An operating description

A Comprehensive Health Planning Board of Directors

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The concept of participation of both health providers and health consumers in the process of health planning has recently become operational in many areas of the United States. As a result, areawide comprehensive

health planning (CHP) agencies have organized new policy-making bodies, boards of directors, with representational mixes that stimulate the curiosity of social scientists. A CHP board characteristically consists of representatives of the highly educated and the poorly educated, the affluent and the poor, the professional and the laborer, the white and the black, the conservative and the liberal.

I believe that a significant contribution to the field of comprehensive health planning can be made by describing the operation of such a formal group. I will focus primarily on comparing the responses of the provider and consumer members of a particular CHP board interviewed in May and June 1971, when I was a graduate student in the department of health administration at the Washington University School of Medicine, St. Louis, Mo.

The CHP agency selected for study, through the personal interviews, was in a metropolitan area of the Midwest. The agency's planning area was bistate, including eight counties. The agency had been in existence for more than 2 years, and its board of directors had been operational about 18 months.

During the period studied the board held 15 meetings, and attendance averaged 50 percent. Average attendance of the providers was 56 percent, and of the consumers, 45 percent. Turnover of the board members totaled 12 of 54: three providers and nine consumers.

The board of directors was composed of 54 members, 32 of whom were classified as consumers. Interviews were conducted with 34 of the 39 members that were designated as eligible. Some board members were deemed ineligible for interviewing, based upon lack of attendance at meetings or recent appointment to the board. Sixteen provider members and 18 consumer members were interviewed. The tape-recorded, structured interviews were directed at obtaining descriptive responses to the following questions;

- Organizational and personal goals
- The decision-making process, including the most important influencing factor and the role of the staff
- Communication among board members and between board members and the staff
- Sources of information for the board as a whole and for the individual members
- Disagreement within the board
- Board participation as an educational experience
- Role of the consumer in health planning
- Recommended changes for the CHP agency

Goals of CHP Agency

The 34 board members interviewed were asked to describe their perceptions of the goals of the CHP agency. Eighteen members mentioned goals for increasing the coordination of the elements within the health system. Responses in this category included avoidance of duplication of health facilities and services and reducing costs through increased efficiency. Other less frequently mentioned categories of goals included basic changes in the health system—mentioned by nine members—and organizing the health planning agency—mentioned by four members.

In the category of basic changes they emphasized the field of preventive medicine, eliminating the free enterprise nature of the health system, and relocating health manpower in areas of greatest need. In organizing the health planning agency they wanted to provide a consumer-provider mechanism and to establish a health data base. Three board members admitted that they could not define the goals of the CHP agency. No significant difference was noted between the responses of the providers and the consumers.

The board members were asked to state their personal goals as board members of the CHP agency. Eighteen members mentioned basic changes in the health system as their personal goal. The only other personal goal—mentioned by 12 members—was increasing the coordination of elements of the health system.

Significant differences were noted between the personal goals of the providers and the consumers. Thirteen consumers mentioned basic changes as their goal, with increased coordination mentioned by four consumers. Eight providers favored increased coordination over the basic changes favored by five providers. The other members did not respond.

These responses provided a comparison of the perceived goals of the organization with the goals of the individual components of that organization. Most of the board members viewed their organization's goals as involving increasing coordination of the elements of the health system. Because of the high frequency of response by the consumers favoring basic changes in the health system, the board members as a group favored basic changes as their personal goals.

Decision-Making Process

The decision-making process was initiated by one person or a group of persons, external to the board, who submitted a written proposal. This proposal was received by the staff, who reviewed it and forwarded it to the board with recommendations. The final stage for the proposal consisted of a vote by the board members at a formal meeting that had a quorum present. The quorum requirement was one-third of the board membership. The board members described such a process most frequently. Nine board members added the step of committee consideration and recommendation to the decision-making process.

The board members were asked to describe the most important influencing factor in their decision making. Ten providers mentioned professional health expertise and recommendations as their primary influencing factors, with the total needs of the community also mentioned by five providers. One provider did not respond.

In contrast, 11 consumers mentioned the total health needs of the community, four mentioned the health needs of the minority groups, and three mentioned personal values attached to the facts available. No consumers mentioned professional health expertise or recommendations as the most important influencing factor.

The role of the staff in the decision-making process was described by the board members. The two responses—"to supply information," mentioned by 12, and to supply information but "it has been insufficient information," mentioned by 13—were stated with similar frequency. Nine providers mentioned "insufficient information" and nine consumers mentioned simply "to supply information."

Communication

The board members were asked to describe communication among themselves and also between themselves and the staff. Twenty-seven said that little communication occurred among the board members. Five stated that communication was good. Two did not respond.

