ALTERNATIVES AND CONSEQUENCES OF HEALTH CARE PROTOTYPES AND DEVELOPING A PUBLIC POLICY EDUCATION PROGRAM

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Health care is an issue which touches all of us. And many experts think our health care system is breaking down. Polls reveal most Americans are dissatisfied with the system, but are satisfied with their own personal health care.

The American public is concerned. A 1991 Gallup poll found that 91 percent of Americans believe we face a national health care crisis, and 85 percent feel the system needs reform (Aging 2000, 1991b, pp. 3-1).

Much of the literature indicates the need for *a health care system approach*. A review of literature identifies many specific issues, to name a few: managed competition, universal access, cost containment, preventive component, voucher to negotiate with insurer, tort reform for medical malpractice, administrative simplification, "kiddy care" program, private market approach, employer-based approach, and government-based approach. But few take a systems approach to studying our health care system.

Aging 2000 began in November of 1989, when a group came together to study ways to improve health care in Rhode Island. The group focused on health care for the elderly. But the detailed analysis of care for the elderly can yield improvements for the system as a whole.

The Study—A Systems Approach

The study, "Aging 2000," relied upon the hard work of ten staff, the dedication and involvement of more than 150 committee members and the cooperation of thousands of people interviewed and observed at work around the state and across the country.

The Aging 2000 Committee began with no preconceived hypoth-

eses. No uniform questionnaire formed the basis for its interviews. Instead, the staff adopted an open-ended approach, allowing those interviewed to set the course of discussion.

Economists, researchers and public policy educators need to look more closely at the opportunities of a systems approach to public issues. A system is a set of parts coordinated to accomplish a set of goals. The systems approach characterizes the nature of the system in such a way that decision making could take place in a logical and coherent fashion and insure that none of the fallacies of narrow-minded TP5.3thinking occur. Time and planning are important elements in any attempt to design human systems. This means laying out a course of action that can be followed to achieve the desired goals (Churchman, p. 29).

Since these early studies of systems, many practical minded managers and citizens have asked whether the systems approach has really paid off in practice. Now CEOs are attempting to see if *total quality management* can cure the health care crisis.

In a New Jersey study, the director of quality management says, "typically, hospitals build their systems around what is convenient for the institution, not the patient" (Gerber, p. 26). Some hospital CEOs believe they have found a useful tool to attack the waste, inefficiency and mistakes that help swell our national health care bill: Total Quality Management (TQM). The system would be more efficient and produce greater customer satisfaction (Gerber, p. 26).

If we go to the leadership literature, we find many techniques that can be used to assist in getting people involved in the process; and to identify issue components, the stakeholders, and the players in the health care system. For example: concept mapping, which begins to get people thinking about the whole system. Concept mapping is a way to pictorially represent concepts and relationships held by an individual or a group. It is a process to draw on individual and group thought and present information to prompt further analysis.

The components of the health care system studied in Aging 2000 included: hospitals, physician care, nursing homes, community health centers, community mental health centers, renal dialysis centers, pharmacies, health insurers, home health care and personal care (homemaker, home health). It also reviewed other care services such as: hospices, ambulance companies, home-based infusion therapy providers, surgery centers, suppliers of durable medical equipment, rescue services, rehabilitation centers, walk-in emergency health centers, laboratories and a host of other providers that round out the Rhode Island health care system. The state departments of Health, Elderly Affairs, Mental Health, Retardation and Hospitals, Human Services, and Children, Youth and Families all provide health programs (Aging 2000).

A number of additional agencies and programs, though not strictly

health related, provide health services particularly to the elderly. These include: sheltered care homes, adult day care and nutrition programs (Aging 2000).

Other authors provide frameworks for looking at an organization. For example, Bennis provides a description of a hospital's *external* environment. The *primary* environments include: 1) suppliers—insurance companies, doctors, labor markets, donors and suppliers; 2) consumers—general public and the research community; 3) interfacing organizations—medical profession, teaching hospitals, board of directors, volunteer groups, health insurance and drug companies. The *secondary* environments include: 1) technological—medical technology, administrative systems and pharmacology; 2) political/legal: medicare system, deductibility of health costs, FDA, licensing agencies; 3) social—public attitudes, health fads, environmentalism; 4) economic—health care costs and domestic business climate; 5) institutional—nursing homes, academic medicine, public sanitation and HMOs. (Bennis and Nanus, p. 159-160).

