Community Participation and Sharing in Control of Public Health Services

ELI GLOGOW, DrPH

A LARGE SEGMENT of the population is discontented with the role of public health departments. This discontent is expressed by other health professionals as well as those whose discipline is public health. Among the questions being raised are: What's wrong with public health? Why have health departments become so out of touch with the times, so out of the mainstream of health matters? Why is the leadership so apathetic? What's going to be left for health departments if more of their functions are taken over by other agencies? Why aren't health departments more involved in the provision of medical care services or of mental health services? Why don't they do a better job about environmental health and automobile safety? The list could be increased because one hears such questions throughout the nation.

Health departments have been described as systems characterized by excessive entropy, a concept that systems theorists define as a law of nature in which organizations move toward disorganization and death (*1*). To fight entropy, say the theorists, organizations must resist becoming closed systems; organizations must import new energy in the form of new people, new ideas, and new programs. These theorists state that as time goes on, organizations become conservative; their members pursue safe, uncontroversial paths and become more concerned with the security of their employees.

Persons concerned about the mission of public health claim that policymaking boards of health represent the establishment's point of view. These boards direct departments to pursue establishment-approved programs. When a dynamic health department impinges on the domain of either private medical practice or private industry, pressure is exerted on the health officer. The result is a retreat to cautiousness. Too often the chastised professionals hesitate to initiate new programs because they fear alienating their professional superiors. Survival becomes the dominating force.

A combination of external forces, such as the elected public officials, appointed health commissioners, and private interests—together with cautious, survival-oriented health department professionals—have contributed to the present static conditions of public health.

This static condition is being recognized. The leadership in the American Public Health Association is attempting to remedy it (*2*), but the task is not easy, and increasing opposition is evident among members who are resisting change. Recent editorials in the APHA's "The Nation's Health" (*3*) have revealed that some members are leaving the association because they are experiencing a "loss of professional status." One member wrote, "I'm being driven to the corner of our professional organization by consumers." Another says the association has become "a consumers' lobby," and has abandoned scientific programs. However, these complaints are not the real issue.

The issue is that in its attempt to break out of the old, traditional, conservative model, the new leadership is attempting to open up the relatively closed system of public health. These leaders are introducing new inputs by listening and relating to other groups in their respective

Dr. Glogow is an associate professor in the Graduate Program in Health Administration, School of Public Administration, University of Southern California, Los Angeles. Tearsheet requests to Dr. Eli Glogow, School of Public Administration, University Park, Los Angeles 90007.

constituencies. These groups include the consumers, the poor, the minorities, and other previously uninvolved segments of society. The APHA is taking strong positions on issues such as national health insurance. In short, the leadership is attempting to revitalize the public health system.

Decentralization and Citizen Participation

Among the solutions being offered for the revitalization of health departments is some form of decentralization, community control, or consumer participation. Proponents of this approach believe that health department bureaucracies must share some of their power with the citizenry, particularly with persons who previously have not been represented in decision-making bodies. The proponents point to accumulating evidence of a movement both in the United States and abroad for people to have a greater voice in their work (*4*), education (*5*), church (*6*), and lives in general (*7*). They predict that this trend toward participatory democracy will continue and the subsequent force can energize public health, thereby bringing it back into the mainstream of health. To explore this movement, there is a need to clarify such much-confused terms as decentralization, community control, community participation, and community involvement (*8*).

Traditionally, decentralization may be used synonymously with administrative decentralization. Decentralization refers to delegation of authority from higher to lower levels within an organization or unit of government. Federal offices are created or street-level bureaucracies are established. The objective of such decentralization is to bring government closer to the people, but not to delegate authority to entities outside the formal structure of government (*9*).

Conversely, political decentralization refers to the delegation of authority not only to lower levels within the formal government hierarchy but also to groups outside the government. Apparently administrative decentralization is markedly different from political decentralization. Administrative decentralization implies retention of power and authority with the formal government unit, whereas political decentralization mandates the sharing of authority with persons outside government (*10*).

Community control or neighborhood control may be viewed as a form of political decentralization. In its extreme version, "control" is assumed to have literal meaning in that the local unit seeks autonomy while at the same time asserts a claim to the fiscal and taxing resources of the wider community (*9a*).

In terms of a health agency, community control has been described as (*a*) the allocation of the all important planning, policy, and operational responsibilities to broadly representative neighborhood health boards with locally responsible neighborhood health administrators, and (*b*) the power of the local community to hire and fire all staff including professionals and to control all departments including the clinical services (*11*).

The terms citizen involvement, participation, or consumerism refer to a variety of devices which allow the individual access to the institutions of government; in this instance, health departments. These devices may be viewed as a continuum of authority, power, and control being shared by citizens and official agencies. This continuum ranges from token citizen involvement to the most extreme form of community control, which all but excludes involvement of governmental or agency representatives.

