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CONSUMER PARTICIPATION IN AREAWIDE HEALTH PLANNING AGENCIES

The Ohio State University

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CONSUMER PARTICIPATION IN AREAWIDE HEALTH PLANNING AGENCIES

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

Martin D. Saperstein, B.A., M.A.

* * * * *

The Ohio State University
1980

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To
Mom, Dad, and Marnie,
all of whom are special beyond words
ACKNOWLEDGMENTS

Profound thanks to the Brookings Institution for making this research possible. Indeed, had Brookings accepted my application for a grant to study the U. S. Department of Energy, this dissertation would never have been written.

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INTRODUCTION

Consumer participation in areawide health planning is a major objective of federal health planning policy. One expression of that policy is the National Health Planning and Resources Development Act of 1974 (P. L. 93-641). The Act created more than 200 areawide Health Systems Agencies (HSAs) and required those agencies to elect governing boards with consumer majorities.

The National Health Planning and Resources Development Act supersedes earlier legislation that established a precedent for consumer participation, but which failed to provide consumers the means necessary to participate as equals with members of the medical profession—the profession that traditionally has dominated the areawide health planning process. The Act was supported widely in both houses of Congress and by consumer activists—most agreed that consumers are essential to the formulation of acceptable solutions to local health care problems.

This research evaluates consumer participation in areawide health planning agencies. More specifically, it addresses the following questions:
1. Is the composition of HSA governing boards consistent with the guidelines contained in P.L. 93-641?

2. To what extent are HSA consumers involved in agency activities, both at and between governing board meetings? and

3. Do HSA consumers influence agency decisions?

These questions are considered important because their answers entail serious implications for the continued existence of the HSAs and for health planning legislation of the future. Indeed, if consumers are found to be participating at acceptable levels, Congress might choose to expand the mission or increase the authority of the areawide agencies. Congress might also have reason to continue funding the agencies during years when concern for a balanced budget places in jeopardy expensive social programs.

However, if consumers are not found to be participating at acceptable levels and if the primary cause can be traced to particular statutory provisions (or omissions), Congress might choose instead to restructure the HSAs, to supplement existing operational guidelines with new statutory provisions, or to replace the HSAs with a new planning mechanism. Should the primary cause prove to be some inherent inability of consumers, Congress might then choose to reevaluate the rationale for consumer participation, and ultimately, to minimize the role of consumers in future
attempts to plan for health. In short, the questions posed above are considered important because their answers may provide Congress an empirical foundation for guiding at least one aspect of federal health planning policy.

The principle goal of the Planning Act is a health care system that is cost effective, rationally organized, and responsive to consumer needs—a system, in other words, that is devoid of the problems that now confront it. Implicit in the Act is the assumption that consumer participation in health planning is necessary to achieve that goal. This research does not test that assumption or measure the degree to which consumers actually have altered the delivery of health services: to do so would involve measuring the impact the HSAs have had on areawide health systems. And the impact of the HSAs cannot yet be measured accurately.

The impact of the HSAs cannot yet be measured accurately for several reasons, all of which stem from the relative incipiency of the agencies and of the Act itself. First, many of the agencies have spent their formative years preoccupied with organizational issues, including the selection of governing board members, the hiring of staff, and the learning of statutory functions. As a consequence, few agencies have engaged in serious planning or have developed working relationships with other planning agencies, with state and local governments, or with other organizations concerned with health. Moreover, few agencies
have been involved in the kind of controversies that have "tested their character"—controversies that would force an agency to take a stand, mobilize resources, and challenge the medical profession. Finally, many of the regulations which are to guide agency decisions (such as those for appropriateness reviews) have not yet been developed by the federal Bureau of Health Planning and Resources Development. In sum, the impact of consumers and of the HSAs cannot be measured accurately because the area-wide agencies are nascent organizations and because all of their statutory tools have not yet been made available.

Nevertheless, this research can indicate whether consumers are likely to effect the delivery of health services by demonstrating whether the Planning Act has succeeded in stimulating consumer participation. For example, if consumers are found to be active, influential participants then a potential would exist for consumer generated change—a potential because consumer participation may be a necessary but not sufficient condition for that change. However, if consumers are not found to be active, influential participants then no consumer generated change could be expected. Though such observations are more limited than definitive conclusions based on impact they may well be useful to policymakers concerned with legislating consumer participation.
The first section of the following chapter describes several of the problems confronting the American health care system. The second section examines the federal response to those problems, focusing almost exclusively on health planning. The purpose of the chapter is to establish a context for the ensuing evaluation of consumer participation.

The second chapter explores the legislative origins of consumer participation in health planning, describes the environment in which the legislation was enacted, reviews the role of consumers in areawide health planning agencies prior to 1974, and details the provisions of P.L. 93-641 designed to strengthen consumer participation. Concluding the chapter is a recapitulation of the research questions and a discussion of the research design.

The third chapter examines the composition of HSA governing boards. It draws on data from several nationwide studies and from two Health Systems Agencies in central and southwestern Ohio. The fourth chapter evaluates consumer participation at and between governing board meetings and the influence of consumers in the health planning process. It too draws on both the nationwide and "case study" data. A final chapter summarizes the empirical findings and suggests strategies for further strengthening the voice of consumers in area wide health planning.
A Crisis in Health Care

In 1932, the Committee on the Costs of Medical Care (34, p. 2) wrote in its final report to President Hoover that

The problem of providing satisfactory medical service to all the people of the United States at a cost which they can afford is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed.

Today, nearly a half-century later, the problem of providing satisfactory, affordable health care persists. "American medicine," writes one observer, "now stands on the brink of chaos; ...it is inferior in quality, wastefully dispensed, and inequitably financed." (77, p. 9) A second insists that a massive health "care crisis afflicts the United States." (189, p. 2) And a third claims that the American people face a "health care crisis" of "enormous" proportions.1 (123, p. xi; see also: 188; 103, p. 37; 208, p. 1092)

That major problems confront the American health care system is an assertion supported by a variety of evidence.
Consider, for example, the figures on health care expenditures: Between 1950 and 1977,

hospital charges skyrocketed to $65 billion from $3.7 billion. Doctors' fees leaped from $32.2 billion from $2.7 billion. Total expenses for health soared to $162.6 billion from $12 billion. And total health costs as a percent of GNP nearly doubled... (25, p. 3)

Consider also that during the decade of the 1960s hospital charges rose four times as rapidly, and physicians' fees twice as rapidly, as other items in the Consumer Price Index. (103, p. 49) To this add the fact that in 1978 the high cost of medical care all but prohibited some 40 million elderly and indigent Americans from obtaining care for major illness. (26, p. 6; see also: 63, p. 1; 183, p. 65)

A second problem confronting the health care system is the maldistribution of health manpower. According to a 1970 study by the American Medical Association (AMA) (103, p. 40), states characterized as "more affluent" averaged 160 physicians per 100,000 population, while states characterized as "less affluent" averaged only 87. The study also shows that large metropolitan areas had a substantially higher physician-to-population ratio than did areas classified as either rural or suburban. Consistent with these figures are those reported by Fahs and Peterson (67, p. 1200), which indicate that over 1,000 remote towns in four Midwestern states did not employ even a single physician in 1965. Small size and declining economies were
cited as causal factors.

In another study, Wolfe (251, p. 322) asserts that low-income residents of central cities receive less hospital care than non-ghetto residents with higher incomes. To support this claim, he reports the findings of Walter and Wolfe (243), Chase (28), and the National Academy of Sciences (167). Finally, former Secretary of Health, Education, and Welfare (HEW) Joseph Califano (26, p. 6) revealed in October 1978 that because health care resources were concentrated in more affluent, populated whereas, 51 million Americans are "medically underserved."

Evidence of inadequately distributed health manpower is also found in studies of manpower shortages. The Health Resources Administration (217, p. 1), for example, reported in August 1978 that 2,985 localities across the nation suffered from a shortage of medical manpower. Fully 519 of those localities needed 3,776 primary care practitioners; 199 needed 212 dentists; 1,400 needed 1,949 podiatrists; 94 needed 1,258 pharmacists; and 91 needed 108 vision care specialists. Similarly, a 1972 study by the U. S. Health Service (103, p. 42) documents a nationwide shortage of 48,000 physicians, 150,000 nurses, 105 environmental health specialists, and 161,000 "other health professionals." Though the precision of these figures has been questioned by the AMA, most observers agree that they accurately reflect a shortage of medical manpower. (see also: 165)
A third problem confronting the health care system is the improper management and utilization of existing health care facilities. Congressman William R. Roy (D, Kansas) (5, pp. 266-67) spoke of this problem on the floor of the House stating that in 1974 there were more than 61,000 excess hospital beds throughout the United States. He then revealed that 97 percent of all hospitals with the capacity to perform open-heart surgery perform fewer procedures than the minimum required for efficient, high quality service. This latter contention is supported by McTaggart (148, p. 74), who claims that during a twelve month period 37 of the 38 hospitals in New York state having open-heart facilities did not perform at least one operation per week, "the minimum needed to maintain the proficiency of the heart surgery team." McTaggart chides the hospitals for a "shocking waste of taxpayers' money" and for purchasing expensive equipment at the request of staff physicians who "are sometimes guilty of trying to 'keep with the Jonses.'"

Additional evidence of misused medical facilities is found in a report by the Committee for Economic Development (103, p. 33). The report shows that between 1963 and 1970 the nationwide ratio of beds per 100,000 population rose from 4.3 percent to 5.0 percent. The increase is said to have occurred "in the face of increasing doubt regarding the justification for hospital expansion." The report reveals further that in virtually every study of hospital
utilization many patients who could be treated in a physician's office, or who are able to receive x-rays or other lab services from ambulatory care facilities, are found occupying hospital beds instead. This practice of "overhospitalization" is said to result in higher medical costs and in a tremendous waste of facilities.

Yet another problem confronting the health care system is the fragmentation of health care programs, services, and agencies. Such fragmentation is alleged to cause variable, conflicting, ambiguous, and weak standards of quality; gaps in coverage; a failure to use the leverage of federal funding to improve the distribution of facilities; and an absence of incentives for the production and effective use of needed resources. Roemer, Kramer, and Frink (189, pp. 2-3) illustrate the problem:

Listings of federal assistance programs have revealed hundreds of separate health programs at the federal level alone, within the Department of Health, Education, and Welfare and other departments. In California, approximately 275 public health programs, provided by separate administrative entities within 83 major agencies operating at five governmental levels—federal, state, regional, local, and special district—are concerned with provision of personal health services. These public programs must interrelate with the even more numerous voluntary and private programs, agencies, facilities, and individual providers that furnish segments of health care.

Each program has its special purpose, its sources of financing, its particular eligibility requirements, its own geographic span, and its individual mode of operation.
Links among the programs and agencies are, at best, tenuous and variable. Indeed, coordinating mechanisms themselves, where they exist, constitute another layer of specialized agencies. The result is fragmentation of health services—a term that has become so hackneyed its significance on real life is often obscured. [see also: 116, chapter IV; 76, p. 28]

The high costs of health care, the maldistribution of health manpower, the misuse of existing health care facilities, and fragmented health services are only the most obvious problems confronting the health care system. Less obvious problems include a tendency among physicians to stress the unusual at the expense of the commonplace; barriers to provider-patient communication; training and educational programs that are frequently unrelated to patient needs; an emphasis on treatment rather than prevention; and an orientation toward patients with acute, physical problems at the expense of patients with mental or chronic disorders. (109, p. 4; see also: 186) In short, the evidence is clear: "millions of Americans are ill-served by the nation's health care system—a system that has grown up helter-skelter, without accommodating very well to changing technology, expanding population, rising costs, or rising expectations." (77, p. 9)
The Federal Response to the Crisis in Health Care

The federal response to the crisis in health care dates back to the Great Depression of the 1930s and to the passage of the Social Security Act of 1935. Indeed, when serious health problems began to emerge in those areas hardest hit by poor economic conditions, Congress reacted by providing support for state and local public health programs and for programs targeted to maternal and child health problems. Legislation of the 1940s and 1950s provided support to states for the construction of hospitals in underserved rural areas and created and expanded the National Institutes of Health, a centralized national resource charged with stimulating and financing biomedical research. Also during the 1950s the Manpower Training Acts provided federal support to universities to encourage the education of health professionals. In the 1960s, Medicare and Medicaid extended health care benefits to the poor and elderly. In essence, between 1935 and the mid-1960s, the federal response to the health care crisis consisted primarily of massive spending for personal health services, biomedical research, and the expansion of both health resources and medical manpower.

During the early 1960s, the efficacy of this response began to be questioned by federal policy-makers, by some elements of the medical profession, and by the general public, for despite substantial allocations little progress
had been made in combatting major health problems: health care costs continued to rise at rates higher than those for other consumer goods, shortages and the maldistribution of manpower and facilities persisted, and the fragmentation of health services endured. (211, p. 35) Moreover, the very programs designed to improve health care had created new problems, including overspecialization and the inappropriate use of sophisticated medical technologies. (48, p. 208)

Yet what could be done? How could a system with so many problems be made both effective and efficient? For many, the answer was a new approach to health care. Part of that approach is health planning.

Health planning is a continuous process that provides an organizational means for change and a base within which health problems are viewed and solutions developed. According to Williams (250, p. 49), that process seems to follow three steps:

1. The survey, during which problems are defined, resources are located, and the facts obtained.

2. The analysis, including forecasting of anticipated conditions and the relation of central issues to those either influencing or influenced by it.

3. The plan, directed towards goals, based on needs and standards, and elaborated with cost estimates and time schedules for implementation.
These steps are similar to the planning activities described by Rosenfeld and Rosenfeld (191, p. 449), who write that health planning begins with the systematic accumulation of information on needs, resources, utilization, and costs and continues with the formulation of alternative strategies for meeting needs; the exploration of the social, economic, and geographic implications of those strategies; the measuring of public attitudes concerning the existing health care system; and the formulation of decision making criteria. The Rosenfelds add that planning activities must be followed by steps toward implementation and, ultimately, the evaluation of progress in light of enunciated goals.9

Other descriptions of health planning focus on its purpose and potential benefits. The preamble to the Comprehensive Health Planning and Public Services Amendments of 1966 (P. L. 89-749), for example, states that health planning is a process that facilitates rational decision making about the use of private and public resources to meet health needs. Klarman (121, p. 7) suggests that the purpose of health planning is to assure a population access to an adequate supply of medical manpower and facilities, and to provide services of acceptable quality at the lowest possible cost. To this, Anderson and Robins (8, p. 657) add that health planning emphasizes the need to more systematically organize and rationalize the health care system, while Mott contends that planning in the field of
health not only increases attention to community needs, but provides more information to decision makers, broadens the perspective of health care providers, and sharpens goals and objectives. (see also: 161, p. 239; 83, p. 3; 212, pp. 20-34; 189, pp. 182, 186, 280; 108, p. 68; 39, p. 136; 200, p. 1) In sum, health planning is a process, or set of activities, the goal of which is a responsive and rational health care system—a system that provides at acceptable costs and to virtually all Americans high quality, appropriate health care.

Can health planning achieve this goal? Critics of the concept do not think so: effective planning, they argue, is limited by the political nature of the planning process, by the complexity of the planning environment, and by the absence of agreed upon means to reach stated objectives.

David Banta (15, p. 329) discusses the first of these obstacles, noting that rational planning is a difficult endeavor because it seeks to maximize the "public good" in a society where "public good" has no single definition. Mechanic (149, p. 6) explains that because the health industry "involves a variety of...groups that tend to view priorities from their own...perspectives...it is enormously difficult to achieve a consensus." Moreover, groups are said to resist planning "unless it appears there is something in it for them."
Krause (129, p. 239) suggests that existing power centers, including organized medicine and the health insurance corporations, may effectively control the way in which new planning activities are introduced. He adds that groups with an interest in rationalizing services, such as public health officials, medical schools, and hospitals, may implement planning programs only to the extent that their "own economic and power-related ends" are advanced. The following passage summarizes these concerns:

The process of planning is inevitably and basically a type of power politics involving either the preservation of the status quo or changes in it. To the degree that powerful interest groups exist in fields such as health before the introduction of any new attempt at planning, they can be expected to frustrate or twist, or co-opt the planning process away from its original intent. (129, pp. 239-40; see also: 55; 211, p. 32)

The second obstacle to effective planning is the complexity of the planning environment. A report by the General Accounting Office (GAO) (93, p. 190) makes clear this complexity by enumerating the factors which health planners must consider: the types, size, age, condition, and distribution of facilities; use patterns, including service areas within hospitals; population characteristics and size; availability and accessibility of services and facilities; supply of physicians and other health personnel; income levels; levels of medical technology; health insurance coverage; climate; and the habits of people. The report also
states that planners must be able to project changes in population, technology, health care financing, delivery systems, and patterns of utilization.

These considerations are so inextricably entwined and so difficult to measure that, according to Navighurst (93, p. 190), many planners are unable to make hard-and-fast judgements, or to establish firm standards for decision making. Navighurst concludes that "in such circumstances, the pressures of politics become dominant."

A third obstacle arises when participants in the planning process agree in principle on a goal worth pursuing, but disagree on the proper means to achieve that goal. Taft and Levine (211, p. 46) illustrate the point by noting how different health professionals approach the goal of a health care system free of fragmentation. For example, physicians in private practice are said to advocate changes in insurance reimbursement policies so that services previously offered only on an inpatient basis may be offered in a physician's office. Presumably, this would enable patients to receive treatment without shuttling between individual providers and community hospitals. Hospital administrators, on the other hand, view such a solution as unacceptable because its actual effect would be more fragmentation, rather than less. For this group, the answer lies in centralizing virtually all health services among and between existing facilities. In short, though the physicians
and hospital administrators are well-intentioned, their different perceptions of an appropriate solution may frustrate the planning process.

Federal Health Planning Policy Prior to 1974

The federal experience with health planning through 1974 tends to support the critics' viewpoint. Consider, for example, the Hospital Survey and Construction Act of 1946 (P. L. 79-725), the first major federal legislation containing health planning provisions. Known as Hill-Burton, the Act provided matching grants to states for the construction of hospitals in underserved areas. To obtain these grants, states were required to develop plans detailing health needs and resources, projecting future needs, and establishing health priorities. Yet even though grants were awarded ($75 million in the first year alone), most states did little more than to survey their facilities to determine bed-to-population ratios—an outcome that many saw as inevitable because the act failed to stipulate how planning was to be done. The act also failed to provide incentives for planning, detailed measures of performance, or explicit criteria for determining facility needs. (211, p. 33)

Hill-Burton was opposed by organized medicine and by civil rights activists who objected to a "separate but equal" clause allowing government funding of segregated
hospitals in the rural South. It should be stressed, however, that this opposition was not responsible for the near absence of planning as prescribed by law; the problem was that those responsible for developing plans knew little about planning and found little in the statute to help them. (129, p. 241; see also: 83, pp. 8-9; 95, pp. 69-72; 146, pp. 353-56)

Nearly two decades later, Congress enacted the Heart Disease, Cancer, and Stroke Amendments of 1965 (P.L. 89-239). Unlike Hill-Burton, which emphasized the planning of individual health care facilities, these amendments promoted regional cooperative arrangements among medical schools, research institutions, and hospitals for the purpose of centralizing and rationalizing new health services. (103, p. 191) The amendments also established Regional Medical Programs (RMPs) in 56 regional medical program areas.

Each RMP was responsible for setting regional health priorities and for developing implementation strategies. To aid in the performance of these tasks, the programs were encouraged to hire and consult with physicians, nurses, health planners, allied health personnel, demographers, statisticians, and health service administrators. The programs were further encouraged to create Regional Advisory Groups (RAGs) composed of
practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives of other organizations, institutions and agencies concerned with activities of the kind to be carried out under the program... (129, p. 250)

The Heart Disease, Cancer, and Stroke Amendments were vigorously supported by numerous "client groups," by university medical schools, by technocrats at HEW, and by the Debakey Commission, a group drawn from the research and academic establishments by President Johnson for the purpose of developing a "realistic battle plan leading to the ultimate conquest of the [named] diseases..." (146, p. 356) Yet despite that support, most RMPs operated with no discernible focus and effected "rationalizing" of only the most minimal consequence. (11, p. 12)

That the RMPs performed poorly is not surprising for P. L. 89-239 states that planning was to proceed without "interfering with the patterns or methods of financing, of patient care, or with the administration of hospitals." Known as the "AMA Amendment," this emasculating passage is alleged to have been the result of a deal struck between organized medicine and President Johnson in which the former agreed not to oppose Medicare if the latter promised that the RMPs would become only a grant mechanism for innovative educational and research projects. In short, politics (rather than a lack of know-how) was responsible for the near absence of significant change. (129, pp. 248-52; see
The final elements of federal health planning policy prior to 1974 were the Comprehensive Health Planning and Public Services Amendments of 1966 (P. L. 89-741), the Partnership for Health Amendments of 1967 (P. L. 90-174), the Medical Facilities Construction and Modernization Amendments (P. L. 91-296) and the Public Health Services Amendments (P. L. 91-515), both of 1970, and the Social Security Amendments of 1972 (P. L. 92-603). This legislation came to be known as the Comprehensive Health Planning, or CHP Amendments because its primary objective was to stimulate the planning of all health services through the involvement of and cooperation among diverse community interests. More specifically, Congress declared through the Amendments that high quality health care for all Americans hinges on an "effective partnership involving close governmental collaboration, official and voluntary efforts, and the participation of individuals and organizations...." Congress declared further that federal assistance would be directed towards the "marshalling" of all health resources.

The CHP Amendments established a network of state and areawide health planning agencies. Each state or "A" agency was to work with a State Advisory Council representing a variety of health interests, including voluntary groups, public agencies, general planning agencies, universities, health professionals, and health care consumers. Together
the agencies and councils were to establish state and areawide health goals; define the health needs of communities in relation to those goals; inventory the relationships among local, state, federal, and voluntary health programs; assist those programs in marshalling resources for a greater impact on health care problems; and provide those programs with the data, analyses, and recommendations necessary to allocate health resources effectively. Additionally, the agencies and councils were to review and integrate the efforts of all other groups and agencies within the state dealing with health facilities, services, and manpower. (146, pp. 360-61)

The most notable of these groups and agencies were the areawide, or "B" agencies, created by the CHP Amendments for the purpose of developing a Comprehensive Health Plan, a document suggesting areawide health goals and the actions required to achieve them. The "B" agencies also were authorized to draft "position papers" on pertinent issues of local, state, areawide, and national concern; to gather vital statistics relevant to health; and to "review and comment" on proposals offered by health professionals for the construction of new facilities or the provision of new services. Through this latter function, each "B" agency was to influence the allocation of its area's health resources in a manner consistent with the goals, objectives, and priorities incorporated in its areawide health plan. Note,
however, that because the "B" agencies could not approve or veto proposals they had a regulatory function without regulatory power.

The "B" agencies were also to work with a council representing area health interests. Local governments, hospitals and other health facilities, practicing physicians, and health care consumers were among the interests to be represented.

The CHP Amendments were hailed by many as landmark legislation. To President Johnson they were a major "event" in the history of medical care. To HEW Secretary John Gardner they were among the most significant health measures ever enacted by Congress. (170, p. 391) And to Congressmen Paul G. Rogers (D, Florida) and James F. Hastings (R, New York) they were a vital step toward a rational health care system. The congressmen expressed confidence that the Amendments would increase the accessibility, acceptability, continuity, and quality of all health services and would restrain increases in health care costs. (103, p. 158) In essence, the CHP Amendments were seen by many as a "New Deal" for health.

Despite such optimism, the Amendments accomplished little. Between 1966 and 1970, when the cost of all consumer items increased by 20 percent, the overall cost of medical care increased by 29 percent. Physicians' fees increased by
30 percent and hospital charges by a staggering 71 percent. (103, p. 49) Moreover, by the end of this period there were no indications that problems arising from the fragmentation of health care delivery or from the misuse of health care resources were any less prevalent than they had been four years earlier.5

Among the primary reasons for these results was the poor performance of the "B" agencies. Indeed, studies by the GAO (93, p. 190) and HEW's Comprehensive Health Planning Service (228) indicate that many of the agencies were unable to develop widely accepted plans or to gather the data necessary to make informed judgements on provider requests. The studies also revealed that a majority of the agencies could neither stimulate community support for planning nor project on the basis of master plans a matter as elementary as the facility needs of an area. O'Connor (170, p. 391), in article appropriately titled "Comprehensive Health Planning: Dreams and Realities" addresses "B" agency performance:

Eight years after the signing of the original CHP legislation and seven years after funds were first appropriated, much criticism has been levelled at an alleged lack of accomplishment on the part of the CHP agencies. There has been great dissatisfaction on the part of many with an ostensibly widespread disparity between the theoretical promise of CHP and its actual performance. Although all...of the states eligible for federal support under the CHP program have received grants and are conducting such programs, reproaches such as the "planlessness of the planning movement" and the "futility in
planning to plan" are heard frequently.

The poor performance of the "B" agencies was seen by some as the ineluctable result of attempting change in a hostile environment. Health professionals, they argued, were generally satisfied with the status quo and therefore had refused to develop or implement plans perceived as threatening to their professional prerogatives. Others, however, considered this explanation simplistic: they argued that poor performance was the result of statutory deficiencies. One deficiency was a failure to provide agency control over the federal and private funds used to initiate services and construct facilities. As Taft and Levine (211, pp. 37-38) explain it, the "B" agencies could hold meetings, foster communications between groups controlling health resources, and reach decisions about how those resources might best be used. However, since the Amendments allowed the agencies only a "review and comment" function they could enforce neither specific decisions about resource allocation nor more general decisions contained in areawide plans. Furthermore, the agencies had no authority over other agencies whose cooperation was essential to effective planning. In short, the Amendments failed to provide any mechanism for enforcing coordination in an environment where administrative control over health activities was highly "diffused." (see also: 103, pp. 181-84)
A second statutory deficiency was a provision stating that planning was to proceed without interfering "with existing patterns of private professional practice of medicine, dentistry, and related healing arts." (Sec. 2a)

Similar to the "AMA Amendment," which debilitated the Regional Medical Programs, this restriction severely limited the number and kinds of action an agency could take since almost any action that deviated from traditional practice might be construed as interference. Krause (129, p. 252), in a discussion of this provision, notes that the CHP Amendments were created as an absurdity. Obviously, nothing real can be accomplished if the program is not allowed to correct inadequacies in the present pattern of service.

In a related discussion, Somers and Somers (206, p. 446) suggest that CHP proclamations were not fortified with clear definitions of goals, forthright development of strategies or techniques, adequate fixing of accountability, or sufficient incentives to motivate hospitals to forgo their own institutional ambitions. The Somers infer from these limitations and from the proviso to avoid interference that the "B" agencies were provided neither the tools nor the authority to effectuate change.

A third statutory deficiency was the manner in which the agencies were funded. Specifically, the Amendments required each agency to "match" a portion of its federal
grant with money obtained from local sources. Since many of those sources were the institutions most affected by planning, agencies often were reluctant to advocate controversial policies—the agencies, in other words, considered health planning to be a "battlefield between interests" who might withdraw their support in the face of plans limiting their growth and activities. A report of the New York Expectation Project (129, p. 256) clarifies the point:

Because of the need to "panhandle" for its basic support, an agency frequently can be placed in an awkward position when making decisions affecting the operations of its contributors. In order to survive, an agency may see as its constituency its financial supporters rather than the community.

A second implication of the matching funds provision is that agency staff devoted most of its time to raising funds. As a consequence, council members often received too little assistance to effectively perform their data gathering and planning functions. This problem was intensified by the "review and comment" provision which, according to Hyman (104, p. 11; 103, pp. 150, 307-09), "siphoned" the staffers from planning to regulatory tasks. In short, the funding provisions unwittingly discouraged planning by requiring agencies to use their staffs for non-planning purposes.

A final statutory deficiency was a definition of "consumer" so vague that many council members formally
classified as consumers had strong ties to the health care community. Though this point is detailed in the following chapter, it is worth noting here that these "closet providers" are alleged to have supported health professionals opposed to major changes in the health care system.

The National Health Planning and Resources Development Act

Between 1972 and 1974, Congress reexamined the health care system and concluded that poor planning continued to be a major cause of the nation's unmet health needs. In particular, Congressmen Paul G. Rogers (D, Florida), William B. Roy (D, Kansas), and James P. Hastings (R, New York) had become convinced that a new network of planning agencies was essential if health planning was ever to succeed. To create that network, legislation was drafted which after minimal debate and several minor amendments became the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). (44)

The Act abolished the Regional Medical Programs, Hill-Burton, and the CHP "A" and "B" agencies and replaced them with State Health Planning and Development Agencies (SHPDAs), Statewide Health Coordinating Councils (SHCCs), and areawide Health Systems Agencies (ASAs). The State Health Planning and Development Agencies were to be the ultimate authority for all state health planning activities.
The functions of those agencies were to include (1) preparing a preliminary state health plan for submission to the State Health Coordinating Councils; (2) implementing the final state health plan; (3) administering a Certificate of Need (CON) program; (4) reviewing all new institutional health services provided throughout the state; (5) reviewing the appropriateness of existing institutional health services; (6) coordinating all health data collection activities; (7) assisting the State Health Coordinating Councils in their work; (8) administering federally assisted facilities construction programs; and (9) administering optional programs for rate reviews. In essence, the SHPDAs were to play the role of coordinator, integrator, and source of final decision for all planning matters within the state. Note, however, that Congress intended these agencies to be guided primarily by the recommendations of the HSAs. The SHPDAs, in other words, were to be "reactive and review" agencies rather than creative developers of their own plans. (103, p. 425)

The purpose of the State Health Coordinating Councils was to advise the State agencies. Composed of two members from each HSA within the state and of other representatives appointed by the governor, the Councils were to (1) prepare and approve a statewide health plan based on the preliminary plans developed by the HSAs; (2) review and coordinate the planning activities of the HSAs; (3) review the annual
budgets of the HSAs; (4) advise the SHPDAs in their work; and (5) review all state plans and appropriations for funds made available to state government by federal health legislation.