Data Collection

The research took Aging 2000 staff to high-rise apartment buildings for the elderly, meal sites, adult day care centers, nursing homes, Medicaid offices, senior centers, and to public hearings on issues of concern to the elderly. They rode on vans, met with social workers, made rounds with visiting nurses, visited hospice patients, talked with ambulance drivers and interviewed doctors. Aging 2000 held round table discussions with pharmacists, hospital discharge planners, hospital patients, and the residents and staffs of nursing homes.

The people and institutions visited opened the doors to their lives and their jobs, allowing the staff to understand "the system" from the inside looking out. Without the cooperation and openness of all those who participated, the study could not have been as thorough.

To build a framework for what the researchers discovered about the Rhode Island health care system, in a broader context, the staff studied the national literature on health care for the elderly and visited states and other nations that have instituted innovative programs.

The Aging 2000 staff performed a strategic cost analysis of Rhode Island health care institutions. The cost analysis reduced how an institution spends its time and money to minutes and dollars. To analyze the system, staff observers spent months following doctors, nurses, aides and patients in health care settings: nursing homes, physicians' offices, hospital units, emergency rooms and private homes.

The Aging 2000 staff synthesized what it learned and presented

findings and observations to the committee. Committee members broke into smaller groups to review problems and devise solutions.

One physician explained, "They don't teach us group dynamics in medical school, physicians aren't trained to work in a team" (Aging 2000, 1991b, p. 6-6). Because teamwork and the sharing of responsibility is not encouraged, the choice becomes either to legally allow individual nurses, social workers and others to exercise judgment in performing certain functions or to discourage them from doing so. The increasing threat of malpractice litigation and regulatory restriction reinforces a health care culture built on following orders (Aging 2000, 1991b, p. 6-9).

The use of semi-autonomous teams to take responsibility for quality, the trend known as Total Quality Management, that has proved so successful in other industries, has just begun to permeate health care. The lag in adopting such practices is especially unfortunate because the variety of needs and varying nature of patients makes health care particularly inappropriate for overly rigid standardized procedures and regulations (Aging 2000, 1991b, p. 6-9).

Once the data has been collected it is important to facilitate discussion as to the interpretation of the data. To build consensus as to what the data means and how it can be used to change and improve the system.

Researchers and public policy educators have the knowledge, resources and experience to educate and assist groups with data collection skills. However, we may need to expand our techniques to include those skills that complement the concepts of "total quality management": interviewing, listening, clarifying, questioning, facilitating and observing skills. Others include: group dynamics, focus groups, team work and conflict management.

In our research and education can we change to an open-ended approach, not predicting the outcome with a preconceived hypotheses and using a uniform questionnaire?

Perhaps we also need to ask ourselves some questions. How best can we contribute to improving the health care system? How much time can we commit to such a project? An Ernst & Young partner says TQM efforts need continuity of leadership to survive (Geber p. 27).

Findings, Conclusions and Recommendations

Aging 2000 found that consumers and providers were most concerned about seven major problems: 1) Poor information flow and work organization impede the delivery of quality care. 2) Bureaucracy hinders professionals who attempt to offer responsive health care. Bureaucracy also frustrates and confuses patients. 3) Medications are too costly and too often misused by elderly patients. 4) Cir-

cumstances of the system conspire to force many elderly Rhode Islanders to give up their homes as they age. 5) The lack of education and training about the aging process hinders the ability of consumers, caregivers and providers to respond appropriately and effectively. 6) The cost of health care continues to climb. 7) No clear ethical principles consistently guide medical decision making (Aging 2000, 1991a).

The major report discusses each of these problems and presents recommendations for solving them. It aims to stimulate discussion among all Rhode Islanders which will lead to improving health care within their state.

Though the study focused on the population over age 65, problems of high cost, poor quality and excessive bureaucracy affect the entire health care system. Innovations that succeed in providing high quality care at reasonable costs for senior citizens can point the way to improving the health care system for everyone.

Quality Control Problems in Health Care

The health care system does not exhibit many of the fundamental principles that have produced quality work organizations in other settings. Information flow is poor. Rigid hierarchies discourage front-line workers from taking responsibility. Quality control systems are inadequate. Excessive specialization impedes teamwork. Patients shuttle from one provider to another with little continuity. Mental health problems are ignored. Reimbursement regulations create perverse incentives, driving patients into more costly and less appropriate settings. Until the systemic inhibitors of quality are removed, the health care system will not deliver the quality of care the elderly deserve (Aging 2000, 1991b, p. 6-21).

