THE FORMULATION OF FEDERAL HEALTH CARE POLICY*

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The federal government's health policy (and it is federal health policy upon which I shall concentrate) is in many ways opaque and even paradoxical. Until recently, health was an area forbidden to the federal government, one in which meaningful interventions were blocked by "veto groups"—notably the American Medical Association (AMA)—before which federal politicians cowered. Federal support of biomedical research and new hospital construction were acceptable, but the idea that the government might play a large and direct role in paying for medical care and in organizing the delivery system, much less in regulating it, was unthinkable. This federal timidity was of course widely deplored by critics of the American health-care system (or nonsystem, as they prefer to call it).

Since 1965 the situation has changed astonishingly. The federal health-care strategy dominant for two decades after World War II—putting up funds for research and hospital construction—has been supplemented and overshadowed by other interventions. In addition to subsidizing the status quo, the federal government now pays the medical bills of a portion of the population under Medicare and Medicaid; has made efforts to sponsor new organizational forms of health-care delivery, most notably neighborhood health centers and health maintenance organizations; and even plans and regulates the system to some degree by means of health systems agencies, Professional Standards Review Organizations (PSROs), and rate-setting programs in certain states.

If one lists the major criticisms advanced against our health-system by social scientists and health experts (categories not entirely exclusive), one

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or more federal programs will be found to address most of them. It is
alleged that the quality and appropriateness of physician care is in des-
perate need of monitoring. The PSRO program attempts to do this. It is
charged that physicians are seriously maldistributed by speciality and place
of practice. The Health Professions Educational Assistance Act of 1976
(PL 94-484) included incentives to encourage medical schools to train
more family practitioners and for medical students to spend some time in
underserved areas. It is said that hospitals have too many beds, are
excessively acquisitive, and are extravagant with inpatient care. Over the
last few years outlays under the Hill-Burton act have shifted from new bed
construction toward ambulatory units. Certificate-of-need legislation, in
effect in about half the states by the early 1970s, has been required of all
states receiving funds under the National Health Planning and Resources
Development Act of 1974 (PL 93-641). Necessity of admission and
appropriateness of length of stay in hospitals are monitored to some extent
under PSROs.

It is often argued that third-party reimbursement creates overutilization by
substitution of inpatient for outpatient care (even when the latter is adequate),
wasteful diffusion of medical technology, and neglect of preventive medicine.
Federal promotion of health maintenance organizations emphasizes preven-
tion and the cost-effectiveness constraints of a fixed annual budget for both
inpatient and outpatient services. Federally supported state rate-setting expe-
riments are exploring more direct cost controls.

Finally, it is declared that what our system really needs are planning,
coordination, and regulation—preferably on a regional or areawide basis
and preferably accompanied by substantial consumer participation. The
federal government has established health systems agencies on an areawide
basis, linked to a central decision-making state body requiring participation
by a strictly defined set of consumers.

These programs, in addition to Medicare and Medicaid, comprise a
remarkable legislative record in the last 12 years. (Indeed, most emerged
within the last five years.) So far outmoded is the old image of a federal
government deadlocked by opposition from organized medicine that it is
fair to say that in no other area of social policy has the federal government
been so flexible, responsive, and innovative.

Yet, dissatisfaction with federal health policy, both inside and outside
government, is great and growing. It is widely believed that the system is in
a crisis, and that the federal efforts recounted above amount (as Alford
Paradoxically, dissatisfaction with the health-care system seems to have grown almost in direct proportion to federal responsiveness.

Critics of the system self-confidently explain that our incentives to change physician distribution by specialty and area are ineffectual; that PSROs assign the fox to guard the chickens; that certificate-of-need procedures are a mere shadow of real public utility regulation of hospitals; that health maintenance organizations would be too little and too late even if they were catching on, which they are not; that state rate-setting experiments are not controlling rising charges; that health systems agencies are poor vehicles for planning and regulation and their approach to consumer participation doomed to failure; that none of these programs is coordinated with or reinforces the other—and so on down a list as long as the programs and problems themselves.

Many of these programs are too new for serious evaluation; few sound evaluations, even of older programs, have been done; and any serious discussion of the merits, theoretical or empirical, of any of these programs, let alone of the whole list, lies outside the scope of this paper. But the datum itself—the paradox of dissatisfaction growing directly with the size and scope of the federal effort, what might be called the paradox of responsiveness without effectiveness—deserves exploration. It is this paradox which carries the question of how health policy is formulated beyond the question of how a bill becomes a law and which makes the question interesting and intellectually problematic.