The HSAs were to be public or private, non-profit agencies with jurisdiction over multi-county Health Service Areas. Each was to elect a governing board having a consumer majority. Each was to be run by a professional staff of prescribed size. And each was to be "conditionally" designated by HEW until it could demonstrate an ongoing ability to perform all relevant statutory functions.

The primary function of the HSAs was to diagnose the health related problems and needs of the population served by the agency. On the basis of that diagnosis, the agencies were to prepare long-range goal plans—called a Health Systems Plans or HSPs—consisting of general health goals and priorities. The agencies were also required to prepare Annual Implementation Plans (AIPs) in which specific objectives and priorities among programs were identified.

Other functions of the HSAs were to include (1) providing technical and/or financial assistance to those seeking to implement the provisions of the HSPs or AIPs; (2) coordinating activities with Professional Standards and Review Organizations (PSROs) and other appropriate planning and regulatory entities; (3) reviewing and approving or disapproving applications for federal funds for areawide...
health programs; (4) assisting states in the performance of capital expenditures reviews (i.e., Certificates of Need); (5) assisting states in performing "appropriateness reviews" of all institutional health services; and (6) recommending to states on an annual basis projects for the modernization, construction, and conversion of areawide medical facilities. All of these functions were to be performed for purposes specifically stated in the statute, including improving the health of area residents, increasing the accessibility, acceptability, continuity, and quality of health services, constraining increases in the cost of services, and preventing unnecessary duplication of health resources.

In addition to establishing a new health planning bureaucracy, P. L. 93-641 required the Secretary of HEW to issue national health planning goals consistent with health priorities made explicit in the statute. The Act created a National Council on Health Planning to assist the Secretary, authorized grants to states for projects demonstrating the effectiveness of rate regulation, and, finally, authorized at least five centers for the study and development of health planning.

Although the National Health Planning and Resources Development Act repeated many of the provisions found in earlier health planning legislation, it departed from that legislation in significant ways. One departure is a
narrowing of focus for the areawide agencies. Note, for example, that the CHP "B" agencies were expected to cope with virtually all aspects of whatever effected health:

from air pollution to nurse training, from public health education to disaster planning, from hospital prices to family planning, from nursing home safety to retarded children's programs, from health facilities development to health manpower, from patient's rights to federal grant reviews, from solid waste disposal to community mental health, from highway safety to emergency communications to drug abuse to housing quality. (201, p. 15)

In contrast, the HSA assignment was focused on the "health system," by which Congress meant the complex of institutions and people that provide, administer, finance, and regulate personal health services and facilities in well-defined geographic areas. Though the Act did mention environmental and occupational health briefly, most of its content, the relevant House and Senate committee reports, and the ten "national health priorities" enunciated in the statute all stress only the "health system" proper.

A second difference is a shift in how change was to occur in the regions served by the areawide agencies. Specifically, the HSAs, unlike the "B" agencies, were expected to take the initiative in determining the health care needs of a region. Health providers, in turn, were to respond to the long and short term plans developed by the agencies by proposing programs to meet stated objectives. Under CHP, health providers proposed plans and the planning
agencies reacted.

A final difference between P. L. 93-641 and earlier legislation is an unprecedented emphasis on consumer participation. Indeed, the Act stipulated not only that consumers must comprise a majority of each HSA governing board, but that consumers on the board shall be "broadly representative" of consumers at-large. Other provisions provided consumers the professional support presumed necessary for responsible decision making and defined the terms "consumer" and "provider" with the specificity needed to ensure that consumer trustees were actually consumers, rather than health professionals in disguise.

P. L. 93-641 has received considerable attention from the academic and health communities: numerous studies discuss its provisions, its legislative antecedents, and the rationale underlying its passage. Few studies, however, systematically examine the impact the law has had on the nation's health care system. A report by the General Accounting Office (GAO) (35, p. i) explains this by suggesting that more time must elapse before the effects of the state and areawide agencies can be measured accurately. "Such an analysis," the report asserts, "probably cannot be done for several...years."

Though the GAO may well be correct, sufficient time has elapsed to begin addressing the host of questions
relevant to those who seek to determine if the agencies and actors involved in planning are performing the tasks prescribed by the statute. Several such questions focus on consumer participation: for example, are HSA consumers as involved as providers in agency activity? And, do consumers and providers have equal influence in the HSA decision making process? These and other questions are examined in the following chapters.
1. Not all observers agree that a crisis exists. M. Stanton Evans (64, p. 204), for example, claims that

the "health care crisis" cried up by Kennedy and confessed by the Republicans is almost totally devoid of factual content. The truth of the matter is that the quality of health care in our society has been getting better and better, that the benefits of such care have been made increasingly available to ever larger numbers of people, and that most of the asserted shortages and deficiencies complained of are imaginary.

Similarly, Schwartz (195) contends that the cries of crisis are entirely unfounded and that United States medicine has been doing an outstanding job. To this, the AMA (109, pp. 3-4) adds that

The constantly improving American health care system is the best in the world and must not be stifled by adopting a government-controlled national health insurance program... When considering a national plan for this country, it is necessary to take cognizance of the strengths of our own method of health care delivery...this will assure that our excellent system will continue to improve and will not suffer the stifling effects experienced in other countries... American medical service and technology have developed at an unparalleled rate...presently there is more and better medical technology here than anywhere else in the world.

The documentation supporting these claims notwithstanding, Evans, Schwartz, and the AMA represent a minority viewpoint. (see also: 74)
2. A second part of the approach has been to promote Health Maintenance Organizations, or HMOs, designed to provide a full range of medical services to a defined, or enrolled population, in return for a fixed annual fee paid in advance. According to Van Meter (237, p. 7), HMOs symbolize the "government's competition-inducing capabilities," and according to Decker (48, p. 210), they combine the available experience with prepaid health plans with the "Chinese custom of paying the doctor when you are well."

The Nixon Administration began to push for HMOs in 1970, claiming that they would (1) cut costs for consumers of health care, and (2) reduce governmental expenditures which had grown dramatically during the years of President Johnson's Great Society. HMOs drew additional support from advocates of prepaid group and individual plans; economists who envisioned them as a means of introducing competition and avoiding public regulation; elements of the insurance industry who saw them as a way of widening policy offerings and holding down premiums; and health care progressives who believed that they were a vehicle for preventive medicine. (206, p. 231)

Despite opposition from the American Medical Association (AMA), which argued that HMOs would be vulnerable to the "evils" of both contract prices and government intervention (110, p. 143), the first Health Maintenance Organization Act became law in December 1973. (see also: 71, pp. 231-32)

A third part of the approach involves "peer review" of the necessity, appropriateness, and quality of in-patient health services provided to recipients of Medicare, Medicaid, Maternal and Child Health program funds. The reviews are conducted by Professional Standards Review Organizations (PSROs) created by the 1972 amendments to the Social Security Act (P. L. 92-603), comprised of practicing physicians, and empowered to recommend to HEW "appropriate action against persons responsible for gross or continued overuse of services or for inadequate quality of services." PSROs are also responsible for developing standards related to length of stay, type of care received, and type of facilities employed (175, p. 324).

PSROs were accepted reluctantly by the AMA because they were said to be "government interference in the practice of medicine." Also, the AMA complained that the penalties for poor performance by a physician were much too severe. The consumer advocate organization, Health-Pac, on the other hand, argued that the penalties were much too weak,
although its members supported the organization in principle.

PSROs represent a compromise with the medical profession. They call for mandating "professional standards review" in federal funded programs, but allow that review to be performed by the profession itself. (211, p. 93)

Nevertheless, organized medicine fears that the PSRO legislation will lead to surveillance of physicians in most if not all health care settings.

A fourth part of the approach involves developing new categories of health manpower, such as physician's and anesthesiologist's assistants. Advocates reason that "lesser trained assistants could be developed to augment medical manpower." They could be trained more quickly than physicians, at lower expense, and would anticipate receiving lower incomes. According to Decker (48, p. 211) experimental programs have been developed and evaluated to retrain former service corpsmen (MEDEX) and to educate personnel de novo (physician's assistants). Decker also notes that two difficulties must be surmounted before this "federal thrust can be fully utilized." The first deals with public acceptance and the residual reluctance to entrust one's health to any but the best available doctor. The second deals with the heightened need for supervisory organization when utilizing lower levels of personnel in health care. Decker concludes that until the health care system is rationalized the latter will remain a problem.

3. The steps and activities outlined by Williams and by the Rosenfelds describe "rational" planning. Freymann (80, pp. 239-40) outlines different steps and activities which he claims describe "pseudorational" planning. He notes first a "Let's go now and find out where we are going later" approach. Here resources are channelled into a project with little thought for other uses to which they could be put or for what the project accomplishes in terms of overall community needs. The proliferation of open-heart surgical units in the 1960s is a consequence of this type of planning.

A second approach begins with arbitrarily chosen numbers representing goals to be achieved. When the numbers—be they of beds, square feet, or operating rooms—are not related to the satisfaction of specific health needs, this approach is called the "Tootsie-Roll technique," for it implies how the numbers were chosen." Freymann explains:
The Tootsie-Roll technique is based on the principle that applies when a small boy is asked how many Tootsie-Rolls he wants. Any small boy would base his answer not upon actual need for candy but upon what, in his fondest dreams, he thought he could get away with. facetious as this may sound, planning of at least one university hospital has been approached in this fashion. Every member of the faculty was asked to list his space needs. The result would have required a building 1 block square and 100 stories high...

The Tootsie-Roll capacity of a small boy is limitless. Planning by this method will certainly inflate the size and cost of the health industry, but it will be only haphazardly related to the total health needs of society. (p. 239)

To this, Freymann adds that such haphazard "creations" appear to be governed by Parkinson's Law: they soon "generate reasons for their own existence." (p. 239)

A third pseudorational approach to planning is to begin by estimating the available resources. According to Freymann, this occurred in planning a major teaching hospital in 1968:

The first step was to hire a fund-raising firm to estimate how much money could be raised. The planning process, which in this instance might be called the "passing the buck to the bucks" approach, consisted of reconciling the square feet that could be built with this sum with the off-the-cuff demands of various clinical departments for beds... The key question, "What are the health needs of the community?" was never asked... (p. 240)

Yet another pseudorational approach involves gathering reams of operational data and collecting everyone's ideas on what a program should do. This is labelled the "find out where we have been so we know where we are now" approach. Freymann notes that since many planners do not know where they have been, such an effort is not worthless. He adds, however, that programs which eventually emerge from such a process "will inevitably be anchored to past accomplishments and present needs." He adds further that
Planners who use this approach fail to heed Peter's warning that, if they do not know where they are going, they may end somewhere else. They become so involved in current operations and imperatives that the key question, "What are we trying to accomplish is forgotten before it can be asked. Instead the program will likely reflect the loudest demands and most powerful influences in the local power structure or the whims of an outside consultant who has no commitment to its implementation. (p. 240)

Freymann concludes his discussion of pseudorational approaches with the assertion that they embody no methodology beyond a series of reports, drawn on retrospective standards, which lead only to narrower options and reduce innovation to a minimum. He asserts, in short, that pseudorational planning is to be avoided.

4. The state agencies were called "A" agencies after the section in the statute creating them. For a similar reason the areawide agencies were called "B" agencies.

5. These reproaches not withstanding, the CHP Amendments did have an impact on health services in the United States. According to Anderson and Robbins (8, p. 656), the legislation was responsible for (1) a greater concern among all parties with the organization of health; (2) a more widespread conviction that a changed organizational arrangement would benefit consumers; and (3) broader participation by lay public officials and consumers in the debate over medical care organization issues. Although the CHP Amendments may have been neither a necessary nor sufficient condition for these changes to occur, Anderson and Robbins suggest that the statute made a major contribution by establishing a forum for the expression of these societal trends.

6. Section 1511 details several criteria for establishing Health Service Areas. Among these are population size, the presence of a medical center with "highly specialized health services," and a size large enough to insure the availability of the full range of services for an Area's population. The statute gives the Governor of each state responsibility for establishing Area boundaries.

In general, the Health Service Areas were expected to include between 500,000 and three million persons. However, where population is either highly concentrated or widely dispersed, exceptions were permissible.
Moreover, boundaries were expected to be consistent with Standard Metropolitan Statistical Areas (SMSAs), although again exceptions were possible with HEW approval. (103, p. 420; 146, p. 364)

7. In fact, much of the research that has been done examines only the current state of the health care system. Those studies tend to conclude that many of the problems P. L. 93-641 was designed to correct are continuing into the 1980s: "corrosive inflation" still marks health care costs, health resources still are distributed inequitably, manpower shortages still are common, and treatment rather than prevention still is stressed. Worth noting is that despite these continuing problems the federal government has remained committed to health planning. As former HEW Secretary Califano (26, p. 4) explained in 1978

Unless innovation in health care [is] attended closely by rational planning..., unless planning precedes and accompanies step in future growth of our health system and the setting of health care policy, we will be unable to achieve our goal of quality health care at reasonable cost.

8. For a discussion of the reasons why the GAO may well be correct see the Introduction.
CHAPTER II
BACKGROUND: CONSUMER PARTICIPATION

A major objective of federal health planning policy is consumer participation in the areawide health planning process. The first section of this chapter reviews the legislative origins of that objective, focusing on three statutes enacted between 1966 and 1970 and on regulations issued by the Comprehensive Health Planning Service (CHPS) in 1972. The second section describes the political environment in which the statutes were passed. And a third examines consumer participation in the areawide agencies established by the Comprehensive Health Planning and Public Services Amendments of 1966.

The fourth section details the provisions of the National Health Planning and Resources Development Act of 1974 (P. L. 93-641) designed to strengthen consumer participation. It also explores several controversial passages of the Act which, according to critics, limit consumer participation. A final section outlines the questions addressed in this research and describes the research design.

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Legislative Origins

The legislative origins of consumer participation in areawide health planning date back to the Comprehensive Health Planning and Public Services Amendments of 1966 (P. L. 89-749). The statute authorized state governments to designate state ("A") and areawide ("B") health planning agencies and required the state agencies to establish advisory councils. Each advisory council was to represent the public and private health interests throughout the state. Moreover, health care consumers were to comprise a majority of each council's members.

P. L. 89-749 did not require the areawide agencies to establish advisory councils or to involve consumers in the performance of agency functions. The statute is significant, however, because its intent was to bring consumers into the planning process.

In 1970, Congress enacted the Medical Facilities Construction and Modernization Amendments (P. L. 91-295). This legislation opened the areawide agencies to health care consumers by authorizing the Secretary of Health, Education, and Welfare (HEW) to withhold funding from agencies that failed to provide for the "appropriate representation" of health care consumers. Though "appropriate representation" was not defined, the statute did indicate that consumers were to contribute to the "development of a coordinated and interrelated community-level system of health-care
facilities..." (222, p. 3343)

Also in 1970, Congress enacted the Public Health Services Amendments (P. L. 91-515), legislation which required the areawide agencies to establish advisory councils similar to those established by the state agencies four years earlier. The councils were to include as members representatives of local governments, health care providers, and "consumers of health services." Each council was to have a consumer majority.

Additional regulations governing the composition of the areawide councils were issued by the Comprehensive Health Planning Service (CHPS) in 1972. The regulations required council membership to be "generally" representative of the population served by an agency and repeated the proviso that consumers were to comprise a majority of each council's members. The regulations also stated that a "consumer" of health care was a person whose "major career occupation is neither the organization, financing, or delivery of health services, nor the teaching of or research in health sciences."

The CHPS regulations entailed for consumers a descriptive rather than formal mode of representation. (143, pp. 137-41; see also: 174) Consumers, in other words, were not to be elected by particular groups within the community for the purpose of making health-related decisions in their behalf; instead, agencies were to appoint
"grass-roots" consumers who would speak for others with similar demographic characteristics. Exploring the rationale for descriptive representation, Sieverts (201, p. 24) found that

the CHP agencies were encouraged by the federal leadership...to look for board members who did not come from established major community interests, on the ground that a principle purpose of CHP was to provide a forum for powerless, previously unheard, grass-roots consumers to play a powerful role in the health planning system.

Similarly, Seidman (197) found that the emphasis on descriptive representation was intended to minimize the input of consumer elites and maximize the input of "real" consumers—those in a unique position to identify the indignities, frustrations, and deficiencies present in the current health system.

One objective of the CHP Amendments was to provide consumers a formal, powerful role in health planning. Yet despite that objective the legislation described in meager detail the mechanism in which consumers were to participate. P. L. 89-749, for example, devotes less than 250 words to the creation of the state and areawide agencies and less than 50 words to the composition of the state advisory councils. P. L. 91-296 devotes less than 75 words to the issue of representation. And P. L. 91-515 devotes less than 100 words to the composition of the areawide councils. The
result of this statutory terseness was a body of law that failed to define precisely the role of consumers in the planning process, the decisions consumers were expected to influence, or the manner in which such influence was to be exercised. In short, although the legislation established a health planning bureaucracy and invited consumer participation, it did not provide consumers a specific statutory mission.

Political Environment

The Comprehensive Health Planning Amendments were enacted by Congress during a turbulent period in American history. During the latter half of the 1960s minorities and other disadvantaged citizens were protesting the alleged failure of the nation's political, economic, and social systems to distribute society's benefits equitably. The disadvantaged argued that the "system" represented only the most powerful interests and that new institutions with new forms of representation were essential for the achievement of social equality.

The most sweeping expression of this discontent was a demand for "administrative decentralization," the delegation of authority within bureaucracies to local officials who were instructed to involve local citizens in the development and administration of local programs. (114) The demand for administrative decentralization, in other words, was a
demand for "maximum feasible participation." (164)

In the field of health, leaders of the black and Spanish-speaking communities were the first to advocate administrative decentralization. They expressed dissatisfaction with the quality, accessibility, and cost of health care and complained that decisions concerning the allocation of health resources were dominated by health care providers motivated by personal and professional gain. They argued further that health care throughout the country would improve if consumers were granted an active, policy-making role in the health planning process. (98, pp. 1699-1702; see also: 100, p. 705; 182)

Similar sentiments were expressed by members of the academic community who saw provider domination of health planning as a fundamental cause of the nation's health care problems. Duvall (57, p. 41), for example, claimed that the "Planning of medical care facilities has largely been done [by providers] for the benefit of the medical profession." Vladeck (242, p. 27) stated that "health professionals have run the system...in their own interest..." And Feingold (72, p. 805) observed that "health professionals...have followed the general practice of placing more emphasis on the interests of the provider and less on those of the consumer, while obfuscating the issue by asserting that there was no conflict of interest between the two." (see also: 48, p. 209; 240, p. 133)
These and other observers also agreed that recipients of health services would be better served if consumers were actively involved in the planning process. Note, for example, Duvall's (57, p. 41) remark that "change in the health care delivery system must be accomplished through the utilization of consumer participation." The National Advisory Commission on Health Facilities advocated "community responsibility with...consumers participating in decisions." And the Report of the Task Force on Medicaid and Related Programs (226) concluded "that greater consumer involvement in decision making is required to overcome deficiencies in the health system." The report added that without consumer participation health institutions can become "self-serving" to the point of ignoring fundamental community health problems, user identity with services can deteriorate, inappropriate use of services can occur, and providers can become isolated from knowledge about a population's medical and health needs.

In short, these observers advocated consumer participation because they recognized that consumers and providers often have different interests when planning an Area's health care system and because they expected planning decisions to be more responsive to consumer needs if consumers were active in the planning process. The point here is more easily understood by noting that providers tend to overemphasize the treatment of acute illness while
neglecting opportunities in preventive medicine and the problems of the aged and chronically ill. According to Sapolsky (192, p. 115), the "root cause" for this orientation is the "prevailing status hierarchy in medicine, which assigns the highest prestige to those specialists, affiliated with medical schools, who are working on the most complex problems in acute care." Sapolsky adds that the entire health care system is so dominated by acute care values that lower-ranking institutions, seeking to gain status in order to compete more effectively for the affiliation of physicians, offer the same expensive programs and facilities found in major medical centers. And they do this with only minimal concern for the actual health needs of consumers. According to advocates of consumer participation, active and influential consumers would change this orientation by incorporating their interests in health planning decisions.

Furthermore, Kissick and Martin (119, p. 152) argue that the need for consumer participation touches on several important dysfunctional areas within the health care industry:

The health field, as presently constituted, lacks the economic incentives or accountability of the market place and its discipline of consumer choice. Health care exists in a "no-man's-land" where the ultimate buyer, the patient, does not make the decisions as to whether or not to purchase services, nor does he have the
opportunity to influence the purchasing power of his health care dollar by having available alternatives. The patient is therefore seeking avenues of influence over the organization and function of the health care system.

From this perspective, consumer participation is an opportunity for patients to retrieve the bargaining power dissipated through third party payment mechanisms and to insure that services provided will be of high quality, affordable, and responsive to the needs of those for whom they are intended. (103, p. 53; see also: 171, p. 231; 225, pp. 227-28)

Still other advocates of consumer participation spoke of the contributions consumers would make once given a role in the planning process. The contributions included:

- identifying and articulating health needs as seen from the consumers' viewpoint
- providing clearer pictures of the inadequacies of the health care delivery system
- bringing to bear in the planning process diverse brands of expertise
- improving the realism of expectations held by providers and consumers
- offsetting both narrow-minded and self-centered professionalism and racist attitudes
- reorganizing centralized decision making in the health industry by injection of political, social, and economic know-how
- providing meaningful feedback to consumers about inappropriate usage of health care
providing reassurance to consumers about the integrity of the system, and

providing access to a community power base for social action which no trade or profession could mobilize (21, pp. 455, 458; see also: 48, pp. 209-10)

In sum, consumer participation in health planning was supported during the mid-1960s by a variety of diverse groups. These groups—which Alford (2, pp. 218-20) calls "equal-health advocates"—hoped that the CHP Amendments would provide consumers the means necessary to participate as the equals of health professionals.

Consumer Participation: 1966 - 1974

Despite the passage of the CHP Amendments and the hopes of the equal-health advocates, consumer participation in areawide health planning was more a whisper than a shout during the years following the creation of the areawide agencies. In many agencies, the regulations governing consumer representation were ignored. In others providers continued to dominate decisions on resource allocation. And, in still others, consumers failed to attend council meetings with the regularity required to become well-informed on planning issues. Several studies document these claims.

Evans (65, p. 551), for example, interviewed 540 council members of seven areawide agencies in Michigan and found "poor" representation of minority and disadvantaged
citizens despite a great deal of rhetoric to the contrary. Only two of the seven agencies met the 20 percent informal standard established by the state, and in one, minority representation was virtually non-existent. Evans also found that minorities and the disadvantaged were almost always represented by middle and upper-middle class blacks; that white middle-class consumers comprised on average only nine percent of the councils; and that on each council the percentage of poor minorities was twice the percentage of poor whites. The latter finding contrasts sharply with a statewide population ratio of nearly two poor whites for every poor minority group member.

In a study of an areawide agency in northern New Jersey, Hyman (103, p. 256) found that even though more consumers than providers served on the agency's council more providers than consumers attended council meetings. Fifer (75, p. 767), too, found poor consumer attendance in a study of an areawide agency in Minnesota: he reports that the three consumers on an agency task force attended only seven of the 27 meetings convened during a two-year period. Finally, Evans (103, p. 256) found that providers attended council meetings more frequently than did consumers and that roughly one-quarter of the consumers studied did not attend even a single board or committee meeting. (see also: 170, pp. 404-05)
Still other studies document provider domination of the planning agencies. Roseman (190, p. 17), for example, reports that despite the regulation requiring consumer majorities, providers tended to dominate council activity through "superior knowledge." Providers, he writes, sought "to absorb compliant consumers to satisfy legal requirements and occasionally twinges of conscience." Nutt (169, p. 392) examined the relationship between consumers and providers in an areawide agency in Ohio and found that mixing consumers and experts [i.e., providers] failed to produce meaningful participation from consumers...[Providers] systematically influenced the consumers to the point that the consumer members merely reflected the values and preferences of the experts.

In a third study (223, p. 7885), the Senate Labor and Public Welfare Committee reported that provider domination had stifled effective planning. The committee acknowledged "the valuable contribution providers of health services can and must make," but added that "if what is to emerge is to be viable, their influence in the planning process must be appropriately limited." Furthermore, Hyman (103, p. 219) observed that

The consumers, as board members on the "B" agencies, have had little voice in determining the public interest. As the most logical representatives of the public interest, they have failed to exert what influence and authority they were given in the...[CHP
Amendments]. They have generally acted as junior partners.

These findings, though not comprehensive, clearly suggest that consumer participation in areawide health planning fell far short of the hopes of both Congress and the equal-health advocates. They suggest that consumers, despite their numerical majority, were not a majority in attendance, voting, or contribution.

The failure of consumers to participate as the equals of health professionals can be traced to several sources. One source is a provision in the statute defining "consumer" as a person whose major career occupation is not the organization, financing, or delivery of health services, nor the teaching of or research in health sciences. This definition did not exclude persons, who as a result of other affiliations, were likely to maintain views sympathetic to health professionals. Consider, for example, a person who holds a fiduciary interest in a provider; serves on the board of a health care facility; has recently retired from the medical professional; or is a member of a provider's immediate family. Such a person, though eligible for the consumer classification, is extremely likely to approach planning as would a provider. Such a consumer, in other words, is likely to be a "closet provider."
Whether the areawide agencies actually selected closet providers is difficult to know with certainty. Anderson (7, p. 10), however, has shown that many consumers were presidents of state mental health associations, chairmen of state boards of health, chairmen of county boards of health, and chairmen of metropolitan health and hospital associations. Moreover, of all the council members in Evans' (65, p. 551) study informally perceived by agency staff to favor the interests of health professionals, fully 11 percent could be classified as consumers on the basis of their full-time occupations.

In another study, Parkum and Parkum (173) found that 21 percent of the consumers of an areawide council in Pennsylvania considered their occupations to be health-related. The study also shows that consumers and providers displayed similar values on planning issues, a finding that suggests that "despite the law there is some question whether the agencies ever achieved the kind of consumer participation intended." (171, p. 233)

In still another study, of 80 areawide agencies, Ryman (103, p. 247) reports that the medical community had a "strong hand" in the selection of council consumers. He infers from this that many consumers had strong ties to health professionals and that decision making in many councils had a provider orientation.
These studies do not demonstrate that council consumers actually approached planning as would a provider, or that "closet providers" undermined the goals of "real" consumers. Nevertheless, the studies suggest that the consumer voice on the areawide councils was a different voice than Congress had expected to hear.

A second source of "poor" consumer participation was boredom. As Hyman (103, p. 247) explains it, many consumers became bored by the technical nature of planning discussions shortly after their selection to council membership. As boredom increased, attendance at council meetings declined, a turn of events that left decision making in the hands of health professionals. Hyman adds that boredom was not a problem for providers because they had an immediate and vested interest in health planning issues.

The boredom hypothesis is supported indirectly by Bellin (18, p. 1371) who examined consumer participation in 22 committees in New York City established through the Ghetto Medicine Program. He found that committee work initially was "novel, ...robust, and fascinating," but quickly degenerated into a "repetetive hacking away at a tangled underbrush of nettlesome problems." Moreover, committee members often were required to write and discuss reports and prepare resolutions on issues of only marginal interest. All of this was perceived by the committee's consumers to be "terribly dull," a perception that did
little to sustain either their attention or participation.

A third factor hindering the participation of consumers was their lack of knowledge about the health care system. According to O'Connor (171, p. 404), the issues involved in planning were so technical and so often discussed in argotic language, that many consumers felt ill-equipped to handle their role effectively. Consequently, consumers often withdrew from technical discussions or deferred to the presumed expertise of providers. Krause (129, p. 223) notes that consumer deference may have extended to non-technical issues as well. Providers, he claims, often argued that issues appearing to be strictly political or economic (i.e., issues about which consumers were more likely to be knowledgeable) in fact had direct implications for the quality of care delivered. Since consumers often had too little information to challenge such contentions they tended to accept them uncritically. (see also: 161, p. 246; 101, p. 31)

Feelings of intellectual inadequacy and their effects on participation may have been neutralized had the staffs of the areawide agencies educated council consumers. The available evidence, however, suggests that they did not. A study of 13 agencies in New York (103, p. 333), for example, shows a complete absence of training. In an agency in Seattle, some training did exist, but was "mostly informal, sporadic, and brief." (101, p. 24) Furthermore, Klarman
(120, p. 96) shows in a review of several studies that the information furnished to consumers by agency staff bore excessively on procedures, rules and regulations, rather than on the problems of patients, the health care system, or alternative means and opportunities to distribute health resources equitably.

Compounding this problem were staff attitudes: members of the staff frequently held a specific health orientation instead of a "more useful" and broader "planning focus." (103, pp. 9, 254) These orientations are said to have caused feelings among numerous consumers that the staff placed less value on their opinions than on those of health professionals. Frazier (78, p. 1702) adds that staff attitudes caused "new" consumers to feel that information they received from the staff was intended to manipulate their behavior.

