will ask you to make arbitrary decisions and you may often want more information on which to base your answer. Please answer the question on the basis of what is given and as an expression of your feeling in general. Of course you may decline to answer any question, but this will be damaging to the study. Also, please advise if any question is unclear.
>
> I hope that you enjoy your part of the interview as much as I shall mine. Complete confidentiality is guaranteed to all persons participating in the interviews. Thank you."

Then the legislator is asked the questions orally by the interviewer. The questions appear on the next few pages. They are arranged here in progressive sequence about the four principal areas of interest of the study. These four broad categories of information being sought are:

A. Knowledge of Health by Legislators and Their Priority Ranking of Health.

B. Attitudes/Views of Legislators Toward Health Administrators, Medical Doctors, Registered Nurses, and Other Health Professionals.

C. How Health Decisions Are Made.

D. General Political Attitudes/Values

The questions are arranged about these four topics so as to facilitate the reader's understanding of the purpose of each question and the rationale of the total interview. During the interview itself the legislator is asked the questions in another order altogether. This order is designed to capitalize on the following interviewing techniques.

A. Placement of open-ended questions early during the interview so as to avoid creation of a "demand factor" in the response. Also, these questions are intended to measure the level of awareness of health issues and must be asked before being contaminated by information given in other questions.

B. Placement of the least threatening and least controversial questions early in the interview.

C. Placement of questions of like types together in order to conserve time.

D. Mixing of questions so that those designed as validating questions will not be recognized as such.

E. Questions most likely to elicit the interest of the legislator are placed early in the sequence.

Two other points are worthy of mention. The phrasing of the questions is tailored by the interviewer to fit the mental set of the legislator. The backgrounds of the legislators are widely varying; likewise their familiarity with current terminology in health affairs is widely varying. The investigator, then, appraises the general background of the legislator early during the interview and phrases the questions in a way appropriate to the educational level, social class, ethnic background, and geographic residence of the confident. The objective is to assure that questions have the same meaning to all respondents.

In the case of multiple choice questions with lengthy or numerous alternative answers the confident is given a single sheet of paper on which the answer choices are shown. This allows him to make a selection independent of the order in which the answer possibilities are given by the investigator.

CATEGORY "A" - Knowledge of Health in Public Affairs by Legislators and Their Priority Ranking of Health

A - 1. What do you see as being the greatest needs in development of Oklahoma's human resources over the coming ten years?

A - 2. Do you see Oklahoma as having any major health needs? If so, what are they?

A - 3. In terms of dollars spent and persons employed, the health industry ranks in which of the following levels among other industries in the U.S.?

a. 1st to 5th
b. 6th to 10th
c. 11th to 20th
d. 21st to 30th

A - 4. The cost of staying in a hospital should be about the same as the cost of staying in a motel plus the cost of meals.

T
F

A - 5. Even though it is a non-profit enterprise, the community hospital should strive to have its revenues exceed its operating costs during each year.

T
F

A - 6. The administrator in the majority of Oklahoma hospitals is a medical doctor.

T
F

A - 7. We have ways to measure accurately the quality of medical care in Oklahoma.

T
F

A - 8. Health statistics show that the U.S. has the best medical care of all nations in the world.

T
A

A - 9. Physicians in private practice engage primarily in preventive medicine.

T
F

A - 10. The state agency responsible for making Medicaid payments to hospitals and doctors in Oklahoma is the State Health Department.

T
F

A - 11. Which of the following would you say represent acute health problems in the State of Oklahoma?

a. Shortage of medical doctors.
b. Shortage of hospital beds.
c. Medical and hospital costs.
d. The need for a new category of doctors called "family physicians".
e. The incidence of communicable diseases.
f. The duplication of services by hospitals in the same community.
g. The maldistribution of medical doctors.
h. The amount of mental illness.

