

Barriers to Adoption of New Programs as Perceived by Local Health Officers

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A GREAT VARIETY of new public health programs are recurrently pressed upon local health officers in the United States for addition to their present arrays of services. Such mandates for change in their departments' programs may arise from numerous external sources, including the effects of consultants and special-interest advocates, and a changing political, social, and technological environment. In another study I identified 36 specific new local health programs recently discussed in the professional literature (1).

It is acknowledged that few innovations are easily and rapidly adopted by the majority of local health departments. However, a few official units find it possible to innovate continually. This paper describes some of the barriers which impede engagement in or planning for newer programs.

Method of Study

As a part of a general study of innovation in public health programs, I conducted field studies which included interviews with local health officers in 40 full-time local health departments in California. The interviews dealt specifically with seven newer local health programs—alcoholism, accident prevention, early detection of chronic illness, home nursing serv-

ice, direct medical care, research, and family planning.

For each of these seven new programs, I determined the current program activities being conducted by each local department. Elicited also was information about plans for (a) future expansion of current program activities, (b) engaging in new activities within current programs, and (c) adopting any of the seven programs as a new activity for the department. Each health officer was asked also to describe what he perceived as barriers to the expansion of his current activities or the adoption of new programs by his department. The free-response data which these interviews yielded were analyzed, and 42 mutually exclusive categories subsumed under five super-categories were established. Following is a list of the barriers reported by local health officers.

Within the local health department

Staff:

- Insufficient personnel, short staffed, cannot recruit.
- Staff lacks technical competencies required.
- No specialized personnel, no one to administer or plan program.
- Routine duties too demanding, other activities more pressing.
- Time needed for integration into present staff activities.
- Staff member(s) or health officer antagonistic or disinterested.
- Staff or health officer interested only in certain components.

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Organization :

Department not large enough or equipped to do this.

No space is available for this program, space shortage.

Would require specific assignment of responsibility to department.

Uncertain future organization, dependent on reorganization.

Dependent on success of present demonstration.

Related to the community served

Opposition :

Community groups antagonistic.

Physicians antagonistic or need convincing.

Business interests antagonistic.

Demand :

No community interest, social or emotional climate not right, no mandate.

Physical characteristics :

Physical distances makes collaboration difficult.

Related to the local government

Local governing body :

Reluctant to accept project funds, fear need for future local financing.

Political antagonism against "frill" spending, holding budget line.

Supervisors will not approve, on record as disapproving, need convincing.

Funds :

Awaiting funds, funds not presently available.

Would require project money, no local tax funds for new programs.

Other local government :

Awaiting needed State or national leadership, legislation.

Do not have legal authority to conduct essential components.

Related to other local agencies and organizations

Function has been pre-empted by another agency.

Health department unwilling to ally with other agency.

Other agencies fearful of our entry into this area.

Other agencies unwilling to accept program as health department wants it.

Other agency doing program resistant to intervention.

Other agency should do this, not appropriate for health department.

Other agency (s) already doing it satisfactorily.

Awaiting development of relations with another local agency.

Awaiting development of this program in another agency.

Awaiting withdrawal of another agency from this program area, transfer.

Related to perceived need or appropriateness

Not much of a problem yet in this jurisdiction.

Those in need already getting service, present programs satisfactory.

Other things more important, low priority for this program.

Lack of data on needs.

Awaiting study, survey, research results, or reports. A local program will not answer this problem.

Technological knowledge is lacking, doubt that available means effective.

The time is not propitious, timing improper.

The health departments were classified into three types according to attitude toward the seven programs (table 1).

• Departments planning either to inaugurate or to expand their activities in one or more of these programs.

• Departments not planning but desiring to engage in one or more of the newer programs.

• Departments neither planning nor desiring to engage in any of the seven programs.

Basic Findings

Departments planning engagement or expansion. It would appear that internal problems of health departments are the most telling barriers to future plans, and of these the majority relate to staff rather than organizational matters (table 2). Barriers which relate to staff include outright personnel shortages, inability to recruit needed replacements, lack of technical competency within the staff, employees already perceived to be overburdened with daily routine activities, and staff members' disinterest or antagonism toward a new program. There can be little wonder that these inhibitors have a telling effect, for one is constantly amazed that small staffs, after working in wholly inadequate physical quarters, are able to meet even the responsi-

Table 1. Status of 40 local health departments regarding new public health programs in California

Program	Planning to engage or expand	No plans but desire to engage or expand	No plans and no desire to engage or expand
Alcoholism -----	11	17	12
Accident prevention-----	7	21	12
Home nursing-----	12	13	15
Early detection of chronic disease--	14	19	7
Direct medical care services----	13	10	17
Research or evaluation-----	14	15	11
Family planning----	20	11	9

bilities of the daily routine, let alone raising their views to encompass newer programs.

