Consumer and provider representatives in comprehensive health planning
by Donna Jean Schramm Ensrud

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University
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Abstract:
The problem dealt with in this study was the role of consumer representatives in the health care delivery system. The purpose of the study was to investigate the characteristics, motivations, and levels of satisfaction experienced by consumer and provider representatives in Comprehensive Health Planning at the areawide level in Montana.

Data was collected by use of a survey questionnaire devised by the researcher and sent to the one hundred sixty seven (167) areawide council representatives in Montana.

The questionnaire requested 17 closed-ended responses and 3 open-ended responses relating to the representative's characteristics, motivations, and level of satisfaction with their participation in Comprehensive Health Planning.

A total of one hundred and thirty three (133) questionnaires (79%) were returned between September and November 1974 when tabulation of data began. Library programs were used in the cross-tabulations and frequency distributions were developed from responses of the consumer and provider groups. Analysis of data revealed that there were no significant differences in characteristics, motivation or level of satisfaction between the two groups.

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Date April 24, 1975

CONSUMER AND PROVIDER REPRESENTATIVES IN COMPREHENSIVE HEALTH PLANNING

by

DONNA JEAN SCHRAMM ENSRUD

A thesis submitted in partial fulfillment
of the requirements for the degree

of

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To my daughters, Keri and Jami, as we begin new adventures in our life together as a family, I dedicate this work.

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ABSTRACT

The problem dealt with in this study was the role of consumer representatives in the health care delivery system. The purpose of the study was to investigate the characteristics, motivations, and levels of satisfaction experienced by consumer and provider representatives in Comprehensive Health Planning at the areawide level in Montana.

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Chapter 1

THE PROBLEM AND ITS SETTING

INTRODUCTION

The trend toward "consumerism," or consumer participation in many aspects of American life today is a reflection of diverse factors. In recent years there has been an increase in political awareness by segments of society who had been content to leave the conduct of many important affiars up to others. The demand for public involvement as a technique for making organizations more responsive to the groups they serve has been a striking development in the United States.[1] As a result of this general trend, persons not heretofore actively involved in the health care delivery system are now assuming new roles.

Some consumer participation has long been a part of the health care system. Persons acting as representatives of the consumer of health services have served in various capacities, ranging from advisory side-lines roles to actual policy initiating roles. These consumer roles have traditionally been filled by persons representing the more

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[1]Herbert Kaufman, "Administrative Decentralization and Political Power," Bureaucratic Power in National Politics, ed. F.E. Rourke (Boston: Little, Brown and Co., 1972), 2d ed., p.380.

powerful, already organized segments of a community. In the past, consumer representatives had often been ineffective in decisively influencing the delivery of care at the patient-therapist level.

The role of the consumer as a substantive participant in the delivery of health services has become more evident with the advent of Comprehensive Health Planning and the initiation of various projects under the Office of Economic Opportunity. From its inception, Comprehensive Health Planning was to depart from the traditional, elite-dominated, facility-centered health planning.[1] Many health care providers have resisted the current trend towards "consumerism" which they see as the "politicalization" of health care or as a threat to the quality of care.[2] In general the new form of consumer participation has not been as effective as predicted or anticipated. The Montana State Low-Income Health Task Force Report of 1971, cites as one of the major barriers preventing the health care delivery system from dealing with

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[1]John Ehrenreich and Barbara Ehrenreich, The American Health Empire: Power, Profits, and Politics. (New York: Random House, 1970), p. 210.

[2]Anne R. Somers, Health Care in Transition: Directions For the Future. (Chicago: Hospital Research and Educational Trust, 1970), p. 82.

the health problems of the medically indigent the limited sanction for the involvement of consumers especially low-income consumers, in decisions and planning affecting the health care delivery system.[1]

At the Montana Governor's Conference on Health Care Systems in 1970, James Kent asserted, "There are very few places where there is meaningful consumer participation."[2] This result has not been unexpected by some providers who feel good health care can be achieved just as effectively and at less expense (monetary and human) without consumer involvement. The actual role of the consumer representatives involvement in the health care system has not been thoroughly investigated or described in a manner which might provide a basis for making their participation more effective.

The Need for the Study

There may be many reasons to account for the ineffectiveness of consumer involvement in the health care system.

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[1]Montana State Low-Income Health Task Force Report, Part 1, prepared by Jim Parker, Montana Comprehensive Health Planning Advisory Council, Helena, Montana, December, 1971, p. 41.

[2]James Kent, "Medical Care as Seen by Consumers," Montana Governor's Conference on Health Care Systems, Helena, Montana, April 1971.

The lack of substantive achievement by consumer participation could be attributed to:

1. Persons fulfilling the consumer representative roles are using this method of obtaining other goals--such as to be treated like an equal citizen of society or to influence the entire health system or health services establishment.
2. Consumer representatives defer to the judgment of providers who are seen as experts within the health care field.
3. There may be misunderstandings between the consumer and provider groups as to the real motivations behind the involvement of individual group members.

