Self Care as an Innovation in Health Care Delivery: The Health Systems Agency as Medium and Barrier

Yvonne Marie Visssing
Western Michigan University

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SELF CARE AS AN INNOVATION IN HEALTH CARE DELIVERY:
THE HEALTH SYSTEMS AGENCY AS MEDIUM AND BARRIER

by

Yvonne Marie Vissing

A Dissertation
Submitted to the
Faculty of the Graduate College
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requirements for the
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This is an inquiry into the attitudes of Health Systems Agency Boards of Directors toward the use of self care as part of the health and delivery system. Self care is viewed as a current social movement in health care. Contributions and limitations of both classical social movement theory and resource mobilization theory were examined for their utility in understanding and making predictions about the self care movement. Self care attitudes of the boards of directors from all eight Michigan Health Systems Agencies (HSAs) were analyzed through the Self Care Attitude Index (SCAI). Data were gathered via self-administered, mail questionnaires. Board member endorsement of a series of proposed self care programs was analyzed according to the member's consumer/provider sex status, and socioeconomic status (SES). None of these variables were found to be associated with self care endorsement when analyzed in bivariate fashion. Age, consumer/provider role and SES were found to contribute one-third of the variation of self care endorsement when analyzed through the use of a stepwise multiple regression model. Formal policy statements of the HSAs were also analyzed to determine HSA support for self care. It was found that HSA board members are highly supportive of self care in the
abstract, but that HSA goals do not reflect a strong commitment to self care.
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Yvonne Marie Vissing
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CHAPTER I

Statement of the Problem

Introduction

This dissertation is about the attitudes of health planning boards of directors toward the use of self care as part of the health care delivery system. Levin (1977) regards self care as the most frequently used health maintenance behavior by individuals, yet it is not typically a part of our total health care delivery system. It is asserted that self care can reduce health care expenditures while benefiting the health of individuals. Self care is advocated as a component of disease prevention and wellness, as opposed to ex post facto medicine (Ardell, 1976; Ullman, 1978). Self care is regarded as a health care movement, promoting a new health ideology that places greater emphasis for health maintenance in the hands of the individual (Levin, et al., 1979).

But how successful is this health care movement in influencing those individuals who have been mandated with the responsibility for health care planning? Do health care planners support the basic premise of this movement? If the planners do support this health care movement, to what extent is this support manifest on a public level? To what extent is it reflected in the formalized health care structure?
Before these questions can be addressed, one must first understand the nature of the agencies that are responsible for health planning, the Health Systems Agencies, as well as the nature of self care.

HSAs - History and Structure

Health Systems Agencies (HSAs) are health planning organizations that have been created and mandated by the Federal Government to deal with current problems of the health care delivery system. These agencies are based on the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). Approximately 200 HSAs have been established nation-wide to plan, allocate resources, and monitor health services in their geographic area. HSAs are federally monitored and financed, and are given responsibility for data collection and analysis, for plan development and implementation, and for review of applications for the development and expansion of medical facilities and programs. PL 93-641's primary objective seems to be the cost containment of health services, but other major HSA objectives are: to improve the health of the residents of their service area; to increase the accessibility, acceptability and continuity of health services; and to prevent unnecessary duplication of services. The planning legislation places the primary responsibility for planning at the regional (substate) level to give precedence to local perspectives in the preparation and implementation of plans. At the regional level
professional planners are hired as staff to recommend plans for ac-
tion and to review existing programs, but the ultimate legislative
power for implementing plans and programs resides in the hands of
the boards of directors (Mott, 1978).

While some administrative staffs in social agencies have been
shown to control boards of directors and the administrative policy
directions, "...the ultimate social agency authority inheres in the
board of directors" (Slavin, 1978, p. 111). While professional
staffs have the ability to influence a board of director's policy
decisions to some degree, it must be noted that the staff and boards
have different functions and different ideological orientations
(Slavin, 1978). The HSA board has more autonomy from staff in-
fluence because of the presence of health care providers as board
members; historically, providers of health care have fully deter-
mined health care services and policies. It is difficult for the
HSA professional staff to equal the medical experience and expert-
tise held by physicians (Perrow, 1963).

According to federal mandate, the HSA boards of directors must
consist of a consumer majority of 51 percent - 60 percent, recruited
from residents of the area. The consumers must be broadly represen-
tative of the social, economic, linguistic and racial population of
the area (Young, 1979). The consumer majority is designed to give
consumers of health care services a greater role than they his-
torically have had in the operations of our health care delivery
system. Consumer participation is regarded as a significant
methodology to assure public accountability and equity within the context of community held beliefs (Klaw, 1975).

The remaining percentage of the board of directors are comprised of direct providers of health care services (i.e., hospital administrators, physicians) or indirect providers (doctor's spouse, banker, who is also a hospital health insurer, et cetera) (Young, 1979). Consumers and providers are expected to bring different perspectives to issues and to generate solutions for health care problems from these perspectives. Issues of concern for health care are expected to be reflected in the discussions about health needs, and especially in the decisions and policies the board members advocate. The consumer majority of the HSA board of directors theoretically assures that consumer interests will be advocated and protected by the HSA.

Self Care

What is self care?

Although self care is a concept that appears so self explanatory that it is seldom formally defined, the concept in its "common sense usage" is currently the subject of professional and lay meetings, conferences and articles (Linn and Lewis, 1979, p.183). Levin (1975) has offered the following definition of self care:

...a process whereby a lay person can function effectively on his own behalf in health promotion and prevention and in disease detection and treatment at the level of the primary health resource in the health care system (Levin, 1975, p.242.)
Self care encompasses the traditional health education concepts of health promotion, health maintenance, and illness prevention as provided by the individual (Linn and Lewis, 1979). Self care is based on intervention at the individual level by the individual. Self care proponent Tom Ferguson, founder of the Journal of Medical Self Care, states that most people do not know enough about evaluating and improving their health before they get sick and they are not knowledgeable about preventing illness. They also do not know how to cope with illness effectively when it does occur (1978).

Self care focuses on health care delivery as provided by the individual to oneself or one's family, in lieu of care provided by a physician or other health care professionals. Self care emphasizes personal responsibility for maintaining proper health and avoiding disease. If intervention is required, providing as much of the needed intervention as possible without psychological or economic dependence on outside health care professionals is also encouraged (Levin, et al., 1979).

Self care is also regarded as a crucial part of the holistic health orientation. Ullman (1979) says that holistic health is actually based on four current health care movements. These movements are the self care movement, the human potential movement, the women's movement, and the environmental movement. Self care is also promoted in Donald Ardell's works on high level wellness (1976). He advocates taking proper care of oneself on mental, spiritual and physical levels in order to not only avoid illness, but to establish maximum health, or a condition he refers to as
"wellness."

But the thrust toward self care can be seen as more than one aspect of the holistic health orientation. It can be seen as a social movement in and of itself. Levin et al. (1979) regard self care as a social movement that is gaining considerable power. They note:

From the point of view of the individual, (self care) would be consistent with psychological development, needs, and desires. From the social point of view, it would embody and express generally recognized ideals or democratic participation and the citizen's right to pursue life and happiness. Applied to the field of health, these social/political goals would encourage professionals and administrators to facilitate the widest possible participation of the individual in the maintenance of his own health and psychic well being (Levin et al., 1979, p. 32).

Self care then is but one of a series of health movements that are currently developing. These health movements provide alternatives to many of the practices and delivery procedures used by the traditional health care system.

Self Care Utilization. Self care is not a new or uncommon phenomenon. Several researchers (Levin, 1977;) have found that 75 percent to 80 percent of all health care is provided by lay people to themselves and their families without professional intervention. Self care is by no means limited to minor ailments, and may focus on chronic diseases as well.

Lay people appear to be almost entirely responsible for their own strategies of health promotion and prevention, and the control of
symptomatic episodes, nondisabling illnesses and injuries, and the continuing responsibility for chronic conditions. Needless to say, the lay resources in self care is not accounted for in health planning (or delivery) (Levin, 1977, p. 51).

Godfrey Hochbaum (1978) has calculated that the average person spends less than one-tenth of one percent of his/her lifetime in direct contact with a member of the medical profession. In developing the importance of this observation he states:

That is less than one hour in every 2000. The other 1999 hours you are on your own. You make decisions about eating, drinking, smoking, exercising. These are more important than any the doctor may make for you. So, in effect, you already are acting as your own doctor most of the time. The trouble is, you need some training (Hochbaum, 1978, p. A-12).

In a very real sense the professional care system is supplementary to the lay health or self care resource (Levin, 1977).

The best estimates available indicate that the medical system (doctors, hospitals, drugs, etc.) affect 10% of our usual health indices; the remaining 90% are determined by factors over which doctors have little or no control, such as individual lifestyle or environmental factors (Wildavsky, 1977). Knowles (1977) asserts that the health care system would be more effective if it focused on the prevention of disease instead of focusing on treatment. He notes that a shift toward prevention will be difficult, since it requires forsaking habits detrimental to health acquired over a lifetime. It calls upon the individual to make a philosophic as well as a practical shift in viewing the importance.
of self care as a treatment strategy. Knowles states that a self care-prevention orientation would not only help the individual to achieve better health, but that it would also help avoid the dehumanization often present in professional medical systems.

**Economic Benefits of Self Care.** A component of self care ideology is that such self care implementation would result in significant economic benefits to the individual and to society (Levin et al., 1979). In 1978 more money was spent on medical care in the United States than ever before. Over 216 million individuals spent $139 billion (8.6% of the Gross National Product (GNP)) on drugs, physician fees, surgery, laboratory tests, hospital overhead, and so on. This is an increase from $39 billion (5.9% of the GNP) in 1965 (Ferguson, 1978; Knowles, 1977).

But is this expense for health care really necessary? Knowles (1977, p. 75) states that a move toward self care, focusing on helping individuals prevent diseases and care for themselves in certain cases, could have significant economic benefits.

No one—but no one—can deny the fact that billions of dollars could be saved directly, and billions more indirectly (in terms of family suffering, time lost, and the erosion of human capital) if our present knowledge of health and disease could be utilized in programs of primary, secondary, and tertiary prevention. The greatest portion of our national (health care) expenditures goes for the caring of the major causes of premature, and therefore preventable, death and disability (heart disease, cancer, strokes, accidents, etc.) (Knowles, 1977, p. 75).

Brody (1978) points out that crisis oriented, after-the-fact
medicine is too costly and not likely to produce a healthier population, whereas an emphasis on prevention can not only improve the health and increase longevity but also could cut the costs of health care by as much as half. In 1978 more than 98% of the nation's medical care bill was spent on attempts to cure and control illness; less than 3% was devoted to prevention, and less than 1% was for health education (Brody, 1978). As Theodore Cooper, former Assistant Secretary of Health in HEW wrote:

We do not have to await some discovery or parade of discoveries to open up new paths to better health for Americans. What we need is a new attitude toward health; the idea that individuals and communities have a major responsibility for their own health (Brody, 1978, p. G-3).

Self care in its most basic sense is thought to be a concept that serves to benefit the individual (Levin, et al., 1979). The emphasis on self care would also call upon other individuals besides the traditional medical community to be providers of health care services.

Alternatives to professional intervention appear to offer more accessible, acceptable, less hazardous and less costly service—beginning with self care by the lay person and peers. It may well be that the professional resources required for chronic disease management are educational services, renderable by and large through and under the control of nonmedical institutions (e.g., schools, churches, union, service clubs) (Levin, 1977, p. 49).

Levin (1977) states that in the ideology of self care that the "consumers" of health care of today could be turned into the "providers" of health care tomorrow merely by a recognition and re-definition of the active role all individuals could play in their own
health care. The term "prosumer" has been coined to illustrate the merging of the provider and consumer roles (Toeffler, 1980).

**Limitations of Self Care.** The benefits of self care have been posited in individual, medical, and economic terms. Yet, as Kronenfeld (1979) notes, self care should not be regarded as a panacea for the ills of the health care system. She explains that a danger exists in this approach, the danger of a sophisticated form of "blaming the victim." She fears that people who are too poor or too uneducated to participate in self care will be accused of 'causing' their ill health. She also discusses: the lack of assessment on the realistic possibilities of self care among individuals from different social strata; the many important influences on health that an individual cannot change alone; and the actual potential of the self care movement to reach large numbers of people and to effect significant changes in their behavior. Kronenfeld states that the self care movement is essentially a white middle-class movement. This movement seems to be endorsed by a limited section of the population rather than being endorsed by a broadly based population. She warns us that self care: can be used as a pacification technique to reduce demand for more or better health services; may have little transferability to the poor; and that it may be a fad or will be co-opted by the health establishment. Thus, the criticisms of the self care concept go beyond the question--is the individual capable of providing health care to oneself? - to larger, more important structural questions.
Conclusions

The nature and endorsement of self care ideology suggest that the consumer orientation present in the HSA boards and the consumerism of the self care ideology could create a natural identity of interests and approach. This would indicate that the HSA board members would be supportive of self care ideology. But to what extent is this true?

This promotes the questioning about the HSA as an effective vehicle for promoting self care ideology. It seems appropriate to view self care as a social movement, or as one of a system of related social movements. An attempt will be made to understand the relationship of self care as a social movement to the HSAs. HSAs are at the same time reflections of the existing health care structure as well as a logical vehicle for achieving the social movement objectives.
CHAPTER II

Theoretical Orientation and the Development of Propositions

Various theorists (Levin, et al., 1979; Kronenfeld, 1979) regard self care as a current social movement; however, no attempt has been made to link systematically this self care movement with characteristics of social movements. In this section, such a linkage will be developed to determine in what ways one can regard self care as a social movement. Through this analysis, key variables will emerge that will guide the development of research propositions for this research.

What is a Social Movement?

There are many definitions of social movements. Blumer (1951) regards a social movement as a collective enterprise to establish a new order of life. Heberle's (1951) definition is similar, focusing on collectivities bringing about fundamental change in the social order. Turner and Killian (1972) expand the definition of social movements to a collectivity acting with some continuity to promote or resist a change in the society or group of which it is a part. They combine the key aspects of several social movement definitions in a more elaborate definition. They see a social movement as a dedicated group of people organized to promote or resist change. This group has definite goals and ideology, while they consciously and purpose-
fully promote change through political and educational activities.

It will be shown in this section in what ways self care can be seen as a social movement. The collectivity of individuals who are dedicated to the increased role of self care in our health care delivery, will be discussed, as well as how they promote change within our traditional medical institution. Medical self care has an ideology which surrounds it, complete with values, beliefs and goals. This ideology is promoted through a variety of educational activities and confrontations with the existing medical power structure.

In order to view self care as a social movement, one must first focus upon characteristics of which a social movement consists.

**Characteristics of Social Movements**

Among theorists of social movements, several characteristics of social movements are cited with near unanimity. A collectivity of people must have shared grievances over problems, and view these shared experiences through a common ideology or system of beliefs. Social movements must rise from discontent produced by some condition of structural elements, and the movement collectivity must develop goals to change the source of their discontent. Social movements require the presence of both leaders and followers (Heberle, 1951; McCarthy & Zald, 1977). McCarthy and Zald (1973) maintain that traditional social movements also require communication among the members, noting that environmental factors may effect the communication process and, ultimately, the possibility for social action.
While these characteristics are generally agreed upon as present in all social movements, some theorists develop specific concepts they feel to be more crucial to the understanding of the nature of social movements. Curtis and Zurcher (1974) promote the existence of social movement goals and the condition of membership requirements as the most crucial elements to consider. Goals may either be: expressive - goal oriented toward satisfying the social and psychological needs of the members; or instrumental - accomplishing specific tasks which are external to the organization. Membership requirements may be either: inclusive or exclusive. In the inclusive type, there is no rigorous screening of members, providing little or no indoctrination period, with minimal activity levels necessary for commitment. In the exclusive type, a rigorous affiliation process exists, from initial screening, through membership duties. Turner and Killian (1972) have attempted to classify social movements into types, but note that social movements never fall exactly into a given type meeting all the characteristics. Social movements vary in the emphasis given to its characteristics, and over time may change its focus. They state that most movements contain either a power orientation or a value orientation, and that movements will vary according to which of these elements is dominant.

The collectivities participating in social movements may vary according to their degree of organization. Blumer (1951) discusses the difference between crowd, mass and public. These groups may effect the development of a social movement in different ways. He notes that there are four main characteristics of a crowd. A crowd
usually is formed around an exciting event which catches the attention and interest of people. Because of this event, people mill together, becoming more aware of others and their concerns until a common objective of attention emerges. Crowds need to be stimulated to act on behalf of the objectives that have been set, and often do so because of their feeling of unanimity. It must be pointed out that crowd objectives may range from release of tension to full scale plans of action.

Blumer (1951) describes a mass as a number of separate individuals, each responding independently to the same stimulus in the same way. The distinguishable features of a mass are: membership may come from all walks of life; individuals tend to be anonymous; little interaction or exchange of experience between members occurs; and that the mass is loosely organized and not able to act with the unity of a crowd. A mass has little, if any, social organization. Members of a mass tend to act spontaneously with each individual acting in behalf of his or her own needs.

A public refers to an aggregate of people who are confronted by an issue, people who may be divided in their ideas as to how to meet the issue, and who engage in discussion over the issue. In a public, there is no "we-ness," or fixed roles of members. A public is marked by disagreement and discussion, and often tries to shape opinion by arousing emotional attitudes and even by providing misinformation.

Blumer concludes by explaining that a crowd acts by developing rapport; a mass acts by convergence of individual selections; and
a public acts by arriving at collective decision and developing a collective opinion.

Hopper (1973) uses Blumer's descriptions in his explanation of the development of social movements. He says that movements pass through distinct stages, from mass to crowds to publics and finally to the institutional stage. The mass stage is sufficiently noted previously in the description of Blumer's work. Hopper elaborates more on the crowd stage. He states that this stage is a time of popularization of unrest and discontent, a time when the dissatisfaction of the people results in the development of collective action. Intellectuals are often brought in to provide credibility to this effort. This stage may become so popular it seems contagious because of the high degree of emotion that is involved. Clear objectives develop which can be achieved through the in group relationships, and the formation of informal fellowship associations. Leaders here tend to be of the prophet or the reformer type.

The public stage is also more fully described by Hopper as it pertains to social movements. In this stage the previous stage becomes more formalized both in issues, goals and procedures. The roots of the movement must go beyond sensationalism and fad; it must appeal to the essential desires of the people. Discussion and deliberation over the issues must result, even at the expense of conflict between members. Policies begin to emerge, and goals, values and ideologies develop which represent the group's consensus. The public often criticizes and condemns an existing social order which the movement is seeking to change. The public also has a defense
doctrine to justify its goals and ideology. Leadership in this stage is carried out by people who are able to formulate policies and who will attempt to make these policies into practice.

The last stage, institutionalization of the issue, represents the subsiding of conflict between the social movement and the existing social order. Accommodative and/or assimilative processes emerge within the existing social order, and administrators become the major leaders. Thus, the need for a social movement subsides.