Barriers relating to local government account for a close second place. They tend to divide between funding problems and political relations with the local governing body. For example, apparently there was a wave of local conservatism which precluded significant increases in local health budgets in most localities

studied. Capital improvement, as reflected in public works projects, seems to have become the vogue within counties, with personnel expansion consequently suffering.

Tied closely to this phenomenon is a widely held local philosophy in California (and perhaps elsewhere) in favor of "holding the line" with respect to budgets and taxes. "Frill" spending usually is discouraged by local govern-

Table 2. Barriers to adoption or expansion of seven new health programs in California as perceived by local health officers

Reason categories	Alcoholism	Accident prevention	Home nursing	Detection of chronic illness	Direct medical care services	Research and evaluation	Family planning	Total barriers mentioned
Departments planning engagement or expansion								
Health department:								
Staff.....	6	5	5	12	6	0	10	44
Organization.....	2	2	3	3	2	0	2	14
Community:								
Opposition.....	0	0	2	8	2	0	6	18
Demand.....	1	1	1	0	1	0	1	5
Physical characteristics.....	0	1	0	0	0	0	0	1
Local government:								
Local board.....	0	0	4	0	0	4	6	14
Funds.....	4	0	2	7	1	3	6	23
Other.....	3	1	1	1	2	0	0	8
Other agencies.....	1	1	4	4	3	1	3	17
Need and appropriateness.....	1	0	0	1	1	3	0	6
Departments not planning but desiring engagement or expansion								
Health department:								
Staff.....	9	19	2	14	3	22	1	70
Organization.....	2	3	0	6	3	1	1	16
Community:								
Opposition.....	2	0	3	5	0	1	4	15
Demand.....	3	0	0	0	0	0	2	5
Physical characteristics.....	0	0	0	0	0	0	0	0
Local government:								
Local board.....	4	5	2	6	1	4	3	25
Funds.....	3	11	4	3	2	3	0	26
Other.....	2	0	0	2	2	0	1	7
Other agencies.....	4	2	7	0	2	0	2	17
Need and appropriateness.....	9	11	2	3	3	7	8	43
Departments neither planning nor desiring engagement or expansion								
Health department:								
Staff.....	4	1	1	0	2	8	1	17
Organization.....	0	0	1	0	0	5	0	6
Community:								
Opposition.....	0	0	0	0	0	0	3	3
Demand.....	1	1	2	1	0	0	0	5
Physical characteristics.....	1	0	0	0	0	0	0	1
Local government:								
Local board.....	1	0	0	0	1	3	0	5
Funds.....	1	0	0	0	1	2	0	4
Other.....	0	1	0	0	0	0	0	1
Other agencies.....	5	5	10	3	21	3	8	55
Need and appropriateness.....	8	10	3	4	6	4	3	38

ments, and many new public health programs apparently are viewed by local boards of supervisors as frills or as "do-gooding" for elements of the population not deserving tax-supported services. An example of this is opposition to programs to care for indigent alcoholics.

The relative weight of barriers differs as one inspects the data for each program. In programs relating to alcoholism, lack of staff and funds account for the major inhibitions to current plans for engagement. In chronic disease detection, community opposition (sometimes from the medical profession) is cited with staffing problems as a significant barrier. Similarly, family planning programs seem blocked by a combination of staff, community opposition (mainly religious), local board conservatism, and funding problems. Research and accident prevention activities seem to enjoy few barriers to their planning, with obstacles which have been reported for research concentrated in the local governing bodies (conservatism) and those for accident prevention in the health departments (primarily lack of competency).

Departments not planning but desiring engagement or expansion. Of the departments not planning but with desire to engage in one or more of the newer programs, 17 were interested in alcoholism programs, 21 in accident prevention activities, 13 in home nursing, 19 in early chronic disease detection, 10 in direct medical care services, 15 in research, and 11 in family planning (table 1). As with the health departments with current plans to adopt new programs, the most compelling barriers to planning again center about the health department and, in particular, about staffing problems (table 2). These barriers are followed closely in these instances by governmental inhibitors (related to funds and the unwillingness of local boards to support expanded programs) and by questions about need or appropriateness.

Staff deficiencies, such as shortages, lack of competency, and lack of time, were noted on 70 occasions by health officers in interviews (table 2). In the field, one encounters many health departments with less than 50 employees, and some with as few as 7. A number of departments have many vacancies which, because of remote locale, budget shortages, and similar reasons, seem destined to remain unfilled. How

then can a health officer presume even to desire to adopt new programs when faced by day-to-day deficits of staff time?

Within the categories of barriers, taken by individual program, staffing problems within the health department are the most pervasive inhibitor to planning in alcoholism, accident prevention, chronic illness detection, and research.