The Statement of the Problem

The recent trend towards consumer participation in the health care delivery system has been termed ineffectual. In Montana little is known as to the characteristics of persons who assume consumer or provider representative roles in the planning of health care. In a democratic society, an attempt to assure citizen participation in one of it's most important institutions deserves investigation. This study is an investigation of the characteristics, motivations, and level of satisfaction experienced by consumer and provider

representatives in Comprehensive Health Planning at the areawide council level in Montana.

The Purposes of the Study

The purposes of this study are:

1. To identify the characteristics of the consumer and the provider representatives in Comprehensive Health Planning at the areawide council level in Montana.
2. To determine what motivates an individual to assume the roles of a consumer or provider representative in Comprehensive Health Planning at the areawide council level in Montana.
3. To compare the level of satisfaction experienced by consumer and provider representatives in Comprehensive Health Planning at the areawide council level in Montana.

Assumptions

Basic assumptions on which the problem was approached were:

1. Consumer involvement in the health care system is a current trend.

2. In a democratic society, persons have the right and responsibility to participate in the making of decisions which effect them.

Definition of Terms

Inorder to clarify terminology used throughout this study, the following definitions were established:

1. Provider--one who earns a living through the provision of health services.
2. Consumer--one who does not earn a living by the provision of health services and who does or may use the services of providers.
3. Health Care System--The totality of resources a population or society distributes in the organization and delivery of health services.[1]

Limitations of the Study

This study will deal only with the responses elicited from the limited population of those persons who have served as a regional or state advisory council consumer or provider representative as designated by the Montana office of Comprehensive Health Planning.

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[1]Samuel Levey and N. Paul Loomba, Health Care Administration (Philadelphia: J. B. Lippincott Company, 1973). p. 4

Chapter 2

REVIEW OF LITERATURE

Consumer participation in the delivery of health care is based on Lewin's theory that people who participate in identifying a problem and thinking through a proposed solution will be more committed to carrying out that solution. According to Lewin, the involved person will be less resistant to change and will have increased opportunities for learning.[1] Consumer influence today is reflected in demands for increased participation in many of society's institutions. According to some authors, participation and involvement by many is slowly replacing decision-making by a few in health care.[2]

Consumer demands to share in decision-making in the health care delivery system are predominately social issues, not medical issues. Segments of the population, such as minority groups and poor people are increasingly demanding full and equal access to all the resources and services that society is capable of providing. Until recently these

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[1]Kurt Lewin, The Principles of Topological Psychology (New York: McGraw Hill, 1936).

[2]Antonette Adam, "Revise and Consent," American Journal of Nursing, 64 (January, 1964), 85.

people played essentially passive roles and had been largely deprived of society's benefits.[1] Accessibility to high quality health services is, however, not the only issue, perhaps it is not even the most important or urgent issue. Such demands of the users of health care are due to an awakened and steadily growing need and desire to live and feel and be treated as equal citizens of society.[2] Consumer participation not only reflects organizational change within today's institutions generally, but as individuals such activity is sometimes seen as a method of advancement within one's own career field outside of health care.[3] Studies done on Neighborhood Health Centers are seen as examples of new institutions which provide popular participation in and control over the formation of social policy.[4]

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[1]G. M. Hochbaum, "Consumer Participation in Health Planning: Towards Conceptual Clarification," American Journal of Public Health, 59 (August, 1969), 1970.

[2]Ibid., p. 1966.

[3]Nancy Milo, "Dimensions of Consumer Participation and National Health Legislation," American Journal of Public Health, 65 (April, 1974), 360.

[4]Eugene Feingold, "A Political Scientist's View of the Neighborhood Health Center as a New Social Institution," Medical Care, 8 (March/April, 1970), 108.

DECISION-MAKING IN HEALTH CARE

The sharing of decision-making in the delivery of health care results in problems because of different and conflicting attitudes and expectations between the groups involved. For the most part, health care in the United States is organized so that it is the provider of services rather than the user that sets the conditions and specifies the terms of necessary health care.

Medical care is characterized by professional monopolies with severe restrictions on the flow of information and competition, and the regulation of supply or services and the conditions of provision.[1] The law, custom or an official status within an organization entitles certain professionals (mainly physicians specialists and health research workers in medical schools and universities) to monopolize certain kinds of work. They can be called "monopolistic" because they have nearly complete control over the conditions of their work, buttressed by the traditions of their profession and/or institutions.[2]

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[1]David Mechanic, Public Expectations and Health Care: Essays on the Changing Organization of Health Services. (New York: John Wiley and Sons, Inc., 1970)

[2]Robert R. Alford, "The Political Economy of Health Care: Dynamics Without Change," Politics and Society, Winter, 1972.