Worth noting is that much of the failure of agency staff to adequately assist council consumers was result of the statutory provision governing agency funding. Indeed, recall (from Chapter I) that the areawide agencies were required to supplement federal grants with matching funds from local sources. Recall also that many staffers devoted more of their time to raising money than to the substantive affairs of their agency—an ordering of priorities that affected consumers more than providers because the former had fewer alternative sources of relevant information.
Moreover, many "B" agencies had difficulty attracting a qualified staff. This was due to a shortage of trained personnel and a lack of funds for appropriate compensation. Hyman (103, p. 254) claims that this difficulty lead first to the hiring of young, inexperienced staffers, and ultimately to "credibility gaps" whereby consumers had little faith in staff leadership, expertise, or quality. (see also: 170, p. 403; 191, p. 444)

That consumer participation in areawide health planning was more a whisper than a shout during the half-decade following the passage of the CHIP Amendments is a well-documented fact. The consumer experience, however, may reveal more about the statutes and guidelines establishing the areawide agencies than about inherent inabilities of council members. For example, the evidence concerning "closet providers" and consumer ignorance suggests only that consumers actually were ineffectual and not that consumers would remain ineffectual if provided a different planning mechanism. The implication here is that the poor performance of council consumers was, as Klarman (120, p. 82) suggests, "susceptible to legislative remedy."
The National Health Planning and Resources Development Act

Between 1972 and 1974 two congressional committees studied the performance of the "B" agencies and concluded that the consumer voice would have to be strengthened if health planning was ever to succeed. Senator Edward M. Kennedy (D, Massachusetts) (225, p. 188), chairman of the health subcommittee, affirmed that conclusion in hearings on a new health planning statute: "[The] voice of the consumer," he declared, "should be further advanced."

To achieve that objective, Congress enacted the National Health Planning and Resources Development Act of 1974 (P. L. 93-641). The act represented no new or unique federal interests (157, p. 1) and its goals were similar to those of earlier health planning legislation. However, the act did include in unprecedented detail numerous provisions for strengthening consumer participation in areawide health planning.

One provision created new areawide health planning agencies called Health Systems Agencies, or HSAs. Replacing the "B" agencies, the HSAs were to elect governing boards of from ten to thirty members. Larger boards were permissible only if an executive committee was formed of not more than 25 members and had delegated to it the same authority as the board itself. According to Hyman (103, p. 420), the intent of Congress in limiting the size of governing boards was "action, which in its deliberations it concluded would be
inhibited by...large unwieldy governing bod[ies]." Congress also concluded that small boards would facilitate consumer participation.

A second provision stipulated that a majority, but not more than 60 percent, of each governing board was to consist of consumers who were residents of a gubernatorially designated Health Service Area and who were "broadly representative" of the social, economic, linguistic, and racial populations, geographic areas, and major purchasers of health care served by the agency. The provision also defined "consumer" in exclusionary language: a consumer could not (1) hold a fiduciary interest in a provider such that more than ten percent of his income was derived from a provider; (2) serve on the board of a health entity; (3) have been a provider during the 12 months immediately prior to becoming a board member; or (4) be a member of provider's immediate family. Additionally, the Act encouraged HSAs to elect consumers who were either local community leaders or representatives of organized, established constituencies. "Grass-roots" consumers no longer were preferred exclusively.

This emphasis on "interest group" consumers reflects an altered congressional perception of the role of consumers in developing and implementing areawide health plans. The CHP Amendments had stressed the need for a dialogue among members of the councils who would advocate in an independent
and tough-minded fashion the interests of ordinary consumers. In contrast, the new act stressed the need for governing boards to wield influence in their Health Service Area through the ability of their members to reach significant and diverse constituencies and by their ability to speak authoritatively for important community interests. (201, p. 24) House Report 93-1382 (220, p. 184) clarifies the point:

The credibility and ability to seek change through influence and the seeking of assistance can be attained in part through the representation on the governing body of the USA of the community's change agents and power structure. Thus, while the governing body should accurately represent the community's consumers of health care, including the poor, and minorities, so that their needs will be reflected in the agencies' health plans, the governing boards should also include representatives of newspaper editors, judges, bankers..., industry, and others who, once the plans are drawn, can assist the agency in implementing them.

This emphasis on interest group consumers also reflects a congressional preference for highly-educated, sophisticated consumers who by virtue of their social status would be likely to possess participatory predispositions and who would not be intimidated by health professionals. (see: 41, p. 971; 97, pp. 194-200)

Congressional concern with governing board representation did not focus exclusively on consumers.
Indeed, sensitive to claims that the areawide councils under and overrepresented certain types of providers, Congress required the HSAs to "adequately and equitably" represent all of the providers in a Health Service Area, including health professionals, allied health professionals, representatives of health institutions, health insurers, and representatives of health professional schools. House Report 93-1382 (5, p. 181) stresses the importance of selecting such providers, stating that "care must be taken to assure that [providers] are not dominated by any particular part of the Area's health industry."

Congress also required that the providers of each HSA be split among "direct" and "indirect" providers such that the former comprised at least one-third of the provider total. Direct providers were defined as persons who had received professional training in the provision of medical care and who were licensed or certified by the state. Indirect providers were defined as persons who held a fiduciary interest in a provider, were a member of a provider's immediate family, engaged in issuing health insurance or medical service benefits, or received more than ten percent of their gross annual income from the production of drugs or from health related research or instruction. (154, p. 8)

Two additional provisions for strengthening consumer participation dealt with agency staff and funding. The first
required each HSA to hire a minimum of ten planning professionals, or one professional for every 100,000 Health Service Area residents (up to a maximum of 50), whichever was greater. As a group, the professionals were to be expert in gathering and analyzing data, in health planning, and in developing and utilizing health resources. The agencies were to pay the professionals at a rate comparable to the rate for similar positions in other public or private health agencies, and to establish selection, promotion, and discharge policies that would attract applicants of the highest calibre.

The second provision stipulated that HSAs were entitled to "planning grants" of not less than $175,000, but not more than $3,750,000, for the purpose of compensating agency personnel, collecting data, planning, and performing the routine functions outlined in the statute. (The funding granted each agency was to be determined by multiplying the number of Health Service Area residents by $0.50.) Additionally, agencies could receive matching grants up to a maximum of $0.25 per capita if local contributors were not health care providers and if federal authorities were satisfied that local contributions carried with them no quid pro quo obligations.

The purpose of the staff and funding provisions was to enable the HSAs to hire and retain a skilled, competent, numerically adequate staff, free to assist governing board
members. Such staffs, Congress reasoned, could provide the information and guidance necessary to reduce the participatory disparity between consumers and providers.

Still other provisions for improving consumer participation limited the statutory mission of the areawide agencies. Recall (from Chapter I) that the agencies established in 1966 were charged with the planning of all aspects of whatever effected health, while the HSAs were to focus almost exclusively on the "health system." This narrowing of scope was expected to decrease the depth and breadth of new, unfamiliar information consumers would need to assimilate in order to become effective participants in the planning process.

Finally, the new health planning act included a provision requiring the HSAs "to reimburse...members for the reasonable costs incurred in attending meetings of the governing body." The provision sought to stimulate attendance among low-income consumers by easing the burden of board membership. The provision also was expected to make board membership more attractive (albeit slightly) to consumers willing to join the board, but unable to do so for financial reasons.

The National Health Planning and Resources Development Act cleared the Senate on December 19, 1974 and the House on the following day. Two weeks later it was signed by
President Ford. Throughout that period, proponents of the law spoke optimistically of a restructured, responsive health care system and of the significant role consumers would play in achieving that objective.

That optimism was not shared universally: shortly after the law was enacted, concern was expressed that many of its provisions would foster a form of consumer participation unintended by either Congress or the equal-health advocates. Sieverts (201, pp. 22-23), for example, argued that the unusually detailed criteria concerning the composition and size of the governing boards would hamper the selection of consumers "whose appointment reflects a consensus as to their capacity to be 'representative' ...at the same time that they have the sophistication, strength, and local status to be effective participants in agency affairs." Sieverts then noted that even Health Service Areas with relatively homogenous populations would be divided into more than two dozen categories (e.g., the urban poor, the elderly, blacks, women, the handicapped, union members), each of which would require a seat on the board if the board as a whole was to be "broadly representative." He claimed that since HSAs are encouraged to limit the size of their boards to 30 members, approximately 13 to 15 consumers (i.e., more than 50 percent, but less than 60 percent) would have to be found to "represent" the dozens of categories, a task held to be extremely difficult, even though most
consumers would fall into several categories. In essence, Sieverts feared that since federal grants would be distributed only to those agencies with representative boards, the principle criteria for selecting consumers would be categories, not competence; that, for example, a black, poor, barely literate woman from a particular geographic area might be selected instead of a white male with a demonstrated record of community leadership simply because the former was needed to satisfy federal guidelines.

A second critique of the Planning Act was voiced by Klarman (121, pp. 11-12), who argued that interest group consumers—the type HSA's were encouraged to elect—are incapable of the kind of "give-and-take" necessary for the development of plans that stand a reasonable chance of being adopted. Local interest groups, he said, tend to be motivated by a single concern and tend to represent their concern inflexibly:

If each has a fixed set of priorities [Klarman writes] there is little if any leeway for mutual accommodation in the absence of a surfeit of resources to satisfy everybody's high priorities. (121, pp. 11-12)

Klarman's complaint is a simple one: the Act's emphasis on interest group consumers may work to minimize the impact of consumer participation by inviting behavior ill-suited to the resolution of health care problems in an environment of limited resources.
A related concern over interest group consumers stems from the contention that consumer representatives of local organizations are almost always advocates for a particular disability group. The problem here, according to Pifer (75, p. 767), is that once these consumers are elected they are likely to participate in discussions related to their concern, but not in discussions of other topics, such as environmental health, hospitals and nursing homes, medical education, and general health programs. Clearly, such behavior would limit the contribution consumers might make to a coordinated and interrelated health care system.

A third critique of P. L. 93-641 stresses the absence of provisions "appropriately limiting" the influence of health professionals. Vladeck (242, p. 27) suggests that this might have been done by creating a conflict of interests among providers—a conflict that would force providers to seek the support of consumers when lobbying for or against particular proposals. A conflict, in other words, that would reduce the influence of providers by increasing the need for consumer support.

Vladeck suggests two additional approaches for limiting provider influence. The first is to make providers accountable to the public through an electoral mechanism, or to a hierarchical authority (e.g., the state) through a system of legal regulation that defines what providers can and cannot do. The second is to
internalize within providers, through education or acculturation, values to be promoted. Physicians can be taught community medicine, for example, with the hope that over 20 or 30 years their outlooks will begin to coincide more nearly with the public interest.

P. L. 93-641 employs none of these approaches. It creates no conflict of interests among providers and no accountability to anyone. Nor does it contain a mechanism for raising provider consciousness. Instead, the statute limits the percentage of providers that may serve on a board with the expectation that fewer providers will exercise less influence—an approach which Vladeck claims is flawed because the influence of providers is derived less from their numbers than from the personal resources they bring to the planning process.

Krause (128, p. 674) too explored the potential for provider domination and concluded that despite the statute pro-provider governing boards could still be formed. He illustrate the point by noting that even though 60 percent of each board must be consumers, half that percentage may be elected officials dependent on local elites for campaign support. If in fact half are elected officials, providers would then be the largest single group of governing board members. Krause adds that because the statute contains no rules for determining how governing board seats shall be distributed among the numerous representation categories,
consumer "tokenism" remains a strong possibility.

A final critique of P. L. 93-641 addresses the absence of provisions preventing "B" agency councils from becoming HSA governing boards. In particular, the Act does not prohibit "B" agencies from being designates as HSAs. Nor does it prohibit consumers from becoming HSA members. In fact, the act encourages such "lateral" shifts by allowing for governing boards of more than 30 members if an executive committee is established. The point here is that a new relationship between consumers and providers may fail to evolve if a substantial number of governing board members are "B" agency alumni. (103, p. 435)

Research Design

P. L. 93-641 contains numerous provisions for strengthening consumer participation in areawide health planning. Many of those provisions were not included in earlier health planning legislation and most were written in unprecedented detail. Nevertheless, the act itself is no guarantee that consumer members of HSA governing boards will actually participate in a manner consistent with the intentions of Congress. Indeed, whether HSA consumers are now participating as the equals of health professionals is an empirical question.

To answer that question this research first evaluates the implementation of the provisions dealing with the
composition of HSA governing boards:

1. Do consumers comprise more than 50 percent, but less than 60 percent, of each governing board?

2. Do consumers represent the social, economic, linguistic, and racial populations, geographic areas, and major purchasers of health care served by the agencies?

3. Do governing boards include both "grass roots" and "change agent" or elite consumers? And finally,

4. Have the agencies eliminated closet providers from among their consumer members? (I.e., do any consumers serve on the board of a health entity? Do any consumers hold a fiduciary interest in a provider? Have any consumers been a provider during the 12 months prior to becoming a governing board member? And, are any consumers a member of a provider's immediate family?)

The answers to these questions will help to determine whether the HSAs have elected the kinds of consumers preferred by Congress. This is important because such information may effect conclusions about consumer participation. Consider, for example, research that demonstrates that many consumers are closet providers and that consumers and health professionals have near-equal influence in the setting of agency policy. These findings would warrant a very different conclusion from findings indicating near-equal influence but that no or few consumers were closet providers. In short, the questions dealing with implementation are important because they establish a
context for understanding the interactions of governing board members.

Once that context has been established, consumer participation is assessed. Participation is defined as a construct having two components—an activity component and an influence component. The activity component focuses on those behaviors in which trustees engage during and between governing board meetings. It includes, for example, attending governing board meetings, asking questions and expressing opinions, offering motions and seconds for the board to consider, and studying materials prepared by the staff.

The influence component addresses the question "Who on the board can persuade others to think and act in a particular way?" Influence is measured by examining formal leadership positions and centrality, defined as the location of governing board members in a board's interaction network. Influence is also measured using a variation of the "reputational approach" employed by Hunter (102).

Since an implicit goal of P. L. 93-647 is to "bring providers and consumers into transactions with equitable partnership" (126, p. 2), the mode of analysis throughout this research is comparative: the participation of consumers is compared to the participation of providers. The approach is expected to reveal whether such a partnership has replaced the participatory disparities that characterized
the "B" agency councils.

The analyses contained in the following chapters are based on data from several national studies conducted by or for agencies of the federal government and on data collected by the investigator from two HSAs in central and southwestern Ohio, the Mid-Ohio Health Planning Federation (Columbus) and the Miami Valley Health Systems Agency (Dayton). These agencies were selected from among the more than 200 HSAs nationwide for several reasons. First, both agencies were located less than 75 miles from the investigator. This permitted at an acceptable cost numerous "site" visits for the purpose of gathering documents, speaking with staff, and attending governing board meetings. Convenience also was important because it enabled the investigator to conduct personal (i.e., face-to-face) interviews with governing board members who refused to be interviewed over the telephone.

A second reason for selecting the agencies was their willingness to participate: each staff agreed to make available a variety of pertinent documents (some of which were not in the public domain), encouraged the investigator to attend board and committee meetings, and approved without restrictions a request to conduct both staff and board member interviews. Such consent proved to be vital as many board members refused to be interviewed until permission to
do so had been granted in writing by their agency's Executive Director.

A third reason for selecting the agencies had a theoretical origin. Specifically, much of the literature on small group behavior indicates that the size of a group effects the participation of its members. To test that proposition in the HSA setting, it was necessary to examine boards with substantially different numbers of members: the board in Columbus has 71 members and the board in Dayton has 30.

The final reason for selecting the agencies was that both were conditionally designated on May 1, 1976, more than two years before this research began. Two years was considered a sufficient length of time for members of the board and the staff to have settled into routine patterns of behavior—behavior considered more interesting and potentially more revealing than behavior characterized by the learning of roles and responsibilities.

The data collected from Mid-Ohio and Miami Valley were obtained from several sources. The primary source was telephone interviews with 60 of the 71 (84.5 percent) Mid-Ohio "trustees" and with 25 of the 28 (89.2 percent) "trustees" of Miami Valley. Though an effort was made to interview every trustee, those who were not either refused to be interviewed, or could not be reached by telephone.
When the board member interviews were completed, personal interviews were conducted with selected members of each agency's staff. Those interviewed from Mid-Ohio included the Executive Director of the agency, the Assistant Director, the Director of Project Review, the Assistant Director of Project Review, and a Health Planner assigned to "promotion and prevention" issues. Similarly, those interviewed from Miami Valley included the Executive Director, the Associate Director, the Director of Project Review, the Director of Planning, the Director of Health Resources Management, and a health planner responsible for drafting the annual Health Systems Plan. These staffers were selected after several visits to the agencies during which it had become apparent that they had the best understanding of the relationship between consumers and providers. Moreover, the selected staffers expressed an interest in the study as well as a willingness to be interviewed.

A third source of data was agency documents. These include areawide Health Systems Plans, Annual Implementation Plans, Annual Reports, HSA Grant Applications, board and committee meeting minutes, and intra-agency memoranda. Additional documents were obtained from the Office of Health Planning, the Ohio Department of Health.

This research is essentially two case studies—an in-depth analysis of consumer participation in two Health
Systems Agencies. It differs from earlier, but related research, in that it addresses more comprehensively a broader range of issues than any other single study. Consider, for example, a 1976 study by the General Accounting Office (GAO) (35) in which questionnaires were distributed to the governing board members of 15 HMA's for the purpose of "assessing the implementation of P. L. 93-641." The questionnaires covered a variety of topics including the procedures for selecting governing board members, board and committee meeting attendance, the "representativeness" of consumers, and the influence of consumers in agency decisions, relative to the influence of providers and agency staff. Unfortunately, however, the GAO (for unknown reasons) tallied responses to only 13 of its 34 questions. Among the responses not tallied were many concerned with consumer participation. In short, the GAO study promised much, but delivered substantially less.

Another problem with the GAO study is a reliance on interview data where data gleaned from other sources or other indicators would have been more appropriate from the standpoint of minimizing measurement error. In particular, the GAO failed to examine board meeting minutes or to interview members of agency staff when considering overall patterns of attendance or the behavior of consumers and providers. Additionally, the GAO employed no indirect indicators (e.g., formal leadership positions) when
considering questions of influence.

A second study of consumer participation was conducted by the Orkand Corporation (231, 232) under the direction of the Office of Health Resources Opportunity and the Bureau of Health Planning and Resources Development. This study, also conducted in 1976, focuses on board and staff composition to the exclusion of other issues such as board member influence, turnover, and attendance. Furthermore, the study is entirely descriptive, containing neither an explanation of the findings, nor a discussion of the implications the findings entail for consumer participation.

In a third study, Randolph Grossman (87, 88) explores voting behavior in the Project Review Committee of the nation's third largest HSA. Grossman attempts to discern whether the theory of "interest-group liberalism" can be used to describe correctly consumer-provider interaction.

Grossman's research covers a period from December to July 1977 and analyzes 23 review committee votes using the Rice Index of Voting Cohesion. Though the study is methodologically sound and theoretically important, it addresses only a single aspect of that relationship. This observation is less a criticism than a reminder that additional aspects of the relationship between consumers and providers must be explored if consumer participation in areawide health planning is to be fully understood.
One additional consideration distinguishes the present research from two of the studies reviewed above. That consideration is the relationship between research sponsorship and respondent bias. Specifically, the GAO and Orkand studies were conducted by or under the auspices of federal authorities at least partially responsible for reviewing USA budgets. It seems likely that members of the boards and staffs participating in those studies were aware of this. It also seems likely that such an awareness increases the potential for interview respondents to tell the investigator what he wants or expects to hear. Though no evidence exists to support this contention, it entails the inference that an investigator with no attachments to federal agencies will be privy to insights and information respondents might in other circumstances be unwilling to share. If this is correct, it then follows that the interview data collected for this research is less biased than comparable data in at least some of the other studies.
ENDNOTES

1. According to Henry Clay Smith (203, p. 111), the key to descriptive representation is empathy—"the tendency of a perceiver to assume that another's feelings, thoughts, and behaviors are similar to his own." He contends that a person with particular demographic characteristics is better able to be empathetic with respect to others with the same characteristics than are persons whose demographic characteristics are different. (see also: 141, pp. 126-32; 112, pp. 29-32)

2. That the Comprehensive Health Planning Service was serious about including grass-roots consumers on the areawide councils is demonstrated by its tacit approval of agency by-laws prohibiting consumers from representing established constituencies. For example, the by-laws of the Puget Sound Health Planning Council contain language stating that all persons selected for council membership were required to serve "as individuals" and "not as representatives of any organization." According to Danaeau (101, p. 19), this language was not meant to preclude from being represented, but was meant to inform council members that they should not advocate only the interests of a particular group.

3. It should be noted that provider domination also has been found in health programs unrelated to the CHP Amendments. Douglass (52, 53, 54), for example, analyzed the effects of consumer participation on decision making in programs for the delivery of personal health services in eight cities in Michigan that received Model Cities grants. He reports that in all eight programs providers were more influential than consumers. "The data strongly suggest," he writes, "that providers dominated decision making in every city." Douglass adds that a "requirement for a certain provider-consumer mix on a planning body will not ensure a decision that is representative of this particular mix." (52, pp. 160-62)

Along similar lines, Falkson (70, pp. 161-62) examined consumer participation in neighborhood health centers and concluded that "citizen participation...had only a very marginal impact either in shaping health and education
policy-making or in affecting the attitudinal and behavioral orientation of involved clientele and constituency populations."

4. Hyman's discussion is reminiscent of Robert Michels' "Iron Law of Oligarchy" (153) by which he generalized the formation of ruling cliques in the German Social Democratic Party. Michels contends that power acquired through the consent of the masses becomes a possession available for coercion. In the present context, bored consumers relinquished their "power" in the decision making process to providers, who in turn dominated agency activity. It would seem to follow from Michels' "Law" that providers did not always act in the consumers' behalf. (see also: 81, pp. 329-30)

5. The board member interviews were conducted between August 29 and November 11, 1978. They averaged 34 minutes in length and ranged from 15 minutes to 64 minutes. The average length for consumers and providers was virtually identical (33.6 minutes v. 35.5 minutes). Two Mid-Ohio governing board members were interviewed in person.

6. Those interviews averaged 63 minutes and were conducted between December 4 and December 6, 1978.
CHAPTER III
GOVERNING BOARD COMPOSITION

Since January 3, 1975 more than 200 areawide Health Systems Agencies have been designated by the Secretary of Health, Education, and Welfare. Each operates in a multi-county Health Service Area; each has received planning grants to cover operating expenses; and each has established a governing board. This chapter examines the composition of those governing boards for the purpose of evaluating the implementation of the provisions of P. L. 93-641 designed to strengthen consumer participation.

The first section of the chapter evaluates implementation nationally, drawing on data gathered by the Health Resources Administration (HRA) (230) and by the Orkand Corporation (231, 232) under the direction of the Office of Health Resources Opportunity (OHRO) and the Bureau of Health Planning and Resources Development (BHRPD). The second section evaluates implementation in two HSAs in Ohio. Though both sections review many of the same provisions, the second is considerably more detailed. Moreover, it establishes a specific context for the fourth chapter which evaluates the impact the law has had on consumer
participation in the two Ohio agencies.

The link between the statutory provisions discussed in this chapter and the behaviors those provisions are presumed to effect is an uncertain one, since strengthened consumer participation does not follow a priori from the successful implementation of P. L. 93-641—neither Congress nor the equal-health advocates have demonstrated that connection. As a consequence, the significance of this chapter is less certain than the significance of the one that follows.

A National Overview

Governing Board Size

Section 1512 of P. L. 93-641 sets strict limits on the size of NSA governing boards. Each agency, the statute reads,

shall have a governing body...of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established an "executive committee" composed of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action as the governing body is authorized to take.

Table 1 and Table 2 focus on the implementation of these provisions. They show that by February 1978 no governing board contained fewer members than the minimum required by law, that no executive committee contained more members than the maximum required by law, and that the number of
<table>
<thead>
<tr>
<th>Number of Members (^b)</th>
<th>Number of Agencies</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 20</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>20 to 29</td>
<td>11</td>
<td>5.4</td>
</tr>
<tr>
<td>30</td>
<td>101</td>
<td>49.5</td>
</tr>
<tr>
<td>31 to 50</td>
<td>26</td>
<td>12.7</td>
</tr>
<tr>
<td>51 to 70</td>
<td>40</td>
<td>19.6</td>
</tr>
<tr>
<td>71 to 100</td>
<td>21</td>
<td>10.3</td>
</tr>
<tr>
<td>More than 100</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>204</td>
<td>100.0</td>
</tr>
</tbody>
</table>


\(^b\) The number of members ranges from 15 to 137. The total number of members on all 204 boards is 8,707. This figure does not include 193 vacancies.
Table 2. HSA Executive Committee Size

<table>
<thead>
<tr>
<th>Number of Members</th>
<th>Number of Agencies</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 10</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>11 to 15</td>
<td>13</td>
<td>13.8</td>
</tr>
<tr>
<td>16 to 24</td>
<td>17</td>
<td>18.1</td>
</tr>
<tr>
<td>25</td>
<td>61</td>
<td>64.9</td>
</tr>
<tr>
<td>94</td>
<td></td>
<td>100.0</td>
</tr>
</tbody>
</table>


The total number of executive committee members is 1,966. This figure does not include 37 vacancies.
executive committees exceeded the number of boards with more than 30 members. The latter observation suggests (however tenuously) that most, if not all, of the larger boards have established executive committees.

According to Orkand, the "average" HSA governing board contained 44 members. This figure is notable in light of both a claim by Donoghue (51, p. 9) that 42 members served on the "average" "B" agency council and the HRA report which indicates that 113 HSAs were originally "B" agencies. The point here is obvious: though virtually all of the HSAs had implemented the size provisions by 1978, it is likely that many of the "B" agencies that became HSAs did so without reducing the size of their governing body. It is likely, in other words, that in many HSAs, the executive committee provision was seen as a loophole allowing larger boards than Congress had intended.

Table 1 also shows that slightly less than half of the boards contained precisely 30 members. This suggests that many agencies were reluctant to establish an executive committee. The origin of that reluctance may have been fear that a committee of 25 members (having the authority to act on the agency's behalf) would be less representative than the entire board and would delegate to it only ceremonial or symbolic tasks. Kennelly (118), however, speculates that in many agencies these or similar fears may have been offset by the need for community support coupled with the willingness
of local interests to support the agencies only in exchange for representation. Therefore, the size of a particular governing board probably reflects the number of health-related interests in its agency's Health Service Area as well as the influence or power those interests wield.

Consumer Majorities

In addition to limiting governing board size, Section 1512 states that "consumers of health care" shall comprise a majority, but not more than 60 percent, of each board's members. The HRA found that 53.1 percent of all governing board members were consumers and Orkand found that on the "average" board the percentage of consumers was 52.8. Orkand also found that 12 boards (9.0 percent) were either evenly split or had a provider majority and that two boards (1.5 percent) had a consumer majority in excess of 60 percent. These figures indicate that nearly 90 percent of the 134 boards Orkand examined had complied with the provision mandating limited consumer majorities as early as June 1976.

Donoghue (51, p. 9) reports that consumers on the "B" agency councils averaged 55 percent, a figure remarkably similar to Orkand's. This too is an indication that nomenclature may be the primary difference between HSA governing boards and the "B" agency councils the boards replaced.
Consumer Representativeness

A third passage of Section 1512 stipulates that governing board consumers shall be "broadly representative of the social, economic, linguistic, and racial populations, geographic areas of the health service area, and major purchasers of health care." Orkand examined the implementation of this provision by borrowing from Eugene S. Paitek (177) the concept of parity and applying it to three demographic indicators: race, sex, and occupation.

Parity refers to a comparison of the percentage of a particular group on a board with the percentage that group comprises in the population of the Area an agency serves. For example,

One HSA governing board may have five Black members of a total of 50 board members; the level of Black representativeness would be 10 percent. If the area population was 40 percent Black, the parity measure would be 10/40 or 25 percent. On the other hand if an agency with the same population percentage of 40 percent Black contained one Black HSA member on the 50 member board, the board [sic] representativeness would be 1/50 or 2 percent, and the parity measure would be 2/40 or 5 percent. (231, p. 8)

Although parity of 100 percent is the implementor's ideal, Orkand considers parity of from 80 percent to 120 percent to be indicative of adequate or successful implementation. Stated differently, Orkand considers groups on a board having parity of less than 80 percent to be underrepresented and groups having parity of more than 120 percent to be
Before reviewing Orkand's findings, two problems with the parity measure should be explored. The first is the measure's lack of stability when the groups on a board consist of only a handful of members. Imagine, for example, an HSA serving an area with a black population of 11 percent. Imagine further that among that board's members are 20 consumers, two of whom are black. Should one of the two resign and be replaced by a non-black, black representativeness would shrink from ten percent to five percent and black parity would drop from 91 percent to 45 percent, a shift in parity of 46 percentage points. Now imagine a second HSA serving an area with a black population of 11 percent. Among the members of this agency's board are 80 consumers, eight of whom are black. If one of these blacks resigned and was replaced by a non-black, black representativeness here would drop from ten percent to slightly less than nine percent. Black parity would drop from 91 percent to slightly more than 79 percent, a percentage point shift of roughly 11.

Had parity been measured before the imaginary resignations, conclusions about the black presence on each board might well have been identical. However, had parity been measured after the resignations, the black presence on the smaller board would have been judged severely deficient, despite the fact that only a single member resigned from
each board. In short, there is an inverse relationship between the size of a group on a board and the stability or reliability of the parity measure.

The dramatic shifts in parity associated with seemingly minor changes in the composition of smaller governing boards may argue for highly specific regulations concerning minority representation. For example, it may be appropriate to require that minorities be represented by no fewer than some minimum number of persons at all meetings of a board during which agency business is transacted. It may also be appropriate to establish a 30 day limit (the typical interval between governing board meetings) for filling vacancies created by the resignations of minority members. Such regulations are likely to facilitate minority representation.

A second problem with the parity measure is its focus on "representativeness" rather than on "representation." The concept, in other words, describes "who" or "what" board members are, not the points of view they champion. This is a problem because subsequent to the completion of the Orkand study House Conference Report 95-500 (218, p. 22) stated that in drafting Section 1512, Congress had been concerned only with representation. It was not the intent of Congress, the report explains, "to require representatives of a particular category to be members of the class they represent."

