ATTITUDES OF MICHIGAN RESIDENTS TOWARD GOVERNMENT- SPONSORED PREPAYMENT PLANS FOR HEALTH CARE

Thesis for the Degree of M. A.

MICHIGAN STATE COLLEGE

Sheldon G. Lowry

1950

This is to certify that the

thesis entitled

"Attitudes of Michigan Residents
Toward Government-Sponsored
Prepayment Plans for Health Care"

presented by

Sheldon G. Lowry

has been accepted towards fulfillment
of the requirements for

M.A. degree in Sociology

Charles R. Hoffer
Major professor

Date Mar. 7, 1950

O-169

ATTITUDES OF MICHIGAN RESIDENTS TOWARD GOVERNMENT-SPONSORED PREPAYMENT PLANS FOR HEALTH CARE

By
SHELDON G. LOWRY

A THESIS

Submitted to the School of Graduate Studies of Michigan State College of Agriculture and Applied Science in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

Department of Sociology and Anthropology

1950

ACKNOWLEDGEMENT

The writer expresses his appreciation to all members of the Department of Sociology and Anthropology at Michigan State College, especially to Dr. Charles R. Hoffer who directed the study and guided the writing of this thesis, to Dr. Charles P. Loomis, Head of the Department of Sociology and Anthropology and Director of the Social Research Service, and to Dr. Duane L. Gibson who proved an invaluable source of information for the statistical computations used in the study. Appreciation is also due to Betsey Castleberry and Fay Blakely who read the manuscript and made many valuable suggestions.

TABLE OF CONTENTS

PAGE

LIST OF TABLES

TABLE PAGE

CHAPTER I

SOCIAL CHANGE AND HEALTH INSURANCE IN THE UNITED STATES

The idea of applying the insurance principle to sickness had its beginning in the United States almost 100 years ago, though early attempts to provide health insurance were not successful.[1] In practice health insurance takes many forms. However, in principle it implies a periodic prepayment of a fixed sum of money in return for certain financial or medical benefits during illness.

Health insurance, and for that matter any social measure, is the result of certain lines of social evolution which have been molded and shaped by the various social pressures and forces over a long period of time. Among the numerous factors which have been important in the development of health insurance measures the industrial revolution has probably had the greatest effect. Along with the benefits of the industrial revolution came also such misfortunes as low wages, inferior jobs, unemployment, inflation, deflation, lack of personal property, accidents, sickness, and a general lack of security for the industrial workers and their dependents. Social security from these adversities was sought in mass organization.

Another factor which has been influential in the development of health insurance is the great strides in the scientific progress in

---

1 Helen Hershfield Avnet, Voluntary Medical Insurance in the United States: Major Trends and Current Problems, New York: Medical Administration Service, Inc., 1944, p. 1.

2 A. M. Simons and Nathan Sinai, The Way of Health Insurance, Chicago: The University of Chicago Press, 1932, pp. 15, 41.

methods of diagnosis and treatment of diseases. The great advances made in the science of medicine no longer limits medical practice to the traditional methods of diagnosis and treatment, but old remedies are discarded as soon as others have been demonstrated to be better.

Probably as important as the great advances in the field of medicine is the fact that the conception of prevention and treatment of disease has become broadened to include social concern and social action. Heretofore, sickness was a matter left entirely to the individual doctors and their patients, but such a view has disappeared with the advance of medical science and the increased understanding of the social significance of good health. The following statement is indicative of the changing attitude toward the whole approach of protection against sickness: "Long life without health is not only an individual, personal tragedy, but a social evil seriously threatening national economy".[3]

Along with the advances of medicine has developed a large body of well trained men and women, highly organized and centralized largely in urban areas, but locally and nationally concerned with all phases of health and medical care. This centralization is the result of the shift from a rural-handicraft economy to an urban industrial economy. In many sections doctors have become so busy that they have found it difficult, if not impossible, to make house calls and still care for the patients at the office. Therefore, in many instances house calls have been discouraged or even discontinued. Others have increased the price of house calls to compensate for the extra time and money involved in traveling. Because of this, and in spite of modern transportation facilities,

---

3 Edward J. Stieglitz, editor, Geriatric Medicine Diagnosis and Management of Disease In the Aging and In the Aged, Philadelphia: W. B. Saunders Company, 1934, p. 4.

many people have become somewhat isolated from adequate medical care. This is particularly true of rural areas.[4]

The scientific advancement of medicine, though more effective, has also been a factor in the increased cost of medical care. When medical equipment was limited to what a physician could carry in his bag and medical knowledge was limited to what he could retain in his head, the cost of medical care was reasonable and predictable for the individual patient. Even when illness did strike the economic effect was not necessarily catastrophic. The poor were cared for by the community and in many cases without charge by the charitable physician. However, with the scientific advancement of medical knowledge, the training and the equipment necessary to practice modern medicine have become very expensive. Hence, medical facilities, to be utilized to their maximum efficiency, have become very costly.

Social action in the field of health, to be made more effective, came to be supported by the government because it was recognized that the function of the government was no longer simply one of ruler and protector, but that it also had an important function as a positive agency in the promotion of human welfare. As a result of this development came the vast programs of immunization, sanitation, quarentine and disease prevention - - - the whole tatics of war upon disease being

---

4 For a comparison of rural and urban medical facilities in Michigan see: Charles R. Hoffer, "Health and Health Services in Three Michigan Communities," East Lansing: Michigan State College Agricultural Experiment Station (Section of Sociology and Anthropology), Quarterly Bulletin, Article 31-12, August, 1948. Also Charles R. Hoffer, "Health and Health Services for Michigan Farm Families," East Lansing: Michigan State College Agricultural Experiment Station (Section of Sociology and Anthropology), Special Bulletin 352, September, 1948.

shifted to one of mass social action supported by the government. This new concept of government, largely a product of the last half century spread throughout almost every nation and is receiving increased acceptance.[5]

The earliest prepayment plans as we know them today were set up in the latter part of the 19th century by lumbering, mining and railroad companies.[6] During the last quarter of the nineteenth century before workmen's compensation and social security laws were instigated and before costly medical techniques had been developed, loss of earning caused by accidents and illness was a greater financial risk than were the costs of medical care. As a result, losses were cushioned by disability benefits by the aforementioned companies. This was also the primary protection offered by the commercial companies and non-profit associations which developed later.[7]

As medical service became more available and medical costs began to rise medical care absorbed an increasing proportion of the wage-earner's budget. As indicated by Anderson,[8] 10 percent of the people pay for 40 percent of the costs of medical care in any given year, and that even though the data are not available a higher percentage of the people undoubtedly paid a lower proportion of the total costs of medical care 100 or even 50 years ago. Consequently, cash benefits started to give way to medical benefits. There was not only a gradual change from an economic to a medical emphasis, but there was also a steady extension of

---

5 Simons and Sinai, op. cit., pp. 18-19.

6 Frederick D. Mott and Milton I. Roemer, Rural Health and Medical Care, New York: McGraw-Hill Book Company, Inc., 1948, p. 438.

7 Avnet, op. cit., p. 2.

8 Odin W. Anderson, "The Health Insurance Movement in the United States: A Case Study of the Role of Conflict in the Development and Solution of a Social Problem," Published Doctoral Dissertation, Publication 959, University of Michigan, 1948, p. 249.

coverage from the mining, lumbering, railroad, and industrial workers to the commercial, office and agricultural workers. Also, benefits were gradually extended to the families of these employees. The over-all trend was one of a gradual shift from protection against poverty caused by illness to one of preservation of health.

Commercial companies were successful in 1890 in issuing policies indemnifying the holders against loss of earnings because of certain illnesses. Some of the more important items of interest in connection with these early policies are worth noting here.[9] Policies were held separately, for group insurance was not known at that time. There was a period, usually the first seven days of illness, during which loss of earnings was not compensable. Benefits were usually limited to a maximum of 26 weeks. The policy holder received indemnity for only a limited number of diseases which were specifically stated. However, after the turn of the century the list was somewhat expanded, but the cost of coverage was beyond the financial reach of a large proportion of the population having low incomes.

Because of the failure of commercial companies to provide services within the budget limitations of large numbers of the population in the lower and middle income brackets, and because society had still failed to meet the problems of insecurity which had evolved from the changing social and industrial order, limited benefits began to be offered, in the latter part of the nineteenth century and the early part of the twentieth century, by such non-profit associations as fraternal societies, employee's mutual benefit associations, and trade unions.[10] The benefits offered by these organizations were very meager, being limited in most cases to financial benefits with no medical care provided. Their influence

---

9 Avnet, op. cit., p. 3.

10 Ibid., p. 4.

was so small that they had little or no effect on the total scheme. The organized influence of trade unions was not felt until recent years.

That period in the development of health insurance in the United States from 1850 to 1910 was one of experimentation and trial and error. Some of the more important trends and contributions of this period may be summarized as follows:

1. The Industrial Revolution and the changing social order which accompanied it was the basic factor in the origin and development of health insurance.

2. Scientific advances in the medical field and its subsequent centralization had the effect of isolating large numbers of the population both physically and financially from adequate medical care.

3. In the beginning cash benefits to the insured for loss of wages during illness was of first importance, but there was a gradual shift to an emphasis on medical care with cash benefits receiving only a secondary consideration.

4. There was a growing recognition of the need for unifying all health activities into a well organized and highly coordinated program.

5. The government was also becoming vitally interested in public health and was beginning to exert a more dominant influence in other aspects of health.

6. Some of the more important contributions to the field of health insurance which these early experiences provided were the following: the use of the periodic prepayment method to finance a health program; the waiting period before benefits begin; and maximum benefits specifically stipulated in advance.

CHAPTER II

TWO CAMPAIGNS FOR GOVERNMENT HEALTH INSURANCE

Government health insurance in the United States has been under active discussion in two distinct periods.[11] The first period began in the pre-World War I era about 1912 and extended to 1920 when it gradually died out. The next movement began about 1927 and, with the exception of a lull during the war years, has become increasingly active to the present time (1950).

THE EARLY CAMPAIGN

The first American campaign for government health insurance had two distinct phases. One was a period of education preparation which culminated in the publication of the "Standard Bill" in November of 1915. The second phase was a period consisting largely of legislative consideration, the "opening gun" being fired in 1915 by the "Standard Bill" and continuing to 1920 when interest gradually waned.

As early as 1907 Henry R. Seager, at the first annual meeting of the American Association for Labor Legislation held at Madison, Wisconsin, outlined a program of social legislation making special reference to wage-earners. He emphasized that illness which was not directly traceable to employment should be sought either in compulsory sickness insurance or in subsidized and state-directed sickness insurance clubs. He indicated his preference for the latter plan because he felt that it was better adapted to American conditions than compulsory sickness insurance.[12]

---

11 For a comprehensive historical analysis of the health insurance movement in the United States see: Anderson, op. cit.

12 Pierce Williams, The Purchase of Medical Care Through Fixed Periodic Payment, New York: National Bureau of Economic Research, Inc., 1932, p.34.

