Results of a 21-month study

Community and Professional Participation in Decision Making at a Health Center

KAY B. PARTRIDGE, RN, DrPH

Dr. Partridge is staff assistant to the director, Department of Nursing, Johns Hopkins Hospital. *This research was supported in part by PHS Fellowship No. 5 F04-Nu-27, 246-02, and in part by PHS General Research Grant No. 5 401--RR05445.* *Tearsheet requests to Dr. Kay B. Partridge, Department of Nursing, Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Md. 21205.*

COMMUNITY participation continues to perplex health workers. In a previous article White and I described the methodology used to analyze two factors affecting participation—the status of the participant and the organizational focus of his participation (*1*). I now present the results of a 21-month study of the relationship between these two factors and decision making in a neighborhood health center funded by the Office of Economic Opportunity (OEO).

Whether the participants were professionals or nonprofessionals and whether they were members of the health center board or its advisory council were the two major variables investigated. Partici-

pation was defined as involvement in discussions and decisions in which the resources of the health center were allocated. We hypothesized that members of the group making more allocative decisions would report more competence, influence, and satisfaction than would members of the group making fewer allocative decisions. Finally, it was hypothesized that professionals would perceive greater competence, influence, and satisfaction than would nonprofessional participants.

The board and the advisory council were the two official mechanisms by which members of the community could become involved in the health center. The bylaws of incorporation of the center provided for a board with equal representation from the community action agency, a medical school, and a group health organization. The board was responsible for policy formulation, fiscal management, and ultimately for the success or failure of the center.

Because none of the community action agency representatives on the board qualified as potential health center users as required by OEO, it was necessary to create an advisory council on which community residents comprised at least 51 percent of the membership. Nowhere in official health center documents was it spelled out exactly what was expected of the advisory council or where it fit into the overall health center organization. Professionals and nonprofessionals served on both the board and the council.

Data for the study were gathered from meetings of the board and council and from interviews held with all members of both groups 4 months after incorporation of the center and again 1 year later. The meetings were analyzed to identify the number and nature of the topics discussed, the decisions made, and whether or not the decisions involved the resources of the health center. Interviews provided data on how participants viewed their competence in, and their influence on, 11 areas of decision. Also, responses to open-ended questions were analyzed to categorize the respondents' views on the goals of the health center and the roles of the board and council. The rationale and contents of the categories are discussed fully in the earlier article (*1*).

Results

Analysis of meetings. Analysis of the meetings of the council and board provided information on the extent and caliber of the formal participation that the professionals and nonprofessionals in the two groups experienced. Eighteen board meetings and 25 advisory council meetings were held during the 21 months covered by this study. Nearly two-thirds of the 12 board members were present at board meetings, which lasted on the average 1 hour and 51 minutes. No changes occurred in board membership during the study. Only 11 board members were included for analysis, however, because one member was on a 6-month sabbatical leave and unavailable for the followup interview.

In contrast, membership on the advisory council was so uncertain and unstable that it was difficult to estimate the average attendance at council meetings. For the study, therefore, anyone who had attended at least one council meeting and had not formally resigned from the council was considered to be a council member. At the initial interview, there were 6 professionals and 20 community people on the council. One year later, there were 5 professionals and 12 community members. The average attendance was nearly nine persons per meeting, and each meeting lasted 1 hour and 48 minutes, on the average.

Table 1 shows the number and types of topics discussed by the board and the council during the study. In the board meetings, topics that related to administration of the health center dominated discussions (63.3 percent of the total topics). The second most popular category, administrative and community topics, that is, administrative topics that affected community interests or resources, comprised 14.1 percent of the 319 topics discussed.

In the advisory council meetings, on the other hand, administrative and community topics accounted for nearly one-third of the topics discussed, while topics defined solely as administrative were discussed only 16 percent of the time. Topics related to the health center (first eight categories in table 1) represented 84.8 percent of all the topics discussed by the board compared with 59.8 percent for the council. Conversely, 38.6 percent of the council topics related to formulating council roles and managing its meetings (9th and 10th categories), whereas the board dedicated just 12.2 percent of its discussions to these topics.

As seen in table 2, similar percentages of the topics discussed by the board and the council required a decision (45.5 percent for the board and

40.5 percent for the advisory council). A crucial criterion in the study was whether or not the topics and decisions affected the health center's resources. Of the topics discussed by the board, 58.9 percent affected the allocation of resources (table 2) compared with only 30.9 percent for the council. An even more revealing differentiation occurred in the percentage of the board's and the council's discussions that both affected resources and required a decision. The proportion for the board was 31 percent and for the council, 13.7 percent.