Most respondents viewed communication among board members as occurring only during the monthly meetings, where the large number of persons and the formal atmosphere prevented any meaningful communication. Six persons mentioned that there was better communication at committee meetings, but it was pointed out that only a few board members were on each committee and that most of the committee members were not board members.

Six persons, three providers and three consumers, stated that they thought many providers often experienced informal communication because they were likely to meet and communicate during the functions of their professional jobs.

Communication between board members and the staff consisted primarily of formal written materials, mailed out to individual board members.

Respondents who rated board-staff communication in their descriptions were nearly equally divided among three ratings: poor 12, adequate 12, and good 10. A breakdown of provider-consumer responses about board-staff communication demonstrated no significant differences.

Sources of Information

Concerning the board as a whole, the respondents most often mentioned two sources of information: written material of the staff, mentioned by 17 members, and the health professional's expertise, mentioned by 10. Seven persons mentioned various other sources, such as consumer's witness of health needs, committee reports, and health institutions.

The description of personal sources of information demonstrated differences in responses between the providers and the consumers. Ten providers mentioned their own health expertise, and 10 consumers mentioned written material from the staff. The remainder mentioned other miscellaneous sources.

Disagreement Among Members

The board members were asked if disagreement existed among the members and, if so, to describe the disagreement. The responses were categorized as evident or not evident and as constructive or destructive.

Thirty members said that disagreement was evident, and four stated that disagreement was not evident. Twenty-one members responded that the disagreement was of a constructive nature. Four persons responded that the disagreement was destructive. The remainder were undecided.

Educational Experience

The 34 board members interviewed were asked if their participation on the board was an educational experience. Seven members said "No." Twenty-seven members said "Yes." They mentioned increased knowledge of the health system, increased knowledge of the area's health

needs, and increased knowledge of the health planning process.

Six providers, but only one consumer, were among those who stated that participation on the board was not an educational experience. Those who rated participation as educational were divided equally among the three categories of increased knowledge. Eight consumers mentioned increased knowledge of the health system, and five mentioned increased knowledge of the health planning process.

Role of Consumer

The board members were asked to describe the role of the consumers who were not health professionals in health planning. Twenty-nine members stated that the most important contribution of the consumers was their input into the health planning process. Five board members, all providers, responded that it was the health professionals and not the consumers who were necessary for effective health planning.

CHP Changes Recommended

Board members were asked if they would recommend changes in the CHP agencies to increase effectiveness. Organizational changes in the structure of the health planning agency were mentioned; for example, decreasing the size of the board or redefining the consumer to exclude upper class persons. Operational changes that would change the direction in which the agency was going were mentioned; for example, formulation of master plans and criteria for health facilities and establishing a data base.

Even though organizational changes (22 of the 50 recommended) and operational changes (24 of the 50 recommended) were mentioned with similar frequency, there were significant differences in the responses of the providers and the consumers.

The providers most frequently mentioned operational changes (15 of the 23 recommended) and the consumers most often mentioned organizational changes (16 of the 27 recommended). Five board members recommended no changes. Some respondendents mentioned several changes.

Summary and Conclusion

Of the board members interviewed, the providers responded most frequently to the questions asked. They were primarily interested in coordinating the health system and viewed this goal as not only personal but also as the goal of the health planning agency. The provider's major source of information was his expertise in health matters, and the most important influencing factor in his decision making was the expertise and recommendations of health professionals.

The board members criticized the information supplied by the staff; the providers thought the information was insufficient for decision making. One-third of the providers stated that board participation was not an educational experience; and the providers most frequently recommended changes in operation of the CHP agency.

The consumers were concerned with changing the health system, even though they viewed coordination of the health system as the primary goal of the CHP agency. Thus they recommended changes in the organization of the agency. The consumers stated that the health needs of the community were the most important influencing factor in their decision making. They saw themselves as dependent on staff material for sources of information. The consumers viewed the role of the staff in the decision-making process as supplying information and were not critical of the information or the role of the staff. Increased knowledge of the health system was the most frequently mentioned type of educational experience.

The results of this study should not be used to draw conclusions or make evaluations of comprehensive health planning and its organizations. The results included some perceptions of the participants in one organization toward the operation of that organization, and hence are limited in their applicability to other organizations.

I believe that the implications of this study are such, however, that CHP agencies should undertake the task of describing the operation of their board as a formal group. Such an operating description is a necessary prerequisite before questions like the following can be approached: How can the progress and development of the board be evaluated? How can the board members be given a meaningful educational experience?

How can the board's creativity be enhanced? What are some of the important differences in board members' viewpoints, and how can these differences be used constructively?

The potential is apparent for further studies. Application of the research design employed in gathering information for this paper should be made to other CHP boards. Comparison of such results could become an important aspect of developing an evaluation model for CHP agencies.