During the year following Mr. Seager's statement there was a definitely increased interest in compulsory health insurance by social scientists and social workers throughout the United States. It was during this year (1908) that the Russell Sage Foundation sent Dr. Lee K. Frankel, a social work administrator, and Miles M. Dawson, consulting insurance actuary, to Europe to study the various systems of social insurance which were already in operation there. The findings of these two men were published by the Foundation in 1910 and were entitled "Workingmen's Insurance in Europe".[13] This report did much to stimulate the early movement in this country.

Mr. Louis D. Brandeis, in addressing the social workers at the National Conference of Charities and Corrections (later called the National Conference of Social Work) early in 1911, emphasized the need for social insurance against illness, unemployment, invalidity, and old age. At this meeting the Conference appointed a "Standards of Living and Labor" committee to study and to formulate standards of occupational life necessary to prevent social distress. The committee presented its report at the annual meeting of the Conference held in Cleveland the next year, 1912. The sixth and last of the minimum standards which they presented called for an effective system of compensation or insurance for heavy losses due to accident, illness, old age and unemployment. The report, accepted by the Conference, was taken to the National Convention of the newly formed Progressive Party in Chicago. Here it was embodied in the party's platform on social legislation. At the meeting of the Conference in Seattle the next year Mr. Frank Tucker presented his presidential address on "Social Justice" in which he emphasized the necessity of a provision for sickness.

---

13 Ibid., pp. 34-35.

It was during the year 1911 that workmen's compensation laws were introduced in the important industrial states. These laws made employers liable for losses suffered while workers were on the job. However, it should be mentioned that the original workmen's compensation bill contained a medical aid provision which was dropped in the legislature. This was not remedied until 1917 when the Medical Aid Act was passed to provide medical and surgical care for industrial injuries. It is notable that some of the better medical plans now in operation and sponsored by industry had their origin during this same period. Two examples are the Endicott-Johnson plan and the Tennessee Coal and Iron Railroad Company plan. According to Avnet,[14] the workmen's compensation laws were an educational instrument which drew the attention of progressive employers to the health problems of their employees. Aside from this educational effect they have probably had little influence on the movement for non-industrial health insurance.

It was also during 1911 that the principle of group insurance was first used in life insurance. However, it was not adapted to the health insurance program until 1920, as will be discussed later.

The "opening gun" of the early American campaign was probably fired in December of 1912 when the American Association for Labor Legislation created a National Committee on Social Insurance. This Committee organized the first national conference on the subject of social insurance. At the first meeting, which was held in 1913, an outline was drawn up which the Committee followed in drafting a bill for health insurance.

After two years of labor, with the aid of the American Medical Association, the Committee issued nine standards for a health insurance

---

14 Avnet, op., cit., pp. 6-7.

law. Then in November the first tentative draft of the "Standard Bill" was published.[15] The movement immediately preceding this bill was undoubtedly influenced by the adoption of the British Insurance Act of 1911; however, the bill itself seems to be an adaptation of the German model.

Probably the next stepping stone for the whole social insurance program was to be the International Conference on Social Insurance which was scheduled for 1915 in Washington. However, due to the outbreak of the war this Conference was not held. To substitute for the Conference the International Association of Accident Boards and Commissions called a meeting in Washington in December, 1916. The bulletin which followed in 1917 contained a section on health insurance. It simply summed up the details of operation of compulsory health insurance as well as the arguments for and against it. The Conference took no formal action one way or the other.

The movement for compulsory health insurance reached the United States Congress in 1916 with a resolution (H. J. Res. 159) to create a Federal Commission to formulate a plan for national insurance for sickness, invalidity and unemployment. Hearings were held but no action was taken at that time. It was referred to a committee, but was never heard from afterwards. However, in 1917 the same person introduced an almost identical bill (H. J. Res. 189). It came before the House January 16, 1918, but met serious opposition and lost. That was the end of federal activity on health insurance during the first period.

In keeping with the legislative trend between 1915 and 1920 eleven of the states appointed official commissions to investigate compulsory

---

15 For a review of these nine standards see Williams, op., cit., pp. 40 ff.

health insurance. Legislative measures were introduced into 15 states but all of them were defeated. The peak of legislative consideration in the various states was reached in 1917 when 12 states introduced health insurance measures and 8 states appointed commissions for investigation. New York state seems to have been the most consistent, having introduced health insurance measures into the legislature every year from 1916 through 1920.

By about 1918 or 1919 opposition became more highly organized and interest began to wane. By the end of 1920 the movement had died out.

Those who were opposed to compulsory health insurance were divided into four general groups: employers, insurance companies, organized labor, and the medical profession. Although all four groups were agreed that there was a need for some kind of organized measure to alleviate and to prevent sickness, they were opposed to a system of health insurance under state operation and control.

The employers objected to compulsory sickness insurance because they felt that it was too expensive and drew disproportionately from industry. They felt that such a program, if put into effect, should be supported by taxation.

Insurance companies, probably the strongest opponents, objected because they would be excluded from participation as carriers. Some of the arguments of Dr. Frederick L. Hoffman of the Prudential Insurance Company were published under the title, More Facts and Fallacies of Compulsory Health Insurance.[16] His main arguments were that there was no particular need for compulsory health insurance; that what need there was could be taken care of by voluntary insurance agencies by cash benefits;

---

16 Frederick L. Hoffman, More Facts and Fallacies of Compulsory Health Insurance, New Jersey: Prudential Press, 1920.

that compulsory health insurance was not based on sound insurance principles; that the whole idea of compulsory health insurance is un-American.

In the beginning, organized labor was divided on the matter of compulsory health insurance. The president of the American Federation of Labor, Samuel Gompers, and the executive council were definitely opposed to such measures. They felt that the trade unions should be the ones to take care of such matters. However, in 1916 the American Federation of Labor declared against insurance for profit as applied to industrial, social or health insurance, and in 1918 the Executive Council was instructed to investigate the area of health insurance. Although many State Federations of Labor went on record as favoring compulsory health insurance, the American Federation of Labor took no official position as a body until 1935 after the Social Security Act was passed. At this time it made a clear stand in favor of health insurance legislation.

The attitude of the medical profession seems to have changed between 1913 and 1917. The interest of the medical profession increased and was particularly manifested early in 1916 when the American Medical Association appointed a committee to study social insurance as it related to the medical profession. The committee, in its report in June of the same year, presented the facts of the situation in light of their recent study, and recommended that no action be taken at that time either for or against health insurance as a whole.[17] It also presented a list of 15 standards which it considered to be essential to any insurance law. A good estimate of the attitude of the medical profession can be gained from the articles appearing in the official journal of the American Medical Association.

---

17 "Reports of Subcommittees of the Council on Health and Public Instruction (Report of Committee on Social Insurance)", Journal of the American Medical Association, 66: 1951-1985, June 17, 1916.

Until about January, 1917 articles in the journal were quite noticeably favorable to health insurance, not only to the principle itself but also to the system which had been proposed for the United States.[18] Between January and June of that same year the arguments against the system seemed to be in the majority.[19] However, in June articles on the subject ended, probably because the doctors' interests were increasingly being devoted to the war effort. There was little discussion among the medical men on the subject until 1919 when the New York Legislature was considering compulsory health insurance for the fourth time. It was at this time that the medical men of New York expressed opposition to such a program. However, it was not until 1920 that the American Medical Association voiced official opposition to compulsory health insurance. The state medical associations were still divided on the subject. Since the report of the Committee on the Costs of Medical Care opposition from the American Medical Association has become even more pronounced. The official position of the Association is quite clearly revealed in the ten principles adopted by the house of delegates and reported in the Journal of the American Medical Association, June 30, 1934.[20]

---

18 See Alexander Lambert, "Health Insurance and The Medical Profession," Journal of the American Medical Association, 68: 257-262, January 27, 1917; Dr. B. S. Warren, "Health Insurance: Its Relation to the Medical Profession", Journal of the American Medical Association, 67:1966, December 23, 1916; Dr. B. S. Warren, "Health Insurance: Its Relation to the National Health", Journal of the American Medical Association, 67:1015 ff, September 30, 1916; "Endorsement of Health Insurance by Health Authorities", Journal of the American Medical Association, 67:832-33, September 9, 1916.

19 See "Symposium on Compulsory Health Insurance", Journal of the American Medical Association, 68:801 ff, March 10, 1917; Frederick L. Hoffman, "Compulsory Health Insurance Unnecessary as a Public Health Measure", Journal of the American Medical Association, 68:480, February 10, 1917; Eden V. Delphey, "Arguments Against The 'Standard Bill' For Compulsory Health Insurance," Journal of the American Medical Association, 68:1500-1, May 19, 1917.

20 "Report of Special Committee", Journal of the American Medical Association, 102:2199-2201, June 30, 1934.

As evidenced by the lack of major articles in the quarterly, Labor Legislation Review, the American Association for Labor Legislation was not active on behalf of compulsory sickness insurance after the defeat of the New York Bill in 1920.[21] However, they resumed an active campaign in the recent movement.

It has already been mentioned that the principle of group insurance was first used in connection with life insurance in 1911. It was not until the 1920's when the first campaign for compulsory health insurance was drawing its last breath, that the principle was adopted to the underwriting of disability benefits in the field of health insurance. In fact, this is probably the event of greatest consequence in the field of health insurance between the death of the first campaign and the beginning of the recent campaign in 1927. It became recognized that coverage could be provided at a much lower cost where a homogeneous group of "good risks" were insured together. This fact is argued by some as being one of the greatest advantages of compulsory insurance --- that of including enough healthy people to support the sick ones at a lower cost. As an indication of the prevalence of group health insurance plans immediately following their inception it will be noted that between 1925 and 1934, 76 percent of all plans which were organized were group insurance plans.[22]

THE RECENT PERIOD

The recent campaign for government health insurance, like the first one, has been divided into two phases. The first phase, from 1927 to about 1938 was one of study and discussion; from 1938 to the present time (1950) the trend has been toward increased action.

---

21 Williams, op. cit., p. 55.

22 Avnet, op. cit., p. 8.

The recent campaign began in 1927 when the Committee on the Costs of Medical Care was appointed to investigate and to find a solution for the problem of furnishing good medical care to all of the people at a price which they could afford to pay. The Committee was composed of physicians, social scientists, and laymen. Funds were provided by the Rockefeller Foundation, the Russell Sage Foundation, the Carnegie Corporation, the Milbank Memorial Fund, and others. A five year program of research and study was developed, and with the coming of the depression in 1929 the new movement received increased interest and encouragement.

