An Overview of Citizen Participation in Health Planning: Lessons Learned from the Literature

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Ever since the mid-1960s, Americans have been concerned with involving citizens in a variety of planning processes, from health systems to social systems to political systems. Citizen participation, however, has ebbed and flowed in political and popular favor and practicality. During the 1990s, a climate of volunteerism, devolution, and community partnerships has heralded the return of community involvement in planning processes and hence scholarly interest in it.

One of the main goals of citizen participation is to improve a planned program by including the concerns and desires of those who will use or benefit from a program and thereby empower individuals and communities to effect sustainable change. But it may also result in establishing a mechanism by which to gain community acceptance for a plan and subsequent implementation. Abraham Winkler, who has written extensively on citizen participation, discusses only community development and social action, since it is his opinion that citizens generally have not played a major role in social planning. Nevertheless, citizens have had some role, no matter how limited, in social planning activities. For instance, citizens were consistently involved in health planning during the 1960s and 1970s, specifically in regional health systems agencies (RHSA).

Although participatory community planning is often a required component of many health programs, until recently it has been relatively ignored as a process for systematic investigation. In many respects, citizen involvement in social planning differs considerably from community development and social action. In community development, citizens engage in voluntary cooperation
and self-help efforts to improve social and economic conditions. In social action, disadvantaged segments of the community organize, confront the dominant institutions, shift power relationships, and make the system work for them. In social planning, however, citizens provide input into a technical process of problem solving and review proposals for the delivery of goods and services to people who need them. Planning is not usually citizen-driven. Formal social or health planning, then, appears to be a more technical, prescriptive process, unlike the ad hoc planning and strategizing that go on in community development and social action efforts.1

Although an expert or consultant is often used in community development, social action, and social planning, their prescriptive and facilitating roles differ. Community development practitioners are often seen as knowledge or resource utilization specialists who either serve as facilitators or train the trainers. They are not seen as the dominant force in the effort. On the other hand, social action organizers mobilize communities through creative confrontation and hard-nosed negotiation.2 Social action organizers go beyond facilitating and training, to developing leadership and giving both strategic and tactical solutions. Although social action organizers are more intercessor and proactive in programs than community development practitioners are, social and health planners are more prescriptive and detached. They seldom educate or train citizens in the planning process. Planners are called upon to make rational recommendations or propose the best alternatives for decision makers. This function necessarily separates them from the emotional and immediate needs of citizens.3

Recently, evaluation experts and consultants have become more directly involved in citizen participation efforts. One group of evaluators has identified four stages in an empowerment evaluation of community health initiatives: agenda setting, planning, implementation, and outcome.4 R. B. Cobb and C. D. Elder argue that agenda setting, the process of determining the problems and solutions for consideration and possible action, is the most potent form of citizen participation.5 However, in many programs the agenda is specified by the funding agency. By contrast, planning involves community members in developing a vision, goals, and strategies to bring about changes in a local system such as health care.

In this paper, we attempt a systematic review of the literature on citizen involvement in health planning. From the mid-1960s through the early 1980s, citizens were directly involved in planning regional health systems and in setting the agenda, by oversight boards of community-based health centers and agencies. We primarily examine studies of citizen participation in community health planning activities under the 1966 Comprehensive Health Planning Act (PL 89-740), the 1974 National Health Planning and Resources Development Act (PL 93-641), and the last 1975 amendments (PL 97-79). In addition, we draw upon the more recent literature on decision making and leadership in community partnerships and coalitions for substance abuse prevention funded under the 1988 Anti-Drug Abuse Act (PL 100-690). Both community

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Health planning and community partnerships directly involved citizens in planning activities.

We have organized our discussion into seven broad themes that are addressed in the literature on citizen participation and empowerment. They are, from the most general to the most specific:

1. Systems change
2. Knowledge transfer
3. Civic engagement
4. Inclusion
5. Decision making
6. Project organization
7. Project leadership

Several of these topics are similar to components of the Civic Index (National Civic League, 1993) developed by the National Civic League: citizen participation and community leadership, intergroup relations, civic education, information sharing, and capacity for cooperation and consensus building. We include some specific comments at the end of each section and then conclude with lessons learned that can be applied to various attempts at community-based, participatory health planning processes.