Despite these problems, Orkand's data are instructive: they reveal that racial and ethnic minorities comprised an average of 19 percent of each board's consumers. Blacks averaged 14 percent, Hispanics four percent, and Asians and Pacific Islanders the remaining one percent. For all minorities, parity on 12 boards was less than 80 percent; on 21 boards parity ranged from 80 percent and 120 percent. And on 70 boards parity exceeded 120 percent. The HRA adds that only 6.9 percent of all 204 boards experienced "problems" recruiting minority representatives. Clearly, data from both national studies indicate that minorities were rarely underrepresented and frequently overrepresented on the boards of Health Systems Agencies.

Such a contention requires further comment, for it obscures the fact that on most boards minorities held only a small fraction of the available seats—a circumstance which probably limits the expression of minority viewpoints as well as the "clout" minorities have in agency decision making. In Blum's (21, p. 458) words,

> Experience has indicated that appointing a tiny contingent of minorities...to a board does not suffice to encourage them to come to meetings or to keep them in activities. Token representation has too frequently soon meant no representation of these groups.

Orkand's data also show that women averaged 33 percent of each board's consumers and that parity for women was less than 80 percent on slightly more than two-thirds of the
boards. Apparently, the tendency to overrepresent minorities did not extend to females.

Worth noting is that minority females were found to comprise 39.1 percent of all minority consumers, while white females were found to comprise only 31.4 percent of all white consumers. Though the difference is not dramatic, it suggests that some agencies attempted to satisfy representation guidelines by "double counting" certain types of members—in this case minorities and women. Orkand (231, p. 14) speculates that this "practice" may have been used to "maximize representation." Also likely, however, is that the practice was intended to minimize the number of seats and votes distributed to the double-counted groups.

Orkand next examined the current, primary occupations of HSA consumers using categories established by the U. S. Census. Presumably, occupation was considered to be an indicator of social and economic status. As Table 3 shows, 68 percent of the consumers held either a professional or managerial position. An additional 10.6 percent held positions which are neither professional nor managerial, and 21.4 percent were not employed. In contrast, data from the 1970 Census indicates that only 13.2 percent of the nation's adult population held either a professional or managerial position, that fully 45.2 percent held a position of lower status, and that 41.8 percent were not employed. On the basis of these (and the parity figures), Orkand concludes
Table 3. HSA Consumer Occupations:
Census Bureau Categories\(^a\)

<table>
<thead>
<tr>
<th>Occupation Category</th>
<th>Mean Percent on Governing Boards(^b)</th>
<th>Percent Nationwide</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional, Technical and Kindred Workers</td>
<td>31.0 (896)</td>
<td>8.5</td>
<td>367.0</td>
</tr>
<tr>
<td>Managers, Officials, and Proprietors</td>
<td>37.0 (1067)</td>
<td>4.7</td>
<td>789.4</td>
</tr>
<tr>
<td>Clerical and Kindred Workers</td>
<td>3.1 (90)</td>
<td>10.4</td>
<td>29.8</td>
</tr>
<tr>
<td>Sales Workers</td>
<td>1.9 (55)</td>
<td>4.1</td>
<td>46.3</td>
</tr>
<tr>
<td>Craftsmen, Tradesmen, and Kindred Workers</td>
<td>1.3 (37)</td>
<td>8.1</td>
<td>16.0</td>
</tr>
<tr>
<td>Operatives and Kindred Workers</td>
<td>.8 (22)</td>
<td>10.4</td>
<td>7.7</td>
</tr>
<tr>
<td>Service Workers</td>
<td>.2 (7)</td>
<td>6.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Private Household Workers</td>
<td>.2 (6)</td>
<td>.9</td>
<td>22.2</td>
</tr>
<tr>
<td>Farm and Farm Managers</td>
<td>2.4 (70)</td>
<td>1.0</td>
<td>240.0</td>
</tr>
<tr>
<td>Farm Laborers and Foreman</td>
<td>0.0 (0)</td>
<td>.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Laborers Except Farm and Mine</td>
<td>.7 (20)</td>
<td>2.7</td>
<td>25.9</td>
</tr>
<tr>
<td>Not in Civilian Labor Force</td>
<td>21.4 (618)</td>
<td>41.8</td>
<td>51.7</td>
</tr>
<tr>
<td>100.0 (2888)</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


\(^b\)Data are from consumers of 134 boards. Data from 231 consumers were not available.
that "the higher-status occupational groups were extremely overrepresented while persons of lower status occupational groups and not in the civilian labor force were extremely underrepresented." (231, p. 15)

Orkand's second analysis of consumer occupations employed a four-category scale developed by Richard Rice (187, pp. 344-56). The scale ranges from High-Status-White-Collar to Low-Status-Blue-Collar, with Low-Status-White-Collar and High-Status-Blue-Collar occupying the intermediate positions. This analysis, as seen in Table 4, shows that nearly 67 percent of the 2,858 consumers for whom data were available fall into the High-Status-White-Collar category. Only 2.1 percent fall into the three remaining scalar categories, while 20 percent are not employed, and 2.4 percent hold "farm occupations." In short, both analyses indicate that HSA consumers tend to be white collar, blue chip citizens.

A majority of the "B" agency consumers also were high status citizens. According to Donoghue (51, p. 9), most held "high educational backgrounds," most were professionals, and exceptionally few had clerical, skilled, or unskilled jobs. Evans (65, p. 553) claims that only nine percent of the board members he studied could be classified as middle class, middle income consumers and that a majority were either top-level corporate executives, self-employed entrepreneurs, or professionals such as lawyers,
Table 4. HSA Consumer Occupations:
The Richard Rice Index

<table>
<thead>
<tr>
<th>Occupation Category</th>
<th>Number of Consumers</th>
<th>Mean Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Status-White-Collar</td>
<td>2,105</td>
<td>73.6</td>
</tr>
<tr>
<td>Low-Status-White-Collar</td>
<td>3</td>
<td>.1</td>
</tr>
<tr>
<td>High-Status-Blue-Collar</td>
<td>21</td>
<td>.7</td>
</tr>
<tr>
<td>Low-Status-Blue-Collar</td>
<td>51</td>
<td>1.8</td>
</tr>
<tr>
<td>Farm Occupations</td>
<td>73</td>
<td>2.6</td>
</tr>
<tr>
<td>Not in Civilian Labor Force</td>
<td>605</td>
<td>21.2</td>
</tr>
<tr>
<td></td>
<td>2,858</td>
<td>100.0</td>
</tr>
</tbody>
</table>


\*Data are from consumers of 134 boards. Data for 253 consumers were not available.
accountants, and engineers. To this, both he and Hyman (103, p. 248) add that even those consumers designated as "minority-disadvantaged" often were from middle and upper-middle income families.

Blum (21, p. 454) paints a slightly more elaborate picture of "B" agency consumers. He contends that

The...consumer board members [were] predominately of two types. The first [was] the middle-class traditional joiner, volunteer agency type who is sometimes involved socially with or married to persons employed in some aspect of the health care machinery. The second consumer type [was] the upper class business and community leader who is at least the social peer of the [health] professional.

Blum's comments are instructive not because they show that the "B" agencies recruited middle and upper middle-class consumers, but because they suggest that few if any consumers were of the grass-roots or "victim" variety—the type of consumer for whom the councils had been created.

These reports of "B" agency consumers, when coupled with reports of their participation in agency affairs (see Chapter II) indicate that a high status occupation is not a sufficient condition for vigorous participation: though most council consumers had high status occupations, few were active participants. Consequently, Orkand's analysis does not warrant an expectation of improved participation among HSA consumers, despite the fact that high status consumers have been recruited. Furthermore, the similarity in the
occupational status of "B" agency and HSA consumers adds still more weight to the contention that many of the "B" agencies that became HSAs did little more to their governing body than change the name from "council" to "board."

Provider Representativeness

In addition to requirements governing the selection of HSA consumers, Section 1512 contains guidelines for the selection of HSA providers. The statute states that

The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (I) physicians..., dentists, and other health professionals, (II) health care institutions..., (III) health care insurers..., (IV) health professional schools, and (V) the allied health professions.

The statute also states that at least one-third of each board's providers shall be direct providers, defined as persons who actually provide health care and are licensed by the state to do so.

orkand reports that 44.8 percent of its 134 boards contained no representative of a health professional school and that 26.1 percent contained no health care insurer. The remaining categories, "With one or two exceptions, ...were represented on each of the boards." In contrast, the HRA found that only two percent of all 204 boards did not include a provider from a health professional school and
that 3.9 percent did not include a health care insurer. These differences suggest that during the months between June 1976 and February 1978, when the two studies were conducted, many HSAs recruited providers to fill most of the vacant provider categories. The differences suggest, in other words, that during their term of "conditional" designation many agencies, either on their own or as result of pressure from Washington, took steps to correct at least one kind of deficiency in the composition of their governing bodies.

Orkand also reveals that on virtually every board at least one-third of the providers were direct providers and that the average percentage of direct providers was 66.7. Although these figures reflect "successful implementation," they also suggest that providers were not equally distributed across all five provider categories. Table 5 illustrates the point. It shows that 36.3 percent of the providers were health professionals, that 24.1 percent were from health care facilities, and that 30.9 percent were allied health professionals. Only 4.6 percent were health care insurers and only 4.1 percent were representatives of health professional schools.

In a discussion of the "B" agencies, Ryman (103, p. 250) asserts that there too "unbalanced ratios" frequently occurred within the provider classification. He notes that although health care was then a burgeoning field with many
Table 5: HSA Provider Representativeness

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Number Providers</th>
<th>Mean Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors, Dentists, Nurses, and Other Health Professionals</td>
<td>1,022</td>
<td>36.3</td>
</tr>
<tr>
<td>Health Care Institutions</td>
<td>680</td>
<td>24.1</td>
</tr>
<tr>
<td>Health Care Insurers</td>
<td>130</td>
<td>4.6</td>
</tr>
<tr>
<td>Health Professional Schools</td>
<td>117</td>
<td>4.1</td>
</tr>
<tr>
<td>Allied Health Professions</td>
<td>873</td>
<td>30.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,822</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>


*Data are from providers of 134 boards. Data from nine providers were not available.*
varied professions and interests, traditional forces in the foreground of health systems policy played the most visible and dominant role:

The proportion of representation related to physicians, hospitals, ...and health facilities far exceeds any other representation and in enormous disparity to the 1970 census ratios of health professionals to the population mix as a whole... While it becomes clear that many health interests cannot be represented, the sheer number of which interests are represented leaves little doubt as to which health interests are being expressed.

It appears, then, that, with few exceptions, the interests represented by HSA providers are similar to those which had been represented by providers on the "B" agency councils. This, of course, is still further evidence of the similarity between these councils and the HSA governing boards.

Unlike consumers, providers were not required to be "broadly representative" of the population within their Health Service Area. Nevertheless, Orkand examined "provider representativeness" and found that minorities comprised an average of six percent and women an average of 18 percent of each board's provider contingent. These figures are substantially lower than those for minority and female consumers, suggesting that the selection of providers was governed by considerations other than race and sex. Yet this may not be entirely true for the selection of providers may
have been guided (at least in part) by an interpretation of representativeness which employs as a baseline only the provider population.² Orkand (231, pp. 16-17) supports this contention, albeit indirectly:

Consumers were selected from the general population of which 18 percent were racial and ethnic minorities nationwide. Minorities were a much smaller percentage of the provider population. For instance, minorities contributed 9 percent of the nation's physicians. The fact that only 6 percent of the physicians on the HSA boards were minorities was much closer to the 9 percent minority physicians nationwide than the 18 percent of minorities in the general population.

Miscellaneous Provisions

Three provisions in Section 1512 address the entire membership of HSA governing boards. The first states that board membership shall

include (either through consumer or provider members) public elected officials and other representatives of governmental authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health.

The second states that board membership shall

include a percentage of individuals who reside in nonmetropolitan areas within the Health Service Area which percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas.

A final provision requires each governing board to include
as ex officio members representatives of the Health Maintenance Organizations and Veteran's Administration health care facilities located within the Health Service Area.

Neither Orkand nor the HRA evaluated the implementation of these provisions in detail. The HRA does note, however, that 14 boards (6.9 percent) did not include a representative from an area Health Maintenance Organization, that ten boards (4.9 percent) failed to include a proper percentage of "nonmetropolitan" members, and that 14 boards (6.9 percent) "experienced problems" recruiting public officials.

To this point the evaluation of the implementation of Section 1512 has shown that by February 1978, the size of most HSA governing boards was consistent with statutory guidelines; on virtually all of the boards consumers comprised a numerical majority; minorities often were overrepresented and women underrepresented; the vast majority of employed consumers had high status occupations; on most boards each provider category was represented; and a plurality of providers were both health professionals and direct providers. The evaluation suggests that the selection of providers may have been guided by an interpretation of representativeness based on an area's provider population. And finally, it indicates that a great many "B" agencies may
have become HSAs without altering the composition of their governing body.

Two HSAs in Ohio

Although Orkand and the HRA examined a large number of agencies, their analyses fail to address several issues either adequately or at all. Neither examines the geographic or linguistic representativeness of consumers, the extent to which consumers are "closet providers," or the social and economic status of consumers using indicators other than occupation. Furthermore, neither explores the relationship between representativeness and representation.

To offset these deficiencies, data were collected from two Health Systems Agencies in Ohio, the Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency. The principle sources of data from these agencies are grant applications submitted to the Department of Health, Education, and Welfare, telephone interviews with governing board trustees, and personal interviews with agency staff. For the purpose of computing parity, 1970 census data were obtained for the 23 counties comprising the relevant Health Service Areas.

Mid-Ohio's governing board consists of 71 trustees, of whom approximately 52 percent are consumers. Each consumer speaks English as his or her primary language, although two claim a competency in Spanish. Women constitute 20 percent
of the consumers and blacks slightly more than 11 percent. Parity for blacks is 142 percent and for women, 39 percent. Parity for persons speaking a language other than English is more than 900 percent, if the two Spanish speaking consumers are included in the parity computation. If they are not, the figure drops to zero. In contrast, Miami Valley's board is comprised of 28 trustees, of whom roughly 54 percent are consumers. Each consumer speaks English exclusively. Women constitute nearly 47 percent of the consumers and blacks slightly more than 13 percent. Parity for women is 91.4 percent and for blacks, 137 percent. Parity for those who do not speak English is zero. In sum, Mid-Ohio's governing board is substantially larger than the national average and Miami Valley's is substantially smaller. Both boards have a consumer majority, both overrepresent blacks, and Mid-Ohio's underrepresents women. For all consumers, English is their primary language.

These boards attempt to maintain their consumer majorities through the application of agency-specific formulae. Mid-Ohio's formula reserves 37 seats for consumers and Miami Valley's reserves 15. However, the actual number of consumers on either board fluctuates as a function of both resignations and the availability of appropriate replacements. If it is true that consumers resign more frequently than do providers and that consumers typically are more reluctant to participate in health-related
community affairs, then it is likely that despite the formulae each agency occasionally will operate without a consumer majority. Consider, for example, the period immediately prior to January 13, 1978: as a result of resignations Mid-Ohio's governing board consisted of 35 consumers and 34 providers. Had one of the remaining consumers resigned before a replacement had been recruited, consumers would have lost (at least temporarily) their majority status. The point here is that despite the formulae and the statutory guidelines agency policy still may be set in the absence of a consumer majority—a circumstance that violates the intent of the National Health Planning Act.

Compounding this problem is a provision stating that for an agency's decisions to be binding, meetings of the board must be attended by a majority of members, rather than by a majority of consumers. If consumers attend meetings less often than do providers (as was true for council consumers), then again, the potential exists for provider majorities at governing board meetings and for provider domination of agency affairs.

As noted earlier, Section 1512 stipulates that HSA consumers must be "broadly representative" of the geographic areas served by their agency. The implementation of this provision is critically important because HSAs have the authority to recommend where new health care facilities
<table>
<thead>
<tr>
<th>County</th>
<th>County Population</th>
<th>Percent of Health Service Area Population</th>
<th>Number of Consumer Members</th>
<th>Percent of All Consumer Members</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>861,700</td>
<td>55.2</td>
<td>20</td>
<td>55.4</td>
<td>100.7</td>
</tr>
<tr>
<td>Fairfield</td>
<td>85,700</td>
<td>5.5</td>
<td>2</td>
<td>5.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Licking</td>
<td>114,000</td>
<td>7.3</td>
<td>2</td>
<td>5.5</td>
<td>75.3</td>
</tr>
<tr>
<td>Marion</td>
<td>66,900</td>
<td>4.3</td>
<td>1</td>
<td>2.8</td>
<td>65.1</td>
</tr>
<tr>
<td>Scioto</td>
<td>83,300</td>
<td>5.3</td>
<td>1</td>
<td>2.8</td>
<td>52.8</td>
</tr>
<tr>
<td>Pike</td>
<td>20,800</td>
<td>1.3</td>
<td>1</td>
<td>2.8</td>
<td>215.4</td>
</tr>
<tr>
<td>Ross</td>
<td>61,200</td>
<td>3.9</td>
<td>1</td>
<td>2.8</td>
<td>71.8</td>
</tr>
<tr>
<td>Fayette</td>
<td>26,200</td>
<td>1.7</td>
<td>1</td>
<td>2.8</td>
<td>164.7</td>
</tr>
<tr>
<td>Delaware</td>
<td>50,400</td>
<td>3.2</td>
<td>1</td>
<td>2.8</td>
<td>87.5</td>
</tr>
<tr>
<td>Wayandot</td>
<td>22,400</td>
<td>1.4</td>
<td>1</td>
<td>2.8</td>
<td>200.0</td>
</tr>
<tr>
<td>Morrow</td>
<td>24,000</td>
<td>1.5</td>
<td>1</td>
<td>2.8</td>
<td>186.7</td>
</tr>
<tr>
<td>Knox</td>
<td>43,200</td>
<td>2.8</td>
<td>1</td>
<td>2.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Union</td>
<td>27,400</td>
<td>1.8</td>
<td>1</td>
<td>2.8</td>
<td>155.6</td>
</tr>
<tr>
<td>Pickaway</td>
<td>43,600</td>
<td>2.8</td>
<td>1</td>
<td>2.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Madison</td>
<td>32,000</td>
<td>2.0</td>
<td>1</td>
<td>2.8</td>
<td>140.0</td>
</tr>
</tbody>
</table>

1,562,800   100.0   36   100.0
Table 7. Geographic Representativeness: The Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>County</th>
<th>County Population</th>
<th>Percent of Health Service Area Population</th>
<th>Number of Consumer Members</th>
<th>Percent of All Consumer Members</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery</td>
<td>584,400</td>
<td>52.4</td>
<td>6</td>
<td>39.9</td>
<td>76.2</td>
</tr>
<tr>
<td>Miami</td>
<td>87,300</td>
<td>7.8</td>
<td>1</td>
<td>6.7</td>
<td>85.9</td>
</tr>
<tr>
<td>Darke</td>
<td>54,200</td>
<td>4.9</td>
<td>1</td>
<td>6.7</td>
<td>136.7</td>
</tr>
<tr>
<td>Shelby</td>
<td>40,100</td>
<td>3.6</td>
<td>0</td>
<td>0.0</td>
<td>---</td>
</tr>
<tr>
<td>Preble</td>
<td>36,400</td>
<td>3.3</td>
<td>1</td>
<td>6.7</td>
<td>203.0</td>
</tr>
<tr>
<td>Clark</td>
<td>151,400</td>
<td>13.6</td>
<td>2</td>
<td>13.3</td>
<td>97.8</td>
</tr>
<tr>
<td>Greene</td>
<td>127,900</td>
<td>11.5</td>
<td>3</td>
<td>20.0</td>
<td>173.9</td>
</tr>
<tr>
<td>Champaign</td>
<td>32,200</td>
<td>2.9</td>
<td>1</td>
<td>6.7</td>
<td>231.0</td>
</tr>
<tr>
<td></td>
<td>1,113,900</td>
<td>100.0</td>
<td>15</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
shall be located and which facilities shall receive funds for capital improvements.

The figures in Table 6 and Table 7 have been gleaned from grant applications. (156, pp. 85-91, 133-37; 152, pp. 119-22) They reveal that each of the 15 counties served by Mid-Ohio is formally represented by at least one consumer: 13 counties have a single consumer, Fairfield and Licking have two, and Franklin has 20. Though skewed, this distribution accurately reflects the distribution of the Area's population. Moreover, no alternative distribution of consumers would significantly improve the overall picture drawn by the parity measure.

It should be noted that consumers from Franklin County outnumber consumers from the remaining counties 20 to 16 and that a majority of Mid-Ohio's trustees reside in Franklin County. This suggests that if issues polarize along county lines, the interests of Franklin County could not be overruled. In short, geographic representativeness works to the advantage of the largest county at the expense of counties with smaller populations.

A slightly different picture emerges from Table 7. It shows that seven of the counties in Miami Valley's Health Service Area are represented by at least one consumer, but that the only trustee from Shelby County is a health professional. The table shows further that Montgomery County is the Area's most populous county, that its consumers
comprise less than half of the board's consumer contingent, and that parity for Montgomery County consumers is approximately 76 percent. Had Montgomery County been allocated two additional consumers, parity for that group would have been an almost ideal 100.5 percent. However, such a distribution would have made those consumers the numerically dominant consumer grouping. Unknown is the extent to which this consideration was instrumental in the decision to allocate Montgomery county six rather than eight consumer seats.

Two characteristics of board composition that neither Orkand nor the HRA examine adequately are social and economic representativeness. The HRA reports only the number of agencies "experiencing problems" in these areas, while Orkand relies exclusively, if not superficially, on occupation data. According to Milbrath and Goel (158, p. 90) other suitable indicators are family income and education; these are examined in Table 8 and Table 9.

Table 8 shows that 64.6 percent of Mid-Ohio's consumers are college graduates. Twenty-nine percent attended some college and 6.4 percent advanced no father than high school. Parity for the college graduates is nearly 600 percent. In contrast, parity for those with the least education is less than ten percent. Among Miami Valley's consumers, 53.3 percent are college graduates, 40 percent attended some
Table 8. Consumer Education: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

**Mid-Ohio**

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Percent of Health Service Area</th>
<th>Percent of Consumers</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No College</td>
<td>79.0</td>
<td>6.4</td>
<td>8.1</td>
</tr>
<tr>
<td>Some College</td>
<td>10.0</td>
<td>29.0</td>
<td>290.0</td>
</tr>
<tr>
<td>College Graduate</td>
<td>11.0</td>
<td>64.6</td>
<td>586.4</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>586.4</td>
</tr>
<tr>
<td>(1,562,800)</td>
<td></td>
<td>(31)</td>
<td></td>
</tr>
</tbody>
</table>

**Miami Valley**

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Percent of Health Service Area</th>
<th>Percent of Consumers</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>No College</td>
<td>54.9</td>
<td>6.7</td>
<td>12.5</td>
</tr>
<tr>
<td>Some College</td>
<td>9.8</td>
<td>40.0</td>
<td>408.2</td>
</tr>
<tr>
<td>College Graduate</td>
<td>35.3</td>
<td>53.3</td>
<td>151.0</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>151.0</td>
</tr>
<tr>
<td>(1,113,900)</td>
<td></td>
<td>(14)</td>
<td></td>
</tr>
</tbody>
</table>
### Table 9. Consumer Family Income: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

#### Mid-Ohio

<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>Percent of Health Service Area</th>
<th>Percent of Consumers</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>33.0</td>
<td>3.3</td>
<td>14.4</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>26.0</td>
<td>3.3</td>
<td>75.6</td>
</tr>
<tr>
<td>$15,000 to $25,000</td>
<td>30.0</td>
<td>16.7</td>
<td>194.0</td>
</tr>
<tr>
<td>More than $25,000</td>
<td>11.0</td>
<td>76.7</td>
<td>870.7</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1,562,800)</td>
<td></td>
<td></td>
<td>(31)</td>
</tr>
</tbody>
</table>

#### Miami Valley

<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>Percent of Health Service Area</th>
<th>Percent of Consumers</th>
<th>Parity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>49.2</td>
<td>7.1</td>
<td>14.4</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>28.3</td>
<td>21.4</td>
<td>75.6</td>
</tr>
<tr>
<td>$15,000 to $25,000</td>
<td>18.4</td>
<td>35.7</td>
<td>194.0</td>
</tr>
<tr>
<td>More than $25,000</td>
<td>4.1</td>
<td>35.7</td>
<td>870.7</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1,113,900)</td>
<td></td>
<td></td>
<td>(14)</td>
</tr>
</tbody>
</table>
college, and 6.7 percent advanced no farther than high school. Clearly, these figures indicate that Mid-Ohio and Miami Valley consumers overrepresent highly educated consumers in their respective agency's Health Service Area.

These consumers also overrepresent families with above average incomes. As Table 9 shows, more than three-quarters of Mid-Ohio's consumers and one-third of Miami Valley's consumers have annual family incomes in excess of $25,000. Parity for these groups is roughly 697 percent and 870 percent, respectively; figures which are more than 60 times greater than those for the groups at the opposite end of the income scale.

Since education and income are correlated with occupational status (158, p. 91), it is not surprising that Mid-Ohio and Miami Valley consumers tend to have high status occupations. Specifically, of the 31 Mid-Ohio consumers interviewed, five are business executives, three are lawyers, two are professors at a local university, and two others are administrators of health benefits plans for major employers in or near Columbus. Other Mid-Ohio consumers include a real estate salesperson, a sales manager, a shoe manufacturer, an air-conditioning and heating contractor, an accountant, a lesor of automobiles, a pastor, a director of a health-related "information and referral service," an elected official, an equal opportunity employment officer, a retired banker, a retired public servant, and a retired
professor. Only four consumers are either homemakers and mothers or part-time community volunteers. Worth noting is that more than 80 percent of these consumers have occupations subsumed by the top two of the 11 Census Bureau categories (see Table 3).

Miami Valley's consumers are similarly employed. Four are public officials (or representatives of public officials), one is a lawyer, one is a business executive, one is a social service supervisor at a county welfare department, one is a retired air force officer, and one is a retired post office employee. Three consumers are housewives, although one claimed to be an "unemployed community activist."

The preceding analysis indicates that Mid-Ohio and Miami Valley consumers tend to be of high social, economic, and occupational status and as such are atypical of consumers at large. Stated more pointedly, Mid-Ohio and Miami Valley consumers are not (descriptively) representative of consumers in their Health Service Areas.

The grant applications also reveal much about these boards' providers. For example, 34 providers serve on Mid-Ohio's board. Of that number, 24, or 70.6 percent, are direct providers. Moreover, although all five provider categories are represented by at least one trustee, health professionals far outnumber the other provider types: health
professionals comprise 67.7 percent of the providers, representatives of health care institutions 20.6 percent, health care insurers 5.9 percent, and representatives of health professional schools and allied health professionals 2.9 percent each.

Miami Valley's application reveals that 11, or 78.6 percent, of that board's providers are direct providers and that only four of the five provider categories are represented. Health professionals comprise 57.2 percent, representatives from health care institutions 21.4 percent, health care insurers 7.1 percent, and providers from health professional schools 14.3 percent. No provider is an allied health professional. Note that in these agencies, as in the agencies studied by Orkand, a majority of providers are direct providers and health professionals. Note also the similarity between these providers and those of the "B" agency councils.

During the drafting of P. L. 93-641, concern was expressed that many consumers on the "B" agency councils actually were "closet providers." In response to that concern, Congress included in the new health planning act a definition of consumer designed to exclude persons whose recent past employment, sources of income, and personal and professional associations might foster a provider mentality. Specifically, a person could no longer be a "consumer" if
"within the twelve months preceding appointment" to board membership he had been a provider, if more than ten percent of his gross annual income is derived from "entities or associations" which provide health care services or supplies, or if he is a member of a provider's immediate family. To eliminate ambiguity, "immediate family" was said to include "parents, spouse, children, brothers and sisters" who reside in a provider's household.

An examination of the grant applications indicate that no consumer either violates the income provision, or is a member of a provider's immediate family. But had any consumer been a provider during the twelve months prior to appointment?

To answer this question, consumers were asked: "Have you ever held a paid position where you were involved in providing health care services?" Three of Mid-Ohio's consumers responded in the affirmative. One said that she had been a nurse 15 years earlier and another said that "many years ago" she had been the director of a county medical center. The third stated that he was involved in the provision of free emergency medical service, a revelation that agency staff were unable to explain and that places in doubt the appropriateness of that trustee's consumer designation.

Three of Miami Valley's consumers also claimed to have once been a provider. Two said they had been nurses (but not
within the last 12 months) and the third, for unstated reasons, declined to be specific. In sum, although a total of six consumers claimed to have experience in the provision of medical care, at least four of the six were not so employed in the recent past. Moreover, while "closet providers" have not been eliminated entirely, they appear to be less of a problem for the HSAs than they were for the "B" agency councils.

Consider next the issue of representation: Do consumers speak for consumers at large, or for organized, established constituencies? If they speak for constituencies, which are represented and which are not? This issue is important because "interest group" consumers are said (120, 75) to be less flexible in negotiating differences and more likely to participate in the discussion of a narrow, parochial range of issues, than are their counterparts who speak for consumers at large. Stated differently, if the HSAs have recruited "interest group" consumers, there is reason to expect that consumer participation will be less vigorous, less conciliatory, and less influential than Congress had intended. It may also be true that consumer trustees will not adequately reflect the more general interests of consumers, while stressing those of a few well-organized consumer groups.
To measure representation, consumers were asked: "In your capacity as a governing board trustee, what groups or organizations do you feel you represent?" Responses from Mid-Ohio's trustees reveal that nine consumers represent either consumers in general or consumers of a broad geographic area (e.g., an entire county). An additional seven represent a specific consumer group as well as consumers in general, and ten represent a consumer group only. (Four consumers claimed to speak for themselves.) Note, however, that among the groups mentioned most often are the poor, rural people, senior citizens, and women—groups that are not "organized and established" in the sense that representatives are elected by and accountable to group members. This suggests that the HSAs have not elected a predominance of "interest group" consumers (as the term is defined by Klarman and Fifer) and that consumer representation is informal.