Influence of other agencies is an interestingly significant inhibitor to planning for home nursing services, suggesting in several localities that a strong organization outside the health department, already operating the required program, is reluctant to see another agency enter its sphere of operation. Such barriers erected by other agencies are manifested in a variety of ways. Outright opposition before legislative and appropriating bodies has occurred. Frequently, the fact that another agency is involved in a specific activity is sufficient to discourage health officers from planning parallel or perhaps competing activities within their departments. Often, scarce personnel are committed to the program of another agency, and therefore would not be available to the health department requiring them in a new program.

Apparently conditioned by perceived need or appropriateness are decisions to plan for programs of alcoholism and accident prevention. In addition, technological deficit—a lack of the tools and techniques to meet the needs of new programs—whether real or imagined is important in precluding adoption of new—and often contentious—programs by many local health departments.

Departments with no desire to plan or adopt new programs. Reasons health officers give for lacking the desire to plan or adopt new programs indicate an interesting shift in major barriers (table 2). The influence of other agencies and questions of need and appropriateness appear to be the compelling inhibitors to interest in innovative programs.

The fact that other agencies are involved, or perhaps more appropriately should be involved, discourages many local health departments from wishing to adopt programs in home nursing, medical care services, and family planning. Conversely, questions of the need for, or appropriateness of, new programs are

the main precursors of decisions not to plan for adoption of alcoholism, accident prevention, and chronic illness detection programs.

In several instances when no desire existed to plan for engagement in the new programs, health officers told of their serious doubts that "anything can be done" about the problem. Many health officers, during interview sessions, expressed their personal conviction that no problems which would require adoption of one or another of the new programs existed within their jurisdictions. Such feelings were expressed about family planning and alcoholism programs. Particularly astonishing were several instances when this feeling was expressed with respect to accident prevention programs. For example, it is difficult to believe that accidents, representing generally the fourth leading cause of death in the United States, can fail to be a problem in any jurisdiction.

Research planning seems barred mainly by internal staff problems centering about the lack of time which staff members have to devote to such new activity and by the health officer's resistance.

General Conclusions

For all categories of program readiness, the barriers within the health department were mainly insufficient personnel (short staffed, recruitment difficulties, and so forth) and day-to-day demands of routine duties which are felt to be too pressing to permit inauguration of newer activities. To a somewhat lesser degree, antagonism or lack of interest by the health officer or by members of his staff occur as barriers.

Among barriers which relate to the local community, opposition by the local medical profession, community disinterest (expressed as lack of demand), and direct antagonism from groups within the community rank highest. Many newer programs considered in this study might seem to represent considerable departure from the status quo, and thus would be resisted by elements of the community power structure. Such threats to the status of existing community organizations and to their beliefs and convictions ordinarily would be expressed in some form of opposition. Many health departments apparently have found ways to circumvent pres-

ures from vested interests, perhaps by massing the countervailing forces which represent the majority wish.

Governmental barriers related to local county and city governments revolve mainly about lack of funds which are perceived by health officers as necessary to engage in new programs; secondarily, about political conservatism—philosophies of fiscal austerity and local government antagonism against spending for programs which are not considered "proper" functions of their local health department.

Regarding the effect of other agencies as barriers to local health department plans and desires, two compelling forces emerge:

1. The preception looms large that a given new program properly should be undertaken by another agency or that the activity is not an appropriate health department function.

