



The Journal of Sociology & Social Welfare

Volume 7
Issue 5 *September*

Article 9

September 1980

Purposive Social Change and Interorganizational Networks: The Case of Three Prepaid Health Programs

Gale Miller
Marquette University

Charles K. Warriner
University of Kansas

Follow this and additional works at: <https://scholarworks.wmich.edu/jssw>

 Part of the [Politics and Social Change Commons](#), [Social Work Commons](#), and the [Work, Economy and Organizations Commons](#)

Recommended Citation

Miller, Gale and Warriner, Charles K. (1980) "Purposive Social Change and Interorganizational Networks: The Case of Three Prepaid Health Programs," *The Journal of Sociology & Social Welfare*: Vol. 7 : Iss. 5 , Article 9.
Available at: <https://scholarworks.wmich.edu/jssw/vol7/iss5/9>

This Article is brought to you for free and open access by the Social Work at ScholarWorks at WMU. For more information, please contact maira.bundza@wmich.edu.



Purposive Social Change and Interorganizational Networks:
The Case of Three Prepaid Health Programs

Gale Miller

Department of Sociology, Anthropology,
and Social Work
Marquette University

Charles K. Warriner
Department of Sociology
University of Kansas

ABSTRACT: An important perspective emerging in the areas of community and organizational analysis is the political economy approach to interorganizational relations. This approach treats organizations as seekers of basic political and economic resources which are found in their environments. This approach has special implications for persons interested in the study and/or implementation of programs of change, because it sensitizes the observer to the problems of political and economic conflict in inter-organizational relations. The perspective also offers useful insights into the development of intervention strategies that minimize the conflicts often associated with social change. In order to demonstrate the usefulness of this approach to social change and interorganizational relations, three attempts at creating prepaid health care programs in rural areas of the midwest are considered.

Historically, sociologists have tended to treat social change within a macroscopic perspective that emphasizes the unplanned and societal-wide consequences of general social movements and trends.¹ Recently, some sociologists have turned their attention to less encompassing attempts at social change that involve implementation of limited programs of change that are restricted to the community or sectors within it. Such efforts include attempts to alter the community sectors of juvenile justice, social welfare, and health care.² In an effort to distinguish this type of social change from others, Warren calls it "purposive social change".³ This is planned change that takes the form of specific programs of action that seek to alter the existing type and/or range of services in the community. Purposive social change takes place within a restricted and identifiable environment or organizations, associations and publics that constitute the local community. Thus, not only does purposive social change have an outcome that is limited to the community level, but the community elements that are most likely to be influenced by the change also constitute a portion of the most immediate and relevant environment of the change agent.

This paper is concerned with the relationship between purposive social change and community organization. Specifically, this paper reports the findings of an exploratory study on factors influencing the implementation of three prepaid health care programs in three rural communities in the midwest. Before considering the research itself, it is necessary to review the important theoretical and empirical concepts and issues that surround the study and analysis.

THE COMMUNITY CONTEXT OF PURPOSIVE SOCIAL CHANGE

In the past the community has been conceptualized from a number of perspectives, but recently some sociologists have begun to treat it as a social unit that is made up of interconnected organizations, associations and publics.⁴ Although the linkages between the organizational components may vary from community to community or even shift over time within a single community, it is possible to conceptualize the various components and linkages as sufficiently stable that they constitute a series of networks that are directed toward differing areas of community activity and control. The community, for example, is partially made up of a health care network, a criminal justice network and a social welfare network.

Because communities are conceptualized as sets of inter-organizational networks, a central problem involves the sources for network integration. That is, what are the factors that contribute to the linkage of the various organizations, associations and publics? Because much of this research has been directed toward limited types of interorganizational linkages, the findings tend to emphasize single factors. Thus, Levine and White emphasize the importance of exchange relations, Litwak and Hylton emphasize coordinating agencies, Dill stresses information, and Aiken and Hage emphasize the integrating consequences of joint programs.⁵ Recognizing the limited influence of any single factor, other analysts have attempted to identify sets of factors that simultaneously operate to integrate inter-organizational networks. Evan's notion of the organization set is, for example, based on the combined influence of personnel role-sets, information, personnel flows and flows of products and services.⁶ Similarly, Perrow emphasizes the impact of various types of "technological inputs" and Warren, et. al. stress the combined impact of domain agreements, system norms, and institutionalized thought structure.⁷