The latter point is supported by responses to an item asking consumers how they learn of the health-related interests of those they represent. Thirteen of Mid-Ohio's consumers said they knew their constituents' needs and preferences from their own interaction with members of other boards and committees on which they serve. Six others claimed to learn by "observation," by "just talking to people," or by being "aware of the issues." The final six said they learned directly from the people with which they
work. Responses from Miami Valley's consumers were nearly identical.

A second perspective on consumer representation was obtained by asking agency staffers who consumers represent. A majority of the responses from Mid-Ohio's staff indicate that in general consumers represent only themselves. According to one staffer

The trustees represent themselves; they vote their conscience. There is no constituency in the sense that they are accountable... Consumers are more concerned with helping people.

A second member of staff was more adamant. He stated that

Nobody on the board represents an interest. We get the consumers as individuals... Our board members do not come from organizations... This is absolutely a grass-roots organization with a grass-roots orientation.

To this, a third staffer added that

consumers represent neither organized interests or grass-roots consumers. They are appointed by various groups, but they are involved on the board because they have become involved in health planning. They are interested and they do things... They are interested in health care...

In contrast, the remarks of Miami Valley staffers suggest that many of that board's consumers do represent a constituency. One staffer noted that
The consumers see their role as constituency oriented. Many... are professional board members; they are very much aware of who their constituency is. There are two types of consumers on the board, but they all define a constituency for themselves.

A second staff member asserted that about "70 percent" of the consumers represent a constituency, including senior citizens, blacks, business, and so on," while a third said

We have a lot of constituency representation; we don't go pulling people of the street. Our nominating committee looks for people who have a constituency. [One consumer], for example, is a welfare mother; she has a constituency. She was recommended by a poverty agency; so she is more than just a welfare recipient.

The latter three comments appear less consistent with the comments of Miami Valley's trustees than do the comments of Mid-Ohio's staff and board. Why this is so is far from clear; however, it may be argued that Miami Valley's staff views representation in less formal terms than do their Mid-Ohio counterparts.

The issue of representation has one additional twist. Implicit in the congressional guidelines for the recruitment of HSA consumers is an assumption that only consumers represent consumers—that, in other words, consumer interests cannot be represented by health professionals. This assumption should not be left unchallenged, for if providers do represent consumers then the utility of employing a consumer-provider distinction as the most
fundamental criterion in the selection of HSA trustees is less obvious.

The assumption was tested by asking providers which groups or organizations they feel they represent and by dividing the substantive responses into two categories—consumer interests and provider interests. Of the 27 responsive Mid-Ohio providers 19, or 61.9 percent, claimed to represent at least one consumer interest. Moreover, 74.3 percent of the direct providers and 50 percent of the indirect providers represent only a consumer interest, while 48.1 percent of all providers claimed to represent at least one interest of each type.

Responses from the Miami Valley providers are similar: 8, or 72.3 percent, claimed to represent a consumer interest, fully 25 percent of the direct providers and 66.7 percent of the indirect providers represent only a consumer interest, and 6.7 percent of all providers represent at least one interest of each type. In sum, even though many providers represent both consumer and provider interests, a majority purport to have the interests of consumers in mind.

It is worth stressing that indirect providers are more "consumer oriented" than are direct providers. As noted above, half of Mid-Ohio's indirect providers (compared with 14.2 percent of the direct providers) and two-thirds of Miami Valley's indirect providers (compared with 38.1 percent of the direct providers) represented consumer
interests exclusively. Yet no indirect provider on either board represented only provider interests. These observations suggest that some indirect providers are a new type of trustee: a "closet consumer."

Since all of the evidence on representation is based on trustee self-reports, its reliability is subject to question. Indeed, the interests an individual claims to represent may differ markedly from those which are actually supported when votes are cast at meetings of the governing body. Moreover, when divergent interests are represented, each, undoubtedly, is assigned a priority. This may mean that while providers represent consumer interests "in the abstract," in actuality, the interests of their profession may always take precedence.

Several conclusions emerge from the preceding discussion:

• As required by law, Health Systems Agencies have been designated by the Secretary of Health, Education, and Welfare.

• Each has established a governing board and virtually all have a consumer majority.

• The social, economic, and occupational status of consumers tends to be much higher than the status of Health Service Area residents.

• Many consumers claim to represent, either exclusively, or in addition to consumers in general, a specific group of consumers, although the nature of that representation
appears to be informal.

- The distribution of providers among the five provider types is similar to the distribution that characterized the "B" agency councils.

- Though the evidence is not compelling, many providers claim to represent the interests of consumers.

- The new definitions of consumer and provider have almost eliminated "closet providers," but may have created "closet consumers." And

- At least some indirect evidence suggests that many "B" agencies became HSAs without substantially altering the composition of their governing body.

One inference which follows from these conclusions is rooted in remarks by Hyman (103, p. 323), Seidman (197, p. 46), and Blum (21, p. 456) as well as in the findings stated earlier about the participation of "B" agency consumers. Specifically, Hyman argues that the health planning priorities of providers and high status, or elite, consumers are virtually identical, especially when compared to the priorities of grass-roots consumers. Seidman agrees with this contention, noting that that there is little difference "between the priorities of the providers and those of the elitest consumer representatives." Seidman also notes that elite consumers are incapable of representing grass-roots consumer interests because only grass-roots consumers "are in a position of identify the indignities, frustrations, and deficiencies" to which they are subjected. To this, Blum (21, pp. 456-57), citing Weisner (150), adds that high
status consumers typically "defer to," "socialize with," and are "catered to by" health professionals.

Now recall that most of the consumers on the "B" agency councils had high status backgrounds and that their participation in council activities was marked by poor attendance, deference to the presumed expertise of providers, and their inability to grapple with many of the complex, technical issues involved in planning.

What follows from these remarks and from data that indicate that HSA consumers have many of the same characteristics of the consumers they replaced is the expectation that on HSA governing boards consumer-provider interaction will be characterized more by consensus than by conflict, that consumer participation will again be uninspired, and that providers will continue to dominate the health planning process, despite their numerical minority. It also follows that while providers may represent the interests of some consumers, the latter are unlikely to be of the grass-roots variety. The extent to which these expectations reflect reality is explored in Chapter IV.
ENDNOTES

1. The HRA report was published in February 1978. It summarizes data from 204 HSAs. Data for the Orkand study were gathered in June 1976 from 134 HSAs. This number represents 82 percent of the agencies conditionally designated by that date.

2. According to Orkand (231, p. 7), representativeness involves a comparison between the percentage of governing board trustees possessing a given characteristic and the percentage of Health Service Area residents possessing the same characteristic. Representativeness is different from representation in that only the latter concept "incorporates issues such as method of selection, relationship between the board representative and constituents (e.g., accountability), and so on." (see also: 21, pp. 438-39)


4. Orkand fails to note whether the agencies with no such representative are located in Health Service Areas having health professional schools or health care insurers.

5. An alternative explanation is that many agencies had difficulty locating minority and female providers willing to serve on the governing board. Unfortunately, no evidence addresses the question of provider availability.

6. Of all these conclusions this one is perhaps the most uncertain. Indeed, to conclude on the basis of aggregated data and mean percentages that the change in the composition of any single board was small is to risk committing an ecological fallacy. Stated differently, it is quite possible for similar averages (one referencing the "B" agencies, the other the HSAs) to conceal large shifts at the individual agency level. The point here is well illustrated by noting that the last year Mid-Ohio was a "B" agency was its council contained 51 members. The
first year it was an HSHA, however, its governing board contained 71 members, an increase of 39.2 percent. Moreover, even though 37, or 72.5 percent, of the original 51 members served on the newly created board, less than half of that board served when Mid-Ohio was a "B" agency.
CHAPTER IV
INVOVEMENT AND INFLUENCE

This chapter examines consumer participation in two areawide Health Systems Agencies (HSAs). The first section measures involvement in activities appropriate at governing board meetings. A second section measures involvement in activities appropriate during the time between governing board meetings. And a third measures the relative influence of consumers in the HSA decision making process. Each section draws on documents prepared by agency staff and on interviews with the trustees and staff of the Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency. Moreover, each section employs a comparative mode of analysis: the involvement and influence of consumers is compared to the involvement and influence of health professionals.

Involvement at Governing Board Meetings

P.L. 93-641 requires the governing board of each Health Systems Agency to meet at least six times per year. One meeting must be held in each calendar quarter and all meetings must be attended by a quorum, defined as one plus
one-half of a board's full membership. Meetings must be well-advertised, open to the public, and convened only after "adequate notice" has been provided.

Meetings of the governing board are organized by agency staff. They are run by an elected president and their primary purpose is the ratification of agency policy. During the typical meeting, proposals for new or expanded health care facilities may be discussed; reports on committee activity may be presented; portions of the agency's budget may be reviewed; changes in agency membership may be announced; and progress toward goals may be acknowledged. All that transpires is recorded by a member of staff.

Governing board meetings afford both consumers and providers numerous opportunities to participate in areawide health planning. Trustees can (1) attend meetings; (2) ask questions, express opinions, and share information; (3) offer motions for the board to consider; and (4) second motions offered by other trustees. Though trustees may also engage in other activities, these were selected because they are authorized either by federal statute or regulation, or are consistent with formal parliamentary procedure; they may be engaged in by all trustees, regardless of type; and they may be measured by direct observation, by trustee self-reports, or by analyzing readily available documents compiled by the agency.
Attendance

Trustee attendance is not required by federal statute. Many agencies, however, have established an attendance requirement to encourage attendance and to sanction members frequently absent. Mid-Ohio's requirement is found in the agency's "Code of Regulations" (155, p. 40):

The term of any trustee shall automatically terminate if he fails to attend any four (4) consecutive meetings held during any twelve (12) month period, unless the member provides a reasonable written excuse to the President...

Miami Valley's requirement is more detailed. It states (151, p. 169) that

In the event that a trustee shall fail to attend any three consecutive meetings, the Secretary shall notify that trustee...of such failure. If such trustee fails to indicate the existence of good cause for his failing to attend any two of the three meetings missed...the presiding officer...shall declare such a Trustee's membership on the board vacant...

What constitutes "good cause," or, as in Mid-Ohio's case a "reasonable" excuse, varies between agencies and among trustees. There are, however, three excuses that evoke no sympathy from either board: ignorance of the date, time, or location of the meetings. This lack of sympathy is easily understood, for every trustee is notified in writing as to where and when the board next meets. Furthermore, at most, if not all meetings, the date of the subsequent meeting is
announced orally and printed in the agenda.

Between September 1977 and August 1978 the governing boards of Mid-Ohio and Miami Valley each met for 12 regular meetings. The minutes of Mid-Ohio's meetings reveal that attendance overall averaged 44.6 trustees, or 63 percent, of the entire board. No meeting was attended by fewer than 40 trustees (56.3 percent) or by more than 51 (71.8 percent).

The minutes also indicate that the "average" meeting was attended by 65 percent (22.2 trustees) of Mid-Ohio's providers and by 61.4 percent (22.4 trustees) of Mid-Ohio's consumers. Though small, the difference between these percentages is significant because providers were an attending majority at eight of the twelve meetings studied.

Similar patterns are revealed by the minutes of Miami Valley's meetings. Attendance overall averaged 66.4 percent (18.4 trustees) and ranged from 53.6 percent (15 trustees) to 82.1 percent (21 trustees). Consumer attendance averaged 64 percent (9.6 trustees) and provider attendance, 69.2 percent. Moreover, consumers were an attending majority at eight of the twelve meetings.

Table 10 recapitulates the attendance data. It shows that roughly two-thirds of all trustees attended the average meeting; that providers attended meetings at a slightly higher rate than did consumers; and that providers frequently were an attending majority. The latter
Table 10. Attendance at Governing Board Meetings: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th></th>
<th>Mid-Ohio</th>
<th>Miami Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Attendance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Trustees</td>
<td>44.6</td>
<td>18.6</td>
</tr>
<tr>
<td>Percent of Trustees</td>
<td>63.0</td>
<td>66.4</td>
</tr>
<tr>
<td>Number of Consumers</td>
<td>22.4</td>
<td>9.6</td>
</tr>
<tr>
<td>Percent of Consumers</td>
<td>61.4</td>
<td>64.0</td>
</tr>
<tr>
<td>Number of Providers</td>
<td>22.2</td>
<td>9.0</td>
</tr>
<tr>
<td>Percent of Providers</td>
<td>65.0</td>
<td>69.2</td>
</tr>
<tr>
<td><strong>Minimum Attendance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Trustees</td>
<td>40</td>
<td>15</td>
</tr>
<tr>
<td>Percent of Trustees</td>
<td>56.3</td>
<td>53.6</td>
</tr>
<tr>
<td><strong>Maximum Attendance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Trustees</td>
<td>51</td>
<td>23</td>
</tr>
<tr>
<td>Percent of Trustees</td>
<td>71.8</td>
<td>82.1</td>
</tr>
<tr>
<td><strong>Consumer Majorities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Meetings</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Percent of Meetings</td>
<td>33.3</td>
<td>66.3</td>
</tr>
</tbody>
</table>
observation indicates that the statutory provision guaranteeing consumers a majority share of each board's membership fails to guarantee consumers a dominant presence when agency policy is ratified. Undeniably, this failure creates a potential for provider domination of governing board proceedings, a potential, that if realized, would violate the spirit of the law.

Mid-Ohio's attendance data reveals a second potential violation when viewed from a county perspective. To appreciate the point, recall that one passage of Section 1512 stipulates that HSA consumers shall be "broadly representative" of the geographic areas--usually defined as counties--of the Health Service Areas. Recall also that each of the 15 counties in Mid-Ohio's Health Service Area was found (in Chapter III) to be represented by at least one consumer.

In principle, this distribution formally, if only minimally, satisfies the letter of the law. In practice, however, the issue is far less clear for, as Table 11 demonstrates, consumers of only two counties were officially represented at all 12 meetings. By contrast, consumers of eight counties were officially represented at from six to 11 meetings, while consumers from the remaining five counties were represented at fewer than six. The table indicates, therefore, that one-third of the counties in Mid-Ohio's Health Service Area was not represented by even a single
Table 11. Consumer Attendance by County:  
The Mid-Ohio Health Planning Federation

<table>
<thead>
<tr>
<th>County</th>
<th>Meetings Attended By At Least One Consumer</th>
<th>Percent of All Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield</td>
<td>12</td>
<td>100.0</td>
</tr>
<tr>
<td>Franklin</td>
<td>12</td>
<td>100.0</td>
</tr>
<tr>
<td>Fayette</td>
<td>11</td>
<td>91.7</td>
</tr>
<tr>
<td>Knox</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Licking</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Scioto</td>
<td>8</td>
<td>66.7</td>
</tr>
<tr>
<td>Delaware</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>Morrow</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>Pickaway</td>
<td>7</td>
<td>58.3</td>
</tr>
<tr>
<td>Wyandot</td>
<td>6</td>
<td>50.0</td>
</tr>
<tr>
<td>Pike</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>Madison</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Marion</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Ross</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Union</td>
<td>2</td>
<td>16.7</td>
</tr>
</tbody>
</table>

The 12 meetings examined were held between September 1977 and July 1978.
consumer at fully one-half of the meetings studied.

The preceding observations illustrate how the implementation of federal policy may be hampered by the absence of full cooperation from the actors involved. The observations also illustrate how a seemingly appropriate, yet loosely worded statutory provision may produce consequences both unanticipated and undesired. Indeed, had quorum been defined as "not less than one-half of a board’s trustees, a majority of whom must be consumers, who together officially represent all of the relevant geographic areas," rather than as a simple majority of members, the violations discussed above would not have been at issue. Why Congress settled on the minimally demanding definition is not known. It is possible, however, that more demanding definitions were perceived as too great an impediment to the convening of meetings.

To this point, the data have shown that consumers attend governing board meetings slightly less often than do providers, that providers often are an attending majority, and that many counties are not represented by even a single trustee at many meetings. The data have not shown, however, whether some consumers attend virtually all meetings and others only a few, or most consumers attend meetings sporadically.

This issue is addressed in Table 12. It reveals that in neither agency did more than ten percent of the consumers
Table 12. Consumer Attendance by Agency: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Percent of Meetings Attended</th>
<th>Percent of Mid-Ohio Consumers</th>
<th>Percent of Miami Valley Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 21</td>
<td>3.2</td>
<td>0.0</td>
</tr>
<tr>
<td>21 to 40</td>
<td>9.7</td>
<td>0.0</td>
</tr>
<tr>
<td>41 to 60</td>
<td>16.2</td>
<td>50.0</td>
</tr>
<tr>
<td>61 to 80</td>
<td>48.4</td>
<td>35.7</td>
</tr>
<tr>
<td>More than 80</td>
<td>22.6</td>
<td>14.2</td>
</tr>
<tr>
<td></td>
<td>100.1</td>
<td>99.9</td>
</tr>
<tr>
<td></td>
<td>(31)</td>
<td>(14)</td>
</tr>
</tbody>
</table>
attend less than two-fifths of the meetings at which attendance was expected; that 64.6 percent of Mid-Ohio's consumers and 85.7 percent of Miami Valley's consumers attended between 41 percent and 80 percent of the meetings; and finally, that the percentage of consumers attending more than 80 percent of the meetings was in both agencies less than 25. In short, the table indicates that while a few consumers attended virtually all of the meetings and even fewer attended virtually none, most consumers attended most meetings.3

It is worth noting that despite the absence of large numbers of consumers attending either all or very few meetings, individual attendance figures vary from 16.7 percent to 100 percent. One explanation for this variation focuses on the distance consumers must travel to attend meetings of the board.

Note the maps in Figure 1 and Figure 2. The first illustrates that consumers from Franklin County can live no farther than 15 miles from downtown Columbus, the location of Mid-Ohio's meetings. By contrast, consumers from outlying counties may live as far as 80 miles from downtown Columbus. At permissible speeds, a trip covering such a distance would require approximately 90 minutes, and a round-trip approximately three hours. Figure 2 paints a similar, though less extreme picture: Miami Valley's consumers living in Montgomery county must travel no farther than 20 miles to
Figure 1. Ohio Health Service Area No. 5.
Figure 2. Ohio Health Service Area No. 2.
attend meetings, while consumers from Shelby county, for example, must travel approximately 50. The point here, simply, is that the time required of consumers to travel to and from meetings varies considerably and for some may be sufficiently burdensome to inhibit regular attendance.

Though intuitively appealing, this explanation lacks empirical import: as Table 13 shows, consumers from the outlying and core counties attend meetings at similar rates. In fact, Miami Valley's consumers from the outlying counties averaged a slightly higher rate than the agency's Montgomery County consumers. Furthermore, of the four Mid-Ohio consumers attending less than half of the meetings, only two were not from Franklin County; that of the six Miami Valley consumers attending less than 60 percent of the meetings only three were not from Montgomery County; and finally, that in response to an item asking if the time and place of meetings were "convenient," only one (Mid-Ohio) consumer stated that excessive distance was a problem. In sum, it appears that the distance consumers must travel does not inhibit attendance at governing board meetings.
Table 13. Consumer Attendance by Core and Outlying Counties: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Agency</th>
<th>Mean Percent of Meetings Attended by Consumers from Core Counties</th>
<th>Mean Percent of Meetings Attended by Consumers from Outlying Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Ohio</td>
<td>70.6</td>
<td>64.5</td>
</tr>
<tr>
<td>Miami Valley</td>
<td>62.5</td>
<td>66.7</td>
</tr>
</tbody>
</table>

The figures are a 12 meeting average. Mid-Ohio's core county is Franklin, Miami Valley's is Montgomery. Core county is defined as that county in which governing board meetings are held.
Asking Questions and Expressing Opinions

A second form of participation appropriate at governing board meetings is asking questions and expressing opinions. Those who wish to speak must first be recognized by the presiding officer. However, recognition is easily obtained: at all of the meetings attended by this observer not only was every trustee requesting to speak permitted to do so, but few if any discussions were terminated either arbitrarily or prior to a call for additional comments."

To measure involvement in this activity, trustees were asked: "In general, how frequently would you say you ask a question or offer an opinion at each governing board meeting you attend?" Table 14 summarizes the responses. It shows that 9.3 percent of the consumers, 16.1 percent of the direct providers, and 12.5 percent of the indirect providers claim to address the board more than five times per meeting. The table shows also that more than half of the consumers spoke less than twice per meeting, while the comparable figures for direct and indirect providers are 45.2 percent and 37.5 percent, respectively.

The figures in Table 14 warrant three comments. First, consumers appear to be slightly less vocal than either direct or indirect providers, though the differences are not dramatic. Second, indirect providers appear to be slightly more vocal than direct providers, though the differences
Table 14. Asking Questions and Expressing Opinions at Governing Board Meetings: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency (Combined)\(^a\)

<table>
<thead>
<tr>
<th>Number of Comments</th>
<th>Percent of All Consumers</th>
<th>Percent of All Direct Providers</th>
<th>Percent of All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than Two</td>
<td>53.5</td>
<td>45.2</td>
<td>37.5</td>
</tr>
<tr>
<td>Two to Three</td>
<td>26.5</td>
<td>32.3</td>
<td>37.5</td>
</tr>
<tr>
<td>Four to Five</td>
<td>11.6</td>
<td>6.5</td>
<td>12.5</td>
</tr>
<tr>
<td>More than Five</td>
<td>9.3</td>
<td>16.1</td>
<td>12.5</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.1</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>(43)</td>
<td>(31)</td>
<td>(8)</td>
</tr>
</tbody>
</table>

\(^a\)The figures represent the responses of trustees from both agencies.
are again small and occur, possibly, because a high percentage of indirect providers have careers that require public speaking.

Finally, the modest differences between the consumer and provider percentages should not be construed as indicating that the opinions and questions offered by the different types of trustees are perceived as comparably perceptive, informative, or well-reasoned. Supporting this point are numerous comments criticizing consumer input. One trustee, for example, asserted that "some consumers talk a lot, but don't say anything." Another claimed that "the smart consumers are the ones who keep their mouth shut." And a third stated that "many of the most vocal consumers don't know what they are talking about." In contrast, the questions and opinions of providers as a group were never criticized, although in several instances specific providers were accused of delivering self-serving, pontifical monologues.

Much of the literature on small group behavior suggests that for any group member, the number of questions asked and opinions expressed is partially determined by group size. Hare (92, pp. 224-45), for instance, cites research by Williams and Mattson (250), Gibb (82), and Dave (47), which demonstrates that "the average amount of participation per member diminishes as group size is increased. Two factors
are said to explain this relationship. The first, a "mechanical constriction," stems from the time available for speaking:

The time available per member for overt communication during a meeting of any given length decreases as the group size increases... [Consequently, as] the size of...groups is increased...the average number of remarks per [member] decrease[s]... Thus the effect of increasing size appears to involve...a mechanical constriction of time per member... (92, p. 231)

The second factor involves psychological discomfort. As Hare explains it, the proportion of members who report feelings of threat and who attempt to minimize those feelings by inhibiting or stifling impulses to speak increases as groups become larger. He contends, in other words, that many individuals who might address a small group will never or rarely speak when placed in a large group setting.

Thomas and Fink (216, pp. 102-03) take Hare's analysis one step farther. They argue that as group size increases the "distribution of participation" shifts from one where all members participate at roughly similar rates to one where a minority of members speaks very frequently and a majority speaks very infrequently. The latter group is said to consist of less self-assured members, while the former of those who feel more efficacious.
This research entails two testable propositions. The first posits that average amounts of "oral expression" (i.e., asking questions and expressing opinions) will be less in larger than in smaller governing board. The second posits that if, as O'Connor (170, p. 404) suggests, consumers feel less efficacious than do providers then decreases in oral expression which accompany increases in the size of governing boards will occur disproportionately among consumers.

To test these propositions, the figures in Table 14 were recomputed first for Mid-Ohio's trustees and then for Miami Valley's. Table 15 contains those figures. It shows that 52.4 percent of Mid-Ohio's trustees either asked a question or expressed an opinion less than twice per meeting and that the percentage who spoke more than five times per meeting is 10.2. By contrast, only 39.4 percent of Miami Valley's trustees were minimally vocal, while fully 17.4 percent were "very" vocal. Considering that Mid-Ohio's governing board is more than twice the size of Miami Valley's, it appears that the recomputed figures support the first proposition.5

Table 15 also shows that Miami Valley's least vocal trustees are drawn in nearly equal proportions from consumers and direct providers, but that Mid-Ohio's least vocal trustees are predominantly consumers. Stated more pointedly, the difference between Mid-Ohio's consumers
Table 15. Asking Questions and Expressing Opinions at Governing Board Meetings: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency (Separate)

**Mid-Ohio**

<table>
<thead>
<tr>
<th>Number of Comments</th>
<th>Percent of All Consumers</th>
<th>Percent of All Direct Providers</th>
<th>Percent of All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than Two</td>
<td>60.0</td>
<td>47.8</td>
<td>33.3</td>
</tr>
<tr>
<td>Two to Three</td>
<td>23.3</td>
<td>34.8</td>
<td>33.3</td>
</tr>
<tr>
<td>Four to Five</td>
<td>10.0</td>
<td>4.3</td>
<td>16.7</td>
</tr>
<tr>
<td>More than Five</td>
<td>6.7</td>
<td>13.0</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>99.9</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(23)</td>
<td>(6)</td>
</tr>
</tbody>
</table>

**Miami Valley**

<table>
<thead>
<tr>
<th>Number of Comments</th>
<th>Percent of All Consumers</th>
<th>Percent of All Direct Providers</th>
<th>Percent of All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than Two</td>
<td>38.5</td>
<td>37.5</td>
<td>50.0</td>
</tr>
<tr>
<td>Two to Three</td>
<td>30.8</td>
<td>25.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Four to Five</td>
<td>15.4</td>
<td>12.5</td>
<td>0.0</td>
</tr>
<tr>
<td>More than Five</td>
<td>15.4</td>
<td>25.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>100.1</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>(13)</td>
<td>(8)</td>
<td>(2)</td>
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</tbody>
</table>
and direct providers who asked a question or expressed an opinion less than twice per meeting is 12.2 percentage points, compared to a one percentage point difference between Miami Valley's least vocal consumers and direct providers. In short, the data suggest not only that governing board size affects trustee participation, but that larger governing boards affect consumers the most.

The preceding discussion fails, of course, to address a critical question: For a given agency, is the less frequent participation of many consumers more desirable from planning and goal attainment perspectives than the more frequent participation of fewer consumers? If the answer is "no," it may well indicate that governing boards with large numbers of consumers are the least representative of consumer interests. Ironically, it may also indicate that one method of minimizing consumer input in areawide health planning is to establish large boards and recruit to them a percentage of consumers equalling the legal maximum.

A point worth noting is that considerations other than size may explain the observed inter-board differences in rates of oral expression. Dave (47), for example, has shown that group members seated near a formal group leader (e.g., the chairman) speak more frequently than members seated at the group's periphery. She has also shown that the magnitude of this "spatial effect" is partially determined by the physical arrangement of the seats in the room in which
meetings are held.

Dave's research is relevant because the arrangement of seats in Miami Valley's meeting room is substantially different from the arrangement of seats in Mid-Ohio's. Specifically, every member of Miami Valley's board sits around a u-shaped table, on which are plastic name plates and from which meetings are chaired. Guests and staff sit immediately behind the trustees in a single row of chairs. In contrast, only a minority of Mid-Ohio's trustees (including the president) sits around a table. The majority sits with guests and staff in rows of chairs and several couches, all of which are comparatively isolated from the physical center of action. Given Dave's research, it may be argued that Mid-Ohio's trustees tend to speak less at meetings because a larger proportion of members feels removed from the proceedings.

Since the location of the chair occupied by each Mid-Ohio trustee was not recorded, it is impossible to determine if the average rate of oral expression for those sitting around the table differs from the average rate for those who did not. Such a difference would have supported Hare's contention. It should be mentioned, however, that several trustees did complain about meeting-room logistics: one who often sat among guests and staff, rather than at the table, said "It's darn difficult to follow what's going on when you're trying to balance a cup of coffee on one knee
and the agenda on the other."

The data measuring oral expression have shown that consumers tend to speak less often at governing board meetings than do either type of provider, though the differences are modest; that the oral contributions of consumers may be held in lower regard than those of providers; and that large boards inhibit oral expression, especially among consumers. Furthermore, meeting-room logistics may explain some of the inter-board difference in rates of oral expression.

Motions

A third activity appropriate at governing board meetings is offering motions for the board to consider. This activity merits attention because motions are formal statements of choices and, as such, may effect how issues are decided. Moreover, since motions are typically followed by votes, to discover who offers motions is to gain at least some insight into which trustees attempt to control or limit the amount of discussion an issue receives.

Involvement in this activity was measured by examining the minutes of Mid-Ohio’s meetings. The minutes reveal that from September 1977 to August 1978, 148 motions were offered by 27 trustees, or 38.0 percent, of the entire board. Of those trustees, 13, or 48.1 percent, were consumers. The
minutes reveal further that 35.1 percent of all Mid-Ohio's consumers, compared with 41.2 percent of all Mid-Ohio's providers, offered at least one motion during the period of the study.

Note, however, that consumers initiated 54.0 percent of all the motions and that the "average" consumer was responsible for a number of motions slightly larger than the comparable figure for the "average" provider (6.2 v. 4.8). In short, the evidence suggests that while more providers offer motions, consumers offer motions more often.

The percentage of Mid-Ohio's trustees offering no motions during the period of the study (62.0 percent) is roughly similar to the percentage claiming to have asked a question or expressed an opinion less than twice per meeting (52.5 percent). Furthermore, only 12.9 percent of those infrequently speaking trustees offered a motion, and that for those who did, the average was 2.8. The average for the remaining trustees (who motioned) was six. What these percentages suggest is that many trustees who rarely, if ever, offer a motion ask questions and express opinions infrequently.