Greater impetus was given the movement with the publication, in 1932, of the final reports of the Committee on the Costs of Medical Care.[23] While there was general agreement among the committee members that there was a definite need for some kind of program for health care, they could not reach an agreement as to what kind of program should be adopted. The majority report favored experimentation with and encouragement of voluntary insurance on a group basis thereby profiting and expanding from the experience thus gained. They advocated that such a program could be financed from both private and government sources. The minority did not feel that there was as great a problem in the area of medical care as did the majority. They also regarded individual practice as superior to group practice. They claimed that voluntary insurance plans had failed everywhere they had been tried and cited Europe as an example where many of the countries have replaced voluntary plans with compulsory systems under government control. However, their principle objection was to group practice and not so much to the application of the insurance principle

---

23 For a review of the findings and recommendations of the Committee on the Costs of Medical Care see: Harry Alvin Millis, Sickness and Insurance: A Study of the Sickness Problem and Health Insurance, Chicago: The University of Chicago Press, 1937, pp. 121 ff.

to finance the costs of medical care. They objected to insurance plans unless they were sponsored and controlled by the medical societies.

The National Social Security Act of 1935 was passed just as the country was emerging from the depression. Under this Act health insurance was the only major form of security omitted. However, medical care became part of the larger social security context and was carried along by the efforts of the state and federal governments. During this same year the "Model Bill" was formulated primarily under the direction of Abraham Epstein. This bill probably occupied the same place as the "Standard Bill" twenty years before. From then on the movement accelerated and more and more bills were introduced into the legislatures of both state and federal governments. Worthy of mention is the bill, S. 1620, proposed by Senator Wagner in 1939 which was designed to amend the Social Security Act and to provide health security.[24] It was revised in 1943 by Senators Wagner and Murray and Representative Dingell and has since become known as the "Wagner-Murray-Dingell Bill." Failure of this and similar bills which followed have not deterred the drive for health security. On the contrary, there seems to be an increasing interest in such measures.

As planning has proceeded and opinions have become more crystallized there has been an accelerated trend toward more definite and concrete legislative action. The drive has become further mobilized by President Truman's open support of compulsory health insurance in November of 1945,[25]

---

24 "National Health Program", Congressional Record, Vol. 84, Part 10, 76th Congress, 1st Session, August 4, 1939, p. 10983 ff.

25 U. S. Senate Committee on Education and Labor, 79th Congress, 1st Session, National Health Act of 1945 (Committee Print No. 1), Washington: Government Printing Office, 1946.

and again in May of 1947[26] when he transmitted a special message to Congress containing his recommendations for the enactment of a national health and disability insurance program. Immediately following each of these events, revised versions of the "Wagner-Murray-Dingell Bill", S. 1606 and S. 1320 respectively, were introduced into the Congress.[27] The recent survey which was requested by President Truman and made by Oscar R. Ewing[28] and Mr. Ewing's subsequent recommendation to the President to continue to urge the Congress to enact government health insurance, has undoubtedly had a marked influence in stimulating legislative proposals for government health insurance. A recent example is S. 1679 which was introduced into the Senate by Senator Thomas in April, 1949.[29] The opposition has also been active in its legislative proposals against government health insurance as evidenced by the proposals, S. 2143 by Senators Taft, Smith, and Ball in 1946;[30] S. 545 by Senators Taft, Smith, Ball and Donnell in 1947;[31] and S. 1581 by Senators Taft, Smith and Donnell in 1949.[32]

---

26 "National Health and Disability Insurance Programs —— Message From The President of the United States", Congressional Record, Vol. 93, Part 4, 80th Congress, 1st Session, May 19, 1947, pp. 5490-91.

27 National Health Program, Hearings Before the Committee on Education and Labor, S. 1606, United States Senate, 79th Congress, 2nd Session, Washington: Government Printing Office, 1946. See also the Hearings on S. 1320.

28 "The Nation's Health - a Ten Year Program", A report to the President by Oscar R. Ewing, Federal Security Administrator, Washington: Government Printing Office, September, 1948.

29 "National Health Insurance and Public Health Act", S. 1679, by Senator Thomas and others, 81st Congress, 1st Session, Arpil 11, 1949.

30 "Coordination and Expansion of Federal Government Health Activities", Congressional Record, Vol. 92, Part 4, 79th Congress, 2nd Session, May 3, 1946, pp. 4389-91.

31 "National Health Act of 1947", Congressional Record, Vol. 93, Part 1, 80th Congress, 1st Session, February 10, 1947, p. 911.

32 "National Health Act of 1949", S. 1581, by Senator Taft and others, 81st Congress, 1st Session, April 11, 1949.

The recent developments in England and the experiences which the people there encounter will certainly be brought to bear on any further action that may be taken in this country by both those favoring and those opposing national health legislation.

SOME COMPARISONS OF THE TWO CAMPAIGNS

The two campaigns for government health insurance in the United States were alike in that they both went through a phase of discussion and study and from there into a period of legislative activity. However, there are many other comparisons which can be made.

There are certain shifts of interest from the first to the second period which are worthy of mention. The first campaign was primarily between individuals while the second has been between large groups. While the first campaign never went beyond the state level, the second has been primarily on the federal level with activity in the states receiving only minor recognition. During the first period, and even as late as the early 1930's, the issue was health insurance per se regardless of the type of sponsorship. However, with the publication of the report of the Committee on the Costs of Medical Care, the depression, and the subsequent enactment of the Social Security Act, health insurance came to be recognized as a device to spread the economic risk of illness. By 1939 the main issue was not whether health insurance but how to administer it.

In both the earlier campaign as well as the recent one the people have been divided into essentially three groups according to their attitudes toward government health insurance: those who take the extreme position against government health insurance; those who take the extreme position in favor of such a program; and those who feel that while government health insurance, as proposed, has many advantages it also has certain

defects which need to be eliminated before it can be successful.[33] To the first group the very thought of government health insurance is abhorrent. They have attacked it as the first step toward communism or socialism, and that it would stifle professional initiative and progress. The second group has taken an attitude on the opposite extreme. They see government health insurance as a "cure-all", a panacea for all problems of individual and public health. The third group, while recognizing that the present insurance system has many defects and that government health insurance as has been proposed also has many shortcomings, feels that there may be a great deal of advantage in applying the insurance principle to meet the costs of medical care in certain groups on a national level.

In the first period the American Association for Labor Legislation was the major group supporting compulsory health insurance. The strongest opposition came from the insurance companies which have openly opposed compulsory health insurance from the beginning. Frederick L. Hoffman of the Prudential Insurance Company of America resigned from the Committee on Social Insurance of the A.A.L.L. in 1916 in protest against its activities favoring government health insurance. Also of significance is that organized labor was somewhat divided in its stand in the early period, but in the recent drive it has become one of the most powerful forces backing government health insurance. It seems to be taking the position which was held by the A.A.L.L. in the first period. On the other hand, while the American Medical Association favored a government-sponsored insurance program during the first years of the early drive its position had changed by 1920 and, as has been indicated, in June of 1934 its official position was stated in opposition to such a program.

---

33 Simons and Sinai, op. cit., p. vii.

In June, 1945, the A.M.A. adopted the "Constructive Program For Medical Care" which was a platform of 14 points designed to extend and to improve the health and medical care of the people.[34] In 1946 this program was clarified and elaborated into a ten-point program, the "National Health Program of the American Medical Association".[35] Most notable among the changes are the exclusion of those points specifically related to the war effort, numbers 10, 12, and 13 of the former platform. One of the most recent steps taken by the American Medical Association is the adoption of a twelve-point program designed primarily to expand voluntary hospital and medical care plans.[36]

It should be mentioned that although the American Medical Association has been definitely opposed to government health insurance, the various state medical societies and other medical groups have been somewhat divided on the subject. Some of the more prominent medical groups supporting compulsory health insurance are the Physicians Forum, the Committee of Physicians for the Improvement of Medical Care, Inc., and the National Medical Association. In the opposition are such groups as the American College of Surgeons, the National Physicians Committee for the Extention of Medical Service, the American Dental Association, and the American Hospital Association which endorsed compulsory health insurance in the first period.

---

34 "Constructive Program for Medical Care", Journal of the American Medical Association, 128:883, July 21, 1945.

35 "The American Medical Association Health Program and Prepayment Sickness Insurance Plans", Journal of the American Medical Association, 130:494-496, February 23, 1946.

36 "Doctors Offer Plan for More Medical Aid", Detroit Free Press, February 14, 1949. See also "Health Job in Cabinet Proposed", Detroit News, February 14, 1949.

ARGUMENTS FOR AND AGAINST GOVERNMENT HEALTH INSURANCE

The arguments for and against a plan for government health insurance have been substantially the same in both periods. Although the arguments have been many and varied, six of the more frequent ones against government health insurance are listed as follows.[37] That:

1. Government health insurance is state medicine; it is socialistic and communistic.
2. Such a system would be compulsory.
3. Too much power would be concentrated in the Federal Government.
4. There are neither sufficient personnel nor facilities to sponsor such a program in this country.
5. It would cost too much.
6. It would open the way to many abuses such as lowered quality of medical service, lack of freedom of doctors to choose patients and patients to choose doctors, insufficient remuneration to give doctors an incentive to maintain interest in his patients, and political interference.

While the arguments against government health insurance, as listed above, will be treated specifically the arguments for a government health insurance program are inherent in the discussion below.

With regard to the first argument, that of government health insurance being state medicine, socialistic and communistic, the proponents of a government plan argue that no such thing is being proposed since the term "state medicine" would imply that the government would own and operate the hospitals and that the physicians would be employed by the government for a salary and would therefore, come under full government supervision.

---

37 The arguments for and against government health insurance were taken primarily from Ewing, op. cit., p. 105 ff. For a classification of arguments into four categories, i.e., Personal and Medical, Economic, Ideological, and Administrative, see Anderson, op. cit. pp. 222-223.

They indicate that the system which is being proposed is one which uses the insurance principle the same as private plans, the difference being that the sponsoring agent would be the government instead of a private company. Those who favor a government system remind the opponents that their argument that government health insurance is socialistic and communistic is the same one which they used a few years ago against the voluntary, private health insurance plans which they now wholeheartedly support and promote.

The argument that this would mean compulsion is met by pointing out the success of the unemployment insurance and the old-age benefit program. Its supporters indicate that a government health insurance program would be compulsory in only one aspect, that of persons in certain categories being required to pay to the government a stipulated percentage of their income in return for which they would be entitled to medical services. If they preferred to patronize doctors operating on the fee-for-service basis, they would be free to do so. The doctors in turn would in no way be compelled to participate.