Recently, several analysts have attempted to bring the various factors influencing interorganizational integration into a more

general and theoretical perspective, i.e., the political economy approach.⁸ This perspective is perhaps best summarized by Benson who claims that organizations are primarily concerned with the problem of resource acquisition.⁹ The most critical resources being money and authority. Authority is the basis for the organization's domain which consists of agreements about the nature and types of activities that it can control. Money, on the other hand, is a basic resource that is necessary for developing and maintaining organizational facilities, programs, and personnel. Interorganizational networks emerge out of the process of resource acquisition because the establishment of patterns of exchange and dependency become necessary if organizations are to attain the resources that are required for operation. When the relations of exchange and dependency become patterned and stabilized, it is possible to speak of the interorganizational networks as being in a state of equilibrium.¹⁰ The equilibrium is not totally static, however. It is stabilized to the extent that resources continue to flow and are distributed in patterned ways, but a change in either the flow or distribution of resources will disrupt the equilibrium. When this occurs, units within the interorganizational network act to preserve or expand their control over basic resources.

Many efforts at purposive social change have the general consequence of disrupting the established pattern of interorganizational relations within the community. Consequently, efforts at purposive social change may--intentionally or unintentionally--provide some members of an interorganizational network with the opportunity to increase their control over basic resources. Those organizations that successfully take advantage of such opportunities will improve their political and economic positions in the community. In addition, there is another possible consequence of purposive social change that is important for those concerned with community organization and social change. That is, many of the most fundamental bases of interorganizational power are often hidden during times of stability and equilibrium. Indeed, it may be recognized by organizational leaders that it is in their best interests to mystify or in some other way hide some features of their relationships with other organizations. Because they disrupt both the obvious and the hidden aspects of interorganizational relations, efforts at purposive social change often have the unintended consequence of exposing the most basic sources for interorganizational power and dominance. The study of interorganizational relations during times of purposive social change, then, offers a number of advantages to those persons interested in developing the political economy perspective.

In the final section of the paper we will consider how some of the issues raised here are related to the problem of changing

the organization and delivery of health care services within communities. Before turning to these issues, however, it is necessary to look at the nature of the research project and the research findings on which this paper is based. These concerns occupy the next two sections.

RESEARCH PROBLEM AND DESIGN

The research that is partially summarized below is part of an exploratory study of nine attempts at creating prepaid health care programs in six different communities in the states of Iowa, Missouri, Kansas, and Nebraska. All of the communities are of relatively small size with the largest being a city of a little less than three hundred thousand. The significant community factor influencing the development of these programs, however, is not population size, but the nature of the interorganizational relations that constitute their health care networks. This is especially true for many rural areas where the health care network may extend over a large territory and is not limited to a single town.

Each of the health organizations studied claimed to be a part of the general "health maintenance organization (HMO) movement" that seeks to restructure health care organization and delivery. Like many similar programs of change, the general intent of HMO legislation is subject to differences in interpretation.¹² Tessler and Mechanic summarize its major intent by stating:

Its primary goals are to encourage early and preventive medical care utilization through comprehensive benefits made available to consumers on a prepaid basis, to guard against unnecessary hospitalization and surgery through financial disincentives to providers, and to foster efficiency through the pooling of resources and the effective use of health manpower.¹³

Thus, the major goals of the HMO movement are the reduction of medical costs through preventive practices, the efficient use of medical knowledge and personnel and the discouragement of unnecessary services. The Health Maintenance Organization Act of 1973 also implies that HMOs offer the opportunity to expand medical care to persons and groups that have previously not had regular access to such care, such as the poor.¹⁴ In addition, they offer a means of introducing greater consumer influence into the organization and delivery of health care services. The HMO Act, for example, requires that all HMOs have consumer membership on policy boards. In general, HMOs represent a potentially

innovative approach to health care organization and delivery that could have implications for consumers and providers alike.

Whether HMOs are effective in achieving these goals, is, of course, a subject of considerable debate. Some observers note that although HMOs may not be a panacea for current American health care problems, there is evidence that they are effective in achieving some of their goals.¹⁵ Others note that HMOs are often implemented in such a way that they either do not significantly change the established practice of medicine or they exacerbate the problem of patient powerlessness and estrangement from providers by encouraging impersonal and "assembly-line" practices.¹⁶ It is not the purpose of this paper to assess the effectiveness of HMOs in achieving their goals, nor to take sides in this debate; rather, it is to discuss some of the problems associated with their establishment in rural areas. It should be noted, however, that many of the promises of the HMO movement are of special importance to rural people because these areas are among the most disadvantaged in receiving integrated and comprehensive health care. For this reason, many persons concerned with rural health care look upon the HMO movement with considerable interest.¹⁷ The evidence indicates, however, that although HMOs may be useful in dealing with the problems of rural health care delivery, these organizations tend to locate in other areas.¹⁸

