MARGINAL STATUS OF CONSUMERS IN A VOLUNTARY
PLANNING AGENCY

Thesis for the Degree of M. A.
MICHIGAN STATE UNIVERSITY
AMANDA ANN BECK
1972

Marginal S

The hi

in social p

was discusse

The mar

gional compr

features of

tion, and soc

The impl

gram designed

Thesis Commit

Dr. George

Dr. Lawrenc

Dr. Louis G

ABSTRACT

Marginal Status of Consumers in a Voluntary Planning Agency

By

Amanda Ann Beck

The history of formal inclusion but ineffective participation
in social planning agencies by recipients of the planning decisions
was discussed.

The marginal status of consumers vs. professionals in a re-
gional comprehensive health planning agency was documented on the
features of attendance, powerlessness, normlessness, social isola-
tion, and socio-economic status.

The implications of these findings were discussed and a pro-
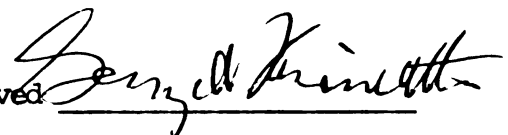gram designed to alleviate this marginal status was suggested.

Thesis Committee:
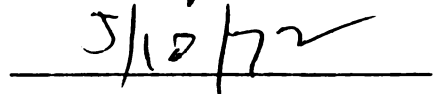
  Dr. George W. Fairweather, Chairman

  Dr. Lawrence I. I'Kelly

  Dr. Louis G. Tornatzky

Approved _____

Date _____

in p

MARGINAL STATUS OF CONSUMERS IN A VOLUNTARY PLANNING AGENCY

By

Amanda Ann Beck

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

Department of Psychology

1972

I wou

their assis

My col

moral suppo

viewing ag

My fat

to succeed.

My bos

his patienc

My corr

and Louis G.

and form of

Project

long hours an

Many fri

M.S.U. r

Division of

vided the ne

ACKNOWLEDGMENTS

I would like to express my deep gratitude to the following for their assistance in this endeavor:

My colleague, Peter C. Bishop, for his unselfish devotion of moral support, time, and expertise to developing these ideas, interviewing agency members, and computer analyzing the data.

My father, Charles J. Beck, for his unfailing faith in my ability to succeed.

My boss in M.S.U. Residence Halls Programs, W. "Red" Knaak, for his patience and support in these long months of preparation.

My committee members, George W. Fairweather, Lawrence I. O'Kelly, and Louis G. Tornatzky, for their assistance in developing the content and form of this document.

Project secretary Tami L. Tyson, for her unselfish devotion of long hours and excellent assistance in preparation of this manuscript.

Many friends who gave support when it was needed.

M.S.U. Department of Psychology and U.S. Department of H.E.W., Division of H.S.M.H.A. for grant # CS - P(01) 552005-01-72 which provided the necessary financial assistance.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

It is now documented that participation in the decision-making process by the recipients of the decision generally leads to greater acceptance of the decision and, hence, more successful implementation (Collins and Guetzkow, 1964; Gilmer, 1961; Tannenbaum, 1968). In a governmental planning agency, the basic task is decision-making, and the recipients of such decisions are the consumers of the programs planned. In such agencies, citizen participation in the decision-making process plays a vital and powerful role in "monitoring" professional plans and making sure that the planning professionals and technical experts do not design programs with either disregard for citizen interest or simply for the interests of certain power groups (Altschuler, 1970; Dubey, 1970).

While the concept of citizen participation as a valuable contribution to the decision-making process may have been accepted by many, incorporation as an operating concept in most planning agencies has been, on the whole, slow and ineffective.

Some voluntary efforts to encourage low income participants in neighborhood social action were begun in the 1890's, 1900's, and 1930's. It was not, however, until the early 1960's, that the requirements for Ford Foundation grants and government regulations of O.E.O. and H.U.D. programs forced a more active role on community representatives in social reform decision making. The funding of Model Cities programs, for example, required that policy making boards consist of a majority of

citizen representatives. The greatest attempt to expand the domain of
citizen participation and provide for "maximum feasible participation of
the poor" was incorporated in the Economic Opportunity Act of 1964
(Moynihan, 1970). Unfortunately, the confusion surrounding the defini-
tion of the term "maximum feasible participation" and the methods by
which this was implemented in various areas led to development of Com-
munity Action Programs (C.A.P.) ranging from complete policy control and
major political power afforded the citizens, all the way to a mere source
of employment for the participants. As Sherry Arnstein (1969) explained
citizen participation has ranged from: a) token states of informing the
citizen, consulting his opinion, or placating his desires, b) through a
condition of partnership or delegated power in decision-making, and
rarely, c) to effective citizen control. In concluding remarks she
agreed with the OSTI conclusions that "in general, citizens are finding
it impossible to have significant impact on the comprehensive planning
that is going on". Thus professionals have traditionally acted upon the
assumption that only they possess sufficient expertise to plan and have
continued to "benevolently" plan for the public. Unfortunately also,
the laws requiring citizen participation have been a rather uncoordinated,
undirected attempt to alleviate this marginal status. Consumers, there-
fore, even after their forced entry into planning activities and their
less than enthusiastic welcome have usually remained second-class citi-
zens in real decision-making activities of the planning agencies (Bloomberg,
1969).

Fairweather (1967, p. 5) recommends that programs "... be developed
to change the status of those who only marginally participate...". He
further recommends that initially such programs be in the form of socially

innovative experiments that compare programs designed to improve such person's marginal status and that the first step be an operational definition of the social position occupied by those in the marginal status.

An opportunity for an in-depth investigation of the position of the citizen participant in the decision-making process of planning has been afforded by a Comprehensive Health Planning "b" agency established in 1968 as a result of Federal legislation for "Partnership in Health". It is a regional agency planning and coordinating health delivery services in a tri-county area of lower Michigan with financial resources consisting of Federal H.E.W. funds matched 1 to 1 with local contributions. Its personnel consists of a paid full-time professional planning staff and volunteer part-time members of two types: providers of health services (anyone who earns his livlihood in teaching, delivery, or administration of health services), and consumer representatives (anyone who does not earn his livlihood in health teaching, delivery, or administration). Staff and providers are both therefore considered health professionals in this agency.

The internal organization of the agency is composed of the staff just mentioned, a Board of Trustees, an Executive Committee (acting between Board meetings), and five planning committees. The Board of Trustees, meeting quarterly, consists of 45 members and the Federal legislation requires that at least 51 percent of them be consumers. Planning committees, meeting monthly, range in size from 12 to 43 members, and generally reflect the same consumer to provider ratio as the Board. Consumers should thus have more political power than providers in a "one-man, one-vote" form of decision making.

Marginal status of a participant in such an agency can be described by three general features: (1) behavioral or other objective

measures of his integration into the decision-making process, (2) his
attitude toward himself and other participants, (3) attitudes of other
participants toward him.

The most obvious feature of a person's marginal status is probably
his own marginal behavior which can primarily be described by his lack
of participation in actual decision-making meetings.

His attitudes of marginality may be described by his internal self-
perception of his situation: a sense of powerlessness, normlessness, and
social isolation. Bloomberg (1969) explained these to be some of the com-
ponents of alienation. Bloomberg (p. 125) described powerlessness as a
sense of "being at the mercy of a system which controls the individual
for purposes other than his own .....". He described normlessness as a
state "when goals and standard of conduct" do not "have that self-evident,
convincing quality we usually take for granted but instead appear uncer-
tain, capricious, and conflicting....". Relating it more closely to mar-
ginal status, it means that no clear behavioral role exists for the mar-
ginal participants. Finally he described social isolation as a percep-
tion of separation from other members of the group. These definitions
are in agreement with the more classical ones proposed by Seeman (1959),
and Dean (1961).

In addition to being self-perceived features, powerlessness, norm-
lessness, and social isolation can also be described by the attitudes of
the "in group" members toward the marginal members in which they ascribe
the marginal member little power, an unclear role, and negligible accep-
tance into the group.

The present investigation will describe the social position of citi-
zen consumers compared to health providers in a health planning agency

and will ascertain whether the consumers are, as they often appear to be, in a marginal status with respect to the activities and other members of the agency.

HYPOTHESES AND METHODS

Sample

All 144 participants in the agency were randomly divided into 2
groups, 1/2 being assigned to 1 interviewer (the author), and 1/2 being
assigned to another interviewer (author's associate). For various rea-
sons some people were unable to be interviewed eg., no current address,
on sabbatical leave, two refused. 111 people were individually inter-
viewed for about 1 1/2 hours each, at the time and place of their
choosing. Sections I and III were asked by the interviewers and Sec-
tion II was self-administered (Appendix).

The sample was made up of 5 staff (S) members (100 percent of pos-
sible), 52 consumers (C) (72 percent of possible), and 54 providers (P)
(75 percent of possible). There was no significant difference on inter-
viewers as to number, sex, or committee origin of respondents. There
was no significant difference between the total number of Cs and Ps inter-
viewed or between the number of Cs and Ps interviewed from each committee,
except for Committee A. On this committee significantly more Ps than Cs
were interviewed, but since this ratio reflects the actual ratio of Ps
to Cs existing on the committee, it is considered acceptable.

Due to the small sample size of the staff (N = 5), that group was
not included in analysis where such a small sample would produce re-
sults of very limited validity.

Hypotheses, Measurements and Analyses

Overall marginal status was described by each of the four components tested by hypotheses: I. lack of behavioral participation, II. powerlessness, III. normlessness, or lack of role clarity, and IV. social isolation. The hypothesis of participation was tested by a simple behavioral analysis. Since however, the most realistic view of most situations is usually comprised of two facets (that of the person or persons involved as the object of the issue, and that of the person or persons involved in viewing or interacting with the issue object) the components of powerlessness, normlessness, and social isolation were examined from two perspectives, internal and external. Internal perspective is the Cs viewpoint of his own situation and the balancing perspective is one external to the Cs viewpoint, i.e- either that of the providers or some more objective measure if possible.

I.   Participation - Ho: Compared to Ps, Cs have a lower record or participation in agency decision making meetings.

   A.   Measurement: Attendance records were examined for all committee meetings the agency held from August 1970 through July 1971.

   B.   Analysis: Attendance was scored dichotomously, 1 = non-attendance, 2 = attendance, X^2 was run for frequency distribution into categories for Cs vs. Ps for each of the committees individually and the agency as a total.

II. Powerlessness - General Ho: Cs have less power in agency decision-making activities than Ps.

   A.   Internal - Ho: Cs see themselves as having less power than Ps.

      1)   Measurement:

         a)   Neal-Seeman (1964) Internal External Powerlessness Scale was taken from Bonjean (1967) and adapted to this study,

(Appendix, Section II, Items 13-18). Powerlessness in
this case is considered directly related to the percep-
tion of external control and inversely related to the
perception of internal control.

b) Tannenbaum (1968) measure of influence was adapted to
this study (Appendix, Section I, Items 7A, 8A, 9A, 10A).
Tannenbaum asserted that the total power available in the
organization is not a fixed quantity and therefore high
power attributed to one participating group does not neces-
sarily imply that low power must be attributed to other
participating groups.

2) Analysis

a) Neal and Seeman: Item response was scored dichotomously,
1 = power, 2 = powerlessness. X^2 was computed for indivi-
dual items on the difference in distributions for Cs and
Ps. t test was computed on the difference in means of Cs
and Ps on the entire scale.

b) Tannenbaum: Item response was scored 1-5 to correspond
to "none" to "great deal". For measurement of item 7A,
the subjects perception of his influence, Cs and Ps were
grouped separately and a t run on the difference in means
for the two groups ($7A_c$ vs. $7A_p$). The responses from Cs
only were grouped together for items 8A (S influence),
9A (P influence), and 10A (C influence), and t tests run
on the differences in means for 8A vs. 10A, and 9A vs. 10A.

B. External - Ho: Ps see Cs as having less power than Ps and S.

    1) Measurement: Tannenbaum (1968) same as in Alb above. (Appendix, Section I, Items 8A, 9A, 10A).

    2) Analysis: Scored the same as in Alb above. Responses from Ps only were grouped together from items 8A, 9A, and 10A. t tests were run on the difference in means for influence of 8A vs. 10A and 9A vs. 10A.

C. Interaction External and Internal - Cs and Ps see Cs as having a small amount of power or influence in agency decision making activities.

