DETERMINANTS OF CONSUMERS’ HEALTH BEHAVIORS: THEORY AND EMPIRICAL TEST

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ABSTRACT

Research suggests that consumers’ beliefs can have important effects on their utilization of health care services and health information as well as their enactment of various health maintenance activities (Lau 1988; Oliver and Berger 1979; Rosenstock 1974; Zaltman and Verhulst 1971). One type of belief, health locus of control, has received a great deal of attention in the literature. Health locus of control (HLC) reflects the extent to which consumers believe health outcomes are contingent upon their own behaviors, capacities, and personal qualities (i.e., internally controlled) or alternatively, are under the control of health professionals, luck, or are uncontrollable (i.e., externally controlled).

Research investigating the effects of HLC beliefs has shown that compared to individuals with an external HLC, individuals with an internal HLC have higher levels of health knowledge (Seeman and Evans 1961); are more likely to engage in a variety of preventive activities (Dabbas and Kirscht 1971); and are more likely to take action and follow treatment regimens if disease is contracted (Wallston, Maida, and Wallston 1976).

Despite these findings, other research has failed to replicate health locus of control effects for these and other health behaviors (see Lau 1988; Strickland 1978; Wallston and Wallston 1978 for a more complete discussion). For example, some research has found that health locus of control has no relationship to smoking reduction (Lichtenstein and Keutzer 1967), weight loss (Manno and Marson 1972), use of contraceptives (Phares 1976), and utilization of outpatient health services (Kern 1974).

The present research suggests that these contradictory findings may be caused, in part, by variation in other important individual and situational characteristics. To systematically test for this possibility, a comprehensive model of the effects of health locus of control beliefs on health behaviors is proposed. This model includes five individual characteristics (health status, health knowledge, preventive orientation, and curative orientation) and two situational characteristics (perceived behavioral control, and income) on the relationships between health locus of control beliefs and health behaviors (see Moorman and Matulich 1991 for a more detailed presentation of the theory driving this research).

The framework was tested in an exploratory fashion using a randomly selected sample of 180 staff members at a Northeastern University. Ninety-five individuals returned the mail surveys, resulting in a 52 percent response rate. Health locus of control was measured using the Lau and Ware HLC Scale (Lau and Ware 1981). This scale assesses four HLC belief dimensions: beliefs in self control over health (HLCSELF), beliefs in provider control over health (HLCPROF), beliefs in chance health outcomes (HLCCCHANGE), and beliefs in the existence of general health threats (HLCTHREAT). HLCSELF is internally oriented, while the other three HLC dimensions are externally oriented. The effects of these beliefs were assessed on various health behaviors, including health information seeking behaviors and health maintenance behaviors. These health behaviors were classified as primarily self-oriented (e.g., diet restriction, stress reduction) or health-provider oriented (e.g., going for check-ups).

To summarize a few of our preliminary results, HLCSELF had a positive and significant relationship with self dependent health behaviors, but had no relationship with provider dependent health behaviors. HLCPROF, on the other hand, had a positive and significant relationship with provider dependent health information seeking behaviors and a negative and significant relationship with self dependent health behaviors; HLCCPROF was not related to the provider dependent health maintenance behaviors. HLCTHREAT and HLCCCHANCE were not significantly related to any dependent health behaviors.

Turning to the moderating influences, all seven individual and situational characteristics interacted significantly with the various health locus of control beliefs to predict various health behaviors. Although the interactions were significant, they were not always in the hypothesized direction. For example, high income strengthened the relationship between HLCSELF and self dependent information seeking and diet restriction; however, it weakened the relationship between HLCSELF and stress reduction.

This research has several theoretical and managerial implications. The key theoretical contribution of this research is the comprehensive nature of the proposed framework. By including the moderators and a variety of relevant dependent variables, the
research provides a more complete picture of the effects of health locus of control beliefs. With regard to managerial implications, results could be used to design health programs to: 1) reinforce existing relationships between productive health belief and health behavior patterns and 2) change existing relationships between unproductive health beliefs and health behavior patterns.

Limitations of this research include the relatively small sample size, which makes subgroup analysis problematic. Moreover, several of the scales used in this research had low reliabilities, suggesting that further refinement in these scales may be necessary to adequately test the proposed framework.

References available from the first author.

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