The issue of how to establish HMOs in rural areas is, then, an important one for both practitioners and theorists in the areas of health care delivery and interorganizational relations. During the time of this research (1975-76), formal government criteria defining HMOs were of little relevance in most rural communities. Like many urban prepayment programs, many rural people interested in the HMO concept found the government guidelines too restrictive and expensive; consequently, they did not seek government certification, although they did incorporate many of the characteristics of certified HMOs in their programs.¹⁹ If a stricter definition had been used, the research would have been impossible, because at that time there were no full-fledged HMOs in the rural areas of these four states. Because none of the programs were certified as HMOs, they are here referred to as "prepaid health care programs."

The major technique used in the research was the interview and, for the most part, the data were collected through interviews with as many knowledgeable persons within the community health care networks as possible. Because each health care network varied in its elements and organization, there was some variation in the types of persons and organizations contacted, but in general the sponsor or

sponsors of the prepaid programs were interviewed, as were representatives of the local medical associations and other physicians, hospital administrators, members of the local health planning councils and any other persons or agency officials who were found to be significant in influencing the fate of these programs. In all eighty persons representing sixty-one organizations, associations, or publics were contacted. In addition, public documents--such as feasibility studies, grant applications, newspaper reports and official minutes of meetings--were used to supplement the interview data.

Data were collected on the nature of the health care networks within the communities, the implications of the prepaid programs for those networks, and the responses of members of the networks to the new programs. Because the research was exploratory, the data collection and analysis techniques were qualitative, rather than quantitative. These techniques were useful in identifying the critical events surrounding the establishment of each of the prepaid programs studied. Because it is difficult to fully report on nine case studies in a short paper, we have selected three cases to discuss here. Each of these cases is representative of the general findings of the research. In addition, each represents a different approach to the introduction of prepaid health care programs into rural areas. Thus, they provide a basis for the more general discussion of the best ways to create change within the political and economic structure of rural communities. This discussion will follow the description of the cases.

THREE APPROACHES TO IMPLEMENTING PREPAID HEALTH CARE PROGRAMS IN RURAL AREAS

Case One

This case involves a collaborative attempt by a local migrant worker organization and the federal Department of Health, Education and Welfare (HEW) to provide health care services to the rural poor and others in an eight county area of this state. The local agency was originally organized by HEW to provide housing and related services to migrant workers in the 1940s and 1950s. Because many of the migrant workers remained in the area, the organization has more recently become involved in health care services. Specifically, the organization developed a health care program for the settled workers that was similar to a standard medicaid program. That is, the migrant worker organization certified the eligibility of the applicants and the local providers provided the medical services. One important problem with this program, however, was that the migrant worker organization had no control over the providers' fees and, consequently, some providers charged exorbitant fees to such patients.

Because the migrant worker organization had experience with a significant portion of the poor population and the medical providers in the area, the HEW plan for a prepayment program was implemented through it. The plan was not limited to former migrant workers, but was intended to include the general population of the area, since they all suffer from the problem of inadequate health care services. As the program developed, it became separate from its original sponsor and developed a new administrative component and new agreements with providers.

The major changes accompanying the program were for physicians. Under this plan, each physician member receives eighty percent of his or her usual fee for each prepaid patient treated. The other twenty percent was held until the end of the fiscal year (in part, to protect against cost overruns) and the money left at this time was distributed among the physicians. One reason for this practice was the desire to build into the program an incentive for reducing overtreatment. None of the other medical providers were directly affected by the program. The hospitals, for example, continued to receive fee-for-service payments.

The new program did, however, introduce a new organization into the local health care network. This organization was the administrative component of the prepaid program. Indeed, the addition of this organization into the interorganizational network was important because it continued to maintain its ties to HEW which provided funds for both the indigent members of the program and its administrators. Thus, the prepaid health care program emerged as a powerful element in the health care network of this region. In addition, its initial development and power rested on the actions of an agency outside the local area. This is one important reason why the program was resisted by many local providers, particularly physicians. There are three primary factors that account for this resistance.

The first factor is the time and location of the implementation of the program. The program was not introduced into all eight counties at the same time; rather, a three county area was initially selected for the program and it was gradually introduced into the other counties. This procedure was consistent with the general policy of the planners and administrators who hoped to continue to expand the territory of the program until it included much of this region of the state (perhaps as many as twenty-two counties). A major source of resistance to the program was the physicians located in the original three counties. Related to this, and the second factor, was resistance based on type of

medical practice and setting. Generally, the solo and small group practitioners who practice general and family medicine were most resistant to the program and the practices in the original counties were overwhelmingly of this type. Thus, the resistance of the physicians in the initial counties should not be interpreted exclusively in terms of the time factor.