    1) Measurement:

        a) Tannenbaum (1968) as in Alb above but item 10A only.

        b) Zero-sum: Tannenbaum (1968) in reviewing the reasoning behind this model reports that the amount of influence in an organization can be considered a fixed quantity. He explains that, in this viewpoint, for every gain in power one group gets, all other groups involved must lose power so that the total loss is equal to the total gain, and therefore the sum of the power exchange equals zero. In this study respondents were asked what percent of the total influence on a typical agency decision would they attribute to Cs, Ps, and S. (Appendix, Section I, Item 11).

        c) Arnstein (1969) ladder of participation adapted for this study. (Appendix, Section II, Item 30). From observation of actual community participation in similar agencies Arnstein constructed a rating scale ranging from mere consultation to full citizen control.

2) Analysis:

    a) Tannenbaum: Absolute level of influence accorded to Cs and Ps was described. A level at or below the median point (3) of the scale confirmed the Ho.

    b) Percent of total influence: percent accorded to Cs by Ps and Cs was described. Since by Federal law Cs must have 51 percent of the votes on agency decisions, and therefore have atleast 51 percent of the influence, any level below 51 percent confirmed the Ho.

    c) Arnstein: Absolute level of participation accorded to Cs was described. Since by Federal law Cs must have 51 percent of the vote on agency decisions, any level below F "control over decisions" confirmed the Ho.

III. Normlessness

A. Internal - Ho: Cs do not perceive themselves as having a clear role in the activities of the agency.

1) Measurement: "Task Assignment": Respondents were asked to choose the one group (C, P, S) which most performed each of the tasks indicated. Options were also given for response of "no one" and "don't know". A variety of tasks supposedly being accomplished by the agency were listed. (Appendix, Section II, Items 35-49).

2) Analysis: Responses from Cs were grouped together. For the category "don't know" frequency was recorded and the percent of assignment based on the total number of Cs. For the category "no one" frequency was recorded and the percent of assignment based on the total number of Cs who knew who to assign the task to. For C, P, and S categories the frequency was

recorded and the percent of assignment based on the total
number of respondents assigning the task to one of these
three groups. If not group clearly performed the task, a
random split in responses would be expected 33 1/3 percent
staff, 33 1/3 percent consumers, and 33 1/3 percent providers.
A significantly different distribution from that expected by
chance - an increase over random would indicate that chosen
group to be clearly performing the task, i.e. included in the
task assignment and vice versa for exclusion.

A breakdown of inclusion, exclusion, or response within ran-
dom expectation was obtained for each task. (+ = inclusion,
- = exclusion, 0 = random expectation). Whatever group had
the task assigned to it received a weighted score indicating
the clarity of the role assignment.

$$4 = +, -, - /\text{clearly chosen}$$

$$3 = +, -, 0/\textbf{fairly clearly chosen}$$

$$2 = +, 0, 0/\text{not too clearly chosen}$$

$$1 = +, 0, +/\text{shared assignment}$$

B. External - Ho: Ps do not perceive Cs as having a clear role in
the agency.

1) Measurement: Same as internal measurement A1 above.

2) Analysis: Same as internal analysis A2 above except that
P response will be grouped together.

IV. Isolation

Components:

A. Group Attraction-Acceptance

B. Information

    1) Knowledge deficit

    2) Exclusion from information network

C. Constituency

A. <u>Group Attraction and Acceptance</u>

    1) Internal - Ho: Cs are less attracted to the committee they belong to than are Ps.

        a) Measurement: Variables were drawn from the general concept of Jackson (1959) that a person's psychological membership in a group is composed of two components: his attraction to the group, and the group's acceptance of him. In this study attraction will be operationally defined in two ways (a) a list of statements describing ways in which a person could show attraction to a committee as a whole, (Appendix, Section III Item 3), and (b) a list of items describing attractive attributes of the people on the respondents committee which he uses to give ratings to each member of his committee, (Appendix, Section III, Item 1).

        b) Analysis

            1) Attraction to the group as a whole. Response on each item was scored from 1-5 to coincide with "strongly disagree" to "strongly agree".

            2) Attraction to group members. Responses were scored as above and ratings from each member for each other person on his committee were summed across items to give a

scale sum for each member. Means were obtained from Cs
and Ps as separate groups and a t test run on the dif-
ference.

2) External - Ho: The committee as a whole will be more accepting
of P members than C members.

   a) Measurement: Same items as internal measurement list (b)
   above, (Appendix, Section III, Item 1).

   b) Analysis: Item responses were scored 1-5 to coincide with
   "strongly disagree" to "strongly agree". Scores received by
   each member were summed over all the respondents rating him.
   Group means were obtained and compared by a t test for C vs. P.

B. Information

   1) Knowledge deficit:

   a) Internal: Cs perceived their knowledge of health planning to
   be less adequate than Ps see their knowledge as being.

      1) Measurement: Cs and Ps were asked their perception of
      the adequacy of their health planning knowledge. (Appendix,
      Section II, Item 7).

      2) Analysis: Item responses were scored 1-5 to coincide with
      "very inadequate" to "more than adequate". X^2 was run on
      the difference in frequency distributions for Cs and Ps.

   b) External - Ho: Cs do not have as much knowledge of medical
   planning matters as Ps do.

      1) Measurement: Questions concerning some of the general
      features of Comprehensive Health Planning, and some of
      the major activities of the local health planning agency.
      (Appendix, Section I, Items 12-14, 15a, 16, 18, 19)

Items were placed in 4 categories:

I = General health planning knowledge (Appendix, Section I,
Items 12-14).

II = Names of Planning Committees, and Planning Committee
Chairmen.

III = Names of staff members.

IV = Items in Work Program

2) Analysis: Each item was scored dichotomously, 1 = no,
2 = yes, if the answer, person, or committee was "not
known" or "known". Means for Cs and Ps were compared for
each scale by a t test.

2) Communication Network

a) Internal Ho: Cs are not satisfied as Ps are, with the extent
of their inclusion in the informal communication network.

1) Measurement: Cs were asked if they are satisfied with
the amount of contact they have with agency staff, the
amount of contact outside of committee meetings with
people on their committee, and the amount of contact with
people not on their committee. (Appendix, Section I,
Items 15c, 24d, 25d)

2) Analysis: Responses were scored from 1-5 to coincide
with "much less often" to "much more often". A sum and
mean was obtained over the three items. t test was used
on the difference in means between Cs and Ps levels.

b) External - Ho: Cs are not included in the informal communi-
cation network of agency members to the extent that Ps are.

1) Measurement: Each respondent was asked how often he talked with (a) staff members, (b) members of his committee outside of committee meetings, and (c) members of the agency who are not members of his committee. (Appendix, Section I, Items 15 a and b, 24 a and b, 25 a and b).

2) Analysis: Frequency of contact with each recipient was scored 1-5 (1 = less than 1 contact/month, 2 = 1-2 contacts/month, 3 = 3-4 contacts/month, 4 = 5-8 contacts/month, 5 = more than 8 contacts/month). Mean frequency of contacts given were calculated. (i.e. number of people in the agency the respondents said he knew) Mean frequency of contacts received was calculated (i.e. the number of respondents that knew a particular individual). Each response was also given a density weight to correspond to the 1-5 frequency of contact rating. Mean weighted averages of contacts given and received were calculated. t tests were run on the difference in means for Cs and Ps on the average number of people known and the density of contacts.

C. Constituency

1) Internal - Ho: Cs do not perceive themselves as having a constituency.

a) Measurement:

1) Respondents are asked if they formally or informally represent any group. (Appendix, Section I, Item 22a)

2) Respondents are also asked various questions to determine if any group represented has any effect on the

respondents participation in health planning activities.

(Appendix, Section I, Items 23 a - f)

b) Analysis

1) Responses to item 22a regarding constituency existence were scored dichotomously, 1 = No, 2 = Yes. Percentage of Cs indicating a constituency was described. X^2 analysis compared the distribution into categories for P vs. C.

2) Responses to items 23 a - f, constituency expectation were coded 1-5, 1 = lowest category, 5 = highest. A sum and mean over items was obtained for each respondent. Cs and Ps were grouped separately and t run on the difference in means.

2) External: Cs are perceived as having a constituency less often than Ps.

a) Measurement: All respondents were asked to indicate which members of their committee represent a group. (Appendix, Section III, Item 2)

b) Analysis: Responses were scored dichotomously, 1 = No, 2 = Yes. The percent of C received a "yes" response was described. Cs and Ps were grouped separately and a t test run on the difference in means.

V. Consumers have a lower income and less formal education than Providers.

A. Measurement: Respondents were asked to indicate their annual family income, their formal education level, and their perception of the amount of health knowledge they themselves had. (Appendix, Section II, Items 52, 53, 56)

B. Analysis: Educational level was scored from 1-7 to indicate grammar school through professional degree.

Health education was scored 1-5 to coincide to "none" through "great deal". Annual income was scored 1-5 to indicate 5 categories ranging from "under $7,000" to "above $30,000". x^2 analysis compared distribution into categories on each variable for Cs vs. Ps.

RESULTS

Hypothesis I
Behavioral Participation

Tables 1 a-g (Committee by Attendance) shows the data relevant to

hypothesis I. To standardize attendance and allow comparison between

Cs and Ps, the percent of attendance of each group at committee meetings

was calculated. Each percentage is based on the total number of regu-

lar committee meetings held for that committee. X^2 values are based on

the actual cell frequencies. Committee E met only once during the year

and was therefore not included in the analysis because of the limited

validity of attendance statistics. Examination of percent attendances

shows that P attendance exceeds C attendance on every committee. The

X^2 on overall attendance (15.29, P <.001), gives definite support to

the primary hypothesis, that on the whole, Cs participate significantly

less than Ps in decision-making meetings of the agency.

Examination of individual committees shows that for the most power-

ful decision making groups in the organization, i.e. Board of Trustees

and Executive Committee, C attendance was significantly less than P

$(X^2 = 13.31, P < .001; X^2 = 5.17, P < .05)$. On the analysis of individual

committees, X^2 was significant at the .01 level for Committee C. X^2

values were not significant at the .05 level for the other three com-

mittees but percent of attendance on each of these was higher for Ps

than Cs.

18

TABLE 1a

Committee by Attendance[1]

OVERALL

	Consumers	Providers
Membership[2]	75	77
Total Attendance Possible[3]	429	452
Attendance[4] (N)	174	234
Percent of those attending[5]	42.65	57.35
Percent of classification attending	40.56	51.77
Non-attendance (N)	255	218
Percent of those not attending	53.91	46.09
Percent of classification not attending	59.44	48.23

$$X^2 = 15.29 \; [6]*** \; (1df)$$

[1] Attendance (August 1970 - July 1971) Committee E omitted

[2] Repeats members with membership on more than one committee

[3] Considered total number of attendance opportunities

[4] Frequency of attendance summed over all meetings

[5] Calculation based on the total attending

[6] X^2 based on frequency of attendance (N) and non-attendance (N)

*** $P < .001$

TABLE 1b

Committee by Attendance[1]

BOARD OF TRUSTEES

	Consumers	Providers
Membership	27	16
Total attendance possible[2]	108	64
Attendance[3] (N)	38	41
Percent of those attending[4]	48.10	51.90
Percent of classification attending	35.19	64.06
Non-attendance (N)	70	23
Percent of those not attending	75.27	24.73
Percent of classification not attending	64.81	35.94

$$X^2 = 13.31 \ ^{[5]}*** \ (1df)$$

[1] Attendance (August 1970 - July 1971)

[2] Considered total number of attendance opportunities

[3] Frequency of attendance summed over all meetings

[4] Calculation based on the total attending

[5] X^2 based on frequency of attendance (N) and non-attendance (N)

*** $P < .001$

TABLE 1c

Committee by Attendance[1]

EXECUTIVE COMMITTEE

	Consumers	Providers
Membership	8	6
Total attendance possible[2]	56	42
Attendance[3] (N)	23	27
Percent of those attending[4]	46.00	54.00
Percent of classification attending	41.07	64.29
Non-attendance (N)	33	15
Percent of those not attending	68.75	31.25
Percent of classification not attending	58.93	35.71

$$X^2 = 5.17 \text{ [5]} \quad (1df)$$

[1] Attendance (August 1970 - July 1971)

[2] Considered total number of attendance opportunities

[3] Frequency of attendance summed over all meetings

[4] Calculation based on the total attending

[5] X^2 based on frequency of attendance (N) and non-attendance (N)