Morrison (1973) approaches the understanding of a social movement by noting that one must focus upon deprivation as the key variable in the explanation of movements. Deprivation concerns discontent over the situation one is in. Deprivation also depends on the wants of a collectivity of people, as well as their needs. Thus, social movements are regarded as power oriented, posing those who are deprived against the elite. Morrison states that the notion of deprivation as it applies to social movements has two components. One component concerns legitimate expectations that a group feels are good, expectations or goals that they have a right to obtain. The other component concerns the barriers to obtaining the desired goals or expectations. Real or perceived blockages for realizing the goals thought to exist, and that these barriers can be removed if the movement is successful.

Killian (1973) defines social movements as having: the existence of shared values or goals which are sustained by an ideology; a sense of member participation or "we-ness" - a distinction between those for and those against; special norms regarding how the members
should act, definitions of out-groups, and the redefinition of symbols to take on new meanings; and a structure must develop which divides the leaders from the followers of the movement. Leaders may be charismatic, simplifying and symbolizing the ideology of the movement; administrative - promoting the ideology of the movement; or intellectual - elaborating and justifying the ideology. A lack of any of these characteristics can lead to weakness within the movement.

Other theorists state that while the traditional characteristics of social movements are important, a more updated approach is needed if one is to understand current day social movements. McCarthy and Zald (1973, 1977) have developed the 'resource mobilization theory' to add to our understanding of social movements. They elaborate on traditional social movement theory, especially on how elites attempt to exercise control over the movements. The resource mobilization theory directs social movement theory away from social psychology and focuses more on social processes. McCarthy and Zald (1977) question the link between discontent, belief and the rise of social movements, and promote the resource mobilization theory as an alternative which focuses more sharply upon the power and process aspects of social movements. They note that professionals hired by social movements to represent the cause on a full-time basis are increasingly common; that much financial support is provided by interested third parties to help the movement's momentum; and that the mass media can be used - especially by the elite - to represent and control the momentum of the social movement. McCarthy and Zald
(1977) admit that their resource mobilization theory is only a partial theory, and that its central concepts are proposed more than supported. Thus, while the theory has limitations, it can provide insight into the understanding of social movements.

The notion that the mass media are an important influence in the progression of social movements is not unique merely to the resource mobilization theory, but applies to all social movements today. Molotch (1974) states that the movement does not shape the media coverage it receives, rather the media shapes the movement. Molotch agrees with McCarthy and Zald that the media are a tool of the ruling elite. Those individuals controlling the media decide what is newsworthy and how to portray the issues involved, which ultimately affects society's perception of the movement. Politics, social values, and competitive desires are all involved, and Molotch states that the elite tend to control these.

But social movements do not consist merely of characteristics at a given time, rather social movements are seen to go through distinct stages as they develop from a concern over a problem to its resolution.

In the early stages of a social movement one can expect communication to be poor, and that specific goals will be unclear. The goals stem from a general, common grievance, and as the movement progresses—as a well defined leadership and communication system develops—one sees more defined goals and group action develops. The ideology takes form and becomes a crucial element to the social movement. The size and intensity of a social movement is
thought to reflect the existence or nonexistence of grievances. Mauss (1973) notes how all social movements move through stages, from inception of the problem, to the coalescence of concerned individuals into action. If the movement has been successful in the coalescence of members around a grievance, then change on an institutional level to reduce the source of the grievance is sought. If the movement is successful and the desired social changes are incorporated into the institutional structure, then the movement will cease to exist.

The success or failure of a social movement depends on the complex interaction of many factors. In traditional social movement theory the political elite are gatekeepers of the movement. The elite can either respond or fail to respond to the goals of the social movement collectivity, and in doing so, the memberships are satisfied or frustrated (McCarthy & Zald, 1973). McCarthy and Zald predict that elites will generally not be receptive to social movements, and the established social institutions will not vigorously support new movements. They assert that elites will try to control the direction of dissent or attempt to minimize the dissent. Mauss (1973) adds to this understanding by his notion that the establishment will try to repress social movements when the goals are not to its advantage, and will try to co-opt the movement when the goals can be used for its advantage. Either way, there is a tendency for the elites and the establishments of which they are a part to control and reduce the social movements.
Does the self care phenomenon exhibit those characteristics that permit us, in the useful fashion, to view it as a social movement?

Self Care as a Social Movement

Self care has been proclaimed to be a social movement (Levin, et al., 1979; Kronenfeld, 1978), yet it has never been systematically analyzed as such. The self care movement can be usefully regarded as a social movement because it meets the essential characteristics of a movement. The ideology of self care concerns greater consumer (or patient) responsibility for one's own health, less dominance of the consumer by the provider/physician, greater humanization of health care services, a greater emphasis on prevention, and low cost yet quality health care (Carlson, 1977; Levin, et al., 1979; Strauss, 1975).

The members of the self care movement share common grievances against the medical system. These grievances are illustrated by the establishment of formalized goals. The goals of this self care movement essentially attempt to give the consumer more information on the prevention, diagnosis, and treatment of disorders so that the consumer is more independent from the professional health care system. Individual education on the "how-to's" exist via literature, workshops, and through interpersonal communication (Reeder, 1977; Ferguson, 1978). Provider education also exists, largely through the political realm (Reeder, 1977). The goals of the self care movement can be understood through Curtis' and Zurcher's expressive
goal description. In this case social and psychological needs must be satisfied. The social and psychological needs that the consumers have to gain greater control over their health care are great. The healing process is based on the psychological level in large degree (Frank, 1974; Simonton, 1978), so a case could be made that self care may lead to greater health merely by giving individuals more "control" over their health care delivery. Reports of consumers feeling "dehumanized" and "victimized" in the health care delivery process (Strauss, 1975) also lay a foundation for psychological and social needs of consumers that must be satisfied through this movement.

Inherent in the self care movement is the grievance that the consumer of health care services is often powerless in determining the types and quality of medical care received by health care professionals. The members of the self care movement point out that the expert oriented, impersonal health care structure removes the ability for the ordinary person to become the master of his/her own destiny. Often health care professionals act as if the consumer of health care services is unable to grasp the complexities of how the body functions, while the consumer actually knows a great deal about how his/her body operates (Illich, 1977; Strauss, 1975). The goals that self care advocates promote do more than give the consumer greater control over their health care; it seeks to question and undermine the powerful position of the health care provider. Structural changes within the traditional health care delivery system are inherent in the self care movement--changes that concern who
should give, which health care strategy, where, at what time, at what price, and in what manner.

The collectivity that makes up the self care movement can be best described through Blumer's and Hopper's understanding of the public. As this relates to the self care collectivity, we find that the self care issue has passed beyond the mass and crowd stages into the more formalized stage of the public. It is popular for many isolated individuals to criticize the health care system; however, when one moves beyond the popularity and emotionality of the discontent, the formation of group discussion and deliberation over substantive issues must result. People who criticize the health care system are not necessarily members of the self care movement. Therefore the existence of the public may be a precursor to a broad social movement and a feeder into the present self care social movement to the extent that it exists. Those individuals who seriously debate the role of health care, who set forth concrete goals and strategies for achieving those goals, are the true members of the self care movement. The ideology of the self care movement is fully developed, meeting a central criteria of a public. The self care movement has developed elaborate documentation to support their positions. The collectivities that best reflect the self care movement are groups like the National Women's Health Movement; other women's health organizations; consumer groups akin to Ralph Nader; self help groups like "families for home dialysis;" or Alcoholics Anonymous; or organizations like The Committee for Choice in Cancer Therapy or the Cancer Control Society. These groups may not consult with each
other and may act independently with specialized goals, yet they are reinforcing because of the similar orientation and similar impact they have on the health care delivery system.

These collectivities rely on intellectual leaders or professionals/experts to promote their positions. This aspect also meets the criterium for establishment of a public. The self care movement must rely on expert documentation in order to present a valid argument against the health care delivery system. Of the three types of leaders discussed by Killian, the self care movement tends to have several intellectual leaders, like Lowell Levin (1975); Richard Knowles (1977); and others who advocate self care as part of other health care ideology (Illich, 1977; Carlson, 1977). Administrative leaders are less recognizable, with consumer advocate Ralph Nadar exemplifying the leader who promotes the values of the movement within the larger structural element. No truly charismatic leader for the self care movement has yet emerged to symbolize the values of the movement.

Self care, then, can be regarded as a social movement because it does contain key elements necessary for a social movement - shared grievances, ideology, goals, leaders, and followers. Yet it is important to note that self care is not as developed as many social movements. There is an emerging trend, however, that illustrates how interest in self care is becoming generated into a more formalized social movement.

There exists historic documentation for the discontent that many individuals felt toward the health care delivery system (Ehrenreich,
This early discontent was regarded as a personal problem of the health care consumer, until individuals became aware that other consumers of health care services had similar grievances (Boston's Women's Health Book Collectivity, 1977; Corea, 1977). So the early stages of the movement in which there was an unfocused sense of discontent, no goals, and poor communication among potential members was succeeded by a more developed stage. In this new stage ideology and goals developed, leaders and followers began to emerge, and the size of the movement began to grow. No longer was discontent with the health care system a private problem - it became a social problem which many researchers began to address (Friedson, 1963; Illich, 1977; Carlson, 1977). The discontent with the health care delivery system became more defined and specific. Self care became the specific issue, not health care reform in general. Health care reform was seen to be too broad an issue to tackle, whereas self care was more manageable. As Mauss describes in his stages of social movements, in the second of the three major stages (after inception and before institutionalization), the movement has begun to coalesce into action. The self care movement is coalescing support from increasing numbers of members, and more intellectual leaders are emerging in this movement which focuses on both power and value concerns. Whether or not the self care movement will be successful in impacting the institutional level depends on the degree of coalescence.

Traditional social movement theory has been useful as a guide in explaining self care as a social movement. Generally, traditional
social movement theory is more useful in explaining self care as a movement than is the resource mobilization theory. While resource mobilization theory is useful in focusing on the role of the media and professional participation, it seems limited in application to self care because it downplays the role of discontent and beliefs in the development of social movements. As will be shown, the role of discontent and beliefs plays a critical part in our understanding of self care as a social movement. However, this is not to say that mobilization theory is not a useful approach. McCarthy and Zald (1973) discuss the way the government has created professional participants in social movements. By requiring citizen participation on either an ad hoc or permanent basis to social programs and agencies, the government has attempted to create a forum for the articulation and resolution of grievances. The HSA board of directors would be a prime example of this point. The resource mobilization theory also brings attention to the importance that the media play in the construction of a social movement. While Molotch points to the media as a tool of the elite, the media have been at least somewhat critical of the establishment, the traditional health care system (Reeder, 1977), intentionally or unintentionally giving support to the self care movement.

The most salient elements between the self care movement and HSAs have been chosen for analysis in this research. Not every characteristic of the self care movement will be studied - only those most relevant for the convergence of self care and HSAs were chosen. These concepts are: how an established structure responds
to a social movement; the extent of the "consumerism" of the HSA consumer board members; the role of deprivation in the development of the social movement; and to what extent the social movement has been successful in influencing policy decisions (i.e., to what degree has structural change resulted?).

The review of both traditional and resource mobilization theories leads us to the conclusion that the self care issue in the United States has spawned what can be provisionally described as a social movement. Both the traditional definition and the resource mobilization definition of social movements are useful in describing, ordering and organizing the phenomenon. For this research the self care organizations and interests will be considered as a social movement in the making. The development of the propositions will lead from this perspective.

Development of Propositions

Proposition 1: Health System Agency Boards of directors will not be supportive of the self care movement.

Proposition 2: Health System Agency consumer board members will be no more supportive of self care ideology than are HSA provider board members.

Elites and Social Movements. In the analysis of social movements, it has been noted (McCarthy and Zald, 1973; Mauss, 1973) that established social institutions are not supportive of new social movements. They point out that established social institutions tend to be controlled by the elites, powerful members who have much to
gain in the existing social order. Such individuals do not give up their power easily, and tend to maintain the existing social structure. The more powerful an individual is, the more conservative that person will be as it relates to structural changes that will jeopardize his position (Lipset, 1959).

The elites in social institutions are often professional. Professionals in general hold a great deal of power over the non-professional individual. There are characteristics of all professions that help us to understand the nature of their positions. According to Vollmer and Mills (1966), professionals as a group are probably the most privileged and satisfied stratum in society. Their superior position is demonstrated by the high degree of prestige accorded them by the general public, and the high wages they receive. Professionals are usually upper middle class individuals who tend to live comfortable lifestyles. They tend to find more autonomy and freedom for personal decision making in their occupations. It is no surprise that professionals tend to be very satisfied with their jobs, and very satisfied with the status quo. Professionals tend to be among the more conservative elements in society, and generally oppose change, especially when it threatens their personal and professional positions.

Professions by their very nature contain control that experts have over the consumer of services. Goode (1960) asserts that once a professional group becomes established, it begins to consolidate its power by formalizing social relationships that govern the interaction of the professionals with their clients, colleagues, and
with official agencies outside the profession. This interaction creates society's recognition of the profession's claim to competence, as well as the profession's ability to control its own membership. This is seen to be necessary if public acceptance of the profession's claims to competence and the profession's control over its membership is to occur. The control that a profession obtains then may not be based on actual competence, but portrayed competence. Power can often be transformed into perceptions of competence.

The professionals in the health care delivery system who wield the greatest power are physicians. This is largely due to the powerful organization of the medical profession. While alternative providers of health care exist, they are not readily recognized since they are not a part of the traditional medical profession. Most of what we know about disease and their proper treatments comes from what the medical profession in general, and more specifically, from what physicians tell us. Physician control of our perception of disease and their respective treatments has "invaded the consciousness of Americans through (a variety of public education efforts and through) extensive media coverage so that few people are free from some passive acquiescence in accepting the doctors' pronouncements" (Ehrenreich and English, 1978, p. 4).

The power held by health care providers over their consumer counterparts cannot be denied. The power physicians hold as health care providers is apparent from both economic and prestige ratings. Physicians are the highest paid health professionals, and among the highest paid American occupations. The median 1978 income for
private office practice physicians was $70,000, while many earn much more (Cohn and Millios, 1979). According to Hodge's (1964) prestige rating of United States occupations, physicians were found to be the second most prestigious occupations in the nation, following only Supreme Court Judges. This prestige rating of physicians has been constant for many years. Thus, the occupation of a physician has strong monetary and prestige value associated with it. Combining these factors with the autonomy that accompanies the physician role, the physician can wield a great deal of control over the average individual.

**HSAs and Consumerism.** McCarthy and Zald (1973) discuss the importance of citizen participation/representation on governing boards of institutions. This consumer representation is asserted to provide an open forum in health and social planning representing a segment of the population that has previously been excluded from the planning process. Greater consumer representation is thought to create policies that are more satisfying to citizens who make use of the services. The inclusion of consumers in administrative capacities creates a visible forum for dealing with grievances that certain segments of the population feel (McCarthy and Zald, 1973). Indeed, it is commonplace to find consumer representation in administrative capacities in most health and social institutions (Lauffer, 1978).

Schwartz and Kart (1978) indicate that citizen participation, or consumerism, tends to take on some of the characteristics of a social
movement. Consumerism in health care may be seen as a product of shared perspectives. People in similar situations tend to view their problems alike and to evaluate them similarly. As in other movements, they note that there is a redefined perspective — the role of the consumers and providers of health care is altered. Consumerism manifests itself also in satisfaction or dissatisfaction with the system.

Killian (1973) notes in his study of social movements that it is critical to the success of the movement for a sense of "we-ness" to develop. This sense of we-ness creates a clear distinction between the movement members and those who are a part of the structure they wish to change. Cohesiveness between members creates solidarity which gives the movement greater internal strength to withstand external opposition. This sense of we-ness stems from the common grievances and ideology which have developed into the social movement. Inherent in this concept is the belief that common goals will be sought for and supported.

Health Systems Agencies (and their predecessors, Community Health Planning Agencies) are the first comprehensive governmental efforts to influence the health care system according to consumer perspectives. The role of the consumer on the HSA boards is regarded as an important one to allow for diverse community involvement and to downplay the historically dominant role of the physician (PL-93-641). Some HSAs have been found to be very oriented toward consumerism due to the number of consumer representatives on their boards of directors; however, some HSAs have been lead
toward increased consumer interests by "progressive" providers (Checkoway, 1980). This observation leads to the question—to what extent do HSA consumer board of director members advocate policy positions that are different from those of providers?

Research indicates that the differences between the consumers and providers on HSA boards are minimal (Grossman, 1978). Several studies have shown that HSA boards tend to underrepresent women, minority groups, low income groups, and the elderly (Nations Health, 1978; Hyman, 1976) in favor of white, middle class, middle aged men. Health care providers have been heavily weighted in favor of physicians and hospital administrators, with only a relatively small number of other health care providers represented (Southern Regional Council, 1977). Young (1979) promotes the notion that while there are consumers who may be attitudinally different from providers when they initially become HSA board members, during their membership they come to think and vote like providers. During the early days of HSA board membership, a learning process occurs in which consumers may change or realign their attitudes, beliefs, and advocacy positions and roles so that they are no longer representative of the views of their constituency. They become, rather, provider oriented.

Grossman (1978) found that consumers and providers tend to vote similarly when approving or denying project reviews. He states that consumers and providers tend to share the same interests and do not behave differently in their voting patterns. One reason why consumers may vote like providers may be due to a significant number of HSAs whose consumers have direct or indirect ties to health care
providers. Representatives of local government, big business, banks, and major purchasers of health care are known to serve in "consumer" seats on boards of directors (Parker, 1970; Philadelphia Health Care Project, 1977). Thus consumer board members of HSAs may not be representative of the actual consumers of health care in their area, despite the HSA mandate to have guidelines for membership categories (Young, 1979; Hyman, 1976; Marmer and Monroe, 1980).

Consumer board representatives have a problem with competence when they join with provider representatives in policy-making situations. Many professionals on boards hold that the consumer does not have enough knowledge or experience to make appropriate decisions about the medical profession's service delivery. This belief is one not easily dismissed, and has been at the heart of failures of consumer advocacy roles in human service agencies (Mitton, 1978; Mott, 1978). Mechanic (1976) discusses this concept in relation to the medical and lay administration of hospitals. He discusses expert knowledge and the ability of the medical profession to oppose lay administration decisions. The lay administration is not in a position to contest claims made by health care providers since she/he usually lacks the basis for evaluation of medical problems and also lacks official sanction to make competent medical decisions. Were the lay persons to achieve a position of power and competence, they must proceed along either of two lines. One is to have a group of medical consultants or a committee of medical personnel to serve as a buffer between the lay and medical administration perspectives. The more effective way for lay individuals to achieve power in rela-
tion to professionals is to obtain, maintain, and control access to information and instruments, thus making professionals dependent upon the lay community. However, both of these courses appear to be difficult (and infrequently achieved) for the consumer on the HSA board to implement as a normal course of action. The lack of knowledge, credibility, power, and organization of the consumer board representatives are big factors to overcome if they are to challenge the professional's position.

