Educational Needs as Perceived by Community Health Decision Makers

CAROL C. RIDDICK, MS
SAM M. CORDES, PhD
CHARLES O. CRAWFORD, PhD

ONE OF THE MOST SIGNIFICANT ASPECTS of social welfare policy and legislation in the last two decades has been the growing emphasis on citizen participation in solving local problems. Participatory democracy was once the political norm in the United States, but gradually, as communities grew in size, there was a shift to representative democracy. Silver and Burke, as well as others, believe that this shift has led to unwieldy bureaucracies, a less responsive and accountable government, and conflict between the will of the people and professional expertise (*1, 2*). Today there appears to be a growing movement to strengthen the citizens' role in the decision making process (*3*). Stenberg described these changes as a movement from nonindigenous to indigenous citizen representatives and from the assumption of advisor-persuader roles to the pursuit of coalition-adversary roles (*4*).

The January 1975 enactment of the National Health Planning and Resources Development Act (Public Law 93–641) is consistent with the New Federalism's renewed emphasis on citizen participation and local control. This legislation mandates a nationwide network of health systems agencies (HSAs) that are empowered to plan, develop, and regulate health services and facilities within their service areas. In carrying out its functions, each HSA is required to have a governing board consisting of a majority of local residents who are consumers of health services. In other words, the framework has been established for health-related organizations to develop structures responsive to local health care needs and consonant with local values (*5*).

The Health Planning Act is not the first such effort to cultivate citizen input in the health policy arena. Similar efforts were made under the 1966 comprehensive health planning legislation (Public Law 89–749 was also known as the Partnership for Health Act). Unfortunately, according to several scholars, the anticipated outcome of a significant increase in grassroots input never really materialized under the 1966 act (*6–8*). Among the reasons for this failure to meet expectations was that persons with little formal training and experience in health policy were asked to represent consumer interests in the planning and development of community health services (*9–12*).

Without systematic and imaginative educational efforts, there is no reason to believe that effective citizen input will unfold in the scenario for the Na-

Mrs. Riddick is an instructor in extension health education, Dr. Cordes is associate professor of agricultural economics, and Dr. Crawford is associate professor of rural sociology, the Pennsylvania State University, Department of Agricultural Economics and Rural Sociology.

This investigation was supported by a grant from the U.S. Department of Agriculture's Extension Service. Gerald Farmer, executive director of the Comprehensive Health Planning Council of Northwestern Pennsylvania, assisted in this investigation.

Tearsheet requests to Carol C. Riddick, Cooperative Extension Service, Pennsylvania State University, 106 Weaver Bldg., University Park, Pa. 16802.

tional Health Planning and Resources Development Act. In short, educational efforts are needed to spur community development and to provide citizens with the skills and knowledge that they need in their new roles and responsibilities as community health decision makers (*2, 10–12*).

Community Health Services Project

In 1974, the Cooperative Extension Service of the Pennsylvania State University was awarded a grant to help meet the educational needs of community health decision makers. The grant's objective was to increase the knowledge of these decision makers so that they could become more effective in identifying and resolving community health problems. Before developing educational materials and as a guide to the subjects that should be covered, we attempted to identify specific informational and educational needs of the decision makers in health matters. The methodology and results of that effort will be described. Three question were addressed in the study.

1. What specific informational and educational needs do community health decision makers perceive as most important?

2. Do decision makers who are providers of health care differ from consumers of health care in their perception of informational and educational needs?

3. Do these needs, as perceived by the decision makers, vary according to the nature of the decision maker's community and its supply of health care resources?

Methodology

In the fall of 1974 agreement was reached with the Comprehensive Health Planning (CHP) Council of Northwestern Pennsylvania to involve the health councils of Clearfield, Forest, and Mercer Counties in the educational program. Although the CHP Council was the designated "b" agency for a 13-county area, each county also had a health council. (The CHP council was subsequently designated the HSA for an 11-county area.) The 13 councils were formally organized to advise the "b" agency on matters related to the development of local health services. Each council was empowered to elect a 21-member board of directors whose responsibilities included review and comment regarding health facility construction in their respective counties.

The 1973 data in table 1 highlight key differences among Clearfield, Forest, and Mercer Counties. (Although educational needs were surveyed 2 years after the data in table 1 were collected, there were no significant changes in population size and medical care resources in the three counties during this period.) Forest County had a 100 percent rural population in 1970, relies extensively on tourism as its primary industry, and has the fewest people of any county in Pennsylvania. Clearfield County is semirural (71 percent rural in 1970). The Youngstown, Ohio-Sharon, Pa., metropolitan area gives Mercer County an urban

and industrial flavor (50 percent rural in 1970). Clearfield and Forest Counties have only about one-half as many physicians per capita as Mercer County. Clearfield is the best endowed with hospital beds; Forest has no hospital.

In 1975 a questionnaire listing 18 potential topics for educational programing was mailed to each member of the health councils in the 3 counties. The mailing list for the health council members included a few persons who were not official members but wanted to be kept informed of the health councils' activities. Their responses were included with the responses of the official members.