With regard to centralization and concentration of power in the Federal Government, the proponents of a government plan reply that the intent is to place the actual administration of the program mainly with the states and localities with the Federal Government lending its aid where necessary. It would also handle the finances of the total system.

While the proponents recognize that the argument of lack of facilities and personnel is a good one, they use this as another argument to show the need for such a system. They indicate that there would need to be a "tooling-up" period in which the needed personnel and facilities would be provided and during which proper organization and coordination could be developed.

The argument of cost is met in a number of ways. It is pointed out, first of all, that the nation needs to spend more for health. It is also indicated that such a program would emphasize the distribution of costs rather than increased costs. By distributing the costs over a large number of people in small payments and over a long period of time, it would be easier for the lower income people to meet the expenses of adequate health care. Another factor which is presented is that the expenses connected with soliciting and advertising which are associated with private plans would be eliminated.

As to the abuses which might arise, it is argued that the experiences of other nations have shown that the abuses are exaggerated and can be controlled by proper organized action by the doctors and the administrative body.

The various arguments about the quality of service being lowered are attacked by the proponents as being unfounded. It is reasoned that with the "tooling-up" period more and better facilities would be available for the use of the physicians and hospitals, and that the diagnosis and treatment of the patients would not be limited because of finances nor because of lack of facilities.

The statement that the doctors would not be free to choose their patients and the patients to choose their doctors is met with the argument that many people do not have free choice of doctors today, not only because of lack of doctors in many areas, but also because of financial barriers. The proponents of government health insurance claim that under a government plan this would be rectified. They state that under a government system the individual would be guaranteed his choice of physician the same as he does now. The physician could limit his practice to as many patients as he desired.

The argument that remuneration would be insufficient to give incentive to the doctors to provide good services and to maintain interest in their patients is considered by the opponents to be a poor argument because they feel that it is assuming that the doctor's chief interest in his patient is the fee which he collects. It is pointed out that if such were the case one would expect to find the situation at its worst where doctors are paid on a salary basis. However, in many of the most famous clinics and university medical schools and hospitals in the country the doctors are paid on a salary basis.

The proponents deny that politics would enter such a system since the sole function of the Federal Government would be to collect and distribute the money, and to prescribe certain standards which should be met. The administration would be left in the hands of the local boards to be composed of doctors and laymen.

CHAPTER III

PURPOSE AND SCOPE OF THE PRESENT STUDY

In social planning it is extremely important to recognize that the attitudes which people have toward social problems not only help to create the conditions but also to delay or to speed their solution. It is obvious from the foregoing discussion that a sociological analysis of the attitudes of the people toward a government system of health insurance would aid in clarification and eventual solution. Ultimately the people will decide whether or not they desire to have such a program in this country.

PURPOSE

The purpose of this study is to determine the attitudes of a scientific sample of adult residents in Michigan toward government-sponsored prepayment plans for health care.

While there are many questions which are of interest and of value in such a study, some of the more important questions which it attempts to answer are the following:

1. To what extent do the residents of Michigan favor or oppose health insurance as a method of paying hospital and doctor bills?
2. To what extent are the residents of Michigan familiar with government-sponsored prepayment plans for health care?
3. What are the attitudes of the residents of Michigan toward government-sponsored prepayment plans for health care?
4. What are the opinions which the residents of Michigan express about government-sponsored prepayment plans for health care.

5. To what extent are the residents of Michigan familiar with the "Wagner-Murray-Dingell Bill" for health care?

6. To what extent are the residents of Michigan familiar with "socialized medicine" as a method of paying hospital and doctor bills?

7. To what extent are government-sponsored prepayment plans for health care associated with the term "socialized medicine"?

8. Among those who have heard or read about "socialized medicine", what are their attitudes toward such a program?

9. What are the characteristics or attributes of those with different attitudes and differing amounts of information with respect to the issues indicated above?

IMPORTANCE OF THE STUDY

At this time when government health insurance is pending in the Congress; when heated disputes are being carried on by various groups, all of which have tremendous influence in shaping public opinion; when the whole attitude toward health and health care is shifting from one of private to public concern; a study such as the one here proposed seems particularly timely. Despite the arguments of the various groups over the subject of government health insurance the present controversy is one which will eventually be settled by the people themselves. Public opinion and demand will be the deciding factor as to the outcome of the present movement for government health insurance. Any program without the support of the public would be doomed to failure from the very beginning.

Under the American constitutional system the people will be able to cast their votes in favor of or against a health insurance program through those men chosen to represent them in the Congress. Hence, this study would seem to be of first importance to the public administrators since no one can be expected to adequately represent the attitudes of any group unless he knows what those attitudes are.

It is important to the social scientist not only in terms of method, but also because it serves as a measure of the attitudes of a scientifically selected sample of people toward a social movement which is of vital importance to all. Since it is the attitudes of the people which will determine the eventual outcome of any social movement, it seems that this is the crucial time for comprehensive studies to be made to determine what those attitudes are. Thus, this study is a step in that direction.

It is important to the medical profession because it furnishes information whereby its members may gain a better understanding of the population which they serve.

This study is of particular importance since, to the knowledge of the writer, there has been no study of attitudes toward government health insurance which is similar in scope and intensity to the Michigan Health Survey.

ORIGIN AND DEVELOPMENT OF THE STUDY

The data used in this study were obtained from a comprehensive state-wide health survey of the state of Michigan which was originally conceived and developed by members of the Social Research Service of Michigan State College in cooperation with the Michigan State Medical Society. The study was conceived in 1947 and the first plans were drawn up by the joint committee members in December of that year. During the months to follow the program was revised and expanded and a schedule of questions was drawn up. In the spring of 1948, after a series of revisions and trial interviews, the schedule was put into final form. The bulk of the interviewing was done in the summer of 1948 by interviewers especially trained for the job. The results were coded and punched on cards for machine tabulation.

SELECTION OF THE SAMPLE

The sample was designed to provide a complete random cross-section of the adult urban, mentropolitan, village, and open country population of the state of Michigan, exclusive of Wayne county. Wayne county was not included in the sample because too large a portion of the total sample would have been taken in that area since Detroit alone makes up approximately 44 percent of the total population of the state. To take such a large number of records in Wayne county would cause the proportion in the rural area to be too small for statistical purposes.

In order to secure the best possible scientific sampling materials the services of the Iowa State Statistical Laboratory were used. This laboratory has exceptional resources for drawing samples such as the one required in the present study. The complete sample was drawn by them to meet the specifications of the study, and maps and aerial photographs showing the exact location of each sample segment were provided. Detailed instructions to the interviewers were also prepared. Because of limitations of time and finances the attitude and opinion section of the study, from which the data for this thesis were derived, included a scientific selection of one-third of the adults in the sample households. This random sample was determined according to the number of adults in the household. Following such a procedure a sample of 717 adult interviewees provided information about attitudes and opinions. Two hundred and forty-five were from the open country areas, seventy-four from villages, one hundred and two from metropolitan areas, and two hundred and ninety-six from urban centers. Sixty of the eighty-three counties were represented in the sample by one or more sample segments. If a county had no representation in a particular area (the rural area for example) a segment from a comparable county was chosen.

DEFINITION OF TERMS

1. The term "attitude" is here defined as an acquired or learned tendency to behave in favor of or in opposition to any particular referent.

2. The term "opinion" refers to an expressed view on a particular subject; it is a verbalization of an attitude which may or may not be based on fact.

3. "Government-sponsored prepayment plan for health care" refers to any government-sponsored plan in which the people would pay a certain percentage of their income to the government and in return members of the family would have their doctor and hospital bills paid for by the government. For purposes of this study it will be used as synonymous with "government health insurance" and "compulsory health insurance".

4. Because "socialized medicine" is a concept which has come to have many connotations there is no definition attempted here, nor is there any need for one. The primary interest of this study is in the reactions to the concept, "socialized medicine", in terms of its implications to the informants and not to any particular program. No definition was spelled out for the informants.

5. "Urban" refers to incorporated places having 2500 or more people according to the 1940 Population Census.

6. "Metropolitan" refers to that area immediately adjacent to the urban area which is often referred to as the "fringe" area.

7. "Village" refers to incorporated places having less than 2500 people (1940 Census).

8. "Open country" refers to those unincorporated places outside of urban, village, and metropolitan areas.

9. "Adult" refers to any person 21 years of age or over, and any head of a household who is under 21 years of age.

STUDIES OF ATTITUDES AND OPINIONS REGARDING GOVERNMENT HEALTH INSURANCE

There have been many polls of opinions toward government health insurance, and these have had a wide range of authenticity as well as a wide range of results. However, the nation-wide polls covering both rural and urban people have indicated that, on the whole, there is a tendency for the majority of the people to be in favor of some kind of government health insurance program.

In 1942 a survey by Fortune magazine revealed that 74.3 percent of the people polled indicated that they felt that the Federal Government should collect enough taxes after the war to provide medical care for everyone who needs it.[38] There was not a single dissenting majority in any income or occupational group nor in any section of the country; only 21 percent gave a negative reply. In 1943 a Gallup Poll showed that 59 percent favored the extension of the social security program to provide benefits for sickness, disability, doctor and hospital bills while 29 percent did not favor such an extension.[39] Those answering in the affirmative were asked further if they would be willing to pay 6 percent of their salary or wages in order to make such a program possible. Forty-four percent of these persons answered "yes" and 11 percent answered "no" to the question. A survey by the Opinion Research Corporation for the National Physician's Committee for the Extension of Medical Service revealed that 37 percent favored a "Federal Government Plan" for health security while 20 percent answered "don't know". However, this survey was severely criticized by the Physicians' Committee on Research, Inc. which pointed out that the questions used by the Opinion Research

---

38 "The Fortune Survey", Fortune, Vol. 26, No. 21, July, 1942, p. 14.

39 "American Institute of Public Opinion (Gallup Poll)", Public Opinion Quarterly, Vol. 7, August 13, 1943, p. 488.

Corporation were leading and suggestive.[40] In 1944 the Physicians' Committee on Research, Inc. sponsored a survey which was conducted by the National Opinion Research Center. Their results showed a somewhat more favorable attitude.[41] They found that 68 percent favored having the social security law broadened to provide for paying doctor and hospital care. When asked if they would favor such a program if it meant increased contributions by 1.5 percent the proportion fell to 58 percent. It was found in that same year that 59 percent of the farmers in the state of Washington preferred "health cooperatives" with prepayment plans to all-out "socialized medicine", while 24 percent said that medical services should be made available to people free of charge and paid for out of tax funds, just as public schools are freely available to all children.[42] A survey of the rural people of the state of Washington in 1947 revealed that two out of every three persons (62.2 percent) wanted a change from private medical practice to some other form.[43] Of this group, 25.2 percent preferred "the Social Security program as outlined by President Truman"; 21.9 percent preferred a plan comparable to that sponsored by the various county Medical Bureaus; 8.7 percent stated a preference for State Medicine; and 11.4 percent desired Cooperative Medicine. Of those who did not state a desire for a change, 22.4 percent indicated a preference for private practice, and 10.4 percent were not sure.