The Paper Trail

The growth of bureaucracy in health care does more than frustrate, confuse and deny care to consumers and providers. It means Americans are paying more and getting less value for their money than citizens in other developed countries.

When nurses spend their time filling out forms, they are not giving care. When doctors prepare files to document treatment for reimbursement purposes, they are not treating patients. When tax dollars fund trails of paper, they cannot also pay for quality care. The paper trail can compromise quality. The paper trail costs money—money better spent on health care (Aging 2000, 1991a, p. 45).

Problems with Medications

Medications are vital to controlling chronic conditions, preventing death and curing disease. However, medications also can cause sig-

nificant health risks—when taken incorrectly. Drug reactions, side effects and the results of dangerous combinations take many forms (Aging 2000, 1991b, pp. 8-13).

Better education among both consumers and providers, as well as a better flow of information in the health care system, can improve the chance of avoiding adverse drug reactions (Aging 2000, 1991b, pp. 8-13).

The *Senior Series* has a unit on medication. These educational materials provide a starting point of opportunities for educators, to bring together the individuals, groups—public, private and non-profit—to provide interaction, exchange of information, and consensus about policy.

Housing and the Elderly: The Struggle to Stay Home

Today most elderly people live in the homes they chose when they were not elderly. Those houses may need modification and helpers to serve as appropriate homes for frail, disabled or ill occupants.

Elderly people cannot always obtain modifications or assistance and are forced to weigh the advantages of where they live against the disadvantages of going without help. When their need for services overshadows the benefits of home, they must uproot their lives to obtain help, often moving from place to place, repeatedly undergoing the stress and disruption of moving and adapting to new surroundings.

It is not always the debilitating stroke or the advancing cancer that forces people to leave their homes. It is the little things—help around the house. While moving to a more structured setting may be a welcome relief for some elderly people, those who dread such placement should have more alternatives. Unwanted nursing home placements can cripple families and cause elderly people to give up their will to live (Aging 2000, 1991b, pp. 9-21).

With cooperation and collaboration of housing and health care professionals, there are numerous research and education materials available for addressing elderly housing options. For example: *Housing As We Grow Older*. There is a need to create policy at the community level so these options are available.

Caring for the Elderly: The Education Gap

The better educated and trained doctors, nurses, social workers and other health professionals are, the better equipped they will be to care for an aging society. But the system of education and training is neither comprehensive nor systematic (Aging 2000, 1991b, pp. 10-17).

Elderly consumers and their families, when armed with knowledge and understanding about the aging process and about programs available for older people, can more successfully navigate a difficult system at a difficult time of life. But often older people understand little about what is happening to them and less about what programs are available to help (Aging 2000, 1991b, pp. 10-18).

The *Senior Series* provides initiative for establishing interdisciplinary/interagency groups to research issues and develop education regarding health care policies and programs.

The Costs of Caring

Fear of litigation, unnecessary emergency room visits, reimbursement policies that encourage institutional care, poor flow of information that causes duplication of tests and services and lack of in-home care—they all drive costs in health care.

Through the detailed cost analysis performed by Aging 2000, we have met the drivers of health care costs, and they are a multitude of reimbursement-driven rules, regulations and traditions that create administrative costs and poor work organization.

The Aging 2000 study suggests that the real villain in rising health care costs is not expensive technology, nor tests, nor extreme medical events. The villain lies in the way Americans organize the work of health care (Aging 2000, 1991b, pp. 11-30).

Ethical Dilemmas

Thousands of individual decisions are made every day in the United States that implicitly apply ethical standards to health care. Too often these decisions are not guided by clear ethical guidelines which have been explicitly developed. As a result, many consumers and care givers are left with uneasy feelings about the values that underlie the way our health care system actually operates.

For a system to be truly driven by explicit ethical standards, moral ideals must be established as goals, even if they cannot always be met to the letter in practice. These goals must address issues of equality of access to care, the degree to which trust should govern, who has the responsibility for care and for end-of-life decisions and whether care should be rationed based on economic and community goals. Our system does not do this today (Aging 2000, 1991b, pp. 12-13).

The proceedings of the September, 1992 Association of Leadership Educators Annual Conference: Ethics and Leadership proceedings, plus other resources provide opportunities for education and policy development regarding ethical guidelines or standards.

Rhode Island Initiatives for Elderly Care

Rhode Island institutions have begun to address the problems identified in the Aging 2000 report. While limited in scope, these ventures contain the seeds for improved comprehensive care. They point the way toward constructive and far-reaching reform (Aging 2000, 1991b, pp. 13-1).