Seconds

A fourth activity appropriate at governing board meetings is voicing seconds to motions offered by other trustees. Unlike both speaking and offering motions, this
activity is not "regulated" by the presiding officer: trustees may respond to a call for a second without being recognized.

Mid-Ohio's board meeting minutes indicate that each of the motions discussed above received a second by one of 35 trustees, or 49.3 percent, of the entire board. Though virtually half (i.e., 17) of those trustees were consumers, providers were responsible for nearly 60 percent of the seconds. Moreover, among those trustees who voiced at least one second, providers averaged 4.8 compared to 3.6 for consumers. In sum, roughly equal numbers of providers and consumers offer seconds, but providers offer seconds more often.

While 27 trustees offered at least one motion and 35 trustees voiced at least one second, only 38 trustees engaged in either activity. This suggests that within Mid-Ohio's governing board is a group or "core" of trustees who are more highly involved than their peers. Which trustees are among the "core" depends, of course, on how "core" is defined. Worth noting, however, is that only 14 trustees—seven consumers and seven providers—offered at least one motion, voiced at least one second, and asked a question or expressed an opinion at least once per meeting. Also worth noting is that five trustees—three providers and two consumers—were responsible for precisely half of all motions and seconds. These five spoke no less than twice per
meeting and attended meetings at an average rate of 88.3 percent, a figure considerably higher than the full board's average.

Involvement Between Governing Board Meetings

Prior to meetings of the governing board, each trustee receives by mail a packet prepared by the staff, containing an agenda and summaries of the project proposals on which the board must act. Trustees are expected to review these summaries to determine if the proposed facilities and services are consistent with the goals of their agency. Trustees are further expected to contact their fellow trustees as well as members of the staff if additional information or explanations of complex issues are required. The point here is a simple one: the activities comprising board meeting participation are not the only activities in which trustees engage. Others include (1) preparing for meetings, (2) contacting other trustees, and (3) contacting members of the staff.

Board Meeting Preparation

One activity involved in preparing for governing board meetings is reviewing the packets received from the staff. This activity is critical to the health planning process because the packets are for many trustees either the only or the most comprehensive source of information about the
facilities and services proposed for a Health Service Area. Furthermore, since reviewing the packets may prompt additional forms of involvement (e.g., contacting staff to obtain more information about a particular proposal), it is seen as the most fundamental preparatory activity.

In response to an open-ended item requesting trustees to detail the agency-related behaviors they engage in during the time between meetings, 90.7 percent of both agency’s consumers, 83.9 percent of both agency’s direct providers, and 70 percent of both agency’s indirect providers claimed to study on a regular basis the materials contained in the packets. Though the differences among these percentages are small, they are consistent with other information. For example, several direct providers stated that they rarely examine the packets because their experience with the "system" and their frequent contact with health professionals affords them sufficient information to be knowledgeable health planners. In the words of one provider:

Ordinarily I know what issues will be discussed before they get to the board... I glance at the agenda, but I know the system well enough that I don't need to review the packets.

Since no consumers claimed a similar awareness, it is not surprising that the percentage of consumers claiming to study the packets is larger than, the comparable percentage for direct providers.
Also explicable is the relatively small percentage of indirect providers claiming to study the packets: roughly half of those trustees hold formal leadership positions, positions which frequently require the occupant to handle and process information before it is summarized by the staff. Many indirect providers, in other words, may not study the packets because for them the packets contain little new information.

Though revealing, these explanations should not obscure this section's primary point: more than 90 percent of the consumers interviewed claimed to study the packets. Such a figure is noteworthy, considering the low levels of involvement commonly associated with consumers on the "B" agency councils.

Contacting Other Trustees

A second activity in which trustees engage during the time between board and committee meetings is contacting other trustees. During these contacts information is exchanged, opinions are expressed, questions are asked and answered. According to several trustees, attempts to exercise influence also are commonplace.

This activity was measured by asking board members: "With which trustees do you most frequently discuss agency business during the time between board and committee meetings?" Responses were tabulated by counting the number
Table 16. Contacting Other Trustees: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Number of Trustees Contacted</th>
<th>Percent of All Consumers&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Percent of All Direct Providers&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Percent of All Indirect Providers&lt;sup&gt;d&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>33.3</td>
<td>26.7</td>
<td>33.3</td>
</tr>
<tr>
<td>One</td>
<td>21.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Two</td>
<td>26.2</td>
<td>10.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Three</td>
<td>4.8</td>
<td>20.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Four</td>
<td>11.9</td>
<td>16.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Five</td>
<td>2.4</td>
<td>13.3</td>
<td>11.1</td>
</tr>
<tr>
<td>More than Five</td>
<td>0.0</td>
<td>13.3</td>
<td>11.1</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>99.9</td>
</tr>
<tr>
<td></td>
<td>(42)</td>
<td>(30)</td>
<td>(9)</td>
</tr>
</tbody>
</table>

<sup>a</sup>The figures represent the responses of trustees from both agencies.

<sup>b</sup>The average consumer contacted 1.5 trustees.

<sup>c</sup>The average direct provider contacted 3.1 trustees.

<sup>d</sup>The average indirect provider contacted 26 trustees.
of different board members mentioned.

Table 16 contains the relevant figures. It shows that fully one-third of the consumers and indirect providers spoke with no other trustees during the periods between meetings, and that a moderately smaller percentage (26.7 percent) of direct providers did likewise. The table also shows that direct providers contact the greatest number of trustees: 63.3 percent spoke with three or more, compared with 33.3 percent of the indirect providers and only 19.1 percent of the consumers. When the responses are averaged a similar pattern is obtained: direct providers, indirect provider, and consumers spoke with 3.1, 2.6, and 1.5 different trustees, respectively. In sum, the data show that both direct and indirect providers speak with more trustees than do consumers.

A Miami Valley staffer anticipated this finding and offered an explanation: many direct and indirect providers are prominent members of the local medical community, and, as such, serve together on a variety of boards and committees. All of Miami Valley's hospital administrators, for example, gather once each month for a meeting of the Dayton Area Council of Hospital Administrators. These and similar groups, the staffer continued, provide the attending trustees with opportunities to discuss agency affairs with numerous other trustees. In contrast, most of the board's consumers serve jointly only on the NSA governing board and,
unlike providers, rarely interact in a professional capacity. The staffer concluded that consumers speak with fewer trustees because convenient opportunities to do so are comparatively limited.

Though seemingly cogent, the staffer's explanation is partial, at best, for it fails to reveal why the "target" of roughly one-third of each agency's provider contacts is a consumer—a trustee whom the typical provider is unlikely to encounter at meetings of other boards and committees. It may well be that providers contact more trustees than do consumers not only because of convenient opportunities, but also because providers are more interested in the issues confronting the agencies and are affected more directly by agency decisions.

Contacting the Staff

A third activity in which trustees engage during the time between meetings is contacting members of agency staff. In the agencies studied, most members of staff perform at least two functions. One is a substantive function involving such activities as planning the services and facilities of some aspect of the health care system, directing agency communications with the public and government officials, coordinating programs with other health planning bodies, and providing technical assistance to project proponents. The second function is to serve as the agency's "representative"
to trustees of a specific county. As a "representative," staffers are required to work with trustees, answering questions and providing information.

This latter function is especially important because it stresses the need for trustee-staff communication—a problem for the "B" agency councils—and provides those trustees who are personally unfamiliar with the staff a specific agency contact. The function is not, however, intended to discourage trustees from speaking with any staffer perceived as being best qualified to resolve a particular problem. In fact, members of both boards were frequently encouraged to seek answers to substantive questions from staff specialists.

Trustee-staff interaction was measured by asking trustees to identify the members of staff with whom they speak most frequently. The responses, as summarized in Table 17, show that 95.2 percent of all consumers, 96.8 percent of all direct providers, and 100 percent of all indirect providers claim to contact at least one staffer on a regular basis. The responses reveal further that two-thirds of the indirect providers regularly contact three or more staffers, while roughly one-half of the direct providers and only one-third of the consumers do likewise.

These figures warrant two conclusions. First, contacting agency staff is an activity in which virtually all trustees engage. And second, providers of both types
Table 17. Contacting the Staff: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Number of Staffers Contacted</th>
<th>Percent of All Consumers</th>
<th>Percent of All Direct Providers</th>
<th>Percent of All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>4.8</td>
<td>3.2</td>
<td>0.0</td>
</tr>
<tr>
<td>One</td>
<td>35.7</td>
<td>29.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Two</td>
<td>26.2</td>
<td>12.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Three</td>
<td>14.3</td>
<td>25.8</td>
<td>33.3</td>
</tr>
<tr>
<td>Four</td>
<td>11.9</td>
<td>19.4</td>
<td>22.2</td>
</tr>
<tr>
<td>Five</td>
<td>4.8</td>
<td>3.2</td>
<td>11.1</td>
</tr>
<tr>
<td>More than Five</td>
<td>2.4</td>
<td>6.5</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>100.1</td>
<td>100.0</td>
<td>99.9</td>
</tr>
</tbody>
</table>

\( \text{Percentages rounded to the nearest whole number.} \)

\( a \) The figures represent the responses of trustees from both agencies.

\( b \) The average consumer contacted 2.2 trustees.

\( c \) The average direct provider contacted 2.6 trustees.

\( d \) The average indirect provider contacted 2.8 trustees.
contact more staffers than do consumers. Note, however, that when staffers were asked during personal interviews to describe the mix of trustees they speak with and the purpose of the conversations, nearly all agreed that trustee contacts were almost equally split between consumers and providers. They also agreed that, with few exceptions, the conversations were not instigated for the purpose of "twisting arms." In the words of a Mid-Ohio staffer:

Pretty much the same number of consumers as providers contact me. And when they do call, it's usually for information... Few calls could be considered an attempt to manipulate or influence.

Another staffer said that the trustees who contact him were split "fifty-fifty" between consumers and providers, and went on to say that:

Consumers call mostly for information, while providers want technical assistance, information about specific projects and what facilities or services already exist, and what the [federal] guidelines are. Very few try to manipulate me... Some have tried, but they give up once they find out that I'm not receptive to that sort of thing.

To this, a Miami Valley staffer added:

Consumers and providers contact me about the same. Usually they want histories on projects, or they want to know why a local official opposes a project. Most consumers want general information, but a few want specifics... Overall, I don't get any pressure to support anything. Most of the the things that get thought of as pressure are
really attempts to educate us, to give us more information.

Why staff perceptions and trustee responses yield dissimilar conclusions is not readily apparent. What is apparent is that the differences among the percentages in Table 17 should not be overinterpreted.

**Hours Devoted to Agency Business and Trustee Turnover**

Two indicators of participation remain to be examined. One is the amount of time trustees devote to the affairs of their HSA. The other is trustee turnover. Though not activities per se, these indicators do measure, albeit crudely, opportunities for participation.

The amount of time trustees devote to the affairs of their agency was measured with the following item: "Not counting the time you spend in board and committee meetings, about how many hours a month do you usually devote to agency business?" Table 18 summarizes the responses. It shows that 50 percent of the indirect providers, 43.2 percent of the direct providers, and only 23.2 percent of the consumers claim to devote at least six hours to agency business. The table also shows that the "average" direct provider devotes 7.7 hours, compared to 5.4 hours for the "average" consumer.

These averages conceal a striking interagency difference. Consider Table 19: it shows that the average hourly figure for Miami Valley's consumers is more than twice as large as the comparable figure for Mid-Ohio's
Table 18. Hours Devoted to Agency Business: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency (Combined)\textsuperscript{a}

<table>
<thead>
<tr>
<th>Number of Hours Devoted Per Month</th>
<th>Percent of All Consumers\textsuperscript{b}</th>
<th>Percent of All Direct Providers\textsuperscript{c}</th>
<th>Percent of All Indirect Providers\textsuperscript{d}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than Six</td>
<td>77.0</td>
<td>56.7</td>
<td>50.0</td>
</tr>
<tr>
<td>Six to Ten</td>
<td>12.9</td>
<td>36.6</td>
<td>50.0</td>
</tr>
<tr>
<td>More than Ten</td>
<td>10.3</td>
<td>6.6</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>100.2</td>
<td>99.9</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>(39)</td>
<td>(20)</td>
<td>(10)</td>
</tr>
</tbody>
</table>

\textsuperscript{a}The figures represent the responses of trustees from both agencies.

\textsuperscript{b}The average consumer devoted 5.4 hours per month to agency business.

\textsuperscript{c}The average direct provider devoted 7.7 hours per month to agency business.

\textsuperscript{d}The average indirect provider devoted 6.5 hours per month to agency business.
Table 19. Hours Devoted to Agency Business: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency (Separate)\(^a\)

<table>
<thead>
<tr>
<th></th>
<th>Mean Number of Hours Per Month Devoted by Consumers</th>
<th>Mean Number of Hours Per Month Devoted by Direct Providers</th>
<th>Mean Number of Hours Per Month Devoted by Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Ohio</td>
<td>4.0 (26)</td>
<td>6.1 (21)</td>
<td>6.4 (1)</td>
</tr>
<tr>
<td>Miami Valley</td>
<td>8.2 (13)</td>
<td>5.2 (8)</td>
<td>6.7 (5)</td>
</tr>
</tbody>
</table>

\(^a\)The figures are means computed on ungrouped data. The numbers in parentheses are the number of trustees on which the means are based.
consumers (6.2 hours v. 4.0 hours). Note also that Miami Valley's consumers average a greater number of hours than the providers of both agencies, while Mid-Ohio's average fewer. What this suggests is that the amount of time consumers devote to agency business varies widely across agencies and that circumstances do exist in which consumers will be more participatory than their provider counterparts.

The concept of "turnover" focuses on those trustees who resign their membership prior to the expiration of an officially designated term of office. Resignations may result from a lack of commitment to health planning, from frustration with the planning process, from a low sense of efficacy, or from pressures, opportunities, and constraints imposed by other professional and personal commitments. Yet regardless of why they occur, all resignations engender two consequences. The first is governing board vacancies that may remain unfilled for extended periods, during which the interests represented by the resigning trustees are likely to lack for an advocate.

The second consequence stems from the fact that an effective trustee is one who has acquired knowledge about the community's health care system, has become familiar with the agency's policies and planning documents, and has developed a working relationship with the staff and other trustees. Since it is likely that new trustees—and especially new consumers—have comparatively less relevant
knowledge and that developing rapport takes time, it also is likely that new trustees are less effective than trustees with more experience. Many of the comments volunteered during the staff interviews support such a contention. One staffer, for example, stated that

Some of our new consumers are easily intimidated and don't say much when they first join the board...but this tends to change after they've been around for a while.

Between September 1977 and August 1978, five of Mid-Ohio's trustees, or seven percent of the board, tendered a resignation. Of those trustees, four were consumers. This indicates that 10.8 percent of Mid-Ohio's consumers, compared to only 2.9 percent of the agency's providers resigned. Moreover, between August and December, 1978, the period during which interviews for this research were conducted, 96 trustees were contacted and asked to permit an interview. Eight of the 96 refused, stating that they had recently terminated their membership. Of those eight, six were consumers. In short, though turnover is not a widespread problem, consumers seem more likely to resign their membership than do health professionals.

Consumer Involvement and the HSA Staff

Section 1512 of P. L. 93-641 establishes size and competency requirements for the staff of Health Systems
Agencies. The same section also prohibits agencies from accepting "funds... or contributions... from any individual or private entity" with a "direct interest in the development, expansion, or support of health resources..." Section 1516 replaces "matching funds" formulae with "planning grants," to be distributed annually among the HSAs, for the purpose of performing statutory functions.

Though seemingly disparate, these provisions comprise the response of Congress to several staff-related inadequacies which are alleged to have hindered the participation of "B" agency consumers. Specifically, the new size and competency requirements were designed to improve both the amount and quality of staff support by eliminating understaffing and the hiring to staff positions of persons inexpert in health planning. The prohibition on contributions was expected to eliminate pressure from health care facilities demanding preferential treatment in return for financial favors. And the abolition of matching funds formulae was intended to redirect staff resources from raising money to assisting trustees.

Yet despite these provisions, there remains a potential for staff to hinder participation. Consider, for example, a member of the staff whose previous employment experiences or personal values foster dispositions unsympathetic to a particular group of trustees. Such a staffer might selectively discourage trustee involvement by behaving in an
antagonistic or threatening manner when answering questions or providing information.

Consider also that the staff gathers and disseminates much of the information trustees receive about projects the boards review. A "biased" staffer may manipulate that information, and in so doing alienate or frustrate potentially active trustees privy to other, more objective sources of data. The comments of one Mid-Ohio provider well illustrate how this might occur:

The position of the executive director...is one of great power. The Director commands a staff of nearly 33 persons who presumably respond to his commands. The Director can by his own action or actions of his staff create documents and synopses and issue statements that can adversely affect, and most surely even defeat projects or services proposed by health care institutions. The staff can create and convey by statements and other means to the board and the public positive or negative attitudes regarding health care institutions in the fifteen county [Health Service] Area.

In essence, then, though P. L. 93-641 goes farther than earlier legislation in providing trustees the support necessary to plan for health, the extent to which agency staff encourages participation remains an empirical question.

To answer that question, Mid-Ohio and Miami Valley consumers were asked to agree or disagree with the following statements:
- Agency staff respond to your questions thoroughly and competently.

- Agency staff present information in a manner which is easy to understand.

- Agency staff is cooperative.

- Agency staff occasionally withhold relevant information.

Responses to these statements, as tabulated in Table 20, reveal that most consumers are favorably impressed with staff performance: 92.9 percent agreed that staff is responsive and competent; 85.7 percent agreed that the information prepared by staff is easy to understand; 97.7 percent agreed that staff is cooperative; and only 25.0 percent agreed that staff occasionally withholds relevant information. Of the ten consumers who agreed with the final statement, eight qualified their response, noting that typically information was withheld as a result of poor judgment, not as a consequence of dubious motives.

Several consumers spoke at length about staff performance. One Mid-Ohio consumer boasted that staff do

a super job. They are well-organized, know what they are doing and what they are talking about.

Another Mid-Ohio consumer stated that his HSA

has one of the best staffs in the country. They do a phenomenal job; they keep the board ahead of the game, especially when it comes to keeping us abreast of what has to be done to meet federal guidelines.
Table 20. Consumer Evaluations of Agency Staff: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Response Category</th>
<th>Statement 1\textsuperscript{b}</th>
<th>Statement 2\textsuperscript{c}</th>
<th>Statement 3\textsuperscript{d}</th>
<th>Statement 4\textsuperscript{e}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>38.1</td>
<td>16.7</td>
<td>44.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Agree</td>
<td>54.8</td>
<td>69.0</td>
<td>53.5</td>
<td>25.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>7.1</td>
<td>14.3</td>
<td>2.3</td>
<td>47.5</td>
</tr>
<tr>
<td>Strong Disagree</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>27.5</td>
</tr>
<tr>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>(42)</td>
<td>(42)</td>
<td>(43)</td>
<td>(40)</td>
</tr>
</tbody>
</table>

\textsuperscript{a}The figures represent the responses of trustees from both agencies.

\textsuperscript{b}The statement reads: "Agency staff respond to your questions thoroughly and competently."

\textsuperscript{c}The statement reads: "Agency staff present information in a manner which is easy to understand."

\textsuperscript{d}The statement reads: "Agency staff is cooperative."

\textsuperscript{e}The statement reads: "Agency staff occasionally withholds relevant information."
A Miami Valley consumer was equally effusive. She claimed that staff performance was "excellent, very thorough," and added that "they are especially good at getting information to consumers and at helping lay people to understand the issues."

Though many consumers spoke well of staff, several of Mid-Ohio's consumers did offer less positive evaluations: four complained that staff too often summarizes information that should be analyzed; three grumbled that staff "favors providers;" and two stated that staff produces more reports and documents than is reasonable to expect part-time volunteers to read. To this, an especially dissatisfied consumer added that members of staff are mostly trained in social work, but they should have a background in business administration. Furthermore, they are not critical of what they are doing; they have little desire to exhaustively study the details of a proposal... They do not ask the hard and gutsy questions which would enable the board to make better decisions. Most of the staff curry favor with the providers; they are overly solicitous of the hospital administrators and doctors... Consumers are shielded from the facts... Cost containment is a subject that is distasteful to staff, as is attention to institutional health care...

These remarks not withstanding, it is clear that most consumers consider the staff to be a valuable, helpful resource. It is also clear that few, if any, consumers, admit to being so threatened, deceived, or overwhelmed by the staff that inclinations to participate are stifled. In
short, it appears that the staff in no way hinders, and in fact may encourage, consumer participation.

The preceding examination of involvement in activities both at and between governing board meetings has revealed that in most of the activities studied providers are more involved than consumers. More intriguing, however, is that HSA consumers appear to be more involved in areawide health planning than were their "B" agency predecessors. Indeed, the large participatory disparities between providers and consumers as well as the generally low rates of consumer involvement alleged to have characterized the "B" agency councils seem to have been replaced by smaller disparities and by generally high rates of consumer involvement. But involvement in activities is not the same as influence. Consumers may now attend meetings and offer motions at rates similar to those for providers, but their impact on agency decision making may not have increased. The following section addresses this issue.

Influence in HSA Decision Making

Edward Banfield (14, p. 3) defines influence as the "ability to get others to act, think, or feel as one intends." Dahl (45, p. 40) claims that influence is a "relation among actors" in which one actor induces other actors to behave in ways they otherwise would not. To
Friedrich (81, p. 200), "Influence exists when the behavior of B is molded by and conforms to the preferences of A, but without the issuance of a command." And, according to Lasswell (45, p. 51), influence is a "special case" of power, involving neither actual nor threatened sanctions for noncomformity.

Lasswell's distinction between influence and power implies that the exercise of influence is limited to means which Friedrich calls "psychic." Friedrich (81, p. 200) illustrates the point, noting that

The fascination emanating from a powerful personality, or the persuasive seductiveness of a person of superior intelligence, the charm of a lovable man or woman—these are some of the psychic means of influencing the conduct of others.

Friedrich concludes by explaining that "psychic" means are almost entirely limited to individuals, since groups of persons do not have a "psyche," except in those rare instances where, moved by a common inspiration, group members feel and act in unison.

These definitions suggest that influence can only be exercised when two conditions are satisfied. The first is that the actors involved in an influence relationship must (1) have different goals, (2) weight similar goals differently, (3) prefer different means to achieve similar goals, or (4) have goals that are not well-defined. If this condition is not satisfied, a consensus would exist and the
exercise of influence would be unnecessary. The second condition is the absence of a highly stable coalition of like-minded actors who comprise a majority of all the actors in a decision making process characterized by issues that divide that majority from the rest of the actors. Should such a coalition exist the majority could dominate decisions without exercising influence.

These two conditions are clearly met in the two Ohio HSAs. When trustees of both agencies were asked "What do you personally think are the most important goals of health planning?" fully three-quarters of the consumers mentioned "cost containement," compared to 60 percent of the indirect providers and only 38.1 percent of the direct providers. In contrast, 90.5 percent of the direct providers mentioned improving the quality of health care facilities and services, compared to 40 percent of the indirect providers and 64.9 percent of the consumers. It appears then, that while many trustees favor the same goals, consumers and direct providers weight them differently: the former are concerned predominately with containing costs, the latter with improving the quality of facilities and services.

Evidence of the second condition is found in the attendance data, which indicate that neither providers nor consumers are an attending majority at all governing board meetings, despite the requirement that consumers comprise a numerical majority of a board's membership. Additionally,
when trustees were asked if, during the discussion of issues, providers tend to support one position and consumers another, 93.9 percent claimed that opinions rarely polarized along a consumer-provider dimension. More than 70 percent also claimed that their board has no lasting coalitions. In short, both the attendance and interview data indicate that no stable, dominant coalitions rule the HSAs by virtue of the votes they command and that individual providers and consumers must exercise influence over all types of trustees if they wish the board to approve or disapprove policy and projects that initially lack majority support.

It should be noted that the "exercise of influence," rather than the "exercise of power" is appropriate usage in the HSA setting because board membership provides no trustee the means to reward or punish another. Moreover, board membership often neutralizes pre-existing sanctions resulting from professional associations. The comments of one Mid-Ohio provider are instructive:

I am a senior member of a four doctor group. We are all hospital based and must deal with hospital administrators. Normally, they can blow you away, but if you are a trustee, they have to have your vote to get their projects through. So board membership gives me torque.
Measuring Influence

A common approach to the study of influence focuses on participation in decisions. According to Dahl (45, pp. 52-53), the approach involves an examination of both the "kinds of activity" in which actors engage, as well as the frequency of actor involvement. Dahl adds that the approach is appropriate for tracing various patterns of influence; for distinguishing influence in one issue area from influence in another; and for isolating those who have influence in many issue areas from those whose influence is more narrowly defined.

Though potentially revealing, this approach is ill-suited to the study of influence in Health Systems Agencies. First, much of the activity preceding votes of a governing board occurs among trustees and the staff either in private or at closed meetings of other organizations. As a consequence, trustee involvement could be measured only indirectly, using recall data which are likely to suffer from faulty memories, an unwillingness to betray confidences, professional courtesy, and a desire to conceal activities motivated by self-serving, parochial interests.

A second problem is that activity is not equivalent to influence. For example, a new trustee may review documents prepared by the staff, attend meetings, and vote frequently. Yet he also may be much less adept than the board's president at persuading others. Conversely, a trustee may be
highly influential even though he participates directly in no activities. In the latter case, a perceived "intention to become active" may serve to assure compliance. (32, p. 154)

A final limitation of the participation approach is its lack of explanatory power. The approach, in other words, fails to explain why some trustees have influence, while others do not.

An alternative approach to measuring influence (and one better suited to Health Systems Agencies) focuses on specific properties that are sources of influence for individuals in a small group setting. Those properties are formal leadership positions and centrality, defined as a group member's location in a group's interaction network. (Hopkins)

**Formal Leadership Positions**

Much of the research on small group behavior demonstrates that holding a formal leadership position is a source of influence. Hare (92, p. 299), for example, reports that "The influence of a member...will be enhanced if he is placed in a...position of leadership." According to French and Raven (79, p. 617), influence derived from a leadership position stems from the "internalized values in P which indicate that O has a legitimate right to influence P and that P has an obligation to accept that influence." Lippitt and his colleagues (136, p. 481) suggest that
The behavior of a member in a high power position is sometimes perceived as representing group standards, and so his acts are spontaneously imitated as group-approved or group-desired acts.

To this, Collins and Geutzkow (32, p. 148) add that leadership positions are a source of influence even when group members are personally unfamiliar with position occupants. They claim that past experience with persons holding leadership positions tends to produce through a "socialization process" a conscious attitude that authorities have a right to demand compliance.

Hopkins (99, pp. 73-74) approaches the position-influence relationship from a second perspective. He contends that position increases "observability," defined as opportunities to observe a group's "events and conditions," and that as observability increases, so does a member's ability to persuade others. Hopkins admits that no systematic data supporting this proposition yet exists, but argues that the link between the concepts probably rests on the amount of accurate knowledge about group members which observability affords.

Once each year, at an Annual Meeting, Mid-Ohio's governing board members elect six of their peers to leadership positions. The positions include one president, four vice-presidents, and a treasurer. The position of president affords, in Hopkins' terms, the greatest
"observability," for the occupant is responsible for chairing meetings, working with the staff to set agendas, supervising committee activity, and appointing other trustees to various permanent and ad hoc committees, subcommittees, and advisory groups. The president also is responsible for maintaining the staff and for notifying all trustees of the time and place of upcoming meetings. The "observability" afforded by the remaining positions is far less clear: Mid-Ohio's by-laws state only that the duties of these officers "shall be those usually pertaining to such offices."

In addition to the six trustees holding elected positions, 11 trustees hold appointed positions on four of the agency's five permanent committees. Four of those 11 are committee chairmen. The remaining seven are committee vice-chairmen.

Since much of the agency's business involves reviewing proposals for new or improved health care facilities and services, the committee position affording the most observability is chairman of the Project Review Committee (PRC). The occupant of this position has greater first-hand access to a wider range of information than do other committee chairmen and is responsible for reporting committee recommendations to the full board.

The importance of the Project Review Committee—and by extension its chairman—in the project review process is
illustrated by the responses of Mid-Ohio's trustees to the question: "Generally, when decisions are made on proposals for capital expenditures, how important would you say each of the following actors are?" The responses indicate that 39.7 percent considered the PRC to be "most important," while the full governing board was said to be "most important" by 24.1 percent. Sub-area councils and the staff were considered "most important" by only 13.8 percent and 10.3 percent, respectively.

Miami Valley's trustees elect five or six officers at their Annual Meeting. They include one president, one first vice-president, one or two additional vice-presidents, and one non-voting secretary who is neither a consumer or a provider. Again, the office of president affords the greatest observability:

The president shall be the principle executive officer of the agency and shall, in general, supervise and control all of the business and affairs of the agency. (151, p. 170)

Included in this mandate is responsibility for presiding at all meetings of the board (regular and special), signing deeds, mortgages, bonds, contracts, and other instruments authorized by the board, and performing "all duties incident to the office...and such other duties as may be prescribed...from time to time."
In the absence of the president, the vice-presidents, in the order of their election, are authorized to perform his duties and when so doing have all his powers and are subject to all his restrictions. The secretary is responsible for recording the minutes of all meetings and for notifying trustees as to where and when the board will meet. Finally, the treasurer is responsible for maintaining the agency's fiscal records and for reporting to the board the agency's financial status. (151, pp. 170-71)

Who holds these leadership positions? Throughout the period of the study Mid-Ohio's president was an indirect provider. Two of the four vice-presidents were direct providers, and the remaining vice-presidents as well as the treasurer were consumers. At the committee level, seven consumers, three direct providers, and one indirect provider occupied positions of leadership. Note, however, that the Project Review Committee was chaired by a direct provider. Note also that Miami Valley's president was an indirect provider, as was one vice-president. Miami Valley's secretary was a direct provider, and two vice-presidents, including the first vice-president, were consumers. In short, it appears that while consumers occupied more than half of the leadership positions, providers held the three positions offering the greatest observability.
Centrality

The second property associated with influence is centrality. According to Hopkins (99, p. 29), the concept designates how close a member is to the "center" of the group's interaction network and thus refers simultaneously to the frequency with which a member participates in interaction with other members and the number or range of other members with whom he interacts.