---

40 "What Do The American People Think About Federal Health Insurance?" (Report of a Nation-Wide Survey of Civilian Adults, Conducted for the Physicians' Committee on Research, Inc. by the National Opinion Research Center), University of Denver, October, 1944. See also the review in Time, Vol. 44, December, 1944, p. 70.

41 Loc. cit.

42 Carl F. Reuss, Farmer Views on the Medical Situation, Pullman: State College of Washington Experiment Station (V Circular No. 20), September, 1944, cited by Mott and Roemer, op. cit., p. 558.

43 R. W. Roskelley, "The Rural Citizen and Medical Care," Pullman: State College of Washington Institute of Agricultural Sciences, Agricultural Experiment Station Bulletin No. 495, December, 1947, 16 pp.

As has been indicated, the medical professional groups are divided regarding their attitudes toward a program of government health insurance. While the American Medical Association favors many of the features of the over-all program it clings tenaciously to private plans. Strongly behind a national program for health insurance, however, are the Physicians Forum, the Committee of Physicians for the Improvement of Medical Care, and the National Medical Association, a professional group of Negro doctors.[44]

A very enlightening survey of the attitudes of the medical profession as a whole was done in 1946 by Arthur Kornhauser of the Bureau of Applied Social Research at Columbia University.[45] This study revealed that 99 percent of all the medical authorities, of which over 50 percent were physicians, favored some form of health insurance. Sixty percent favored a compulsory plan sponsored by the government and 40 percent favored private and voluntary insurance. The physicians of the group were divided almost exactly 50-50, while the social and economic authorities (those who were not physicians) favored a government plan 75 percent to 25 percent.

---

44 "Statement of Dr. Ernst P. Boas, Chairman of the Physicians Forum", National Health Program, Hearings Before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606, Washington: Government Printing Office, Part 2, April 18, 1946, pp. 735-738; "Statement of Dr. John P. Peters, Secretary, Committee of Physicians For the Improvement of Medical Care", National Health Program, Hearings Before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606, Washington: United States Government Printing Office, Part 2, April 23, 1946, pp. 981-1016; "Statement of Dr. E. I. Robinson, President, National Medical Association, Accompanied by Dr. Paul B. Cornelli", National Health Program, Hearings Before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606, Washington: United States Government Printing Office, Part 2, April 18, 1946, pp. 787-794.

45 "Should We Have Health Insurance?" (Poll of experts conducted by Arthur Kornhauser, Bureau of Applied Social Research, Columbia University), The American Magazine, 141:40-41, 116, January, 1946.

The various studies serve to indicate that, up to 1947 at least, the attitudes of the people, although not fully crystallized, tended to be in favor of a nation-wide government health insurance program. However, in the last few years the people of the United States have had an opportunity to devote their attention to activities not directly connected with the war effort and, therefore, they probably will have developed a more definite attitude toward other phases of security. This crystallization of attitudes was undoubtedly further mobilized not only by the open support of government health insurance by the President of the United States and other prominent national figures, but also by the vociferous campaigns which have been presenting a convincing case for the opposition. The present study is an attempt to find out what the attitudes of the people of Michigan are toward such a program.

CHAPTER IV

ATTITUDES OF MICHIGAN RESIDENTS TOWARD GOVERNMENT-SPONSORED PREPAYMENT PLANS FOR HEALTH CARE

The present chapter will deal with the following problems. What are the attitudes of the people of Michigan toward insurance, per se, as a method of paying medical expenses. To what extent are the people of Michigan familiar with government-sponsored prepayment health plans. Granted that there is a difference in the attitudes of the people toward government health insurance, what are the socio-economic factors, if any, associated with those who favor and those who oppose such a system. It was felt that these were the first and foremost questions which should be answered in order to gain a better understanding of the attitudes of the people of Michigan toward government-sponsored prepayment plans for health care.

ATTITUDES TOWARD INSURANCE AS A METHOD OF PAYING MEDICAL EXPENSES

Since government health insurance arose out of the general insurance principle, it seemed advisable first to find out whether or not the people favored insurance as a method of paying their doctor and hospital bills before inquiring about their attitudes toward a government-sponsored program for health care. In the event they did not favor the insurance principle as a method of meeting the costs of health care there would probably be no justification for carrying the investigation further, unless, of course it was determined that the people felt that a government-sponsored program would not be based on the insurance principle.

When the people of Michigan were asked whether or not they thought that insurance plans for paying hospital and doctor bills were a good idea, it was found that an overwhelming majority, 89.5 percent, favored such plans.[46] Table 1 clearly reveals that the insurance principle, per se, as a method of paying hospital and doctor bills is no longer in question. It is quite evident that the residents of Michigan were, on the whole, convinced of its value.

Table 1. Attitudes of the adult residents of Michigan toward insurance as a method of paying medical costs, 1948

Attitudes	Number	Percent
Good idea	634	89.5
Not good idea	35	4.9
Uncertain	40	5.6
Total responding	709	100.0
No response	8	

The question, then, becomes "What kind of insurance and by whom administered" and not "Insurance or some other method". The major portion of this study is devoted to the question of whether or not a government-sponsored prepayment plan for health care is the kind that the majority of the people of Michigan preferred, what segments favored and which opposed such a plan. However, it seems important to find out first to what extent the residents of Michigan are acquainted with such plans.

---

46 For the exact wording of the questions see the schedule in Appendix B.

FAMILIARITY WITH GOVERNMENT PREPAYMENT HEALTH PLANS

Despite the activity which has been going on both for and against government-sponsored prepayment plans for health care only 28.0 percent of the respondents indicated that they had heard of such a plan while 69.6 percent said that they had not heard of such a program. See Table 2. The probability that such a difference between these two proportions

Table 2. Familiarity with government prepayment health plans

Response	Number	Percent
Yes	198	28.0
(Yes, socialized medicine)*	(51)	(7.2)
No	492	69.6
Uncertain	17	2.4
Total responding	707	100.0
No response	10	

*The 51 cases who respond "yes, socialized medicine" are also included in the 198 cases who respond "yes". They were separated for comparison.

could have been due to chance was less than .01.[47] Of the 28.0 percent who had heard of a plan for government health insurance 7.2 percent identified it as "socialized medicine". It is also interesting to note that only 2.4 percent were uncertain as to whether or not they had heard of any such plans. Ordinarily the tendency is for the respondents to feel that they probably should have heard of such plans even though they have not and, therefore, to answer in the affirmative or perhaps to say they are uncertain. However, the decided lack of respondents answering in this manner substantiates the finding that the majority of the people

47 For the statistical measures used in this study see Appendix A.

were unfamiliar with a program of government health insurance. It also leads to the conclusion that the people were quite sure they had not heard of a government health program.

To get a better idea as to the extent of familiarity which the people had with government prepayment plans for health care, they were asked whether or not they had heard or read of the Wagner-Murray-Dingell Bill. The Wagner-Murray-Dingell Bill in this case does not refer to any one particular bill which was introduced by these men, but rather this designation was chosen because of the fact that these persons have become some of the most popular exponents of government-sponsored insurance programs for health care. It was felt that if the people had heard of any specific government proposal it would more probably have been one with which these men were associated.

Table 3 reveals that even a lower proportion of people were acquainted with a specific plan than they were with government-sponsored health plans generally. Seventy-nine and two-tenths percent reported that they had not heard nor read of the Wagner-Murray-Dingell Bill as compared with 16.8 percent who had heard of it. However, it is likely that some had heard of it but had forgotten.

Table 3. Familiarity with Wagner-Murray-Dingell Bill

Response	Number	Percent
Yes	118	16.8
No	558	79.2
Uncertain	28	4.0
Total responding	704	100.0
No response	13	

The above findings seem to be rather significant in view of the fact that if such a program were to be established it would have either a direct or indirect effect upon almost every one of the respondents. If the state of Michigan can be taken as representative of the United States as a whole, it would indicate that the controversy over a government-sponsored health program has not taken into consideration the attitudes of the people themselves. It has been an issue between one group which feels that such a program would benefit the people, and another group which is equally convinced that it would not be to the people's best interests. In either case it is quite evident that except in a general way neither side has taken into account the attitudes and opinions of the people whom they supposedly represent. Both groups have apparently made proposals which they feel will be to the best interests of the country, or perhaps their own vested interests, and have not reached the people with information about their plans, nor taken the time to inquire of them what their ideas are.

It must be concluded, therefore, that the attitudes which the people do have toward a government health insurance program are, on the whole, not based upon their knowledge of such programs. They are probably based more upon the degree of satisfaction with the present system.

ATTITUDES AND SOCIO-ECONOMIC FACTORS ASSOCIATED WITH ATTITUDES

Attitudes Toward Government Prepayment Health Plans:

In order to get at the attitudes of the people toward a government-sponsored prepayment plan for health care they were asked whether or not they favored a plan in which the people would pay a certain percentage of their income to the government and in return members of the family would have their doctor and hospital bills paid for by the government.

Table 4 reveals that, of all those who responded to the question, exactly 50.0 percent favored such a program while 30.5 percent opposed it. The

Table 4. Attitudes toward government prepayment health plans

Attitudes	Number	Percent
Good idea	329	50.0
Not good idea	201	30.5
Uncertain	128	19.5
Total responding	658	100.0
No response	59	

T test of significance indicated that the probability that such a difference could have been due to chance was less than .01. These results compare very favorably with the results of the 1943 Gallup Poll, mentioned earlier, which indicated that 59 percent favored an extension of the social security program to provide benefits for sickness, disability, doctor and hospital bills whereas 29 percent did not favor such an extension.[48] However, the National Opinion Research Center, in their nation-wide survey conducted in 1944, found a somewhat higher proportion (68 percent) who favored broadening the social security law to provide doctor and hospital care.[49]

It is important to note that such a high portion of the people should favor government-sponsored plans for health care when there is such a limited number who have heard of them. This may be indicative of a certain amount of dissatisfaction with the present system. This was found to be the case among the rural people of Washington state where

48 "American Institute of Public Opinion"(Gallup Poll), op. cit.

49 "What Do The American People Think About Federal Health Insurance?", op. cit.

two out of every three persons desired a change.[50]

Of the 50.0 percent who favored a government-sponsored health program there were 16.7 percent who favored it but with certain reservations.[50a] The reservations which were most frequently specified were as follows: "If it isn't too expensive" and"If you can choose your own doctor". Thirty-one people (4.7 percent) mentioned the former and only 7 people (1.1 percent) mentioned the latter. However, on the whole the reservations were very generalized and not too specific.

