Michigan Community Health Services Study

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THE PHILOSOPHY of the Michigan Community Health Services Study, especially those concepts which relate to comprehensive regional and statewide health planning, is consistent with the intent of Public Law 89–749, "Comprehensive Health Planning and Public Health Services Amendments of 1966" (*1*). The Federal approach is almost the same as that adopted by the Michigan study. In some respects, Michigan is 2 to 3 years ahead of most States in readiness to implement this legislation. Not only have regional and statewide data been collected and analyzed, but 246 community leaders have been organized into regional task forces and have become informed by participating in the study.

For the first time in Michigan, leaders of the community have studied and identified health difficulties and have taken action to improve health services. After considering alternative ways of solving these difficulties, they have come up with a series of recommendations for the improvement of health services, especially as these health services relate to the work of official health departments on a local and regional level. Members of the task forces have studied the work of voluntary agencies, health care institutions, and departments of State government. As yet, the task forces have not studied in depth such services as mental health, the administration of public medical care, and the planning of health facilities.

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Purpose of Study

The Michigan study, begun in 1963, is comprised of two subsidiary projects. The first project, "Organization and Financing of Community Health Services Throughout Michigan" financed by a grant of $64,234 from the W. K. Kellogg Foundation, was started in 1963. Its purpose is "to administer a comprehensive study of community health services throughout Michigan, as a basis for modifying the present systems of organization, administration, and financing, to more effectively and realistically meet the current and emerging community health needs." The second project is entitled, "Involvement of Top Decision Makers as an Instrument to Promote Change in the Organization and Financing of Community Health Services," and is financed by a 3-year grant of $286,618 from the Public Health Service. The second project, begun in 1965, was combined with the first project to form the study.

The purpose of the second project is, as a demonstration, to test the extent to which systematic involvement of community leaders designated as "top decision makers" in the constructive analysis of public health organization and finance will (*a*) "lead to positive action on their part to change the system for the better and (*b*) result in actual and significant modification of the current patterns of operation." The study is sponsored by the department of

community health services, University of Michigan School of Public Health, the Michigan Department of Public Health, and Michigan Health Officers' Association.

The Regions

The State was divided into six regions for the study (map, table 1). The borders of the regions were determined by socioeconomic status, trade centers, travel patterns, local mores, voluntary health agency boundaries, hospital flow areas, school districts, health department unions or associations, district boundaries of State and voluntary agencies, and what may be called natural affinities. Obviously, natural geographic divisions were important in delineating regions 1 and 2.

The Task Forces

The study's aim, stated in the grant, is to get decision makers in the State and community to (*a*) "identify themselves as a part of and as leaders in the health power structure, (*b*) establish loyalties and fruitful lines of communication in two directions, that is to top decision makers and to the health hierarchy, (*c*) participate and become involved in the process of study and analysis to the extent that the final reports and recommendations will genuinely be their own and they would feel impelled from within to see to the implementation of the recommendations."

The first task of the research policy committee, composed of two representatives of each of the three sponsors, was to identify top decision makers in each of the 83 counties and for the entire State. The methodology used by the process analysts of the National Commission on Community Health Services (*2*) to determine if community leaders had participated in the 21 self-studies which the commission had sponsored throughout the country was adapted to the identification of decision makers.

A questionnaire was sent to the health officer of each county or, if there was no full-time health department, to the public health nurse in that county. A comparable questionnaire was then sent to certain persons holding positions of authority in the county such as the president of the largest bank, the editor of the largest paper, and the superintendent of schools. These

Table 1. Population of the regions of the Michigan Community Health Services Study and task force meetings

Region	Number of meetings	Number of counties	1960 population	Percent of State population
1. Upper Peninsula	9	15	305, 952	3. 9
2. Northern Michigan	6	28	355, 614	4. 5
3. Southwestern Michigan	7	10	1, 148, 552	14. 7
4. Central Michigan	7	9	760, 367	9. 7
5. Detroit-Southeastern Michigan	5	7	4, 181, 354	53. 5
6. Saginaw Valley-Eastern Michigan	7	14	1, 071, 355	13. 7
Total	41	83	7, 823, 194	100. 0

persons were invited to complete the questionnaire identifying influential persons and decision makers who were participating in social actions such as annexations, civil rights, fluoridation, local income-tax proposals, school bond issues, and extension of public water and sewage facilities.

