Consumer participation in health programs has political, psychosocial, and educational dimensions. Through real involvement with each other in the discussion-decision process, consumers and providers of health services can learn to work together. The experience of one neighborhood health center is presented.

WORKING RELATIONSHIPS BETWEEN PROVIDERS AND CONSUMERS IN A NEIGHBORHOOD HEALTH CENTER

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THE idea of consumer participation is by no means new. The literature is replete with references to the notion of citizen involvement in neighborhood programs. Health educators as well as other change agents have long advocated a role for the consumer in programs that they were expected to support and utilize. One rationale for such advocacy was based upon the educational theory that people who participate in identifying a problem and thinking through a proposed solution would be more committed to carry out that solution, less resistant to change, and have increased opportunities for learning.[1]

Recently, consumer participation has received the support of legislators, top-level administrators, and others influential in establishing social policy. Thus today we find that various service programs that include health, have policy statements which in one way or another stipulate consumer participation.

The Hough-Norwood Health Center in Cleveland, Ohio, is one of over 40 neighborhood health centers funded by the Office of Economic Opportunity. Consumer participation is stipulated as a part of the health center program. The center is operated by a Board of Trustees which acts for a nonprofit corporation. The chief executive is the project director.

The planning that preceded the grant award for the establishment of the Cleveland project was typical of the planning which precedes far too many programs which are federally funded.[2] There is usually a deadline for the grant application to be filed, and this, coupled with the tendency to design proposals so as to satisfy the grantor rather than reflect local needs and desires, often leads to lack of involvement and questionable understanding and support of the venture by the consuming community.

The status of consumer-provider relationships at the time of the funding of the health center was as follows: (a) existence of two slots for consumers on the board of 24 members; (b) plans for the "organization" of a Neighborhood Health Advisory Committee (NHC); and (c) a consumer Community Opportunity Board (COB) which had an annual review process of *all* OEO-funded programs in the service area that includes health. The COB is a neighborhood arm of the city-wide Community Action Agency.

Definitions

To clarify the terms used here, the following definitions are given:

Consumer—A person living in the service area who meets all eligibility criteria to utilize services and is therefore a user or eligible potential user.

Provider—A person actively involved at any level of program effort who is not a user or eligible user, and who has training in the broad field of health.

Service advocate—A person residing or employed in the service area who is not a consumer nor a provider as defined above, but who is a participant at some level(s) with providers and consumers and oriented toward greater relevancy of services to the users.

Policy level—The organizational forum point at which decisions are made that shape and control the program.

Planning level—The organizational forum point at which activity is channeled toward the development of additional resources or the modification of existing resources that create the capability for policy and/or operational change in program. (Though planning can take place at the board or staff level it is often delegated by boards to special ad hoc committees or task forces, and the like, thus the distinction here.)

Operational level—The organizational point at which services are delivered and utilized (administrative and staff level).

Consumer set—That number of *consumers* relating to providers at *one* given *level* (see definition of "levels" above).

Provider set—That number of *providers* relating to consumers and/or *service advocates* at *one* given *level.*

The Emergence of Political Conflicts in Consumer-Provider Relationships

During the first year, the NHC became quite knowledgeable of the program at the operational level. Some experiences that contributed to this were a tour and inspection of the center's facilities, attendance and observation of staff orientation sessions, the enrollment of some NHC members in the program as patients (without their being identified as NHC members), the organization of a grievance subcommittee, and the planning of hearings in which key staff and administrators participated. On the other hand, the COB chose only to exercise its annual review prerogative, remaining relatively unfamiliar with the project.

During the annual refunding-review process, both the NHC and the COB participated, but separately. Inasmuch as the NHC was an advisory group, it submitted its report and recommendations to the administration of the health center which was the pattern of relationship that had evolved. The COB submitted its report directly to the Office of Economic Opportunity by virtue of its OEO affiliation.