Here are a few examples of hospital programs: geriatric assessments and multidisciplinary team treatment, hospital-based outpatient geriatric assessment, and home care programs (Aging 2000, 1991b, 13-1-3).

Community programs address the needs of the elderly for getting out, staying active and socializing, which play an important role in preventing illness. Especially as seniors begin requiring help to get around and losing friends and loved ones to death, their risk for depression and isolation increase. The Department of Elderly Affairs coordinates and develops programs and activities often referred to as the "aging network" (Aging 2000, 1991b, 13-4).

Other community programs include: transportation, senior centers, nutrition programs, senior clubs, support groups, adult day care centers, respite services, emergency response systems, hospice and housing (Aging 2000, 1991b, 13-4-12).

Almost all institutions and programs that work with the elderly require support of hundreds of volunteers. Creative efforts by several religious organizations mobilize volunteers to reach the elderly in institutions as well as in the community (Aging 2000, 1991b, 13-12-13).

Programs now exist that help elderly people who are at risk of being institutionalized to remain in the community. In addition, many Rhode Island nursing homes have organized interdisciplinary teams and specialized services to improve care. For example: the Medicaid "waver channeling program," nursing homes without walls, nursing home to hospital linkages, nursing home team meetings and specialty units providing care in the areas of rehabilitation, dementia and alzheimer's (Aging 2000, 1991b, pp. 13-14-16).

Educational initiatives in long-term health care have emerged along with others: the New England Gerontology Academy, a collaborative effort; multidisciplinary program; staff and family education, training programs for nursing assistants; education programs by college students at senior centers, adult day care centers and housing complexes; and advocacy programs (Aging 2000, 1991a, pp. 13-16-17).

The capacity of professionals and consumers to create innovative, effective and exciting programs provides many opportunities. New collaboratives are always being formed and new services devised. These programs point the way toward a system that could provide

better care, that would allow more people to remain in their homes and that would improve training in geriatrics (Aging 2000, 1991b, pp. 13-19).

Opportunities abound to identify existing health care programs, create an educational environment for discussion of more effective program delivery, and form networks and collaboratives. There is a need for people to understand the difference between cooperation and collaboration. Example: Interagency Collaborative of Newport. Twelve human service agencies provide services to middle school students but their future goal is to work with the family. Costly fragmentation in service delivery has prompted reformers like Wegenke to call for collaboration among agencies serving children and families. Not only can collaboration help existing institutions better use current resources and avoid duplication, it has the potential to help children and families develop educationally, socially, and emotionally simultaneously. (Bruner, p. 5).

National Models

Providing cost-effective, appropriate, responsive care to the elderly is a challenge nationwide. Many states and agencies are launching innovative approaches to meet the challenge.

To learn from the experience of others, Aging 2000 looked at how other places are addressing problems of health care for the elderly. Rhode Island will require Rhode Island solutions, and efforts that work well in Oregon may not work well in Rhode Island. However, many public and private programs around the country are devising new ways to approach common problems (Aging 2000, 1991b, p. 14-1).

Although state governments have far less power over health care than does the federal government, more state legislatures and governors are acting to reform the parts of the health care system they control. Almost two dozen states have passed or are considering legislation to fill the policy vacuum created by Washington, D.C.'s inaction on health care. They have acted because the problems of access and runaway costs are having a tremendous impact on state budgets and on the quality of life for many people. Health care expenses—particularly Medicaid and health insurance for public employees—have increased so much in the last ten years that they are among the leading causes of state budget crises (Niedergang, p. A-17). Niedergang indicates change is much easier to bring about on the state level—where a group has more clout—than on the national level.

If researchers and extension identify health care as an issue, consideration must be given to: identifying internal (within the land grant university) and external networking; identifying groups, organizations and policymakers that are involved with health care pol-

icy and programs; sharing research and education information; and building new relationships with health care providers and professionals. A critical element is to focus on the goal.

Recommendations

Aging 2000 recommends that:

- Explicit ethical guidelines inform the delivery of health care to the elderly.