The answers from the respondents were used to identify influential persons and decision makers, and these answers were analyzed by using marginal punchcards. If the respondent classified a person as a "decision maker," the person classified was given a weighted value of 2. If he was classified as a "general influential," the value was 1. The leaders were further classified into 16 occupations (table 2).

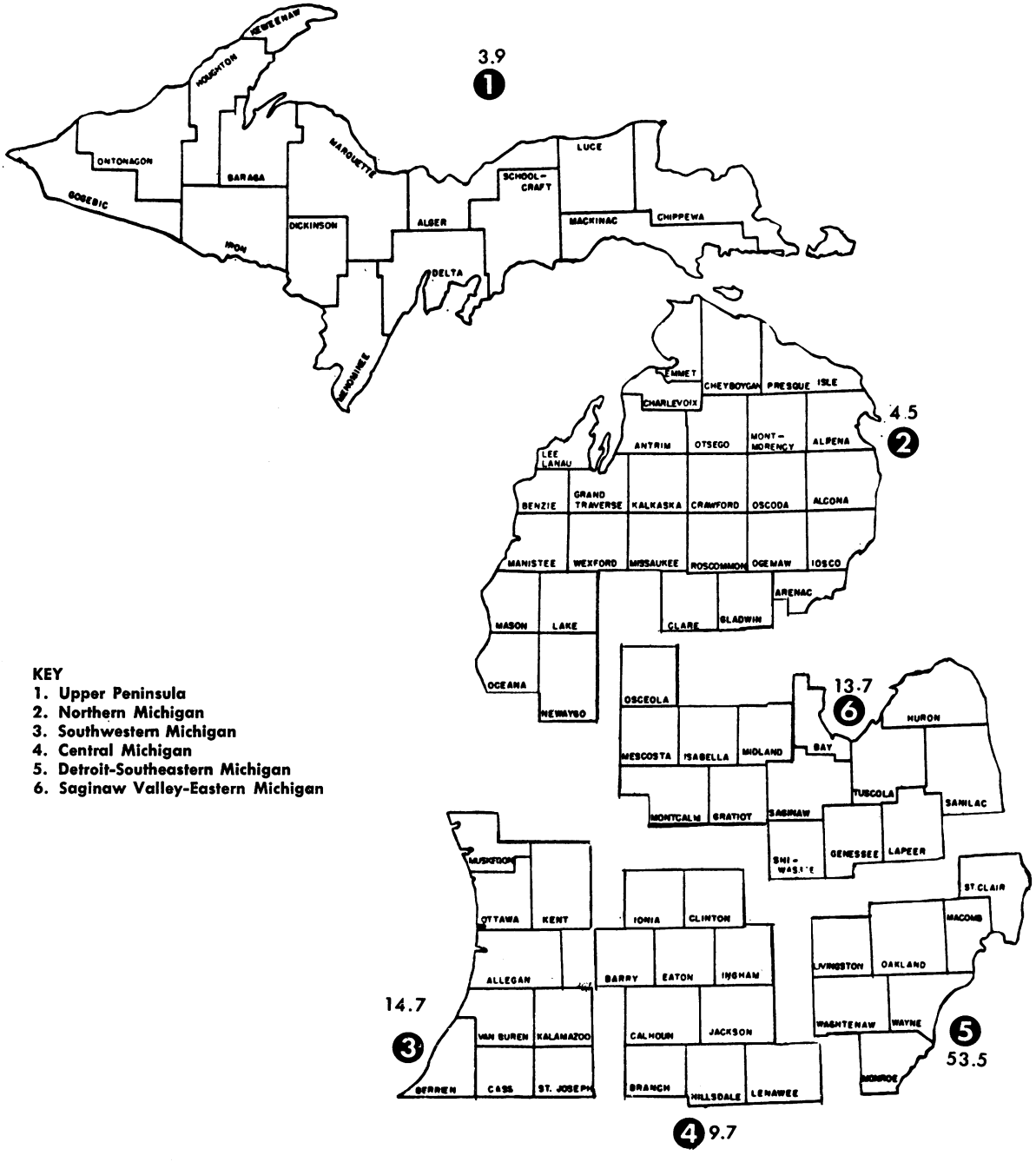
The task force members were then selected by the research policy committee from the persons who were identified by this method most frequently as influential persons or decision makers. These persons composed approximately 75 percent of each task force. Finally, using their knowledge of persons in the region, representatives of the three sponsors and the local health officer selected the remaining 25 percent of the task force members. This quarter of the task force was added to assure both geographic and occupational representation.