The topics on the list had been developed during meetings with the professional staff of State, county, and voluntary health-related agencies and organizations. The 18 topics were put into two groups: general concepts and background information and special topics and current issues.

For each topic, respondents were asked to indicate, on a 5-point scale, the importance of developing educational materials concerning the topic. For analysis, responses of "crucial" or "important" were classed as important; "somewhat important," "not too important," and "not important" as unimportant. Respondents were asked to define themselves as a provider or consumer of health care, and they were given an opportunity to suggest additional topics which they felt were important.

Of the 191 questionnaires mailed, 99 went to Mercer County health council members and 46 each to council members in Clearfield and Forest Counties. A reminder letter and replacement questionnaire were sent to nonrespondents about 6 weeks later. Eighty-five questionnaires were returned in prepaid postage envelopes. This number represents a 45 percent response rate, which is within the bounds of acceptability for a mail questionnaire (*13*). Of those responding, 36 identified themselves as consumers, 47 as providers, and 2 provided no identification. Response rates were not significantly different at the 5 percent level among the three counties or between providers and consumers (table 2).

Results

The list of topics for educational programing was apparently sufficiently comprehensive to include the major educational needs perceived by the respondents. Of the 18 topics listed, 16 were judged to be an important need by more than one-half of the respondents (table 3). In addition, only a few respondents added new topics to the list. No item appeared consistently among the write-in responses.

Six topics were judged important by at least three-

Table 1. Population and selected medical care resources in Pennsylvania and three of its counties, 1973 [1]

Geographic unit	Population	Physicians in patient care		Number of hospitals	Hospital beds	
		Number	Per 100,000 population		Number	Per 100,000 population
Pennsylvania	11,896,100	17,363	146	239	53,870	453
Forest County	4,800	3	62	0	0	0
Clearfield County	75,600	49	65	3	440	582
Mercer County	129,700	148	114	4	670	516

[1] 1970 data were used for osteopathic physicians.
SOURCES: Distribution of Physicians in the U.S., 1973. American Medical Association, Chicago, 1974. Licensed Health Personnel in Pennsylvania: Geographic Distribution. Pennsylvania Department of Health, Harrisburg, 1972.

Table 2. Questionnaire response rate by county and provider-consumer status

County	Questionnaires mailed			Questionnaires returned			Response rate (percent)		
	Total	Provider	Consumer	Total [1]	Provider	Consumer	Total [1]	Provider	Consumer
Clearfield	46	24	22	19	13	6	41	54	27
Forest	46	23	23	18	6	11	39	26	48
Mercer	99	65	34	48	28	19	48	43	56
Total	191	112	79	85	47	36	45	42	46

[1] The numbers of providers and consumers do not sum to total because 2 respondents failed to indicate whether they were provider or consumer.

fourths of the respondents. Most of these were in the special topics and current issues category:

Alternatives to institutionalization of the elderly and mentally disabled
Factors affecting the cost of health care
Emergency medical services
Physician extender personnel
Primary health care centers and satellite clinics
Strategies of community health planning

Topics defined as important by more than 60 percent but less than 75 percent of the respondents were termed medium priority. The following six topics were in this category:

Measuring the health status of a community
Defining and analyzing a health care system
A review of major health legislation
Factors influencing physician location
Sources of data and other information related to health and health care delivery
Evaluative procedures for measuring the impact of health planning and health care services

Table 3. Importance of selected educational needs to community health decision makers in northwestern Pennsylvania

Selected educational needs	Respondents who ranked need as important											
	Total [1]		By role in health care [2]				By county of residence					
			Consumer		Provider		Clearfield		Forest		Mercer	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
General concepts and background information												
1. Strategies of community health planning	62	75	26	74	36	77	15	83	12	67	35	75
2. Measuring the health status of a community	60	72	25	74	33	70	17	90	12	67	31	67
3. Defining and analyzing a health care system	56	70	20	63	34	74	14	82	11	65	31	67
4. A review of major health legislation proposed at the State and national level	56	68	24	69	31	67	14	78	12	67	30	64
5. Sources of data and other information related to health and health care delivery	55	66	22	63	31	66	14	78	11	61	30	63
6. Evaluative procedures for measuring the impact of health planning and health care services	50	62	17	50	32	68	11	58	8	44	31	67
7. Guidelines in interpreting health statistics	49	58	21	60	27	57	13	68	7	39	29	62
8. History, structure, functions, and purposes of comprehensive health planning [3]	38	45	20	57	17	36	9	47	8	44	21	45
9. Definitions of health planning terms and acronyms	36	43	18	51	17	37	10	53	4	22	22	48
Special topics and current issues												
10. Alternatives to institutionalization of the elderly and the mentally disabled	71	86	31	89	39	85	16	85	13	72	42	91
11. Factors affecting the cost of health care	68	85	26	79	40	89	18	95	13	77	37	84
12. Emergency medical services	65	85	27	82	38	86	15	88	14	78	38	86
13. Physician extender personnel	65	79	28	82	37	79	14	78	16	94	35	75
14. Primary health care centers and satellite clinics	62	79	26	79	35	80	14	78	14	82	34	77
15. Factors influencing physician location	55	68	19	56	34	76	12	67	12	67	31	69
16. Professional Standards Review Organizations	47	60	16	49	30	68	13	68	7	41	27	63
17. National health insurance	43	55	20	59	23	55	10	56	10	56	23	55
18. Prepaid health insurance	40	51	16	49	24	55	10	56	8	47	22	51