The professional monopolies are generally satisfied with the status quo and are usually not involved in proposing reforms, except when their powers and prerogatives are threatened by others.[1] Control by the medical profession over the provision of medical services is a basic element of the health care system and this control is maintained by the physicians through their professional associations of the supply of physicians, the distribution of services, the cost of services and rules governing health facilities.[2] These circumstances have developed under the aegis of protecting the consumer of medical services, which they do in part, but they even more powerfully protect the interests of the professionals.

The interests of the community population affected by or needing health care are by far less organized and less powerful than those of the professionals. In regards to health care, the average person does not have the information necessary to play an important political role: they do not know the levers of power, the interests at stake, the actual nature of the operating institutions nor the political resources necessary to acquire that information.[3]

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[1] Ibid., p. 146. [2] Ibid. [3] Ibid.

In addition, there is little accumulation of political and organizational experience by community groups as their leaders are constantly either being absorbed into the existing health system or dropping out of activity.[1]

COMPREHENSIVE HEALTH CARE

Comprehensive health care requires that health education, personal preventive services, diagnostic and therapeutic service, and rehabilitative and restorative services be available to individuals and families.[2] Comprehensive health planning is a process of continuously examining the health needs, goals and resources of a community, state or the nation in order to provide for their orderly and efficient interrelationship for the overall health of that community, state or the nation.[3] Planning, thus, takes into account the present programs and service delivery patterns related to health and formulates and initiates new programs

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[1] Ibid.

[2] National Advisory Commission on Health Facilities, A Report to the President (Washington, D. C., U. S. Printing Office, 1968), p. 8.

[3] Public Health Service Publication #1488, The Role of Health and Welfare Councils in Comprehensive Community Health Planning (Washington, D.C., U.S. Printing Office, June, 1966) p.6.

and services designed to improve the quality and accessibility of health care for all. Planning also includes the simultaneous evaluation of change so that those results can be modified as a part of the ongoing planning process. Therefore, as put by Herman & McKay, the success of comprehensive health planning "must be measured not in the excellence of a planning document but in the demonstrable effect the process has in improving the health of the people."[1]

FEDERAL LEGISLATION AND POLICY

A major step towards reorganization of health care was the Heart Disease, Cancer, and Stroke Legislation of 1965 (P.L. 89-239). The legislation focused superficially on the major killer diseases but in actuality it was a first step toward regionalization of the nation's health facilities and personnel. In effect, the nation was invited to regionalize itself and to disregard internal political boundaries (state, county and municipal). This act dealt with one of the country's most delicate internal political issues--state's rights. It now bears the title Regional

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[1]Harold Herman and Mary Elizabeth McKay, Community Health Services (Washington, D. C., International City Managers' Association, 1968), p. 33.

Medical Program. Its effect has been to stimulate dialogue and experiment towards reorganization of the nation's health resources along systematic lines.

The Comprehensive Health Planning and Public Health Services amendments of 1966 (P.L. 89-749) gives authority for broad health planning to the individual state governments. This legislation was to promote and assist in the extension and improvement of comprehensive health planning and public health services, to provide for a more effective use of available Federal Funds for such planning and services, and for other purposes. In Section 2(a) of the law, Congress declared:

> That fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living: that attainment of this goal depends on an effective partnership involving close intergovernmental collaboration, official and voluntary efforts and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources--national, state and local--to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private practice of medicine, dentistry and related health arts.

This declaration is followed by Section 2(b):

> To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive planning for health services,

> health manpower and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capabilities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible.

With this purpose in mind, Congress designed a system of grants to the states, to public and non-profit private areawide health planning agencies, to schools and agencies for training personnel for health planning, and for special areas of need. The following summary of Section 314 briefly details the grant system.

> Section 314(a) provides for the establishment of a single State agency as the sole agency for supervising the administration of the State's health planning function; and the establishment of a State health planning council to advise the State agency. The Council must represent both providers and consumers of health services, with the consumer in the majority.
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> Section 314(b) provides that public or non-profit private areawide health planning agencies may apply for grants to develop comprehensive regional, metropolitan area, or local area health planning; to develop and revise areawide health plans; and to coordinate existing and planned health services, manpower and facilities. Applications must be approved by the State health planning agency to assure coordination of local, regional and State planning efforts.[1]

In 1967 the 90th Congress further amended the Public Health Service Act to extend and expand the authorization

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[1] (P.L. 89-749).

for grants for comprehensive health planning and services, to broaden and improve the authorization and research and demonstrations relating to the delivery of health services, to improve the performance of clinical laboratories and to authorize cooperative activities between the Public Health Service hospitals and community facilities. The "Partnership for Health Amendments of 1967" have enhanced the possibilities for successful comprehensive health planning by promoting further research in planning and provision of services.[1]

P. L. 89-749 rest upon several basic assumptions which are recognizable in the statement of policy. The first assumption is the recognition that national health problems vary from area to area and the policy shows a strong state emphasis. Second is the assumption that further progress in improving availability and quality of comprehensive health care requires planning as reflected in Section 314. The third assumption is that planning can best be done at the level most closely related to the individuals requiring service while still covering a broad geographical base; thus,