These guidelines would create a standard that all health care professionals would strive to meet and would include the following principles. All elderly are entitled to: 1) adequate and appropriate health care, regardless of age, race, religion, ethnic background, degree of frailty or level of income; 2) the right to guide decisions about their care even when they become very old. Health care providers should encourage patients to play an active part in important decisions about their care whenever possible. They should educate consumers about options and alternatives and provide all the information necessary for knowledgeable decisions; 3) a health care system that operates on the basis of trust between patient and doctor, doctor and insurer, patient and institution, and doctor and institution and all of these must be able to operate on the basis of trust in relationship to government, where trust breaks down. Health care providers should be held morally accountable for their actions, but, whenever possible, this accountability should be addressed by internal review groups rather than be the subject of litigation; 4) a system that encourages families and friends to take care of one another in times of need and particularly in old age, promotes this ethic, supports caregivers and volunteers and catalyzes community support; and 5) an ethics committee of religious, health care providers and consumers to set explicit ethical guidelines, which would be revised over time and reviewed for major ethical questions (Aging 2000, 1991b, pp. 15-2-3).

An ethical system of care would place higher priority on the physical, mental and functional well-being of the individual than on following protocols for how to cure a specific, acute problem (Aging 2000, 1991b, pp. 15-2-3).

- A statewide patient information system.

This information system would insure ready access to accurate, up-to-date information essential to providing sound care.

This data would take into consideration the patient's full condition to improve the quality and efficiency of health care and assist professionals in providing appropriate and responsive treatment and reducing costs. This computerized patient information database, with access terminals in the offices of health care pro-

viders, would store information such as medical history, pre-scribed medications, living circumstances and emergency con-tacts. A small plastic "smart card" would be embossed with an electronic device to store this information. Information would be added or deleted as conditions change (Aging 2000, 1991b, pp. 15-7).

- Improved quality and control costs in the health care system.

This would be achieved by working with providers to accelerate the introduction of total quality management and high perform-ance work organizations. The key characteristics include: quality control in a "bottoms up" process; development of a process that involves all employees in continuous, incremental improvements in work procedures to achieve the goals, development of meas-ures to assess progress toward the goals—direct assessment of consumer satisfaction; assumption of group responsibility for re-sults combined with a positive incentive system that encourages success and uses failure as a learning device; increased responsi-bility for frontline workers and a more collaborative approach to problem solving; increased emphasis on training and education on a continual basis to improve skills; reduction in bureaucracy and documentation; and a greater overlap in job function to reduce the rigidities and frustrations associated with narrow job definitions (Aging 2000, 1991b, pp.15-10-11).

- The establishment of a Training and Resource Center.

This center would sponsor lectures, seminars and inservice teaching for health care professionals, students outside the health care field, police officers, transportation drivers and fami-ly caregivers. The center could become a 24-hour resource for elderly consumers and their families with access to up-to-date in-formation from published materials, counselors and staff and provide help filling out forms and respond to questions about medications and services. The Center could organize teaching programs in hospitals, nursing homes, community centers and apartment buildings, and offer on-site courses on special topics. Medical, nursing and social work schools should offer courses in geriatrics and gerontology; and colleges and universities should establish clinical experiences in community settings and institu-tions (Aging 2000, 1991b, p. 15-15).

- Three models for elderly health care delivery: 1) the advocate, 2) total-care, and 3) home-care.

Ideally these models would coexist, providing choices for con-sumers but would still be based on the overall principles and or-ganizational framework of this research.

The advocate model or the consumer driven model would have these characteristics: 1) a multidisciplinary assessment that con-

siders functional and social needs as well as physical and mental needs; 2) trained professionals (advocate) offer guidance in mapping an appropriate care plan with each client; 3) would function under a global budget and operate its own quality assurance system; and 4) by pooling resources and stripping away traditional restrictions, the money saved could be reapplied to a broader range of preventive services and work to keep clients as healthy and active as possible.

The total care model would offer a continuum of services through a single organization that pays for and provides care with these characteristics: 1) all services—health, social services, preventive, educational and informational—delivered through a community health care center; 2) multidisciplinary team would assess each client and the client would participate in care planning which would enhance continuity and coordination; and a global fund would be negotiated each year with federal, state and third party insurers.

The home care model is a system of community-based services for elderly residing in their own residences and wishing to stay within the current health care system, which might include the following components: 1) on-site clinics, physician visits, pharmacy reviews, a mobile health unit and a 24-hour response line; 2) community centers could serve as hubs, be an affiliate with physicians who make house calls; the delivery system could be designed to make optimum use of home health aides, visiting nurses, transportation services and home delivered meals; and expand respite care; and 3) modifications to residences to accommodate elderly needs.