Systems Change

Systems change is characterized by a sustainable or institutionalized transformation of interorganizational relationships. It is this focus on permanence that separates problem solving from systemic change. All too often, community projects can make small improvements or incremental changes within the existing set of relationships and regulations, and then the projects dissolve. This means they never really challenge systemic assumptions or become involved in policy formation. The literature suggests that if citizens involvement in health planning for systems change is to be successful, there must be (1) some type of external change agent, (2) an attempt to level the playing field between the dominant power holders and other compliance or state groups, (3) a collaborative policy formulation process, (4) shared management of the change process, and (5) a community entry that becomes institutionalized.

Systems change can be the result of either inside-outward or outside-inward effort. An inside-outward effort occurs when a person or community with a problem perceives that many others are similarly afflicted, and they are then able to empower themselves by gaining support, building a social movement, and bringing about change. This is the community-driven approach in which local leaders or citizens at the grass roots start and lead a group that defines its goals and methods generally. Such groups have been credited with various reforms, from consumer legislation to revitalization of neighborhoods.
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Involved large numbers of local citizens in an open decision-making process for the first time, in regard to local health issues. But a General Accounting Office report noted that few agencies had actually prepared comprehensive health plans, and those that were preparing them were unsure of what nature, purpose, and content the plans should have. As a result, the 1974 National Health Planning and Resources Development Act created a network of state and regional planning units—the health systems agencies. The 1978 Amendments strengthened HSA staff support for consumers to enable them to better participate in plan development and decision making.

All of this was to be accomplished through broad-based citizen participation. But this was easier said than done. In a 1978 article, Stuart Langton pointed out that many agency and program administrators are ambivalent about citizen participation, and Wanderingman found that many citizens who participate in such activities are equally ambivalent about their participation and confused about their functions on committees and boards. Wanderingman emphasized that simply mandating participation does not provide the strategies, training, or motivations to develop effective participation. Hence, the general conclusion that an outside agent of some sort is needed.

Commentary. Systems change requires a multifaceted approach. The external change agent must function as a catalyst for change. In addition, an established body or entity is needed to function as both process helper and resource linker to ensure that the community has the capacity to effect change. These three components of change provide a necessary (but not sufficient) framework for successful systems change.

Broad-based citizen participation in the planning process is often beset with distinctive challenges. Formal social or health planning is a technical, prescriptive process that does not fit well with the more informal, ad hoc nature of citizen involvement common in community development and social action. Citizen participation in creating and writing a health plan may bear an extraordinary burden of specialized personal support and guidance, but not dictate, processes and products.

Finally, broad-based citizen participation has the potential of going off in unanticipated directions. A funding or sponsoring agency has to have criteria for deciding when the planning process has gotten too far off course and a strategy for how to stop it in its tracks or redirect priorities or financial resources and staff. Setting clear, somewhat detailed goals and objectives for program content sets boundaries on what is acceptable but leaves room for the citizens to work out the best way for them to achieve these ends through the plan.

Knowledge Transfer

Change agents cannot assume that citizens come to participate with equal (or any) knowledge about the entity or the process to be changed. The type of knowledge needed is also difficult to predict. Consumers in some health care
systems, such as those in Europe and Japan, experience integrated and sequentially linked health services, from neighborhood clinics to referral hospitals. Presumably the knowledge these consumers need to navigate such a system is straightforward. American consumers face a complex health care system with a multitude of insurance plans, little consumer oversight and regulation, and extensive competition within and among the health care providers, government, employers, and employee organizations. The recent trend toward corporatization and managed care franchise systems, though understandable as a free market response to cost containment, has done little to simplify rather than the health care system or the knowledge needed by the American consumer.

