Commentaries

Consumer-Based Boards of Health Centers: Structural Problems in Achieving Effective Control

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Abstract: The fact that consumers have problems in utilizing their formal power as board members is usually attributed to individual deficiencies or cultural differences. The position argued here is that such views need to be questioned and amended. Thus, the ties between a health center and the larger health care system, the relations of consumers to their community environments, and the internal organization of health centers are examined as structural factors which limit the effectiveness of consumer board members. Despite the magnitude and durability of such factors, suggestions are made for increasing the effectiveness of consumer-based boards. (Am. J. Public Health 68:578–582, 1978)

With the passage of P.L. 93-641, The National Health Planning and Resources Development Act of 1974, and the efforts to implement that Act, interest in and concern about consumer participation in the delivery of health care has reached a high point. With the legitimacy gained through such legislation, it is now taken as axiomatic that such consumer involvement is both desirable and inevitable. Consumer participation is seen as maximized when it goes beyond the form of "advisory boards" to involve boards of directors of health care organizations on which consumers constitute the majority of members.[1-4]

However, an alternative view is that consumer control of health care delivery, leaving aside the question of its desirability, is not necessarily inevitable—even when consumers occupy the majority of seats on a board of directors. This paper examines certain structural features associated with consumer-based boards of directors which mediate *against* effective consumer control and thereby perpetuate the traditional power structure of providers and other professionals in the health care field.

This paper examines the "structural" characteristics of health care facilities with consumer-based boards of directors, characteristics which create governance problems for consumers that are independent of those created by the differing values and attitudes of providers and consumers.[5-8] This is not to deny that some of the difficulties faced by consumer-based boards result from individual prejudices, stereotypes, professional ideologies and the like; indeed, there is some support for this position in the literature.[9, 10] However, the problems consumers face in achieving an effective voice in directing the delivery of health care can best be understood if the issues are "de-personalized."

In order to focus the argument about the importance of structural features, the discussion will concentrate on consumer-based boards which govern community health centers. Such health centers exist within a larger system of health care delivery; they also exist within a social and political framework, including community, regional, and national levels. In addition, health centers are themselves social organizations, and as such are characterized by certain patterns of structure and process. Therefore, this emphasis on social structure will focus on the relations of health centers to larger sociopolitical environments and on their internal organization.

The pertinent questions are:

- Exactly how do the relations between a health center and other elements in a health care delivery system reduce the effectiveness of consumer control?
- How do the connections between consumers and other social and political organizations in a community impede consumer governance of a health center?
- What is it about the internal structure and processes of a health center which mediates against the formal control which consumers might possess?

In attempting to answer these questions, I will draw on an extensive review of the literature as well as my own experience as a board member of a rural health center. Although my experience has been with a full-service clinic, the points

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raised here should apply to a wide range of health centers with consumer-based boards of directors.

Relations between the Health Center and Other Elements in a Health Care Delivery System

The fact that health centers are one part of a larger network of organizations and institutions makes it naive to assume that effective consumer involvement can be accomplished simply by granting formal consumer control over one element in this larger structure. A complex system predicated on professional control will not be altered simply by introducing formal consumer control at one point in that system. This is not simply a matter of individual attitudes or the peculiar psychology of providers and consumers; it rests also on specific organizational features of the larger institutional framework. Several of these will now be examined.

The Institutional Structuring of Information

It is important to consider the sources and nature of the information received by board members as they develop and evaluate policy and programs. It is through the center's information network—linkages to regional and national offices of HEW; to state and county level health departments; to regional Health Systems Agencies; to medical and dental societies on various levels; and through linkages to other agencies—that issues are defined and channeled into the health center and to board members. This information network is important because it provides opportunities for the consumer board members to consider program options and problems as defined by health care providers and the larger health care system. When other agencies in the health care system communicate with the health center, it is done through contact with the director or professional staff, rather than through consumer board members. Thus, these traditional controllers of power define the realities within which alternatives and difficulties are stated and understood. Funding problems, mandated programs, definitions of need, resources available—all these and more are articulated in a framework controlled by nonconsumers. As the consumers exercise their controlling vote on the board, they do so based on information made available through, and reflecting the assumptions and values of, the traditional professionally dominated health care system.