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[1]Jean Lindstrom, Comprehensive Health Planning, Social Work Papers, The Ohio State University, Number 5.

the provision for areawide planning within the state. Fourth is the assumption that effective planning must involve both providers and consumers of health services with the resulting advisory councils of the primary health planning agency within the state which must have a balance of providers and consumers. Last, there is the assumption that abstract planning needs a built-in capability to do something about the problems inorder to have a sense of accomplishment and continued motivation to plan; the various grant procedures were designed for this purpose.[1]

Several basic issues are involved in the formulation of national policy regarding comprehensive health planning. The issue of centralization versus decentralization is one of the most primary.[2] Although ultimate power is vested in the Federal Government, national policy is based on the assumption that planning is best when related to the needs of the people when carried out on a local level, and that the people affected must be involved in the planning process.

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[1]James H. Cavanaugh, "Address," in Papers from the Fourth Annual Institute for the Staffs of Areawide Health Facility Planning Agencies, December 12-17, 1966. Center for Health Administration Studies of the University of Chicago, pp. 32-33.

[2]Lindstrom, op. cit.

The decentralization of power is assured by the authority vested in the state planning agencies and the granting of funds on an areawide as well as a statewide basis.[1] In addition the Federal policy focuses on structure and process of planning and on general goals rather than on specific program content and operations.[2]

Another issue closely related to decentralization is that of flexibility.[3] National policy is designed to maximize flexibility in planning and the provision of services on the state and local levels. Federal funds are granted for the development of the planning capability in the state, Kahn observes, "The intent is to create an ongoing planning operation and a staff capable of effective programming and feedback analysis."[4] The delivery structure and program content should be able to accomodate initiation and innovation in combining the old and the new for the best possible system of comprehensive health care.

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[1] Ibid.

[2] Alfred Kahn, Studies in Social Policy and Planning (New York: Russel Sage Foundation, 1969), p. 236.

[3] Lindstrom, op. cit.

[4] Kahn, op. cit., p. 237.

In a critique of existing comprehensive health planning Lindstrom states;

> . . .several changes seem necessary. The implication that comprehensive health planning can occur "without interference with existing patterns of private professional practice of medicine, dentistry and related healing arts" (P.L. 89-749) seems invalid. A truly comprehensive planning effort will require greater coordination and reorganization of present health service units. In addition, I would include a compulsory clause requiring all states to develop comprehensive health planning capabilities and plans within a given time period inorder to receive further public health funding of any type. Criteria and standards must be set at the national level, . . .there is no reason why citizens residing in some states should receive less adequate care than citizens residing in other states. P.L. 89-749 does little to recognize the interrelatedness of health planning to other kinds of social and physical planning. I would propose a system for coordination of all kinds of planning in an attempt to assure comprehensive development of services relating to the physical and social environment.[1]

To summarize national policy and legislation relating to comprehensive health care, the Comprehensive Health Planning and Public Health Services amendment of 1966 (P.L. 89-749) give authority for broad health planning to the individual state governments. The concept of planning has recently broadened to include an organized attempt to rationalize the relationships among the autonomous entities in health care. Steps have been taken to move toward a

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[1]Lindstrom, op. cit.

coordinated system of facilities and personnel which hopefully could offer comprehensive services in a given area. The grant approval function of planning could be a mechanism for allocation of area "resources" to maximize output and accessibility to health care. The so-called "Partnership for Health Legislation" enacted by Congress in 1967 was intended to establish machinery in each state to accomplish planning goals. Health planning councils have been established all over the nation. The effectiveness of such councils has been questioned partly because their functions have not been clearly defined by Washington or the states. In addition, the councils are local or state voluntary groups without adequate administrative frameworks or the power of legal enforcement.[1]

COMPREHENSIVE HEALTH PLANNING IN MONTANA

Comprehensive Health Planning is organized on the state, areawide and in some places, the local level in Montana. On October 28, 1966, Montana's Governor, Tim Babcock, designated the Montana Board of Health as the single state agency for

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[1]Herman M. Somers, The Health of Americans, ed. Boisfeuillet Jones (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1970),pp. 167-203.

Comprehensive Health Planning. When the legislature changed the name of the Montana State Board of Health to the Montana State Department of Health and Environmental Sciences, the renamed Department became the designated state agency. Comprehensive Health Planning became the legal responsibility of state government when in 1969, the Montana legislature amended Chapter 41, title 69 of the Revised Codes of Montana of 1947 to include a new section establishing the State Department of Health and Environmental Sciences as the sole and official state agency on Comprehensive Health Planning. The State Department of Health was also given the charge to prepare a plan for Comprehensive State Health Planning. The Division of Comprehensive Health Planning was created with the State Department of Health to carry out this responsibility. The plan for Comprehensive State Health Planning was completed and distributed in the fall of 1974.