Pamela Doisy noted in 1980 that the issue of consumer participation in setting policy and decision making in the health care arena was most clearly commended by the self-appointed Citizens’ Board of Inquiry into Health Services for Americans in their 1972 report, Heal Yourself. The report, which was widely distributed by the American Public Health Association, called for restructuring the health care delivery system to reflect the needs, preferences, and interests of consumers by ensuring that they have a dominant role at all levels of decision making. To make policy and establish goals, objectives, and priorities for the new system, consumers had to overcome a knowledge gap and become informed about the financing, operations, and mechanisms of the delivery system.

Similarly, the need for knowledge transfer to consumer participants was clearly evident in studies of HSAAs and state health coordinating councils (SHCCs). A survey of consumer representatives involved in health planning in four cities (Birmingham, Alabama; Chicago, Los Angeles, and New York) revealed that one-fourth of the consumers neither considered themselves well informed on health issues nor had working knowledge of the 1974 National Health Planning and Resources Development Act. Participants also were not given an explanation of the review-and-comment process, the rationale for certificates of need, or the definition and purpose of the health systems plan and the annual implementation plan.

Based on a review of the literature, Doisy noted that consumers often lack legal and bureaucratic expertise. Health planners may assume that consumers and purchasers of health care are already familiar with and request technical assistance. Citizens participating in HSAAs, however, complained about the amount of information and reading that was required for the planning effort. Furthermore, moving toward policy formulation and implementation requires a certain amount of consumer education on the how-tos of health care reform. Wunderman went a step further and stressed the importance of including both citizens and staff in any training and knowledge transfer sessions. In particular, both groups have to learn how to develop and maintain working relationships on boards and committees, including various reporting and review mechanisms as well as having liaisons between committees and boards. This need for a certain level of technical expertise becomes even more poignant when one considers some alternative approaches to knowledge transfer.

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According to Doisy, the Citizens’ Board advocated consumer participation in decision making based on individual value judgments and experience. They did not see a need for consumers to be given a crash course on the intricacies of the health care delivery system. Doisy’s review of the literature, however, revealed that although common sense and personal experience raised issues of sensitivity to patient needs and humaneness of treatment, it hampered efforts at system reform. One study of consumer participation in twenty-two hospitals found that dealing with personal horror stories about hospital personnel and services made it more difficult for some committees to abstract from these private troubles and move on to effective action and organizational-level changes. This suggests that processes that simply allow consumers to vent, unguarded and unselfconsciously, may do little to ultimately move systems change forward. Instead, participants may get bogged down in details and stories that do little to help them understand the system and how to change it. This type of knowledge transfer, though cathartic, may be less useful to the change process.

One problem in knowledge transfer is the difficulty of relating abstract knowledge and technical information to personal, practical experience. For instance, the Havelock included among their propositions on training for change agents that the users or decision-making groups must be able to appreciate research knowledge and understand how it is generated and validated in order to derive help from resource persons or consultants. The crucial knowledge transfer is from the experts abstract and science-based statistical knowledge to the user’s need for practical insights and specific solutions to his or her circumstances and problems. Unfortunately, it is not easy to meet these user needs.

Further, effective knowledge utilization may be a self-fulfilling prophecy; the user’s expectations that efforts to retrieve and apply knowledge will pay off in a good indicator that they will. This would logically favor participation by the better-educated professional and business segments. In fact, some have argued that planning and proposal writing are very demanding cognitive activities and found that higher education was related to increased satisfaction—and that income was positively related to better ratings of the team plans for community-based substance abuse prevention programs.

Commentary. It would appear that much more needs to be given to the proposition that a citizen’s committee can come up with a comprehensive health plan without substantial orientation in the planning process as well as using staff and consultants who can transfer and explain the knowledge of the health system; that is required for an informed policy and planning effort. The usual difficulties that staff might encounter in launching a new initiative with largely volunteer labor can be compounded when both staff and volunteers need considerable training and support in the process envisioned for health care policy, planning, and systems change.