Hopkins (99, p. 74) adds that for any member of a small group, "the greater his centrality, the greater his influence" because centrality facilitates observability. He supports this claim citing research by Bass (17), Strodbeck (210), and March (142). 15

Unfortunately, data on the frequency of trustee contacts are unavailable for members of the Mid-Ohio and Miami Valley HSAs. What is available are figures on the number of trustees each board member contacts as well as the number of board members contacting each trustee.

The number of trustees each board member contacts was examined earlier in this chapter (see Table 16). That discussion indicates that one-third of the consumers and indirect providers spoke with no trustees during periods between meetings, compared to 26.7 percent of the direct providers; that 63.3 percent of the direct providers spoke with three or more trustees, compared with 33.3 percent of the indirect providers and only 19.1 percent of the
consumers; and that the average number of contacts for direct providers, indirect providers and consumers was 3.1, 2.6, and 1.5, respectively. These data suggest that more direct providers are more central in an agency's communication network than either indirect providers or consumers.16

Table 21 shows that only 3.1 percent of the consumers (from both agencies) contacted at least once, were contacted by more than four trustees. The comparable figures for direct and indirect providers are both 33.3 percent. Moreover, more than 40 percent of the consumers contacted at least once were contacted by one trustee, compared to only 14.3 percent of the direct providers.

To this point, the analysis has shown that providers tend to occupy the formal leadership positions affording the greatest observability and that providers are closer than consumers to the center of the board's interaction network. These findings suggest that providers possess more of the properties associated with influence than do consumers, which in turn suggests that providers are more influential than consumers in the HSA decision making process.

Additional support for this conclusion is found when influence is measured using a variation of the "reputational" technique employed by Hunter (102). The technique is similar to Hunter's in that influence is
Table 21. Trustee Contacts by Other Trustees: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Number of Trustees Contacted By</th>
<th>Percent of All Consumers</th>
<th>Percent of All Direct Providers</th>
<th>Percent of All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>40.6</td>
<td>14.3</td>
<td>33.3</td>
</tr>
<tr>
<td>Two</td>
<td>28.1</td>
<td>19.0</td>
<td>16.7</td>
</tr>
<tr>
<td>Three</td>
<td>21.9</td>
<td>14.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Four</td>
<td>6.2</td>
<td>19.0</td>
<td>16.7</td>
</tr>
<tr>
<td>Five</td>
<td>0.0</td>
<td>9.5</td>
<td>33.3</td>
</tr>
<tr>
<td>Six</td>
<td>3.1</td>
<td>14.3</td>
<td>0.0</td>
</tr>
<tr>
<td>More than Six</td>
<td>0.0</td>
<td>9.5</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>99.9</td>
<td>99.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>

---

*a* The figures represent the responses of trustees from both agencies.

*b* The average consumer was contacted by 2.1 trustees.

*c* The average direct provider was contacted by 3.8 trustees.

*d* The average indirect provider was contacted by 3.0 trustees.
measured by asking "judges" who in a group is influential. However, it differs from Hunter's in that a small number of judges "suggested by various sources" was not asked to tender evaluations. (94, p. 51) Instead, every trustee and staffer interviewed was given an opportunity to do so.

Specifically, trustees were asked: "In your opinion who are the most influential or powerful trustees?" In response to the item, Mid-Ohio's board members mentioned 27 different trustees 248 times.17 Of those 27, 16, or 59.2 percent, were providers. Furthermore, 199, or 80.3 percent, of all the mentions referenced a provider and, for the trustees referenced, the "average" provider received 12.4 mentions, compared to 3.1 for the "average" consumer. Further still, only 29.7 percent of all Mid-Ohio's consumers were mentioned at least once, while the comparable percentage for providers is 47. Finally, all four trustees mentioned most often not only were providers, but together were responsible for fully 43.5 percent of the names mentioned.

The responses from Miami Valley's board members are roughly similar: 17 trustees were mentioned 93 times; 11 of the 17, or 64.7 percent, were providers; 68.8 percent of all the mentions referenced a provider; 84.6 percent of all providers were referenced at least once, compared to only 40 percent of the consumers; and, of the four trustees mentioned most frequently, two were providers. In sum, the responses indicate that in both agencies more providers than
consumers are perceived to be influential by members of the governing board.

When members of staff were asked to name the trustees they perceive to be most influential, five Mid-Ohio staffers named 13 providers and four consumers 37 times. The consumers averaged only a single mention each, while the provider average was 2.5. Moreover, the five trustees named most often by members of the staff all were among the top seven named most often by members of the board.

Miami Valley's staffers named 15 different trustees 35 times. Of those, ten were providers. Of the 35 mentions, 71.4 percent referenced a provider, and providers averaged 2.5 mentions, compared to 2.0 for consumers. Clearly, the perceptions of the staff match those of the trustees: not only are more providers than consumers perceived to be influential, but providers are perceived to be influential more often.

Worth noting is that the two trustees mentioned most often by members of Mid-Ohio's staff and board were the president and the chairman of the Project Review Committee. The trustee mentioned most often by Miami Valley's trustees was the president, also. This overlap tends to support Hare's contention that position is a source of influence.

Also worth noting is that when board members were asked why they selected particular trustees as being influential, the responses focused on superior knowledge, the ability to
articulate effectively, and experience with the health care system:

They have been around. They can think on their feet and can field tough questions. They have lots of moxie.

These people stay involved, are better prepared, more vocal. You realize quickly that they have done their homework.

They are...knowledgeable in their areas of expertise and...bring to the board reasonable, rational input. They are expressive... They do their homework.

Experience. They are articulate and raise valuable questions; they demonstrate knowledge of a complicated system.

By virtue of the position they hold. This is their milieu. They are not reluctant to express an opinion and since they seem to know what they are talking about they get listened to.

Because 85 percent of the issues are resolved in a manner consistent with how these people vote. They are not necessarily the most critical, vocal, or recommending. But they usually have sufficient time prior to meetings to research an issue and argue from a position of strength... They can persuade other less knowledgeable trustees to vote as they do.

What is interesting about these statements is the absence of "political" references and the emphasis on the articulate expression of relevant information. Indeed, the tone of the statements suggests that "superior knowledge" is likely to be the key component in the influence calculus.

The obvious implication of such a contention is verified in a study of 15 HSAs by the General Accounting
Office (GAO). (35, p. 45) When the GAO asked approximately 450 trustees "How much knowledge of the health care system in your Health Service Area do you feel..." consumers and providers have? 80.4 percent said providers have either a "very great" amount or a "substantial" amount, while only 1.6 percent said providers have either a "small" amount or "little or none." In contrast, the comparable figures for consumers are 27.4 percent and 30.4 percent, respectively—indicating that providers more than consumers are perceived to possess one property associated with influence.

The preceding analysis has shown that in general providers occupy those positions affording the greatest observability, that providers tend to be the board's most central members, and that providers are perceived by other trustees and by the staff to be more influential than consumers. But do providers exercise the influence they seem to possess? Do they, in other words, tap those sources to persuade consumers to adopt policy they otherwise might not? Consider the following.

When consumers and providers were asked to describe their "most important" health planning goals, similar goals were ranked differently: consumers emphasized cost, providers quality. Implicit in this difference is the expectation that issues on which the full board votes will
divide the board when votes are cast.

Yet a divided board was extremely rare. Of the 146 votes cast by Mid-Ohio's trustees during the period of the study, 82.9 percent were unanimous, 7.5 percent were contested by a single trustee, and only two percent were contested by as many as ten. For the 36 votes dealing with proposed facilities and services—those most likely to divide the board—the pattern was much the same: 72.2 percent were unanimous and 11 percent had a minority of one. Furthermore, of the 35 substantive votes cast at meetings of the Project Review Committee, 77.1 percent were unanimous, 11.4 percent were contested by one trustee, and only a single vote split the committee nearly in half (i.e., six yeas and five neas).

What might explain this lack of conflict, this high degree of unanimity, despite goals that are weighted differently? One explanation was offered by a Miami Valley staffer who argued that many votes are unanimous because controversial issues rarely reach the board: some are tabled in committee; others are made acceptable by project proponents, staff, and trustees working together prior to meetings; and still others are removed from the agenda by proponents convinced that the board would act unfavorably.

Unfortunately, the staffer's explanation lacks empirical support, for when trustees were asked "How often would you say the substantive issues the agency deals with
are controversial?" 67.5 percent said "more than half the time" and only 3.6 percent said "hardly ever." Additionally, more than 90.0 percent were able to mention at least one issue which had aroused heated, often emotional debate.

A second explanation, provided by Grossman (87, 88), suggests that many votes are unanimous because most trustees, having neither the time nor inclination to examine each issue with care, simply accept the recommendations of the committees reviewing the projects. This explanation is partial at best for it fails to reconcile the high percentage of unanimous votes cast at meetings of the PRC, the committee whose members presumably do have the time and inclination to examine issues with care.

A third, and potentially more defensible explanation, is that providers—those trustees who are (1) perceived to be more influential than consumers; (2) possess more relevant information than consumers; (3) hold leadership positions affording the greatest observability; and (4) are more central than consumers in an agency's communication network—persuade consumers to accept policies providers favor, and in so doing exercise influence. (Occasionally, of course, providers fail to agree. When this happens nonunanimous votes result.)

Unfortunately, such an explanation cannot be documented directly: since the goals of specific policies may be perceived differently by different trustees and since the
discussion of most policies is short-lived, it is impossible to determine if the policy position a trustee favors when or after he votes is his original position or a position to which the exercise of influence has moved him—a position, in other words, he has been persuaded to believe is consistent with his health planning goals.

The third explanation can, however, be verified inferentially by noting that a large majority of the comments volunteered by consumers, providers, and the staff point in a similar direction: consumers do raise important, often embarrassing questions; they do contribute a "novel perspective" to the planning process; and they do temper provider tendencies for "bigger and better" health care facilities and services. Yet on the whole, when decisions are made consumers are ill-equipped to combat provider rhetoric and expertise. The following excerpts are instructive:

The providers know a lot more about these projects than the consumers do... As a layman, I must accept what they say. I'm in no position to evaluate the technical aspects of a proposal.

Consumers bitch and moan. But they vote with providers... By the time a project is presented most consumers have a feeling that while it's not perfect, it's something we need; the guy makes sense... Maybe it's something we don't need, but it sounds good, so they go for it.

Consumers vote with their emotions much of the time, but often their heads snap around
to see how the influential providers are voting. [Provider X] is so persuasive when he makes a case for something he could sell ice boxes to Eskimos.

Consumers keep providers honest; they are not embarrassed to ask tough questions, but when providers introduce projects that run counter to the guidelines they [i.e., the providers] make emotional appeals; you know, the kind that "gets you right here." This makes it very hard for the consumers to say no. In fact, there is very little consumers can say when providers appeal to emotion.

Providers are the strong force in discussions; they are the experts. Consumers turn to the providers they trust to ask if something about a project seems right. For example, a proponent may say that added services will increase costs but not charges. This is malarky; and somebody has to explain this to consumers and its the providers who do the explaining. This doesn't mean that providers dominate consumers, but it does mean that consumers are apt to be swayed by what the providers say.

Providers have a high degree of ability to present a point. They are more articulate, more familiar with the terms than consumers. And many consumers are intimidated, so this keeps them quiet, although some do ask embarrassing questions. But in general, consumers look around to see who is voting how.

Most of the things the board deals with affect providers directly, but consumers only indirectly. So providers definitely dominate... It's usually the providers who decide if something will fly and consumers follow suit. Providers are guided by expertise that consumers don't have.

Additional support for the contention that providers dominate HSA decision making is found in a study by Knox (126, p. 2), who visited 12 Health Systems Agencies in June, 1977. After interviewing trustees and staff in an effort to
measure "their attitudes, opinions, and experiences of consumer participation," he concluded that

To a large extent, consumer participation in local health policy making and planning has at best been advisory, but more often cosmetic.

HSAs [do not] have an organizational mechanism which permit[s] the formation of an identifiable consumer focus and function within the agency; conversely provider members have clearly delineated focus and function in political, economic and social organization of planning, and they are sustained and reinforced by natural coalitions of provider interests and through access to a variety of support networks supplied by their institutions.

To argue that providers dominate HSA decision making is not also to argue that providers act in concert, ignore concerns expressed by consumers, or behave in a parochial, self-aggrandizing way. Nor is it to argue that consumers are particularly dissatisfied with either the progress their agency has made or is likely to make, or the statutory functions their agency has chosen to stress. Both qualitative and quantitative evidence address these points.

First, when Mid-Ohio and Miami Valley consumers were asked how well their personal health planning goals were reflected in their agency's health planning documents (i.e., the Health Systems Plan and the Annual Implementation Plan), 55 percent said "very well" and an additional 30 percent said "moderately well." In contrast, only 24 percent of the direct providers said "very well," while 40 percent said
"moderately well." Moreover, only 7.5 percent of the consumers, compared to 16 percent of the direct providers felt that the relevant plans reflected their goals "not well at all." (see Table 22) It seems then, that despite provider domination of decision making more consumers than providers are satisfied with the planning documents the agencies develop. A potential explanation for this finding is that consumers may readily accept plans that promise an improved health care system, while providers may view any plan as a restriction on their personal ambitions or on the ambitions of the institutions they represent. Moreover, since plans effect the immediate concerns of consumers less than the immediate concerns of providers, the former may be less familiar (or even unfamiliar) with a plan's provisions—a circumstance which is likely to minimize critical comments.

Additional evidence of consumer satisfaction with agency performance is found in the study by the GAO (35, p. 36). Specifically, when the GAO asked trustees of 15 HSAs to evaluate the extent to which their agency could "contain overall health care costs," 17.6 percent of the consumers said either to a "very large extent" or to a "substantial extent." The comparable figure for providers was 13.0 percent. Trustees were also asked about achieving seven other health planning goals and, as Table 23 shows, for five of the seven relatively more consumers than providers said the extent would be at least "substantial." On the basis of
Table 22. Trustee Health Planning Goals as Reflected in Agency Planning Documents: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency

<table>
<thead>
<tr>
<th>Response Category</th>
<th>Percent of All Consumers</th>
<th>Percent of All Direct Providers</th>
<th>Percent of All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Well</td>
<td>55.0</td>
<td>24.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Moderately Well</td>
<td>30.0</td>
<td>40.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Less Than Moderately Well</td>
<td>7.5</td>
<td>20.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Not Well At All</td>
<td>7.5</td>
<td>16.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

| Total                  | 100.0                    | 100.0                          | 100.0                           |
| (40)                   | (25)                     | (10)                           |

aThe figures represent the responses of trustees from both agencies.
Table 23. Trustee Evaluations of Agency Ability to Achieve Health Planning Goals<sup>a</sup>

<table>
<thead>
<tr>
<th>Health Planning Goals</th>
<th>Percent of All Consumers&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Percent of All Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restrain Construction of Unneeded Health Facilities</td>
<td>51.7 (108)</td>
<td>62.4 (121)</td>
</tr>
<tr>
<td>Restrain Acquisition of Unneeded Equipment</td>
<td>41.6 (85)</td>
<td>48.7 (95)</td>
</tr>
<tr>
<td>Contain Overall Health Care Costs</td>
<td>17.6 (36)</td>
<td>13.0 (25)</td>
</tr>
<tr>
<td>Regulate Rates Charged by Hospitals</td>
<td>10.9 (22)</td>
<td>5.8 (11)</td>
</tr>
<tr>
<td>Regulate Health Manpower Supply</td>
<td>8.1 (16)</td>
<td>5.3 (10)</td>
</tr>
<tr>
<td>Regulate Geographic Distribution of Health Manpower</td>
<td>9.3 (19)</td>
<td>4.2 (8)</td>
</tr>
<tr>
<td>Improve Access to Health Care</td>
<td>27.3 (57)</td>
<td>19.6 (38)</td>
</tr>
<tr>
<td>Educate the Public in the Use of the Health Care System</td>
<td>41.1 (86)</td>
<td>38.5 (74)</td>
</tr>
</tbody>
</table>


<sup>b</sup>The figures represent the percentage indicating that their HSA can accomplish the specified goals either to a "very large extent" or to a "substantial extent."
Table 24. Trustee Evaluations of the Importance of Agency Functions: The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency\textsuperscript{a}

<table>
<thead>
<tr>
<th>Health Systems Agency Functions</th>
<th>Mean Difference for All Consumers</th>
<th>Mean Difference for All Direct Providers</th>
<th>Mean Difference for All Indirect Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathering and Analyzing Data</td>
<td>9.9 (36)</td>
<td>18.9 (27)</td>
<td>5.7 (7)</td>
</tr>
<tr>
<td>Developing an HSP and an AIP</td>
<td>7.5 (38)</td>
<td>23.5 (27)</td>
<td>20.1 (7)</td>
</tr>
<tr>
<td>Reviewing Proposals</td>
<td>7.1 (38)</td>
<td>13.1 (27)</td>
<td>8.6 (7)</td>
</tr>
<tr>
<td>Working with Individuals and Organizations to Achieve the Goals Stated in the HSA and AIP</td>
<td>17.2 (37)</td>
<td>23.8 (27)</td>
<td>28.3 (6)</td>
</tr>
</tbody>
</table>

\textsuperscript{a}The figures were computed by averaging the differences between thermometer ratings for each trustee type. The numbers in parentheses indicate the number of trustees on which the means are based. Responses of trustees from both agencies are included.
these figures, the GAO concluded that "provider board members were slightly less optimistic about HSAs achieving... goals" than were consumers.

Still more evidence of consumer satisfaction was found when Mid-Ohio and Miami Valley trustees were read a list of four functions HSAs are required to perform** and asked to imagine a thermometer where 100 degrees means "very important" and zero degrees means "not important at all." Trustees then were asked to locate each function on the thermometer, first indicating how important they personally consider the function to be, and then indicating how important they think their agency, on the whole, considers the function to be. When the differences between the respective ratings were computed and averaged across trustees of similar type, the results, as displayed in Table 24, demonstrate that the "distance" between personal preference and perceived emphasis was, for all four functions, smaller for consumers than for direct providers and for three of the functions smaller for consumers than for indirect providers. In short, here again is an indication that despite provider domination of decision making, consumers do not appear to be particularly dissatisfied.

Finally, the comments of many trustees and staffers suggest that in general providers are not villains on the health planning landscape:
Overall providers are pretty good. Sometimes they even surprise me because most of them aren't parochial. At the review group level, they are valuable because they know a lot about the technical stuff and the regulations and problems. They tell us when other providers are trying to pull the wool over our eyes. They help us educate the consumers.

Professionalism and integrity are alive and well. Not all providers fit the Nader stereotype; not all are parochial... All providers aren't bad.

Parochialism among providers stops at the front door. They are willing to accept the priorities established by the agency collectively. There has always been general agreement among the providers to follow what the plan says.

Providers have the position and background needed to be convincing. Yet they are not working in concert. They have experience that is essential to health planning and they share that experience with consumers...

I am there trying to do an honest job as a medical spokesman. Physicians know more about how to care for sick people than anyone else. It's a challenge to go into (the meetings) with all the different kinds of people and tell the story so they can understand it.

This chapter has shown that health professionals are more involved than consumers in activities at and between governing board meetings, although overall levels of involvement do not appear to be markedly different; that more providers than consumers possess the properties associated with influence; that more providers than consumers are perceived to be influential; and that providers appear to exercise their influence by persuading
consumers to accept policy they otherwise might not. In perspective, the chapter has shown that the relationship among governing board trustees is both similar to and different from the relationship which had existed among members of the "B" agency councils: providers continue to dominate agency decisions, but consumers are now more involved in planning activities than were the consumers the replaced.
ENDNOTES

1. One such activity, voting, is not included in the analysis because the votes of individual trustees are not recorded in either agency. Instead, the presiding officer asks for a show of hands and records only the totals.

2. Each board also met for an Annual Meeting at which members and officers of the governing board are elected.

3. Considering that each board's average meeting was attended by slightly less than two-thirds of its consumers, it may be inferred that the "mix" of consumers varied more at Miami-Valley's meetings than at Mid-Ohio's.

4. One provider complained that Mid-Ohio's trustee-chairman was "often guilty" of allowing only those who "support his position" to speak. No evidence was found to support this assertion.

5. A Mid-Ohio provider, presumably without the benefit of Thomas and Pink or Hare, volunteered this conclusion when he stated "The bigger the crowd, the smaller the noise."

6. Indirect providers are not included in this discussion due to the small number for whom data are available.

7. In the agencies studied trustees are elected to three year terms and may be re-elected for second terms. However, after serving a second term, a trustee is not eligible for further election until one year has elapsed.

8. One staffer, aware of such criticism, said: "Some consumers say they don't have enough information to make decisions. But if they get a summary it's not enough. If they get a complete analysis as well as a summary, they complain we're wasting paper and that it's too much to read. So you can't win."
9. The comments encompassed such activities as modernizing existing facilities, purchasing sophisticated equipment including Computerized Axial Tomography (CAT or CT) scanners, and adding maternity wards and intensive care beds where they are needed.

10. It might be argued that trustees can reward or punish other trustees by voting for or against particular projects. The point, however, is that no trustee can decide the fate of any proposal by acting unilaterally. Stated differently, a trustee who wishes to effect decisions must do so by persuading others to think and vote as he does.

11. The board also has a secretary, but this office is occupied by the agency's Executive Director, rather than by a trustee.

12. The president is an ex officio member of all standing committees.

13. The five standing committees are the Nominating Committee, the Legislative Committee, the Plan Development Committee, the Project Review Committee, and the Executive Committee. This last committee has no officers; meetings are chaired by the president.

14. Similarly to Mid-Ohio, Miami Valley has standing committees. Yet unlike Mid-Ohio no committee members—not even those holding leadership positions—serve on the board of trustees. Members who do not serve on the board are neither consumers nor providers in any formal sense. Consequently, Miami Valley's committee leadership positions are not examined in this analysis.

15. Verba (239, p. 133) takes exception to Hopkin's assertions. He writes "...it is reasonable to assume that the individual who makes the most suggestions or gives the most opinions has the greatest effect on the group. But to link the amount of interaction initiated with the amount of influence over the group product is tantamount to equating talking the most with contributing the most to the group—an obviously invalid equation. Before one can move from a knowledge of interaction rates of an individual to the influence that an individual exerts within a group, one would have to know if the interactions in which the individual attempts to direct the group were successful and effective."

16. Worth noting is that 38.9 percent of Mid-Ohio's trustees, compared to 60.7 percent of Miami Valley's trustees were mentioned at least once. This suggests that in the latter agency influence may be more broadly distributed.

17. One Miami Valley staffer was unwilling to offer names in response to the question. He stated that "No one has more influence than anyone else. All members speak when they have something to say, and they all can sway other members... At one time or another they have all been influential." Similarly, a Mid-Ohio consumer said "Anybody who wants to talk can; it's the American system of voting. Every man's vote is equal."

18. Precisely who the dissenting trustees are is impossible to determine because how each trustee votes is not recorded.

19. The functions include (1) gathering and analyzing data; (2) developing the Health Systems Plan and the Annual Implementation Plan; (3) reviewing proposals for facilities and services; and (4) and working with individuals and organizations in the community to achieve the goals stated in the agency's plans.
CHAPTER V
CONCLUSIONS

This research evaluates consumer participation in the areawide health planning agencies established by the National Health Planning and Resources Development Act of 1974. It examines the composition of HSA governing boards, the involvement of consumers in agency affairs, and the influence of consumers in agency decisions. The Mid-Ohio Health Planning Federation and the Miami Valley Health Systems Agency serve as principle sources of data.

Throughout the study, the involvement and influence of consumers is compared to the involvement and influence of health professionals. This approach was designed to determine whether the participatory disparities that characterized the CHP "B" agency councils have been replaced by the "equitable partnership" envisioned by Congress.

Major Findings: Governing Board Composition

More than 200 areawide Health Systems Agencies have been designated by the Department of Health, Education, and Welfare. All of the agencies have established governing boards and virtually all of the boards have consumer
majorities.

HSA governing boards tend to underrepresent women and to overrepresent minorities and consumers of high social, economic, and occupational status. Representation, however, was found to be informal and descriptive, as no trustee was accountable to a specific health care constituency. HSA providers were found to represent consumer as well as provider interests, although the evidence is not compelling. Finally, the refashioned definitions of consumer and provider have all but eliminated "closet providers," but may have created "closet consumers."

The overall composition of the HSA boards is very similar to the overall composition of the "B" agency councils the boards replaced. Similarities obtain for both consumers and providers and extend to the size of the governing bodies as well. These findings suggest that despite the law, many of the "B" agencies that became HSAs did little more to their governing bodies than change the name from "council" to "board."

**Major Findings: Involvement and Influence**

HSA consumers are less involved in agency affairs than are health professionals. They attend governing board meetings slightly less often, are less vocal at the meetings they do attend, contact fewer trustees and staffers during the periods between meetings, devote less time to agency
business, and more frequently resign their board memberships. Worth noting, however, is that the actual levels of consumer and provider involvement are not dramatically different. This suggests that HSA consumers are more involved in health planning activities than were their "B" agency predecessors. It also suggests that consumers have narrowed the gap in activity that had persisted, despite earlier efforts to create an "equitable partnership."

Measures of influence indicate that providers hold the formal leadership positions affording the greatest observability and tend to be more central in their agency's interaction network. Additionally, providers were named more often than consumers by trustees and the staff as the boards' most influential members. Providers appear to use their influence to dominate agency decisions.

In short, this research indicates that HSA consumers are less involved in agency affairs and much less influential in agency decisions than are health professionals. Consumers, in other words, continue to be "junior partners" in the areawide health planning process.

One explanation for these findings is that providers are more knowledgeable and articulate than consumers with respect to health care issues and use these personal resources to persuade consumers to accept policies they otherwise might not. Persuasion is effective because many
consumers believe that health professionals are experts deserving of deference and because few consumers distinguish between the expertise required to practice medicine and the skills required to plan effectively.

Furthermore, health concerns, though important, are intermittent for most consumers. They are not as clearly or continuously salient as, for example, the condition of housing or children's schools—situations that confront consumers daily. (143, p. 136) Consequently, the typical consumer is less likely to have (and to be strongly committed to) well-formulated health policy positions than is the typical provider, whose livelihood and professional opportunities may be directly affected by planning decisions. Arguably, this difference is partially responsible for the forceful appeals providers render at governing board meetings and for the lack of resistance to those appeals evidenced by consumers. Note also that, in the absence of strong commitments, consumers may view the "costs" of participating (e.g., the time required to prepare for and attend meetings) as particularly high—a factor that contributes to a lower level of involvement. (37, p. 370; 143, p. 128)

A related explanation for the research findings focuses on the statute itself: since the law does not specify how consumers shall be selected or require that they be accountable, and since most agencies have therefore employed
demographic characteristics as the primary criterion for choosing consumers, the consumers who are selected approach planning with no concrete health agenda, few resources other than those provided by the agency, no institutionalized channels of communication through which community needs and reports of trustee behavior can be conveyed, and little fear of being sanctioned for failing to represent specific health concerns adequately. The statute, in other words, permits (if not encourages) the selection of consumers who lack both a mandate and a mission. (143, p. 128; 126, pp. 3-4)

In contrast, most providers have a concrete health agenda as well as the incentives (e.g., financial and professional gain) and resources (e.g., information) to pursue it. (143, pp. 135-36) Those incentives and resources are tantamount to influence in the HSA decision making process.

Discussion

Given the presumed benefits of consumer participation, the domination of agency decisions by health care providers indicates that consumer participation needs to be strengthened. Though providers were found to be somewhat benevolent, is seems likely that benevolence will evaporate when consumer and provider interests conflict: few providers will encourage decisions that limit their professional prerogatives. It also seems likely that strengthened
consumer participation will increase the potential for planning decisions that are more responsive to consumer needs. Consider, for example, a board's behavior when reviewing a proposal by an Area hospital for the purchase of a CT scanner. Though some providers will oppose the proposal on the grounds that another (or their) institution is more deserving, most will not because opposition now may evoke opposition later, when the board considers proposals in which those providers have a special interest. Providers, then, may favor the purchase of the CT scanner whether or not it will significantly improve the quality of services available.

To consumers with no concrete health agenda, provider support may well be compelling: they are the experts and they do make sense. However, to consumers with a planning agenda and constituency support, provider recommendations may be less compelling, especially if the proposed purchase is inconsistent with needs expressed by constituents. The point here is a simple one: when consumer and provider interests conflict, active and influential consumers will be better equipped to challenge providers and, ultimately, to effect the outcomes of planning decisions.

That consumers will realize this potential is, of course, an empirical question that cannot be answered now. There is, however, evidence from other federal programs that suggests they may. Cole and Caputo (31, pp. 102-03), for
example, report that cities that did not encourage citizen participation in decisions concerning the allocation of general revenue sharing funds were "more likely" to allocate those funds for public safety functions. In contrast, cities that did encourage citizen participation were "more likely" to evenly distribute their revenue sharing dollars and to spend those dollars in such areas as street and road repair, parks and recreation, direct tax relief, and social and health services. Similarly, Van Horn (236, p. 112) reports in a study of the Community Development Block Grant Program, that a survey of 880 city and county officials found that citizen participation was viewed as the "most influential factor shaping the direction and development of their community development application. (see also: 58, 50) In short, both of these studies indicate that involved citizens can (and did) effect local decision-making processes.