A final factor influencing the resistance of some physicians (particularly, those in the original three counties) was the procedure for introducing the program. The prepaid program was designed by members of the migrant worker organization and they only included medical providers as consultants who were sought out at a very late date in the planning process. Thus, some resistance to the program stemmed from suspicions of physicians and others about the full implications of the program for their practices. This suspicion and resentment was exacerbated by two additional factors. First once the prepaid program was placed in a new organization, the issue of selecting a project director became important. According to those who resisted the program, a local congressman who had been instrumental in developing the program intervened to get a local political supporter appointed as the project director, although the person had no experience in the field of health care. A second issue involved the continued rejection by HEW of recommendations of the local health planning council about the program. Although this body approved the initial feasibility study, it consistently recommended against HEW funding of the program that was created. Each time, however, the program was funded and the opposition (particularly physicians) resented it.

In sum, although the program involved relatively little change in the practices of local providers, it was resisted because of the way it was introduced. Of special importance here is the fact that it was initiated by two organizations (HEW and the migrant worker organization) outside the local health care network. Indeed, the program did not gain significant provider support until it was expanded into a new area that contained a large multi-specialty clinic.

Case Two

Program Two involved a prepaid plan developed by a hospital located in a city of about one hundred thousand. It differed from Case One in that the sponsor is an active member of the community health care sector and its impact was primarily limited to the immediate community and its periphery. This program is also unique because it was still in the planning stage at the time of the research and it was, therefore, impossible to study the full process

of implementation. At the same time, the planning was sufficiently developed that it was possible to assess the responses of other members of the community's health care sector. In fact, as will be seen later, the significant factor of concern to the program planner was not the responses of local health care providers, but uncertainty about the requirements of federal certification as an HMO.

Another difference between Case Two and Case One is that this program was initiated by a hospital that has been operating a type of prepaid program for many years. The hospital was originally built and operated by a railroad company that limited hospital services to employees and their dependents. It has employed a full-time staff of physicians and other medical personnel who work for the hospital exclusively. In addition, the board of directors of the hospital has been dominated by members of the railroad company, both management and labor. Thus, for the past forty years the railroad has operated on principles that are consistent with the HMO movement.

More recently, the hospital has shifted from a strict orientation to the railroad company to a more community-based approach. Specifically, the hospital has begun to accept patients from the larger community, regardless of their occupational affiliations, and it allows its physicians to maintain limited fee-for-service practices outside the hospital. At the same time, the board of directors of the hospital continues to be dominated by railroad company employees and the majority of the hospital's patients are affiliated with the railroad.

The history of the hospital is important in identifying its place in the community health care sector. Specifically, the hospital has been an important, but isolated member of the health care network. It has served a restricted clientele that is recognized and easily identifiable within the community. In doing so, it has not competed with existing hospitals that serve different segments of the community. The physicians who have worked for the hospital have also restricted their practices to the hospital setting and have not been involved in either competitive or collaborative relations with other physicians. Even with the expansion of hospital and physician services into the larger community, the impact has been quite limited. Consequently, it is possible to characterize the hospital, its staff, and clientele as isolated parts of the health care network that are defined by clearly understood notions about proper domain.

For the most part, the prepaid program of the hospital was simply an extension of its past activities and more recent movement into the nonrailroad segments of the community. As such it involved relatively little change in the ongoing practices of other elements of the health care sector. First, the program had little impact on physicians because the primary care services would be provided by three new primary care physicians who would be recruited from outside the community and would work for the prepaid component of the hospital exclusively. Specialist services would be paid on a fee-for-service basis. Because the hospital was developed as a more or less self-contained health facility, many of the services that might otherwise involve outsiders--such as laboratory services--were already available in the hospital and would, therefore, involve no change for these elements of the community health care network. Similarly, the board of directors and administration of the prepaid program would be the same as those of the larger hospital.

The responses by members of the health care sector of the community were neither supportive or oppositional; indeed, most responses can best be characterized as indifferent. The county medical society, for example, originally established a liaison committee to keep informed on the hospital's plans, but disbanded it after only two meetings. In addition, interviews with physicians and hospital administrators in the community indicated a widespread state of ignorance about the program and very little desire to know more about it. The indifferent response of members of the health care network was reflected in the planners' feeling that the most significant problem retarding the implementation of the program was the federal government (HEW) and the various restrictions placed on programs seeking HMO certification.