A - 12. Which of the following would you say are good health goals for the state?

a. More mental health clinics.
b. More tuberculosis facilities.
c. Development of areawide planning in each region of the state.
d. A complete hospital in each community.
e. Gradual phasing out of nursing homes through the provision of additional hospital beds.

A - 13. Assume that $1,000,000 in new state revenue becomes available for appropriation by the legislature. Given that the entire amount must go to only one program, rank the following state programs in the order in which you feel these new funds would be needed.

____Conservation and Wildlife
____Economic/Industrial Development
____Health
____Higher Education
____Highways and Roads
____Parks and Recreation
____Penal and Correction
____Public Safety
____Public Schools
____Welfare

CATEGORY "B" - Attitudes/Views of Legislators Toward Health Administrators, Medical Doctors, Registered Nurses, and Other Health Professionals.

B - 1. What meaning for you has the term "Health Statesman"?

B - 2. What is your attitude toward group medical practice as opposed to solo practice?

a. Strongly favor
b. Mildly favor
c. Undecided
d. Mildly oppose
e. Strongly oppose

B - 3. Charitable immunity should be maintained for hospitals in Oklahoma.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

B - 4. Who is legally responsible for the general quality of medical care in a community hospital? (Select one).

a. County Health Officer
b. Hospital Nursing Staff
c. Hospital Governing Board
d. County Board of Health
e. Hospital Medical Staff
f. Hospital Administrator

B - 5. With which of the following do you primarily associate the Oklahoma Medical Center?

a. Research in Health Sciences.
b. Health services to patients.
c. Education of health professionals.
d. All of the above.

B - 6. A pharmacist is more a businessman than he is a professional.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

B - 7. In principle, licensure by the state should be required of hospital administrators.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

B - 8. It is appropriate that doctors who work full time in hospitals be paid by the hospitals as opposed to the charging of separate fees to each patient. (Excludes interns and residents).

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

B - 9. What should be the degree of influence by medical doctors in state public policies relating to health?

a. Actually make the important decisions.
b. Very influential.
c. Fairly influential.
d. Small degree of influence.
e. Not influential at all.

B - 10. What should be the degree of influence by hospital/health administrators in state public policies relating to health?

a. Actually make the important decisions.
b. Very influential.
c. Fairly influential.
d. Small degree of influence.
e. Not influential at all.

B - 11. What should be the degree of influence by registered nurses in state public policies relating to health?

a. Actually make the important decisions.
b. Very influential.
c. Fairly influential.
d. Small degree of influence.
e. Not influential at all.

B - 12. Which of the following best describes the role in <u>health affairs</u> of medical doctors as a group?

a. The group in ultimate authority - plays a dominant role in shaping public policy.

b. A very effective group which influences health affairs greatly.
c. A leadership group among other equal leadership groups in the health profession.
d. A group which is mildly influential in health affairs.
e. A group of professionals who have little influence in health affairs.

B - 13. Which of the following best describes the role in health affairs of the typical, individual medical doctor?

a. A very active and effective participant in public affairs related to health.
b. An active participant in shaping health affairs.
c. About average among professionals in interest and effectiveness in public affairs.
d. Mildly active and influential.
e. Preoccupied with the demands of medical practice - not active outside medical practice.

B - 14. Rank in order of prestige the following occupational groups.

____Registered Nurses
____Ministers
____School Teachers
____Medical Doctors
____Laboratory Technologists
____Health/Hospital Administrators
____Medical Social Workers
____Practical Nurses
____Attorneys

B - 15. How do you see the relationship between the community hospital and the medical doctor?

a. The hospital governing board is in complete control.
b. The medical doctors are in complete control.
c. There is shared authority, but the board dominates.
d. There is shared authority, but the medical doctor dominates.
e. There is shared and equal authority.

B - 16. The health care resources (practitioners, hospitals, etc.) in Oklahoma meet adequately the health needs of the people.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

CATEGORY "C" - How Health Decisions Are Made.