A competitive rivalry between these two community organizations, which were largely latent at the outset, surfaced during the refunding period. This is true, not only due to their separate attempts to influence the health center program, but also due to the pressure of the NHC for its members to be represented on the health center board. While pressure from the NHC for board representation existed from the beginning, it was intensified during the refunding period which was viewed as a strategic time by the group.

The board of trustees ultimately voted to modify its structure so that one-third of its makeup would be consumers. However, out of recognition of the politics of the COB's affiliation with the OEO structure, the COB was asked to submit representatives for board membership.

Shortly thereafter, the Area Council (a third neighborhood organization) received a grant to develop consumer par-

ticipation in all neighborhood programs from the city-wide Community Action Agency and formed a Priorities Commission for this activity made up of area council members and COB members.

The NHC, recognizing its relative political impotence on the one hand and its high involvement and knowledge of the health center on the other hand, held discussions with the COB with the idea that its membership should become the nucleus of a standing health committee for the COB. The NHC felt this would insure continued consumer input at the operational level, relate to the needs for political power of the members of the NHC in their relationships with the health center providers, and eliminate interorganizational conflicts between the two groups.

The foregoing developments represent examples of conflict between consumer groups as well as confrontations with providers, both of which were political in nature.

Some Educational Dimensions of Consumer-Provider Relationships and Efforts to Address Them

Three problem areas faced by the Hough-Norwood Health Center are selected for mention here, not because they are exhaustive, but because efforts to deal with these three have been the key points of working relationships between the providers and consumers of service. While these problems are discussed in terms of their educational dimension, it is recognized that they have psycho-socio-economic dimensions as well. They are:

(1) *"walk-in"* versus appointment usage of services;
(2) *demand* for services versus *supply;*
(3) *Continuing comprehensive care* versus *acute episodic care.*

A significant aspect of these three problems is that they are highly interrelated; in fact they relate as cause and effect.

Table 1 gives an illustration of the health center's utilization experiences for the quarter from July 1 to September 30, 1969. The table reveals that 62.8 per cent of appointed patients actually kept their appointments. Walk-in patients, on the other hand, accounted for 30.7 per cent of the total number of patients seen during the quarter. Thus, while approximately one-third of the *appointed* patient load were "no shows," one-third of the total patient volume was walk-in utilization. Ostensibly this would suggest that, in number (9,499 appointments given to 8,602 patients seen), the health center actually provided less services than planned. However, the number of appointments given include *all* services available at the health center, whereas walk-in patients usurp an inordinate amount of staff nurse and physician time for appropriate clinical screening activities in comparison to the time consumed through wider distribution of services to appointed patients among the total staff.

Table 1—Appointment and walk-in utilization patterns of Hough-Norwood Health Center for quarter July 1-September 30, 1969

	Appointments given	Appointments kept	Appointments missed	Total patients seen	Walk-in patients seen	Appointed patients seen
Number	9,499	5,962	3,537	8,602	2,640	5,962
Per cent	100	62.8	37.2	100	30.7	69.3

Educational efforts by the center were in the form of educational interviews of "walk-in" patients, home visits, and group meetings. The attempt was to interpret the purpose of the center, the nature and value of appointments, and the advantages of comprehensive care over episodic care. However, these efforts resulted in (1) a demand for appointments at a rate which could not be accommodated by the center; (2) understandable continued walk-in use of the center on an episodic basis (in view of (1)); and (3) increased complaints by patients—directly and through their consumer representative organization—concerning increased waiting time, not seeing their regular physicians, and other problems that naturally ensue when organization and program planning of a specific design are forced to accommodate still another pattern.

The above utilization patterns reflect in part an adaptive pattern by low-income consumers that is not unrelated to their past experiences in seeking and utilizing health services, given the options they have had relative to resources available to them.

The foregoing health center experiences give rise to the following questions:

1. If the need and demand for service exceeds the supply, can priorities be established for who gets served when? If so, how? Who establishes such priorities?
2. What, if anything, can be done concerning those consumers eligible for services who are lower on the priority list than others?
3. Can the "walk-in" problem, which disrupts the appointment system (held to be the most effective means of delivering comprehensive continuing health care), be effectively resolved?
4. What can be done about the conflict between the responsibility of the health center to provide continuing family health care, and the *need* and *demand* for acute episodic care?