In sum, the program was conceived by an isolated and somewhat marginal member of the health care network. The isolation and marginality of the hospital was largely based on the generally recognized domain of this organization that limits its impact primarily to one segment of the community. The prepaid program was seen as an extension of that domain into the larger community, but not a sufficient expansion to alter the hospital's domain or relationship with other health care elements.

Case Three

Program Three was initiated by two organizations. One of the collaborators was a private-nonprofit insurance company that was responsible for the recruitment of members and the insurance aspects of the program, e.g., collecting premiums and paying charges. The other component was a multi-speciality clinic in a

small town (less than three thousand people) which primarily served the local and the surrounding communities.

The clinic was begun by a physician who formerly worked for the Mayo Clinic and wished to return to his hometown and reproduce it on a smaller scale. Thus, he wished to bring together a number of specialists into a professional corporation which would provide specialized treatment as well as primary care services to persons in the area. At the time of this study, the success of the clinic was reflected in a number of ways. First, the clinic had a relatively large staff of physicians and others who provided highly specialized services, including obstetrics, dermatology, surgery, internal medicine, pediatrics, optometry, dentistry, ophthalmology, psychiatry, and psychiatric social work. Second, the clinic was the major health care organization that served not only persons in the immediate community, but patients from larger communities in surrounding counties. Third, there was only one other physician in the county and he was part of the prepaid program. Using involvement in some aspect of the clinic as the major criterion, then, the clinic controlled all physician services in the community. Finally, the success of the clinic was reflected in its ability to get a hospital built in the community (about 25 years earlier) even though sufficient hospital facilities were available in nearby towns. It has expanded as the clinic has grown and demanded new facilities and services.

Utilizing Lehman's terminology, this clinic was a type of health care empire because it controlled most of the local health care agencies and resources.²⁰ In addition, it was significant in shaping the health care networks of surrounding communities by competing with nearby physicians and hospitals for patients. Indeed, the initiation of the prepaid program is best understood within the larger context of the region, because its implementation was an attempt to expand the domain of the clinic to outlying areas.

The prepaid program involved little meaningful change in the organization and delivery of health care services. All of the providers continued to operate as they had in the past with no new controls over their operations. In addition, most of the established financial arrangements remained. The non-clinic physician continued to charge the insurance company on a fee-for-service basis, as did the hospital and any other providers outside the clinic who might be used. The physicians within the clinic were only indirectly affected by the prepaid program because they continued to receive their salaries from the clinic. The impact of the program was indirect in that the physicians--being partners in the corporation--shared in the profits of the clinic at the end of the year. The physicians found it in their best interests to minimize overtreatment because the insurance company paid the clinic a capitation fee based on the number of patient members and any

money saved from the capitation fee (profits) was distributed among the clinic physicians.

The only source of resistance to the program came from providers in the surrounding counties. Several physicians and medical societies in these counties protested to the state medical society and the state insurance commissioner. The claim of the protesting physicians (which was supported by some hospital administrators) was that the prepaid program was one more ploy in the continuing strategy of the clinic to win patients from the surrounding area. The state insurance commissioner responded by requiring the prepaid program officials to abide by any decision made by the state medical society on the matter. The state medical society placed two limitations on the program. First, the clinic could not offer the prepaid program to any out-of-county patients who had not been using clinic services for two years. Second, the clinic had to offer membership in the prepaid program to all physicians in the surrounding area. Not surprisingly, none of the physicians accepted membership. Because the state medical society limitation was for only three years, some of the competing physicians began to organize themselves into group practices that could eventually offer similar prepaid programs.

The third prepaid program, then, involved a sponsoring organization that was centrally located within two interrelated health care networks. It was the dominant organization within its community and an important organization in the health care network of the region. The involvement of the clinic in the prepaid program was based on the competitive relations of the larger region and officials of the clinic explicitly stated their primary concern was with expanding their clientele. The major opposition to the program, then, stemmed from competing providers in nearby counties.

DISCUSSION AND CONCLUSION

The above descriptions involve several issues of importance for students of purposive social change. First, despite the rhetoric of the HMO movement, each program involved limited commitment to it. None of the programs, for example, was significantly committed to preventive health care programs, little effort was directed to providing health care services to previously excluded groups, and they did not offer new avenues for the expression of patient concerns or control over health care organizations and professionals. Instead, each of the sponsors used the rhetoric of the HMO movement for their own ends. The migrant worker organization and HEW used the HMO movement as a means to justifying their alteration of the existing pattern of funding health care for the poor, the hospital used the HMO movement to justify expansion of a previous policy toward greater community

involvement, and the sponsoring clinic used the HMO movement as a mechanism for making inroads into new sources for patients in the surrounding counties.