C - 1. By which, if any, of the following are you influenced in deciding how to vote on health legislation?

a. Desires of constituents.
b. Personal knowledge.
c. Counsel of your family physician.
d. Counsel of other health professionals.
e. Other

C - 2. In general, how do you make voting decisions on health bills?

a. Legislative committee recommendations.
b. Counsel of health administrators.
c. Counsel of legislative colleagues.
d. Counsel of legislative representatives.
e. Other.

C - 3. What is your opinion of the effectiveness of the Oklahoma Medical Association relative to other lobbying groups?

a. Much more effective.
b. Somewhat more effective.
c. About the same amount of effectiveness.
d. Somewhat less effective.
e. Much less effective.

C - 4. Assume that there is before the legislature a bill dealing broadly with HEALTH AND MEDICAL CARE. Rank in order of relative importance those of the following to whom you would turn in getting advice as to how to vote.

____Influential members of the electorate.
____Oklahoma Hospital Association.
____Administrator of the State Department of Health.
____Your electorate in general.
____Oklahoma Medical Association.
____Close associates and friends.
____Your family physician.
____A group of Oklahoma hospital administrators.
____Legislative Committee recommendations.

C - 5. Assume that there is before the legislature a bill dealing with IMMUNIZATION OF CHILDREN FOR COMMUNICABLE DISEASES. Rank in order of relative importance those of the following to whom you would turn in getting advice as to how to vote.

(Same choices as in C - 4).

C - 6. Assume that there is before the legislature a bill dealing with PAYMENT FOR HOSPITALIZATION. Rank in order of relative importance those of the following to whom you would turn in getting advice as to how to vote.

(Same choices as in C - 4).

C - 7. Assume that there is before the legislature a bill dealing with AN INCREASE IN SCOPE OF SERVICES AND APPROPRIATIONS TO THE STATE DEPARTMENT OF HEALTH. Rank in order of relative importance those of the following to whom you would turn in getting advice as to how to vote.

(Same choices as in C - 4).

C - 8. A legislator is usually not sufficiently informed on pending health legislation; therefore he should seek the counsel of health professionals in deciding how to vote.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

C - 9. Have you or a close relative of your suffered recently a prolonged or tragic need for medical care?

a. Yes
b. No

C - 10. Describe the extent of your contact with medical care or hospitalization as a result of the health of yourself or your family.

a. A great deal.
b. A more than average amount.
c. An average amount.
d. A less than average amount.
e. Very little.

CATEGORY "D" - General Political Attitudes and Values.

D - 1. STATEMENT OF FACT: Constitutionally the state (as a governmental level in the U. S.) is sovereign in health affairs; yet the Federal Government has assumed vast "de facto" powers in health.

PROPOSITION: This is fitting and appropriate as it is the best way the health needs of our nation may be met. How do you feel about this proposition?

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

D - 2. Provision of high quality medical care is a right of citizenship for Americans.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

D - 3. It is maintained that U. S. Citizenship affords a right to health care. Can we afford provision of such a right in the case of $30,000 kidney transplants? $100/day hospitalization? Rising physician fees?

a. Yes	a. Yes	a. Yes
b. No	b. No	b. No

D - 4. What is your attitude toward the new concept of specific health services as a right through application of the social insurance principle (Title XVIII, Part A) as opposed to the concept of various categories of needy people provided health care on a means test basis?

a. Strongly favor
b. Mildly favor
c. Undecided
d. Mildly oppose
e. Strongly oppose

D - 5. What is your attitude toward comprehensive (total) health care to needy groups as opposed to item-by-item provision of care to these groups?

(Same choices as in D - 4).

D - 6. The United States ought to have a universal Federal Government Health Insurance Program available for all citizens.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

D - 7. Some persons see a need to consolidate/organize the several components of the American health industry into an integrated, unified system. Do you agree with this proposal?

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

D - 8. If you agree with the preceding question, who should take the lead in this?

a. Blue Cross and other Insurance Companies with Health Plans.
b. Health administrators.
c. State Government.
d. Hospitals.
e. Medical doctors.
f. Federal Government.
g. Local Government.