Some brief clarification of terms may be in order. First, what do I mean by policy? To some, nothing less than a central plan should be dignified by that term. To others, the term is synonymous with the word "program." I prefer a middle ground: a policy is a strategy of intervention, a statement of general goals accompanied by publicly established means (programs) to attain them. Federal health policy today consists of four major strategies: 1) support for providers and increase of the supply of health resources—for example, National Institutes of Health biomedical research, the Hill-Burton program of health-facility construction and renovation, and programs to train physicians and allied medical manpower; 2) support for the elderly, poor, and medically indigent in paying their medical bills—meaning Medicare and Medicaid; 3) support for new forms of health care delivery—most especially neighborhood health centers and health maintenance organizations; 4) support for planning and regulation of
health-care services and institutions—notably PSROs, health systems agencies, and rate-setting efforts.

In short, federal health policy may be viewed as a four-ring circus. It is not a master planner's dream, nor is it totally random, ad hoc, or chaotic. (Indeed, these strategies emerge largely as efforts to rationalize the effects of previously adopted ones.) It is not absurd to speak of federal health policy in this sense.

Second, what do I mean by formulation? As I shall use the term, formulation is a multistage process whereby a problem is identified (inside and outside of government); proposals are advanced to deal with it; some of them find their way onto the public agenda and receive serious consideration by politicians; are refined legislatively and then further defined administratively by the federal bureaucracy; and are finally implemented, for better or worse, by the private sector, state and local governments, or both.

How does this process work? And can a glimpse at its workings help explain the paradox which I earlier belabored?

Federal health policy results from interplay among five major participants: interest groups, the president, Congress, the federal bureaucracy, and state and local governments. Each interacts with others; none monopolizes any particular stage of policy development. Each has its own "'game to play" or "'positive policy contribution to make,"' as one prefers. The only way to describe the process in a few pages is to look briefly at each of these five participants and to try to make some general points.

Analysis of federal health policy begins—but no longer ends—-with interest groups, especially organized providers, most especially the AMA, upon which I shall focus here. The AMA is politically powerful because it enjoys a combination of six resources: 1) organization (and therefore a full-time staff to refine and express positions, gather information, and keep tabs on supporters and opponents); 2) money (and therefore the wherewithal to maintain that organization and to reward and punish politicians at election time); 3) professional legitimacy (and therefore the right to be consulted and heard that comes with providing complex and valuable services); 4) single-mindedness (and therefore politicians' awareness that members' votes will be cast on the basis of medical issues alone, not on the basis of overall performance); 5) unchallenged leadership (and therefore the advantages of facing virtually no important rivals as spokesmen for physicians on the national scene); and 6) geographical distribution.
(and therefore the accumulated influence that comes from applying these resources in most congressional districts).

Few interest groups enjoy all these resources; very few indeed enjoy them in so high a degree as organized medicine. This was the political raw material which created deadlocks for many years and it remains important enough to shape the general contours of health-care policy today.

These resources tend to work more strongly on Congress than on the executive and more strongly on Republicans than on Democrats. Pre-Medicare politics reflected these tendencies. After World War II President Harry Truman hoped to enact some form of national health insurance. The AMA hoped that he would not succeed, and mobilized its resources to make sure that he would not. In the ensuing deadlock Congress took the initiative in areas where the AMA supported (Hill-Burton) or at least was neutral (biomedical research) and stayed out of areas where it was opposed (financing programs and manpower-training efforts). The Eisenhower administration was disinclined to lead in the health field, AMA-sanctioned programs grew under congressional leadership, and until the mid-1960s there was little more to add.