Looked at one way, then, these findings indicate that organizations use programs of social change in order to better pursue their political and economic goals. There is, however, at least one other way of looking at these cases and findings. Each of the cases involves a somewhat different point of introduction of change into the communities and their surrounding regions. In the first case change was initiated by two organizations that were tenuously connected to the health care networks of the affected communities. In the second case the sponsor of the program was an established member of the community health care network, although it was somewhat isolated based on its ties to the railroad. The third case involved the introduction of change through an insurance company that was external to the community and a clinic that controlled significant portions of the affected area.

Because two of the three cases described have become operational and the other case has neither succeeded or failed, it can be claimed that each of them offers a different example of how purposive social change can be introduced into rural areas. On the other hand, if purposive social change is conceptualized as involving some degree of commitment to the development of new approaches to social problems, then all of them cannot be seen as equally promising. Notably the third case involves no attempt or real incentive to redefine health care and the problems associated with it. Although the capitation arrangement between the clinic and the insurance company may be seen as one mechanism for encouraging physicians to minimize overtreatment and to encourage preventive health practices, the major thrust of the program is not in the direction of redefining the health care problem, the organization of health care services or the place of the consumer in the health care network. Rather, this case is an example of how programs of change can be coopted by established organizations so that few or none of the aims of the program are achieved.

The first case offers a better approach because it involves two organizations that are connected to the local health care network, but they are not directly involved in it. It could be assumed that such agencies are not so likely to define their self interests in terms of the local market for patients. The problems with this approach are apparent in the above description. First, such an approach involves implementation through existing health care organizations that may not view the new program favorably. A second problem with this approach is that the sponsors are external

to the affected communities and this may give rise to local resistance. Such resistance may be exacerbated when local providers are ignored by the planners and funders, as occurred in Case One. The problems of such a strategy are the same as those described by Warren, et. al.; that is, the local organizations and professionals that are needed to implement the new program either coopt the innovation by redefining it within existing modes of thought and action, or they attempt to destroy it by refusing to cooperate with the sponsor or by engaging in political activities to discredit it.²¹

A third approach to implementing purposive social change is offered by Case Two in which an established, but non-competitive, agency within the community health care network is the sponsor of the program. Several factors deserve special note here. First, the sponsor of the program exists as an established part of the community health care network. This means that the sponsor has worked within the prevailing agreements about interorganizational domains, norms and modes of thought and it is not an outside agency that is "imposing" itself on the local providers. Indeed, in this case the sponsor is an accepted and trusted member of the health care network of the community; rather, it has traditionally dealt with a limited clientele and responded to a special and limited set of community interests. Such a position has allowed the sponsor to respond to its constituency in ways that have been different from the prevailing community patterns without incurring serious opposition from other health care elements. Finally, the sponsor is an established health care provider that is organized to provide a wide range of health care services without fundamentally altering its traditional structure. Thus, the prepaid program does not involve the establishment of a new agency in the community nor does it significantly alter the number and types of health care professionals.

What we are suggesting is that many interorganizational networks contain members that are accepted, but marginal. In such networks, the marginal member is freer to innovate because such activities are less likely to be perceived by other organizations as threatening to the existing patterns of resource distribution. To use the language of Benson, it is insufficient to only be concerned with the monetary resources of interorganizational networks.²² Intervention policies must also consider the issue of authority (agreements about organizational domain). When authority is considered, the range of viable sponsors for innovative programs is limited. In the case of prepaid health care programs in rural areas, such sponsors might include railroad affiliated hospitals, university medical centers, union sponsored health programs, or rural co-ops. Because

programs of purposive change involve considerable time, staff and money, agencies interested in facilitating change should be selective in the organizations that are used as community-based sponsors. In some cases, appropriate sponsors may be unavailable and other strategies must be used, but the risks of local opposition and cooptation are greater in these communities.

In conclusion, the political economy perspective on interorganizational relations is a useful approach to understanding the dynamics and problems of purposive social change. By emphasizing the importance of resource acquisition in interorganizational relations, this approach sensitizes observers to the political and economic consequences of change. Equally important, it provides a theoretical framework for developing intervention strategies that minimize some of the problems associated with purposive change. The above discussion of prepaid health care programs is one example of the usefulness of this approach.