There are other more specific consequences of this structure of communication for consumer control. Clearly, the nature of the language used in traditional medical fields imposes a burden on consumers.[11, 12] Consumers frequently rely on professionals to interpret the political language of relevant legislation as well as the medical terminology integrally related to operations of the health center. This dependence does not generate self-confidence and assertiveness on the part of consumer board members.[13] These problems are often magnified when some consumer board members are non-English speaking.

Since the information tends to come through the structural ties of health centers to other agencies in the health care system, consumers must rely on staff directors for information.* Consumers tend not to have structural ties to the larger system, and the resulting reliance on a few key professionals can reduce the effectiveness of their formal control. In sum, the structural ties between health centers and the larger health care complex results in a communication network which processes information and defines issues from a provider standpoint. This effectively limits the impact of a consumer-based board of directors.

Finally, because of the complex and uncertain relations between health centers and other agencies in the health care system (especially funding agencies), health centers must remain flexible in terms of future directions. Specific goals cannot be developed and rigorously adhered to, since changing economic and political fortunes may mean radical changes in programs and policies. How does this affect the role of consumers? It means that the potential for consumer control in terms of defining long range goals is reduced, leading to the re-focusing of consumer attention to relatively less significant matters. This may help explain the interest consumer board members show in internal administrative matters, such as complaints about inefficient staff members. The uncertain future for health centers leads to ambiguous or unstated goals, and this results in a re-direction of consumer attention to matters which are more properly administrative.[15]

The Institutional Structuring of Time

The issue of "time" is of critical importance in the administration of health centers. Deadlines for grant applications would be an obvious example; there are also the periodic reporting requirements involving both medical and financial data. For the purposes of this paper, however, only one aspect of these various issues of time will be examined.

By virtue of its ties to other agencies in the larger health care system, it is not uncommon that a health center will become aware of program possibilities or requirements with only a very short time to respond or take action. The director may hear about deadlines several days after the monthly board meeting, and find that action is required prior to the next meeting. Empowering executive committees to act on such matters carries the danger of creating schisms and conflict on the board, so it is common practice for the professional staff to develop a proposal subject to the later approval of the board. Once again, consumers with their majority vote on a board find themselves confronting policy which has been formulated and commitments which have emerged—not necessarily because of personal desires of professionals, but in this case because of a framework of time requirements imposed by the larger health care system.

As Sparer, et al.,[16] have noted, applications get submitted before consultation with consumers for a variety of reasons. Indeed, sometimes key decisions are made even before consumers are brought into the decision-making process.[15] Nevertheless, it is important to point out that this need not be attributed solely to the traditional dominance of

*Austin[14] makes the same point in regard to Community Action Agencies.

health providers. Instead, the existing structure of health care delivery again works against effective consumer control. Simply because of existing bureaucratic arrangements, consumers can find themselves taking a "reactive," rather than an "initiator"[17] role as board members.

The Structural Basis of Contacts and Careers

The ties between health centers and other elements in the institutionalized structure of health care mediate against consumer control through the mechanisms of social contacts and professional careers. Consumer board members do not have much contact with providers and other professionals outside the health center. Non-consumer board members and professional staff, on the other hand, have frequent contact with other health care personnel in both business and personal contexts. This means that consumer board members are not tied into the larger health care system as well as non-consumers are. Non-consumer board members tend to have professions which directly or indirectly keep them in contact with health care personnel at various levels—professional associations, regional meetings, and other local health organizations. Because of this difference in contacts, non-consumers are better informed concerning health matters of importance to a health center. In addition, they are better able to integrate their health center activities with their normal work responsibilities. Provider and other professional board members and staff members can thus speak with a greater degree of confidence and authority, while consumers often become passive and withdrawn because they lack the information such contacts could provide.