When the pattern broke, it did so under the leadership of liberal Democratic presidents (John F. Kennedy and especially Lyndon B. Johnson) with sizeable, supportive Democratic majorities in Congress. In the post-Medicare era the AMA is a powerful interest group but no longer a veto group. The reason, I think, is not because it has grown organizationally inept, not because it is tainted with the scandal of opposition to Medicare, and not because politicians have ceased to take it seriously. The major change in the post-Medicare era is that the federal government has itself emerged as a full partner in the purchasing of care. With the federal budget deeply implicated in medical care, and under statutes that put federal spending largely beyond control of the annual budget process, the government has an ongoing, institutionalized stake in "doing something" about American health care. This entry of government as a senior partner in the system can produce strange patterns—a conservative Republican president, Richard M. Nixon, suggesting that the federal government take the lead in changing the delivery system by means of health maintenance organizations, a conservative Republican president, Gerald Ford, suggesting a health-insurance plan that put the financial burden largely on employers, regulatory programs emerging from a benefit-minded Democratic Congress, to cite three examples—and more surprises are probably on the way.
The post-Medicare federal commitment has had three major consequences. First, it has demoted the AMA and its allies from veto groups to interest groups. Second, it has muted—but not ended—partisan differences in the health field. Republicans may be concerned about cost control, but know that benefits are bound to expand; Democrats may wish above all to extend benefits, but know they must have responsible cost containment. All protagonists see that benefit cost analysis must be taken seriously—or must appear to be—and this has led to a third consequence, a growing demand for policy analysis and bright ideas in general within the federal government, especially within the executive branch. The executive, after all, is expected to take the lead in rationalizing the diverse and uncontrollable pieces of the health-care puzzle.

Despite the conventional wisdom of political science lore, presidential leadership in the health field has been more the exception than the rule. For 20 years after the war, those presidents with the will to lead (Harry S. Truman and John F. Kennedy) lacked the power, and the one who may have had the power (Dwight Eisenhower) lacked the will. Under the circumstances, Congress developed and consolidated its own leadership. After the 1964 elections will and power finally came together in the Johnson administration, and much new legislation emerged. In the Nixon-Ford years presidential initiatives tended with a few exceptions to be modest, halting, and not taken very seriously by Congress or (apparently) by the administrations themselves.

President Carter has inherited accumulating commitments in the subsidy, financing, reorganization, and regulatory arenas, along with a sense of crisis and demands that something be done. To expand benefits without promising cost containment will appear irresponsible; to contain costs as a prelude to the expansion of benefits may squander political capital. The times seem to call for an integrated package which will attempt to introduce harmony and good management into existing efforts. The key question is whether the executive branch is suitably organized to generate such a package.

Broadly speaking, a president has two options in formulating health policy. He can rely heavily on the federal bureaucracy, especially the Department of Health, Education, and Welfare (HEW), to work up a program or he can turn to outsiders, usually panels and task forces of experts and eminent individuals, for ideas. The two approaches have complementary advantages and disadvantages. The bureaucracy has a unique grasp of detail, operational problems, and problems of implemen-
tation, but its policy vision may be narrow and limited to suggesting how marginal changes in the programs it knows best would improve matters. For bold, new ideas, unfettered by quibbles about workability, task forces and commissions are often excellent, but they tend to be impractical and are unlikely to think hard about political acceptability, administration, and detail. Moreover, the task force is likely to have little idea how existing programs are actually working out "at the point of service delivery," something a bureaucracy understands better, if not very well.

In theory, a president should reconcile both perspectives, especially at the level of the secretary, under-secretary, and assistant secretaries of HEW. In practice, however, the department is badly organized to turn promising proposals into sound legislative initiatives.

I doubt that anyone really knows, in depth and in detail, how HEW is organized for health policy. The department clearly suffers from many problems. Some are long standing: for example, ongoing disagreements between public health advocates and their critics; unclear goals and missions (should HEW emphasize research, prevention, delivery of care to select populations, or what?); demoralization of lesser units in the face of National Institutes of Health predominance and favor. Some problems are of more recent vintage: rapid enactment of such ill-defined and difficult-to-launch new programs as health maintenance organizations, PSROs, and health systems agencies; the eclipse of the assistant secretary for health by the Nixon administration which was suspicious of the health bureaucracy and hostile to it, and by a Congress which was suspicious of Nixon appointees; constant reorganizations, seldom monitored and evaluated with care from above—a description which will probably and unfortunately apply to the recent reorganization undertaken by HEW Secretary Joseph Califano. In short, it is hard to see how an integrated, realistic policy package can emerge from or be developed by the health units of HEW as presently organized. Departmental reorganization is a central issue: bureaus should reflect an appropriate distribution of functions; the assistant secretaries’ positions should be strengthened politically; most fundamentally, goals and missions need to be clarified. All of this amounts to saying that a fundamental presidential initiative is required within and on behalf of HEW before that department can be expected to serve him well in the legislative process—a question-begging recommendation.