REFERENCES

The data that are included in this paper were collected, in part, for Gale Miller's Ph.D. dissertation, "Organizational and Professional Responses to Change: A Sociological Study of the Environmental Responses to Health Maintenance Organizations," University of Kansas, 1976. The research was partially funded through the Office of Research Administration and the Graduate College of the University of Kansas (project number 3292-5038).

1. Roland L. Warren, "Types of Purposive Social Change at the Community Level," Brandeis Paper on Social Welfare no. 11 (Waltham, Mass.: Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, 1966).

2. See Walter B. Miller, Rainer C. Baum and Rosetta McNeil, "Delinquency Prevention and Organizational Relations," in *CONTROLLING DELINQUENTS*, ed. Stanton Wheeler (New York: John Wiley & Sons, Inc., 1968): 61-100; Roland L. Warren, Stephan M. Rose and Ann F. Bergunder, *THE STRUCTURE OF URBAN REFORM: COMMUNITY DECISION ORGANIZATIONS IN STABILITY AND CHANGE* (Lexington, Mass.: D. C. Heath and Company, 1974); Nancy Milio, "Health Care Organizations and Innovation," *JOURNAL OF HEALTH AND SOCIAL BEHAVIOR* 12 (June 1971a): 163-173; Nancy Milio, *NINETY TWO TWENTY SIX KERCHEVAL: THE STOREFRONT THAT DID NOT BURN* (Ann Arbor: University of Michigan Press, 1971b).

3. Warren, (1966).

4. Norton E. Long, "The Local Community as an Ecology of Games," *AMERICAN JOURNAL OF SOCIOLOGY* 64 (November 1958): 251-261; Herman Turk, "Interorganizational Networks in Urban Society: Initial Perspectives on Comparative Research," *AMERICAN SOCIOLOGICAL REVIEW* 35 (February 1970): 1-19; Roland L. Warren, "The Interorganizational Field as a Focus for Investigation," *ADMINISTRATIVE SCIENCE QUARTERLY* 12 (1967): 396-419; Roland L. Warren, *THE COMMUNITY IN AMERICA* (Second Edition) (Chicago: Ran McNally, College Publishing Company, 1972).

5. Sol Levine and Paul E. White, "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," *ADMINISTRATIVE SCIENCE QUARTERLY* 5 (1961): 583-601; Eugene Litwak and Lydia F. Hylton, "Interorganizational Analysis: A Hypothesis on Coordinating Agencies," *ADMINISTRATIVE SCIENCE QUARTERLY* 6 (1962): 395-415; William R. Dill, "The Impact of Environment on Organizational Development," in *CONCEPTS AND ISSUES IN ADMINISTRATIVE BEHAVIOR*, ed. Sidney Mailick and Edward H. Van Ness (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1962): 94-109; Michael Aiken and Jerald Hage, "Organizational Interdependence and Intra-Organizational Structure," *AMERICAN SOCIOLOGICAL REVIEW* 33 (December 1968): 913-930.

6. William M. Evan, "The Organization Set: Toward a Theory of Interorganizational Relations," in *APPROACHES TO ORGANIZATIONAL DESIGN*, ed. James D. Thompson (Pittsburgh: University of Pittsburgh Press, 1966): 173-188.

7. Charles Perrow, "A Framework for the Comparative Analysis of Organizations," *AMERICAN SOCIOLOGICAL REVIEW* 32 (April 1967): 194-208; Charles Perrow, *ORGANIZATIONAL ANALYSIS: A SOCIOLOGICAL VIEW* (Belmont, Cal.: Brooks/Cole Publishing Company, 1970); Warren, et al. (1974).

8. J. Kenneth Benson, "The Interorganizational Network as a Political Economy," *ADMINISTRATIVE SCIENCE QUARTERLY* 20 (1975): 229-249; Burton Gummer, "A Power-Politics Approach to Social Welfare Organizations," *SOCIAL SCIENCE REVIEW* 52 (September 1978): 349-361; Mayer N. Zald, "Political Economy: A Framework for Comparative Analysis," in *POWER IN ORGANIZATIONS*, ed. Mayer N. Zald, *ORGANIZATIONAL CHANGE: THE POLITICAL ECONOMY OF THE YMCA* (Chicago: University of Chicago Press, 1970b); Gary Wamsley and Mayer N. Zald, *THE POLITICAL ECONOMY OF PUBLIC ORGANIZATIONS: A CRITIQUE AND APPROACH TO THE STUDY OF PUBLIC ADMINISTRATION* (Lexington, Mass.: D. C. Heath and Company, 1973).