STATE ADVISORY COUNCIL

Organizing for participation in Comprehensive Health Planning in Montana began with the naming of a State Advisory Council in 1968. The Bylaws of the Montana Advisory Council for Comprehensive Health Planning provide for representatives of those State and Federal agencies required by State and

Federal law for councils advisory to Comprehensive Health Planning and Medical Facilities Construction and Modernization programs. The general membership is to have representatives of non-governmental groups concerned with health services in Montana. A majority of the Council is to be made up of consumers and the membership is to be selected from a broad geographical basis. (Bylaws, Article III, Section 1). Each member of the Council, which is not to exceed 39 members, holds office at the pleasure of the Governor. All appointments to the Council are to be for a term of two years, (Bylaws, Article III, Section 2 and 3).

The Montana Comprehensive Health Planning Advisory Council is charged with the responsibility of advising the State Department of Health and Environmental Sciences as to: scope of planning and activities to be undertaken by the Department; recommendations to be made by the State Department to other agencies, programs and groups as necessary; necessary review and comment of State Comprehensive Health Planning, Hospital and Medical Facilities Construction, and the State Plan for Community Mental Health Centers; and review and comment on proposed hospital and related facility standards for maintenance and operation. The Council is charged with the responsibility for

facilitating communication and cooperation between State agencies, voluntary health organizations, professional organizations and the general public.

One of the first tasks undertaken by the Council was to name committees which were to deal with health problems relating to facilities, the environment, services, manpower and areawide health planning. The areawide health planning committee proposed the division of Montana into five health planning regions which was adopted by the Council in 1968.[1] The State Comprehensive Health Planning Agency has the authority to recognize one organization that is responsible for total health planning within each designated area. The following is a discussion of the recognized areawide Comprehensive Health Planning Organizations in Montana (Appendix A).

Region 1--The Northwestern Areawide Health Planning Council

In 1966 a group of interested people under the leadership of Dr. Pat McCarthy formed the Western Montana Areawide

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[1]Cooperative Comprehensive Health Planning Grant For Montana, Document prepared for Grant application by the Northwestern Montana Areawide Health Planning Council, North Central Montana Health Planning Council, South-Central Regional Health Planning Council, Inc., and the Division of Comprehensive Health Planning, Department of Health and Environmental Science, Helena, Montana.

Health Facility Planning Committee. This committee met on a regular basis and had representatives of both consumers and providers. In July of 1969, the committee was renamed the Northwestern Montana Health Planning Council, Inc., and later in that year became designated as the official area-wide Comprehensive Health Planning organization for Region 1. The function for which the Region 1 council was formed was:

> to be, and to serve as, a non-profit corporation to conduct and carry on the Northwestern Montana Health service planning activities in cooperation with the Montana State Department of Health, the United States Department of Health, Education, and Welfare, and any other agencies, public or private, which are now or may hereafter be formed for any purpose related to health for the people in Northwestern Montana; and to provide a broad representative community or areawide basis for problem solving, decision-making, and long-range community planning for better coordinated and more efficient health benefits.[1]

The general membership of the corporation is to provide for broad representation of the major public and voluntary health agencies, organizations and institutions concerned with physical, mental and environmental health services, facilities and manpower in the seven county area. The majority of membership of this corporation is to be consumers of health services, generally reflecting geographic,

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[1]Articles of Incorporation, Bylaws of the Northwestern Montana Areawide Health Planning Council.

socio-economic, racial and ethnic groups. The membership is to be those persons designated each year for that purpose by each of the county health planning councils. Any person or interest seeking membership in the recognized county health planning council needs only to petition that council for membership and to receive that council's approval.[1] In addition to the area wide council, three local health planning organizations have been formed, Ravalli, Missoula and Flathead counties. The Board of Directors of the council is composed of 22 persons with a minimum of 2 people from each of the 7 counties.[2]

Region 2--The North Central Montana Health Planning Council

In the summer of 1969, a group of around 200 people interested in forming an areawide health planning organization met in Fort Benton. At this time, a Steering Committee was elected. This Committee created a set of bylaws and at the following meeting they were presented to the

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[1]Cooperative Comprehensive Health Planning Grant, op. cit., p. 128.