The institutional difficulties of executive leadership in areas of complex social policy are familiar enough. In the health area they are especially
severe, however, for one basic reason: the legislative activity—some would say the hyperactivity—of Congress. According to many scholars, the congressional role tends to be one of oversight and reaction to executive leadership. This is not the way it works in the health field. Congress—meaning members and staffs—has been an active, equal, often dominant partner in health policy since World War II, and almost everything about federal health-care policy reflects congressional activism.

Why is Congress so lively in this policy area? The reason is straightforward. As David Mayhew has pointed out, Congress is above all geared to its members’ need for reelection and therefore to their needs for what Mayhew calls advertising, credit claiming, and position taking to place members in a favorable light with their constituencies. Although controversial among interest groups, health care is a popular issue among voters. If you have your health, a television commercial reminds us, you have just about everything—an opportunity for credit claiming that businessmen seldom overlook. Much congressional activity aims at finding policy directions which will prove popular with voters while avoiding the antagonism of interest groups. Biomedical research and the Hill-Burton Act fit this description well, and Congress became and remains their strong protector.

Post-Medicare politics is, for Congress as for the rest of government, more complex, and it is fair to say that today health politics in Congress goes on within three quite distinct subsystems.

First, there is the politics of the old subsidy programs. Congress continues to defend and protect NIH research and Hill-Burton spending despite strong executive opposition under Nixon and Ford, including some angry vetoes. These programs confer or promise to confer tangible benefits, arouse little organized opposition, and are Congress’ own. Most members care little about the substance of these programs, but, secure that the political arithmetic of grant awards gives them some stake in their preservation, defer leadership to a small number of members who watchfully guard them. These members are the chairmen of the Labor-HEW subcommittees of the House and Senate Appropriations Committees—Fogarty (D., R.I.) and Hill (D., Ala.) throughout most of the 1950s and 1960s, Flood (D., Pa.) and Magnuson (D., Wash.) today.

Second, there is the politics of the financing programs, Medicare and Medicaid, and, today, the quest for national health insurance. Whereas subsidy programs tend to be bipartisan, nonideological, and happily entrusted to the care of a few specialized congressmen, financing programs
tend to be partisan, ideological, and characterized by much individual position taking. Congress divides into blocs of those strongly committed, those mildly committed, a few who are indifferent, those mildly opposed, and those strongly opposed to any given proposal. Under these conditions, congressional initiation of legislation is virtually impossible. Nevertheless, once a presidential initiative is taken, the coalition-building process among the various blocs ensures that the initiative will be rewritten extensively, as Medicare was by Wilbur Mills (D., Ark.) in 1965, to enable spokesmen for major blocs and interest groups to claim credit for a share of the outcome. The principal participants in financing politics are the House Ways and Means and Senate Finance Committees.

Finally, there is the politics of reorganization and regulation, largely thankless tasks, which involve remote benefits and the more immediate imposition of constraints. As in the case of subsidy politics, the many remain indifferent and tend to defer to the leadership of the few—in this case, Representative Rogers’ (D., Fla.) Health and the Environment Subcommittee of the Interstate and Foreign Commerce Committee in the House and Senator Kennedy’s (D., Mass.) Health and Scientific Research Subcommittee of the Human Resources Committee (formerly Labor and Public Welfare) in the Senate. In this area, action is possible largely because of an odd coalition of conservatives who want to save money and liberals who want to plan and regulate the health-care system. But, because their political stakes are small at best, these programs support a majority coalition only if their funding is limited and their powers few. Coalition building is further complicated and program coherence further compromised because Senate enactments under Senator Kennedy’s leadership tend to be more liberal than House enactments under Congressman Roger’s leadership. As a result, much difference splitting goes on in conference and much peculiar legislation emerges.

Three points stand out. First, health-policy formulation in the Congress goes on in three different subsystems, regularly involving six different committees and at least as many congressional “health leaders,” with little coordination among them. Second, the political logic of coalition building virtually guarantees that any measure—presidential or congressional—that emerges successfully will have been changed in ways its proponents probably did not foresee or desire. Third, congressional health policy-making is asymmetrical, steadily producing a favorable ratio of benefits to restraints over time. Under these circumstances executive leadership—
especially of the coordinating and rationalizing type—is very difficult. So too is administration within HEW.