This indicates that at least a certain portion of the population are not willing to accept any kind of program that may be put into effect, but feel that there are certain qualifications which must be met before it would be beneficial to the people. This does not indicate that they were opposed nor less in favor of a government health plan than those who flatly stated that they approved a government health program. On the contrary, it indicates that they realize that there are certain problems which would have to be overcome before such a program could function successfully and to the best interests of the people. As a matter of fact this group would probably contribute more to the success of such a plan than those who were not aware of many of the problems which must be met.

More important than knowing that a certain proportion of the population favor and a certain proportion oppose a government-sponsored plan for health care is to know which segments of the population favor and which oppose it. The reamining portion of the study primarily will be devoted to this problem.

---

50 R. W. Roskelley, op. cit.

50a The 16.7 percent refers to the total sample.

Attitudes By Familiarity With Government Prepayment Health Plans:

As indicated above, only 28.0 percent of the residents of Michigan had heard of a government plan to insure the people against sickness and that 16.5 percent had heard of a particular plan such as the Wagner-Murray-Dingell Bill. It must be assumed, therefore, that the opinions which were expressed by the majority of people were not based upon a knowledge of any specific plan nor upon information which they had received concerning government-sponsored health plans generally. It seems rather pertinent, however, to determine whether or not there was a difference between the attitudes of those who had heard of government plans and those who had not.

It was found that there was a slight association between attitudes and familiarity with government plans. The coefficient of contingency showed a correlation of .18, and the Chi-square test indicated that the probability that such a distribution was due to chance was $.05>P>.02$.[51] See Table 5. Probably the most notable difference between the two groups

Table 5. Attitudes by familiarity with government prepayment health plans

Attitudes	Percent Having Heard or Read of Government Plans: Yes	No	Uncertain	No Response
Good idea	48.1	51.2	42.8	3 cases
Not good idea	38.5	26.9	28.6	5 cases
Uncertain	13.4	21.9	28.6	- - - -
Total percent	100.0	100.0	100.0	- - - -
Total responding	179	457	14	8
No response	19	35	3	2

51 The category, "No response", was excluded from all Chi-square tests.

is that those who had heard of a government plan had a significantly higher proportion ($P=<.01$) who stated that they did not favor such a plan. On the other hand, of those who favored such a plan there was no significant difference between those who had heard of it before and those who had not, as shown by the T test. There was also a higher proportion of those who were not familiar with government plans who were uncertain as to how they felt about them. This difference was also significant, $P=<.05$.

Among those who had heard of government-sponsored prepayment plans for health care there was a slightly higher percentage who favored such plans than who opposed them. However, the difference was not large enough to be statistically significant. On the other hand, among those who had not heard of government-sponsored plans there was a significant difference ($P=<.01$) between those who favored and those who opposed. There were such a limited number of cases who were uncertain as to whether or not they had heard of a government plan that little can be said with confidence about their attitudes.

It is difficult to make an explanation of the distribution in Table 5 since there was no investigation into the extent of information which the people had received nor was it known what kind of information they possessed. It is possible that those who had heard of government health plans received negative or unfavorable propaganda from factions which opposed such plans. Hence, this may account for the larger proportion who said they were opposed to such measures. On the other hand, it is entirely possible that they received accurate information concerning a particular government plan of which they disapproved. In either event, it cannot be concluded that those who had heard of government-sponsored

plans for health care opposed and those who had not heard of such plans favored them. It would probably be more accurate to conclude that those who had heard of government plans were somewhat less favorable toward them than were those who had heard of them. It can also be concluded that those who had heard of government plans for health care were more certain about their attitudes than were those who had not heard of such plans.

Attitudes By Sex:

When the attitudes of men and women were compared, as shown in Table 6, it was found that men had a tendency more highly to favor

Table 6. Attitudes by sex

Attitudes	Sex	
	Men	Women
Good idea	55.7	46.6
(Good idea, reservations)*	(21.4)	(13.9)
Not good idea	30.6	30.5
Uncertain	13.7	22.9
Total percent	100.0	100.0
Total responding	248	410
No response	30	29

*This category, "Good idea, reservations", is also included in the response, "Good Idea". It was separated in this way for the sake of comparison and in the future will be indicated simply by parentheses.

government-sponsored prepayment plans for health care than women. Fifty-five and seven-tenths percent of the men favored such plans as compared with 46.6 percent of the women. The probability that such a difference could have been due to chance was less than .05. There was also a significantly higher percentage of men who stated that a government plan would be a good idea but with certain reservations. However, there

was virtually no difference between men and women on the response, "Not a good idea". On the other hand, there was a significantly higher proportion of women who were uncertain.

The above results indicate that the women tended to be the more conservative than the men. Even though they were more favorable toward government health insurance, the men had a tendency to consider the various ramifications which might be involved in a government-sponsored health program.

Attitudes By Age:

Table 7 shows the distribution of attitudes by the age of the respondents. When the Chi-square test of significance was computed for

Table 7. Attitudes by age

Attitudes	Age						
	29 and under	30-39	40-49	50-59	60-69	70 and over	No Response
Good idea	59.3	46.6	42.3	45.0	44.3	63.3	2 cases
Not good idea	26.9	33.4	31.6	33.0	32.9	24.5	- - - -
Uncertain	13.8	20.0	26.1	22.0	22.8	12.2	- - - -
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	- - - -
Total responding	167	150	111	100	79	49	2
No response	5	20	10	11	9	4	0

Table 7 it was found that the probability that such a distribution could have happened by change was .10>P>.05. Such a probability, although not extremely significant, is possibly indicative of a trend. The tendency was for the younger and the older people to be more highly in favor of a government program than those between the ages of 30 to 69 years. The T test of significance also bears this out. Among those who favored a government plan there was no significant difference between those below

29 years of age and those 70 years of age or above. However, there was a higher proportion in both of these two age groups who favored it than in the age groups between 30 and 69 years. The difference is statistically significant. Among those who opposed government health plans there was no significant difference.

Although age was not highly associated with attitudes toward government-sponsored health plans, there was a tendency for the younger and the older segments of the adult residents of Michigan to be more highly in favor of such plans than those in the middle age range. One reason for this is probably that they are less secure financially. The younger people who are just starting out have many expenses connected with starting a home and family. They are also just beginning their occupational careers and often find it difficult to adjust their incomes to the demands which are placed upon them. As for the older people, they have passed the prime of life and are at the retirement age. Many of them have little or no income. Unless they have been able to save for this period they, too, may find it difficult to meet the financial demands placed upon them.

Another factor which must be considered is sickness. It has been found that sickness is associated with age. In one study,[52] the highest proportion of sickness was found in the age group 65 and over. It was lowest in youth between the years 15 and 24. Children under 15 closely resembled those people between 25 and 64 years of age. Children also had the highest proportion of disabling sickness and it increased with age. Hoffer, in his study of health and health services among farm families of Michigan, found that the proportion of the population having positive symptoms of illness increased with age.[53] Ewing also reported

---

52 T. Lynn Smith, The Sociology of Rural Life, New York: Harper & Brothers, 1947, pp. 107-8.

53 Hoffer, op. cit., Bulletin 352.

that chronic diseases increase with age.[54] This not only helps to account for the attitudes of the older people but also those under 29 years of age who are more apt to have young children.

Attitudes By Place of Residence:

It has been demonstrated rather conclusively by Hoffer and Schuler,[55] Mott and Roemer,[56] Ewing,[57] Roskelly,[58] and others that there is a difference in the availability of medical facilities between the rural and the urban populations. The rural areas have been found to have a larger incidence of illness as well as a great lack of medical facilities to meet their health needs. The rural people are more isolated from medical facilities and even with modern means of transportation the time and expense involved in getting to a doctor are often greater than for those living in urban centers. The cost involved in bringing a doctor to the home is much higher in rural than in urban areas. It also becomes difficult at times to find an urban doctor who is willing to attend people in outlying areas. Because of the concentration of medical facilities in the larger urban districts special consideration has been given the rural areas in certain of the bills advocating government health programs which have recently been introduced into the Congress.[59]

---

54 Ewing, op. cit., p. 134.

55 Charles R. Hoffer and Edgar A. Schuler, "Measurement of Health Needs and Health Care", Michigan State College, Social Research Service, Reprinted from American Sociological Review, Vol. XIII, No. 6, December, 1948. See also Hoffer, op. cit., Bulletin 352.

56 Mott and Roemer, op. cit., Part V.

57 Ewing, op. cit.

58 Roskelly, op. cit.

59 Senator Thomas, op. cit.

In view of the foregoing discussion it seemed advisable to compare the attitudes of the people by residence. The results are shown below in Table 8. The Chi-square test indicated a probability between .10 and .20

Table 8. Attitudes by place of residence

Attitude	Place of Residence			
	Open Country	Village	Metropolitan	City
Good idea	53.7	60.4	41.3	47.2
(Good idea with reservations)	(18.9)	(35.3)	(8.7)	(12.9)
Not good idea	26.0	29.4	37.0	32.5
Uncertain	20.3	10.2	21.7	20.3
Total percent	100.0	100.0	100.0	100.0
Total responding	227	68	92	272
No response	18	6	10	25

that such a distribution could have occurred by chance. Though this probability is sufficiently high to suggest further investigation it was concluded for the present study that no further calculation of difference was warranted. However, it should be pointed out that the residents in metropolitan areas tended to have a less favorable attitude toward government-sponsored health plans than did those of the other places of residence. This was brought out by the fact that the T test, when applied to the proportions who favored such plans, revealed a significant difference ($P=<.05$) between the residents of the metropolitan area and the people of the open country and village areas, respectively. There was no significant difference between the attitudes of metropolitan and urban residents. The only significant difference between those who opposed these plans was between the metropolitan and open country residents. Another indication that the metropolitan people were less in favor of a government health insurance program than the other residence groups is that they were the only ones which did not have a significantly higher proportion who favored than who

opposed a government plan. In the other three residence groups this difference was significant ($P=<.01$). It is also interesting to note that as the proportion of those favoring a government program increased the percentage who stated reservations also increased. This indicates that among those who were more highly in favor the tendency was to consider the various aspects of such a program. Conversely, among those residents who were less highly in favor the tendency was to make an unqualified answer either for or against such a plan.

One factor which helps to explain the position of the metropolitan residents is the composition of this portion of the population. They are, on the whole, composed of two widely divergent types of people. On the one hand, there is a group which lives in single units, own their own homes, and are often engaged in work which affords them a generally high level of living. On the other hand, there is another group which lives in unfinished homes, are quite mobile and, on the whole have few ties with the community. In neither instance would one expect to find a high proportion in favor of government health plans.