The first task force was organized on July 21, 1965, in the Upper Peninsula. Local and

State health department personnel did not serve on the task forces since the demonstration was to determine the effectiveness in getting community leaders to participate as agents of change in the organizing and financing of community health services. Professional public health personnel were available to task force members to serve as consultants and as resource persons.

It was the plan that a task force would consist of 30 to 40 persons. The final membership ranged from 30 to 44 with an average membership of 36. One research associate was to serve as the staff for two task forces. The entire staff

Percent of State's population contained in regions studied by task forces



KEY

1. Upper Peninsula
2. Northern Michigan
3. Southwestern Michigan
4. Central Michigan
5. Detroit-Southeastern Michigan
6. Saginaw Valley-Eastern Michigan

(three regional staff associates; a co-director who staffs the statewide committee; a sociologist who serves as a process analyst and evaluator; three secretaries; and a part-time research assistant) is housed in university facilities in Ann Arbor. The chairman of the department of community health services is director of the study, and the University of Michigan is the administrative agent. Staff of the Michigan Department of Public Health and of local health departments assisted in the fieldwork.

Identifying Problems and Data Processing

At the first meeting of each task force, there was a concerted effort to have members identify community health difficulties. It was made clear that the members were to make the study, to identify difficulties, to analyze data, and to formulate recommendations. The staff, sponsors' representatives, and State and local health professionals were to serve as consultants and resource persons; they were not to ask the task forces to act as rubber stamps or as lobbyists for agencies.

In addition to general background data on definitions, services, and responsibilities of local health departments, a series of schedules of information were sent to each task force member. Some of the more important information schedules were (*a*) methods of distribution of State funds to local health departments and minimum requirements of eligibility in the 50 States, (*b*) State fiscal aid in Michigan, (*c*) organization of community health services by counties and regions and the distribution of services by type of program, (*d*) an analysis of the health functions of 11 other State departments and their statutory authority, (*e*) the financing and analysis of 33 types of health services as furnished by 21 selected statewide voluntary agencies, (*f*) an overview by region of medical facilities and services including the analysis of care and facilities for acute illnesses, long-term care, mental disease, mental retardation, rehabilitation, and domiciliary care of the aged.

Each member was assigned homework before meetings of subcommittees, the executive committee, or of the task force as a whole. Some members attended as many as 20 separate meetings lasting from 2 to 6 hours each.

To facilitate the work of the task forces, leaders were given a model of procedures and methods to follow (see box, p. 929).

Table 2. Participants, by occupation, in task force and Committee of Forty

Occupation	Region						Committee of Forty	Total [1]
	1	2	3	4	5	6		
Physicians, osteopaths	1	4	2	0	4	3	4	17
Bankers	1	0	0	1	1	1	2	6
Businessmen	2	3	3	4	5	4	4	24
Industrialists	1	3	2	1	3	3	2	15
Labor leaders	1	0	1	3	0	1	1	7
Elected officials (including farm leaders)	6	9	5	8	7	6	4	43
Government employees (excluding health and welfare employees)	1	6	8	3	4	3	2	25
Educators	8	6	2	4	3	6	11	37
Church representatives	2	2	1	1	1	0	2	8
Lawyers, judges	3	1	0	1	1	0	0	6
Health professionals	2	[2] 4	3	2	2	3	4	17
Welfare professionals	2	1	1	1	2	1	3	11
Women's organizations	3	0	2	0	4	1	0	10
Mass media	[2] 1	[2] 4	1	1	3	0	2	12
Dentists	1	1	1	0	1	1	1	6
Opticians, podiatrists	0	0	1	0	1	0	0	2
Total	35	44	33	30	42	33	[1] 42	[1,2] 246

[1] 12 members of the Committee of Forty representing the 6 regional task forces are counted only once in total column and grand total.