Another problem for the consumer HSA board member exists, a psychological problem that stems from having a lack of knowledge, credibility, and power. This concerns feeling inadequate and unaccepted by those individuals who are in the group of which the consumer is becoming a member. Research conducted by Kurt Lewin (1953) is useful in our understanding of the problems of new group members. Lewin notes that during most of our adult life we act not purely as individuals but as members of social groups. The various groups a person belongs to are not all equally important at a given time, for some will be more valued than are others. Generally, the individual knows the nature of the groups to which he or she belongs, where he or she stands, and these help determine appropriate behavior. But there are occasions when a newcomer in a group may feel uncertain whether he or she belongs to that group, or whether he or she is accepted. This is especially true when those already in the group display a great deal of confidence and acceptance. A period of uncertainty of acceptance can last for months. This psychological state leads to uncertainty in behavior. If a person does not feel
comfortable there will be a tendency for him or her to feel self conscious, inhibited, or to act inappropriately. This uncertainty and subsequent inability to pursue independent goals within the group occurs because the individual is crossing the boundary of one group into another group – moving from familiar group to unfamiliar ground. This affects how he or she acts in the old groups.

It is characteristic of individuals crossing the margin between social groups that they are not only uncertain about their belonging to the group they are ready to enter, but also about their belonging to the group that they are leaving (Lewin, 1953, p. 148).

Lewin notes that individuals may become uncertain whether they actually belong to which group, and to what respect and degree. Since the assimilation process into a new group can have a significant impact on how one relates, not only to the new group, but to one's position in the old group, it can create problems in determining loyalties, attitudes, and values.

The new group member's uncertainty can be used by the new group to incorporate him or her into their ideological orientation. The process of doing so, or of recruiting members with the goal of increasing institutionalization, is referred to as cooptation (Selznick, 1949). The strategy of cooptation is frequently used within organizations. Outsiders may be potentially threatening to those in power, and must be socialized to the legitimacy of the existing policies of the dominant faction in the organization if threat is to be minimized (Perrow, 1970). Coopted members are often given seats on the boards of directors and a say in policies which
might affect the organization they are to represent. Perrow (1970) notes that once coopted, there is no assurance that the member can be controlled completely, but by moving him/her into a policy making level the risk of wide publicity outside the organization is minimized. Thus, the new members will be "educated" to the needs of the community as the dominant group perceives them, and be put in a position which makes it awkward for them to oppose the policy of the dominant faction. Gouldner (1972) notes that this process of cooptation and control over outsiders is a commonly used practice in systems, like the medical system, to attempt to engulf individuals or subsystems that may be in conflict or opposition to its policies.

By achieving a more active role within the system the individual may think she/he can alter the system. In actuality, the system has gained tighter control over them and reduced their ability to gain access to power or cause conflict.

This cooptation process can greatly effect the role of the consumer in the health planning process. If the consumer board member lacks technical knowledge and is unsure about the appropriate role to play, cooptation may occur. The result is the consumer not representing his/her constituency, but adhering instead to the perspectives of the health care providers. HSA's have been found to be vehicles for specialized interests or providers, but consumers can be influential when they analyze technical information, take strong consumer positions, and express themselves with authority (Checkoway, 1980). But the lack of technical knowledge—or lack of investigation into the technology in question—is but one reason why
consumers do not play as active a role in health planning as they could. Provider groups have been shown to be able to mobilize technical as well as political resources, as opposed to the lack of organization and leadership of the consumers.

Levin, et al., (1979) fear that self care activities will be coopted by health care professions. They feel that damage to the integrity of self care will occur if professionals directly organize self care programs, or have influential roles in advising them. Self care research designed by health care professionals employs only professional criteria and therefore is seen to serve purely professional rather than public interests. Levin, et al., note that professional cooptation of self care literature, resources, and products has already begun.

Self care is an ideology that is seen to directly benefit the consumer of health care services. The majority of HSA board members are consumers of health care services. Thus can we logically assume that the consumer representatives on the HSA board of directors will be supportive of self care? For purposes of this research, such logic would be incomplete. It has been shown that HSA provider and consumer board members have not been very different in terms of voting patterns or demographic make-up. The literature also informs us about the impact that physicians can have over individuals who are not part of the medical profession—physician authority often overrides consumer advocacy positions since they hold expertise that the consumer cannot have.
Physician Attitudes Toward Self Care. How has the medical profession responded to the development of self care efforts? Only a minority of physicians seem active in purporting self care as a professional function for the individuals they serve. Darby (1973) notes how self help and self medication are very commonly used practices, and that they can be an effective and expensive way of treating the majority of unwell symptoms. Yet he concludes that current trends, including the expansion of the medical system and governmental legislation seek to minimize this practice as much as possible. Darby notes that professional resources and even detailed literary information on self care is controlled by the medical profession so that only limited information is available to the lay person.

Levin et al. (1979) state that the resistance by health professionals to increase the use of self care techniques is to be expected for many reasons. The reasons they cite are:

1. Professionals may deplore or resist the perceived invasion of their areas of expertise and exclusivity.

2. If primary care providers must transfer some of their present functions to individuals (patients or their families), they will likely transfer alternative or supplementary functions, like education.

3. Concern that self care will disrupt the doctor-patient relationship.

4. Health professionals may perceive a direct threat from self care to their economic position.
5. Shift toward self care runs counter to broad tendencies in society toward increased technological, expertise, and specialization.

Linn and Lewis (1979) have conducted a study indicating that medical profession reluctance to advocate self care services may be linked to negative attitudes toward self care by physicians. Approximately 200 physicians in California were surveyed to assess their attitudes toward self care. The authors found that the majority of physicians expressed negative attitudes toward self care. For example, over half of the physicians reported that self care would not reduce visits to the doctor, and may create more harm than good. The majority of physicians also felt that people cannot learn to take care of themselves adequately, don't want to, and shouldn't. Physicians with the most favorable attitudes toward self care were likely to have come from a Jewish background, to be under 46 years old, and to be employed in a group practice or clinic. Physicians with the least favorable attitudes toward self care were likely to have a Protestant background, to be between 46 and 63 years old, and be practicing medicine in a private practice. Linn and Lewis encourage the use of their survey instrument by other investigators to assess self care ideology by other practitioners and consumers of health care services.

Goldbeck (1978), has stated that while there exists much discussion on the merits of health (and self care), the demonstrated outcome of such discussion has been only discussion. He feels that neither the public nor the government nor the medical profession
have demonstrated a real commitment to such health care ideologies. He asserts that all three of the key components—the public, the government (especially through HSAs), and the medical profession—could make significant contributions in this area if they would make a true commitment to health.

In this section it has been noted that HSAs have an historical and philosophical potential to support self care/health concepts. Some researchers believe that HSAs will actively support self care in the future. HSAs were created to help the medical profession operate more effectively and efficiently. While the minority of its representatives on the board of directors are health care providers (hospital administrators and physicians—Southern Regional Council, 1977), their power cannot be underestimated. The power of the medical profession is demonstrated in the high wages, prestige, and autonomy accorded its members. Professionals tend to oppose change, and this is apparent from research conducted on the physicians regarding self care attitudes (Linn and Lewis, 1979). Use of self care strategies has been thought to result in increased benefits for the consumer of health care services, but it may not be in the best interests of the physician who wishes to maintain a powerful professional role. Physicians, through their expertise and tight professional organization, have the ability to influence the lay person on the appropriate use of self care technique. To date there has not been a demonstrated commitment to self care by the medical profession.
While it has been shown how the HSAs can be a vehicle for realizing the self care movement goals, it has also been pointed out that the members of the self care movement may not be able to effectively use the HSA because of the ability of the provider board members to circumvent the self care goals and coopt those who could logically represent self care movement interests. The self care movement is at the stage where it is becoming formalized and growing in power. However, it does not yet appear to be at the stage where it can mobilize administrators like the HSA boards of directors to support the movement ideology. HSA boards of directors as a whole are not expected to be supportive of self care, leading to the development of the first proposition.

Proposition 2 is an outgrowth of Proposition 1. Proposition 1 deals with the support of HSAs in general toward self care, while Proposition 2 focuses on providers and consumers of HSA boards of directors similarity of perspectives regarding self care. Due to: the power of the provider to influence those who consume health care services; the lack of medical expertise of most HSA consumer board members; and the potential cooptation process that may exist, it is proposed that consumer board members will not be any more supportive of the consumer oriented health care innovation of self care than are provider HSA board members.

Proposition 3: The SES of the HSA board of director members has no association with their endorsement of self care programs.

Proposition 4: Female HSA board of director members will be more supportive of self care programs than will be male HSA board members.
Social movements often result from the mobilization of individuals who feel anger, discontent, or deprivation, and the self care movement is no different in this regard. Consumeristic movements manifest themselves most predominently in terms of the expression of satisfaction and dissatisfaction with a specific system or structure (Reeder, 1977). Dissatisfaction has been shown to be related to wants or needs that cannot be obtained due to barriers within the structure or by the elites within the structure. Wants or needs that cannot be realized are forms of deprivation. Deprivation, as Morrison (1973) notes, is the key variable in the explanation of social movements.

Deprivation may take two forms—absolute deprivation and relative deprivation. Absolute deprivation refers to the actual lack of goods/services necessary to maintain survival. Relative deprivation refers to the lack of access to goods/services that the majority of individuals have in a given society. It can also refer to perceived inability to maintain a standard which one feels she/he ought to maintain (Stouffer, 1942).

The concept of relative deprivation is more useful for understanding the motivation behind the self care movement. The members of the self care movement have access to health care; it is the quality of care and their right to be actively involved in the health care delivery process that become central to their perceived deprivation.

Turner and Killian (1972) state that social movements revolve around power or value orientations; those individuals who form social
movements have power and/or value perspectives that are in opposition to those held by the ruling structure. The professionals within a structure (like the physicians) can maintain their power because they deprive certain groups (health care consumers) of realizing needs or wants. Due to differential power and/or value orientations, those who feel deprived tend to be supportive of social movements as a way to promote their position.

Therefore, deprivation is a critical element in one's support of social movements like the self care movement. According to PL 93-641, consumers are supposed to broadly represent the social, economic, and racial breakdowns of the area, yet studies indicate that this does not in fact occur; often people who secure consumer positions are people who occupy powerful occupations or positions within the community (Nations Health, 1978; Southern Regional Council, 1977; Parker, 1970; Philadelphia Health Care Project, 1977). These individuals may not feel the alleged deprivation nearly as much as the "average" consumer of health care services. Since they may not feel the deprivation as intensely as the "average" consumer, it is proposed that they may not see the need for the goals behind the self care movement.

Grossman (1978) states that the consumer/provider role distinction may not be the most accurate one in analyzing board member advocacy roles, and that other variables may be more useful. Assessing the socioeconomic status of HSA board members could be useful in determining if the SES of board members tends to be high to the exclusion of lower SES levels. Individuals who are involved in social
movements often tend to be from middle class SES, and the self care movement is similar in this regard (Kronenfeld, 1979). The movement consists of people who can identify the sources of their perceived deprivation and who can develop alternatives to avoid the deprivation.

Besides low and middle SES individuals, another deprived group present in the HSA board of directors is women. Women have been shown historically to make up the majority of health care workers, yet have not held administrative positions to give feminist input to the health care delivery system (Ehrenreich and English, 1978). Women have subsequently become major advocates for health care reform and to provide input, whether solicited from the medical profession or not, on health care issues in general and women's health care issues in specific (Boston's Women's Health Group; National Women's Health Network, 1977).

These two variables, socioeconomic status and sex, have been chosen as major variables for analysis with regard to the self care movement. Clearly a variety of other variables can be examined with respect to the self care endorsement by HSA boards. Race, geographic setting of the HSAs, the existence of poverty in the HSA catchment area, marital status, and years of HSA membership are but a few possible variables one could choose to analyze with respect to self care and HSA boards. Only those variables which were critically considered in the literature and thought to be important to the research topic were chosen for analysis. Other factors were omitted.
from this research because of their perceived unimportance or because of their intrinsic limitations. An attempt will be made later to see how appropriate the variable selection was when an explanatory model of self care endorsement is developed.

**Role of Socioeconomic Status.** The socioeconomic status of an individual has been shown to be related to one's willingness to support change, to try innovations. Lipset (1959) has found that individuals are basically conservative in their ideology, but that wealth and political conservatism are positively correlated. If individuals are suffering economically or are unemployed, they tend to abandon conservatism and advocate change. Individuals are liberal or conservative to the degree that they will benefit from that position. Lipset states that the contact a lower SES individual has with an upper SES individual does have an influence on his/her attitudes and behavior. People are more likely to be interested in their own betterment than in "collective justice." People will thus be attracted toward the rich and prestigious individuals, and be in awe over those who have lifestyles in which wealth and power are inherent. Individuals may pursue ideology of more upper class individuals when they feel they can benefit in some way from adherence to such positions.

Kohn (1966) notes that social class position has a great impact on how willing one is to pursue his/her own interests or conform to the interests of others. He has found that the higher one's SES the more likely one is to pursue individual interests, while the lower
one's SES, the more one will tend to conform to others' interests. He feels this is the same for all segments of society, regardless of race, religion, national or geographic background. He found that social class stands out as more important for determining one's values and attitudes than does any other line of social demarcation. Upper SES individuals tend to see themselves as competent members of an essentially benign society, while lower SES individuals see themselves as less competent members in an indifferent or threatening society. Following one's interests is an orientation based on the possibility of accomplishing what one sets out to do; conformity is based on an orientation that there are dangers in stepping out of line.

Individuals in the lower SES have been shown to be more reluctant to accept new ideas and practices. Changes in health practices, food usage, religious doctrines, family life or educational practices are likely to find their strongest opposition among lower SES individuals. Such individuals tend to have limited education and professional associations, which tends to isolate them and make them suspicious of those who promote change (Lipset, 1959).

O'Donnell and Reid (1978) have found that low income people seldom serve on influential policy making boards; less than one-fourth of the members of such administrative bodies represent the lower income population. Lower SES people are more commonly found on committees rather than boards of directors, allowing them to provide "input" without placing them in positions where they would
have the power to evoke change.

Self care is an ideology that can benefit those of all SES, but especially those on the lower levels who may not be able to secure frequent or extensive medical care. As Lipset states, lower SES individuals who may feel they can benefit economically from change may support it; on the other hand, individuals of lower SES may be attracted by the lifestyles and opportunities of the upper classes and may assume conservative ideologies in the hopes of attaining such status increases. In the women's health care movement that advocated self care techniques, it was found that lower class women were not attracted to self care. Rather, middle class women were more likely to be involved with the self care movement. Ruzek (1978) found that one reason why lower class women did not take part in self care programming was because those women preferred the attractiveness of sophisticated clinics and equipment, and preferred to be seen by high status medical professionals.

The role of SES and preventive health behavior and attitudes is far from being clearly understood, as shown through the literature (Moody and Gray, 1972). Yet, we know that SES shapes one's education, occupation, income, and prestige of individuals, factors that influence behavior and attitudes.

Cockerman (1979) notes that the use of sociodemographic variables has been a common tool in assessing health care utilization attitudes and practices. He points out that perhaps sociodemographic variables are no longer so important in determining health care
practices and attitudes as they were once thought to be. Nonetheless, he states that they should not be ignored when seeking explanations for individual's health care practices and attitudes.

In order to help clarify the relationship of SES to health care attitudes, it is proposed that SES may tend to influence attitudes toward self care. As Kohn found, there is a tendency for lower SES individuals to conform to the viewpoints of those with higher statuses. As discussed earlier, physicians (high status individuals) have been found to not be supportive of self care. There is reason, then, to assume that lower SES individuals and higher SES individuals do hold the same viewpoints. Proposition 3 states that the SES of the HSA board members will have no association with self care endorsement, since it is predicted that higher SES HSA board members and lower SES board members will vote similarly for self care programs.

Role of Women and Self Care. HSA board member distinctions and SES may not be the only variables useful in understanding attitudes toward self care. Substantial information exists indicating that women are the primary providers of medical care to the family, both in prevention and treatment of disease (Parsons and Fox, 1954; Corea, 1977).

It has been found that men receive 90% of their non-professional health care and advice from women. Mothers, grandmothers and sisters were six times as likely to provide health advice as were fathers, grandfathers and brothers (Elliot Binns,
1973). Women are the majority of professional health workers as well (70% of all health workers), yet few hold physician or administrative positions (Ehrenreich and English, 1978).

It has been proposed that women actually are behind the thrust for self care, so that they can gain control of their bodies and gain more knowledge about health so as to take better care of themselves and their families (Boston's Womens Group, 1977; Corea, 1977; Stewart and Stewart, 1979; Ehrenreich and English, 1978). This thrust for more self care has evolved into a women's health care movement (Ruzek, 1978; Fruchter et al., 1978). Two themes run through the women's health movement. One theme is that one's body belongs to the individual; the other theme is that individuals can do many things for themselves better than health care workers can do them (Howell, 1981). The women's health care movement has used this self care orientation primarily in three areas of work: changing the consciousness of individuals about the nature of health care; providing health related services to themselves when appropriate; and struggling to change the established health institutions to be more humane and allow individuals to be more responsible over their own health care (Fruchter, et al., 1978). The women's health movement strategies are specifically intended to alter, improve or change routine medical care for women. By examining this movement, Ruzek (1978) states we can discover how clients as a group can reshape institutions to meet their needs. In this movement client power is not limited to individual efforts to beat the system;
rather the focus is on group action to bring about changes on a societal level, on the institutional level, and in the face-to-face interaction between the patient and the physician.

The feminist health care movement began in the 1960's--the same time period that Berlinger (1978) found the government began to realize that self care and lifestyle were important in the establishment of good health for society. The women's health care movement started with a focus on gynecological services, but has moved to encompass a range of health related concerns. It focused on providing services that were less expensive, less hierarchical, and more open to advocacy and social change than the traditional health care services (Ruzek, 1978). Ruzek notes that the women's health movement doesn't seriously challenge the health system except in ideological issues and minor health care restructuring. She explains that what is wanted in this movement is more product for less money with an assurance of quality control.

Other researchers (Fruchter, et al., 1978) found that the women's health care movement has the potential for significant impact on the entire health care delivery system.

From the first tentative gathering of women sharing experiences and newfound knowledge, and the excitement of the early demonstrations and illegal abortion work, women's health groups have matured and coalesced into a strong and viable movement that is clearly dug in for the long haul (Fruchter et al. 1978, p. 276).

Self care has been of long concern to women, and in the past twenty years has been used as the basis for a women's health care
movement. This movement has opposed the physician's professional authority and domain over health care services and policy. The women's self care movement, as Wilson and Tallman state, is challenging a basic social system that they feel needs to be altered to be more receptive to human needs. Thus, self care is a personal concern for women since they tend to be major health care providers within the family structure. Therefore, it is proposed that women on the HSA board of directors will be more supportive of a move toward self care than will be the men on the board of directors.

**Proposition 5:** The HSA will not show support for self care in its formal policy documents.

The previous propositions look at how the board members of HSAs react to the concept of self care. This proposition looks at the extent to which self care is reflected in the formal decisions of the HSA.