$P < .05$

TABLE 1d

Committee by Attendance[1]

COMMITTEE A

	Consumers	Providers
Membership	12	25
Total attendance possible[2]	84	175
Attendance[3] (N)	35	81
Percent of those attending[4]	30.17	69.83
Percent of classification attending	41.67	46.29
Non-attendance (N)	49	94
Percent of those not attending	34.27	65.73
Percent of classification not attending	58.33	53.71

$$x^2 = 0.49 \ [5], \ NS \quad (1df)$$

[1] Attendance (August 1970 - July 1971)

[2] Considered total number of attendance opportunities

[3] Frequency of attendance summed over all meetings

[4] Calculation based on the total attending

[5] x^2 based on frequency of attendance (N) and non-attendance (N)

TABLE 1e

Committee by Attendance[1]

COMMITTEE B

	Consumers	Providers
Membership	13	7
Total attendance possible[2]	78	42
Attendance[3] (N)	14	36
Percent of those attending[4]	28.00	72.00
Percent of classification attending	33.33	46.15
Non-attendance (N)	28	42
Percent of those not attending	40.00	60.00
Percent of classification not attending	66.67	53.85

$$X^2 = 1.85 \ ^{[5]}, \ NS \quad (1df)$$

[1] Attendance (August 1970 - July 1971)

[2] Considered total number of attendance opportunities

[3] Frequency of attendance summed over all meetings

[4] Calculation based on the total attending

[5] X^2 based on frequency of attendance (N) and non-attendance (N)

TABLE lf

Committee by Attendance[1]

COMMITTEE C

	Consumers	Providers
Membership	11	5
Total attendance possible[2]	99	45
Attendance[3] (N)	51	34
Percent of those attending[4]	60.00	40.00
Percent of classification attending	51.52	75.56
Non-attendance (N)	48	11
Percent of those not attending	81.36	18.64
Percent of classification not attending	48.48	24.44

$$x^2 = 7.39 \text{ }^{[5]}** \quad (1df)$$

[1] Attendance (August 1970 - July 1971)

[2] Considered total number of attendance opportunities

[3] Frequency of attendance summed over all meetings

[4] Calculation based on the total attending

[5] x^2 based on frequency of attendance (N) and non-attendance (N)

** P < .01

TABLE 1g

Committee by Attendance[1]

COMMITTEE D

	Consumers	Providers
Membership	10	12
Total Attendance Possible[2]	50	60
Attendance[3] (N)	10	18
Percent of those attending[4]	35.71	64.29
Percent of classification attending	20.00	30.00
Non-attendance (N)	40	42
Percent of those not attending	48.78	51.22
Percent of classification not attending	80.00	70.00

$$X^2 = 1.44 \ [5], \text{ NS } (1df)$$

[1] Attendance (August 1970 - July 1971)

[2] Considered total number of attendance opportunities

[3] Frequency of attendance summed over all meetings

[4] Calculation based on the total attending

[5] X^2 based on frequency of attendance (N) and non-attendance (N)

Hypothesis II
Powerlessness

Table 2 (Neal-Seeman Powerlessness Scale) and Table 3 (Neal-Seeman

Powerlessness Items by Participant Classification) contain the informa-

tion relative to hypothesis IIA: Internal Perception of Powerlessness.

For the Neal-Seeman scale of Internal and External Powerlessness, mean

and standard deviation values are shown for Cs and Ps. t test on the

difference in these means shows overwhelming support of the hypothesis

(t = 3.65, P < .001). Examination of Table 3 indicates Cs to be higher

on powerlessness on each of the variables, and to be significantly more

powerless on 2 of the 6 individual items: #1, ability to protect in-

terests vs. pressure groups, (X^2 = 5.22, 1df); #2, ability to hold down

medical costs, (X^2 = 4.90, 1df). This series of X^2 significance tests

was compared with Sakoda's (1954) graph indicating the chance probability

of obtaining such significant statistics and found to be acceptable above

the .05 level.

TABLE 2

Neal-Seeman Powerlessness Scale

	$\overline{X}$	s	t
C	1.28	0.24	3.65***
P	1.14	0.15	

*** P < .001

Table 4 (Respondents Influence 7A by Participant Classification) and

Table 5 (Tannenbaum Influence Items by Consumer Response) shows the sta-

tistics obtained from Cs perception of their own individual influence and

TABLE 3

Neal-Seeman Powerlessness Items by Participant Classification

ITEMS	Consumer				Provider				χ^2
	Power		Powerlessness		Power		Powerlessness		
	N	%	N	%	N	%	N	%	
1 coping with pressure groups	19	(37.25)	24	(61.55)	32	(62.75)	15	(38.45)	$\chi^2 = 5.22*$ (1df)
2 preventing rising medical costs	16	(36.36)	28	(59.57)	28	(63.64)	19	(40.43)	$\chi^2 = 4.90*$ (1df)
3 achieving high quality medical care	44	(47.83)	4	(80.00)	48	(52.17)	1	(20.00)	$\chi^2 = 1.96$ (1df)

TABLE 3 (cont'd.)

	Consumer				Provider				X^2
	Power		Powerlessness		Power		Powerlessness		
	N	%	N	%	N	%	N	%	
4 improving community knowledge of medical services	44	(48.35)	6	(66.67)	47	(51.65)	3	(33.33)	$X^2 = 1.10$ (1df)
5 affecting important decisions in own life	42	(48.26)	8	(61.54)	45	(51.74)	5	(38.46)	$X^2 = 0.80$ (1df)
6 influencing medical services	45	(48.91)	5	(62.50)	47	(51.09)	3	(37.50)	$X^2 = 0.54$ (1df)

* $P < .05$

the influence of other groups participating in agency decisions. It shows that on item 7A (Perception of Own Individual Influence) Cs perceived their own individual influence to be less than Ps see their's as being (t = 1.42, P <.10). Examination of the mean values shows that Cs perceive their influence ($\overline{X}$ = 2.19) to be only slightly greater than the category "little" and Ps perceived their influence ($\overline{X}$ = 2.52) to be midway between "little" and "some". It shows also that Cs viewing other Cs as a group (Item 10A), perceived their influence to be much less than that of S (Item 8A) (t = 12.97, P <.001), and much less than that of Ps (Item 9A) (t = 9.59, P< .001). Examination of the mean values shows that Cs perceive the influence of their group ($\overline{X}$ = 2.05) to be about equal to the category "little". They perceive the influence of Ps ($\overline{X}$ = 3.98) to be about equal to the category "quite a bit", and S ($\overline{X}$ = 4.43) to be almost midway between the category "quite a bit", and the highest category "great deal". Thus, results from both Neal-Seeman and Tannenbaum approaches to determining Cs perception of their relative power position strongly support the hypothesis of a relatively powerless C position.

TABLE 4

Respondents Influence 7A by Participant Classification

	$\overline{X}$	G	t
C	2.19	1.20	1.42°
P	2.52	1.07	

°P <.10

TABLE 5

Tannenbaum Influence Items by Consumer Response

Item	$\bar{X}$	σ	
8A: Staff influence	4.43	0.76	t = 12.97***
10A: Consumer influence	2.05	0.90	
9A: Provider influence	3.98	0.90	t = 9.59***

*** P< .001

Table 6 (Tannenbaum Influence Items by Provider Response) shows the data relevant to the hypothesis IIB: that Ps see Cs as having less power than Ps and S. The data supports the hypothesis by demonstrating that at the .05 level, Ps view Cs as having significantly less influence than either S (t = 13.42, P< .001), or Ps (t = 6.86, P< .001). Examination of the means shows that Ps view C influence as only slightly above the "little" category ($\bar{X}$ = 2.12). They view their own group as having "some" influence ($\bar{X}$ = 3.56) but place the staff midway between "quite a bit" and "great deal" ($\bar{X}$ = 4.50).

TABLE 6

Tannenbaum Influence Items by Provider Response

Item	$\bar{X}$	σ	t
8A: Staff influence	4.50	0.79	13.42***
10A: Consumer influence	2.12	0.95	
9A: Provider influence	3.56	1.11	6.86***

*** P< .001

Table 7 (Powerlessness Scales by Combined Consumer and Provider Response) gives the values relevant to hypothesis IIC: that Cs are accorded a powerless role in agency decision making activities. Cs and Ps responses were combined for Tannenbaum Item 10A (Amount of Influence Consumer have in Agency Planning Decisions). The mean value resulting was 2.09, almost exactly equivalent to the category "little influence" which is also the closest category above "none". The overall mean for the zero-sum scale indicating how much influence Cs had in a typical agency decision was 12.90 percent out of a possible 100 percent. The overall mean for the Arnstein scale indicating the amount of power actually exercised by Cs was 2.38. This represents a position less than half-way between merely being "consulted before decisions are made" and "voting on outcomes which are modified by those controlling resources". Each of these values violates the acceptable cut-off limit. This hypothesis is then supported and indicates the Cs position to be one in which the Cs are little more than consulted before decisions are made.

In summary then, the hypothesis of Cs powerlessness is supported both from the Cs view that their own power is less than that of Ps, and from the Ps view that their own power is greater than that of the Cs. Finally, the Cs position is not only one of less power relative to other participating groups, but also one in which the power possessed is very small in absolute amount.

Hypothesis III
Normlessness

Table 8 (Tasks by Task Assignment-Consumer Response) shows the initial values relevant to the Normlessness Internal hypothesis: Cs perceived no clear role for themselves. It shows that in being asked to

TABLE 7

Powerlessness Scales by Combined Consumer and Provider Response[1]

Scale	$\bar{X}$	σ	Cut-off level[3]	σ	Significance Test
Tannenbaum[2]	2.09	.92	3.00	0.00	t = 9.89 ***
Zero-Sum	12.90	7.50	51.00%	0.00	z = 7.84 ***
Arnstein	2.38	1.02	6.00	0.00	t = 35.49***

[1]   Values based on all C and P responses combined

[2]   Values for item 10A: consumer influence

[3]   See page 9 for explanation

***   P < .001

TABLE 8

Tasks by Task Assignment—Consumer Response[1]

Task	Response[2] "don't know"		Assigned to "no one"[3]	
	Frequency	% of Total	Frequency	% of Unknown
01	18	34.62	3	8.82
02	15	28.85	1	2.70
03	23	44.23	3	10.34
04	18	34.62	4	11.75
05	15	28.85	3	8.11
06	21	40.38	5	16.13
07	13	25.00	6	15.38
08	13	25.00	4	10.26
09	12	23.08	1	2.50
10	16	30.77	4	11.11
11	16	30.77	7	19.44
12	17	32.69	7	20.00
13	13	25.00	2	5.13
14	15	28.85	3	8.11
15	16	30.77	5	13.89
$\bar{X}$		30.90		10.91
σ		5.64		5.19

TABLE 8 (cont'd.)

Assigned to a Group[4]

| | STAFF | | CONSUMERS | | PROVIDERS | |
| | | % of | | % of | | % of |
Task	Frequency	Group	Frequency	Group	Frequency	Group
01	13	41.93	0	0 +	18	49.42*
02	18	50.00*	7	19.44+	11	30.56
03	14	53.84*	6	23.07	6	23.07
04	14	46.67*	1	3.33+	15	50.00*
05	21	61.76*	1	2.94+	12	35.29
06	12	46.15*	7	26.92	7	26.92
07	3	9.00+	24	72.72*	6	18.18+
08	17	48.57*	9	25.71	9	25.71
09	33	84.61*	2	5.12+	4	7.69+
10	18	56.25*	3	9.38+	11	34.38
11	12	41.38	5	17.24+	12	41.38
12	13	46.43*	6	21.43+	9	32.14
13	34	91.89*	2	5.41+	1	2.70+
14	15	44.12	0	0 +	19	55.88*
15	27	87.10*	0	0 +	4	12.90+
$\bar{X}$		53.98		15.51		29.75
σ		20.30		18.06		15.01

[1] Responses from consumers only

[2] Percent based on total number of consumer responses

[3] Percent based on total number of consumer responses with "don't know" responses removed

[4] Percent based on number of consumer responses assigning the task to one of the participating groups

* Inclusion P < .05

+ Exclusion P < .05

assign the tasks 30.90 percent of Cs on the average did not even know who to assign the task to. It shows that of those who did assign the task to one of the categories, 10.91 percent, on the average, responded that "no one" in the agency was doing that task. Of the Cs who assigned the tasks to one of the groups participating in the decision making process, on the average 53.98 percent selected staff, 29.75 percent selected providers, and only 15.51 percent selected consumers. For each task assigned to a participating group, any score greater than 44.83 (33.33 + 11.51) indicated that group was selected significantly greater than random, and thus included in assignment for that task. For each task assigned to a particular participating group, any score less than 21.82 (33.33 - 11.51) indicated that group was selected significantly less than random and thus excluded from assignment for that task.