The amount of time and effort that volunteer participants must invest to learn the background and technical details of a health planning process can be
burdensome, if not overwhelming, if participants feel that knowledge transfer is of little interest or use, consultancies may be hard pressed to convince them otherwise. In some instances, not all the informational topics available are seen as being applicable and therefore transferable. This puts consultancies in the difficult position of getting knowledge across to audiences that are overwhelmed, unwilling, or uninterested. Providing participants with the necessary information on the complexities of the health care system and how cost savings work is a basic requirement for success. But doing so does not ensure that participants are willing or able to use such information to the benefit of the process.

Civic Engagement

Civic engagement is a crucial part of creating a community of shared experiences and reciprocal relationships that enables a group of people to develop and select programs matching their needs and values. This process can be initiated and controlled by citizens for purposes they determine, by government to gain support for decisions already made, or by community or philanthropic foundations setting objectives on issues still to be decided.
by well-informed citizens who are carefully selected and who understand the rationales behind the programs and initiatives they will be advising. Liberals favor direct citizen election of representatives in a fashion that guarantees diversity, keeps them accountable to their constituents, and results in community control over the program. Moderates see participations as an educational and enlightening experience, almost an end in itself, that helps make society more open and cohesive.

Although voluntary health planning at the local level has existed in the United States for some time, it has generally been dominated by local health facilities and agencies and carried out through interorganizational bodies affiliated with them. The consumer and citizen participants in these local planning efforts were primarily members of the business, professional, and managerial elites who also served on the boards of voluntary, charitable, and civic associations. The reality, then, is that only a small proportion of the population participates in community-based decision making processes, and they tend to be unrepresentative in that they are higher in education, income, and occupation. This may seem to support the conservative approach, but even these well-informed citizens are often overwhelmed by the number of meetings they must attend, the amount of information they must comprehend, and the personal time and expense they must incur.

The question comes down to how members of the participatory groups are to be selected. In 1972, the Citizens' Board proposed a set of guidelines for ensuring selection of legitimate consumer representatives. First, the process should be well known and clear to the community and consumer groups that would be involved. Second, the individuals and groups must be able to affect the process of selection. Third, the consumer representatives or delegates must be accountable and responsible to the group they represent or were chosen by.

Daley lists four methods of selection: election, appointment, self-selection, and organizational representation. The idea of direct election to community development and planning bodies appears very democratic. The major example is the school board, but this approach offers politics what is seen as a nonpartisan issue and usually has a rather low voter turnout.

Representatives can be chosen by some person or group from among a set of known individuals, or those who nominate themselves. This self-selection appointment process was used in the 1966 federal health planning legislation, but it resulted in a consumer contingent with strong ties to the health care provider, facilities, and agencies. To correct this, the 1974 health planning act specified that consumers could not include spouses, children, or parents of providers, nor could they be individuals who obtained more than one-fifth of their total income from health-related occupations. The selection process, however, was still vested in the existing HSA boards, so the process remained self-perpetuating. Finally, the 1979 amendments mandated an open selection or election procedure so that not more than one-half of the governing board could be appointed by the outgoing board. In addition, consumers representing special populations can now be either actual members of the special population group or nonmember advocates who were selected by members of the group.

The fourth selection method is to allocate consumer seats not to nominal representatives of categorical groups such as the elderly or women but to the consumer and community organizations that can choose their delegate by election, self-selection, or appointment. Daley noted that this reflects a theory of democracy that stresses interest-group pluralism. The presumption is that since the providers on such boards are basically a set of organized health care facilities and professional associations, then adding consumer groups and community organizations to the boards should create a better balance of power. This theory of democracy, however, is challenged by conventional wisdom, which regards politically active volunteers as subverting the ideal of individual-based representation (one person, one vote) as well as internal Revenue Service rules that limit the political and lobbying activities of nonprofit organizations.

The degree and extent to which inclusiveness is achieved depends heavily on the political orientation—conservative, liberal, or moderate—of those initiating or supporting the program. In general, very few people actually participate in broad-based community decision making, and those who do tend to be unrepresentative for a variety of reasons. Therefore, it may be preferable to lean toward use of representative agents who are members of other community-based organizations rather than depending on a typical person who may or may not share the experiences and concerns of his or her group but have no organized constituency to confer with. In short, inclusiveness should flow both ways, not just coming to the table but carrying the message back to the street.