The literature that can best explain the impact of innovations, like self care, on the larger structural element comes from organizational change theory. Killian (1973) states that social movements can succeed or fail in impacting society and its institutions. But very few social movements, he attests, leave no impact on society. Rather, movements that 'sputter out' or are suppressed may have a profound effect on society at a later time. He notes that even in successful movements, the goals of the movement are seldom realized to the extent that the members and leaders had hoped. Parts of the goals of the social movement may be incorporated, some parts may be altered, while other parts may be rejected.
The fact that the changes which result are never those which are anticipated does not refute the evidence that it is the interaction of men with each other, not their unwitting response to culture, which produces social change (Killian, 1973, p. 51).

McCarthy and Zald (1973) note that the elites, or those people in power within a structure, tend to control the direction of dissent within a social movement, as well as attempting to minimize dissent. In this way, those in power can manipulate the parts of the movement they wish to incorporate, and counteract the dissent or movement goals with expert information or suppression. So change may occur as a result of a social movement, but the nature of the change will be controlled by the elites.

Morrison (1973) observes that while social movements create social change, they also are created by social change. Expectations that people may have are a result of societal changes, and such expectations move more rapidly than do the structural-level mechanisms to incorporate such change.

Slavin (1978) sees change in organizations as endemic, propelled by both internal and external pressures. It is imperative for the ongoing survival of organizations to minimize change (and the conflict that may result from those who wish to implement change) and to manage it so that the goals of the organization will not be compromised, and so the organization's strength will not be impaired. Lauffer (1978) adds to this understanding, by pointing out that those individuals in charge of organizations may resist change and prefer to maintain their current structures or modes of operation even
when a change will obviously enhance the accomplishment of the organization's stated goals or mission.

Looking more closely at the health care delivery system and the self care movement, one can trace the roots to the early 1960's when a thrust for social change on all levels and institutions occurred (Reeder, 1977; Berlinger and Salmon, 1979). The self care movement as such, however, is a development of the mid to late 1970's (Levin, et al. 1979), reinforcing Morrison's idea that social changes cause social movements which can create social change.

But will the social movement cause social change? If so, what changes can we expect to see if, as Turner and Killian state, even the most successful social movements goals are altered? Will Mauss (1973) be correct in his assumption that the more successful social movements are likely to be coopted by the elite, and presented as if the movement goals were actually the elite's goals all along? Reeder (1977) is optimistic for changes to occur in the health care delivery system, changes that will result in a greater consumer role over his or her health. Yet other researchers (Gill, 1980) do not share this optimism; in fact, Gill predicts greater resistance by the health care professionals to changes that would benefit the masses because such changes undermine the traditional authority and power of the medical profession.

While medical innovations such as self care are likely to be resisted, they have in some instances been welcomed and received by HSA endorsement and implementation. In Wisconsin (Schramm, 1978) a State
Commission of Wellness has been established, and the HSAs there have been very active in the development of wellness-self care programming. But given the speculation extant in most of the literature about consumer-oriented change within the health care delivery system, and given the nature of the organizational literature which predicts that change will be resisted by the professionals of organizations, it is proposed that the HSAs will not incorporate self care planning into its formal policy statements, as manifest in the Health Systems Plan.
CHAPTER III

Methods for This Research

General Design of This Research

This research was conducted primarily as a survey of HSA board members. The data obtained through the survey was augmented by an examination of the HSA Health Systems Plans (HSP) for the calendar year of 1980-1981. The survey was carried out in order to gather data about the independent variables of: sex; consumer-provider HSA role; socioeconomic status; and race of the HSA board members. The survey research, consisting of a mailed questionnaire, called the Self Care Attitude Inventory (SCAI), also measured the presence, absence, and extent of self care ideology of HSA board members. The extent of self care ideology endorsement of HSA board members constituted the dependent variable for this research.

The data collected was submitted to a series of bivariate analyses testing Propositions 2-4 and finally was incorporated into a stepwise regression model to determine the combined power of the independent variables (joined by other demographic characteristics about the HSA board members) to account for the variance in the endorsement of self care. In addition to proving insight into other useful variables, the stepwise regression model also was useful in determining if the strongest independent variables were those chosen for inclusion in the propositions as developed from the theoretical
The HSA Health Systems Plan for 1980-1981 of each HSA was analyzed in order to determine if self care ideology had been incorporated into the priority health planning goals of the HSAs. By comparing the top ten health planning goals from each HSA to an operational definition of self care, one was able to determine if any of the health planning goals are self care directed. In this way one can assess the degree of influence the self care movement has had upon the formal operating structure of the HSA.

Nature of the Sample

The population of interest for this study is the Health Systems Agency board of directors. A purposive sample, representing all HSA boards in the State of Michigan, was chosen because collecting data from all 200 HSAs nationwide was beyond the scope of this research project, and because of researcher proximity and familiarity with the region (Cornfield & Tukey, 1956). The eight Michigan HSA boards to be studied are: The Comprehensive Health Planning System of Southeast Michigan (CHPSM) located in Detroit; the Genesee, Lapeer and Shiawassee Health System, Inc. (GLS) located in Flint; the Mid-Michigan Health Systems Agency (MM) located in Flint; the Mid Michigan Health Systems Agency (MM) located in Mason; the Northern Michigan Health Systems Agency (NM) located in Petosky; the East Central Health Systems Agency (EC) located in Saginaw; the West Michigan Health Systems Agency (WM) located in Grand Rapids; the Southwest Michigan Health Systems Agency (SW) located in Kalamazoo;
and the Upper Peninsula Health Systems Agency (UP) located in Marquette.

**Logistics of the Research**

In order to obtain access to the sample the coordinator of the Michigan Association of HSAs was contacted to inform him about the intent of this research project, to gain permission for conducting the research, and to gain advice about contacting the HSA board members. His advice was to contact each HSA director individually before sending board members the questionnaire. The possibility of meeting with each HSA and passing out the survey instrument at a board meeting was discussed, but this option was rejected because too many uncontrollable factors existed (i.e., the difficulty of getting on an agenda for some HSAs; the sparse attendance of some HSA board members; irregularity of summer meeting dates).

Each HSA director was contacted by telephone and by letter to explain the purpose of this research, to gain permission for conducting the research within their area, and to give assurances that this was a bona fide research and not an exploitative or evaluative governmental study. Lists of the boards of directors and their addresses were obtained from all eight HSAs. Three hundred and nine board members were sent the SCAI, a letter of explanation (Appendix 1 and 2), and a self addressed, stamped envelope. Post cards were sent to the HSA board members one month after the initial mailing to encourage them to respond to the questionnaire if they had not already done so.
It is possible that this sample may reflect a regional bias which could make the generalizations of findings to the national HSAs less useful. While the sample may be parochial because of a midwest orientation, the Michigan sample reflects differences between urban and rural peoples, industrial and agricultural areas, rich and poor persons, and the upper and lower peninsulars. It is not known if the Michigan HSA boards of directors are representative of the HSAs for the nation. Michigan reflects demographic variations not dissimilar from the national population; however, it is impossible to know to what extent the Michigan HSA board members reflect similarities to the national population of HSA board members. These factors should be considered when attempting to generalize the findings of this research.

**Development of the Instrument**

The questionnaire developed for use in this study contains the SCAI, which consists of twenty-four items. There are two parts to the instrument. The initial section elicits background information on the respondent, which was used to create the independent variables. The second part was a series of twelve vignettes used as the basis of a summated scale measuring HSA board member endorsement of self care programs.

**Independent Variables.** Independent variables chosen for study in this research are: which HSA the board member represents (Proposition 1); consumer or provider HSA board member role (Proposition 2); socioeconomic status (Proposition 3); sex (Proposition 4);
race, age, marital status, and years of HSA membership. These items were asked in a straight forward manner (i.e., what is your sex?"), usually through the use of structured questions (See Appendix 1 for details).

In order to assess the socioeconomic status (SES) of the board members, the respondents were asked to state his/her occupation. Occupations were classified according to a numerical prestige rating, the Duncan Occupational Index (Duncan, 1959). For purposes of analysis in this research, the occupational levels were dichotomized; individuals with scores of 1-49 were categorized as "lower SES," while individuals with scores from 50-98 were categorized as "higher SES."

Dependent Variable. Self care, as discussed in Chapter II, has numerous meanings and connotations. Even at national conferences of self care advocates, definitional differences among self care leaders can be found. The definition of self care chosen for this research was that developed by Lowell Levin et al. (1979). Levin et al. were the first to refer to self care as a social movement, and to date they have written the most comprehensive works on the nature of self care. They have operationalized self care as processes whereby:

1. the individual acts in his/her own behalf in the prevention of disease
2. the individual acts in his/her own behalf in disease detection
3. the individual acts in his/her own behalf in the treatment of disorders

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While Levin et al. (1979) note that self care is basically an individual effort, self care in the context of this research will refer to the collective organization of people who are in pursuit of efforts that will allow them to better initiate self care strategies. The HSA deals with efforts that represent group interests and not with individual interests, and most of the proposals that come before the HSA board of directors reflect group interests. It is therefore appropriate in the context of this research that self care reflect group efforts that will be of help to individual self care.

Twelve vignettes were constructed to measure the dependent variable. The self care issues presented in the vignettes were selected by a review of self care literature and from my observation as an employee of a Michigan HSA. They encompass the types of issues that HSA board members deal with as part of their responsibilities. In a consultant relationship with one Michigan HSA employee I was able to observe the process HSA board members followed when reviewing policy issues. An HSA staff member, Karen Youngs, also reviewed the instrument and provided useful input for the construction of the final survey items. The vignettes represent real life situations, dealing with concerns such as over-the-counter drug use, vaccinations, home dialysis programs, blood pressure tests, and holistic health centers.

The response options to each vignette were constructed to provide a continuum of endorsement for self care. The response category "most supportive" of self care was scored 4, and the category least supportive of self care was scored 1. Each HSA board member was scored for each vignette and in a summated score for the combined
vignettes to provide a measure of endorsement for self care.

In order to develop a meaningful summated score, an attempt was made to develop a Guttmann scale for the twelve vignettes. The result of this analysis was that the twelve items failed to meet the criteria for Guttmann scaling (Nie et al., 1977) (See Appendix 3).

The responses were analyzed by attempting to isolate a single dimension along which a scale could be developed via factor analysis. Three factor analysis rotations were conducted, all yielding the same results. Five of the twelve vignettes fit together well along one dimension (Appendix 4). These vignettes concerned heart attack prevention programs, holistic health services, migraine headache treatment, community medical resource guides, and eye exercise services. All self care in these vignettes require non-prescription drug remedies, activities that promote the individual's taking control of diagnostic and treatment services. The cutting point selected for the factor weights in order to assign items to the factor was .75.

The five items selected for the factor were then subjected to a Guttmann scale analysis to determine if they would meet the criteria of scalability and reproducability. The coefficient of reproducability was .86, and the coefficient of scalability was .53 (Appendix 5). Although these coefficients are slightly below the recommended coefficients of .90 for reproducability and .60 for scalability (Nie et al., 1977), they were sufficiently close to use as a summated scale.

This scale measuring the endorsement of self care has been used as both a continuous variable and a dichotomized variable in this
research. As a summated scale the scores range from 5, least supportive of self care, to 20, most supportive of self care. When the scale score was cut in the middle of the range, those individuals judged to be supportive of self care programs had scores ranging from 13 to 20, while those who were judged not supportive of self care ranged from 5 to 12. Using the dependent variable of self care in both a continuous and a two-category analysis increases statistical analysis options.

**Testing of the Propositions**

To follow are explanations of the testing of the five research propositions. Some data was subjected to additional testing if it seemed warranted by the nature of the findings.

For Proposition 1, that HSAs will not be supportive of self care, the distribution of responses of the Self Care Attitude Scale (SCAS) will be analyzed. The scale is used as a continuous variable to determine the extent of support for self care programs. The distribution of scale scores by the sample indicates the degree of support for self care programs. The respondents distribution will be compared to the theoretically possible distribution of scale scores from "most favorable" to "least favorable" along the range of possible scores for self care endorsement. It is predicted that the distribution of scale scores will not cluster in the "most favorable" area of the range of possible scores. The actual distribution will also be compared to a theoretical distribution of expected scores to determine if the distribution characteristics could have occurred...
by chance. This will be done with the use of a one variable chi-square goodness of fit test, comparing actual and expected scores. This chi-square test will analyze the data not as continuous in nature but by breaking it into two categories, "least supportive" and "most supportive." The chi-square goodness of fit test will allow us to determine if the actual distribution of HSA board member attitudes toward self care occurred by chance.

For Proposition 2, that consumers will be no more supportive of self care than are providers, two statistical tests will be used. First, self care endorsement of HSA board members will be analyzed by dividing the dependent variable of self care into two categories: those who would vote for the self care programs and those who would not. The consumer/provider role of the HSA board member is the independent variable. The chi-square test of independence will be used to assess the relationship between the independent variable of HSA role and the dependent variable of self care, and if the observed distribution could have occurred by chance.² The proposition will also be tested by using the dependent variable in a continuous fashion. The mean for the scale score on the SCAS of providers and of consumers will be compared via the Student's t statistic. This will allow us to see whether the mean scale scores of self care by consumers and providers are equal to each other or if they are significantly different from one another.

Proposition 3 states that the SES of the HSA board member will not be associated with their support for self care. The dependent variable of self care will be divided into two categories – those who
would vote for self care programs and those who would not. The independent variable of SES will also be divided into two categories - "higher SES" and "lower SES," in the manner discussed previously in this chapter. A chi-square statistic will be used to assess the relationship between the independent variable of SES and the dependent variable of self care, and if the observed distribution could have occurred by chance. Pearson's Product Moment Correlation Coefficient will measure the association between the dependent variable of self care and the independent variable of SES.

The fourth proposition states that female HSA board members will be more supportive of self care than will be male HSA board members. This proposition will be analyzed through two statistical tests. The self care endorsement of HSA board members will be analyzed by dividing the dependent variable of self care into two categories - those who would vote for the self care programs and those who would not. The sex of the HSA board member will be the independent variable. The chi-square test will be used to assess the association between the independent variable of sex and the dependent variable of self care, and whether an association could have occurred by chance. The mean for the scale scores of males and of females will also be compared via the Student's t statistic. This will allow us to see whether the mean scale scores of males and females are equal to each other or if they are different from each other.

For Proposition 5, that HSA policies will not reflect support for self care, the Health Systems Plans (HSP) of each of the eight
HSAs will be analyzed. Within each HSP both health status goals and health systems goals are outlined and prioritized. Health status goals, however, represent aspirations by the community and describe optimal conditions. Since health status goals are aspirations, they may not be met due to funding, mobilization, or resource problems. Health systems goals are the result of federal and state guidelines as well as a reflection of community priorities. Since health status goals are merely aspirations which may or may not be met, and since health systems goals have specific objectives and the greater possibility for influencing the community, analysis will focus on the health systems goals.

The number of health systems goals that are present in the HSPs vary among HSAs. The goals in the HSP are all prioritized by the HSA board of directors from "most important" to "least important." Because of the varying number of HSP goals among HSAs, the ten most important goals were chosen for analysis in this research. Only ten goals were chosen because: 1) these goals were those which the HSA prioritized to be of most importance, and 2) any organization has limited time, energy and resources to give to the achievement of any goal, so these are the goals which realistically have the greatest chance of being achieved. It is important to note that while some of the goals may be the same between HSAs, many goals will be unique to some HSAs. Similarities and differences in the HSP goals will exist because the HSAs consider national goal recommendations as well as unique community needs and resources.
The HSP goals will be analyzed according to the operational definition of self care specified earlier. The HSP goals will be analyzed to see what action an individual can take to achieve the HSP goal in light of the operational definition. It was acknowledged earlier that the focus of HSAs is the organizational level rather than the individual level. Therefore, HSP goals will reflect organizational concerns rather than individual concerns. The HSP goals will be examined to determine the extent to which individuals can become involved in the goal achievement. Does the goal direct itself to action that can only be taken through formal organizational structures, or can the goal be achieved by individual action? If lay action can be taken, then what is the probability that the formal structure will provide the individual the way to do it? The analysis of the HSP priority goals will involve the systematic application of these questions in concluding whether self care is contained within the goals. No formal quantitative analysis will be used for examination of this proposition. The analysis will be more descriptive in nature based on the specified criteria and on research examination with HSA goals.

After these analyses have been completed, the data will be subjected to additional stepwise regression analysis to provide a fuller understanding of self care endorsement. The independent variables used in the research propositions plus other variables of race, age, marital status, years of HSA membership, location of HSA, and level of HSA involvement will be combined to assess their contribution to the prediction of the dependent variable of self care.
The regression model will be useful in determining if the strongest variables were chosen for inclusion in the propositions as developed from the theoretical approach set forth in this research. This model will also be useful for developing future research in the areas of social movements, HSA board member behavior, and self care support.
CHAPTER IV

Research Findings

General Characteristics of Respondents

Boards of directors from the eight HSAs in Michigan were surveyed via the Self Care Attitude Inventory (SCAI). Three hundred and nine board members were surveyed, comprising all of the HSAs in Michigan. One hundred and ninety board members responded to this self administered questionnaire, for an overall return rate of 62 percent. Table 1 shows the number of actual responses and the percentages of each HSA board responding to the SCAI.

Table 1

HSA Board Membership and HSA Board Respondents by HSA Region

<table>
<thead>
<tr>
<th>HSA</th>
<th># of Board Members</th>
<th># of Respondents</th>
<th>% Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Peninsula</td>
<td>29</td>
<td>16</td>
<td>55.2</td>
</tr>
<tr>
<td>Southwest</td>
<td>29</td>
<td>19</td>
<td>65.6</td>
</tr>
<tr>
<td>West Michigan</td>
<td>55</td>
<td>39</td>
<td>70.9</td>
</tr>
<tr>
<td>East Central</td>
<td>53</td>
<td>27</td>
<td>50.9</td>
</tr>
<tr>
<td>Northern</td>
<td>28</td>
<td>14</td>
<td>50.0</td>
</tr>
<tr>
<td>Mid Michigan</td>
<td>28</td>
<td>18</td>
<td>64.3</td>
</tr>
<tr>
<td>Genesee-Lapeer</td>
<td>28</td>
<td>19</td>
<td>67.9</td>
</tr>
<tr>
<td>Shiawassee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Health Planning of South-east Michigan</td>
<td>59</td>
<td>38</td>
<td>64.4</td>
</tr>
<tr>
<td>Column Totals</td>
<td>309</td>
<td>190</td>
<td>62.0</td>
</tr>
</tbody>
</table>
The greatest response rate (70.9%) came from the West Michigan Health Systems Agency, located in Grand Rapids. The Genessee, Lapeer, and Shiawassee Health Systems, Inc. (GLS), located in Flint, also yielded a high response rate (67.9%). The areas with the lowest response rates were the Northern Michigan HSA (50%), located in Petosky, and the East Central Michigan HSA (50.9%), located in Saginaw. While every HSA responded with over a 50% return rate, there was a 20% difference in response rates between those HSAs with the highest response rate and those HSAs with the lowest response rates. In order to determine if this difference was significant, a chi-square analysis was conducted. The chi-square equaled 7.73, when the probability level exceeds .05. Therefore the difference in response rates among HSA was not found to be significant.