9. Benson (1975).

10. Ibid.

11. Gummer (1978); Zaid (1970b).
12. Roger W. Birnbaum, HEALTH MAINTENANCE ORGANIZATIONS: A GUIDE TO PLANNING AND DEVELOPMENT (New York: Spectrum Publications, Inc., 1976); Neil F. Bracht, HEALTH MAINTENANCE ORGANIZATIONS: AN ANALYSIS (Washington, D. C.: National Association of Social Workers, 1974); Lawrence G. Goldberg and Warren Greenberg, THE HEALTH MAINTENANCE ORGANIZATION AND ITS EFFECTS ON COMPETITION (Washington, D. C.: Federal Trade Commission, 1977); Doman Lum, "The Health Maintenance Organization," SOCIAL WORK 18 (September, 1973): 16-25; Joel May, "Introduction - Restructuring the Health Delivery System - Will the Health Maintenance Strategy Work?," THE PROCEEDING OF THE THIRTEENTH ANNUAL SYMPOSIUM ON HOSPITAL AFFAIRS, HEALTH MAINTENANCE ORGANIZATIONS: A RECONFIGURATION OF THE HEALTH SERVICES SYSTEM (Chicago: University of Chicago Press, 1971): 2; James M. Rosser and Howard E. Mossberg, AN ANALYSIS OF HEALTH CARE DELIVERY (New York: John Wiley and Sons, 1977).
13. Richard Tessler and David Mechanic, "Consumer Satisfaction with Prepaid Group Practice," JOURNAL OF HEALTH AND SOCIAL BEHAVIOR 16 (March 1975): 95.
14. U. S. Congress, "Health Maintenance Organization Act of 1973," UNITED STATES CODE 1 (St. Paul, Minn.: West Publishing Company, 1973-74): 1015-1042.
15. Goldberg and Greenberg (1977); Merwyn R. Greenlick, "The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation," THE ANNALS OF THE AMERICAN ACADEMY OF POLITICAL AND SOCIAL SCIENCE 399 (January 1975): 100-113; Harold S. Luft, POVERTY AND HEALTH: ECONOMIC CAUSES AND CONSEQUENCES OF HEALTH PROBLEMS (Cambridge, Mass.: Ballinger Publishing Company, 1978); Ernest Seward, Janet Blank and Henry Lamb, SOME INFORMATION DESCRIPTIVE OF A SUCCESSFULLY OPERATING HMO (Washington, D. C.: Department of Health, Education, and Welfare, 1973); Ernest Seward and Merwyn R. Greenlick, "Health Policy and the HMO," THE MILBANK MEMORIAL FUND QUARTERLY 50 (April 1972): 147-176.
16. Emil Berkanovic, Leo G. Reeder, Alfred C. Marcus and Susan Schwartz, PERCEPTIONS OF MEDICAL CARE: THE IMPACT OF PREPAYMENT (Lexington, Mass.: Lexington Books, 1974); David Kotelnick ed., PROGNOSIS NEGATIVE: CRISIS IN THE HEALTH CARE SYSTEM (New York: Random House 1976).

17. Group Health Association of America, Inc., RURAL HEALTH CARE DELIVERY: PROCEEDINGS OF A NATIONAL CONFERENCE ON RURAL HEALTH MAINTENANCE ORGANIZATIONS (Washington, D. C.: U. S. Government Printing Office 1974); Milton I. Roemer, "Historical Perspective of Health Services in Rural America," in RURAL HEALTH SERVICES: ORGANIZATION, DELIVERY, AND USE. ed. Edward W. Hassinger and Larry R. Whiting (Ames, Iowa: Iowa State University Press, 1976): 3-25.

18. Richard McNeil and Robert E. Schlenker, "HMOs, Competition, and Government," THE MILBANK MEMORIAL FUND QUARTERLY: HEALTH AND SOCIETY 53 (Spring 1975): 195-224.

19. For discussions of these problems, see U. S. General Accounting Office, EFFECTIVENESS OF GRANT PROGRAMS AIMED AT DEVELOPING HEALTH MAINTENANCE ORGANIZATIONS AND COMMUNITY HEALTH NETWORKS (Washington, D. C.: Department of Health, Education, and Welfare, 1975); U. S. General Accounting Office, FACTORS THAT IMPEDE PROGRAMS IN IMPLEMENTING THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973 (Washington, D. C.: Department of Health, Education, and Welfare, 1976).

20. Edward W. Lehman, COORDINATING HEALTH CARE (Beverly Hills, Cal.: Sage Publications, 1975).

21. Warren, et. al. (1974).

22. Benson (1975).