Table 9 (Items of Task Assignment by Participant Classification-Consumer Response) shows a breakdown by task according to inclusion of each of the three groups into task assignment or exclusion from it, plus a weighted score for each task, and the group whom the task was assigned by Cs. Two interesting results shown here are that for Task 4 (Coordination of Medical Services) assignment is significant for two groups S and Ps, and that for Task 11 (Help People be Aware of Health Needs) Cs are excluded and there is not task assignment significantly above random.

Table 10 (Summary Participant Classification by Task Assignment, Consumer Response) shows more clearly the results of task assignments in Table 9. It shows that staff received assignment for 11 out of 15 tasks, received a random response 3 times, and was excluded only once. It shows that Cs assigned themselves only one task, gave random response 3 times, and excluded themselves from 11 task assignments out of 15,

TABLE 9

Items of Task Assignment by Participant Classification–Consumer Response[1]

Task	Staff	Consumer	Provider	Weighted[2] Score	Task[3] Assigned to
01	0	–	+	3	(P)
02	+	–	0	3	(S)
03	+	0	0	2	(S)
04	+	–	+	split	(S & P)
05	+	–	0	3	(S)
06	+	0	0	2	(S)
07	–	+	–	4	(C)
08	+	0	0	2	(S)
09	+	–	–	4	(S)
10	+	–	0	3	(S)
11	0	–	0	split	θ
12	+	–	0	3	(S)
13	+	–	–	4	(S)
14	0	–	+	3	(P)
15	+	–	–	4	(S)

[1]
+ = task assigned significantly > random
– = task assigned significantly < random
0 = task assigned within random expectation

[2]
Weighted Sum
   4 = + – –
   3 = + – 0
   2 = + 0 0
   1 = + 0 +

[3]
Task assigned to group receiving the inclusion sign (+)

thus demonstrating an almost exact reversal of staff role. Providers, on the otherhand, were the nearest to a normal distribution being included 4 times, and excluded from task assignment 3 times, and received responses within random range 9 times. This series of significance tests was compared with Sakoda's (1954) graph indicating the chance probability of obtaining such significant statistics and found to be acceptable above the .01 level.

TABLE 10

Summary Participant Classification by Task Assignment-Consumer Response[1,2]

	$+^3$		0		-	
	N	%	N	%	N	%
S	11	(73.34)	3	(21.43)	1	(6.25)
C	1	(6.67)	3	(21.43)	11	(68.75)
P	3	(20.00)	8	(57.14)	4	(25.00)

$$X_c^2 = 24.64*** \quad (4df)$$

[1] Values taken from Table 9

[2] + = task assignment significantly > random
0 = task assignment within random expectation
- = task assignment significantly < random

[3] Task 4 assigned to both S and P

*** P < .001

Table 11 (Participant Classification by Task Assignment Weighted Score-Consumer Response) shows how clearly each task was assigned to the group being selected. It shows that while S was assigned tasks a disproportionate number of times, it was clearly chosen on only 3 (weighted score, ws = 4), fairly clearly chosen on 4 (ws = 3), not very clearly chosen on 3 (ws = 2), and shared assignment for 1 (ws = 1), thus S received an average ws of 2.82, above midway in scale for clarity of assignment. Cs, however, received only one task assignment but were clearly chosen for it (ws = 4), giving them an average ws of 4.0 . Ps received assignment for 3 roles, 2 fairly clearly assigned (ws = 3), and one shared assignment giving them a ws of 2.3, just under midway in scale for clarity of assignment.

TABLE 11

Participant Classification by Task Assignment
Weighted Score-Consumer Response [1,2,3]

	4	3	2	1	Average Weighted Score
S	3	4	3	1	2.82
C	1	0	0	0	4
P	0	2	0	1	2.3

[1] Values are obtained from Table 9

[2]
4 = + - -
3 = + - 0
2 = + 0 0
1 = + 0 +

[3] Task 11 not included

Thus to summarize results from tables 8, 9, 10, and 11, Cs who assigned the tasks to one of the participating groups, did see themselves as having a clear role in the agency, thus not supporting the hypothesis. This

finding should be tempered with the understanding that this role was described by only 1 task out of 15, and Cs saw themselves as excluded from assignment 10 out of 15 tasks. Additionally it should be remembered that on the average 30.90 percent of Cs did not know who performed the task described, and 10.91 percent on the average (of those assigning it) thought that "no one" performed it.

Table 12 (Tasks by Task Assignment, Provider Response) shows the initial values relevant to the external hypothesis of lack of role clarity for consumers, i.e. that providers see consumers as having no clear role in agency activities. It shows that on the average, 19.50 percent of Ps did not know who to assign the task to. It shows that of those who did assign the task to one of the categories, 14.57 percent on the average, responded that "no one" in the agency was doing that task. Of those who assigned the tasks to one of the groups participating in the decision-making process, on the average, 54.38 percent selected staff, 34.51 percent selected providers, and only 10.44 percent selected consumers.

Table 13 (Items of Task Assignment by Participant Classification-Provider Response) shows a breakdown by task according to inclusion of each of the three groups into task assignment, exclusion from it, plus a weighted score for each task and the group to whom the task was assigned by Ps. One interesting finding here is that while Cs (Table 9) included both S and Ps in assignment for task 4 (Coordination of Medical Services), Ps included only themselves and gave S only a response within random expectation. Also interesting is that Ps gave the same pattern of response as Cs for item 11 (Help People be Aware of Health Needs), i.e. assigned the task to no one, excluded Cs and gave a response within random expectation to S and P.

TABLE 12

Tasks by Task Assignment-Provider Response[1]

Task	Response[2] "don't know"		Assigned to "no one"[3]	
	Frequency	% of Total	Frequency	% of Unknown
01	7	12.96	3	6.38
02	10	18.52	0	0
03	8	14.81	9	19.57
04	8	14.81	15	32.61
05	8	14.81	5	10.87
06	16	29.63	14	36.84
07	11	20.37	6	13.95
08	9	16.67	3	6.67
09	4	7.41	1	2.00
10	8	14.81	4	8.70
11	15	27.78	10	25.64
12	10	18.52	9	20.45
13	24	44.44	2	4.00
14	12	22.22	2	4.76
15	8	14.81	12	26.09
$\overline{X}$		19.50		14.57
σ		8.60		11.23

TABLE 12 (cond't.)

Assigned to a Group[4]

Task	STAFF Frequency	STAFF % of Group	CONSUMERS Frequency	CONSUMERS % of Group	PROVIDERS Frequency	PROVIDERS Group	x^2 [5]
01	7	15.90+	1	2.27+	36	81.82*	6.89*
02	24	54.55*	4	9.09+	16	36.36	3.02
03	18	48.64*	9	24.32	10	27.03	1.31
04	12	38.71	0	0 +	19	61.29*	6.34*
05	26	63.41*	1	2.44+	14	34.15	0.21
06	12	50.00*	6	25.00	6	25.00	3.75
07	8	21.62+	22	59.45*	7	18.92+	2.25
08	26	61.90*	2	4.76+	14	33.33	7.18*
09	43	87.76*	0	0 +	6	12.24+	2.64
10	28	66.67*	0	0 +	14	33.33	4.38
11	12	41.37	6	20.69+	11	37.93	0.55
12	23	65.71*	3	8.57+	9	25.71	3.04
13	46	95.83*	0	0 +	2	4.17+	2.82
14	5	12.50+	0	0 +	35	87.50*	9.67**
15	31	91.18*	0	0 +	3	8.82	2.11
$\overline{X}$		54.38		10.44		34.51	
σ		25.00		15.78		24.32	

1
Responses from providers only
2
Percent based on total number of provider responses
3
Percent based on number of provider responses with "don't know" responses removed
4
Percent based on number of provider responses assigning the task to one of the participating groups
5
x^2 based on frequency distributions of Table 8 (C responses) vs. Table 9 (P responses) on task assignment with "don't know" responses removed
* Inclusion P < .05
+ Exclusion P < .05

TABLE 13

Items of Task Assignment by Participant Classification-Provider Response[1]

Task	Staff	Consumer	Provider	Weighted[2] Score	Task[3] Assigned to
01	–	–	+	4	(P)
02	+	–	0	3	(S)
03	+	0	0	2	(S)
04	0	–	+	3	(P)
05	+	–	0	3	(S)
06	+	0	0	2	(S)
07	–	+	–	4	(C)
08	+	–	0	3	(S)
09	+	–	–	4	(S)
10	+	–	0	3	(S)
11	0	–	0	split	θ
12	+	–	0	3	(S)
13	+	–	–	4	(S)
14	–	–	+	4	(P)
15	+	–	0	3	(S)

[1]
+ = task assigned significantly > random
– = task assigned significantly < random
0 = task assigned within random expectation

[2]
Weighted Score
    4 = + – –
    3 = + – 0
    2 = + 0 0
    1 = + 0 +

[3]
Task assigned to group receiving the inclusion sign (+)

Table 14 (Summary Participant Classification by Task Assignment-Provider Response) shows a summary of P assignments given in Table 13. It shows that S received assignment for 10 out of 15 tasks, a response within random expectation twice, and was excluded from assignment 3 times. Cs were included in only one task, given response within random expectation 2 times, and were excluded 12 times. Ps assigned themselves the nearest to a normal distribution, with 3 tasks assigned, responses within random expectation on 9 tasks, and excluded from 3 tasks. This series of significant tests was compared with Sakoda's (1954) graph indicating the chance probability of obtaining such significant statistics and found to be acceptable above the .01 level.

TABLE 14

Summary Participant Classification by Task Assignment-Provider Response[1,2]

	+		0		−	
	N	%	N	%	N	%
S	10	(71.43)	2	(15.38)	3	(16.67)
C	1	(7.14)	2	(15.38)	12	(66.67)
P	3	(21.43)	9	(69.24)	3	(16.66)

$$X^2_p = 26.11^{***} \quad (4df)$$

[1] Values obtained from Table 13

[2]
+ = task assignment significantly > random
0 = task assignment within random expectation
− = task assignment significantly < random

*** P < .001

Table 15 (Participant Classification by Task Assignment Weighted Score-Provider Response) shows how clearly each group was chosen when being assigned tasks by Ps. Thus even though S was assigned a disproportionate number of times, it was clearly chosen (ws = 4) on only 2, fairly clearly chosen (ws = 3) on 6, and not very clearly chosen (ws = 2) on 2. Ps gave no shared assignments, thus S received a weighted average of 3.0, or fairly clearly chosen for their tasks. Cs, however, were very clearly chosen for one task assignment (ws = 4), and therefore had a weighted average of 4.0. Ps assigned themselves 3 tasks, 2 clearly assigned (ws = 4), and 1 fairly clearly assigned (ws = 3), and thus themselves a weighted average of 3.66, better than midway between ws = 3 (fairly clearly chosen) and ws = 4 (clearly chosen).

TABLE 15

Participant Classification by Task Assignment
Weighted Score-Provider Response [1,2]

	4	3	2	1	Average Weighted Score
S	2	6	2	0	3.0
C	1	0	0	0	4.0
P	2	1	0	0	3.66

[1] Values obtained from Table 13

[2]
4 = + - -
3 = + - 0
2 = + 0 0
1 = + 0 +

Thus to summarize results from tables 12, 13, 14, and 15, Ps who did assign the tasks to one of the participating groups, saw Cs as having a very clear role in the agency; thus not supporting the hypothesis.

This finding should be tempered with the understanding that this role was described by only 1 of 15 tasks, and that Ps excluded Cs from task assignment on 12 of 15 tasks. Additionally it should be remembered that on the average 19.50 percent of Ps did not know who performed the tasks described, and 14.57 percent on the average of those assigning a task, thought that "no one" performed it.

<div align="center">

Hypothesis IV
Social Isolation

</div>

A. Committee Attraction-Acceptance

Table 16 (Participant Classification by Attraction to Committee as a Whole) shows the results relevant to the first part of the Isolation-Group attraction internal hypothesis: Cs are not as attracted to the committee to which they belong as are Ps. It shows that for attraction to the committee as a whole, the mean for Ps is higher than that for Cs (t = 1.83, P< .10). Thus, the hypothesis is only weakly supported.