[2] Regional mental health coordinator serving in regions 1 and 2 is counted in both task forces but only once in grand total.

Task Clarification of the Michigan Community Health Services Study

Ultimate goal—to assure communities throughout Michigan of the effective and efficient delivery of high quality health services which are readily available to all communities.

Task force goal—to study, to identify health problems, to consider solutions, to develop plans for the organization and financing of health services, and in the final analysis, to assist in their implementation.

Four Basic Questions

1. What is the present state of affairs in community health services?
2. What are the apparent weaknesses considered in relation to goals?
3. What steps should be taken to improve community health services (alternatives considered)?
4. What is desirable to implement the steps?

Steps to Achieve Goals

- Organization of regional task forces and the State Committee of Forty to study community health services.
- Definition of problems and needs in the area of community health services.
- Analysis and study of what is available now in community health services.
- Consideration of what is needed for the optimum provision of services.
- Realistic setting of goals for the region.
- Examination of the alternatives for reaching goals.
- Recommendations for action based on the best alternatives.
- Action on local, regional, and State levels.

The community health services are so broad that a second model, "Suggested Method of Attack," was developed to divide the study into four manageable components (see box, p. 930).

The Task Force Committees in Action

Although the task force members were not health professionals, they were knowledgeable about health needs in their regions. The members quickly started studying and planning community health services. For the first time, community leaders were discussing health issues on a regional basis. The communication among task force members and the extension of health knowledge into the daily lives of each member have been important contributions in themselves. Task force members expressed their developing interest and concern by attending meetings, reviewing fact sheets sent to their homes and offices, analyzing data, identifying health problems, and finally in preparing recommendations for action.

Activities which were undertaken by the staff to maintain the interest of the committee members are too numerous to describe in detail. One was the staff's preparation of a bimonthly newsletter which was sent to each member and to local health departments, medical societies, and other interested persons. Staff liaison was maintained with the executive committees of each task force. As the task forces developed working subcommittees, the staff met with the individual chairmen. A considerable part of staff time was spent in liaison with members of the task forces, with the staffs of local health departments, and with other persons concerned and interested in the work of the regional task force. This work was augmented, of course, by the collection and analysis of data and the submission of required reports on each meeting of the task force, its executive committees, and subcommittees so as to enable the evaluator to observe the significance of various events as they occurred.

The sociologist, who is the evaluator, has collected data on the attitudes, attendance, and behavior of task force members. An evaluation questionnaire has been sent to all members. Another means of evaluation is the degree to which members took action, outside of the task force, to improve community health services. Final evaluation of the project is, of course, the degree to which recommendations are implemented. This latter phase of evaluation cannot take place until 2 to 5 years after the study is closed in December 1968.

Preliminary analysis of data justifies the conclusion that community decision makers can be effective agents of change in the development of community health services.

From time to time, it became obvious that an occasional member was no longer participating in the work of the group. Some members had moved from the area, others had left because of other responsibilities, and still others had schedule conflicts. The attendance record of members was analyzed carefully because it was realized from the beginning that work on the task forces might interfere with other duties

Suggested Method of Attack

Put components into four broad groupings based on the definition of community health services.

1. Local health departments and State department of public health
2. Other official agencies (welfare, mental health, agriculture, public schools, water resources)
3. Voluntary agencies
4. Medical services (hospitals, nursing homes, home care, and medical care facilities)

For each component and each part of the component ask these three questions.

1. Who does what, how (services, programs, personnel, and administration)?
2. How is it organized to perform functions?
3. How is it financed?