Once a bill finds its way into law it bears the marks of executive uncertainty and obfuscation, extensive congressional reworking to build a majority coalition, and considerable interest-group accommodation. Bureaucratic powers are often unclear or sharply constrained at crucial points, reflecting executive fears of bureaucratic "subversion," congressional fears of bureaucratic "dictation," and interest-group fears of bureaucratic "high-handedness." HEW faces the unenviable task of writing regulations and devising administrative arrangements to produce a sensible program for states and communities while avoiding charges that the bureaucrats are pushing people around. This combination of vague and contradictory legislation calling for clarification and sharp legal and political restraints on those expected to do the clarifying characterizes much federal legislation; it is also a prime source of bureaucratic demoralization and of popular dissatisfaction with the bureaucracy itself. Nowhere is the problem more evident than in the health field.

HEW follows two basic patterns in the administration of health programs. The first pertains to programs that involve more or less direct federal relations with the private sector, with little formal role for state or local government. Examples are NIH grants, manpower subsidies, Medicare, health maintenance organizations, and PSROs. Administrators calculate that they need to calm their enemies and win friends, arguing that "after all, if the program is to work, cooperation of providers is essential." They therefore treat regulations largely as "guidelines," try to "educate" offenders rather than cut off funds, and in general administer with a light hand and a friendly spirit. In these programs, interest groups—organized spokesmen for providers—play a large role and tend to get their way sooner or later. Examples include the research community under NIH, medical schools in manpower programs, local medical societies in PSROs, the AMA and American Hospital Association in Medicare, and organized labor in the health maintenance organization program.

The second pattern pertains to health programs implemented by the states. Examples are Hill-Burton, Medicaid, the health systems agencies, and the rate-setting efforts. In these programs HEW tends to delegate substantive responsibility, in a word, to abdicate goal-setting to the states and to local interests within them. The reason is simple: if Congress
decreed that a program should be administered by the states, it did so because it wanted federal funds to go to the states and wanted the states to play a major role in allocating them. The administering state agencies are legally under the direction of elected governors and legislators who are perfectly capable of crying out to other elected officials (Congressmen) should middle-level bureaucrats in HEW start "pushing their people around." Federal administrators know this and try hard to avoid the appearance of bullying officials at state and local levels. In short, the major reason why meaningful regulation is so hard to impose on the health-care system is the political nature of the American federal system itself. The outcome in this second case is the same as in the first: scrupulous deference to the wishes of private (and public) participants at the state and local levels. As it is implemented, federal health policy is steadily absorbed into state and local health politics, whatever the cost in goal attainment or fidelity to original intentions.

All these various policy strands from all these disparate policy sources are finally visited collectively upon the heads of local officials, providers, and consumers. It is left to them to make sense of it all. Frequently the policy as enacted in law is unclear, and HEW cannot or will not clarify it sufficiently to provide plausible guides to action. State regulators are in an especially frustrating position. They derive powers (of sorts) from a set of programs channeled through the states—Hill-Burton, Medicaid, certificate of need, health systems agencies, rate-setting. However, a set of other programs—research grants, manpower training, health maintenance organizations, PSROs, and others—go more or less directly to the private sector. The powers of the state programs to control or influence private ones tend to be weak or nonexistent. The major generators of inputs—and of costs—remain largely private and largely outside the control of state regulators.

By this time—the points of implementation and service delivery—the capacity of the public to understand the actions of its elected representatives has diminished to zero. (This is perhaps only fair, because almost nothing is known about what, if anything, the public really wants from the health-care system.) The public's ability to hold its elected officials accountable and responsible for their actions disintegrates into a final paradox: a system deliberately fragmented and decentralized in the name of keeping power "close to the people" ends in outcomes impenetrable to the people themselves.
It is easy to deplore this approach to health-policy formulation and to argue the virtues of some "rational actor" model capable of putting the recommendations of social scientists and health planners faithfully into effect. These arguments may come too easily.

The fact is that we have very few answers to most of the crucial operational, programmatic questions about health policy-making. Social science critics typically identify and document problems, point out the need for action, and then invoke fashionable terms: regulation, regional planning, prospective budgeting, and others, leaving a large operational gap between problem and recommendation.