[1] Excludes those who did not respond to a particular item.
[2] Excludes 2 respondents who failed to indicate whether they were providers or consumers.
[3] Significant difference (at .10 level) when examining perceived importance of item by respondent's role in health care.

Low priority topics (important to 60 percent or less of the respondents) were the following:

Professional Standards Review Organizations (PSROs)
Guidelines on interpreting health statistics
National health insurance
Prepaid health insurance
History, structure, functions, and purposes of comprehensive health planning
Definitions of health planning terms and acronyms

It would be reasonable to hypothesize that informational and educational needs would (*a*) differ between providers and consumers of health care and (*b*) vary according to the nature of the decision maker's community and its supply of health care resources. For example, it would be reasonable to hypothesize that providers of health care would have a much different perception than consumers of the need for information about the PSROs. The providers are directly influenced by this program; they are responsible for establishing the PSRO network and ensuring that it functions properly. Similarly, it could be reasoned that decision makers in Forest County, which lacks a hospital, would attach little importance to the need to learn about PSROs.

Contrary to these expectations, Chi square analysis revealed that consumers and providers differed (at the 10 percent level of significance) on only one topic in the importance that they attached to it (table 3). Consumers perceived a greater need for educational materials about the history, structure, functions, and purposes of comprehensive health planning than did providers (57 percent compared to 36 percent). There were no statistically significant differences among respondents by county of residence. Furthermore, additional analysis using Phi and Cramer's V statistics did not reveal a particularly strong association between the educational needs perceived by community health decision makers and their role as a provider or consumer or their county of residence.

Discussion

Although a three-county study cannot lead to definitive generalizations, the results can be suggestive. Five important suggestions or considerations can be drawn from this study.

First, having the target audience determine the direction of an educational program by involving them in the identification of informational and educational needs is feasible and inexpensive if a mail questionnaire is used. The response rate for this survey was acceptable (45 percent) and the cost per usable response was only $1.25.

Second, the results of this study indicate a tremendous need for educational resources for community health decision makers. Third, items perceived as having the highest priority for educational programing are not necessarily those focusing on general health planning concepts, data, and terminology. Instead, information on special topics and current issues (for example, alternatives to institutionalization of the elderly and the mentally disabled) appear to be of greatest importance from the decision maker's perspective.

Fourth, perceived educational needs of providers and consumers do not seem to vary significantly. Fifth, it appears that there are common informational and educational needs as perceived by community health decision makers even when they reside in communities that vary widely in the available supply of health care resources.

References

1. Silver, G. A.: Community participation and health resource allocation. Int J Health Ser 3: 117–131 (1973).
2. Burke, E. M.: Citizen participation strategies. Am Inst Planners 34: 237–294 (1968).
3. U.S. Senate Subcommittee on Intergovernmental Relations: Confidence and concern: citizens view American Government. 93d Cong. 1st Sess. U.S. Government Printing Office, Washington, D.C., Dec. 3, 1973.
4. Stenberg, C. W.: Citizens and the administrative state: from participation to power. Public Admin Rev 32: 190–198 (1972).
5. Schwebel, A., et al.: A community organization approach to implementation of comprehensive health planning. Am J Public Health 63: 675–680 (1973).
6. Milio, N.: Dimensions of consumer participation and national health legislation. Am J Public Health 64: 357–363 (1974).
7. Parkum, K. H., and Parkum, V. C.: Voluntary participation in health planning. Pennsylvania Department of Health, Harrisburg, 1973.
8. Raffel, M. W.: Comprehensive health planning—off and running, but in the wrong direction. Paper presented at the 100th annual meeting, American Public Health Association, Atlantic City, N.J., Nov. 14, 1972.
9. Parker, A. W.: The consumer as policy-maker—issues of training. Am J Public Health 60: 2139–2153, November 1970.
10. Danaceau, P.: Consumer participation in health care: how it's working. Human Services Institute for Children and Families, Inc., Rosslyn, Va., May 1975.
11. Greer, A. L.: Training board members for health planning agencies. Public Health Rep 91: 56–61, January-February 1976.
12. Falkson, J. L.: An evaluation of policy-related research on citizen participation in municipal health service systems. Med Care Rev 33: 156–221 (1976).
13. Kerlinger, F. N.: Foundations of behavioral research. Holt, Rinehart and Winston, Inc., New York, 1973, pp. 410–423.