In terms of careers, it has been pointed out that health care professionals have a vested interest in the existing structure, which motivates them to resist organizational change sought by consumers.[12, 18] In contrast, the investment of time and energy on board matters will have little consequence for the personal careers of consumers. Austin[14] claims that the rewards for consumers are symbolic and philosophical, whereas professionals gain instrumental rewards for their board activities. This is another structural basis which generates different types and degrees of motivation, and which can result in less effective consumer effort in the governance of health centers.

Relations of Consumers to Other Political and Social Organizations in a Community

In general, consumers do not belong to organizations which could provide power resources to back up their board activities.[19, 20] A study of Model Cities programs found that consumer involvement was minimal unless there was "political mobilization" of consumers.[21] The "community" in general does not provide a power base such as that possessed by providers and other professionals who are tied into the larger health care system. Indeed, it has been noted that consumer participation is reduced when they do not serve as representatives of specific organizations.[22]

Even when consumers do have direct or indirect ties to various community organizations, there may be political divisions between these organizations which result in conflict between consumer board members.[23] Providers, on the other hand, are far less likely to be driven apart because of their memberships in other health-related organizations, although this may not be as true for Health Systems Agencies as for the boards of community health centers.

The emphasis thus far has been on the consequences of the absence of ties between consumers and organizations in the community. Ironically, the one tie that consumers do have can work against effective consumer control of health centers. The reference here is to the links between the consumer board member and his or her family and friends. Lacking the career investment and organizational ties of professionals, consumers can come to define their board activity in terms of payoffs of a more personal type. The literature provides examples of consumers using board membership for personal ends,[5, 24] such as seeking special consideration for family or friends. There is also some controversy concerning the policy of paying board members for attending meetings.[11, 25] It is quite possible that consumer board members do come to define their board activities in such personal terms; this can result in a focusing of attention on a very narrow range of clinic operations, such as personnel matters. What this means in the long run is that consumers can gradually drift away from the issues of general policy and concentrate instead on what are essentially administrative details. By default, areas of policy formulation and general philosophy can then become the province of non-consumers on the board. Training consumers about the responsibilities of board members may be futile if the structural basis for effective involvement is not present.

Internal Organization of a Health Center

The forces operating against consumers are rooted in the nature of health centers as social organizations.

Organizational Needs

Roles, norms, authority relations, and communication patterns are needed if organizations are to persist. On a fundamental level, it can be argued that consumer control of health centers is incompatible with the requirements of efficient functioning of these social organizations—e.g., the involvement of "clients" is often dysfunctional for administrative efficiency.[26, 27] Problems of communication are reduced, the authority structure is simplified, and time can be saved by reducing consumer involvement. This can be viewed as an outcome typical of organizational functioning, rather than as the reflection of professional arrogance or the reluctance of professionals to give up their traditional dominance.[10, 28, 29]

There is a tendency for professional staff members, in their desire to successfully carry out the programs of the health center, to increasingly define and understand issues in terms of managerial and bureaucratic needs. Brown[30] refers to this as a trend toward a "corporate systems approach." For example, consumers may take a stand on an issue such as fee schedules based on moral or philosophical grounds,

whereas staff professionals may counter with an argument based solely on organizational needs. It has been my experience that arguments based on the rationale of organizational needs for survival tend to win over those based on more abstract value bases. Since the structural position of consumers in health centers does not allow them information which could be used to counter such arguments, their majority vote on the board is once more of little significance.

Communication Patterns within a Health Center

In addition to the communications linkages between health centers and other organizations discussed earlier, there are communication patterns *within* centers which reduce the effectiveness of consumer control.