In the general study of decentralization and participation, I have found Eisinger's model to be particularly useful (*12*). He presents a rather complex paradigm, the heart of which is control sharing. He describes control sharing as a form of administrative and political organization of municipal service agencies in which the authority to make policy decisions about service levels and general administrative standards is shared. Among the decision makers are professional bureaucrats, elected officials, and democratically selected citizens representing geographic neighborhoods or particular client groups. Another crucial aspect of his concept is the "formally guaranteed presence of democratically selected citizen representatives or client representatives on bureaucratic policy making boards."

Health Departments vs. Decentralization

Proponents of a decentralized, control-sharing scheme for health departments believe it is one of the ways to regenerate public health. They point out that the decentralization of health department services, which began as early as 1915, was administrative: more authority was delegated to public health administrators at the local level (*13–15*).

These proponents claim that although nonprofessionals from the community are members

of the board of health, these persons have been carefully selected by local government officials and have not been elected by their constituencies. This concept of democratic selection is a key aspect of Eisinger's control-sharing model.

Furthermore, proponents say that citizen involvement usually has been in uncontroversial programs, such as immunization campaigns, chest X-ray surveys, community sanitation campaigns, and health education activities. Seldom have citizen groups radically changed the direction of health departments from health education and prevention of communicable disease to politically hot issues, such as the delivery of medical care services, mental health services, or air pollution control programs.

Advocates of decentralized control sharing admit a number of "activist health departments" (*16*) are involved in dynamic, innovative programs. However, most health departments are concerned with carefully circumscribed, noncontroversial activities.

Four Positions

In reviewing the growing literature on decentralization and citizen or consumer participation, I have found no overt opposition to consumer or citizen involvement. It is the degree of citizens' participation that becomes the subject of concern (*17–22*). I have attempted to delineate four positions within this subject as follows.

Participation is good. This position, accepted by almost everyone, represents the ethos of participatory democracy. To oppose it is to admit being totalitarian, and few would dare. Entire programs are built on the participation concept. Programs such as the Office of Equal Opportunity's neighborhood health centers, the Demonstration and Model Cities Act, and the Comprehensive Health Planning Law require a majority of consumers to constitute their board membership.

Community control is better than participation. Advocates of community control say participation is good but that it is not enough; control is the answer. Their position may be illustrated by the following demands on one community by advocates of community control (*23*).

- Self-determination in health care planning (both services and facilities)
- Removal of all outside-appointed administrators and staff working in the community
- Immediate cessation of health care facility construction pending review by a community-appointed review board
- Publicly supported health care provided for short-term illness and preventive medicine (including elimination of all fee-for-service remuneration), that is, free health care for all
- Health education program for all members of the community
- Community control over health care facilities (including hiring, firing, salaries of personnel, and construction)
- Total support from community and extra-community organizations and individuals.

Community control is not enough. The third group comprises persons concerned with the limitations of community control. These critics warn of the danger of participation for the sake of participation, achieving accountability with no increase—and perhaps even a decrease—in productivity or efficiency (*24*). They claim that community control is concerned mainly with administrative problems and suggest that the real power sources must be reached in order to effect significant changes in the health system.

These people warn that community control will fall far short of its objectives unless it becomes a broader struggle for popular, democratic control of all public institutions and the economy (*11, 25, 26*). They feel the movement must go further and escalate its demands.

The case has yet to be made. This group represents an increasing number of persons voicing concern about whether decentralized, control-sharing models work. In a recent issue of the American Behavioral Scientist which was devoted entirely to urban decentralization and community participation, a number of contributors raise flags of caution (*9*). One contributor reports that little evidence can be found supporting or refuting the proposition that greater participation in local governance improves services (*10*).

Another author concludes that neither decentralization nor citizen participation (nor neighborhood control) are waves of the future and that these systems or structures are not likely to be either durable or widely adopted (*27*).

A third contributor writes that "already some early supporters of decentralization measures have begun to move away from their initial positions, and, as disadvantages accumulate with existing experiments, there may likely be a return to the virtues of professionalism and strong central policy direction" (*9b*).

In a nationwide study of citizen participation in Model City programs, Dinerman reported that only 30 percent of the Model Cities directors who responded to her questionnaire described their experience with citizen involvement as being "very effective" (*28*). Most respondents evaluated resident participation as being only "somewhat effective" in stimulating needed changes in community services and programs.