Implementation

Aging 2000 is moving ahead to work with hospitals, nursing homes, physician offices and home health agencies to set aside units, floors or patient populations where they will organize the delivery of care using these methods. Other activities include: disseminating and discussing the report with interested groups; working with health care providers and consumers to plan and implement the recommendations; securing waivers and funding mechanisms to carry out the recommendations by conducting discussions with federal, state and private insurers; and seeking financial support from foundations to pursue these activities.

Public Policy

Health care systems are creatures of public policy in almost all nations. In some countries, the government runs the health care system directly and health care workers are government employees. In others, the government organizes or tightly regulates private groups

that insure consumers or provide health care to them. In the United States, health care services are privately insured and privately delivered for most people, through a regulation process. The main exceptions are the public insurance programs established for elderly and poor Americans.

Health care policy has seesawed between the two conflicting goals of controlling costs and expanding benefits. Cost control measures have focused on: raising premiums and co-payments; freezing doctors' fees; establishing pre-set rates for hospital services; and creating review organizations to oversee hospital and physician practices. Effort to expand benefits has focused on: covering more people and expanding programs to provide more health related services.

Government policy aimed to insure that cost controls did not reduce the quality of care and that the professions and institutions providing care were held to high standards. All of these goals were imposed on the system in an additive fashion. Each piece of legislation fine tuned the existing system without fundamentally changing it. Congress reacted to problems by introducing legislation that responded to only those problems. New legislation created its own set of problems, so another set of regulations addressed those. But the system grew more complex and disjointed and the concurrent goals of increased benefits and cost containment drifted further and further out of reach (Aging 2000, 1991b, pp. 3-5).

In 1981, Congress began to enact health care policy through the Omnibus Budget Reconciliation Act of 1981 (OBRA81), a trend that would continue through the decade. Congressional action has amounted to a tug-of-war between cost containment and coverage. The legislative practice of writing health care policy through budget reconciliation frustrates meaningful reform. The purpose of the budget reconciliation process is to deal with spending not governed by the regular budget appropriation process. As one member of Congress put it, "The process of reconciliation doesn't mesh well with long-term health care needs; it's about saving money here and now" (Aging 2000, 1991b, p. 3-14).

The prospects for controlling costs appear dim against the realities of an aging population, AIDS and rapid inflation in health care. Cost control efforts increasingly focus on limiting access to medical technology and procedures. For the first time, the federal government is preparing to consider cost as a factor in deciding whether Medicare will pay for certain procedures and drugs (Aging 2000, 1991b, p. 3-15).

With all of the forces at work, the health care debate during the 1990s essentially comes down to the same question posed in the last three decades: *how can the nation provide its citizens better access to better health care at a price it can afford?* (Aging 2000, 1991b, p. 3-15). This is our goal.

Despite the wealth of ideas represented by these and other proposals, many knowledgeable observers believe change will continue through incremental measures aimed at solving pieces of the problem. But, reform has evolved in this manner for twenty-five years and has not succeeded. New legislation attempts to correct problems created by previous legislation. Rising costs and lack of coverage continue to plague the American health care system (Aging 2000, 1991b, p. 3-16).

In resolving the health care crisis we face an enormous challenge. From Aging 2000 and other states' efforts there are many indications that significant reform of policies, programs and institutions are needed. The health care experiences suggest the process of change must begin in the way health care is delivered, paid for, funded and organized. Information and education is essential throughout the process.

Some concepts from *Beyond Interdependence* are relevant to health care (MacNeill, et al.). The relationships, interactions and decisions made by government, health care providers, suppliers, insurers, and patients and their families are dependent upon the interdependence of the health care system components.

To make the transition or paradigm shift from where we are in the health care system to where we need to go, means an improvement in the capacity to manage interlocked economic, cultural, social and health institutional components, to set the stage for a secure and sustainable health care system future with a steady improvement in the human prospect.

As a team member, researchers and educators can help set broad new directions for health care delivery. These directions include new principles to govern relationships between government, people and health care providers.

This is a big agenda for the 21st century. Health policy is important to American politics because it is closely tied to the issues of poverty, welfare and social insurance. To reach beyond the short term will require new and expanded tasks for all those involved. Health care policy is fundamental because the resources and attention given to health care, the institutions that deliver it and the way it is received affect the shape of social relations (Cochran, p. 262).

Linking tasks to the policy life cycle—recognition, policy formulation, implementation and control—may be a critical step for success. The intense conflict is in the recognition/problem identification stage. People demand action, the institutions resist it, and the government waffles (MacNeill, et al., p. 66).

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