These are questions that *threaten*, but also *require* effective consumer-provider working relationships.

The health center administration petitioned the board for a policy to curtail the availability of walk-in services, the temporary suspension of new family enrollments, and to set controls on the rate of enrollment when intake was reopened. The contention was that such a policy would create a climate allowing the health center to reorganize and plan its growth and development in a more orderly fashion. The providers on the board were agreeable to such a policy; the consumers were not. The policy was eventually adopted, with a stipulation—satisfactory to the consumers—that it would not take effect until alternative health care plans were adopted.

Such planning for alternate care arrangements is now being developed by representatives from the board, the administration, and the Priorities Commission previously mentioned. Meetings with the several neighborhood conferences (smaller neighborhood groups), each of which will have representatives on the Community Opportunity Board's health committee, are to be held concerning operational plans, patient grievances, and progress reports on the center.

Discussion

It appears useful to discuss the preceding aspects of this paper by raising several key questions that always exist explicitly or implicitly where consumer participation is concerned. For example, are advisory roles for consumers adequate? Should consumers be involved in policy formulation? Will consumer participation in policy decisions be adequate in and of itself? How can issues of adequate "representation" be solved?

Although focused on the consumer, these issues relate to the provider in a real way because they present the challenge as to how, and to what degree, power will be shared.

Are advisory roles for consumers adequate? Unequivocally no. If consumers are confined to advisory roles, their in-

puts are completely dependent upon the disposition of the providers to accept or reject them. Moreover, providers would then be allowed to be selective in terms of the issues felt appropriate for consumer input. The frequently used rationalization for this provider selectivity is the allegation that consumers may be overwhelmed or mystified by certain issues. This, however, constitutes unrealistic, patronizing, and paternalistic notions that, even if nonexplicit, can be sensed by consumers.

Advisory roles not only frustrate the political and psychosocial needs of consumers, but can isolate them from awareness of the complete spectrum of issues and problems involved in delivery and use of health care.

Advisory roles can be effective (if we measure effectiveness as the extent to which providers are receptive and influenced by consumer advice). However, in the experience of Hough-Norwood, there was constant pressure for more board-level consumer representation even though virtually every *request* of the NHC to the health center administration was accommodated. Finally, would providers be content with advisory roles, with consumers controlling health programs?

The answer to the question of consumer involvement in policy formulation is "yes"—not only for the same reasons that advisory roles are inadequate, but also because policy is the name of the game of power; the least sophisticated person understands this or comes to understand it. Policy-level participation can avoid creating the "illusion" of power. It bridges the political chasm, and helps relate to psychosocial dimensions of both providers and consumers who often relate across class lines with preconceived notions of each other that are not healthy. Too, it insures broader-based involvement of the consumer in understanding and grappling with problems.

However, policy-level relationships for consumers are not enough. A policy agreeable and ostensibly positive can be implemented at the operational level in such a way as to be irrelevant and negative. Therefore it is felt that, not only should there be consumer involvement at the operational and policy levels, but that the two different "consumer sets" should have organized mechanisms for mutual feedback so that each is aware of what is ensuing at the other's level. Moreover, at the operational level, consumers should in fact be the constituent base of the policy-level consumers (see Model *A* in Figure 1).

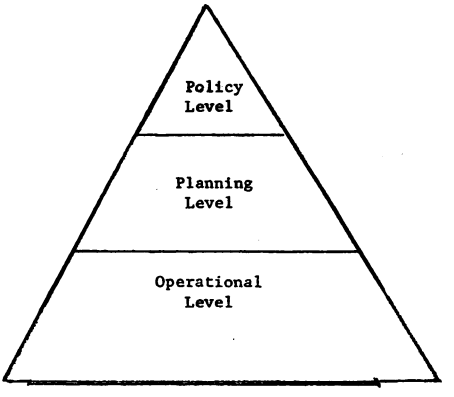
Since planning can occur by special delegation, outside the realm of the board and administration, consumers should be represented at the outset here, as well as throughout the process. Any such consumer should be related (in check and balance terms) to other consumers in a manner outlined in the paragraph immediately above.