Two-thirds of the respondents are white, with only 6 percent of the respondents identifying themselves as minorities. A considerable number (31%) of the respondents did not answer this item, as shown in Table 2. Could this group of "no responses" consist primarily of minorities? Table 1 shows that it was the rural areas that had the lowest overall response rate. If one assumes that the "no responses" came from rural areas, the odds are good that the "no responses" came from white individuals. Within the rural areas of Michigan the population is primarily white. Therefore, the "no responses" probably results in an underestimation of the proportion of white HSA board members. This leads one to the conclusion that the "no responses" are primarily from white persons and would not increase
the proportion of minorities appreciably.

Table 2
Race of HSA Board Respondents

<table>
<thead>
<tr>
<th>Race</th>
<th>Respondents %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>121 (63.7%)</td>
</tr>
<tr>
<td>Black</td>
<td>9 (4.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (.5%)</td>
</tr>
<tr>
<td>No response</td>
<td>59 (31.1%)</td>
</tr>
</tbody>
</table>

Column Total 190 (100%)

In Table 3 it was found that the majority of respondents to the SCAI are males. Less than 30% of the respondents are females. This is in contrast to the actual numbers of males and females on the HSA boards of directors, where 55% of the HSA board members are male, and 45% are female. Therefore a small proportion of females responded to this survey than are actually on the HSA boards. This gives one good reason to suspect that the "no responses" found in Table 3 were from women.
Table 3
Sex of HSA Board Members and Respondents

<table>
<thead>
<tr>
<th>Sex</th>
<th>HSA Respondents</th>
<th></th>
<th>HSA Board Members</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Males</td>
<td>114</td>
<td>(60%)</td>
<td>170</td>
<td>(55%)</td>
</tr>
<tr>
<td>Females</td>
<td>56</td>
<td>(29.5%)</td>
<td>139</td>
<td>(45%)</td>
</tr>
<tr>
<td>No response</td>
<td>20</td>
<td>(10.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>190</td>
<td>(100%)</td>
<td>309</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Most of the respondents are middle aged. While the ages of board members ranged from 21 to 74, most of the respondents are between the ages of 41 and 60 (See Table 4).

Table 4
Age of HSA Board Respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>10-20</td>
<td>0</td>
</tr>
<tr>
<td>21-30</td>
<td>6</td>
</tr>
<tr>
<td>31-40</td>
<td>27</td>
</tr>
<tr>
<td>41-50</td>
<td>49</td>
</tr>
<tr>
<td>51-60</td>
<td>54</td>
</tr>
<tr>
<td>61-70</td>
<td>24</td>
</tr>
<tr>
<td>71+</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>28</td>
</tr>
<tr>
<td>Column Total</td>
<td>190</td>
</tr>
</tbody>
</table>
In Table 5 it was found that over half of the HSA board members (53.7%) are married. However, a very large number of people (40%) chose not to answer this item; one can assume from the low single/divorced or widowed responses that a large number of the no response rate came from single or divorced people.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Respondents</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>102</td>
<td></td>
<td>(53.7%)</td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td></td>
<td>(5.3%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td></td>
<td>(1.1%)</td>
</tr>
<tr>
<td>No Response</td>
<td>76</td>
<td></td>
<td>(40.0%)</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>190</strong></td>
<td></td>
<td><strong>(100%)</strong></td>
</tr>
</tbody>
</table>

If one considers the data in Table 2-5, one gets a picture of the typical HSA board member as a white, middle aged, married male. One can but question how board structure reflects the federal mandate to represent consumers of medical services on the HSA boards.

This observation is buttressed by noting that, while representation of all socioeconomic statuses (SES) are supposed to be represented on all HSA boards proportional to the population of the area, the majority of respondents are in the upper SES levels, as categorized by occupation and interpreted through the Duncan Occupational Index. The majority of board members (93%) were in the upper half of the SES categories (Table 6). Of even greater significance is the
fact that half of the board members were in the highest SES category and sixty percent are in the upper quartile of the range.

Table 6
SES of HSA Board Respondents

<table>
<thead>
<tr>
<th>Duncan Occupational Index</th>
<th>Respondents</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99-90</td>
<td>94</td>
<td>(49.5%)</td>
</tr>
<tr>
<td>89-80</td>
<td>15</td>
<td>(7.9%)</td>
</tr>
<tr>
<td>79-70</td>
<td>15</td>
<td>(7.9%)</td>
</tr>
<tr>
<td>69-60</td>
<td>34</td>
<td>(17.9%)</td>
</tr>
<tr>
<td>59-50</td>
<td>19</td>
<td>(10.0%)</td>
</tr>
<tr>
<td>49-40</td>
<td>2</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>39-30</td>
<td>2</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>29-20</td>
<td>0</td>
<td>(0%)</td>
</tr>
<tr>
<td>19-10</td>
<td>2</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>Low</td>
<td>7</td>
<td>(3.5%)</td>
</tr>
<tr>
<td>Column Total</td>
<td>190</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

The board members were asked if the HSA classified them as consumers or providers of health care services. A slender majority of respondents (53%) identified themselves as consumers, as shown in Table 7. If one considers the "no responses," any division of that category still puts the HSAs well within meeting the federal guidelines of PL 93-641 that consumers of health care services should constitute 51-60% of the HSA board of directors.
Table 7

Role of HSA Board Respondents

<table>
<thead>
<tr>
<th>Role</th>
<th>Respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer</td>
<td>101</td>
<td>53.2%</td>
</tr>
<tr>
<td>Provider</td>
<td>67</td>
<td>35.3%</td>
</tr>
<tr>
<td>No Response</td>
<td>22</td>
<td>11.5%</td>
</tr>
<tr>
<td>Column Total</td>
<td>190</td>
<td>100%</td>
</tr>
</tbody>
</table>

Statistical Analysis of the Propositions

Proposition 1: Health Systems Agency boards of directors will not be supportive of self care programs.

From examining Table 8 it was found that more HSA board members tend to be supportive of self care than tend to oppose it. The entire range of the Self Care Attitude Scale (SCAS) was used, with scores ranging from 5 (indicating minimal support for self care) to 20 (indicating maximum support for self care). The mean score in the range was 13.74, the mode was 20, and the median was 15.68. When the responses are analyzed through the use of cumulative frequencies, it was found that only 8% of the HSA board members are minimally supportive of self care, as shown by their placement in the bottom quartile of the SCAS. Only 18% of the respondents fell in the lower half of the scale. About half of the respondents fell in the upper quartile of the range, indicating that the majority of HSA board members were highly supportive of the self care programs. Twenty-
one "no responses" were excluded from the analysis.

Table 8
HSA Board Respondent Support of Self Care Programs

<table>
<thead>
<tr>
<th>Scale score range</th>
<th>Respondents</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>low 5</td>
<td>5</td>
<td>( 2.9%)</td>
</tr>
<tr>
<td>sup- 6</td>
<td>1</td>
<td>( 0.6%)</td>
</tr>
<tr>
<td>port 7</td>
<td>3</td>
<td>( 1.8%)</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>( 2.4%)</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
<td>( 4.1%)</td>
</tr>
<tr>
<td>10</td>
<td>8</td>
<td>( 4.7%)</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>( 1.8%)</td>
</tr>
<tr>
<td>12</td>
<td>8</td>
<td>( 4.7%)</td>
</tr>
<tr>
<td>13</td>
<td>10</td>
<td>( 5.9%)</td>
</tr>
<tr>
<td>14</td>
<td>11</td>
<td>( 6.5%)</td>
</tr>
<tr>
<td>15</td>
<td>12</td>
<td>( 7.1%)</td>
</tr>
<tr>
<td>16</td>
<td>11</td>
<td>( 6.5%)</td>
</tr>
<tr>
<td>17</td>
<td>17</td>
<td>(10%)</td>
</tr>
<tr>
<td>high 18</td>
<td>20</td>
<td>(11.8%)</td>
</tr>
<tr>
<td>sup- 19</td>
<td>14</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>port 20</td>
<td>35</td>
<td>(20.8%)</td>
</tr>
</tbody>
</table>

Column Total 169 (100%) 100%

The scale score range of HSA board member responses toward self care was then analyzed by a chi-square goodness of fit test to determine if such scores could have occurred by chance. Because the actual distribution of scores was weighted so heavily toward the favorable responses toward self care, the scale score range was divided into quartiles for the chi-square analysis. This was done to determine if the actual scores could have occurred by chance in a more illustrative manner than a dichotomized analysis would have shown. In Table 9 the theoretically expected, uniform, scores are
shown, as well as the actual scores of the HSA board members toward self care. The chi-square for this table was 7.85 with 3 degrees of freedom, p < .05. Thus the actual distribution of self care responses was not uniform across the range of scores. Finding such a skew distribution of scores by chance is unlikely. This suggests that self care in the abstract is not as controversial a health care innovation as much of the literature would lead one to think.

Table 9

Expected and Observed Self Care Scores of HSA Board Members

<table>
<thead>
<tr>
<th>self care endorsement</th>
<th>not at all supportive</th>
<th>very supportive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected Scores</td>
<td>42.25</td>
<td>42.25</td>
<td>42.25</td>
</tr>
<tr>
<td>Observed Scores</td>
<td>13</td>
<td>26</td>
<td>44</td>
</tr>
</tbody>
</table>

Chi-square = 7.85
Degrees of freedom = 3
Probability < .05

Because the SCAS was a weaker Guttman scale than was desired, further statistical analysis was conducted to determine how well the SCAS items fit together as a scale. As a supplementary examination the five items which made up the SCAS were analyzed as separate items to provide further information on the HSA board member endorsement by over half of the respondents. The heart attack prevention program generated the greatest amount of support, with 72% of the HSA board members endorsing it. The eye exercise program proved to be the
least supported, with 54% of the board members endorsing it. Therefore all of the items were supported by over half of the HSA board members. See Table 10 for the complete distributions.

Table 10
HSA Board Member Voting Record for Self Care Programs

<table>
<thead>
<tr>
<th>Self Care Program</th>
<th>Vote For</th>
<th>Voting Record</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Vote Against</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Heart Attack Prevention</td>
<td>137 (72.1%)</td>
<td>32 (16.8%)</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Holistic Health Program</td>
<td>120 (63.2%)</td>
<td>49 (25.8%)</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Migraine Treatment Guide</td>
<td>116 (61%)</td>
<td>53 (27.9%)</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Medical Resource Guide</td>
<td>125 (65.8%)</td>
<td>44 (23.2%)</td>
<td>21 (11%)</td>
</tr>
<tr>
<td>Eye Exercise Program</td>
<td>102 (53.7%)</td>
<td>67 (35.3%)</td>
<td>21 (11%)</td>
</tr>
</tbody>
</table>

Proposition 1 stated that HSA board members would not be supportive of self care, yet Tables 8 and 9 show that HSA board members are indeed supportive of self care, and that scores indicative of support were not due to chance. Therefore the first proposition must be rejected.

Proposition 2: HSA consumer board members will be no more supportive of self care ideology than are HSA provider board members.

This proposition was analyzed by treating the data in two ways. First, self care endorsement of HSA board members was analyzed by dividing the dependent variable of self care into two categories -
those who would vote for the self care program and those who would not. This was done by combining the SCAS responses of "vote for the program" and "voting for the program with some reservations" into a new category of "voting for" the self care program. Similarly, the SCAS categories of "not vote for the program" and "not vote for the program but see merit to it" were combined into the new category of "not voting for" the self care programs. The consumer/provider role of the HSA board member was the independent variable. As shown in Table 11, a greater percentage of providers were supportive of self care than were their consumer counterparts, despite the fact that more consumers responded to the questionnaire. A chi-square test of independence was used to assess the relationship between the independent variable of HSA role and the dependent variable of self care. The chi-square value for Table 11 was 1.6 with one degree of freedom, \( p = .21 \). This indicates that there is no association between HSA role and self care endorsement.

Table 11

Endorsement of Self Care Programs by HSA Role

<table>
<thead>
<tr>
<th>Self Care Endorsement</th>
<th>HSA Role</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consumer</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Vote for</td>
<td>72 (68.6%)</td>
<td>55 (86%)</td>
</tr>
<tr>
<td>Vote Against</td>
<td>33 (31.4%)</td>
<td>9 (14%)</td>
</tr>
<tr>
<td>Column Total</td>
<td>105 (100%)</td>
<td>64 (100%)</td>
</tr>
</tbody>
</table>

Chi-square = 1.6
Degrees of freedom = 1
Probability = .21

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Initially a Student's t statistic was to be used to determine if the scores of consumers and providers were significantly different from each other. Examination of the data shows providers are at least as supportive of self care as consumers, so the use of the Student's t statistic would now be superfluous. However, the mean scores of consumers and providers were calculated on the SCAS to show the similarities between consumer and provider HSA board members. The mean for consumer board members was 14.59 and the mean for the provider board members was 15.27. This reinforces the findings in Table 11 which show that HSA provider board members are more supportive of self care than are consumer board members. Yet the differences between consumers and providers are not significant. There is no real difference between consumer and provider board members in their endorsement of self care, thus Proposition 2 can be accepted.

**Proposition 3:** The Socioeconomic Status (SES) of the Health Systems Agency boards of directors has no association with their endorsement of self care programs.

In this Proposition the variables were analyzed as continuous in nature but reported in collapsed form for display purposes. The dependent variable of self care was divided into two categories - those who would vote for self care programs and those who would not. This was done by creating two categories from the four response options on the SCAS. "Vote for" the program and "Vote for the program with some reservations" were combined into the category of "voting
for the program;" categories of "not vote for the program" and "not vote for the program but see merit to it" were combined under "not voting for" the self care program. The independent variable of SES was calculated by using the Duncan Occupational Index to assess the prestige of the HSA board member occupation. The independent variable of SES was divided into two categories - "higher SES" and "lower SES." In Table 12 it is shown that 94% of the HSA board members have occupations that fall in the upper half of the occupational index. The data, then, are very skewed toward the higher SES statuses. Twenty-four individuals chose not to respond to this item. The chi-square statistic used to assess the relationship between the independent variable of SES and the dependent variable of self care endorsement was found to be .02 with one degree of freedom and a probability level of .89. This indicates that there is no relationship between SES and self care endorsement.

Table 12
Endorsement of Self Care by the SES of HSA Board Respondents

<table>
<thead>
<tr>
<th>Self Care Endorsement</th>
<th>SES</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>high</td>
<td>%</td>
<td>low</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Vote for</td>
<td>122</td>
<td>(78.2)</td>
<td>8</td>
</tr>
<tr>
<td>Vote Against</td>
<td>34</td>
<td>(21.8)</td>
<td>2</td>
</tr>
<tr>
<td>Column Total</td>
<td>156</td>
<td>(100)</td>
<td>10</td>
</tr>
</tbody>
</table>

Chi-square = .02
Degrees of Freedom = 1
Probability = .89

Pearson's Product Moment Correlation
Coefficient = .01
Probability = .44

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A second statistical analysis, a Pearson's Product Moment Correlation Coefficient, was used to measure the association between the dependent variable of self care and the independent variable of SES. It was found that $r = .01$ with a probability of .44. Thus there is no association between SES and self care. Therefore I can accept the third proposition since no association between HSA board members and SES support for self care was found.

**Proposition 4:** Female HSA board members will be more supportive of self care programs than are male HSA board members.

This proposition was analyzed by the use of two methods of analysis. The self care endorsement of HSA board members was analyzed by dividing the dependent variable of self care into two categories - those who would vote for the self care programs and those who would not. The sex of the HSA board members formed the independent variable. Thirty-one HSA board members chose not to respond to this item. It is shown in Table 13 that the majority of respondents (68.5%) were male. Table 13 also shows that the majority of both males and females were supportive of self care programs, with females (86%) more supportive of self care than were men (75.3%). The chi-square test of independence was used to assess the relationship between the independent variable of sex and the dependent variable of self care. The chi-square value was 1.8 with one degree of freedom and a probability of .18. This indicates that there is no relationship between sex and self care support.
Table 13
Endorsement of Self Care Programs by Sex of HSA Board Respondents

<table>
<thead>
<tr>
<th>Self Care Endorsement</th>
<th>Female</th>
<th></th>
<th>Male</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>43</td>
<td>82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>(86%)</td>
<td>(75.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vote for</td>
<td>7</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vote Against</td>
<td>(14%)</td>
<td>(24.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>50</td>
<td>109</td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>(100%)</td>
<td>(100%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chi-square = 1.8
Degrees of Freedom = 1
Probability = .18

Student's t = .46
Degrees of freedom = 168

The Student's t statistic was used to assess whether the mean scale scores of males and females are equal to each other or if they are different from each other. The Student's t value was .46 with 168 degrees of freedom. The mean of self care endorsement for females was 14.34, while for males the mean scale score was 14.75. Comparing these mean scale scores to Table 12, it appears that while more women are supportive of self care programs than are men, those men who endorsed self care did so at a slightly higher level. The difference of self care endorsement between males and females is not significant, so Proposition 4 must be rejected.

**Proposition 5:** The HSA will not show support for self care in its formal policy documents

Ten major goals for each HSA were chosen by examining the proportion of HSA goals, resulting in twenty-two total goals for analysis pur-
poses. Health education was the most accepted goal, with seven of the eight HSAs ranking it as one of their ten priority goals.

Cost containment, primary care and mental health-mental retardation services were tied at the next priority level, with six of the eight HSAs ranking these as priority goals. Eight of the goals (acceptance of HSAs, access to care, accident prevention, cardiac catheterization, CAT scanners, environmental health, chronic care, and diagnostic services) were ranked by two or less HSAs as priority goals. Thus variability does exist in HSA goals, with no goal being universally accepted by all HSAs.

The top ten goals each HSA set forth in its Health Systems Plan were analyzed according to the previously listed operational definition of self care. See Appendix 7 for a full listing of each HSAs prioritized goals.

It could be argued that every health systems goal promoted by each HSA involved self care. But according to the operational definition of self care, as defined in this research, only two of the goals pertain to self care. The first goal is to increase health education of the residents of the HSA area. Health education can result in individuals becoming more knowledgeable about disease prevention/detection, and can provide skills for treatment of some disorders without professional intervention. The individual can learn through health education what disorders can be cared for by the individual and when professional intervention is required. Yet health education is not a new phenomenon, and exists in some form in
most communities. So while this goal is an essential one for increasing one's self care capabilities, the extent of the education, manner of presentation and instructional topics all effect to what degree health education can increase self care.

The second goal that could pertain to self care concerns end stage renal dialysis. Some HSAs encourage home dialysis units for end stage renal dialysis, where the family can provide the dialysis care to the individual at home. This results in decreased cost and a decreased need for professional intervention, and allows the family to take the responsibility for controlling this aspect of health care delivery.

The mention of "self care" as such was not present in any of the goals listed for any of the HSAs. Only in the aforementioned goals was self care an inherent part of the implementation of the goal.