<div align="center">

TABLE 16

</div>

Participant Classification by Attraction to Committee as a Whole

	$\overline{X}$	$\mathfrak{S}$	t
C	3.33	1.00	1.83°
P	3.68	0.79	

<div align="center">

° P< .10

</div>

Table 17 (Jackson Attraction-Acceptance by Participant Classification) shows the attraction-acceptance scores for Cs and Ps, when the committee evaluation is considered to be the sum of the evaluation of individual members. The values do not support the hypothesis that with this

interpretation Cs are less attracted to their committees than Ps are (t = 0.77, NS). It shows both means ($\bar{X}$ C = 3.74, $\bar{X}$ P = 3.83) to be close to the category "moderately agree" thus both indicating a moderate attraction to the members of their committee. Thus if attraction is interpreted as being directed toward the committee as a unit, then Cs are slightly less attracted than Ps, but if it is interpreted as the sum of attraction to individuals in the group, Cs and Ps are about equal.

Table 17 (Acceptance) does shows strong support for the hypothesis that C members are less accepted by their committees than P members are (t = 2.58, P < .025). It shows that the mean acceptance value was 3.53 for Cs, about midway between "neutral" and "moderately agree", i.e. moderately accepted. Mean value for P = 3.72 near the moderately accepted standard. It also shows that while the mean for P stayed fairly constant between attraction (3.83) and acceptance items (3.72), the mean for C dropped (3.74 to 3.53).

Thus in summary, Cs are only slightly less attracted to their committees than Ps are, but are significantly less accepted by their committees than Ps are.

TABLE 17

Jackson Attraction-Acceptance by Participant Classification

| | C | | P | | |
	$\bar{X}$	σ	$\bar{X}$	σ	t
Attraction	3.74	0.44	3.83	0.55	0.77, NS
Acceptance	3.53	0.45	3.72	0.36	2.58*

* P < .05

B. <u>Information</u>

(1) Knowledge Deficit

Table 18 (Participant Classification by Information Satisfaction Category) shows the values relevant to this hypothesis. It shows overwhelming support (X^2 = 19.67, P < .001), of the internal hypothesis that Cs perceived their knowledge of health planning to be less than P perceived their knowledge as being. It shows that 100 percent of those having "very inadequate" knowledge were Cs, and 81.82 percent of the "fairly adequate" responses were Cs, or to summarize, 88.25 percent of those who had less than "barely adequate" knowledge were Cs. Looking at the results across categories, 52.94 percent of Cs thought their health planning information was "barely adequate" or less compared to 86.00 percent of Ps who thought their's was "fairly adequate" or "more than adequate".

Table 19 (Information Category by Participant Classification) shows the results relevant to the social isolation - Information External hypothesis: Cs do not have as much knowledge of medical planning matters as Ps do. It does not generally shows significant support for the hypothesis. It does show that for each of the information categories, P mean were above the C mean, but that none of these differences were significant at the .05 level, and only the Information I was significant at the .10 level. It shows that on the categories I - III (general information, staff and committee names) only about 45 percent of either group correctly identified the responses and for category IV (Work Program Items) only 18 percent did so. Thus while Cs perceive their health planning knowledge to be significantly less than that of Ps, their knowledge of some fundamental items in the planning agency was equal to that of Ps.

TABLE 18

Participant Classification by Information Satisfaction Category

	1 Very Inadequate	2 Fairly Inadequate	3 Barely Adequate	4 Fairly Adequate	5 Very Adequate	$\bar{X}$	σ
C							
N	6	9	12	18	6	3.18	1.21
% of C	11.76	17.65	23.53	35.29	11.76		
% of category	100.00	81.82	70.59	40.00	27.27		
P							
N	0	2	5	27	16	4.14	.76
% of P	0	4.00	10.00	54.00	32.00		
% of category	0.00	18.18	29.41	60.00	72.73		

$$X^2 = 19.674^{***} \ (4df)$$

*** P < .001

TABLE 19

Information Category by Participant Classification

| | Consumer | | Provider | | |
	$\overline{X}$	σ	$\overline{X}$	σ	t
Information I	1.41	0.40	1.53	0.32	1.72°
Information II	1.46	0.28	1.49	0.27	0.46, NS
Information III	1.41	0.33	1.45	0.30	0.64, NS
Information IV	1.18	0.25	1.18	0.22	0.05, NS

° $P < .10$

(2) Information - Communication Network

Table 20 (Participant Classification by Satisfaction with Communication Network Inclusion) shows the results relevant to the social isolation Communication Network internal hypothesis that Cs are not satisfied with the extent of their inclusion in the informal communication network. It shows that while mean satisfaction for P ($\overline{X}$ = 3.82) is higher than that of Cs (3.84), the difference is not significant (t = 1.25, NS).

TABLE 20

Participant Classification by Satisfaction
with Communication Network Inclusion

	$\overline{X}$	σ	t
C	3.61	0.87	1.24, NS
P	3.82	0.70	

Table 21 (Informal Communication Network by Participant Classifica-
tion) shows the statistics relevant to the Isolation - Communication Net-
work - external hypothesis that Cs are not included in the informal
communication network of agency members to the extent that Ps are. There
were not significant differences for the average number of people known
(t = 1.12, NS) or known (t = 0.93, NS) by either group. It shows that
on the average, Cs reported that they knew 17.37 members in the agency
and were known on the average by 16.17 other members. Ps on the other
hand, knew on the average 20.76 members, and were known on the average
by 18.98 members. The weighted averages of contact given, indicated a
mean contact density of 1.58 for Cs or about an average contact of 1/
month for the people that Cs knew. It also indicated a mean contact den-
sity of 1.77 for Ps, or an average contact close to 2/month for the
members that Ps identified. The difference in these means is signifi-
cant (t = 2.13, P < .05). The weighted average of contacts received in-
dicates a mean for C of 1.69, and for Ps of 1.77, which are both near
the 2/month range and not significantly different (t = 0.54, NS).

C. Constituency

Table 22 (Participant Classification by Formal Representation) shows
the values relevant to the constituency internal hypothesis that Cs do
not perceive themselves as having a constituency as often as Ps do. Even
though the X^2 value (1.70) is not significant, the table shows that when
asked if they formally represented some group, four times as many Ps
said "yes" as said "no". When asked the same question, only twice as
many Cs said "yes" as said "no".

TABLE 21

Informal Communication Network by Participant Classification

	Consumers		Providers		t
	$\overline{X}$	σ	$\overline{X}$	σ	
Members Known	17.37	17.77	20.76	12.70	1.12
Weighted average- frequency of contacts given[+]	1.58	0.41	1.77	0.48	2.13*
Number of Members Known by	16.17	13.73	18.98	14.05	0.93
Weighted average- frequency of contacts received[+]	1.69	0.50	1.77	0.48	0.54

* P < .05

[+] Weights given: 5 = ≥ 8 contacts/month
                   4 = 5-8 contacts/month
                   3 = 3-4 contacts/month
                   2 = 1-2 contacts/month
                   1 = < 1 contact/month

TABLE 22

Participant Classification by Formal Representation

	No		Yes	
	N	%	N	%
Consumer	16	(59.25)	33	(44.59)
Provider	11	(40.75)	41	(55.41)

$$X^2 = 1.71, \text{ NS } (1df)$$

Table 23 (Participant Classification by Constituency Effect) also shows the results relevant to the internal hypothesis of consumer constituency. It shows that of those who indicated they did represent a group, Ps felt the group affected their participation in the agency somewhat less than a moderate amount ($\bar{X}$ = 3.60 on a 5 point scale). Cs on the other hand were much nearer to a "neutral" effect. The difference between these means is significant (t = 2.35, P < .05) indicating that even though consumers report a constituency only slightly less often than providers, the effect that constituency has on Cs is much less than the effect that Ps constituencies have on them.

TABLE 23

Participant Classification by Constituency Effect

	$\bar{X}$	σ	t
Consumer	3.31	1.46	2.35*
Provider	3.60	1.30	

* P < .05

Table 24 (Participant Classification by Constituency) shows the statistics relevant to the constituency external hypothesis that Cs are not perceived as representing a constituency. It shows that on the average 16.24 Cs were identified as having a constituency while 40.58 Ps were so identified. Unfortunately the standard deviation values (C = 16.72, P = 31.03) were so high that t = 1.23 fell slightly short of the .10 significant level.

TABLE 24

Participant Classification by Constituency

	$\overline{X}$	C	t
C	16.24	16.72	1.23, NS
P	40.58	31.03	

Hypothesis V
Socio-Economic Status

Table 25 (Participant Classification by Health Education Category) shows the data relevant to the internal hypothesis: Cs perceive themselves to have less formal health education that Ps see themselves as having. The hypothesis is overwhelmingly supported (X^2 = 57.16, P<.001). It shows that the average value for Cs is 2.08, almost exactly equivalent to the category of "little" formal education and the P average is 4.26, which falls between "quite a bit" and "great deal". It shows that 91.30 percent of those falling in the "none" category were Cs and 100 percent of those falling in the "little" category were Cs. It shows on the middle value equal distribution between Cs and Ps. On the category

TABLE 25

Participant Classification by Health Education Category

		1 None	2 Little	3 Some	4 Quite a bit	5 Great Deal	$\bar{X}$	σ
C	N	21.00	13.00	9.00	8.00	0.00	2.08	1.11
	% of C	41.18	25.49	17.65	15.69	0.00		
	% of category	91.30	100.00	50.00	42.11	0.00		
P	N	2.00	0.00	9.00	11.00	28.00	4.26	1.03
	% of P	4.00	0.00	18.00	22.00	56.00		
	% of category	8.70	0.00	50.00	57.89	100.00		

$$\chi^2 = 57.16^{***} \ (4df)$$

*** P < .001

"quite a bit" 57.89 percent were Cs and on the highest category "great deal" 100 percent were Ps. Thus the results show a classic distribution reversal.

Table 26 (Participant Classification by Formal Education Category) shows the results relevant to the external or objectives hypothesis of formal education. The data overwhelmingly supports the hypothesis that Cs have less formal education than Ps (X^2 = 29.17, P<.001). The mean value for C = 3.77, roughly equivalent to a little less than a college Bachelors degree, while the mean value for P = 5.26, a little above a Graduate degree at the Master's level. This table also demonstrates a classic reversal in distribution of responses between P and C.

Table 27 (Participant Classification by Family Income Category) shows values relevant to the hypothesis regarding family income. The values support (X^2 = 12.27, P<.025) that Cs have significantly less family income than Ps. It shows Cs mean equal to 3.20, slightly above the $12,000 - $20,000 category, and Ps mean equal to 3.81, slightly below the $20,000 - $30,000 range. Similar to the other tables on socio-economic factors, the C distribution into categories was the reverse of P, with C constituting 100 percent of the lowest category, and P constituting 70.59 percent of the highest.

TABLE 26

Participant Classification by Formal Education Category

		1 Grammar School	2 High School	3 Para Prof.	4 Bachelor Degree	5 Masters Degree	6 PhD	7 M.D., D.O. D.D.S., etc.	$\bar{X}$	σ
C	N	1.00	12.00	5.00	20.00	9.00	4.00	1.00	3.77	1.34
	% of C	1.92	23.08	9.62	38.46	17.31	7.69	1.92		
	% of category	100.00	92.31	62.50	71.43	8.91	40.00	7.69		
P	N	0.00	1.00	3.00	8.00	19.00	6.00	12.00	5.26	1.27
	% of P	0.00	2.04	6.12	16.33	38.78	12.24	24.49		
	% of category	0.00	7.69	37.50	28.57	67.86	60.00	92.31		

$\chi^2 = 29.17$*** (6df)

*** P < .001

TABLE 27

Participant Classification by Family Income Category

		1 $<$7,000$	2 $7-12,000	3 $12-20,000	4 $20-30,000	5 $>$30,000$	$\bar{X}$	σ
C	N	11.00	4.00	26.00	12.00	5.00	3.20	1.00
	% of C	7.84	7.84	50.98	23.53	9.80		
	% of category	100.00	50.00	66.67	40.00	29.41		
P	N	0.00	4.00	13.00	18.00	12.00	3.81	0.92
	% of P	0.00	8.51	27.66	38.30	25.53		
	% of category	0.00	50.00	33.33	60.00	70.59		

$\chi^2_{,} = 12.27*$ (4df)

* $P < .05$

DISCUSSION

The following chart summarizes the main tests of significance computed on data related to each of the hypotheses tested and presents the basic framework for the discussion which follows.