One strategy for strengthening consumer participation is to "legislate a remedy"—to amend the Planning Act in such a way as to correct observed deficiencies. Three such remedies are offered below. Worth noting first, however, is that most of the findings in this research are based on data gathered during a one-year period from two Health Systems Agencies. Generalizations following from these findings should be accepted provisionally until similar findings emerge from studies of other agencies. Stated differently, this research—by virtue of its limited scope—does not
demonstrate that the consumers of all or even most of the HSA\textsuperscript{s} are less involved and influential than are their provider counterparts. As a consequence, only tentative recommendations for strengthening consumer participation can be offered here—tentative because additional research may prove them to be unnecessary or because they may fail to address major issues additional research brings to light.

A second point worth noting is that no legislative remedy of reasonable complexity can accommodate the variety of circumstances that probably exist in the more than 200 Health Service Areas nationwide. The Areas range in size from several counties to an entire state, and a few encompass metropolitan areas straddling two states. Within these Areas, the availability of interested and capable consumers and of well-trained staff vary widely. The types and severity of health care problems, the level of community support for planning, the availability of health resources, and the attitudes of providers vary widely also. Such variation is likely to render many legislative remedies difficult to implement, unreasonably rigid, and frequently inappropriate.

Moreover, as consumers become more familiar with their roles and responsibilities, as the composition of governing boards change through election and resignation, and as health professionals develop new techniques for circumventing the constraints imposed by planning, the
relationship between consumers and providers may shift in unpredictable ways. These shifts may transform a remedy that now seems desirable into rules and regulations that are excessively intrusive. Finally, the legislative history of health planning suggests that legislating participation is no easy task—not only because those threatened by involved consumers tend to resist that involvement, but also because consumers themselves rarely exhibit a firm and sustained commitment to the planning process.

The point here, simply, is that legislative remedies, though potentially effective, offer no guarantees: they may "promise" to strengthen consumer participation, but whether they actually will is far from certain.

The recommendations offered below are offered with an appreciation for the difficulties their implementation would entail—and with the understanding that modifications based on Area-specific circumstances may be necessary. Moreover, they are offered less as discrete or mutually exclusive suggestions than as suggestions likely to be most effective if implemented concurrently. Finally, an assumption underlying all of the recommendations is that legislative remedies, despite their potential limitations, are apt to be more productive than voluntary action.
I. Accountability and Constituency Representation

Procedures for selecting HSA consumers should emphasize accountability and the representation of health care constituencies, rather than demography. Such procedures might take the following form.

First, each HSA should permit all organized groups within its Health Service Area that claim to speak for a distinct health care constituency (e.g., the handicapped, the poor, the aged) to petition the agency for permission to elect a consumer representative. To qualify for a representative, a group would be required to demonstrate that its officers are consumers (as defined by P.L. 93-641), that its principle sources of income are not providers (again, as defined by P.L. 93-641), and that it speaks for a significant number of Area residents.

Second, each agency should allocate a portion of its consumer seats to the petitioning groups, drawing randomly (without replacement) if the number of petitioners exceeds the number of seats available. In those Areas where the number of petitioners does exceed the number of seats, groups not selected initially would be considered for selection in subsequent drawings. Finally, when groups have been selected they would elect (or appoint) a consumer representative.

These "group-consumers" would serve staggered, two-year terms and would not be eligible for re-election until all
petitioners had elected a trustee. However, all "group-consumers" would be subject to recall.

The remaining consumer seats should be filled by consumers elected "at-large" from specified areas within the Health Service Area in a manner similar to the election of local school boards. These consumers also would serve for staggered two-year terms, but, unlike "group-consumers," they would be eligible for re-election.2

These procedures for selecting consumers are likely to strengthen consumer participation. First, since all consumers will serve and be accountable to health care constituencies they are likely to approach planning with (and be committed to) a concrete, well-formulated health agenda that can guide evaluations of agency planning documents as well as specific proposals that come before the board. Moreover, since some consumers may be removed from the board by recall, and others by election, they all should be sufficiently motivated to monitor their constituents needs and to express (or defend) those needs at governing board meetings. Commitment and sanctions may also stimulate oral expression and attendance at meetings as well as contacts with the staff and other trustees.

Second, "group-consumers" are likely to possess resources other than those made available by their agency. Some groups, for example, might provide their trustee with the means to gather "independent" data, with specialized
training, or with a forum for discussing their planning activities. Quite possibly, these resources can be parlayed into influence.

Third, the limitation on the number of terms "group-consumers" may serve should guarantee a "circulation of interests" by affording every group within a community that seeks (and is eligible) to elect a trustee the opportunity to do so—even though some groups will not realize that opportunity for several years. A "circulation of interests" is important to the extent that it broadens the range of consumer needs expressed at governing board meetings.

Fourth, consumers chosen "at-large" are likely to be political activists and, as such, to remain involved in agency affairs throughout their terms. Moreover, since these consumers will represent a wide range of interests—including some that are represented by "group-consumers"—they are likely to recognize the need for compromise. Consequently, these consumers may serve to buffer the inflexible behaviors often associated (Vladeck, Klarman, Pifer) with "interest group representatives."

Finally, the election process itself is likely to stimulate community awareness of HSA activity. This, in turn, may deter providers from making decisions without considering community needs. An awareness of HSA activity may also result in new community groups composed of
consumers who feel the need to strengthen their voice in the HSA decision making process. (These points are discussed in greater detail below.)

Whether the recommended procedures for selecting consumers would actually strengthen consumer participation is, of course, an empirical question—a question that cannot be answered unless the new procedures are tried. There is, however, some evidence which supports the claims made for them. Marmor and Morone (143, pp. 144-45), for example, report that the experience of the Community Action Programs (CAPs) shows that selection of consumers by groups tended to produce "independent and competent boards" as well as consumers who were "able," who demonstrated a "universalistic orientation," and who were less susceptible to co-optation. Furthermore, Knox (126, p. 3) indicates that the experience of health service delivery programs funded through Model Cities grants shows that "consumers are significantly more influential in determining agency policies if they have a clearly identified constituency."

Yet all of the evidence is not so favorable. For example, Blum (27, p. 444) argues that "self-selection by...groups holds many risks." Not all organizations, he explains,

choose representatives who are interested or capable of participating in planning. Many organizations perfunctorily appoint the person who has the particular officeship or
committee duty that appears to be related to this matter; a few will appoint their most antagonistic or disruptive member, or, as punishment, their most derelict, nonattending member.

Others have argued that the public election of consumers is also problematic, for those who vote may be moved to do so by personal, not policy, considerations. Marmor and Morone (143, p. 146) contend that this was true of CAP board elections in Philadelphia: "Overwhelmingly," community residents voted for their neighbors and other personal acquaintances. And, as a consequence,

the policy formulated by these representatives was...overwhelmingly particularistic. It helped their friends, not the community or the interests they ostensibly represented. Representatives generated little community interest or support. They tended to be ineffective advocates and operatives.

In short, the available evidence suggests that before the recommended procedures for selecting consumers are adopted wholesale, they should be implemented on a limited and experimental basis.

II. Training Programs

HSA programs for training consumers should be expanded and intensified. The programs should deemphasize technical knowledge and stress how consumers can operate more effectively in the planning and decision making process. Training should stress, in other words, how consumers can
steer the process in a direction consistent with community needs. Training should also stress the need to establish regular contacts between consumers and health professionals. For example, consumers should be encouraged (or required) to attend meetings of hospital boards of trustees and of hospital administrators.

Training programs are likely to benefit consumers in several ways. First, they may enable consumers to feel and to be more efficacious when dealing with health professionals. Second, if Milbrath and Goel (158, p. 58) have correctly identified a relationship between feelings of efficacy and political activity, it is likely that training programs will stimulate the involvement of consumers in agency affairs. Finally, frequent contacts between consumers and health professionals may result in a sharing of information which traditionally providers have monopolized.

Though it may be possible for agency staff to develop training programs, the HSAs should not be reluctant to seek assistance from Area universities and from other planning agencies. Additionally, the HSAs should exploit the resources of HEW's Bureau of Health Planning and Resources Development.

Extensive training is time-intensive: attending additional meetings and training sessions, assimilating training materials, and contacting health professionals may add several hours per week to the time already required to
prepare for and attend governing board meetings. Worth noting, however, is that consumers elected either by groups or Area residents are more likely than other consumers to have both the incentive and commitment to tolerate these demands.

III. Community Mobilization

HSAs should develop programs aimed at stimulating community support for the health planning process. According to Checkoway and Doyle (29, p. 221), such support is a "central factor" for consumers seeking influence in HSA decisions. Knox (126, p. 4) adds that the involvement of "community people" can significantly effect an agency's decisions. And Douglass (52, p. 161) contends that "If...community residents [are] active and aware, the interface between residents and health professionals [will]...result in more consumer-oriented programs." A mobilized community, he explains, is "indirectly" influential because it causes providers to consider community reaction when evaluating policy alternatives. A mobilized community is also influential to the extent that community residents monitor the performance of and express their health concerns to their consumer representatives.

Stimulating community support will not be easy: few consumers view health care as a community problem; most do not believe that health professionals or health institutions
(i.e., the presumed "targets" of planning activities) are responsible for their own health difficulties; and many may be hostile or cynical toward political involvement. Furthermore, the health establishment may seek to neutralize the potential impact of mobilized communities by co-opting community leaders. (137, p. 89)

To overcome these obstacles, mobilization programs should (1) emphasize that every community resident will benefit from planning, (2) stress the agency's visible accomplishments, (3) minimize the limits of consumer participation, (4) minimize challenges to local leaders, and (5) characterize planning as experimental and socially innovative. (This may offset any residual skepticism from the CHP "B" agency experience.) (137, pp. 90-93) The HSAs should also sponsor conferences, some of which bring together community residents and the governing board for discussions of local health concerns, and others which bring together residents of different neighborhoods. The agencies might also publish detailed accounts of their activities in local newspapers, distribute informative, health-oriented literature to Area residents, and survey Area residents about their health care needs. (21, p. 464) Finally, the HSAs should employ "community forums" designed to educate consumers about important health care issues. Forums will provide information, increase community awareness, and establish a dialogue between the community and the
Mobilizing community support for the health planning process can be seen, in Schattschneider's terms (193), as "expanding the scope of conflict"—as increasing the number of participants in agency decisions (albeit indirectly) for the purpose of altering decision outcomes. Obviously, such an expansion can strengthen consumer participation only if the additional participants 1) are aware that consumer and provider interests conflict (when they do) and 2) bring to the conflict resources that consumer representatives can convert into influence. An aroused community, arguably, satisfies these conditions.

The point here is that "expanding the scope of conflict" is a strategy available to consumers to strengthen their voice in planning. As such, consumers may benefit by employing it more widely: when interests conflict, consumers should mobilize actors and agencies (other than Area residents) who are not ordinarily involved in planning, but who can be aprised of the conflict and who have resources that may prove useful.

Since the specific actors and agencies that may be mobilized are likely to vary in different Health Service Areas, the consumers of each governing board will need to determine whose support should be enlisted. In most Areas, however, the print and electronic media will probably be an appropriate target. Indeed, media representatives can
publicize planning controversies and report on the proceedings of governing board meetings. They can also conduct investigate studies of the probable impact of decision alternatives, gather information on community needs, and educate the public with respect to the benefits of planning. These activities are likely to strengthen the voice of consumers by further stimulating community support and by attracting the attention of potentially sympathetic community elites. (Of course, it may also attract the attention of community elites who are not sympathetic.)

When planning issues are especially controversial, consumers might enlist the aid of state and local elected officials as well as candidates for public office. More specifically, consumers may encourage officials and candidates to "take and stand" and to suggest alternatives acceptable to actual and potential constituents by moving planning controversies into the electoral arena. Officials sympathetic to consumer needs might pressure providers by threatening litigation or legislation inimical to provider interests. For example, governors might threaten to initiate legislation that would regulate certain aspects of health care delivery, or that would increase the difficulty of obtaining Certificates of Need.

Though providers may be better equipped than consumers to engage in electoral politics (typically, providers are more organized and active), the electoral process should not
be ignored a priori. In other policy areas, such as environmental protection and abortion, for example, citizens have succeeded in persuading officials to act in the "public interest," despite the fact that opponents were well-organized and resistent to change.

Governors might also be encouraged to sponsor symposiums for all HSA consumers statewide. The symposiums could be organized around reports of the obstacles consumers have encountered in dealing with providers and of effective strategies for overcoming those obstacles. In effect, the symposiums could serve as a centralized clearinghouse for reports of "natural experiments"—experiments from which all consumers might benefit.

A third potential source of assistance is an Area's Professional Standards Review Organization (PSRO). This body gathers information in Area providers—information that would assist consumers in developing plans and in reviewing provider requests. Though P. L. 95-142 grants consumers access to these materials, few consumers have actually obtained them. Furthermore, consumers should develop working relationships with members of the PSROs for the purpose of increasing their knowledge of the health care system. (9)

Finally, consumers might enlist the support of powerful community leaders. Presidents of large corporations, labor unions, and financial institutions, for example, could be lobbied for assistance. That assistance may take the form of
pressure applied to particularly self-serving providers or of promises of special consideration for cooperative providers when they are seeking loans or contributions for other projects.

Consumer participation in areawide health planning may well be a necessary ingredient in any successful effort to rationalize the American health care system. Congress, the equal-health advocates, and many members of the academic and health communities all appear to think so. Yet even with highly involved and influential consumers the HSAs may be ill-equipped to fulfill their statutory mission, for much of what occurs in local health care markets is beyond their jurisdiction. For example, the HSAs have little real regulatory power, cannot control the terms of reimbursement, cannot compel sub-standard facilities either to close their doors or to improve their services, and, in the absence of proposals submitted by health providers, cannot decide where new facilities shall be located. Moreover, the HSAs have no mechanism for preventing organizational issues and project review from dominating agency agendas and no effective tools for overcoming the health profession's deep-seated resistance to change.

Further still, the agencies have little incentive to contain health care expenditures because providers benefit directly from those expenditures and because third-party payers relieve consumers of the full financial consequences
of their decisions. Indeed, the reasoning here goes far to explain Havighurst's comment (93, p. 194) that both consumers and providers are "equally content to see more and better health services made available without much regard to cost." It also explains why groups which presumably have an interest in cost containment (e.g., Blue Cross, unions, and major employers) are unlikely to be effective, despite their presence on most agency boards. (71, p. 363)

One conclusion that follows from these observations is that it may be necessary to involve consumers in other efforts to rationalize the health care system if a system responsive to consumer needs is ever to be created. Stated differently, consumer participation in areawide health planning may not be a sufficient condition for significant change in the health care system.

Where else can consumers be involved? First, legislation authorizing a state to regulate Blue Cross rates (such as Ohio's H. B. 448 that was enacted in 1976 by the General Assembly) might include provisions for consumer participation in rate review decisions. These provisions should allow consumers to serve on Blue Cross boards, to express opinions at convenient public hearings, and to appeal rate increases approved by the Department that consumers judge to be excessive. The provisions should also require Blue Cross to encourage consumer participation in rate review decisions through education and
advertising. (40)

The rationale for these provisions rests on the assumption that health care consumers will be more active advocates of cost containment if they are given a voice in decisions that effect them financially. Since many consumers pay for Blue Cross coverage either directly or through their employers, consumers are very likely to exploit the opportunities the provisions provide. Moreover, since Blue Cross can sanction health care institutions that fail to adhere to the plans of Health Systems Agencies, it seems likely that consumer representatives on Blue Cross boards will encourage the boards to use their sanctions when the need arises.

A second (and potentially more powerful) arena for consumer participation is an open and competitive health care marketplace—a marketplace that allows consumers to choose health professionals who provide quality service at the most reasonable cost. A marketplace, in other words, that rewards providers who hold down costs without decreasing the quality of service provided. One approach to a competitive marketplace has been the creation of Health Maintenance Organizations (HMOs). According to Feder (71, p. 131), HMOs 1) assume a contractual responsibility to provide or assume the delivery of a stated range of health services, 2) serve an enrolled, defined population, 3) have voluntary enrollment of subscribers, 4) require a fixed periodic
payment to the organization that is independent of use of services, and 5) assume at least part of the financial risk and/or gain in the provision of services.

HMOs make intuitive sense as a means for cost control because they alter the usual economic incentives in medical care and give providers a stake in holding down costs. This is especially true when HMO incentives are compared with those in a system of extensive third-party reimbursements. (71, p. 136) Moreover, since several HMOs may be established in an area (along with the traditional Blue Cross plans) and since they are based on voluntary enrollments, they give consumers an important role in determining the quality and costs of services available. The point here, simply, is that HMOs may well foster a cost effective health care system that is responsive to consumers, and therefore should be encouraged.

These suggestions for involving consumers in areas other than planning are by no means the only suggestions that might be offered— it might be possible, for example, to establish agencies or regulating the activities of health care institutions and to include consumers on the boards of those agencies. Nevertheless, these suggestions should indicate that state and federal policymakers who are interested in reshaping America's health care system through consumer participation have a variety of avenues open to them.
ENDNOTES

1. In most agencies a nominating committee, appointed by the president and composed of agency members (who may also be governing board trustees), nominates a slate of candidates. The nominated consumers are considered by the committee to be "broadly representative" of Health Service Area residents. Since P. L. 93-641 requires that consumers be "broadly representative," but defines the term only by reference to demographic characteristics, those characteristics are the critical element in consumer nominations.

At an Annual Meeting the agency's full membership votes on the committee's slate. If a majority approves it, the nominees become the board. Otherwise, slates are accepted from the floor. Note, however, that slates judged by the president to violate the composition requirements are ruled "out of order."

2. Clearly, the recommended procedures apply only to the selection of consumers. The procedures for selecting providers should remain as they are. This recommendation is supported by Douglass (54) who demonstrates that providers elected by provider organizations tend to be less "consumer oriented" than providers recommended by nominating committees. Moreover, public elections are likely to produce providers who have financed their campaigns with resources contributed by provider organizations. Arguably, these providers would be no more consumer oriented than providers directly elected by those organizations.
APPENDIX A:

TRUSTEE QUESTIONNAIRE

Name: ______________________
Phone: ______________________
Id #: ______________________

Agency.
1. CORVA
2. Miami Valley
3. Mid-Ohio

Type of member.
1. consumer
2. direct provider
3. indirect provider

Sex.
1. male
2. female

Residence.
1. metropolitan
2. non-metropolitan

County of residence. ______________________

Distance code. ______

Term began. ______________________

Term ends. ______________________

Day of interview. ______________________

Month of interview. ______________________

Time of interview. ______________________

Length of interview. ______________________

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1. First, could you tell me if the monthly meetings of the Board of Trustees are held at a time and place that is convenient for you?
   1. yes
   2. no (GO TO 1a)
   8. DK
   9. NA

1a. (IF "NO") Could you tell me why they are not convenient?

2. How about committee meetings: are they held at a time and place that is convenient for you?
   1. yes
   2. no (GO TO 2a)
   8. DK
   9. NA

2a. (IF "NO") Could you tell me why they are not convenient?

3. In general, how frequently would you say you ask a question or offer an opinion at the governing board meetings you attend? (READ ALTERNATIVES)
   1. once or twice a meeting
   2. two or three times
   3. four or five times
   4. more than five times
   8. DK
   9. NA

4. How often would you say you ask a question or offer an opinion at the committee meetings you attend? (READ ALTERNATIVES)
   1. twice a meeting or less
   2. three to six times
   3. seven to ten times
   4. more than ten times
   8. DK
   9. NA

5. Not counting the hours you spend in board and committee meetings, about how many hours a month do you usually devote to agency business?
   __________ hours

5a. Could you tell me what kinds of things you do during this time? (PROBE) Anything else?

5b. What proportion of those __________ hours do you spend on each of these activities?
6. Prior to each meeting of the governing board you receive from the agency a packet containing information about the issues that will be discussed. How often would you say you receive this packet early enough to study its contents carefully? Would you say almost always, often, not often, or hardly ever?

1. almost always  
2. often  
3. not often  
4. hardly ever

B. DK  
9. NA

7. When these materials do arrive early enough, would you say you examine them very carefully, carefully, not very carefully, or not carefully at all?

1. very carefully  
2. carefully  
3. not very carefully  
4. not carefully at all

7. It varies; depends on the issues

B. DK  
9. NA

8. To what extent do the people you work for encourage you to attend governing board and committee meetings? Would you say they actively encourage you to attend, are indifferent, or actively discourage your attendance?

1. actively encourage  
2. are indifferent; not aware of board membership  
3. actively discourage

6. self-employed  
7. not employed outside the home

B. DK  
9. NA

9. What do you personally think are the most important goals of health planning? (PROBE) Could you be more specific?

10. Would you say these goals are reflected in the latest HSP and AIP prepared by your agency very well, moderately well, less than moderately well, or not well at all?

1. very well  
2. moderately well  
3. less than moderately well  
4. not well at all

B. DK  
9. NA

11. How would you characterize the performance of agency staff in assisting both the governing board and committees? (PROBE) Could you elaborate on that?
12. How often do you contact a staff member during the time between board and committee meetings? (READ ALTERNATIVES)

1. once or not at all
2. two or three times
3. four or five times
4. more than five times

7. depends
8. DK
9. NA

13. Could you tell me which members of staff you most frequently discuss agency business with during the time between board and committee meetings? (PROBE) Anyone else?

________________________________________

________________________________________

14. With which Trustees do you most frequently discuss agency business during the time between board and committee meetings? (PROBE) Anyone else?

________________________________________

________________________________________

15. How often do you feel well-informed or knowledgeable about the proposals you vote on at the governing board meetings you attend? Would you say you feel well-informed almost always, often, not often, or hardly ever?

1. almost always
2. often
3. not often
4. hardly ever

8. DK
9. NA

16. How about issues directly related to the development of the HSP and the AIP: how often do you feel well-informed or knowledgeable about these issues when they come to a vote? Would you say almost always, often, not often, or hardly ever?

1. almost always
2. often
3. not often
4. hardly ever

8. DK
9. NA

17. How often do you feel well-informed or knowledgeable about the issues being discussed at the committee meetings you attend? Would you say almost always, often, not often, or hardly ever?

1. almost always
2. often
3. not often
4. hardly ever

8. DK
9. NA
18. In general, do you feel that the other Trustees value the opinions you express at board and committee meetings?

1. yes
2. sometimes
3. no (GO TO 18a)

18a. (IF "NO") What makes you think this?

19. Now I would like to read you several statements. For each statement would you tell me if you strongly agree, agree, disagree, or strongly disagree?

a. Consumers on the governing board do a good job identifying the health needs of consumers in your agency's Health Service Area.

b. Providers on the board do a good job representing the health professionals in your agency's Health Service Area.

c. Providers tend to dominate the activities of the project review committee.

d. Providers tend to dominate the activities of the plan development committee.

19a. (IF C OR D IS "SA" OR "A") Why do you think that is?

20. In what ways do you think consumers contribute to the health planning process?

21. Generally, when decisions are made on proposals for capital expenditures, how important would you say each of the following actors are in that process? I would like you to choose from very important, important, not very important, and not important at all.

a. how about sub-area councils or committees

b. regional planning agencies

c. the executive committee

d. the project review committee

e. the governing board

f. staff
21a. (IF MORE THAN ONE "VER Y IMPORTANT") Which of these actors would you say is generally most important?

1. sub-area councils/committees
2. regional planning agencies
3. the executive committee
4. the project review committee
5. the governing board
6. staff

7. depends on the proposal
8. DK
9. NA

22. In your capacity as a governing board Trustee, what organizations or groups do you feel you represent? (PROBE) Could you be more specific?

22a. (IF A GROUP IS MENTIONED) How do you learn what the interests of this group/organization are?

23. I would like to read you a short list of functions HSAs are required to perform. Would you locate for me each function on an imaginary thermometer where 100° means that you personally think that the function is very important and 0° means that you think it is not important at all. I would like you to place each function at a different degree.

a. how about gathering and analyzing data; where on the thermometer would you place that _________

b. developing an HSP and an AIP _________

c. reviewing 1122 proposals _________

d. working with individuals and organizations in the community to achieve the goals stated in the HSP and AIP _________

24. How I would like you to imagine another thermometer. This time 100° means that the agency as a whole considers a function to be very important and 0° means that the agency considers it not important at all. Again, I would like you to locate each function at a different degree.

a. how about gathering and analyzing data _________

b. developing an HSP and an AIP _________

c. reviewing 1122 proposals _________

d. working with individuals and organizations in the community to achieve the goals stated in the HSP and AIP _________

25. In your opinion who are the most influential or powerful Trustees? (PROBE) Anyone else?
25a. Could you tell me what makes you think these individuals are influential? (PROBE) Could you be more specific?

26. How often would you say the substantive issues the agency deals with are controversial? Would you say almost always, often, not often, or hardly ever?

1. almost always
2. often
3. not often
4. hardly ever
5. DK
6. NA

26a. (IF "VERY OFTEN" OR "HARDLY EVER") Why do you think that is?

27. Off hand, could you give me an example of a recent issue you personally thought was controversial? (PROBE) Can you be more specific?

28. When a controversial issue is being discussed, would you say that generally providers support one side and consumers the other, or would you say that each side is supported by providers and consumers?

1. same side (GO TO 28a)
2. different sides
3. depends on the issue
4. DK
5. NA

28a. (IF "SAME SIDE") How likely is it that those providers who side together on one controversial issue will again side together on other controversial issues? Would you say it is very likely, likely, not very likely, or not likely at all?

1. very likely
2. likely
3. not very likely
4. not likely at all
5. DK
6. NA

29. In your opinion, does the board of Trustees as a whole represent all of the major consumer and provider groups in your agency's Health Service Area?

1. yes
2. no (GO TO 29a AND 29b)
3. DK
4. NA
29a. (IF "NO") Could you tell me what groups are not represented?

29b. (IF "NO") What do you think is the reason these groups are not represented?

30. Now I would like to read you several statements about the agency's staff. For each statement would you tell me if you agree strongly, agree, disagree, or disagree strongly?

   a. agency staff respond to your questions thoroughly and competently
      AS A O DS DK NA
      1 2 3 4 8 9
   b. agency staff present information in a manner that is easy to understand
      AS A O DS DK NA
      1 2 3 4 8 9
   c. agency staff have been well-trained for their jobs
      AS A O DS DK NA
      1 2 3 4 8 9
   d. agency staff are cooperative
      AS A O DS DK NA
      1 2 3 4 8 9
   e. agency staff occasionally withhold relevant information
      AS A O DS DK NA
      1 2 3 4 8 9

In concluding this interview, I would like to get some more information about you.

31. First, what agency committees do you serve on? (PROBE) Any others?

   __________________________
   __________________________
   __________________________

32. What is your primary occupation?

   __________________________

33. (CONSUMERS ONLY) Have you ever held a paid position where you were involved in providing health care services?

   1. yes (GO TO 33a.)
   2. no
   3. DK
   4. NA

33a. (IF "YES") Could you tell me what that position was?

   __________________________
34. Do you serve on any health-related boards or committees not directly associated with your HSA? (IF "YES") Could you tell me what they are? (PROBE) Any others?

_______ number of boards served on

_______

_______

_______

_______

35. Do any members of your immediate family serve on any health-related boards or committees? (IF "YES") Could you tell me who and on what boards they serve?

_______ number of boards served on by family

_______

_______

_______

_______

36. If you are married, could you tell me your spouse's occupation?

_______

37. How many years of formal education have you completed?

_______

38. In which of the following age groups are you? (READ ALTERNATIVES)

1. 15-34
2. 35-44
3. 45-64
4. 65 and over
5. refused
6. NA

39. Last year, what was your family's total income, before taxes? (READ ALTERNATIVES)

1. under $10,000
2. $10,000-$14,900
3. $15,000-$24,900
4. $24,000-$39,900
5. $40,000 or more
6. refused
7. DX
8. NA

40. Finally, what is your race?

1. white
2. black
3. other: _________________________
4. refused
5. NA
APPENDIX B:

STAFF QUESTIONNAIRE

Name: __________________________
Date: __________________________
Agency: _________________________
Title: __________________________

1. How long have you been with ________________?

2. Do you have any formal training in health planning?

3. Where did you go to school? What degrees did you receive?

4. Before coming to ________________ where were you employed?

Now I'd like to turn your attention to the consumer members on the board.

5. In your opinion, do the consumers represent organized interests or constituencies, or do they represent "grass-roots" consumers?

6. What kind of job have the consumers done in identifying the health needs of consumers in your Health Service Area?
7. How have consumers contributed to the health planning process? Has their contribution been a valuable one? Will their contribution become greater in the future?

8. Do you think the consumers on the board are intimidated by the providers? Why? Will this change in the future?

Now I'd like to talk a little about the providers.

9. Do you think they have done a good job representing the health professionals in your Health Service Area?

10. In your opinion, do the providers tend to dominate agency activities at committee or board meetings? How so? Why?

11. Have the regulations for the composition of the governing board made it difficult to find good people?

12. In your opinion, who are the most influential or powerful trustees?

13. In general, which trustees contact you most often, consumers or providers? Can you name the trustees who contact you most often?

14. For what reasons do trustees contact you? Who contacts you more often for information, consumers or providers? Who contacts you more often to express opinions?
15. Would you say that consumers are more dependent than providers for staff support? Why? Are consumers more ready to agree with staff recommendations and suggestions? Are providers more demanding and critical of staff?

16. How often would you say the substantive issues the agency deals with are controversial? What makes an issue controversial? Is there an underlying or common thread?

17. When controversial issues do arise do they divide trustees along consumer/provider lines? Along urban/rural lines? Does the governing board contain any persisting coalitions? Can you indentify them?
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