Persons in this group raise the issues of benefits in relation to costs and wonder whether the benefits are worth the foreseeable disadvantages. These persons are concerned about the dangers of factionalism being created within neighborhoods and between neighborhoods competing for scarce resources. This faction worries about "alleged leaders" who profess to speak for the communities and about the dismally low percentage of neighborhood residents who vote for representatives to local boards. The group fears the lack of organization, the inefficiency, and the dangers of eventual disillusionment and hostility among local residents who discover their health problems may not have been significantly affected by the community's participation.

Crucial Side Benefits

It may be too soon to determine if decentralized, control-sharing mechanisms result in improved services. A number of studies are now in progress which should provide much needed information (*29*). More time may be required before consumers can develop the needed technical expertise to make the proper decisions affecting their community. However, the comments of E. Kelty, a National Institute of Mental Health official who has had considerable experience with community-controlled organizations, are revealing. In a personal conversation on April 4, 1972, he said: "As a result of their involvement in health programs, there are now low income consumers who can stand up and talk to professionals and who are quite sophisticated about the whole planning process."

There are those who feel that the desire for improved public services may be only part of the rationale for control sharing. They claim that even if higher quality services are not produced, social and psychological benefits will accrue. These rewards, such as reducing the feeling of powerlessness and alienation, may be as important as the provision of direct health services (*12, 30*).

An entire profession, public health education, has been built on the evidence that citizen participation in planning and carrying out health programs yields acute awareness of health problems, increased use of health services, and—in many instances—prevention of disease. In the final analysis, say the proponents of decentralization and community control, unless major changes in services and their delivery are attempted, there may not be too much left for public health departments to do.

One thing appears fairly certain. Barring a backlash toward a repressive political state, one can predict that the movement by people to have a greater voice in their lives will continue and will probably gain momentum. Citizen participation appears to be here to stay (*20, 31*).

Implications for Administration

I began this paper stating there was considerable discontent with the state of public health and reported that one solution being offered was some form of a decentralization, power sharing, or community control. Although there is no consensus as to which form is best, I did say that the participatory democracy theme seems to be pervading most institutions and will likely continue to do so. Widespread practice of participatory democracy, I believe, is a healthy development and a force which administrators could use to revitalize public health.

My major point is that the combination of external forces such as conservative local government, local medical societies, and other private interests—in concert with conservative bureaucracies within health departments—have helped create the status-quo situation in which public health now finds itself.

I believe that public health administrators can effect changes by using new social forces whether they be within or outside the health department. The outside forces are those persons who until now have had little to say about decision making, that is, consumer groups, minorities, uninvolved segments of the middle class, and young professionals going into private law or medical practices. The forces within are the new professionals and the nonprofessional workers entering public health eager to do meaningful work.

Many of these new workers are client centered and advocacy oriented: they have a value system that fits neatly into a progressive mission for public health. Such a mission would provide direct medical services for all people—not just poor

people. These services might include contraception or abortion and deal with subjects currently considered controversial but which directly affect the public's health.

In no way am I suggesting that public health administrators ignore the traditional holders of power such as local government officials, private industry, and private medicine. This would be folly. These groups are important in this pluralistic society. Administrators will have to work with all groups, but such cooperation will require certain knowledge and skills, some of which I will discuss.

1. Administrators will have to realize that their departments must be more truly open systems (*1a*). No longer will administrators have the luxury of running their departments as relatively closed corporations in which the decisions affecting the community's health are made exclusively by a board of health, a group of administrators, a professional staff, or any combinations of these groups. More frequently decisions will have to be based on community needs—not the convenience of the staff. This change will necessitate altering the ratio of time that administrators spend inside their work unit to the amount of time spent outside the unit. There will be a definite shift in the direction of "outside" activities.

2. Administrators have to establish improved mechanisms for feedback not only within their organizations, but for their client groups as well. Feedback must be set up for their patients, patients' families, and other clientele groups. Adequate feedback is not autogenic; it must be engendered by careful planning.

3. System theorists state that organizations must have sensing devices reaching into the environment if they are to survive. Most health departments have been attuned to the established power sources, such as local government, private medicine, and private interests. However, the administrator will have to extend his awareness to those groups who have not been adequately represented. Yet he will have to be aware that there are dangers in interpreting statements of so-called community leaders—leaders who pretend to represent their communities but who in reality may be speaking for themselves.

4. Just as accountability has become a key issue in public education (*24, 32, 33*), so may it be in public health. Administrators in all likelihood will be accountable not only to the recognized power sources, but to the emerging power groups such as the minorities, welfare rights representatives, and consumer groups.

5. The administrator must be aware that the health department's outputs are going to be increasingly scrutinized by its community's constituencies in terms of efficiency and, more important, its effectiveness. Efficiency may be thought of as the "amount of resources used to produce a unit of output" (*34*), but it may not necessarily be related to the quality of output. Measuring effectiveness will be thornier, because it necessitates studying the agency's outputs in terms of its goals. Serious questions will be raised by the emerging community groups concerning the relevance and quality of these goals and, equally important, the agency's value judgment.