Decision Making

The key issues in decision making are commitment to consensus or compromise, whether citizen input is advisory or governing, and what is being governed. Both Daley and Basu noted that consumer participation in decision making during the 1960s and 1970s was inevitably couched in terms of confrontation and conflict. Even mainstream liberal groups such as the 1972 Citizens' Board of Inquiry accepted the conflictual perspective. They assumed that providers and consumers had divergent self-interests and that provider dominance therefore had to be replaced by consumer dominance.

The capacity to build consensus or reach compromise rests on the realization that neither provides nor consumers are homogeneous or monolithic. The social activist and union-organizing tradition that pervaded the social sciences in the 1960s and 1970s spread a conflict-oriented, confrontational approach. But empirical research, free from economic disputation and legal adversarialism, told a different story. Representatives of each side often expressed the views of a variety of interests, and studies of voting in HSAs showed that it generally did not follow the expected provider-consumer fault
It found that 69 percent of the programs with governing boards that permitted policy setting and budgetary control were judged as having implemented citizens' ideas to a significant degree, compared with 57 percent of those with advisory-type committees. Further, regardless of the official label of the citizens' group, 70 percent of those that actually exercised substantial influence over the facility or program budget were able to implement citizens' ideas, compared with 38 percent that did not. The size of the decision-making body can affect both process and outcome. A large governing board increases the potential networking and interactions that can occur and thus can be more representative. But a large board generates time constraints on participation and personal involvement, and it increases problems of coordination and regulation. Cyril House pointed out that a board should be small enough to act as a deliberative body but large enough to carry out the necessary responsibilities. He set the ceiling at thirty-nine members and noted that a large board necessitates creating an inner or executive board or committee. This may be more efficient, but it changes the role of the larger board to one of a primary constituency that is reported to and consulted. "Theodore Cigler recommended that executive committees range from five to nine members, although some are often as large as nineteen. According to Bates, HSA governing structures on the whole appeared large and unwieldy. The average size of the primary governing body of an HSA was a bit high at 44, with one HSA having 137 board members. Executive committees were more reasonably sized, averaging twenty and ranging from six to thirty. Bates contended that the larger size may reflect the need to include a wide range of stakeholders and citizens who had to be represented."

Decision making requires legitimization—that is, in what spheres and over what issues can community members participate in developing and then vote on policies, rules, and procedures? In its narrowest sense, governance can mean internal allocation of a project's budget and establishing policies and guidelines for staff and volunteer activities. In its broadest sense, governance can mean creating a quasi or shadow governmental agency able to promulgate bonding agreements and regulations. In between is the alternative of building an advisory role for the project with respect to the major stakeholders. Governance must be clearly and explicitly defined.

Democratic decisions are made through a process of consensus, or through institutionalized disagreement and compromise. Both must manage confrontation and conflict. Interestingly, the decision-making process in a project often mirrors decision making in the larger community. To create a better decision-making environment, participants should have a clear understanding of what is involved in a planning process and the decisions that go along with it. Furthermore, since most participants nominally represent some interest group, it is often difficult to find a neutral leader or third party to mediate disputes, particularly among the major stakeholders. Attention should be paid to composition of the decision-making group and availability of a mediator.
Project Organization

Dey claimed that one of the most serious defects of consumer participation is that advocates for change are relatively insensitive to the organizational structures, processes, and mechanisms required to attain their goals. For example, the Citizens' Board clearly valued a health system that would eliminate barriers to access and offer services in a sensitive and humane manner. It also wanted consumers to exercise decision-making power in the process. But Dey noted that the board's recommendations concerning the means to achieve these ends were rather vague. Many of the advocates for consumer participation are more ideological and value-oriented than pragmatic and performance-oriented.7

One reason for this lacuna is the finding that community groups dealing with social problems are more successful if they have and maintain an informal, nonbureaucratic structure. Joyce Rochschild-Whit found that such groups view themselves as transitory, consider themselves as part of a social movement but limit their growth and affiliations with other organizations, define their position and values in opposition to the status quo, and have a marginal economic base but do have a group of support professionals or experts to turn to when needed.8 Transformation into a bureaucratic structure develops as the movement becomes large enough to have members who seldom or never participate, comes to value organizational efficiency, builds up an internal set of experts, has an independent outside source of funding, and adopts a monetary reward system. This is the shift from communal to associative groups.