The question of adequate representation is a tricky one. Who is representative, who determines this, and who selects or elects representatives by what criteria? There are no standard answers but there are, in our view, some helpful principles.

Satisfactory representation is subject to challenge initially, and at any point in time in the existence of a representational organization. Providers should view such challenges from consumer groups as problems for the "in-group" consumers to solve. In the Hough-Norwood experience, the NHC and COB worked out their differences, and the development of the Priorities Commission was a prime example of a political coalition through the process of accommodation.

The consumers who are most active and vocal are easily identified. They should be involved, but efforts must be made to reach beyond them to tap others in the community. It is felt that "serv-

Figure 1—Model (A) triangular illustration of consumer-provider relationships



NOTE: The accompanying model attempts to illustrate consumer-provider relationships as they are discussed in this paper. The policy level of consumer-provider relationships is positioned at the apex of the triangle because this level represents the highest order of decision power relative to program. The relative positions of the planning and operational level accordingly reflect decreasing order of decision power.

The perimeters circumscribed by each level above illustrate in terms of consumers: (1) the *number* of consumers participating at the respective levels in proportion to each other; (2) an indication of *communication* between the sets at each level; and (3) the *political* relationship between "consumer sets" at each level. Note then that the operational level would have the largest numerical representation of consumers relative to the other levels, and that operational-level consumers would be the political constituents of consumers at the other two levels (i.e., the latter would be selected or elected by these constituents).

The model does *not* attempt to indicate, at any of the three levels, the proportion of consumers to providers.

ice advocates" (previously defined) can be assets at all levels. They are likely to be familiar with the community, and have a direct stake in the effectiveness of all human service programs in neighborhoods where their agencies serve, even if that stake is only a professional one.

Finally, no "consumer set" at any level should be static or regarded as such. Mechanisms for turnover and the involvement of many consumers over time should be developed either by election or selection processes.

Summary

Consumer participation is not new, but the concept has recently received increased impetus in national social policy through the demands of consumers. Consumer-provider relationships have political and psychosocial as well as educational dimensions. This is evidenced by efforts to gain or maintain power, mutual distrust, and lack of understanding of how to work together effectively. However, both consumers and providers can learn, grow, and develop through real involvement with each other in the discussion-decision process.

Service areas of neighborhood health centers are inhabited by the poorest, sickest, and most frustrated clients. However, this does not mean that they cannot offer valuable input to programs that affect them. Programs in which they are sought as users are destined to experience problems. However, far greater problems appear to be posed unless the programs are designed so as to reverse the historical lack of participation by poor consumers in controlling their own destinies.

The vital issues arising out of this milieu threaten effective relationships between consumers and providers. However, to resolve these issues in such a way as to provide learning experiences for both parties, and to retain or develop community support, effective relationships between consumers and providers are required.

Ideas have been presented concerning the levels and nature of relationships held most positive in terms of consumers and providers. They include the notion that consumers must have broad-

based multilevel relationships with providers to include participation at the policy, planning, and operational levels. Communications should exist between all "consumer sets," preferably with the consumer constituent base at the operational level. Election or selection mechanisms for turnover among all consumer sets should exist.

Difficulties in achieving satisfactory representation should be expected. However, plans and actions should not be delayed if the reason for such delay is noted as the aim for perfect or unchallengeable representation.

One neighborhood health center's experiences can offer little that is conclusive in the way of viable approaches to establishing and maintaining effective consumer and provider relationships. However, it is clear today that health centers, specifically, and human service programs, generally, must strive to more effectively implement these kinds of interactions. For, in general, consumers are no longer willing to passively allow providers to control their destinies.

Practitioners who serve as advocates and/or facilitators of effective consumer-provider relationships must, through action-oriented research, seek methods which have broad applicability in this vital area of human relations.[3]

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