6. The administrator will have to become more knowledgeable and skillful in dealing with conflict. Most present-day administrators come from the middle class and find it difficult to deal with the hostility, verbal abuse, and militancy of the indigenous community (*35*). On the basis of my personal observations of numerous such confrontations, a safe prediction is that as militant groups demand more services, the traditional purveyors of services will protest.

The administrator will be right in the middle and will require considerable skills in negotiation and bargaining to resolve conflicts. Effective involvement of poor people in community decision making will ultimately require the institutionalization of bargaining mechanisms, just as collective bargaining arrangements have become the normal practice in labor-management relations (*36*).

7. In addition to their own feelings, administrators will have to deal with those of individuals in community groups, members of boards of health, and of their staffs. Whether relating to minority groups or to members of the youth counter-culture, both within and outside their agencies, administrators will find that these groups express their feelings more freely and are reluctant to suppress them.

8. Expertise in group dynamics will be another requisite. Increasingly administrators will find themselves working with groups of all kinds, sizes, and functions. Administrators are now using terms such as task force, study groups, autonomous work groups, project management, and matrix organization. All of these terms imply the concept of working in teams or small groups.

Bennis and Slater (*37*) point out that in the very near future there will be a plethora of tem-

porary organizations in our society. These organizations and groups will be continuously forming, dissolving, and being replaced by new ones. Administrators will have to be able to relate to these groups quickly. They will not have the luxury of gradually developing working relationships.

9. The skillful use of politics, which has been described as the ability to influence the actions of others, will be increasingly required in a participatory, control-sharing model. In the past, political activity traditionally revolved around elected officials and the more powerful private and public interests. However, additional segments of society are entering politics, exerting pressures, and making demands. The administrator will truly be the person in the middle, pressed between the private and public providers of health services and the vocal, organized recipients.

10. Administrators will also require a thorough understanding of the health industry, their agencies' functions, and the newer technological developments. These developments include computerization, information systems, planning methodologies, and performance budgeting techniques. Although these are grouped together, I am not suggesting they are of secondary importance. They are part of the required vital tools of the profession.

You might comment after reading the list of recommended knowledges and skills, that no single administrator is likely to have them all. You may be right! If Bales and other investigators (*1b*) are correct in stating that the totality of leadership attributes are rarely found in a single person, then perhaps the administrator's job is to develop a leadership team which has these knowledges and skills. This will necessitate that he share control and power within as well as outside his organization.

Whether he builds a leadership team or attempts to develop his own skills, I suggest that the wear and tear on the nervous system of administrators who work in participatory, control-sharing agencies will be enormous. In view of (*a*) the stress and hazards involved in satisfying the demands of competing power groups and (*b*) the increasing tendency of professionals to follow their profession rather than accept a lifelong career in one particular agency (*38*), the administrator's job tenure in any one position may be limited, perhaps to 4 or 5 years. By that time, he may want to change jobs or have the chance to "recharge his batteries," much like faculty members do in the university sabbatical system. This will necessitate enlightened and basic changes in civil service procedures. Financial limitations and tradition will be difficult to deal with, but it is hoped that they will not be impossible to change.

This paper is not intended to discourage administrators from working in participatory, control-sharing agencies. Admittedly, the problems will be numerous. However, if health departments are again to become relevant, vital agencies, they must more vigorously attempt to become participatory and control sharing.

Summary

The considerable discontent with the present state of public health suggests that a major cause is that health departments have become relatively closed systems. The combination of conservative decision-making bodies outside the health department—such as elected public officials, private medical and other private interests—in concert with bureaucratic, security-conscious leadership within the departments has contributed to the present state in all too many health departments.

New segments of the population, such as the consumer, the minorities, the poor, must be brought into the departments of the decision-making process. Decentralization, community control, and other citizen participation models are discussed as possible ways of revitalizing health departments.

One model of citizen participation was stressed. It contained the following concepts.

1. The community's democratic selection of its representatives to policy-making boards for the health department.

2. Sharing the authority to make policy decisions among the health professionals, elected officials, and the democratically selected citizen representatives.

Whether citizen participation will result in improved services cannot be discerned at this time. A number of studies in progress should contribute much needed data. However, it is asked whether some of the side benefits accruing from citizen participation, such as the combatting of alienation and powerlessness, may not be as important as the improvement of services.

Although no one model of citizen participation or control sharing was identified as optimal, I

believe that some variation of the model is needed if public health is to become relevant again. Administrators who will be working in a participatory, control-sharing model should be aware of the difficulties they will face and the knowledge and skills which will be required for effective administration.

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