In short we see that the majority of HSP goals refer to health care on levels other than what can occur on the individual (self care) level. At least eight other goals (family planning, dental and eye health, primary care, mental health, accident, substance abuse, maternal and infant health, and diagnostic services) could incorporate the role of the individual as a key component in the achieving of these goals, yet the role of the individual is never mentioned. Rather, these goals focus on larger structural components (agencies, the medical profession) to provide services that will lead to the achievement of these goals. The goals of communicable disease, acute disease, and chronic disease are also focused
upon the institutional level with no discussion of the role of the individual in providing aspects of these diseases, prevention and treatment. Eight other goals (EMS, HMOs, acceptance of HSAs, access to and continuity of care, cardiac catheterization, CAT scanners, environmental health and diagnostic services) focus on the medical institution's role in the achievement of these goals.

From reviewing these goals, it appears that HSAs have a significant opportunity to incorporate the role of the individual into its health care goals/policies, but that no mention of self care as such exists. The goals tend to focus on the structural level rather than on the individual level. The widely accepted goal of health education and the lesser accepted goal of home dialysis have inherent aspects of self care, so it would not be appropriate to say that HSAs have no interest in self care. Thus my fifth proposition is supported; indicating that HSA policies do not seriously incorporate the concept of self care into its main policies and goals.

A Model for Understanding Key Variables That Effect Self Care Endorsement

In order to understand which of the independent variables have the greatest utility in explaining self care endorsement, a step-wise regression model was developed. Nine independent variables were used to explain the dependent variable of self care. Only three of the nine variables were chosen for use in formal propositions. Five variables - age, race, marital status, committee involvement, and years on HSA board of directors - were not postulated.
as having a significant role in the explanation of the dependent variable; however, because of secondary reference in the literature and because of personal observation of HSAs, it will be useful to assess how much they did contribute to the explanation of self care endorsement by HSA board members. The nine variables chosen were: which HSA the board member was from; whether the board member was a consumer or a provider of health care services; the age, sex, race, and marital status of the board members; how long the board member had been on the HSA; how active the board member was within the HSA (how many committees the person was involved); and the socioeconomic status (SES) of the board member.

As shown in Table 14, age was the most significant variable in explaining board member endorsement of self care. Whether the board member was a consumer or provider, and the socioeconomic status of the board member were also statistically significant. The sex of the board member, committee involvement, marital status, years on the HSA, and race contributed nothing to our understanding of self care endorsement.
Table 14

Stepwise Regression Model of Self Care Endorsement

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Multiple R</th>
<th>$R^2$</th>
<th>Rsq Change</th>
<th>Simple R</th>
<th>$F^*$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.46</td>
<td>.22</td>
<td>.22</td>
<td>.46</td>
<td>14.3*</td>
</tr>
<tr>
<td>Consumer/Provider</td>
<td>.52</td>
<td>.27</td>
<td>.06</td>
<td>.46</td>
<td>8.1*</td>
</tr>
<tr>
<td>SES</td>
<td>.53</td>
<td>.28</td>
<td>.01</td>
<td>.00</td>
<td>4.5*</td>
</tr>
<tr>
<td>Which HSA</td>
<td>.54</td>
<td>.29</td>
<td>.01</td>
<td>-.10</td>
<td>2.5</td>
</tr>
<tr>
<td>Race</td>
<td>.55</td>
<td>.30</td>
<td>.01</td>
<td>.15</td>
<td>1.1</td>
</tr>
<tr>
<td>Years on HSA</td>
<td>.55</td>
<td>.30</td>
<td>.00</td>
<td>.15</td>
<td>1.7</td>
</tr>
<tr>
<td>Marital Status</td>
<td>.55</td>
<td>.31</td>
<td>.00</td>
<td>.19</td>
<td>1.0</td>
</tr>
<tr>
<td>Committee Involvement</td>
<td>.55</td>
<td>.31</td>
<td>.00</td>
<td>.25</td>
<td>.2</td>
</tr>
<tr>
<td>Sex</td>
<td>.56</td>
<td>.31</td>
<td>.00</td>
<td>.37</td>
<td>.2</td>
</tr>
</tbody>
</table>

* Significant at or beyond the .05 level

This stepwise regression is useful for assessing if the correct variables were chosen for analysis, and to provide guidelines for choosing variables in future research. With regard to the first aspect - if the correct variables were chosen for analysis - it was found that the most important variable (age) was not chosen. In reviewing the literature, the variable of age was seldom discussed as a critical variable in support of social movements or self care. The role of age in general social movements literature is virtually nonexistent, as is the case with most of the social movements in health literature. Only in Grossman's (1978) study on HSA membership was age found to be useful in assessing voting patterns.

The second most important variable - consumer/provider role distinction - was predicted to be important, as was from which HSA
the respondent came, and the SES of the respondent. The literature indicated that these variables may be important. The variable of sex was shown to be of minimal importance in explaining why people support health care innovations like self care.

It was found that two of the four strongest variables in the regression model were used in the research propositions, yet the strongest variable, age, was not chosen. From the variables which were selected for analysis in the stepwise regression, it was found that the model explained 31% of the variance. Thus the model accounted for about a third of the variance contributing to our understanding of self care attitudes. In the regression model the consumer or provider role of the board member and SES were found to be important in explaining self care endorsement, yet they were not found to be significant in the bivariate analyses. This could be true for several reasons. While SES and consumer/provider role were found to be fairly strong in the regression model, still two-thirds of the variance was not explained through this study. Also, multivariate analysis by its very nature will tell us more than bivariate analysis. When variables are analyzed in a multiple regression, an interaction effect occurs among variables that tells us much more than could a bivariate analysis. The variable of age, which was not used in the research propositions, was added in and found to be very important in contributing to our understanding of self care endorsement.
Summary of Results

The responses obtained in this study came primarily from white middle aged males. The majority of respondents tended to be in the top half of the socioeconomic levels as based on prestige ratings of occupations. Most of the respondents were consumers on the HSA boards. The majority of board members have been on the HSA board of directors for several years, thus are not newcomers to the HSA. Most members are active on several HSA committees.

The following information was found through the testing of the propositions. In Proposition 1 it was shown that HSAs as a whole are supportive of the self care movement. The second proposition found that the consumer boards of directors would be no more or less supportive of self care programs than would the provider board members, and this was found to be the case. The third proposition stated that the SES of the respondents would have little effect on their support for self care programs, and this too was upheld, despite the fact that the majority of respondents were from the higher SES and supportive of self care programs. It was also found that the majority of respondents were from the upper half of the prestige ratings, with only a small number from the lower SES. The fourth proposition, stating that females would be more supportive of self care programs than would be males, was rejected since no difference between male and female HSA board members resulted. The fifth proposition, stating that HSA policies would not reflect support for self care, was upheld. Most of the HSAs had at least
one of ten goals that could marginally relate to self care; no HSA had policy goals that related to self care as an alternative form of primary health care.

In the development of a stepwise regression model linking nine independent variables to the dependent variable of support for self care programs, it was found that the age of the respondent was the most critical variable in explaining support for self care. Consumer/provider role distinction, SES, and the particular HSA one is from provide some explanation. Variables such as marital status, sex, or years on the HSA board provided nothing in explaining self care endorsement.
CHAPTER V

Conclusions

Summary of Findings

The HSA board members who responded to the Self Care Attitude Index were found to be predominantly white, middle aged males. Most of the respondents were upper socioeconomic status. The majority of the respondents had been active in HSAs for several years, and participated within the HSA on several committees. Slightly more consumers than providers of health care services were found to be on the HSA board of directors.

Several major points were found about the support of the HSA board members of self care. First, HSA board of directors tend to be supportive of self care on an attitudinal level. Second, consumers and providers were not found to differ in their endorsement of self care projects. It was also found that socioeconomic status had no effect on support for self care efforts; neither did the sex of the respondent. While HSA board members may be supportive of self care in theory, their official health planning documents (the Health Systems Plan) did not reflect overt support for self care.

From assessing the role of all the independent variables in this research, age was found to be the strongest variable in explaining endorsement for self care. Consumer/provider role, and SES also provided some explanation of self care endorsement.
What Do the Findings Tell Us of the Nature of HSAs?

From the findings of this research, three provide insight into the understanding of the nature of HSAs. HSA board members tend to be supportive of self care programs in theory. Yet the HSAs official documents do not mention self care as a desirable health care strategy, nor do the goals of the HSAs. Thus there is a discrepancy between what HSA board members say they feel toward self care and the official health policy and planning action taken by the HSAs. It was also found in this study that there is no difference between consumers and providers in their endorsement of self care. This finding occurred despite allegations that self care is a consumeristic movement (Levin et al., 1979), and that HSA consumer board members are supposed to represent consumer perspectives (PL 93-641).

Each of these findings contributes in isolation to our understanding of HSAs. To combine these findings allows one to gain a fuller picture of how HSAs operate. There are several explanations which could explain the findings of this research, findings which question the relationship between self care and HSAs. Four possible explanations are: lack of the self care movement's impact; 'consumers' turning 'providers' in orientation; professionalism of consumers; and the conservative influence of organizations. These explanations will be provided as competing frameworks in analyzing these findings. These frameworks provide five distinct alternatives for this analysis, and help to provide a critical assessment of the phenomenon.
Degree of the Self Care Movement's Impact. The self care movement has not influenced the health care delivery structure. In this section three possible explanations for this lack of influence are explored. The first concerns self care as a social movement; the second concerns the problems determining exactly what is and what is not self care; and the third explanation concerns the importance of self care as an HSA issue.

The self care movement, as described in Chapter II, has potential for becoming a viable social movement. The thrust toward self care has become a visible area of health care change. However, the self care "movement" as such has difficulty meeting some of the criteria for construction of a social movement. Self care should be more appropriately regarded as a pre-movement stage, rather than as a full scale social movement. By regarding self care as an earlier stage in the evolution toward a social movement, it is easier to understand why the self care "movement" has not yet generated much change in the health care delivery system.

The self care movement has not been able to mobilize effectively large numbers of people around self care concerns. It has been pointed out that the members of the self care movement are small pockets of individuals dispersed across the country who focus primarily on isolated self care issues rather than on the development of a system of self care issues. The common thread that unites the self care advocates is their concern for altering the health care system in ways best described through the official self care journal, Medical Self Care.
The self care movement has few leaders who can generate excitement and commitment to the movement goals; it does not employ professional self care lobbyists. The self care movement has not, as will be shown later, been able to incorporate many of the principles of the resource mobilization theory. The self care movement, given time, may be able to develop into a fuller, more advanced social movement. This criticism of the self care movement is not to doom it to failure; it rather illustrates that self care is not yet in a fully developed social movement stage. It may in the future be able to fulfill many of the criteria for a true social movement, but for the purposes of this research it is more appropriate to regard self care as a premovement.

Changing the health care delivery system to incorporate self care calls for basic philosophic and procedural changes on behalf of the lay and the professional community alike. Philosophically, the argument against self care becomes less intense than it does on the procedural level. Who would actually be opposed to an individual taking steps to be more responsible for his or her own health? The argument against self care stems from procedural questions - how many steps or how large should the steps be that an individual takes in the self care area? The opposition to self care seems to come more from how far an individual should act in his/her behalf as compared to acting at all in one's behalf.

As was shown in the analysis of Proposition 1, it appears that HSA board members do believe in the usefulness of self care when asked to endorse various self care projects. In the analysis of
Proposition 5 it was found that two of the health planning goals could relate to self care, but even these goals were not advocating the use of self care as defined by self care advocates. The two goals - health education and end stage renal dialysis - refer either to ancillary or end care, not to primary or secondary care. For self care advocates, self care is the front line in disease prevention, detection and treatment, not ancillary or tertiary care. The data suggest that HSA board members can support self care on an ideological level, but how and to what degree it should be carried forth becomes more difficult to ascertain. Since the formal policy of the HSAs does not reflect self care use as a primary health care strategy, one is left to assume that HSA board members support self care - but not as a replacement to the traditional health care delivery system.

The benefit and limitations of self care from a consumer perspective have been mentioned in Chapter II. From a provider standpoint, self care has benefits by allowing the physician to see more appropriate types of patients, and by generating a sense of greater responsibility to one's health on the patient's part. Self care has the inherent possibility of demystifying the healing process, deemphasizing provider autonomy, and reducing the provider case load. While the limitations to self care from a provider perspective can be debated, it appears impossible to say unequivocally that self care will be good for the consumers and bad for the providers.

Consumers were found in this study to be no different from providers in their support for self care. This may not mean that HSA consumer board members were inappropriate in their orientation,
rather, it could mean that they are not self care advocates. The pockets of individuals, who are actually self care movement members, dispersed across the country, who join together because of significant perceived grievances or relative deprivation may have no representation on HSA boards.

Learning how to take proper care of oneself is not a quick or a simple process. It requires work and time — things that many people in today's society may not choose to give to health care. It is quicker, although not cheaper, to go to a doctor for health care than to do it yourself.

It must be pointed out that some individuals choose not to care for oneself, even when the opportunities for self care are available. For many individuals, going to a health care "professional" is thought to give the image of better quality health care (Ruzek, 1978). Also, people who are not accustomed to providing health care to themselves may feel uncertain about their ability and prefer the expertise of the physician.

The self care movement, then, has not been able to generate change on the health care delivery structure. It has not been able to mobilize effectively large numbers of people around self care issues. Among those individuals who are interested in self care, many may feel they do not have the knowledge to be self care providers. Others may not want to take the time or responsibility to become self care givers on a significant level. Finally, the term self care has been found to not be as obvious as it sounds, generating confusion over what is the proper domain of self care.
Perhaps the most salient of the explanations concerning the self care movement's lack of influence within the HSA formal structure concerns the importance of self care. While self care has been shown to produce health, economic and consumer satisfaction benefits, it is not a dramatic, vivid type of health care innovation. It is not awesome, like CAT scanners, or seem as evidently important as a new wing and new services of a hospital. Self care does not have strong financial backers and it does not produce immediate, dramatic results. HSAs, on the other hand, do deal with a variety of important issues, like cost containment, avoiding duplication of services, and promoting essential health care services to large geographic areas. HSAs work with influential individuals who have financial backing for their interests, individuals like health care providers, insurance specialists, etc. So HSAs have many important, political issues and interest groups to contend with. HSAs also exist on precarious ground, existing under pressure to prove that they do influence the health care of an area. It is not unlikely that HSA board members would choose to put their efforts in areas which are most visible and viable. Self care is simply not one of those areas.

From an organizational perspective one can understand that there is a limited amount of time, energy, and resources to pursue any goal. Thus goals must be prioritized to determine which efforts are the most necessary and the most achievable. Since self care has existed outside of the official health care delivery system, the case could be made that it is not as necessary as, for example, Emergency Medical Training. The achievements that could be generated through
the use of self care may not be readily apparent. Large numbers of people providing self care, time, and subjective interpretation of the merits of self care must all be considered before the benefits of self care become apparent to larger structural elements like the HSA. As one sociologist put it, "Who cares about self care with all of the economic and political crises in health care going on?" (Daniels, 1981). In short, one basic reason why the self care movement has not influenced the HSA could be that while self care may have benefits, it is simply not as important as many other health care issues which the HSA board members must deal. But how else may one view the relationship between HSA board of directors and self care? Let us turn now to other explanations of this relationship.

Consumers' Appearing 'Providers' In Orientation. According to the literature (Mott, 1978; Levin, 1977), one is lead to the conclusion that providers should be resistant to the self care movement while consumers should support it. This conclusion is based on the notion that providers have little to gain from the self care movement, whereas consumers have a great deal of potential benefit from it. Yet this study found that consumers were not different from providers in their support for the self care movement. The results of this research concur with Grossman's (1978) research—that HSA providers and consumers tend to vote for similar programs with consumers not advocating the consumer interests they were theoretically appointed to represent. There is the possibility that health care providers have assumed a consumeristic orientation; however, the
possibility of consumer board members being coopted to assume the provider orientation seems more plausible. This is especially plausible when one considers the power of the medical profession to advance its positions and perspectives, and the traditional lack of power of consumer groups. As Lewin (1953) notes, it is not uncommon to find that groups like consumer HSA board members assimilate into a more prestigious group so anxiety producing that they give up their own interests, values, and attitudes for those of the group into which they are assimilating. Also, the consumer of health care was shown to not be an expert in the area of health care, so when complex issues emerged within the HSA board, it was not uncommon to find consumers yielding to the providers whom they regarded as 'experts.'

This could mean the consumers do not represent consumeristic perspectives. If they do not, then have they been coopted into representing a provider orientation because of their lack of expertise in the medical area, submitting to the knowledge and authority of the providers? Or could it be that the providers have assumed a self care advocacy perspective so as to maintain control of this area of health care? Perhaps both are possible to some degree in providing an explanation to this concern.

Professionalism of Consumers. It could be the case that the consumer of health care services in the HSA board is not representative of the population of health care consumers, and this could have affected our understanding of the nature of HSAs. Rather, the consumer
board members could have been selected for membership because of their ability to 'think' like providers. The literature (Horty, 1979) indicated that consumer board members among many HSAs were of high class standing with prestigious, professional occupations—not at all like the active population of health care consumers.

The similarity of consumer attitudes to that of providers provides insight about the effects of SES upon self care attitudes. When consumers are appointed to HSA boards to represent the interests of the average health care consumers, it seems highly likely that the banker or lawyer consumer may regard the health care system differently than the welder or factory worker consumer. The majority of consumer respondents in this research fell in the higher SES categories. At least for the purposes of this study the lower SES consumers were not well represented. Is this a reflection of a lack of lower SES individuals on the HSA boards? An HSA may have the designated proportion of consumers on its board of directors, yet, as has been the case with many HSAs, they may appoint consumers who do not reflect low income, minority, youth or aged populations.

In this study it was found that even among high SES individuals there was no difference in endorsement toward self care. Supposedly the self interests of consumer board members and provider board members regarding health care should be different because of their different orientations. But they were not found to be different about self care, even though self care evidently affects providers and consumers differently. Similarities in social class tend to manifest similar attitudes more so than do similarities that result from a
"Provider" or "consumer" orientation.

"Providers" Appearing Consumeristic in Orientation. One interpretation of the data is that consumers are not responding like providers about self care; rather, it could be that health care providers are supporting self care in a manner similar to health care consumers. There are several reasons for this speculation.

Since the mid-seventies, when much of the literature on self care was written, some consciousness-raising on the part of health care providers may have resulted. Increasing numbers of providers are specializing in disease prevention and health care promotion. Some ecological changes may be occurring in medicine. The doctor and patient may function more as collaborators in the healing process than previously when the doctor was the sole decision-maker.

Providers may also be supportive of self care because consumer use of self care could help aid the provider of low profit services, and mundane tasks. To health care planners, self care could even be more attractive because it can reduce health care costs, freeing the provider to give greater attention to more "serious" disorders.

Providers may be supportive of self care because they wish to incorporate it into the health care delivery system where they have some control over it. Many health care alternatives are being promoted today, of which self care may be seen as less controversial than most. It may also be that providers wish to appear more 'progressive,' and protect their image by supporting self care type of programs. While these explanations are speculative they point the
way to further research to explain and elaborate these findings.