We do not really know how to change the distribution of physicians in favor of family practice and underserved areas. We are not very far along in formulating operational definitions of quality of care, reasonable charges, appropriate and timely access, and other such concepts which, we are told, we should monitor and regulate in detail. We do not know whether prepaid group practice can be brought to the population on a large scale nor whether it would work if it were. We have several theories of rate-setting but very little evidence about what happens concretely when these theories are put into practice. Nearly a decade of experience with Comprehensive Health Planning agencies produced almost no useful evaluation and analysis; yet we follow a similar road to planning under the new health systems agencies. We know little about the organizational dynamics of hospitals, about how hospitals differ from one another, and therefore about how to anticipate hospital responses to various regulatory measures proposed, including the cost-containment measures proposed in early 1977 by the Carter administration.

But even if social science disciplines could speak in clear and explicit fashion to operational questions, a prudent policy-maker would still hesitate before basing public policy directly upon them. The social science literature on health-care policy consists of about two thirds economics and one third sociology, and the two disciplines disagree on almost every major intellectual and practical issue. A sure recipe for intellectual humility (and possible schizophrenia) is to read on alternate nights the works of Martin Feldstein, Eliot Freidson, Victor Fuchs, and David Mechanic. In the health field, social science, like government, is specialized and fragmented.

But even if a general, operational social science wisdom could be distilled, it would still be an imperfect guide to public policy because it
could not tell us how to trade off among our three universally valued general goals: enhanced quality, improved access, and cost containment. Critiques of the health-care system today have the character of a duet: the federal government sings out, "We're paying too much for health care," and academic critics chime in, "Yes, and we're not getting our money's worth either." But it may be that the trade-offs among quality, access, and cost implicit in federal health policy are reasonably close to what the public wants or what it would say it wanted if it worked out a position on the matter.

In essence, federal health-care policy is formulated by multistage coalition building: among the bureaucracy, Office of Management and Budget, and policy advisors in the executive; among the parties, committees, and regions in Congress; among providers, state and local officials, and HEW; and among many local interests at the point of implementation. This approach produces strange results, but it speaks to the first limitation of "rational actor" approaches to policy: the uncertainty and disagreement which characterize them. Different institutions in the "dance of legislation" represent different interests, values, and opinions; lacking a better way to make policy, it is not strange that our system follows its structural instincts and leaves great latitude for their expression and interaction.

This approach to policy formulation also speaks to the second major limitation of a rational actor approach: inability to prescribe optimal trade-offs among quality, access, and economy. The general disposition of the government is to expand benefits, sometimes dramatically, sometimes incrementally, and to accompany them by smaller increments of planning, regulation, and control. The latter may not really work; from a central planning standpoint the entire approach is widely perverse. But the approach may conform to the general drift of popular expectations. Perhaps what we want as a people is a progressive expansion of benefits, accompanied by controls strong enough to provide some assurance against egregious waste and abuse but weak enough to allow us to continue escaping those hard and heart-rending choices we are told (but do not believe) we must make, Those who run our political system act as if they thought we wanted this, and they may be right.

Perhaps, when all is said and done, we value the incrementalism of responsiveness more highly than we value the system rationality of effectiveness; or perhaps we value them in approximately the imbalanced ratio the government tends to provide. Responsiveness is a disagreeable com-

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modity; effectiveness is not. In our political system it is only natural that the advantage falls to the former. Many of our discontents come from a radical shift in the last 12 years from a politics under the domination of private interests to a politics that is, at least by usual American standards, democratic and pluralistic. No one ever promised a result pleasing to the eye or to the pocketbook.

NOTES AND REFERENCES

3. See, for example, the account of the consolidation of congressional leadership of National Institutes of Health policy in Strickland, S. P.: Politics, Science and Dread Disease: A Short History of United States Medical Research Policy. Cambridge, Mass., Harvard University Press, 1972, chap. 5.
7. As presidential candidate Jimmy Carter explained to the American Public Health Association in the fall of 1976: "I think we are standing on the threshold of an exciting new era in American health. We have the technology, we have the financial means, we're already spending the money, we have the professional knowledge, and we have deep concern. It's revealed in every poll we run. When Americans are asked, 'What in your life is important enough to raise taxes, if necessary?' the response is always health care." Med. World News 7:64, November 29, 1976
8. See, for example, the articles on policy implementation and bureaucratic guidelines in Policy Sciences 7: December 1976.