These results indicated that for the health center in this study, the board engaged in far more discussions on allocative topics and made more allocative decisions than the council. As defined in our study then, board members, because of their increased involvement in allocative discussions and decisions, participated in the health center more than did advisory council members.

To analyze the impact of the differential experience in participation, we compared the responses from the board with those from council members, the responses from professionals with those of nonprofessionals, and the responses in the first interview with those in the second (interviews that were held 1 year apart).

Competence in decision making. Members of the board and council were queried regarding their perceived competence in the following areas of decision:

1. Setting eligibility limits
2. Handling complaints from patients of the centers
3. Formulation of employment policies
4. Deciding which programs are most important or should have most emphasis
5. Selection of the medical director
6. Evaluation of the care being given
7. Choosing persons for nonprofessional positions, such as secretaries, aides, drivers, and so forth
8. Setting fees to be charged at the center
9. Working closely with community groups and residents
10. Setting health center's hours
11. Approval of the annual budget

Respondents were asked: In which areas do you feel most able to make a decision? Each time a person mentioned an area, it was called a vote. In table 3, the first column of figures represents the total number of votes for all 11 decisional areas. The second column is the maximum number of votes possible (total number of respondents times the 11 areas of decision). The third column is the percentage observed of the maximum number of votes possible. The same information is repeated for the second interview. The last column on the right reports the difference between the results from the two interviews. Results are shown only for those respondents who remained

Table 1. Distribution of topics discussed in board and advisory council meetings, by category

Categories of topics	Board meetings		Advisory council meetings	
	Number	Percent	Number	Percent
Medical-technical	1	0.3	1	0.4
Administrative	202	63.3	42	16.0
Interorganizational relationships	10	3.2	4	1.5
Medical-technical and community	1	.3	3	1.1
Administrative and community	45	14.1	86	32.8
Interorganizational and community	5	1.5	20	7.6
Medical-technical and administrative	3	.9	1	.4
Medical-technical, administrative and community	4	1.3	0	.0
Formulation of group's role	10	3.2	29	11.1
Meeting and group management	29	9.1	72	27.5
Not related to health center	9	2.8	4	1.6
Total	319	100.0	262	100.0

Table 2. Comparison of topics discussed by the board and advisory council

Topics	Board		Advisory council	
	Number	Percentage of total	Number	Percentage of total
Health center	271	84.9	157	59.9
Management of group or meetings	39	12.2	101	38.5
Requiring a decision	145	45.5	106	40.5
Affecting center's resources	188	58.9	81	30.9
Requiring a decision and affecting resources	99	31.0	36	13.7

Table 3. Comparison of respondents' perceived competence to make decisions in all 11 areas of decision, 1st and 2d interviews, for respondents present throughout study

Composition of groups	1st interview			2d interview			Difference [1]
	Number of responses	Maximum possible (N×11)	Percent of maximum	Number of responses	Maximum possible (N×11)	Percent of maximum	
11 board members	59	121	48.8	52	121	43.0	− 5.8
7 professionals	34	77	44.2	36	77	46.8	+ 2.6
4 community members	25	44	56.8	16	44	36.4	−20.4
13 advisory council members	57	143	39.9	48	143	36.6	− 3.3
19 professionals	19	44	43.2	17	44	38.6	− 4.6
9 community members	38	99	38.4	31	99	31.3	− 7.1

[1] Difference between results of the two interviews in percentage of the maximum number of areas of decision that could have been named.

on the board or the council throughout the study period.

In both interviews, the respondents from the board reported a greater perceived competence in the 11 areas of decision than did members of the advisory council (table 3). Both groups, however, reported less competence at the time of the second interview. Board respondents reported a greater loss than did members of the advisory council. This loss was due entirely to a perceived loss of competence on the part of the community members, who reported a reduction of 20.4 percent in their perceived competence.

Consistently, the lowest scoring group was comprised of community persons on the advisory council. In both interviews, they indicated they felt less capable of making decisions in more areas than any other subgroup. Conversely, the only group to report an increase in perceived competence on the second interview was the group of professionals on the board. The professionals on the advisory council initially had scored almost as high as the professionals on the board, but by the time of the second interview their reported competence had dropped.