The Conservative Influence of Organizations. In all eight of
the HSAs the majority of board members reported being supportive of
self care. Yet in assessing the planning goals of the HSAs it was
found that only two of twenty-two goals reflect self care. The role
of the individual was seldom, if ever, mentioned in the health plan­
ning goals. The role of organizations, however, was frequently men­
tioned. Since the HSA is an organization it tends to deal on an
organizational level on health care issues. It focuses on how large
scale organizations, like hospitals, affect the individual. The
HSA also functions to develop large scale health plans, plans dealing
with a multitude of organizations from large geographic areas. The
HSA does not focus on the role of the individual, even though the
individual is the raison d'etre.

According to the HSA directors, no project reviews have been
conducted specifically on self care. If no reviews have been con­
ducted on self care, and since self care is only minimally incor­
porated into their health systems plans, is the self care movement im­
pacting the health planning level? It could be that this social
movement has not yet been effective in being incorporated into the
policy level of health planning.

Goldbeck (1978) noted that there exists discussion on the
merits of health (and self care), yet the outcome of these discussions
has been only discussion. He states that the public, government and
medical profession have not demonstrated beyond rhetoric a real com­
mitment to such health care ideologies. The self care movement seems to have influenced health planners on an attitudinal level, yet not on the larger, structural level. It thus could be that attitudes must change before policies can change, and that the self care movement is in the process of slow evolution toward impacting the policy level.

Or could it be that it is not the slow evolution, but (at least on some level) rather an intentional suppression of the powerful role the individual can play. Both consumers and providers have been shown to accept the same definition of appropriate health care and who are appropriate health care resources. The individual tends to be regarded as what is effected in health care, and is not recognized as part of the health provider resource, or those who affect health care.

Social institutions tend to evolve slowly, tend to maintain the status quo, and tend to be conservative. The federal mandate of HSAs only alludes to benefits of self care and does not dictate that HSAs develop such efforts on their own. Subsequently, most HSAs are not self care oriented from assessment of their HSPs.

Reasons why HSAs have not moved in the direction of self care or other consumer movements have not been well developed. A few possible explanations range from why institutions in general tend to resist social change, to professional control over innovations, to slowness of action within agencies, to confusion over the actual role that self care should plan in health care delivery. As Wagenfeld and
Robin (1980) note, social change within established organizations may be difficult because of the lack of agreement among professionals in the role of innovations in service delivery, and on what extent organizations should be vehicles for social change. This places the innovation in an ambiguous role since the professionals may not agree upon the nature of the innovation and to what degree they should be advocates for it.

These four frameworks provide competing explanations of the research findings listed earlier. My data can not allow me to choose which one is the most accurate. Rather, these explanations provide a foci for future research in the areas of health care movements and health care organizations.

What Do the Results Tell Us of the Nature of the Self Care Movement?

The self care movement is but one in a series of social movements in health that are currently taking place. From these results it appears that the self care movement is in for a struggle if it is to be successful. Two main reasons why this pre-movement may not be as successful as its members would like are: self care's ideological limitations; and self care's organizational limitations.

Regarding the ideological limitations of the self care movement, Kronenfeld (1979) states that the movement is a white, middle-class movement that has minimal impact for the poor. She feels that only those with education, those who have time to spend in health promotion, and those with money to buy the necessary resources can benefit
from self care. The poor often lack an educational background, time, and money necessary for the use of self care. Her points reinforce what other researchers (Rosenthal, 1977) have pointed out regarding the poor's ability to use health care prevention. Yet it seems that structural inequality prevents the self care movement from being useful for all segments of the population, not that the ideology which underlies the movement is bad. In a theoretical sense, the poor could have the greatest gain from the use of self care.

But even if the self care movement cannot mobilize every population, is it doomed to the failure that Kronenfeld thinks is imminent? It must be pointed out that few social movements are successful in attaining all their goals. A social movement can be partially successful if it can influence the operations of a societal structure. It is difficult to change an established social institution, so if a movement can influence it the movement should not be regarded as a total failure.

It was stated in Chapter II that relative deprivation and discontent over a situation are primary factors leading to the development of social movements (Morrison, 1973). The participants in the self care movement have access to health care services—-it is the quality of those services and the method of delivery that provide the impetus for the movement. The literature on relative deprivation provides a useful method of understanding why individuals choose to be involved in the self care movement. The deprivation experienced by the members of the self care movement has influenced
the goals and ideology of the movement. While an ideology and values toward health and self care exist, the specific goals and ways of achieving those goals are not clearly defined. The unfocused orientation of "you challenge or change whatever you want on whatever level you want" simply is not effective for the ongoing success of a social movement. Thus, specific goals are not well defined in an operational sense, nor are the existing goals well communicated. Since no self care movement meetings are held, and since people are fragmented within this movement, communication between members on specific directions is weak. Without adequate communication among members on the goals and directions it will be difficult to make national changes in such a powerful structure as the medical institution. Thus, the deprivation experienced may vary from group to group and be focused upon specific elements of self care rather than addressing uniform issues. This also contributes to the difficulty of the movement being as successful as its members would like.

Another problematic area for the self care movement concerns the leadership of the movement. The self care movement has mostly intellectual leaders who promote research findings and give information to the members in order to make changes in the health care delivery system. No charismatic leaders have appeared to generate strong emotional conviction to the self care movement. The self care movement appeals largely to the intellect, not to the emotions. Few administrative leaders have also appeared to mobilize the movement and to provide concrete direction. Self care members tend to work largely in isolation from one another, and the specific goals
and strategies used may vary from place to place. There has been no effort to coordinate the self care movement on an administrative or national level.

Because of the lack of administrative organization, the self care movement has been unable to mobilize bureaucratic devices which could be of use to the movement's success. The movement has been unable to use the mass communication network successfully. The information that does exist comes predominantly from books, journals and periodic workshops or conferences. The self care movement has not been able to generate strong media support for its efforts.

Mauss (1973) notes that social movements go through distinct stages, with the most critical stage being the coalescing of members. If members are united, if goals and means are well communicated, if they are well coalized, then they have a good chance of impacting change on the institutions they seek to alter. But in the self care movement, this critical stage of coalescence is almost nonexistent in a structural sense. Small groups of people here and there across the country may exist, with aims that vary across locales; no unified body of people exist in this social movement. Thus the self care movement will have a great deal of trouble altering the health care delivery system.

Turner and Killian (1972) noted that social movements may be either value oriented or power oriented. The self care movement seems largely value oriented, thus reinforcing its intellectual background. It does not seem particularly power oriented, except in the
idea of giving the consumer power over his or her health care. When attempting to change a structure as traditionally powerful as the medical institution, when challenging such powerful individuals as the health care professional, it seems that more than a value oriented movement is needed. McCarthy and Zald (1977) noted how elites are not responsive to innovations, to changes that may undermine their base of authority. Thus they will try to control the changes, and coopt those who oppose them in order to control the impact of the social movement.

In this study, no real difference between health care providers and health care consumers was found in their attitudes toward the self care movement. Levin et al. (1979) state that the self care movement must be led by consumers if self care is to actually meet the needs of the general population. Lay control of the self care movement is also regarded as essential if self care is to be fully used and not as a watered-down tool of the medical establishment. If health care providers lead the way for self care, Levin warns that there is danger that the movement will take on the perspective and direction of the medical profession rather than becoming a full scale consumer health care innovation.

Yet we must address whether the self care movement has influenced the health care delivery system. It appears that the health care professionals are more open to self care ideology than they have been in past years, indicating that providers may be able to be self care oriented (Checkoway, 1980). Also, one must address whether the self care movement can be successful without at least par-
tial support/leadership from the medical community. The self care movement is doomed if it polarizes the lay resource from the professional resource in attempting to increase the quality of health care delivery. It will be much easier for the self care movement to alter the existing health care structure if the movement is advocated by health care providers who can penetrate that structure. A mix of leadership and membership from the lay and medical communities could help to make the self care movement ultimately more effective, as opposed to Levin's skepticism of the involvement of health care professionals.

From observation of national self care meetings, the majority of presenters and participants have some provider relationship with the health care system. Few of the participants and even fewer of the presenters at the national conferences were lay persons. The national thrust for the self care movement does seem to be led by providers of health care who wish to activate consumers to become involved in their own health care. So while Levin's skepticism of health care provider input in the self care movement may be warranted, it does seem that if it were not for many health care providers, the self care movement would not be as visible and viable a social movement as it is today.

The success of the self care movement as a consumer based movement which challenges the basic premises of the health care delivery system seems unlikely. This is due to its failure to meet requirements for a strong social movement. However, this does not mean that the self care movement will have no influence on the health care

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delivery system. It could be that the providers of health care services have attempted to coopt and control the self care movement by implementing some changes in the way services are being provided. In this way they will compromise services to meet the desires of the critics while still maintaining control over the services. While this may not, as Levin warns, result in true, consumer-based change, it may result in some degree of change nevertheless. The days of the physician's sole power to make decisions over a patient's treatment seem to be fading, being replaced by a more active role of the consumer in the therapeutic relationship. The increasing number of books and articles on self care are indicative of a trend in health care away from the provider and more into the hands of the consumer. So while the changes may not be as great as the self care advocates may desire, change has still resulted because of their efforts.

The limitations to this kind of change exist, however. Will this change provide the extent of necessary changes in the health care delivery system in the long run? It could be that these changes provide only compromise and force the self care issue to be brought up again at a later time for greater resolution. A different limitation of self care could be that inherent in the concept of self care there are limitations which keep self care from becoming as useful a phenomenon as many members would like. Perhaps self care is useful only in the hands of those who are insightful, educated and motivated in the area of health. A blanket approval of self care may prove to be dangerous for those who lack the knowledge to use the concept properly.
What Do Results Tell Us of the Nature of Social Movement Theory?

Social movements do not always succeed in achieving all of their goals. Sometimes social movements fail—often they do less than succeed. Yet social movement theory can provide a framework for analysis of phenomenon like self care. It gives a good explanation of why the social movement is not meeting with full success.

Both classical social movement theory and resource mobilization theory were used for analysis of the self care phenomenon. Classical social movement theory described the nature and origin of the self care phenomenon. Literature on: relative deprivation; development of goals, values and ideology; characteristics of leaders and followers; power/value orientation of the movement; cooptation; and role of the professional all provide insight into major characteristics of the self care movement.

Yet resource mobilization theory provides further explanation of why the movement has been less successful than its members would have liked. McCarthy and Zald (1973) question the link between discontent, belief, and the rise of social movements. With regard to self care this link seems suitable and provides an accurate explanation for understanding this phenomenon. But the resource mobilization theory's emphasis on power and process also seems to be a critical area of focus. If the self care movement had greater utilized the power arrangement and if one would focus more on the process of social movement operations, one could better understand the nature of social movements and why they succeed or fail. Full
time advocates, a financial support base, and control of the media, to mention a few elements of the resource mobilization theory, could help a social movement to succeed. The self care movement does not have a strong financial base or full time advocates; no doubt if they did the movement would have a greater chance for success. Media coverage is used by both the medical profession and their critics, mostly in a low key, intellectual fashion.

Both classical social movement theory and resource mobilization theory are useful in understanding the self care movement and should not be regarded as separate theoretical tenets. Classical social movement theory provides information useful for our understanding of what has occurred, while resource mobilization theory provides information useful for our understanding of what has not happened.

Self Care Movement and Self Help Movement: A Similar Lesson?

Much of the literature separates "self care" from "self help." While self care is often used to refer to medical care alternatives, self help usually pertains to any sort of assistance that individuals can provide themselves without the use of professionals. It appears that self help care might be appropriately regarded as a subgroup of self help activities, a specialized subgroup focusing primarily upon medical concerns and a group that meets most of the larger definitions of self help groups in general. In this context, how can self care be functionally compared to self help, and what may be problems with both of these orientations in influencing structural change?
Self help groups in general have been found to be effective agents in creating personal and institutional change (Vattano, 1972). Gartner and Riessman (1980) state that self help groups can revitalize health care by providing remedies to patient satisfaction and by providing inexpensive, effective health care services.

Self help groups are by their very essence nonprofessional in nature, and when professionals become involved in such groups their involvement only contaminates the true nature of the group (Gartner & Riessman, 1978). If one agrees that self help groups are non-professional, this creates conflict between the self help groups and the professionals whether such conflict is intended or not. Thus self help groups become political agents that challenge the existing structure (Durman, 1976).

Motivating self help groups towards overt political action may not always be easy, because there exists a continuum of self help behavior, according to Spiegel (1976). Spiegel alleges that self help behavior can range from private concern about a problem (or sense of relative deprivation), to going public and making an open declaration about the support of the self help issue, and finally to broad political action. Therefore the term "supporter" of the self help group implies a whole range of behaviors. Borkman (1978) expands on this notion by including professionals in this range of behavior. She notes that within the professional world there is a great deal of variance over self help issues and self help groups. Indeed we see within self care that many health care professionals are leaders within the self care movement.
Yet Illich (1977) states that as a society we must turn away from professional authority and towards self reliance and self care. In this way he feels one can provide an alternative to professional domination. Yet self care promotion is not embraced by all advocates of health care reform. Victor and Ruth Sidel (1977) are critics of the medical self help movement for the following reasons: They state that medical self help groups may perpetuate inequities in American society and in the health care system because they fail to pressure health care providers to serve the entire population of those in need - especially the poor, aged, and children. Thus self help groups may only expand inequalities of access to health care. Self help groups emphasize individual problems and symptoms, which further fragments people and further encourages the medicalization of human life. The Sidels imply that when people join with a group of individuals with whom they have little in common besides a specific symptom or problem that they do not have a strong basis for a coalization and will not generate the unity necessary for effectively challenging the formal structure. They point out that self help groups, especially those in health, need to have a strong base of power, commitment to each other as well as commitment to an ideology, and a well defined plan of action if they are to influence authorities like the medical profession. If they cannot generate these things, the self help groups may be doomed to fail in their ultimate goal.

The political challenge of self help groups has been examined by Pillemer (1980). He questions whether self help groups really
act as a positive force in society, changing the lives of individuals and helping to create structural change. Rather, do self help groups, through unexpected and unintended ways, actually contribute to a contemporary crisis within modern medicine? Navarro (1976) addresses this point, by stating that self help groups, actually sustain iatrogenic conditions for they do not actively oppose inequities in the distribution of resources and power in society. As Kronenfeld (1979) pointed out earlier, the self care movement is a white, middle class movement (as are the majority of self help movements) which does not address the needs of the poor or minorities. The self care movement in many ways could release the health care profession of many of its current responsibilities by promoting "certain" activities to be no longer appropriate physician activities and more appropriately done by the individual. The self care movement may be able to force a reaction by the medical community, but the reaction may take the form of reducing services as opposed to increasing quality services for all.

So does the self care movement represent a fundamental challenge to the formal health care structures? From the research presented in this study, one is led to the conclusion that it does not. We found in Proposition 1 that HSA board members were supportive of the concept, but on a policy level (Proposition 5) self care emphasis was virtually nonexistent. Earlier in this chapter we looked at some reasons why the self care movement has not generated the kind of social change that it intended. If self care is not reflected in the health planning policies of Michigan, then it appears fair to say
that the formal health care delivery structure has not been challenged
at all by the self care movement. The self care movement seems even
more fragmented, less cohesive a group than other types of self
help groups (like Alcoholics Anonymous, etc.). The emotionality
present in many self help groups is not really present in the self
care groups, nor is its degree of member mobilization. Self care,
as Daniels (1981) stated, may be a non-issue compared with all of
the life or death issues that people must face today. If self help
groups are to be successful in bringing about the goals for which
they strive, then self help must move from a concentration on recti-
fying individual pathology to creating a challenge to the dominant
social order (Pillemer, 1980). If self care is really going to make
an important contribution to the health care field, it needs to go
beyond teaching people how to take their own blood pressures. It
requires that the health care structure and the individual consumer
of health care services reverse many of their traditional roles to
accomodate the development of a health care system which revolves
around the individual, as opposed to making the individual revolve
inside the health care structure. It requires close analysis at the
question - who do the health care services really support, anyway?

Possible Methodological Problems

In any research, problems emerge that may effect the results of
the research. This study is no exception to this fact. Possible
problems could have occurred in four basic areas: difficulty in
obtaining responses; respondent confusion over self care concept;
respondent misinterpretation of items; and sampling bias.

While the response rate in this research was acceptable (62%), it would have been preferable to have obtained a higher response. Two mailings were conducted in attempts to obtain a greater response rate. Some of the sampled individuals reported to HSA staffs or by writing to me that they were suspicious that this was a secret governmental evaluation that intended to make HSAs look bad, so they would not answer the questionnaire. Also within the returned questionnaires some items were systematically left blank. Items on the back page of the questionnaire (demographics) were most frequently left blank. Approximately 10% of the respondents systematically left items blank. If one speculates why HSA board members either did not return the questionnaire at all or left parts of the questionnaire blank, one possible answer could be that they did not think self care was important. It could be, especially considering the large number of HSA board members who were found to be supportive of self care, that those who were interested in the topic of self care responded, while those who were not interested in the topic did not return the questionnaire. Since no respondent ID code was used on the questionnaire, it was impossible to track down a sample of those who did not return the questionnaire to see if in fact they were not interested in the topic of self care.

The second problem resulted from respondent confusion over the definition of self care. From many of the comments written on the questionnaire, it appeared that the board members did not have a uniform understanding of what self care was, and that their bias for
it or against it may have colored how they responded to the items. Self care was intentionally left undefined in order to see how they would deal with the term. However, leaving it up to the respondents entirely to define the term may not have been as useful as providing them with some sort of definition.

Another problem resulted from the respondents misinterpreting items. For instance, several respondents reported that they would not vote for a given project because "who would pay for it?" or "I need more information before I can decide" or "we already have one so to vote for it would be duplication of services." Considering the support shown for self care projects in total, the effects of this misinterpretation are probably minimal.

The fourth area concerned a sampling bias. All of the HSAs in Michigan were surveyed, yet Michigan may not be representative of the rest of the country. The respondents were primarily white, middle-class males of high SES. The respondent characteristics may not be generalizable to the rest of the population, posing limitations on the application of this data to HSAs in general.