One reason for the shift toward bureaucratisation and hierarchy is that citizen participation and leadership may depend heavily on the presence and quality of staff support. The Citizens' Board recommended that consumer boards begin their own staff. Yet, review of fifty-one cases of consumer participation in U.S. Department of Health, Education, and Welfare programs concluded that 75 percent of the consumer boards and committees that had their own staff were able to implement citizen views, compared with 42 percent of those without staff. These boards that were able to use their staff to assemble information that was accessible but not readily available, and to collect and process other requested information, were the most innovative and had the greatest impact. Staff provided continuity and expertise that was missing from boards and committees composed of citizen volunteers. Dey argued that it is by becoming involved in systematic data collection that volunteers and consumers invest, learn, and have an impact on policy.

Much of the literature on citizen participation does not examine the relationship between the funding or sponsoring organization and the site or project. Comparable situations, however, are discussed in the organizational literature in terms of bridging strategies concerned with governance and coordination of multidivisional or M-structures.9 In the business sector, these consist of a general corporate or headquarters office that is responsible for strategic decisions (whether or not to continue, expand, consolidate, and so on) and several product-based or regional divisions that are responsible for operational decisions. Of particular interest are the constraints on the regional divisions. As Richard Scott pointed out, they are subject to the authority system of the parent organization, but they are expected to effectively compete against other companies or providers in a given market. In short, they operate between what Oliver Williamson categorized as "market" and "hierarchy."10

This organizational literature explores interorganizational relationships that are similar to those found between a funding or sponsoring agency and a group of demonstration sites or projects. Arthur Stackeoomber has identified a set of governing and coordinating mechanisms called hierarchical contracts that combine some of the arms-length features of contracts with other control features usually associated with internal authority relations.11 Such contracts would establish working relationships between the funding organization and its partners or grantees. Ideally, hierarchical contracts would contain conditional clauses to handle possible contingencies and to resolve disputes that arise under conditions of extraneous complexity and uncertainty. But this level of specificity is rarely attained.

In Williamson's terms, a governance structure must balance the funding and goals initiated by the funding organization (top-down process) and the needs of the grantees to be self-directing and free to use their discretion to solve problems and reach their goals. Many funded projects enjoy relative autonomy and occasional oversight by the funding or sponsoring agency; each site submits a quarterly report, attends a networking conference with other grantees once a year, and is visited by representatives of the funding agency or evaluators once or twice during the year. Much depends on the skills and commitment of the project director. Funding agencies, however, usually intervene if the local project is unable to self-correct or is clearly going down the wrong path.

Community-based partnership organizations must be able to evolve. The shift is inevitable toward a more open, informal, and bureaucratic structure and process. The more complex the task, such as planning, the more formal and still-driven the organization is likely to be. Trying to keep things informal may be just as destructive as forcing incorporation too soon. The reason for the current uncertainty in funder-grantee relations is lack of experience with hierarchical contracts, or at least lack of clear understanding of the roles and responsibilities of funders and grantees. This is further exacerbated when grantees or organizations receive funds from several funders and become aware of grant management differences and inconsistencies. Selection of the project director is crucial, and the funding or sponsoring agency should have a hand in it. Ideally, the funding agency needs to have confidence that the project director holds a philosophy of citizen participation; understands the evolution of community-based projects; and is able to work
with a local board, community stakeholders, and the representatives of the agency.