Attitudes By Size Of Community:

Closely related to the availability of medical facilities by the place of residence (the type of community such as open country, urban, village and metropolitan) is the unmet medical needs of the people by the size of community. It has been shown that an area with a low density of population will probably have more unmet medical needs than one with a higher density.[60] It has also been shown that the smaller the community the fewer medical services available.[61] A knowledge of these facts suggests

---

60 Hoffer, op. cit., Bulletin 352.

61 Mott and Roemer, op. cit.

the question as to whether or not there is a difference of attitude toward government-sponsored health insurance according to the size of the community.

The coefficient of contingency, when applied to Table 9, showed an association of .25 between attitude and size of community. The Chi-square

Table 9. Attitudes by size of community

Attitudes	Size of Community					
	under 2,000	2,000-3,999	4,000-7,499	7,500-19,999	20,000-29,999	30,000-and over
Good idea	63.5	46.8	46.9	55.8	- - -	41.8
(Good idea, reservations)	(27.8)	(17.0)	(12.2)	(17.9)	(- - -)	(11.8)
Not good idea	23.8	29.8	28.6	21.8	- - -	38.9
Uncertain	12.7	23.4	24.5	22.4	- - -	19.3
Total percent	100.0	100.0	100.0	100.0	- - -	100.0
Total responding	126	47	49	156	- - -	280
No response	13	2	5	8	- - -	31

test indicated that the probability that such a distribution would have occurred by chance was less than .01. Those who lived in communities under 2,000 population were more favorable toward a government health insurance program than any other group. However, there was no significant difference between this group and those who lived in communities of 7,500 to 19,999 population. These groups were the only ones which had a significantly greater proportion who approved than who opposed a government program. On the other hand, there was a significant difference between both of these groups and each of the others.

In comparing Table 8 with Table 9 it is interesting to note that the attitudes of those who live in communities with less than 1,000 population closely resemble those who live in villages; those who live

in communities between 7,500 and 19,999 population resemble those who live in open country areas; those who live in communities between 2,000 and 7,499 population most nearly resemble those who live in cities; and those who live in communities of 30,000 population and over closely resemble those who live in metropolitan areas. Hence, it appears that no consistent trend is evident and that attitudes about government-sponsored prepayment plans are determined in large measure by factors other than residence.

Attitudes By Education:

Table 10 shows a very clear trend toward decreasing favorability of attitude toward government health insurance plans as education increased.

Table 10. Attitudes by education

Attitudes	Education				
	0-4 years	5-8 years	1-4 years high school	1 year college and over	no response
Good idea	67.4	50.4	48.1	44.9	6 cases
(Good idea, reservations)	(16.3)	(15.6)	(15.8)	(25.6)	(0 cases)
Not good idea	14.0	26.1	33.7	41.0	1 case
Uncertain	18.6	23.5	18.2	14.1	3 cases
Total percent	100.0	100.0	100.0	100.0	- - - -
Total responding	49	254	320	83	11
No response	6	24	23	5	1

However, the correlation was only .19 with a probability of .02>P>.01 that it would have been due to chance. Among all educational levels there was a greater proportion who favored than who opposed a government health plan. However, there was no significant difference between those who favored and those who opposed government health insurance on the college level.

The differences were significant on all of the other educational levels. Among those who favored the more highly educated persons were also more likely to state reservations than to approve a plan without any qualifications.

While it might seem possible that the people with higher educations were more likely to have found certain fallacies in government-sponsored health plans and, therefore, were not as highly in favor of such plans this is probably not the case. It has been demonstrated on various occasions that there is a positive correlation between level of health of the family and the education of the husband and wife. Those families with schooling below the eighth grade were found to have greater need for medical attention than those with higher educations.[62] The present study also bears this out. Therefore, it would seem that the difference in attitudes was primarily based upon need and socio-economic factors rather than educational attainment. For example, in this study education and income were found to be positively correlated. The correlation was .45 and the probability that it could have occurred due to chance was less than .01. Income, in turn, is positively associated with health.

Attitudes By Family Income:

In theory at least, health insurance is a method of paying for medical care. Its purpose is to maintain financial solvency in the face of unpredictable medical expenses. Therefore, the question arises as to what segments of the population have the greatest need for aid in meeting their medical expenses. Oscar R. Ewing, in his report to the President, indicated that only 20 percent of the people are able to "afford all" of the medical care they need.[63] He also reported that those families with

---

62 Hoffer, op. cit., and Hoffer and Schuler, op. cit.

63 Ewing, op. cit., p. 11.

incomes of $3,000 or less find it difficult, if not impossible, to stand the costs of "even routine medical care", and that those between $3,000 and $5,000 would have to make sacrifices or go in debt in order to pay for severe or chronic illness. The National Resources Planning Board reported that, in 1935 and 1936, among farm families there was an increase in the amount spent on medical care per family as the income level increased.[64] Furthermore, the U. S. Public Health Service reported that the lower the economic status the higher is the incidence of sickness and morbidity.[65] Other studies have shown that for certain sections of Michigan those families in the lower income groups were also in the lower categories of health and health care.[66]

In view of the fact that lower income groups tend to have more difficulty in meeting their health needs, as well as the fact that 89.5 percent of the people said that they approved health insurance as a method of meeting their needs, the question arises as to whether or not there is any difference in attitudes toward government health insurance programs between the lower and higher income groups.

Table 11 indicates that, with the exception of those with incomes under $1,000, favorability toward government health insurance decreased as the family income increased. However, according to the Chi-square test such a distribution could have happened by chance. Nevertheless,

---

64 National Resources Planning Board, Family Expenditures in the United States, United States Government Printing Office, Washington, 1941, pp. 155-156, cited by Hoffer, op. cit., Bulletin 352, p. 20.

65 Selwy D. Collins, Economic Status and Health, Washington: Government Printing Office, 1927, 74 p. (U. S. Public Health Bulletin No. 165), cited in Anderson, op. cit., p. 107.

66 Hoffer and Schuler, op. cit.; Hoffer, op. cit., p. 19.

Table 11. Attitudes by family income

Attitudes	Income under $1,000	$1,000-$2,000	$2,000-$3,000	$3,000-$4,000	$4,000 and over	no response
Good idea	54.6	58.7	50.8	47.4	43.4	35.0
(Good idea, reservations)	(14.8)	(16.7)	(16.7)	(18.8)	(19.5)	(7.5)
Not good idea	25.0	24.6	29.1	32.1	38.9	40.0
Uncertain	20.4	16.7	20.1	20.5	17.7	25.0
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Total responding	88	126	179	112	113	40
No response	5	12	20	7	11	4

there are a number of factors which must be taken into consideration. Among those whose family income is less than $1,000 there is undoubtedly a large proportion who are charges of the state and are, therefore, already receiving government aid. These people probably receive better medical care than do the poor generally. Another factor which must be considered is that of the attitudes of farmers. As will be seen below,[67] farmers have the fourth highest proportion who favor government health plans. However, they have second to the lowest median income of the occupational groups. This can be explained by the fact that farmers count income differently from people who work for a stated salary. The professional people should also be considered. While they are among the two occupational groups with the smallest proportion favoring government health insurance, they are also among the lower income groups. This can be explained, at least in part, by the low salary of teachers.

Because of these variations with respect to income and occupational standing and because of the trend revealed in Table 11, it seemed advisable

67 See Table 14.

to combine the income groups into two large categories, those with incomes below $3,000 and those with incomes of $3,000 and above. This combination was suggested by the discussion above (see pages 51-52) which indicates that those in the lower income brackets, especially below $3,000, are primarily those who are having a difficult time in meeting their medical expenses. It also seemed justified in view of the fact that among all of the income groups below $3,000 there was a significantly higher proportion who favored government plans than who opposed them. However, there was no statistically significant difference between those who favored and those who opposed among any of the higher income groups. When such a combination was made it was found that there was a definite correlation (.53) between attitudes toward government health plans and income. The probability that such a correlation could have happened by chance was less than .02 but more than .01.

Another trend which should be pointed out is that as income increased there was an increase in the proportion who said that a government health insurance plan would be a good idea but with certain reservations. This can be partially explained by the positive correlation between income and education as indicated earlier.

In view of the findings it must be concluded that when broad income categories, as suggested above, were compared with respect to attitudes toward government health insurance plans those with incomes below $3,000 had a significantly higher proportion who favored such plans than did those with incomes of $3,000 and above. In other words, those for whom government health insurance is primarily designed, with respect to income, were those who most highly favored such plans. However, the data also suggest that income is not the only determining factor, but that other

socio-economic factors must be taken into consideration. A more accurate picture would probably have been gained if attitudes had been studied according to the proportion of income spent for health care.

Attitudes By Size of Family:

Table 12 indicates that, with two exceptions, the proportion who favored government-sponsored health insurance plans increased as the size

Table 12. Attitudes by size of family

Attitudes	Number of members					
	One	Two	Three	Four	Five	Six and over
Good idea	59.4	47.6	50.7	38.8	58.7	60.0
Not good idea	31.2	36.6	32.4	31.3	21.8	21.2
Uncertain	9.4	15.4	16.9	29.9	19.5	18.8
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Total responding	32	183	142	134	87	80
No response	5	23	7	11	6	7

of family increased. Those families with only one member, instead of having the smallest proportion of people who favored government plans had one of the highest proportions. On the other hand, those families with four members, instead of being midway between the others with reference to their attitudes, had the smallest proportion who favored such plans. However, the lower percentage who favored was accounted for by an increase in the "uncertain" category and not among those who opposed. When those who felt that a government plan was not a good idea were compared it was found that, with the exception of the families with one member, the proportions consistently decreased as size of family increased. The correlation between attitudes and size of family was found to be .23 with a probability of less than .01 that such an association could have occurred by chance.

Size of family is related to risk and to need with regard to health and health care. The larger the family the more members there are to become ill. Also, the family income not only must be distributed over a larger number of members but tends to be somewhat smaller in the large families. Therefore, in the event of illness those families with the most members would have a more difficult time in meeting the costs of medical care. On the other hand, those families with only one member not only have the smallest incomes but also they are the oldest people, and age, as has been indicated earlier, is associated with greater incidence of illness. For example, it was found that those families with only one member had a median income of less than $1,000, the lowest median income of all families. See Table 13. Their median age was 64.7 years which

Table 13. Family income and median age of respondents by size of family

Median age and income	Number of Members						
	One	Two	Three	Four	Five	Six and over	Total
Median age in years	64.7	52.8	34.8	37.7	36.1	37.2	41.3
Median income in dollars	under 1,000	2,057	2,617	2,946	2,700	2,660	2,530

was the oldest group.[68] Over 50 percent had incomes under $1,000 and 67.6 percent were 60 years of age or over. These people, on the whole, were probably the widowed and the pensioned people who were too old to be actively employed and who were living on meager incomes. On the basis of the above information it may be argued that since those families with two members have the second highest median age and next to the lowest

68 Age refers to the age of the respondent.

median income their attitudes would be expected to be highly comparable to those of the one-member families. However, their incomes were more than double those of the one-member families and they were comparatively younger, 50 percent being under 52.8 years of age. There were only 33.5 percent who were over 60 years of age as compared with 67.6 percent of the families with one member.