As each component is studied, ask how all components are interrelated and coordinated.

because the participants were busy, active persons holding responsible positions in the community. Nevertheless, in the Michigan study we found that if meetings are carefully planned and persons are given definite responsibilities, they will attend meetings and work responsibly and purposefully.

The Statewide Committee of Forty

A statewide Committee of Forty was created using the same method of selection as was used in selecting the task force except that each task force had two representatives and two alternates on the statewide committee. In addition, State agencies were requested to send consultants to meet regularly with the statewide committee, including representatives of State departments, professional societies, and large voluntary agencies. From time to time, members of the sponsors' research policy committee attended meetings of the task forces and the statewide committee. Thus, ample opportunity was available to give professional guidance and advice to the influential persons and decision makers who comprised the task forces. The Committee of Forty has had only four meetings, and it has organized four subcommittees. After reviewing data presented by the staff, the subcommittees reviewed the provisional regional reports and recommendations.

Task Force Reports

In preparing their preliminary reports the task forces consulted with local health officers, voluntary agencies, and other organizations in their regions. Thus, representatives of health agencies, professional persons, such as physicians, dentists, nurses, and osteopaths, the public-at-large, and representatives of the mass media could review the proposed recommendations for changes and support the reports as presented. All task forces have completed their provisional reports, and the Committee of Forty has in turn reviewed the reports from the six task forces. The committee produced a provisional report, which was sent to the six task forces. Each task force is then expected to prepare its final report and to circulate it throughout its region.

The final report of the Committee of Forty contains not only the recommendations on statewide community health services, but also contains abstracts of the six regional reports. Part of the implementation phase of the study consists of the wide dissemination of (*a*) regional reports within a region and (*b*) statewide reports together with the six regional reports to all task force members, local health departments, legislators, public officials (both State and local) and other important community leaders.

The task forces have been preparing the community for a favorable reception of their final reports by encouraging the public to feel that they have had a part in formulating the reports and the accompanying recommendations. These proposed reports are being distributed with the suggestion that recipients either attend meetings of the task force or send in their opinions. The public is being given every opportunity to participate.

It is anticipated that when the statewide agency and the advisory council under Public Law 89–749 are appointed, many members of the State and regional committees will become members. Some of the staff may be taken over by the statewide planning agency. After the Michigan study is ended in 1968, there will grad-

ually be a transition from a demonstration and research study into the official Comprehensive Health Planning Program.

Conclusions

Individual task force members and the members of the Commitee of Forty strongly favor participation in the official Comprehensive Health Planning Program. They are not interested in making another study which would gather dust on a shelf. The following recommendations for community health planning are offered as a result of the experience gained in the Michigan study.

1. Invite decision makers in various areas of social action to participate.
2. Schedule regular meetings well in advance.
3. Find a means to reimburse persons for out-of-pocket expenses.
4. Supply a competent professional staff to handle routine work so that the task force can concentrate on important problems.
5. Formulate meaningful agendas for meetings.

Persons must be made to feel that their study and work will improve health services. The analysis of community health difficulties and decisions about a plan of action cannot be left entirely to community leaders; they need the guidance and participation of professional health workers. Thus, in organizing comprehensive regional or statewide planning councils there should be ample representation of those professionals in the health services who have a thorough knowledge as well as responsibility in administering specific community health programs.

Finally, while it is too soon to evaluate completely the effectiveness of the demonstration, it is not too soon to draw the following conclusions: (*a*) it is possible to get influential community leaders from various social-action fields to participate in comprehensive study and planning to improve community health services on a regional and statewide level and (*b*) persons holding responsible positions in a community will take an active part in task forces if they are given a meaningful role which leads to action and not merely study.

In Michigan, there have been two increases, amounting to 300 percent, in the State subsidy to local health departments since the study has been in effect. Under the stimulus of the study, the Governor appointed an advisory committee on local health departments. The data collected by the staff and appearances of the staff at meetings were influential in bringing about the first increase. The second increase was brought about by actions of the three sponsors. With the backing of individual task force members, they wrote letters, telephoned, and visited State legislators. Individual members of the task forces and the Committee of Forty have acted positively in support of legislation affecting public health in Lansing and in Washington. One member, a State representative, introduced legislation for a review and codification of health laws.