SUMMARY: Tests of Significance Related to Hypotheses

I. PARTICIPATION

   Hypothesis: <u>Compared to Ps, Cs have a lower record of participation in agency decision-making meetings.</u>

Method	Significance Test	Significance Level
Overall attendance	$X^2 = 15.29$	P <.001
Board of Trustees	$X^2 = 13.31$	P <.001
Executive Committee	$X^2 = 5.17$	P <.05
Committee A	$X^2 = 0.49$	NS
Committee B	$X^2 = 1.85$	NS
Committee C	$X^2 = 7.39$	P <.01
Committee D	$X^2 = 1.44$	NS

II. POWERLESSNESS

A. <u>Internal Hypothesis</u>: <u>Consumers see themselves as having less power **than** Providers.</u>

Method	Significance Test	Significance Level
Neal-Seeman Scale	$t = 3.65$	$P < .001$
Item 1	$x^2 = 5.22$	$P < .05$
Item 2	$x^2 = 4.90$	$P < .05$
Item 3	1.96	NS
Item 4	1.10	NS
Item 5	0.80	NS
Item 6	0.54	NS
Tannenbaum		
Item 7a, C vs. P	$t = 1.42$	$P < .10$
Item 8a vs. 10a	$t = 12.97$	$P < .001$
Item 9a vs. 10a	$t = 9.59$	$P < .001$

B. <u>External Hypothesis</u>: <u>Ps see Cs as having less power than Ps.</u>

Method	Significance Test	Significance Level
Tannenbaum		
8a vs. 10a	$t = 13.42$	$P < .001$
9a vs. 10a	$t = 6.86$	$P < .001$

C. <u>Interaction Hypothesis</u>: <u>Cs and Ps see Cs as having a small amount of power or influence in agency decision-making activities.</u>

Method	Significance Test	Significance Level
Tannenbaum	$t = 9.89$	$P < .001$
Zero-Sum	$Z = 7.84$	$P < .001$
Arnstein	$t = 35.49$	$P < .001$

III. NORMLESSNESS

A. Internal Hypothesis: Cs do not perceive themselves as having a clear role in the activities in the agency.

Method	Significance Test	Significance Level
Task Assignment	$x^2 = 24.64$	P < .001

B. External Hypothesis: Ps do not perceive Cs as having a clear role in the agency.

Method	Significance Test	Significance Level
Task Assignment	$x^2 = 26.11$	P < .001

IV. ISOLATION

A. Group Attraction-Acceptance

1. Internal Hypothesis: Cs are less attracted to the committee they belong to than are Ps.

Method	Significance Test	Significance Level
Attraction to committee as a whole	t = 1.83	NS
Attraction to members	t = 0.77	NS

2. External Hypothesis: The committee as a whole will be more accepting of P members than C members.

Method	Significance Test	Significance Level
Acceptance of members	t = 2.58	P < .005

B. Information

1. Knowledge Deficit

a. <u>Internal Hypothesis</u>: <u>Cs perceive their knowledge of health plan-</u>

<u>ning to be less adequate than Ps see their</u>

<u>knowledge as being.</u>

<u>Method</u>	<u>Significance Test</u>	<u>Significance Level</u>
Adequacy Question	$x^2 = 19.67$	P < .001

b. <u>External Hypothesis</u>: <u>Cs do not have as much knowledge of medical</u>

<u>planning matters as Ps do.</u>

<u>Method</u>	<u>Significance Test</u>	<u>Significance Level</u>
Information I	t = 1.72	P < .10
Information II	t = 0.46	NS
Information III	t = 0.64	NS
Information IV	t = 0.05	NS

2. Communication Network

a. <u>Internal Hypothesis</u>: <u>Cs are not as satisfied as Ps are with the</u>

<u>extent of their inclusion in the informal</u>

<u>communication network.</u>

<u>Method</u>	<u>Significance Test</u>	<u>Significance Level</u>
Satisfaction Question	t = 1.24	NS

b. <u>External Hypothesis</u>: <u>Cs are not included in the informal communica-</u>

<u>tion network of agency members to the extent</u>

<u>that Ps are.</u>

Method	Significance Test	Significance Level
Members Known	$t = 1.12$	NS
Weighted average of contacts given	$t = 2.13$	$P < .05$
Number of members known by	$t = 0.93$	NS
Weighted average of contacts received	$t = 0.54$	NS

c. Constituency

1. Internal Hypothesis: Cs do not perceive themselves as having a

    constituency as often as Ps do.

Method	Significance Test	Significance Level
Reported constituency	$x^2 = 1.70$	NS

2. External Hypothesis: Cs are perceived as having a constituency less

    often than Ps.

Method	Significance Test	Significance Level
Perceived constituency	$t = 1.23$	NS

V. SOCIO-ECONOMIC STATUS

   Hypothesis: Cs have a lower income and less formal education than Ps.

Method	Significance Test	Significance Level
Health Education	$x^2 = 57.16$	$P < .001$
Formal Education	$x^2 = 29.17$	$P < .001$
Income	$x^2 = 12.27$	$P < .001$

I. Participation

The most basic feature of effective input into the decision-making process is participation in those meetings where binding decisions are made. Even if a structure is created to give recipients of such decisions 51 percent of the voting power in determining the decision, the right to vote must be exercised for the potential to become reality. Unfortunately the results revealed that such participation by consumers has been sadly lacking, leaving the voting as well as persuasion opportunities in meetings in the hands of the professionals. If only 41 percent of 51 percent attend, then at maximum only about 20 percent of the votes can be consumers. It is particularly noticeable that the most powerful groups, Board of Trustees and Executive Committee are the ones where consumer participation is most lacking so that effective input is removed not only from review and comment decisions, but policy decisions as well. Thus consumers are clearly marginal to this basic process of decision making.

II. Powerlessness

The results on powerlessness were expected. They demonstrate a very acute power imbalance in the agency. This is most vividly demonstrated by the fact that there was general agreement between Cs and Ps on the significant differences between the influence of S and P (t = 2.33, P < .05) and that of Ps and Cs (t = 5.09, P < .001). This relationship is very well described by the overall description of the mean percent of influence accorded each group: S = 52.6 percent, P = 34.50 percent, C = 12.90 percent. The results on Arnsteins (1969) scale of participation confirmed that the Cs position is one that is not only powerless relative to other groups but

also exists in an absolute sense when more operationally defined. A good

overall description of the Cs powerless position can be obtained using

Arnstein's terminology. The consumer is usually consulted before deci-

sions are made, but at best, and even then not often, votes on decisions

which may be reversed by those controlling necessary resources.

Some interesting results within and between tables are also worthy

of discussion. In the results on Table 3 (Neal-Seeman Powerlessness

Items by Participant Classification) there was a significant difference

between C and P on the first two items: "coping with pressure groups"

and "preventing rising medical costs". It is most interesting to note

that the powerlessness means on these two items are much higher for

both C and P, than the means on any of the other items. About 36 percent

of P, and 60 percent of C marked the powerlessness option for these items.

The high value on "coping with pressure groups" could be explained by the

idea that the pressure group involved is not specified so that, for

example, Cs could feel powerless against the health professional, and Ps

could feel powerless against the Federal government. It is also interes-

ting that while many felt unable to "cope with pressure groups" most felt

able to "affect important decisions in his own life". They seemed to

have indicated that they participate in the decision-making process but

determine its outcomes only when little opposition exists from others.

The high powerlessness values on ability to prevent rising medical costs

(P = 40 percent, and C = 64 percent) may be a demonstration of the

feeling that "this is bigger than all of us". Indeed the inflation trend

is often beyond the power of any group, and consumers who are marginal to

the decision-making may be all but totally powerless.

On the whole, however, the extent of powerlessness indicated by in-

dividuals on the Neal-Seeman scale was not that high (P = 14 percent,

C = 28 percent indicating powerlessness). Tannenbaum's item on "subjects own influence" (Table 4), however, asked much the same question and the results indicated a large degree of powerlessness for both (somewhat less than midway between little and none). An explanation can be drawn by considering the focus of these two scales. Neal-Seeman has items of a general nature pertaining to health issues, and control in general. Tannenbaum, however, relates specifically to the agency under study.

It should also be noted that the Neal-Seeman items generally refer to potential control while Tannenbaum items refer more to utilized power. Thus while members do not feel potentially powerless with regard to control of general health issues, they do believe they exercise little power in this particular agency.

It is also worthwhile to compare responses across Tannenbaum items (Table 5 and 6) for C vs. P. Consumers described their individual influence position as low and described the influence of Cs as a group to be about the same (t = 1.11, NS). Ps on the otherhand, described their individual influence position to be fairly low but described that of Ps as a group to be quite a bit more (t = 4.72, P< .001). This demonstrates that Ps see control being exercised by members of their group even if they personally do not do so, while Cs see neither themselves nor other Cs as exercising any real power in the agency.

Finally in considering the powerlessness results, it is interesting to compare the general pattern of results for C vs. P, on the Tannenbaum items. There was general agreement between C and P of the influence position of S and Cs high and low respectively. Cs however, described Ps as being higher in influence than Ps described themselves (t = 1.95, P almost .05). Thus either Ps are underestimating the influence they exercise or Cs see them as having a lot more influence than they really do. The truth is probably somewhere in between.

III. Normlessness

The results shown on the tables of normlessness (Tables 8-15) were both unexpected and interesting. The hypothesis was not supported by the data. Cs are in fact viewed as having a clear role, that is one for which both S and P were excluded in assignment. This should be examined more clearly before the temptation to say, "they only do one thing, but they do it well". The task they were assigned read: "they represent community problems and opinions". The word "represent" can unfortunately be exercised both as an active and passive role. If the respondent viewed it as a "passive" expression of "who stands for what", most would indeed be likely to designate Cs for representing "community problems and opinions". If on the other hand Cs were viewed as actively representing community opinions in agency actions, it seems most unusual that they were assigned no other roles, in fact excluded from almost all roles which would indicate that they had operationalized this objective. Some interesting features of the breakdown of response categories (Tables 8 and 12) also exist in and "don't know" and "no one" categories. 31 percent of Cs indicated they "didn't know" who performed the tasks compared to only 21 percent of Ps. It is perhaps not bad when 1/5 of a group do not know "who is doing what", but when 1/3 of a group falls in this category there is strong suggestion that such a group is isolated from the proceedings and thus marginal to the process.

It is interesting to note that when the task was assigned there was agreement between C and P on who the task should be assigned to. Cs were assigned the task to "represent community problems and opinions". Ps assigned the tasks of "helping in planning medical facilities" and "providing expert opinion" to themselves. Staff was assigned all the rest. It is noteworthy that Cs were excluded from task 2 "fulfill legal

requirements" when by Federal law at least 51 percent of the governing Board must be consumers for the agency to receive funding. It is also worth noting that while Cs "represent community problems and opinions" they are some how able to do it without task 8 "dealing with other organizations in the community", task 9, "gathering and reporting information", task 11, "helping people be aware of health needs", and task 12 "informing the community about health problems and needs". This pattern strongly suggests that while the philosophical ideal is for Cs to represent community problems and opinions, they are excluded in the operational tasks that would be necessary to actually do this.

Task assignment for Ps was much clearer when Ps responded rather than Cs. Thus Ps perceived themselves as doing much more than Cs see them as doing but as having less power than Cs see them as having.

Finally, in looking at the summary of inclusion and exclusion from task assignment (Tables 10 and 14) one is impressed with the almost classic textbook picture of role reversal and heirarchy of operational involvement in agency activities, ($X_c^2 = 27.20$, P$<$.001; $X_p^2 = 26.11$, P$<$.001). It would appear that the staff does almost everything, the consumers do almost nothing, and the providers fluctuate almost randomly somewhere in the middle. It is entirely possible that the tasks chosen for analysis were not representative of the entire domain of comprehensive health planning activities and indeed sampled primarily staff activities. The tasks were constructed however, to cover the full range of activities as suggested by the literature and members of the agency. It is difficult to believe that another set of items would alter significantly such

a dramatic response pattern. Considering the basic philosophy of equal sharing of rights and responsibilities in the program, it would appear that to the members, the "Partnership for Health" is almost non-existent for consumers and only weakly so for providers.

