Special Article

The singularity of pluralism

George A. Silver

Yale University, School of Medicine, 590 Ellsworth Avenue, New Haven, CT 06511, USA

There are powerful social developments agitating the stream of world events which hint at imminent similar agitation in the medical world. Ethnic, racial, tribal loyalties stir brutal, bloody conflicts. The relation of the healing professions is that the revolts and rebelliousness reflect demands for autonomy – distinct and separate control of social as well as political institutions. It will not be long before the call will come to organize health services along the axis of local custom, local tradition, local resources.

For most of Europe, as well as in the poorer, or only recently organized independent states, the cry is to jettison centralized rule, abandon the lessons of colonial dominance in administration, culture, professional services. An African public health leader, John Karefa Smart, though educated in England and the United States, announced: 'The hospital is not native to Africa.'

In Holland a long-standing experiment in multiple cultural political organization which has been in place since the 17th century, now includes autonomous cultural health organizations. Ethnic and racial groups are directing their own service units and make up the bulk of the providers as well as the consumers of medical care. The medical care system provides for equal, but separate, health service units, supported with public funds as well as with health insurance premiums. The *verzuiling*, separate columns of administration, pertains to education, welfare services and politics as well as to health.

Britain ordains a health service system centrally funded, that allows for little local deviation from central regulations. The United States, with a long tradition of federalism, issues central directives accompanying partial central funding, but does allow for some state variance from central plans. Switzerland, Canada and Germany, other federal states, allow more or less differing administrative approaches in the cantons, provinces or *länder*. Eastern European countries have tended to impose a central pattern on their health systems, although

that may be changing, particularly as dominant states – the Soviet Union, Yugoslavia and Czechoslovakia, break up.

What if the revolt against central authority leads to demands for local autonomy in health services? How can Britain respond? Wales, Scotland, Northern Ireland have made their wishes felt already in the writing of the National Health Service Law reforms over the past two decades. But these efforts have been minuscule, compared with the potential for alteration and regional particularization.

The situation in the United States presents a curious paradox and a unique opportunity. Until the 1930s, in the time of the Depression, traditional American response to welfare and public health needs was to rely upon state and local reaction, not central government. Localities initiated their own plans, state initiated their own, sometimes aided by diffusion of ideas from other communities. In the words of a respected Supreme Court Justice, Louis Brandeis, confirming the value and importance of this process, it was a happy accident that States existed as laboratories, to test a plan or programme on fewer than the whole population, allowing the country to benefit from the varied experiences.

Unlike Britain and other European countries, the United States has a tradition of hostility to government intervention into welfare and health matters. So, in the 19th century in the United States, when welfare and health issues began to become salient for the community, public programmes in these areas were initiated at the local and state level. The dole, almshouses and poorhouses, clinics and hospitals, unemployment payments, occupational and environmental health and safety measures, widows' pensions, support of the aged, blind and poor mothers and children, began without federal intervention. Only after a number of states had passed such legislation and Congress was stimulated by state representatives of the desirability of extending the service to all US citizens, did national action occur.

This traditional pattern was ended when the Depression compelled the federal government to enter into direct support as the states lost their capability to finance any health or welfare measures. Gradually over the years since, the

central responsibilities have widened and the states became dependent on federal initiative, losing their innovative commitment in the federal encroachment.

For the United States, calls for local autonomy have already become pressing political demands. Meeting these demands will mean only a return to the previous natural order, when the states initiated and the central government followed. Still, the traditional principle of equity will require minimum performance standards for each state, and the programs legislated will include some federal financial support. A 'national' medical care program for the United States may very well turn

out to be a congeries of similar though not identical state comprehensive measures.

Given the worldwide political circumstances, the demand for local rather than central control, may affect other federal states, so that Germany and Switzerland, for example, may respond similarly. What can Britain be expected to do? Is the parliamentary system of government as flexibly responsive to local demands as the representative system of government in federalist countries? Will Britain respond to the challenge by permitting a variety of models of the National Health Service to emerge, not only in Wales, Scotland and Ireland, but in regions of England as well?