Project Leadership

The literature on leadership research, as opposed to the didactic how-to or anecdotal how-I-do-it literature, supports a contingency theory that leadership is situational and that the social and organizational environments mediate the relationship between leadership behavior and criteria of organizational performance. One aspect of leadership behavior pertinent to citizen participation is how leaders try to ensure that all parties for whom a decision is relevant have an opportunity to influence the final decision. The implication is that it is the responsibility of the leader to establish and maintain a participative decision-making process. Participative leadership styles do not lend themselves to simple tasks with unambiguous demands but instead are applicable to tasks that are more complex and ambiguous. N. R. Maier found that effective participative leaders exert substantial control over the interaction process during decision making. They share information with participants, prevent dominant personalities from having disproportionate influence, solicit input from relevant participants, minimize blame-oriented assignments, and redirect unresolved discussion.

Another germane concept is that of the emergent leader, that is, an individual who exerts significant influence over others in a task group for which there is no formally allocated authority. In newly formed groups in which the organizational culture is in the process of creating a social order and decision-making process, an emergent leader may better express and solidify the group's beliefs, values, and norms than can the initially designated leader. Harold Guetzkow found that individuals who assumed the leaders role in small-group network studies established themselves by having more adequate perceptions of the organizational situation than others did. They did not force their way into the leadership role, even though they were in a position to do so by withholding strategic information from the group.

John Frenly and Abraham Wanderman examined leadership as an important and crucial maintenance aspect of the organizational control mechanism of small, voluntary coalitions or partnerships. The leader's decision-making style and networking and visibility have been found related to maintenance of the coalition. These researchers asked whether leadership promotes or fails to promote empowerment; they found that an empowering style of leadership results in more active and successful coalitions. Successful leaders are more visible and involved, promote cohesion and involvement, support members' planning and decision making, and provide opportunities to participate in nonmeeting activities. Leaders who promote spending time outside of meetings working on committee tasks had more successful organizations.

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In a study of teams charged with planning and establishing substance abuse prevention programs, Kumpfer, Knott, Hopkins, and Fahren confirmed that leadership that positively affects interrelationships among members, member-staff relationships, communication patterns, and democratic decision making was directly related to improvement in the individual members' knowledge of substance abuse and development of better prevention plans. In addition, they found a direct path relating leadership to satisfaction, satisfaction to increased perceptions of team efficacy, and efficacy to better team outcomes.

Many projects expect participative leadership to emerge and become the champions for the health improvement plans and subsequent implementation projects. The real problem is that little is known about what public-interest group advocates or champions do, and why and how they do it. In a survey of public-interest group founders, Anthony Newies and Grass Neely discovered that even though some public-interest groups are created by foundations or other patrons, most are formed in response to specific, identifiable events or disturbances. The advantage of the latter is that leadership emerges and the free-rider problem does not operate for most small groups just starting out. Coalitions or partnerships that are formally created by granting agencies face the problem of leadership identification and selection; they must overcome the free-rider problem since the one or two members who might pay for or organize the effort on their own have not voluntarily come forward.

In a project that is not created by the community, it is vital to support nonprofessional or nonadministrative individuals who emerge and take the initiative. This is especially true if they cannot count on their efforts on the project as work-related or subsidized. They should also have free rein on rewards such as travel to national conferences. If such an individual becomes the chair or holds another office that requires a good deal of time and energy, he or she may deserve a stipend or at least a reimbursement to cover travel to meetings, phone calls, and faxes. The leader should have some degree of organizational savvy and may need training to be an effective participation-oriented leader.

Conclusion

The topics discussed in this paper go from the general to the specific. We have highlighted some of the existing thoughts on the relative importance of and key issues associated with systems change, knowledge transfer, civic engagement, inclusion, decision making, project organization, and project leadership.

What does the literature tell us about planning efforts to change the organizational focus of health care delivery? Intentionally trying to change the health care system is a complex and multifaceted effort. Requiring broad-based citizen participation in the planning process raises distinctive challenges. To overcome the traditional situation of planning by experts and implementation
by administrators, citizens and other directly affected stakeholders can be brought to the table to actually develop the plans de novo. This can, however, prove to be a formidable task.