First, there are no structural features of health centers which would bring consumer board members together in informal meetings in a manner creating increased awareness of relevant issues. Consumers come together only at board meetings and committee meetings, and these tend to be dominated by professionals.[31] Even when consumers are involved with "underground" channels of information, these do not lead to solidarity among consumer board members.[32]

The normal functioning of organizations requires that meetings be held and that they follow some form of parliamentary procedures. It is necessary that standard topics—budget, personnel matters—be dealt with at these meetings. The result is that these must be business meetings, not informational or training meetings, and they give consumers little opportunity to learn about and discuss significant issues relevant to the health center. The bureaucratic style of communication in these meetings can have a negative impact on consumers' feeling about their competence.[13, 33] This, in turn, can be one factor in poor attendance at meetings,[34] with the final result being a further reduction in consumer effectiveness.

Roles

Roles are perhaps the key structural elements of an organization. Individuals know what is expected of them and what they can expect from others based on the roles they occupy. Partridge[35] found that consumer board members did not have a clear understanding of their role. This leads to a call for the training of consumers. However, given what has been said above about goals and communication, it should be realized that the role of the consumer board member is inherently ambiguous. The roles of providers and staff professionals have the clarity gained from time and tradition; this is not the case with consumer board members. Problems of role definition, therefore, combine with problems of organizational goals and communication patterns as examples of how structural features of a health center can limit the formal power vested in consumer board members.

Implications

The possibility that consumers will achieve an effective voice in the direction of health care agencies such as clinics and health centers does not appear too promising. Continuous calls for "training" of consumer board members[11, 13, 36, 37] may be counterproductive. The arguments *for* training imply that the difficulties lie within consumers as individuals, rather than in the larger structure of health care delivery in this society. Training consumers in Robert's Rules of Order or acquainting them with provisions of recent legislation may miss the mark. Such individual skills and knowledge are not what have made providers and other health care professionals the dominant force in health care delivery. Instead, it is their position in the social structure which provides them with power resources and the experience to use these resources.

To become more influential, and for training to be an effective strategy, consumers need to start from the same structural base as professionals. Since this would, in effect, involve some quite fundamental changes in our social structure, any suggestions put forth to accomplish this end may seem quite idealistic.

Consumers need to be involved in the larger health care system, not just in the governance of local facilities such as health centers.[38] This would provide new power bases, and open up communication channels between higher levels in the health care system and consumers on local levels. The effect would be that local consumer board members would have access to information other than that channeled through the traditional professional channels. It may be that consumer representation on area-wide Health Systems Agencies is a step in this direction. However, even here there are structural factors which mediate against consumers. For example, the use of the category of "indirect provider" results in the classification of those consumers who are interested and active in health care activities as providers, not consumers. They must thus compete with traditional professionals for seats on the HSA. The consumer positions are then filled by persons less experienced and active in health care matters.

Nevertheless, consumers would be more effective if their participation in the health care system carried some of the career implications which it carries for providers. If service on a board of directors could be seen as potentially leading to upward mobility and increased job security, some of the criticisms of consumer performance might diminish. Regional, state, and federal health agencies could more vigorously recruit staff among local consumers with experience in health care agencies, and degree requirements could be waived where necessary. An alternative would be to increase payments to consumers serving on boards, and then acknowledge that such motives are no more mercenary than those which induce non-consumers.

It may be that consumer board members should have some identifiable constituency.[39] This could take the form of official representation of other relevant community organizations, thereby providing a power base as well as relevant organizational experience for potential board members. If this occurs, providers and other professionals should be prepared for an increase in conflict,[40, 41] as consumers would now come to the board with vested interests and increased self-confidence. Staff members especially would experience a decrease in organizational efficiency as more board time would be spent on ideological and political issues.

Even if consumers were to become more effective in exercising their majority control of community health care agencies, it may be that their newly acquired power would be relatively inconsequential in terms of the larger societal power structure.[29, 42, 43] Control of local health centers might be achieved only to find that resources such as funds, personnel, and information were controlled by governmental and professional organizations far beyond the local level.

However, an alternative position is that an increase in consumer control on a local level *would* have significant effects. Consumers may find that control of organizations such as health centers can be the first step in a slow but cumulative process of gaining power resources and acquiring skills in the use of that power. Thus, even if the greater power is located at national and regional levels, consumers may find that gaining control at the local level is one way to gain access to the higher levels.

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