IV. Social Isolation

A. Committee Attraction-Acceptance

Jackson (1959) tried to explain the difference between "formal membership" and "psychological membership" in an organization. He stated that to be anything more than a name on a membership list, a person must be both attracted to the group and accepted by it. Attraction is considered to be a relationship of a person and group structure in which the person wants to belong more than he wants not be belong. Acceptance is defined as being more than sociometric liking and includes the expectations of certain behavior for the group members and the acceptance of him performing some role or roles in the group.

The items on attraction to members of the group and acceptance by them were based on Jackson's research. The items on attraction to the group as a whole were based on Jackson's concept although the referent was the group rather than the individual. There was some discrepancy between attraction to the group as a unit and to the membership with the latter being higher and the difference being somewhat greater for Cs, (t_c = 2.41, P < .01; t_p = 1.56, NS). This difference could be attributed to the idea that consumers are more attracted to the people in the group than the group itself, particularly if the function the group is performing does not seem particularly desirable or because it does not seem to be performing a desirable function very well.

The most interesting feature here however, are the comparisions of attraction and acceptance, for Cs and Ps. They indicate that both Cs and Ps are attracted to their committee and that there is no significant difference between them in this respect. The results indicate simultaneously that Ps are accepted to the same extent that they are attracted but Cs considerably less so. The results would, in Jackson's terminology, represent a position of "psychological membership" for Ps and a "preference group relationship" for Cs. To quote Jackson (p. 17): A "preference group relationship is found in a situation where a person wants to belong to a group but is not assigned a membership role", or as an example, a group in which veterans and new members were both formally members, but the veterans constituted an "elite in group" to which the new members desired to belong.

Considering also the previous evidence on task assignment this description would appear to be a good fit for the situation which exists in the planning agency: professionals constituting the "elite in group" and consumers being formal members of the group, but trying to belong to the "in group" of decision makers.

Jackson also describes a "marginal group" relationship in which the person has positive acceptance but little attraction, this unfortunately does not coincide with the present more general terminology of members who are peripheral to meaningful group process for many reasons.

B. Information

1. Knowledge deficit

The results with regard to the knowledge that the groups had was mixed. The overwhelming support of the hypothesis the Cs perceive their health planning knowledge to be inadequate supported the general

sentiments conveyed in conversations with agency consumers. It is
intriguing however, that Cs did as well as Ps on the objective questions.
The content of these items should then be examined carefully. Informa-
tion category I, on very general and obvious features should be simple
enough for most members to answer. Information II and III involved sim-
ple name recall. Information IV involved more specific information on
the operating programs of the agency and accuracy for both Cs and Ps
dropped dramatically. This would result if such items were not salient
in the cognitive operating structure of the membership. Indeed no pro-
gress reports are regularly presented to members about the progress of
these items on the overall agency program once annual funding has been
reached. Thus it would appear that the knowledge deficit perceived by
Cs had not been adequately sampled or that Cs in fact knew more than
they actually had given themselves credit for.

2. Communication Network

The mixed findings on knowledge deficit are somewhat clarified when
the communication network is examined. The results show that C and P
both want slightly more communication with other agency participants
staff included, and that there was no significant difference between C
and P means.

Also interesting in this same general direction is that on the mea-
sure of contacts given and received, Ps indicated they gave contacts as
frequently as they received them. Cs however, received more contacts
than they thought they gave. Both the unusual results of satisfaction
with the communication network and inclusion into it could be explained
if personal communication contacts in the health area were more salient

and important to Ps than to Cs. Then it would follow that Ps would be likely to desire more contacts and remember all of them. Indeed it would appear that Cs place far too much emphasis on the amount of knowledge they do not have, rather than viewing contacts with other interested Cs and Ps as a way of learning information about ongoing agency activities.

C. Constituency

The results on constituency follow some of the general trend of the information results. Even though Ps perceived themselves as formally representing some group twice as often than Cs, the large values of the standard deviations did not allow the difference to be statistically significant. As constructed, "yes" responses could have ranged from 0 to 45 on the largest committee. Thus a large standard deviation was possible. Further investigation therefore is necessary before obtaining more conclusive results.

V. Socio-Economic Status

Some factors of socio-economic status were examined not so much because they were causes or products of anything specific to the agency's present operations, but because they describe built-in handicaps that Cs bring with them when entering into an agency whose decision-making is in the health area. The results confirm the expectations that consumers report significantly less health education, less formal education, and less income than providers.
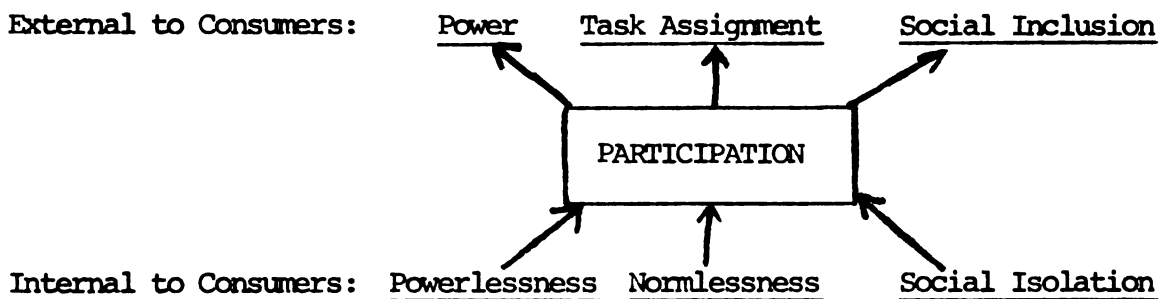
Conclusion

Consumers began with some basic features of marginal status and even after formal and majority inclusion in the decision-making process

of the agency still occupied a marginal status, which was operationally defined in terms of attendance and features of powerlessness, normless-ness, and social isolation. It appears as Fairweather (1967, p. 7) puts it that "marginal status often results in effective social isolation of the persons from meaningful participation", and that consumers may have attempted to "solve their problem or marginality by becoming apathetic and assuming no responsibility at all". But as Bloomberg (1969, p. 126) points out "there may be a self-confirming circularity" in the perceptions of powerlessness, normlessness, and social isolation, which often produce behaviors which ultimately reinforce the marginality of the status.

Thus is may well be the responsibility of those seeking meaningful participation for these recipients of the decision making process to stop these processes of non-involvement and reverse them if possible so that meaningful participation in a democratic society can occur and a position of power, task assignment, and social inclusion can be accorded to the consumers.

It becomes necessary then to do as Fairweather recommends, to develop a program which will "change the status of those who only marginally participate".

Indeed if these processes can be viewed as a system it might look like this:

External to Consumers: Power   Task Assignment   Social Inclusion

PARTICIPATION

Internal to Consumers: Powerlessness   Normlessness   Social Isolation

To provide a program which aims at increasing participation, the mechanism apparently involves reducing the powerlessness, normlessness, and social isolation perceived by consumers. It seems obvious that some program should be created which allows the consumer the social support of a constituency and not only helps him overcome the perceived knowledge deficit by presenting him with some facts utilizable in actual participation, but also introduces him into the functional communication network so that he becomes informed of political as well as factual information. Jackson (1966) believes greater inclusion in the communication network would allow consumers to perceive their role more accurately and clarify it to themselves so that the lack of definiteness in role would not produce what Jackson (1966) calls "discontinuity in expectation" of persons in the actual decision-making meeting. Finally the program should offer new opportunities so that the self-confirming circularity of powerlessness can be broken, and Cs can, with some degree of confidence, enter into participation in the decision process with the expectation that their input will be both meaningful and effective.

Such a program will perhaps not be easy to create, nor accomplish all of these objectives successfully, but such a program should be created and evaluated or society will once again attempt to wash its hands in diagnosis and rhetoric rather than putting them to work in producing change.

BIBLIOGRAPHY

BIBLIOGRAPHY

Altshuler, A. Community Control. New York: Pegasus, 1970.

Arnstein, S.R., "A Ladder of Citizen Participation," American Institute of Planners Journal, 35, #4, July 1969, 216-244.

Bloomberg, W., "Community Organization," in R. Kramer and H. Specht (eds.), Reading in Community Organization. Englewood Cliffs, N.J.: Prentice-Hall, 1969.

Bonjean, C., R.J. Hill, and S.D. McLemore. Sociological Measurement: An Inventory of Scales and Indices. San Francisco: Chandler Publishers, 1967.

Dubey, S.N., "Community Action Programs and Citizen Participation: Issues and Confusions," Social Work, 15, 1, Jan. 1970, 76-84.

Dean, D., "Alienation: Its Meaning and Measurement," American Sociological Review, 26, (Oct., 1961), pp. 753-758.

Fairweather, G.W., Methods for Experimental Social Innovation. New York: John Wiley, 1967.

Gilmer, B., Industrial Psychology. New York: McGraw-Hill, 1966.

Jackson, J., "A Space for Conceptualizing Person-Group Relations," Human Relations, 12, 1959, 3-15.

Jackson, J., "A Conceptual and Measurement Model for Norm and Roles," Pacific Sociological Review, 9, #1, Spring, 1966.

Kramer, R., Participation of the Poor. Englewood Cliffs, N.J.: Prentice-Hall, 1969.

Moynihan, D., Maximum Feasible Misunderstanding. New York: The Free Press, 1970.

Sakoda, J.M., Cohen, B.H., Beall, G. "Test of Significance for a series of Statistical Tests," Psychological Bulletin, 51, #2, 1954.

Seeman, M., "On the Meaning of Alienation," American Sociological Review, 24, (Dec., 1959), 783-791.

Tannenbaum, A. Control in Organizations. New York: McGraw-Hill, 1968.

APPENDIX

APPENDIX

QUESTIONNAIRE USED BY RESPONDENTS

This questionnaire is one part of a longitudinal study designed to survey the services, attitudes, and activities at the agency. It is being conducted with the knowledge and approval of the Board of Trustees and agency staff. However, these questionnaires remain the property of the surveyors, and no information pertaining to particular individuals shall be available to anyone else.

The survey will be divided into three sections. First, there will be a brief section of general questions asked by the interviewer, followed by a section which should be easier to answer by yourself. Finally, we will ask some questions of a more specific nature. In all, the time involved should not exceed one hour.

Name _____   Date _____

Interviewer _____   Time _____

SECTION I: These questions will be asked by the interviewer. For your convenience, however, we encourage you to follow along on this copy of the questions. From time to time, we shall refer to one of these cards which give categories we will ask you to use in your response.

1. Which committee(s) do you serve on at the agency?

   _____

   _____

2. Do you consider yourself a health consumer (1) or a health provider

   (2) at the agency?   _____

3. Why did you join the agency?

4. Which aspects of the agency do you think are most worthwhile and

   which are in need of improvement?

5. What would you suggest to improve health planning at the agency?

6. What do you see as the benefits and disadvantages of consumer

   participation? ˙

Now we would like to move on to some more structured questions. We

ask you to answer the following questions using the responses on Card

#1. (See the following page for Card #1)

7. A. How much influence do you think you have on planning decisions

      in the agency?

   B. Would you like it to be different?

   C. How much influence would you like to have?

8. A. In general, how much influence does the <u>staff</u> have on planning

      decisions in the agency?

   B. Would you like it to be different?

   C. In your opinion, how much influence <u>should</u> the staff have?

9. A. In general, how much influence do <u>health providers</u> have on

      planning decisions in the agency?

   B. Would you like it to be different?

   C. In your opinion, how much influence <u>should</u> health providers have?

CARD #1

5 = A great deal

4 = Quite a bit

3 = Some

2 = Little

1 = None

10. A. In general, how much influence do <u>consumers</u> have on planning decisions in the agency?

    B. Would you like it to be different?

    C. In your opinion, how much influence <u>should</u> consumers have?

11. A. In summary, then, how much is a typical decision influenced by the staff, how much by the providers, and how much by the consumers? In other words, given 100% of the influence in the agency, what percent (to the nearest 10%) is exerted by each of these three groups respectively?

    Staff influence _____ %

    Provider influence _____ %

    Consumer influence _____ %

    B. Would you like it to be different?

    C. What percent of influence would you prefer for each group?

Next, we would like to find out how much information about medical services and health planning the members of the agency have. We do not expect you to be able to answer all of these questions completely.