To ascertain the respondents' perceived influence on the 11 areas of decision, they were asked to answer this question for each of the 11 areas: How much influence do you think community people (professionals) like yourself will have on the final decision? Again, responses are presented only from those council or board members who retained membership in their group throughout the study period.

Table 4 shows that in both interviews members of the board viewed that body as far more influen-

Table 4. Reported influence on decision making in 11 areas of decision, 1st and 2d interviews, for respondents present throughout study

Composition of groups	Number and precentage of responses indicating some or great influence						
	1st interview			2d interview			Difference[1]
	Number of responses	Maximum possible (N×11)	Percent of maximum	Number of responses	Maximum possible (N×11)	Percent of maximum	
11 board members	105	121	86.8	104	121	86.0	− 0.8
7 professionals	64	77	83.1	67	77	87.0	+ 3.9
4 community members	41	44	93.2	37	44	84.1	− 9.1
13 advisory council members	94	143	65.7	81	143	56.6	9.1
4 professionals	35	44	79.5	28	44	63.6	−15.9
9 community members	59	99	59.7	53	99	53.5	− 6.2

[1] See footnote table 3.

Table 5. Board and council members' reported satisfaction from work with their group, 1st and 2d interviews

Composition of groups	Satisfaction reported, 1st interview		Satisfaction reported, 2d interview	
	Little or none	Some or great	Little or none	Some or great
11 board members....	0	[1] 10	1	10
7 professionals.....	0	7	0	7
4 community members.....	0	3	1	3
13 advisory council members.....	6	7	5	8
4 professionals.....	2	2	1	3
9 community members.....	4	5	4	5

[1] One community member said: "I don't know how much satisfaction I've had."

tial than members of the council viewed their group. While responses from the board members remained almost stable, the council members reported a marked decrease in perceived influence. After 1 year, almost 10 percent fewer of the council members than of the board members indicated that they felt they had either some influence or great influence on decisions.

The levels of perceived influence appeared more strongly linked to group experience than to status, since the professionals on the council, who originally had reported high levels of influence, 1 year later reported a sharp loss. Also, the levels of influence that the professionals on the council reported were never higher than those of community members of the board.

Respondents were asked: How much personal satisfaction have you felt so far from your work on the council (board)? As seen in table 5, with one exception, all board members reported some or great satisfaction in both interviews (one did not know). The council respondents were more evenly distributed in their responses; almost half felt some or great satisfaction, while half reported little or no satisfaction. Almost no variation is evident between the first and second interview for either group. Perceived satisfaction appears to have been linked more to group membership than to professional or nonprofessional status.

The final area of analysis deals with the degree of consensus evident within the board and council concerning the goals for the health center and the roles of the board and council. When queried as to what the health center was supposed to do, all board members stated that its purpose was to deliver medical care (table 6). Five of the 11 members responded that the health center should serve as a socioeconomic stimulus to the community; five also mentioned a role for the center in employment and training. One-third said the health center should deliver warm, personal services.

All advisory council respondents said that one purpose of the health center was to provide health care (table 6); 6 of the 13 gave no other purpose for the health center. Seven said that the health center should serve the people with warmth and dignity, while four expressed the belief that the center should provide a social and economic stimulus to the neighborhood.

In the second interview, respondents from the board continued their emphasis on the center's

Table 6. Board and advisory council members' views on health center's purposes, 1st and 2d interviews

Purpose	Board members				Advisory council members			
	1st interview		2d interview		1st interview		2d interview	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Provide health care.....	11	100.0	11	100.0	13	100.0	13	100.0
Provide social services...	2	18.2	4	36.4	2	15.4	3	23.1
Serve as socioeconomic stimulus.....	5	45.6	6	54.5	4	30.8	0	.0
Educate.....	1	19.1	4	36.4	0	.0	2	15.4
Employment and training.....	5	45.6	3	27.3	1	7.7	2	15.4
Serve people with warmth and dignity...	4	36.4	2	18.2	7	53.8	1	7.7
Demonstration project...	3	27.3	2	18.2	2	15.4	2	15.4
Offer opportunity for community participation.....	2	18.2	2	18.2	1	7.7	2	15.4

role of providing a socioeconomic stimulus to the community. Only in respect to this purpose, which was not mentioned by any respondent on the advisory council, could any major difference between the council and board be discerned in the second interview. Respondents from the council again unanimously stressed the purpose of delivering health care. They gave no other purpose even mild emphasis in the second interview. Four council respondents, all community representatives, mentioned the need for the center to provide social services.