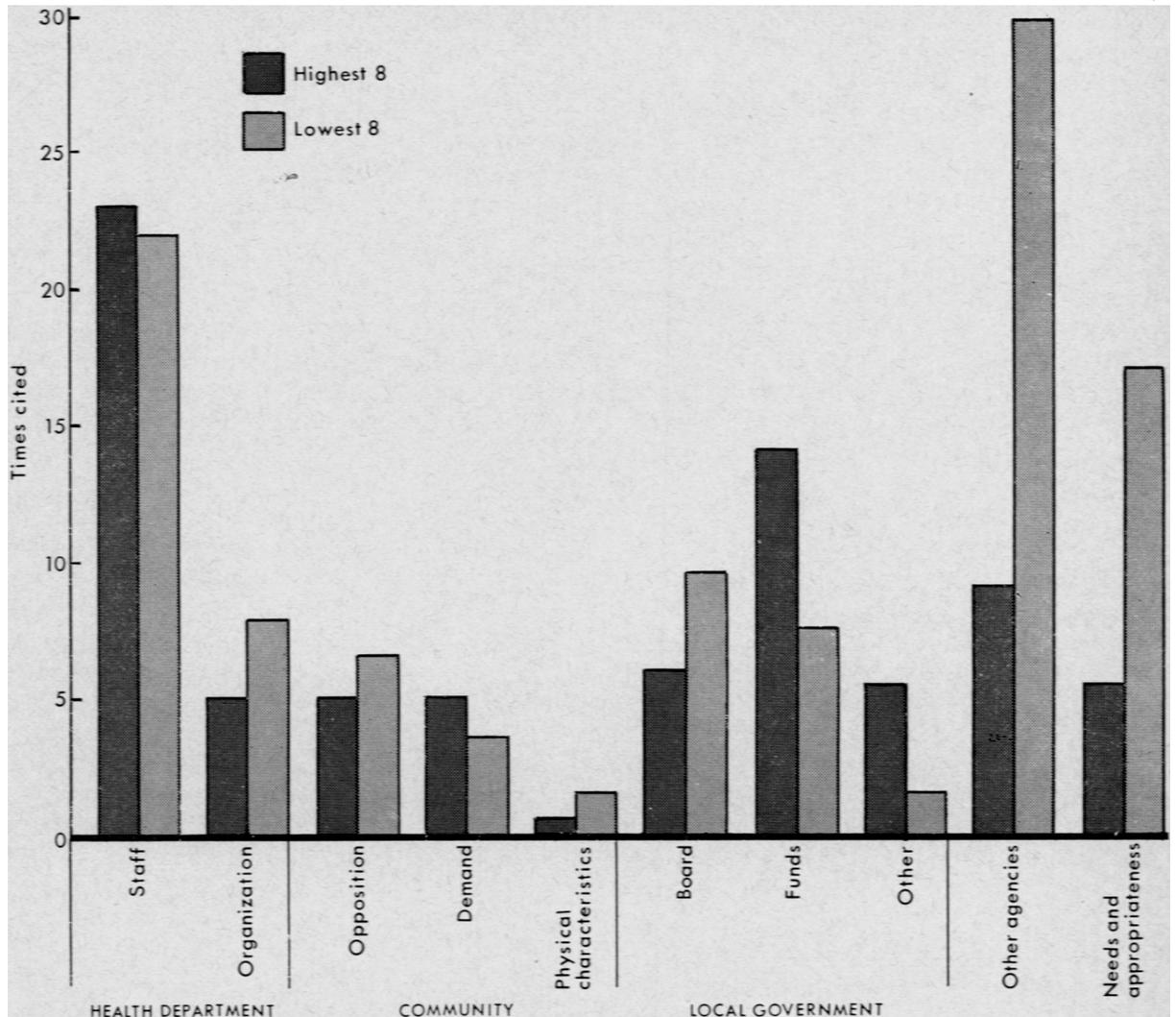
2. The fact that (in the mind of the health administrator) another agency is already satisfactorily carrying out the responsibility seems also to be a barrier.

Questions relating to need for, or appropriateness of, a given new program failed to rank very high as inhibitors to adoption. However, in those instances where these factors were identified, they related to the feeling that (*a*) those in need were already getting the necessary service through existing channels, (*b*) the priority for a given program is too low and other things are more important, or (*c*) there is a technological deficit, implying that even if desire existed, there are deficiencies in current knowledge and technique which would preclude effective programing.

Close similarity exists between the frequency with which certain barrier categories are cited by planners, desirers, and nondesirers. Occasionally, however, a striking difference is noticeable. For example, when considering four of the seven new programs, health officers heading departments of each type perceived barriers involving their staffs with the same salience.

While nondesirers conform closely with the other groups of respondents in most instances, the overwhelming reason they cited for indifference to medical care programs lies in the barriers contingent on "other agencies." This would suggest that in California awareness of services by county hospitals and other organized

Innovativeness scores of 40 local health departments based on their work in seven programs



Barrier

medical services outside the health departments is effectively barring some local health officers from even expressing a desire to have their departments participate in direct medical services. This barrier category generally seems to be the most frequently cited reason for lack of desire.

Another interesting deviation is the emphasis which desirers—not yet planners—place on problems associated with funds as inhibitors to planning for accident prevention programs. Since those presently planning to adopt accident prevention activities do not seem to see lack of funds as an obstacle, one must wonder whether the problem of funds is real or imagined—a

convenient excuse to those who have not carried their desires into the planning stage.

As a phase of a broader study, I developed “innovativeness scores” for each of the 40 local health departments studied. These scores were based upon the extent or degree of their current work in the seven programs. A comparison of the kinds of barriers to innovation reported by the eight most innovative local health departments was made with those reported by the eight least innovative departments (see chart).

When the data are examined, it appears that the most innovative and the least innovative groups to the same extent apparently face about

the same barriers. The one significant exception relates to the effect of other agencies. The least innovative departments perceive this category of barriers as the most significant to them, although it ranks quite low in importance for the most innovative departments. This suggests that the most innovative administrators are those who have found ways to surmount or circumvent these barriers, and that those with less experience in establishing novel activities feel

considerable anxiety about dealing with other agencies. To a somewhat lesser extent, departments with the lower innovative scores perceived matters of need, including technological deficit, as a more significant barrier than high-scoring innovators.

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