12. Please tell me what major department in the Federal government finances the agency's annual budget?

13. Please tell me what a Health Maintenance Organization (H.M.O.) is?

14. Please tell me the difference between an "a" agency and a "b" agency in Comprehensive Health Planning?

15 A. Would you give me the names of as many of the staff members as you know?

    B. Using the categories on Card #2, would you tell me approximately how many times a month you speak with each one you mentioned? (See the following page for Card #2)

CARD #2

5 = More than 8 times

4 = 5 to 8 times

3 = 3 to 4 times

2 = 1 to 2 times

1 = less than 1 time

15. C. Compared to the amount of contact you now have, how often would you like the staff to talk with you?

16. A. Would you name as many of the Planning Committees as you know?

    B. Would you name the chairmen of these committees?

17. Have you ever been to the agency's office?

18. Please tell me the budget for the work program next year?

19. Would you name as many items of next year's work program as you can remember?

Next, we would like to discuss some aspects of your background in the community.

20. A. Do you belong to any other organizations or groups in the community besides your place of employment?

    B. Which organizations are these?

    C. Do you regularly attend meetings at any of these organizations?

    D. Do you make financial contributions to any of these organizations?

    E. Do you serve on any committees for these organizations?

    F. Have you ever held office in any of these organizations?

21. Using the categories on Card #3, approximately how many people outside the agency do you talk to about Comprehensive Health Planning? (See the following page for Card #3)

22. A. Were you selected specifically to represent any group at agency meetings?

    B. If so, which group were you selected to represent?

    C. Quite often people do not formally represent any organization but still reflect the opinions and needs of a greater number of people than just themselves. Do you think you reflect the needs and opinions of any larger group of people?

CARD #3

5 = A great many

4 = Quite a few

3 = Some

2 = A few

1 = None

22. D. If so, which groups of people are these?

23. A. Using the categories on Card #4, how likely is it that the people you mentioned would find out what you do at the agency? (See the following page for Card #4)

    B. Do you feel that the people you mentioned expect you to do anything in particular at the agency?

    C. How much do these people influence what you do?

    D. How important is it that you have these people to back you up?

    E. Are you more likely to speak up at meetings with these people backing you up?

    F. Do you feel that your contribution will carry more weight with these people backing you up?

24. A. Could you name the people you know at the agency other than those on the committee(s) you belong to?

    B. Using the categories on Card #5, approximately how many times a month do you speak with each person you mentioned? (See the following page for Card #5)

    C. What proportion of your discussions with each one are health-related?

    D. Compared to the amount of contact you now have, how often would you like these people to talk with you?

25. A. Could you name the people you know on the committee(s) you belong to who you speak with outside those meetings?

    B, C, D. Same as #24 above.

CARD #4

5 = Very Likely

4 = Probably

3 = Maybe

2 = Unlikely

1 = Very Unlikely

CARD #5

5 = More than 8 times

4 = 5 to 8 times

3 = 3 to 4 times

2 = 1 to 2 times

1 = less than 1 time

SECTION II: Each of the following questions may be answered in one of several ways. Please check the answer following each question which best describes your answer.

1. How long have you been attending meetings at the agency? _____

2. Do you plan on continuing as a member of the agency next year?

   _____ Yes   _____ No

3. Suppose that as a result of <u>strong opposition</u> to the agency from within the community, the agency was in real danger of folding up. How much effort would you be willing to spend in order to prevent this?

                    _____ A great deal

                    _____ Quite a bit

                    _____ Some

                    _____ Little

                    _____ None

4. Suppose that as a result of <u>general member disinterest</u>, the agency was in real danger of folding up. How much effort would you be willing to spend in order to prevent this?

                    _____ A great deal

                    _____ Quite a bit

                    _____ Some

                    _____ Little

                    _____ None

5. How well do you think the agency is doing in the field of Comprehensive Health Planning?

      _____ Very well

      _____ Fairly well

      _____ All right

      _____ Poorly

      _____ Very poorly

6. Consumer participation is a necessary part of Comprehensive Health Planning?

      _____ Strongly agree

      _____ Moderately agree

      _____ Neutral

      _____ Moderately disagree

      _____ Strongly disagree

7. Compared to what you think a person needs to participate effectively in health planning, how adequate do you think your knowledge of health and health planning is?

      _____ More than adequate

      _____ Fairly adequate

      _____ Barely adequate

      _____ Inadequate

      _____ Very inadequate

8. Considering health delivery in general, how important a part is Comprehensive Health Planning?

      _____ Very important

      _____ Fairly important

      _____ Somewhat important

      _____ Not too important

      _____ Not important at all

9. How long do you think it will take before such planning will have significant effects on the quality of health services?

       _____ More than 10 years

       _____ 6 to 10 years

       _____ 3 to 5 years

       _____ 1 to 2 years

       _____ Less than 1 year

The following statements are grouped into pairs. Would you check one statement from each pair which best describes your feelings?

10. _____ A. Better coordination of existing services should be given first priority in meeting today's health problems.

  _____ B. Planning new programs should be given first priority in meeting today's health problems.

11. _____ A. Consumers and providers in the agency should formally speak for some group of people.

  _____ B. Consumers and providers in the agency should express only their own personal opinion.

12. _____ A. This community needs Comprehensive Health Planning.

  _____ B. The people already providing health services can take care of health planning themselves.

13. _____ A. Persons like myself have little chance of protecting our personal interests when they conflict with those of strong pressure groups.

  _____ B. I feel that we have adequate ways of coping with pressure groups.

14. _____ A. I think we have adequate means for preventing run-away medical costs.

  _____ B. There's very little we can do to keep medical expenses from going higher.

15. _____ A. High quality medical care can be achieved by those of us
who work toward it.

_____ B. There's very little we can do to bring about high quality
medical care.

16. _____ A. There's very little persons like myself can do to im-
prove the community's knowledge about medical services.

_____ B. I think each of us can do a great deal to improve the
community's knowledge of medical services.

17. _____ A. This world is run by the few people in power, and there
is not much the little guy can do about it.

_____ B. The average citizen can have an influence on important
decisions affecting his life.

18. _____ A. It is only wishful thinking to believe that one can
really influence what happens in medical services today.

_____ B. People like me can change the course of medical services
if we make ourselves heard.

The following are some of the groups who work together to make health
services what they are today. Please indicate how much <u>influence</u> or
"<u>say</u>" each group has in determining the type of health services that
will be offered.

19. Medical Professional Associations: _____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

20. Community Opinion: _____ A great deal

                                         _____ Quite a bit

                                         _____ Some

                                         _____ Little

                                         _____ None

21. Physicians: _____ A great deal

                                         _____ Quite a bit

                                         _____ Some

                                         _____ Little

                                         _____ None

22. Comprehensive Health Planning Agencies: _____ A great deal

                                         _____ Quite a bit

                                         _____ Some

                                         _____ Little

                                         _____ None

23. Hospital Administration: _____ A great deal

                                         _____ Quite a bit

                                         _____ Some

                                         _____ Little

                                         _____ None

24. State government: _____ A great deal

                                         _____ Quite a bit

                                         _____ Some

                                         _____ Little

                                         _____ None

25. City government:

_____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

26. Other Planning Agencies:

_____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

27. Voluntary (Charitable) Organizations:

_____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

28. Federal Government:

_____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

29. Medical Schools:

_____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

The following statements describe various types of participation consumers could have in Comprehensive Health Planning.

    A.   They are informed of decisions.

    B.   They are consulted before decisions are made.

    C.   They vote on decisions, but outcomes can be modified by those controlling necessary resources.

    D.   They share in making final decisions of resource allocation.

    E.   They have delegated power to make decisions.

    F.   They have control over the decisions.

30. Which statement best describes the way in which consumers are now actually participating in the agency?

A. _____   B. _____   C. _____   D. _____   E. _____   F. _____

31. Do you think this is the type of participation they should have?

_____ No   _____ Yes (go to question 33)

32. Which statement best describes the way in which consumers should be participating in the agency?

A. _____   B. _____   C. _____   D. _____   E. _____   F. _____

33. The following are potentially critical problems in the health field. Please check the ones which you feel are actually problems in the tri-county area.

    _____   A. Not enough adequate care for the poor.

    _____   B. Not enough citizen participation in planning and delivery of services.

    _____   C. Not enough hospital beds.

    _____   D. Too much government intervention.

    _____   E. Not enough adequate care for the elderly.

    _____   F. Too many hospital beds.

    _____   G. Not enough para-professional manpower.

33. (continued)

_____ H. Rising medical costs.

_____ I. Inadequate training of medical personnel.

_____ J. Not enough power in Comprehensive Health Planning.

_____ K. Not enough government intervention.

_____ L. Too many physicians.

_____ M. Lack of cooperation in medical services.

_____ N. Not enough planning for medical facilities and services.

_____ O. Not enough adequate transportation to medical facilities.

_____ P. Not enough physicians.

_____ Q. Too much planning for medical facilities and services.

_____ R. Enviornmental pollution.

_____ S. Duplication of medical services.

34. Would you like any other problems you think are critical in the tri-county area?

The following is a list of tasks which could be performed in a health planning agency. Please indicate which group performs each task the most. Some tasks can be shared by two or more groups, but please select that group which does it more than the others.

35. They help in planning medical facilities.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

36. They fulfill legal requirements for operation.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

37. They search out ways to serve the needy.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

38. They coordinate medical services.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

39. They give information about resources available.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

40. They give a balance of opinion.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

41. They represent community problems and opinions.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

42. They deal with other organizations in the community.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

43. They gather and report information.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

44. They evaluate the feasibility of programs.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

45. They help people to be aware of health needs.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

46. They inform the community about health problems and services.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

47. They provide the time and effort necessary for compiling reports and distributing notices.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

48. They provide expert opinion.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

49. They see to it that planning proceeds smoothly.

_____ Staff _____ Consumers _____ Providers _____ No one _____ Don't Know

The following questions relate to your own background. Please answer by checking the category most appropriate.

50. What is your occupation? _____

51. What is your age? _____

52. Of these educational categories, which one best describes your educational background?

_____ A. Grammar School

_____ B. High School

_____ C. Bachelor's Degree

_____ D. Para-professional Degree

_____ E. Master's Degree

_____ F. Ph.D. Degree

_____ G. Professional Degree

53. A. How much formal educational training have you had in any health related field?

_____ A great deal

_____ Quite a bit

_____ Some

_____ Little

_____ None

B. Have you participated in the Urban League's Consumer Health Training Program?

_____ Yes _____ No

54. Are you, or have you ever been married?

_____ Yes _____ No (go to question 56)

55. How many children do you have? _____

56. Of these categories of annual family income, please indicate which category your family falls into?

_____ Under $7,000

_____ $7,000 to $12,000

_____ $12,000 to $20,000

_____ $20,000 to $30,000

_____ Over $30,000

57. How many years have you lived in the tri-county area? _____

58. How many times have you or a member of your immediate family visited a physician in the last year?

_____ More than 10 times

_____ 6 to 10 times

_____ 3 to 5 times

_____ 1 to 2 times

_____ None

59. How many times have you or a member of your immediate family been hospitalized in the last 5 years?

_____ More than 10 times

_____ 6 to 10 times

_____ 3 to 5 times

_____ 1 to 2 times

_____ None

SECTION III:

1. The following statements are ways in which a person could describe other people on a committee. For each person that you know on this list of committee members, please indicate, using the following choices, how much you agree that each statement describes that person:

      5. Strongly agree

      4. Moderately agree

      3. Neutral

      2. Moderately disagree

      1. Strongly disagree

A. He makes a valuable contribution to the tasks of the committee.

B. When you are undecided on an issue, he can usually persuade you to accept his viewpoint.

C. You enjoy working with him on the committee.

D. In general, he is the same kind of person you are.

E. In general, he is interested in the same things you are.

F. You benefit from his association with the committee.

2. Quite often people do not formally represent any organization but they still reflect the opinions and needs of a greater number of people than just themselves. Do you think that any of the people you know on this list reflect the needs and opinions of any larger group of people?

3. The following statements are ways in which a person could describe his relation to his committee. Using the categories above, please indicate how much you agree that each statment applies to you.

A. You enjoy attending meetings of the committee.

B. The committee makes a valuable contribution to planning in the field of health services.

C. In general, you try to do what the committee expects a member to do.

D. The committee is dealing with the same things you are interested in.

E. You benefit from working with the committee.

F. You usually go along with the committee's decision on issues.