The second source of information concerning consensus within the council and the board related to the respondents' views of the roles of the council and board. When advisory council members initially were asked what they thought the advisory council was supposed to do, three principal roles were identified (table 7). Seven of the 13 council members mentioned representing community needs and serving as a community watchdog. Six of the 13 simply said, "Advise." No other role figured prominently. No advisory council member suggested a policymaking or management-supervision role for the council. Neither did any respondent from the council view its role as one of providing community residents an opportunity to participate.

At the second interview, council members identified another role for the council—to represent the health center in the community. Although only one council member, a professional, had mentioned this role in the initial interview, all four professionals and the three community members mentioned it on the followup interview. Evidently, after 1 year's experience, it had become clear to a majority of the council that such representation was a legitimate concern for the council. In fact, this was the only role mentioned by at least one-half of its members.

Members of the board, in both interviews, indicated three predominant roles for the board: to make policy, oversee management, and respond to the community (table 8).

In the second interview, the role of overseeing management fell in importance; only 5 of the 11 board members mentioned it. Employment and training were mentioned only once in either interview. In the initial interview, two board members had mentioned the role of representing the health center, but in the second interview no one mentioned it. The responses showed agreement among members of the board concerning the purposes of their group.

Although data from the interviews suggest that greater consensus existed among board members than among council members, the differences were not explicit enough to fully support the hypothesis that the group making more allocative decisions would show more consensus. While there was no evidence of disagreement within the groups, the replies from both groups to the open-ended questions were so terse as to make assessment of consensus difficult. In relation to the roles for their respective group, however, the members of the board were more articulate than members of the council and agreed strongly on the principal roles that the board should play.

Discussion

The significance of these results can best be appreciated in the light of events that occurred in the health center, the board, and the council dur-

Table 7. Advisory council respondents, by their status and views on council's roles, 1st and 2d interviews

Roles	1st interview						2d interview					
	Professionals (N=4)		Community members (N=9)		Total (N=13)		Professionals (N=4)		Community members (N=9)		Total (N=13)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Represent community needs	4	100.0	3	33.3	7	53.8	2	50.0	3	33.3	5	38.5
Serve as community watchdog	4	100.0	3	33.3	7	53.8	3	75.0	2	22.2	5	38.5
Advise	2	50.0	4	44.4	6	46.2	2	50.0	4	44.4	6	46.2
Represent health center in community	1	25.0	0	.0	1	7.7	4	100.0	3	53.3	7	53.8
Help in employment and training	0	.0	2	22.2	2	15.4	1	25.0	2	22.2	3	23.1
Role not clear	0	.0	2	22.2	2	15.4	0	.0	3	33.3	3	23.1

Table 8. Board respondents by their status and views on board's roles, 1st and 2d interviews

Roles	1st interview						2d interview					
	Professionals (N=7)		Community members (N=4)		Total (N=11)		Professionals (N=7)		Community members (N=4)		Total (N=11)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Make policy	7	100.0	2	50.0	9	81.8	7	100.0	2	50.0	9	81.8
Oversee management and budget	4	57.1	4	100.0	8	72.7	2	28.6	3	75.0	5	45.5
Respond to community	5	71.4	3	75.0	8	72.7	5	71.4	4	50.0	9	81.8
Represent health center in community	1	14.3	1	25.0	2	18.2	0	.0	0	.0	0	.0
Help in employment and training	0	.0	0	.0	0	.0	1	14.3	0	.0	1	9.1

ing the study. Quite possibly, factors that contributed to the power of the board could be replicated elsewhere. Likewise, those factors that contributed to the attenuated impact of the advisory council within the center possibly could be avoided in other health centers.

The first major area of concern in the study was the difference, if any, between the board and advisory council in respect to the group's access to, and influence on, decision making. The results indicate that the board discussed and reached decisions on a far greater number of topics involving the health center's resources than did the council. Also, members of the board consistently viewed themselves as more competent and influential than did respondents from the council.

The principal reasons for these results were that, first, the board was empowered with traditional, clearcut responsibilities for policymaking, broad management supervision, and relations with other organizations. These roles generally were recognized and accepted by board members. Second, a majority of the members were experienced in board work and had clear ideas of the actions needed to implement the board's roles.