[2]Shirley Isgar, Health Organization Relationships in Montana, Division of Comprehensive Health Planning, Montana State Department, of Health and Environmental Sciences, Helena, Montana. September, 1972.

original group. The group adopted the bylaws and articles of incorporation. The function for which the council was created was:

> To provide a broad representative community or an areawide basis for problem solving, decision-making and long-range community planning for better coordinated and more efficient health services, and to carry on health planning activities in cooperation with the Montana State Department of Health, United States Department of Health, Education, and Welfare and any other agency, public or private, which is now or may hereafter be formed for any purpose related to health of the people of Montana, and to provide through long-range community and areawide planning for better coordinated and more efficient health benefits to the people of Montana.[1]

The criteria for representatives on the Region 2 council is to provide for wide representation of the major public and voluntary health agencies, organizations and institutions concerned with physical, mental and environmental health services, facilities and manpower in a 12-county area. The majority of the membership of the Board of Directors is to be consumers of health services generally reflecting geographic, socio-economic, racial and ethnic groups in the area. Any resident of the area upon request to the Board of Directors shall be granted full active membership in the corporation and shall be entitled to full

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[1]Articles of Incorporation, Bylaws, North Central Montana Health Planning Council.

active membership in the corporation and shall be entitled to full participation of the work of the corporation upon signing of the membership roll.[1] The Board of Directors is composed of at least two people from each county, with one additional person for every population increment of 10,000. One person from each county must be a member of a tribal council or an appointee of the commissioners or tribal council.[2] Region 2 includes the Fort Belknap, Blackfoot and Rocky Boy Indian Reservations.

Region 3--Eastern Montana Areawide Comprehensive Health Planning Council

Due to a sparse population over a large land area, the general distrust of government agencies, and the existence of a voluntary, grassroots organization which had delegate representation from each of the seventeen counties, the Economic Development Association of Eastern Montana (EDAEM) was given the authority to be the Areawide Comprehensive Health Planning Agency. Through a contract with the Department of Health and Environmental Sciences, the Eastern Montana Areawide Comprehensive Health Planning

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[1]Article I, Bylaws, North Central Montana Health Planning Council.

[2]Isgar, op. cit., p. 13.

Council was formed in August of 1973. Region 3 is the only areawide agency in the state which has an umbrella organization such as EDAEM. Completion date for a health plan for the seventeen counties of Eastern Montana is April 30, 1975.

In addition to the Executive Board there are four standing committees in Region 3. Because of the large geographic area served by Region 3, it is divided into 3 districts; three of the standing committee serve as the District Health Facility Committees. These committees consist of five to seven people with the consumers in the majority. The primary function of these committees is to review and comment on grant proposals and to offer a recommendation for approval or disapproval.

The recently formed Health Planning and Coordinating Committee consists of 7 members, including a psychologist, two hospital administrators, and a county commissioner. The purpose of this committee is to act in an advisory capacity to the staff in writing the health plan. They will help establish needs according to priority and offer suggestions and criticisms to the staff. The Executive Board has the final authority in all recommendations made by the District Committees and the Planning Committee.

The Board is made up of seven members: the four officers of EDAEM and three others, one from each district of Eastern Montana.[1]

Region 4--Southwestern Areawide Health Planning Council

In the summer of 1969, several organizational meetings were held within this region. An Areawide Steering Committee was selected from the eleven Southwestern counties on August 4, 1969 in Three Forks. In October, 1969, the Board of Directors had its first meeting and the bylaws were revised and adopted and officers were elected. The council was incorporated in March, 1971. The council has continued to meet on a regular basis and has sponsored workshops and conferences.[2]

Region 5--South Central Regional Health Planning Council,Inc.

Under the leadership of Dr. Colvin Agnew the council for Region 5 was formed in the nine county area in 1968 by a group of interested persons and was incorporated in

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[1]Based on personal correspondence between Helen Strand, Health Planner, Eastern Montana Areawide Comprehensive Health Planning Council, and the writer.

[2]Isgar, op. cit., p. 13.

May of that year. The function for which the council was created was to:

> encourage and develop comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services including the facilities and persons required for the provision of such services.[1]

Membership on the council is to provide for broad representation of the major public and voluntary health agencies, organizations and institutions concerned with physical, mental and environmental health services, facilities and manpower in the area. A majority of the members are to be consumers generally reflecting geographic, social, economic, racial and ethnic groups in the area.[2] The 30 member Board of Directors which runs the affairs of the corporation is to contain a majority of directors who are consumers of health services. The Directors serve a three-year term and vacancies are filled by Board appointment.[3]

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[1]Articles of Incorporation, Bylaws, South Central Regional Health Planning Council, Inc.

[2]Article IV, Section I, Bylaws, South Central Regional Health Planning Council, Inc.

[3]Ibid., Article VI, Sections 1, 2, 4, 5, and 6.

Chapter III

METHODOLOGY AND DATA INTERPRETATION

METHODOLOGY

The data presented in this study were collected by the survey questionnaire method. The written questionnaire was found to be the best method for collection of data in a nonexperimental descriptive research effort. The design is also conducive to data collection over a large geographic area with relative speed and ease.[1]

A survey questionnaire has the advantage of being (1) relatively inexpensive to administer; (2) able to be completed in a short period of time; (3) adaptable to subjects who are cooperative; and (4) is more representative when using a large target population. This technique is contrasted with the "experimental" approach which is usually more expensive, more time consuming, more apt to involve uncooperative subjects and less representative of any large target population.[2]

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[1]Tyrus Hillway, Introduction to Research, (Boston: Houghton Mifflin Co., 1956), p. 201.