Future Research Recommendations

Several recommendations are appropriate for those who will pursue future research in this area. The first series of recommendations spring from analysis of the stepwise regression model. This model indicated that age was an important variable though not originally.
It was found by using age and sex as predictor variables that the younger the board members were, the more supportive of self care they were. This relationship was significant at the .05 alpha level, with a chi-square of 13.46. (See Table 15 for the actual distribution.) Perhaps younger individuals are more supportive of health care innovations like the self care movement because of a more "progressive" orientation to health care; they may be less bound to the conventions of the past. Grossman (1978) found that younger physicians were more supportive of new health care programs than were older physicians. Older individuals may be relating to a different time, a different orientation of the 'way things ought to be done.' Younger individuals probably have a lesser degree of commitment to institutional structures and are more receptive to change. On the other hand, many of the self care programs used in this study could be of use to older individuals. Heart attack prevention programs, eye treatment programs, migraine headache treatment programs all could be appealing to older people whom suffer more of these disorders than do younger individuals. So the role of age certainly should be explored more completely in future research with regard to self care support.
Table 15

Endorsement of Self Care by the Age of the HSA Board Member

<table>
<thead>
<tr>
<th>Self Care Endorsement</th>
<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vote for</td>
<td>5 (100%)</td>
<td>24 (88.9%)</td>
<td>39 (81.3%)</td>
<td>40 (80%)</td>
<td>12 (52.2%)</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Vote against</td>
<td>0</td>
<td>3 (11.1%)</td>
<td>9 (18.8%)</td>
<td>10 (20%)</td>
<td>11 (47.8%)</td>
<td>0</td>
</tr>
<tr>
<td>Column Total</td>
<td>5 (100%)</td>
<td>27 (100%)</td>
<td>48 (100%)</td>
<td>50 (100%)</td>
<td>23 (100%)</td>
<td>2 (100%)</td>
</tr>
</tbody>
</table>

Chi-Square = 13.46
Degrees of Freedom = 5
Probability = .02
Proposition 4 predicted but the stepwise regression failed to reveal that, while women were more supportive of self care than men, sex was not a contributor to the overall understanding of self care endorsement. The literature, however, leads one to expect that women will be more supportive of self care than will be men, but this was not found to be the case. It is suggested, given this counter-intuition and findings that contradict the conventional wisdom articulated in the literature, that sex will be analyzed in more depth to determine in greater detail how men and women are similar and/or different in their support for self care strategies.

The regression model showed that all of the combined variables only explained a third of the self care endorsement attitudes of HSA boards of directors. The variables selected for this research were those that the literature suggested to be the most important, yet it was shown in this research that they explained less than two-thirds of self care endorsement. More variables are needed to predict self care endorsement, and better theory needs to be generated to provide us with a better explanation of self care endorsement. Future research, then, should address the development of new theory and expansion of existing theory in self care and social movement theory alike.

Other variables one may wish to consider in future research which were not considered here are: educational level; political liberalism or conservatism; internal-external locus of control; self care practices used in the home, and by whom; environmental concern over issues like pollution, toxic chemicals and nuclear energy;
lifestyle assessment (exercise, diet, smoking, drinking habits); personal satisfaction or dissatisfaction with the medical care they or their family received; and other self help or "do-it-yourself" interests.

A second recommendation stems from analysis on the HSA level regarding their required breakdowns of membership characteristics. This research hints that the HSAs do not have proper representation by youth, by racial minorities, by low income individuals, and "consumeristic" consumers. Assessment of the biographical information on the board members would allow one to determine if in fact the HSAs do meet the regulations set forth in PL 93-641. Each HSA is required to have such information on every board member as a matter of public record. If HSAs are to fulfill their mission to represent those who have historically been unrepresented in health care planning, then it is essential that they meet these regulations.

A third recommendation is to analyze self care as a social movement more completely. This study provided an exploration to determine if one could accurately say that a self care "movement" exists. Issues to focus on include: who are the leaders and who are the members of the movement?; how are the goals and the ideology conveyed?; what are the areas of greatest discontent?; what process elements are present that contribute to the success or failure of the movement?; what is the relationship of the medical profession to self care promotion?

A fourth recommendation concerns social movement theory development. An increased emphasis on the role of power and conflict
in the development of social movements, the internal dynamics of
the elite group and the groups who advocate change, and characteris-
tics of social movement stages is recommended. Additional research
into the results of social movement action is recommended to ascer-
tain how movements may succeed, fail, or cause alterations in the
social structure. Some research in these areas has been conducted,
but it seems to be so critical that the field could benefit from
further research.

It is necessary to mention that the future of HSAs is bleak,
given the Reagan Administration's emphasis on the decentralization
of government. The future funding of HSAs is, at best, precarious.
It may be within the next few years that HSAs will cease to exist.
Thus the role of HSAs described in this study may be of short term
use in a direct sense. But this is not to say that this research
has no merit; quite the contrary is true.

This study has allowed investigation into some relatively un-
explored areas. First, it has been the first to attempt a systematic
analysis of self care as a true social movement. The term "self
care movement" is found within the literature without any substan-
tial backing for the assumption that self care is a movement. This
study has clarified in what ways self care should - and should not -
be considered as a social movement. Second, this study has con-
tributed to our understanding of how formal organizational struc-
tures react to change, to innovations, to challenges by the recip-
ients of services. Third, this study has helped us to advance so-
cial movement theory, indicating a need for a merger between key
concepts in both classical social movement theory and resource mobilization theory. Thus this study has utility for future researchers and for the advancement of theory even if the HSAs should be eliminated.

Conclusions

This research has attempted to contribute to the body of scientific knowledge in three substantive areas: on HSAs; on the self care movement; and on social movement theory. Traditional social movement theory has been of use for analysis in this research, as was resource mobilization theory. Closer scrutiny of internal dynamics of both the advocates of change and the elites in the dominant structures is encouraged if we are really to understand the intricacies involved in the social movement process. As was suggested for this research, shared grievances - even when they are held by a large number of people - and a strong intellectual base, are not sufficient grounds for the development of a successful social movement.

It was shown through this research that self care can be usefully regarded as a social movement. The self care movement has not, while influencing attitudes of health care planners, been found to create change on a policy level. While there does seem to be a greater awareness of self care and an increasing acceptance of its role in health care, it has not yet significantly impacted the health care planning or health care delivery structures. One may question whether the self care movement is a consumer movement today.
at all. While it began as a grass roots consumer movement, much of its momentum seems to be generated from health care providers, and not by consumers. Journals, books, workshops and conferences in self care have been sponsored by health care providers. Many of the self care movement's leading advocates are physicians.

In this research it was shown that there is no difference between providers and consumers in their support of the self care movement. It does seem as if the self care movement has lost much of its consumeristic orientation. Social movement theory can explain this by looking at the power of the professional to use his/her expertise to control the movement. Who knows more about health care than the health care providers? The providers have the information that the consumers need and want, so the consumers are forced into the domain of the provider whether they like it or not. Information is power, thereby helping the providers to maintain their position and successfully resist change. The cooptation of the consumer by the provider cannot be underestimated, as was discussed in Chapter II.

It seems as if the major barriers to self care in becoming a successful consumeristic social movement lie in the nature of self care itself. Its white middle class orientation alienates its usefulness from a large segment of the population. The fact that the information on many of the practical aspects of self care can be obtained most easily and accurately from the medical profession forces the self care advocate into a disadvantaged position. There
also exists a fine line in self care between the consumer taking over some aspects of health care successfully and attempting to care for situations that require more knowledge than they have. This fine line creates suspicion for some people of the utility of this concept—at what point does its helpfulness become dangerous for the consumer? The confusion over where self care ends and where provider care begins may contribute to the failure of the self care movement to mobilize people in a cohesive manner and to set up clear, attainable goals.

How drastically do HSAs alter the existing health care structure by virtue of its policy decisions? From observing the similarities in the goals from HSA to HSA, due in large part to federal guidelines, the goals are quite similar. Some variation may exist on the practical level where goals are implemented, yet the HSAs do not seem to be promoting major alternatives to the existing health care system. Is the HSA a vehicle for promoting consumer interests, or does it merely perpetuate the existing health care structure? It was found that consumer interests do not seem to be supported by the consumer representatives. Consumer and provider representatives tend to express no real differences in their attitudes toward self care programs. Thus, the HSA does not appear to be a vehicle for promoting consumer interests. Is the HSA a medium or a barrier for health care innovation? The HSA has a great deal of potential for being a medium for health care innovations. Yet while the attitudes of board members seem supportive, the support for self care
has not manifest itself on a policy level. While the HSA may not be actively opposing or suppressing self care as an innovation in health care, it is not actively supporting it either.

It is useful to apply social science research to problems such as the struggle for getting self care recognized as an integral part of our health care delivery system. Conflict does exist between those who advocate social change and the established social institutions. This conflict can be understood in the broader context of ideal vs. real culture. On an attitudinal/theoretical level, support for self care may seem "natural" or in the best interests of the individual and of society. This is an example of ideal culture. Yet we have found that self care is unsupported on a practical, policy level. The verbalizations of support of the self care movement have not become manifest on a societal level. Thus the real culture is something quite different from the ideal culture.

Through the analysis of this social movement we have been able to explore social change. We have found that established social institutions resist change. If change must result, the professionals within the establishment attempt to play an active role in determining the extent and direction of the change. So while this research dealt specifically with a selected type of social change within a given social institution, this research has broader ramifications—advancing our knowledge of social change theory. This research, then, has direct use for the practitioner and the theoretician alike in helping us to understand how society really functions.
FOOTNOTES

1. An attempt was made to develop a scale with stronger coefficient of reproducibility and scalability by developing a scale in which items of .60 and greater were used instead of the .75 factor weight level. This added three more items to the analysis. However, when these variables were tested for scalability and reproducibility, this potential scale proved to be lower, resulting in a coefficient of reproducibility of .84 and a coefficient of .37 (Appendix 6). Thus the initial selection of items for the construction of the dependent proved to be more useful.

2. The alpha level of all inferential statistics will be .05.

3. According to Toeffler (1980), the number of single member and divorced families is skyrocketing. He states that less than 7% of the United States families can be considered nuclear in nature.
APPENDIX A

Self Care Attitude Inventory (SCAI)

Instructions: Listed below are several situations that pertain to self care proposals with which your HSA might deal. Given the information available, please indicate how you as an HSA board member would vote. Assume that the proposals are well thought out and reflect the opinions of a significant number of residents in your area. Also assume that they represent sound programmatic and economic approaches.

1. A lay organization is working with physician's assistants and nurses aides to educate individuals about their blood pressure levels. Individuals would be taught how to take and interpret their own blood pressures. This effort would occur in shopping centers, workplaces, and other places where people gather, and will be directed by the physician's assistants and nurses aides. Assuming these special blood pressure clinics reflect a well thought out plan, as an HSA board member would you:
   ___ Vote for this project
   ___ Vote for this project with some misgivings
   ___ Not vote for this project but see some merit to it
   ___ Not vote for this project

2. An agency that promotes prenatal care services has developed a plan to educate all women of childbearing age about how to care for the health of their unborn children, should they become pregnant. This plan particularly focuses on teenage and lower class women. Assuming this is a well thought out plan, as an HSA board member would you:
   ___ Vote for this plan
   ___ Vote for this plan with some misgivings
   ___ Not vote for this plan but see some merit to it
   ___ Not vote for this plan

3. A group of family members of kidney patients who require dialysis has come before you to encourage your endorsement of a home dialysis program. Presently home dialysis programs are not available in their area. Assuming they present a well thought out plan, as an HSA board member would you:
   ___ Vote for the plan
   ___ Vote for the plan with some misgivings
   ___ Not vote for the plan but see some merit to it
   ___ Not vote for the plan
4. A team of social workers, educators, and medical personnel has come before the HSA for an endorsement for a new program for individuals who have had a heart attack. This program would allow individuals to attempt to treat their condition by a combination of diet, exercise, and behavioral changes. Assuming they present a well thought out plan, as an HSA board member would you:

___ Vote for the plan
___ Vote for the plan with some misgivings
___ Not vote for the plan but see some merit to it
___ Not vote for the plan

5. A family planning organization has come to the HSA with a proposal to eliminate the sales of early pregnancy kits in your area. They assert that the sales of such kits keeps women from seeking appropriate medical care necessary for proper fetal development. Assuming they present a well thought out proposal, as an HSA board member would you:

___ Vote for the proposal
___ Vote for the proposal with some misgivings
___ Not vote for the proposal but see some merit to it
___ Not vote for the proposal

6. A new health organization has asked for your endorsement of its services. The services focus on helping individuals to learn more about health and common disorders. This new health organization intends to take a comprehensive approach to services, in which holistic aspects (an approach to health care that emphasizes prevention by maintaining normal health through education and lifestyle rather than formal medical intervention) aspects of health are provided to individuals. Assuming this is a credible organization, as an HSA board member would you:

___ Vote for the endorsement
___ Vote for the endorsement with some misgivings
___ Not vote for the endorsement but see some merit to it
___ Not vote for the endorsement

7. A group of residents has come before the HSA to seek your endorsement for a petition campaign aimed at the removal of over-the-counter sleeping aid remedies from the shelves of stores because they are useless or harmful for some individuals. The residents are collecting names on petitions to take before the governmental committee that oversees the sales of such drugs. They have developed a plan to accomplish this task. Assuming they present a well thought out plan, as an HSA board member would you:

___ Vote for this endorsement
___ Vote for the endorsement with some misgivings
___ Not vote for this endorsement but see some merit to it
___ Not vote for this endorsement
8. A team of psychologists and counselors have created a new program for teaching individuals how to cope with migraine headaches without the use of medication. The team proposes the use of a variety of relaxation techniques. They would like your support for this program. Assuming they present a well thought out program, as an HSA board member would you:

____ Vote for the program
____ Vote for the program with some misgivings
____ Not vote for the program but see some merit to it
____ Not vote for the program

9. It has been proposed in your HSA region that every school aged child be given influenza vaccine to reduce absences due to illness each year. Advocates of this proposal seek your support for this effort. Assuming this is a well thought out proposal, as an HSA board member would you:

____ Vote for this proposal
____ Vote for this proposal with some misgivings
____ Not vote for this proposal but see some merit to it
____ Not vote for this proposal

10. A public health association has asked for your endorsement of a "Family Medical Resource Guide." This guide would discuss basic medical ailments that families may have, and includes basic information about how to care for the ailments at home. When to seek help by a medical professional is also included in this guide. Assuming this is a medically accurate guide, as an HSA board member would you:

____ Vote for this guide
____ Vote for this guide with some misgivings
____ Not vote for this guide but see some merit to it
____ Not vote for this guide

11. It has been proposed to develop a new program to improve eyesight. This program focuses on a series of eye exercises for individuals who are experiencing eye muscle difficulties. It is hoped that the exercises will become an alternative to wearing corrective lenses. Assuming this is a well thought out program, as an HSA board member would you:

____ Vote for this program
____ Vote for this program with some misgivings
____ Not vote for this program but see some merits to it
____ Not vote for this program
12. The Citizens for Clean Water committee has come before the HSA to seek your endorsement of a water testing kit. This inexpensive kit would allow individuals to analyze their drinking water for pollutants. Assuming the kit accurately tests the water, as an HSA board member would you:

- Vote for the endorsement
- Vote for the endorsement with some misgivings
- Not vote for the endorsement but see some merit to it
- Not vote for the endorsement

13. Are you classified by your HSA as a "consumer" or "provider"?

- Consumer
- Provider

14. In what HSA committees do you participate?

15. What is your sex?

- Female
- Male

16. What is your age?

- 10-20
- 21-30
- 31-40
- 41-50
- 51-60
- 61-70
- 71+

17. What is your race?

- Black
- White
- Hispanic
- Native American
- Oriental
- Other (please specify)

18. What is the title of your occupation?

19. If married, what is your spouse's occupation? Not married

20. How many years have you been on the HSA board of directors?

- years
- months

21. What do you view as the 2 or 3 major accomplishments of your HSA in the past year?
22. Do you think your HSA has been as effective as it could be?  
   ___ Yes    ___ No

23. If you think your HSA could have been more effective, what are 2 or 3 ways that could help to increase your HSAs effectiveness?

24. In your own words, please briefly tell me what you believe the term "self care" to mean.
Dear HSA Board Member:

As you are well aware, today there are many changes occurring in the health care field. Many of the changes involve controversy about their use. One of the changes occurring in the health care field is the increasing emphasis on self care techniques. In discussing the use of self care strategies there are questions that arise concerning the appropriateness and limitations of self care. In the near future HSAs may be asked to deal with proposals regarding self care; perhaps your HSA already has done so.

Enclosed is a questionnaire that allows you to express your opinion about certain self care programs. We realize you are busy, but we would appreciate your answers to these questions. Your responses will contribute to our understanding of self care policy. There is an enclosed stamped envelope so you can mail the questionnaire back to us as soon as possible.

We look forward to receiving your valued opinions.

Sincerely,

Yvonne Vissing
Researcher

Stanley S. Robin
Director, Center for Social Research

YV/SR/am
## Guttmann Scale on All Self Care Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>blood pressure program</td>
<td>.63</td>
</tr>
<tr>
<td>prenatal care program</td>
<td>.88</td>
</tr>
<tr>
<td>home dialysis program</td>
<td>.69</td>
</tr>
<tr>
<td>heart attack prevention</td>
<td>.86</td>
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<tr>
<td>early pregnancy tests</td>
<td>.30</td>
</tr>
<tr>
<td>holistic health program</td>
<td>.78</td>
</tr>
<tr>
<td>over the counter drugs</td>
<td>.15</td>
</tr>
<tr>
<td>migraine treatment</td>
<td>.64</td>
</tr>
<tr>
<td>flu vaccine</td>
<td>.02</td>
</tr>
<tr>
<td>medical resource guide</td>
<td>.66</td>
</tr>
<tr>
<td>eye exercise program</td>
<td>.69</td>
</tr>
<tr>
<td>water test kit</td>
<td>.66</td>
</tr>
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Coefficient of reproducibility = .78  
Coefficient of scalability = .009
### APPENDIX D

**Factor Analysis Varimax Rotation Matrix for Self Care Items**

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<thead>
<tr>
<th>Variables</th>
<th>Factor 1</th>
<th>Factor 2</th>
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<tbody>
<tr>
<td>blood pressure program</td>
<td>.63861</td>
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<tr>
<td>prenatal care program</td>
<td>.66931</td>
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<tr>
<td>home dialysis program</td>
<td>.65041</td>
<td>.50163</td>
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<td>heart attack prevention</td>
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<td>.40813</td>
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<td>early pregnancy tests</td>
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<tr>
<td>holistic health program</td>
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<tr>
<td>over-the-counter drugs</td>
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</tr>
<tr>
<td>migraine treatment</td>
<td>.79480</td>
<td>.27682</td>
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<td>flu vaccine</td>
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<td>medical resource guide</td>
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<td>eye exercise program</td>
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<td>water test kit</td>
<td>.66548</td>
<td>.27923</td>
</tr>
</tbody>
</table>

*Items at > .75 selected for construction of the Self Care Attitude Inventory (SCAI)*

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APPENDIX E

Guttmann Scale for Factor Analysis Items Weighted .75

<table>
<thead>
<tr>
<th>Item</th>
<th>Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>heart attack prevention program</td>
<td>.80</td>
</tr>
<tr>
<td>holistic health program</td>
<td>.83</td>
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<td>migraine treatment</td>
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<td>medical resource guide</td>
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<td>eye exercise program</td>
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Coefficient of reproducibility = .86
Coefficient of scalability = .53
APPENDIX F

Guttmann Scale on Factor Analysis Items Weighted .60

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<th>Item</th>
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<td>prenatal care program</td>
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<td>home dialysis program</td>
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<td>heart attack program</td>
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<td>water test kit</td>
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Coefficient of reproducibility = .84

Coefficient of scalability = .37
# APPENDIX G

## Health System Goals of HSAs

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<th>UP</th>
<th>SW</th>
<th>CHPSM</th>
<th>MM</th>
<th>WN</th>
<th>ECM</th>
<th>GLS</th>
<th>NM</th>
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<td>Dental, vision, eye health</td>
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