D - 9. Relative to the organization of state health and welfare services which of the following do you think is best?

a. Welfare and health organized into two separate agencies.
b. Welfare and health combined in one agency on an equal basis.
c. Welfare as part of a predominantly health agency.
d. Health as part of a predominantly welfare agency.

D - 10. Do you see a greater need for improvement of health in urban or rural areas?

a. Rural
b. Urban
c. Equal

D - 11. Establishment of Program "A" will bring matching Federal dollars to Oklahoma. Program "B" will not. It is best for a legislator to vote state dollars to "A" in order to get the Federal dollars, even though he favors Program "B" over "A".

(Same choices as in D - 7).

D - 12. The State of Oklahoma is doing all that it ought to do in providing health services to the people.

a. Strongly agree
b. Mildly agree
c. Undecided
d. Mildly disagree
e. Strongly disagree

D - 13. Who should oversee the ethics of medical practice in the area of organ transplants, euthanasia, and new definitions of death?

a. Attorneys
b. Government
c. Laymen
d. Medical doctors
e. Other

APPENDIX B

CHARACTERISTICS OF REPRESENTATIVES SELECTED BY STRATEFIED RANDOM SAMPLING FOR THE PILOT STUDY

Number	Party		Origin[1]		Tenure		Assignment[2]	
	Dem	Rep	Rural	Urban	Fresh	Vet	Leg Leader	Non Leg Lead
1		x	x		x			x
2		x	x			x	x	
3		x		x		x		x
4		x	x			x		x
5		x		x		x		x
6	x		x		x			x
7	x		x		x			x
8	x			x	x			x
9	x			x		x	x	
10	x		x			x	x	
11	x			x		x	x	
12	x			x		x		x
13	x		x			x		x
14	x		x			x		x
15	x		x			x		x
16	x		x			x		x
17	x		x			x		x
18	x		x			x		x
19	x			x	x		x	
20	x			x		x		x
Totals	15	5	12	8	5	15	5	15

APPENDIX B

CHARACTERISTICS OF SENATORS SELECTED BY
STRATEFIELD RANDOM SAMPLING
FOR THE PILOT STUDY

Number	Party		Origin[1]		Tenure		Assignment[2]	
	Dem	Rep	Rural	Urban	Fresh	Vet	Leg Leader	Non Leg Lead
1		x		x	x		x	
2		x	x			x		x
3	x		x		x			x
4.	x			x		x	x	
5	x			x		x	x	
6	x		x			x		x
7	x		x			x		x
8	x			x		x		x
9	x		x			x		x
10	x		x			x		x
Totals	8	2	6	4	2	8	3	7

1. The criterion for urbanity is taken from the standard population densities for determination of urban areas as defined by the U.S. Census Bureau in 1960 and as they appear in the Pocket Data Book USA 1967, U.S. Bureau of the Census, pp. 34-43.

2. The assignments included here are President Pro Tempore, Majority Leader, Majority Whip, and Minority Leader in the Senate; Speaker of the House, Speaker Pro Tempore, Majority Leader, and Minority Leader in the House, and membership on the Public Health Committee of either body.

APPENDIX C

THE SCHEME FOR EVALUATING RESPONSES TO QUESTIONS IN CATEGORY A

Question Number	Question Value	Response Key for Assignment of Points
A - 1	8	8 points for any mention of health.
A - 2	10	2 points for each health need.
A - 3	8	8 points for response a. 4 points for response b.
A - 4	8	8 points for false.
A - 5	8	8 points for true.
A - 6	8	8 points for false.
A - 8	8	8 points for false.
A - 9	8	8 points for false.
A - 10	8	8 points for false.
A - 11	8	1 point each for selecting responses a, c, d, f, g, and h, and for not selecting b and e.
A - 12	10	2 points each for selecting responses a and c and for not selecting b, d, and e.
Total	100	

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