The advisory council, on the other hand, did not receive a clear mandate. Participants spoke of their job as being "to advise," but initially no one knew on what or how or whom the council was to advise. Additional confusion surrounded the council's role because its tasks and membership were not clearly differentiated from its predecessor in the community action agency. The council inherited the disagreements, power struggles, and coalitions of the community action agency's health group.

Second, the board's mandate was reinforced by the nature of the tasks that initially reached it for action. Numerous pressing administrative issues were handled with dispatch. Gradually the board created and launched a health center. Progress was slow but visible.

In contrast, the council lacked direction, impetus, and discernible progress. Council meetings, initially highly structured, gave way to being lengthy and often confusing. The few concrete tasks that reached the council were handled poorly because the group was unable to discuss topics and reach decisions systematically. Effective leadership was lacking within the group. The negative effects of an unstable membership were heightened by erratic attendance. No momentum could be built up across a series of meetings because problems had to be defined and discussed over and over.

Also, even after 1½ years, several council members did not know each other. Although an informal subgroup existed and functioned, the council never achieved the cohesion, shared values, and interaction characteristic of a small group. This failure deterred the council from taking the initiative in establishing itself as a recognized element in the health center setting.

Third, patterns for linking the council to the health center staff and board did not develop. Two subcommittees of the board were established to study relationships between the council, the board, and the staff, but the council was not involved. The board president attended some council meetings, and late in the study the chairman of the council attended board meetings. The board, however, avoided face-to-face contact with the council until late in the second year of the center's

operation.

The final reason that the advisory council remained weak was that there never was general agreement on who was responsible for the quality and quantity of community participation. A definite chain of command existed and functioned for administrative items, so that if the administrator failed to fulfill an administrative obligation the board quickly took action.

Unhappily no such chain of command functioned on problems evolving from community participation. Because no accepted pattern existed for detecting and correcting defective community involvement, even to establish that a problem existed was difficult. Moreover, once a problem was recognized, no one was certain who had the ultimate responsibility to insure that the situation was corrected. Confusion about the levels and scope of responsibility of the medical director, the board, and the OEO served to excuse all three groups from taking the initiative to improve the situation.

The second major focus of our study was the impact of the professional or nonprofessional status of members of the groups on their participation in allocative decision making. The professionals reported higher levels of perceived competence and influence than did community respondents. Perceived competence and influence, however, appeared more strongly linked to group membership than to status. The professionals on the advisory council, who initially reported less competence and influence than did the professionals on the board, also reported a much greater drop in perceived competence and influence. This result may have been due to differences between the professionals recruited for the board and for the council.

Another result suggests that the group of which the respondent was a member was a key factor in influencing the respondent's perceptions of his influence and abilities. Consistently higher scores were recorded for community members serving on the board than on the council in respect to their perceived influence and competence in decisional areas. This was true in spite of a large reduction in the second interview in the scores for community members. The dominance on the board of professionals was understandable given their expertise and experience and the nature of most of the tasks brought to the board.

The uncertain role of community members on the board was another factor contributing to the professionals' dominance. If what was expected of community members could have been defined and they had been able to make this contribution, two desirable results might have occurred. First, community problems (that is, problems related to the council and the community) might have been avoided, or at least resolved before they reached the crisis point. Second, community members on the board might have developed a greater sense of their value and of their ability to contribute to deliberations during board meetings. Certainly their jobs as representatives would have been facilitated.

Differences appeared in how professionals and nonprofessionals viewed the health center's purposes and the roles of the council or board. As might be expected, the professionals were able to present a somewhat more complete view of what the health center might contribute.

In summary, the board was identified as the group that participated in more of the discussions and decisions allocating the resources of the health center. As hypothesized, members of the board reported more competence and influence on decision making than did members of the advisory council. They also reported greater satisfaction and consensus than did members of the council, whose members participated less in the decision making of the health center. Although professionals in the study, regardless of their group affiliation, generally reported more competence, influence, and satisfaction, these variables appeared strongly related to the group to which they belonged.

Major factors in the board's greater participation probably include the clarity and nature of the group's mandate; the congruence between the administrative character of the board's role, the administrative tasks it handled, and the administrative abilities of its members; and finally, effective group process and problem solving. Factors that probably contributed to the weak intervention of the advisory council were its nebulous mandate, its ill-defined place in the total health center setting, an ineffectual group process, and confusion as to who was responsible for the quantity and caliber of community participation in the health center.

REFERENCE

(1) Partridge, K. B., and White, P. E.: Community and professional participation in decision making at a health center. HSMHA Health Rep 87: 366–343, April 1972.