In Branch County, a member of the task force persuaded the county supervisors to authorize and finance a study of community health services. The study caused a carefully devised plan to be developed for the health services in a county with a population of 35,000 (*3*). Some recommendations of this study have already been implemented.

For the first time, Michigan has full-time health departments in all counties, and in 1967 many new health officers were appointed. The Michigan study may not have been primarily responsible for these events, but the changes did occur while the health services study was in progress and certainly the study must have had some influence on the action.

Also, the Michigan Department of Public Health has developed a plan for the regionalization of the State health department to assist local health departments in delivery of services. The State health department has received a W. K. Kellogg grant to set up a regional office in the Upper Peninsula. The purpose of the project, now in operation, is to demonstrate the improved delivery of health services on a multicounty basis in a sparsely populated but large geographic area. If successful, the plan is to develop other regional offices of the State health department as funds and personnel become available. These regional staffs are to constitute a pool of public health professionals available to local health departments as consultants and to fill local vacancies on a temporary basis.

Summary

The Michigan Community Health Services Study, begun in 1963, is financed by grants from the W. K. Kellogg Foundation and the Public Health Service. Participating in this study are 246 persons classified as "influential persons" or "decision makers" organized into one statewide and six regional task forces. Each task force has studied health services in its geographic area. In preparing their reports, the task force committees averaged seven meetings and held many subcommittee meetings. The committees studied local and State health departments, other official agencies concerned with health, voluntary agencies, medical services including hospitals, nursing homes, and home care. Provisional reports with recommendations have been submitted to the statewide committee which has prepared a consolidated report.

Experience in Michigan indicated that it is possible to get top decision makers and influential persons in various social-action fields to participate in comprehensive studies and plans to improve regional and statewide health services. These persons will take an active part if they have a meaningful role which leads to action.

The State subsidy to local health departments has increased 300 percent, and members of committees have supported pending health legislation in Lansing and in Washington. For the first time, Michigan has full-time health departments in all counties. As a demonstration project, a regional office of the State health department is now operating in the Upper Peninsula.

REFERENCES

(*1*) Comprehensive Health Planning and Public Health Services Amendments of 1966. Public Law 89–749, 80 Stat. L. 1180.

(*2*) National Commission on Community Health Services: Action-planning for community health services. Report of the Community Action Studies Project. Public Affairs Press, Washington, D.C., 1967.

(*3*) Getting, V. A., et al.: Branch County community health services study. County Planning Commission, Coldwater, Mich., December 1966. Mimeographed.

Number of Patients in Mental Hospitals Declines

The number of patients in State and county hospitals has declined for the 11th straight year.

Statistics gathered by the National Institute of Mental Health, Public Health Service, show that the resident population dropped from 475,202 in 1965 to 452,000 in 1966, a decline of 4.8 percent, and the largest annual reduction in the 11 years. Over this period, the patient population decreased 19 percent at a time when the nation's population rose 20 percent.

Total admissions increased in 1966, but so did the number of patients released, reflecting shorter hospital stays. About 330,000 persons were admitted to the hospitals in 1966 in contrast to 314,000 in 1965, and 178,000 in 1955. Today the number of net releases, 311,827, has more than doubled from the 126,498 patients released in 1955.

More money is being spent for each patient today than a decade ago; however, overall hospital costs of mental illness have fallen because of the drop in the resident patient population.

Patient care cost $1,301 million in 1966 or about $4.43 daily for each patient under treatment, compared to $2.33 in 1955. The cost per patient ranged, in 1966, in various States, from $1.91 in Mississippi to $8.70 in Colorado, $9.90 in Washington, D.C., and $12.62 in Alaska.

These figures are included in a newly released report of the Biometry Branch, "Mental Health Statistics, Current Facility Reports; Provisional Patient Movement and Administrative Data, State and County Mental Hospitals, United States, 1966."