[2]Faye G. Abdellah and Eugene Levine, Better Patient Care Through Nursing Research, (New York: MacMillan Company 1965), pp. 166-167

TOOL

A questionnaire was devised by the researcher to be sent to the 167 members of the 5 regional councils and the State Advisory Council in Montana. The order of questions was not indicative of their relative importance, and there was no difference in format nor content in the questionnaires sent to the two groups, consumer and provider representatives in Areawide Councils of Comprehensive Health Planning in Montana. The questionnaire provided information regarding the characteristics of representatives, the motivations leading to the assumption of the representative role and the level of satisfaction experienced as a result of involvement in the Areawide Councils.

PILOT STUDY

In order to validate and refine the proposed tool, the initial questionnaire was sent to the members of the Gallatin County Local Council of Comprehensive Health Planning. These eight persons were asked to complete the questionnaire, to make suggestions and observations and to estimate the time necessary for completion. As a result of the pilot study, certain changes in format and content were made in the tool.

SELECTION OF THE POPULATION

The researcher consulted the Montana office of Comprehensive Health Planning at the initiation of the project for advice and comments. Members of the areawide councils of the five regions and the State Advisory Council were chosen as the sample population. Names and addresses of persons designated as Areawide Council members were obtained through the Montana office.

METHOD OF COLLECTING THE DATA

The questionnaire, a cover letter explaining the purposes of the study and requesting the participation of the respondents, along with a self-addressed, stamped envelope, were sent to the 167 persons selected as the population on September 17, 1974. A follow-up letter, questionnaire and self-addressed, stamped envelope was sent to non-responders to increase the return rate.

DATA AND ANALYSIS

The data for analysis were obtained from a survey questionnaire. Each response was hand coded and key punched. Data analysis included cross tabulation and frequency distributions of the consumer-provider groups, the five

regions and the State Advisory Council. Library programs were used for analysis. The tables following are excerpted from the printout.

Differences of less than 5% between comparison groups are not mentioned in the narratives. Information regarding demographic characteristics, motivation and the level of satisfaction is analyzed. Detailed information on each category follows. In general the data can be summarized for each category:

Demographic Data--The comprehensive Health Planning representative tends to be between the ages of 45 and 55 years old, male, has a Bachelors degree, is married, lives in a town with a population of less than 5,000, has been involved in Comprehensive Health Planning for 3 years and in the areawide council for slightly over 2 years. The representative tends to attend almost all of the areawide council meetings and the attendance rate has remained the same since joining the council.

Motivation--Most persons became involved in the areawide council as the result of another person who submitted the members name. Over half of the representatives do not feel they represent a specific group.

Level of Satisfaction--Most representatives speak out and make suggestions often and do feel they are somewhat personally involved and as if making significant contributions as a result of their involvement. Consumer representatives are more likely to see the provider group as always or often making good suggestions to the problems at hand. The consumer group is seen by provider representatives as offering good suggestions only sometimes or rarely.

When tabulation of the data began in November of 1974 the researcher had received 133 questionnaires for a 79% return rate of the original 167 questionnaires mailed. Further breakdown revealed that 62 or 48.1% of the 133 questionnaires were returned by consumers. Interestingly, 62 or 48.1% of the 133 questionnaires were returned by providers. Five persons marked themselves as representing both consumer and provider interest, and four failed to identify themselves as either a consumer or a provider, therefore 9 returns or 3.8% were unable to be used for the comparative analyses.

The Frequency Distributions for questions pertaining to consumer and provider characteristics are found in Appendix F. The average age for both groups is between 45 - 55, 38.6%

of all respondents fall in this group. Consumers have a slightly higher age than providers.

More males (61.3%) than females (37.9%) serve as consumer and provider representatives. The percentage of females is slightly higher in the consumer group (40.0%) than in the provider group (37.5%).

Thirty-five or 26.7% of all respondents marked the Bachelors Degree as the highest level of Education completed. The Educational level completed range from 6 persons (4.6%) who were non-high school graduates to 19 (14.5%) persons who had doctorates. Fourteen providers had doctorate degrees as compared with four consumers.

Marital status was approximately the same for both consumer and provider groups. One hundred ten respondents (82.7%) were married, 10 (7.5%) single, 7 (5.3%) divorced and 6 (4.5%) widowed.

Seventy-two people (54.5%) of all respondents live in towns of 5,000 or less people. Forty-one (31.1%) live in towns over 20,000 in population, with 19 (14.4%) living in towns from 5,000 to 20,000.

The total time respondents had been involved in Comprehensive Health Planning was equally distributed with no obvious differences between consumer and provider groups.

Of the total, 26 persons (19.7%) had been involved less than one year, 39 (29.5%) from 1 to 2 years, 39 (29.5%) for 2 to 4 years and 28 (21.2%) for over 2 years.