Changing the health care system, even on a regional or county level, is not something that most civic organizations or community advocacy groups undertake. Rather, they are interested in problem solving and will work to add new services or replace those that are cut. Since the health care system is very complex, an outside-inward strategy for change seems more appropriate. The outside change agent may act as a catalyst, solution giver, process helper, and/or resource linker. Regardless of the role(s) assumed, the change agent should set clear, long-term goals and objectives but leave room for citizens to work out the best way to achieve those ends themselves.

The change agent should facilitate knowledge transfer by means of which everyone—consumers, purchasers, providers, and project staff—can learn about the nuances of the health care delivery system together. This does not mean, however, becoming an expert in health statistics, health insurance, managed care, or referral patterns. Citizen participation in creating and writing a community health plan requires that they understand the planning process and know about specialized personnel who can support and guide them. People turn to consultants when they realize their need for technical assistance, and they prefer consultants who do not dictate process or determine outcomes.

People who participate in planning efforts are more likely to be better educated and have higher incomes. This means they most likely have a regular source of health care and insurance. A citizen's planning effort, then, must overcome barriers to collective action. In addition, if the problem is readily identified and soluble, the tendency is not to plan but to defer to the providers.

Not enough attention has been given to the structure and organization of citizen participation in health planning efforts. Although the number of people who can serve on a steering committee should be limited, many people should have the opportunity to serve on various planning workgroups and thereby contribute to decision-making. Planning is not an informal, ad hoc process. It requires a certain degree of bureaucratization and staff support. Having a competent staff that is accountable to the planning entity improves the process and final product.

In short, if community-based health planning efforts are to be successful, there must be attention to the details at all stages. First, there needs to be an understanding of systems change and a strategy to achieve it. Second, changing health care systems is a complex, technical process. As such, participants must be educated on both the big picture and some small intricacies of the system. Therefore, serious consideration must be given to the type of information provided and the manner in which it is disseminated. Third, by definition, citizen participation in health planning requires civic engagement. However, this is not always easy to achieve, since there are high costs and few incentives for participation. Fourth, participation in and of itself may not be enough. Rather, it is the nature of the participation that matters. Processes that are inclusive and take care to involve an array of representatives may be more palatable, but they are also likely to be more time-consuming.

A fifth point is that citizen participation in decision-making processes should bring all the major players to the table to create consensus, or at least to institutionalize disagreements and negotiate compromises. Sixth, a successful community initiative moves from the informal toward a more formalized structure. Thus, case must be made to organize a project. Seventh, project leadership is a crucial component of success. Those visible project leaders who embrace a participatory style are and effective go a long way toward helping move a project forward. Similarly, national leaders who emerge from the planning process are key to achieving project goals.

Not every initiative contains all seven of these earmarks for success. But the more that are embraced, the greater the likelihood of ultimate success of the project or plan and satisfaction on the part of participants.

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is not always easy to achieve, since there are high costs and few incentives for participation. Fourth, participation in and of itself may not be enough. Rather, it is the nature of the participation that matters. Processes that are inclusive and take care to involve an array of representatives may be more palatable, but they are also likely to be more time-consuming.

A fifth point is that citizen participation in decision-making processes should bring all the major players to the table to create consensus, or at least to institutionalize disagreements and negotiate compromises. Sixth, a successful community initiative moves from the informal toward a more formalized structure. Thus, case must be made to organize a project. Seventh, project leadership is a crucial component of success. Those visible project leaders who embrace a participatory style and are effective go a long way toward helping move a project forward. Similarly, national leaders who emerge from the planning process are key to achieving project goals.

Not every initiative contains all seven of these earmarks for success. But the more that are embraced, the greater the likelihood of ultimate success of the project or plan and satisfaction on the part of participants.

Notes

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24. Consumer Board of Inquiry into Health Services for Americans (1972).


27. Reiss and Swint (1973).


34. Reiss (1958).


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