Total time involved in the areawide councils was also equally distributed with no obvious differences between the consumer and provider groups. Forty persons (32.0%) had served less than one year, 32 persons (25.6%) had served from 1 to 2 years, 35 (28.0%) had served for over 4 years. Of the total, more people had served for less than 2 years than had served for more than 4 years.

Frequency distributions for questions pertaining to consumer and provider motivation are found in Appendix G. A large group of representatives, 75 persons (56.8%) attend almost all of the areawide council meetings. Twenty-six people (19.7%) say they attend all meetings, while 9 persons (6.8%) say they never attend meetings. Results are equally distributed in the consumer and provider groups, with slightly more providers saying they attend sometimes; 10 providers (16.1%) compared to 6 (9.8%) of consumers who attend sometimes.

One hundred one persons (80.2%) report their attendance at areawide council meetings has remained the same since joining the council. Seventeen (13.5%) people have increased

their attendance, while 8 (6.3%) have decreased in attendance. The findings are comparably distributed between the consumer and provider groups, although (82.8%) 48 of the providers have the same attendance rate as compared to 76.3% or 45 consumers.

Over half of the respondents 57.3%, or 75 persons, became involved in the areawide council as the result of another person submitting their name. Twenty-seven people (20.6%) actively sought the position as a result of their own interests. Twenty-nine people (22.1%) joined the council for other reasons. Reasons cited as "other" were "no one else would take the job, appointed by various groups, and as part of the persons job.

The following is a breakdown of the "other" explanation:

By appointment	
Miscellaneous	-3
County Commissioners	-9
Low Income	-1
Tribal Council	-1
Government	-1
As part of the Job	-6
Asked by Comprehensive Health Planning	-1
No one else would do it	-1

Seventy-two persons (55.8%) of all respondents stated they were not representing a specific group. Fifty-seven or (44.2%) of all respondents stated they were representing specific groups. Nineteen consumers, (31.7%) said they did represent specific groups, while 41 consumers (63.3%) said they did not. This is contrasted to the provider responses in which 35 (58.3%) said they represented specific groups, while 25 (41.7%) said they did not.

The following lists the various groups named:

- Indian Population
- County Commissioners
- The County
- EDAEM
- Medical Society
- Low Income
- Public Schools
- Various Health Care Institutions and Agencies
- Arthritis Foundation
- Handicapped Children
- City Council
- Dentists
- Nurses Association
- Regional Medical Program

Frequency distributions of responses to the questions relating to level of satisfaction are found in Appendix H. Seventy-three respondents (58.4%) rate their participation in the areawide council meetings as speaking out and making suggestions as often or at every meeting. Fifty-two persons (41.6%) say they only occasionally or rarely speak out and make suggestions. Thirty-four consumers (60.7%) speak out

and make suggestions often or at every meeting. Thirty-three providers (54.1%) speak out and make suggestions often or at every meeting. However, 22 consumers (39.3%) only occasionally or rarely participate as compared with 28 providers (45.9%).

Ninety-two respondents (74.8%) feel personally or somewhat involved and as if they are making significant or some contributions. Thirty-one respondents (25.2%) feel little or no personal involvement. These results are comparably distributed within the two groups.

Seventy-five respondents (58.1%) did not have a specific problem in mind that they wished to deal with when first joining the council. Fifty-four respondents (41.9%) did wish to deal with a specific problem. The problems indicated feel fairly equally into four general categories: 1) Specific Health problems (Alcholoism, mental health, mental retardation, environmental, emergency health care), 2) Adequate provision of health facilities and personnel, 3) Promotion of specific group interest (Doctors, Nurses, Low Income, Indian, Senior Citizen, Local officials and local control), 4) Coordination of services to promote Community Health. Fifty (59.5%) of those persons who did have specific problems they wished to deal with felt significant or

moderate progress had been made towards a solution. Thirty-four (40.5%) people felt there had been very little or no progress towards solution of a specific problem they had wished to deal with.

Frequency distributions of the rating of consumer and provider participation within the areawide councils are found in Appendix I. Forty-nine respondents (41.8%) felt that consumer representatives always or often offer good suggestions to the problems at hand. Sixty-eight respondents (58.1%) felt that consumer representatives sometimes or rarely offer good suggestions to the problem at hand. Twenty-four consumers (44.5%) saw the consumer group as always or often offering good suggestions, while 30 (55.6%) consumers saw the consumer group as sometimes or rarely offering good suggestions to the problem at hand. Twenty-two providers (39.3%) saw the consumer group as always or often offering good suggestions, while 34 providers (60.7%) saw the consumer groups as sometimes or rarely offering good suggestions to the problem at hand.

Eighty-three respondents or 71.0% felt that the provider representatives always or often offer good suggestions to the problems at hand. Thirty-four respondents (29.2%) felt that provider representatives sometimes or