The families with four members had the highest median income of all families. Their median income was $2,946 with 48.5 percent having incomes of $3,000 or more. This may account, at least in part, for lower percentage of this group which favor government plans. In terms of age they were probably at the peak of productivity. Although the respondents from families with six members and over were of somewhat comparable age the extra members in the family as well as a lower income was probably sufficient to account for the difference in attitude.

It is not to be assumed that income and age are the only factors which account for the trend in attitudes according to size of family. However, at this point they seem to be among the most important.

Attitudes By Occupation:

It has been found that low income, low educational attainment, large families, and unmet medical needs are associated with the laboring classes. Also, the "Farmers", although not necessarily classed as laborers, are not only financially but physically isolated from adequate medical care. The need has been fairly well established and agreed upon. The point in question is whether or not the various occupational groups favor a government-sponsored program to meet this need.

Although there was no significant difference between the attitudes of those who were employed as compared with those who were unemployed,

Table 14 indicates that there was an association between the attitudes of the people toward a government health insurance program and the kind of occupation to which the people belonged. The correlation was .23. The Chi-square test showed that the probability that such a correlation could have been due to chance was $.05>P>.02$.

It was found that the three occupational groups which most highly favored a government plan for health care were the "Skilled laborers", "Other Laborers", and the "Semi-skilled laborers", in order of decreasing favorability. Next to the "Semi-skilled laborers" were the "Farmers"; however, there was no significant difference found between the percentage of farmers who favored and those who opposed a government program. Their attitudes more nearly resembled the attitudes of the "Proprietors" than any other group. On the other hand, the "Servants", "Professional people", and the "Clerks and Kindred workers" were the three occupational groups which least favored a government health insurance program. The "Professional people" and the "Clerks and Kindred workers" were the only occupational groups with a higher proportion who opposed than who favored such a program, although the difference is not statistically significant.

The position of the "Servants" and "Clerks and Kindred workers", especially the"Servants" is probably not so much the result of their own thinking on the matter as it is a reflection of the attitudes of the people whom they serve. Both groups are comparatively unorganized. However, when the percentages which opposed a government plan were arranged in descending order according to occupations, as in Table 14a, the arrangement is more nearly like one would expect on the basis of medical needs, income, educational attainment, size of family, and other socio-economic factors. However, the data do not reveal further explanation of the position of the "Clerks and Kindred workers".

Table 14. Attitudes by occupation*

Attitudes	Occupation								
	Skilled	Other laborers	Semi-skilled	Farmers#	Proprietors	Servants	Professional	Clerks & kindred workers	No response
Good idea	59.7	57.9	50.3	47.2	46.1	45.0	44.0	39.7	53.9
Not good idea	28.2	10.5	26.3	32.6	33.4	30.0	48.0	43.4	26.9
Uncertain	12.1	31.6	23.4	20.2	20.5	25.0	8.0	16.9	19.2
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total responding	124	38	175	89	78	20	25	83	26
No response	10	2	15	12	4	3	2	9	2

*Occupational categories were derived from the U.S. Census, 1940. The occupation of the main earner of the family was considered.

#This category includes one farm laborer.

Table 14a. Percentages opposed to government health insurance in each occupation group

Occupation	Percent which opposed
Professional	48.0
Clerks and kindred workers	43.4
Proprietors	33.4
Farmers	32.6
Servants	30.0
Skilled	28.2
Semi-skilled	26.3
Other laborers	10.5

Attitudes By Union Membership:

Although organized labor has been among the most ardent exponents of government health insurance there was virtually no difference between the attitudes of those who belonged to unions and those who did not. While 50.0 percent of the union members favored a government plan for health care and 31.1 percent opposed, 50.6 percent of the non-union people favored and 30.2 percent opposed such plans.

Even though there was no difference between the attitudes of those who belonged to unions and those who did not there was a significant difference between the different types of unions, as indicated in Table 15.

Table 15. Attitudes by union membership*

Attitudes	Union A.F.L.	C.I.O.	Independent	Uncertain	No response
Good idea	65.6	41.4	35.0	72.2	- - - -
Not good idea	26.2	53.4	45.0	22.2	- - - -
Uncertain	8.2	25.2	20.0	5.6	2 cases
Total percent	100.0	100.0	100.0	100.0	- - - -
Total responding	61	111	20	18	2
No response	5	8	3	1	0

*Except for unmarried informants the union membership of the main earner of the family was taken. Single individuals gave their own union membership.

The coefficient of contingency showed a correlation of .35 between attitudes toward government health insurance and the kinds of unions to which the people belonged. The probability that such a distribution could have been due to chance was less than .01.

According to Table 15 those persons who belonged to the A. F. of L. were more highly in favor of government plans than the C.I.O. or independent union members. Among members of independent unions there was a higher proportion who opposed government plans than who favored such plans. However, there were only twenty cases which makes it difficult to generalize. The percentage of A. F. of L. members who favored government plans was significantly higher than the proportion who favored them among non-union people. However, this was not found to be the case among the C.I.O. members. When the attitudes of the members of independent unions were compared with the attitudes of non-union people it was found that a significantly larger proportion of members of independent unions opposed a government program of health care.

In considering the attitudes of the various union members, particularly the C.I.O. and the A. F. of L. it is well to keep in mind certain differences which exist between them.[69] The C.I.O. is a younger and more progressive union as compared with the A. F. of L. The C.I.O. union was established in 1937, whereas the A. F. of L. union was begun about 1881. The C.I.O. is run by younger men than the A. F. of L. Seventy-three percent of the C.I.O. leaders are under 45 years of age. Only 35 percent of the A. F. of L. leaders are below that age. The leaders of the C.I.O. are also more highly educated. Fifty-nine percent of C.I.O. leaders have completed high school or beyond, as compared with 34 percent of

---

69 C. Wright Mills, The New Men of Power, New York: Brace and Company, 1948, pp. 68-83.

A. F. of L. leaders who have completed this amount of schooling. Also, the C.I.O. has a slightly older and better educated group of leaders exercising authority over slightly younger and less well educated men. However, the A. F. of L. has an older and relatively poorly educated group who have authority over younger and better educated men.

In view of these differences it is surprising to find that members of the A. F. of L. had a higher percentage in favor of government health insurance. One would expect that a younger more progressive group would be more highly favorable to such measures. However, the data do not reveal any explanation of the differences which were found.

When the attitudes of the C.I.O. members were compared with the attitudes of the A. F. of L. members among the Skilled workers, Semi-skilled workers, and Other laborers it was found that within each of these occupational groups the A. F. of L. had a higher proportion who favored government health insurance than did the C.I.O. This indicates that the difference in attitude between the laboring groups is primarily due to union membership and not occupation.

It was also found that the C.I.O. had a higher proportion who had health insurance than the other unions. Eighty-two and seven-tenths percent had some kind of health insurance. There were 64.1 percent among the A. F. of L. and 68.2 percent of the independent union members who had insurance to pay part or all of their hospital and/or doctor fees. However, of those who had health insurance, members of the A. F. of L. had a significantly higher proportion who favored government-sponsored prepayment health plans than the C.I.O.

Attitudes By Political Preference:

In order to get at the political preference of the people they were asked: "In general, which of the political parties do you favor in the Presidential election this fall?" While 37.0 percent of the 717 informants said they were uncertain which political party they favored, 31.9 percent favored the Republican party and 22.3 favored the Democratic party.

Table 16 shows that a higher proportion of Democrats favored a government health insurance program than did members of the other political

Table 16. Attitudes by political preference

	Political preference				
Attitudes	Democrat	Republican	All others	Uncertain	No response
Good idea	61.5	45.5	31.0	51.8	28.5
Not good idea	16.8	41.1	31.0	26.9	53.6
Uncertain	21.7	13.4	38.0	21.3	17.9
Total percent	100.0	100.0	100.0	100.0	100.0
Total responding	143	209	29	249	28
No response	17	20	2	16	4

parties. The correlation between political preference and attitudes was .29 with a probability of less than .01 that such a correlation could have occurred by chance. In view of the fact that the Democratic party has encouraged and promoted government-sponsored prepayment plans for health care it is not surprising to find that those who favored the Democratic party also favored government health plans.

It was found by Lazarsfeld that the people tend to vote like others with similar social characteristics, and on specific questions there is a tendency to become consistent with party position.[70] This serves to

70 Paul F. Lazarsfeld, Bernard Berelson, and Hazel Gaudet, The People's Choice, New York: Columbia University Press, 1948.

explain further the position of the various political groups. While most of the occupational groups tended to be predominantly Republican, the "Servants","Other laborers", "Skilled" and "Semi-skilled" workers, in order from highest to lowest, had the greatest proportion who favored the Democratic party. All of these groups, except the "Skilled" workers, had a slightly higher proportion of Democrats than Republicans. This also verifies further the previous statement that "Servants" were more likely to represent the attitudes of those whom they served. Normally their attitudes would be expected to be more nearly like other Democrats.

Attitudes By Military Service in World War II:

It is assumed by many that the medical care which members of the armed forces receive is highly comparable to the care the people would receive under a government-sponsored health insurance program. Therefore, it seemed advisable to compare the attitudes of those who had been members of the armed forces during World War II with those with no military service.

It was found (see Table 17) that there was no association between military service and attitudes toward government-sponsored health plans.

Table 17. Attitudes by military service in World War II

	Military Service				
Attitudes	Yes, self only	Yes, others	Self and others	No	No response
Good idea	53.8	47.9	- - -	50.3	4 cases
(Good idea, reservations)	(21.5)	(9.2)	(- - -)	(18.2)	(1 case)
Not good idea	27.7	33.6	1 case	29.6	5 cases
Uncertain	18.5	18.5	1 case	20.1	- - - -
Total percent	100.0	100.0	- - -	100.0	- - - -
Total responding	65	119	2	462	10
No response	6	5	0	46	2

The probability that such a distribution could have been due to chance was between .80 and .90. It must be concluded, therefore, that experiences connected with military service had no appreciable effects upon the attitudes of those who served as compared with those who did not serve. It is possible that World War II had some effects upon the attitudes of the people as a whole. However, there is no way of determining this with the data at hand.

CHAPTER V

ATTITUDES TOWARD GOVERNMENT-SPONSORED HEALTH PLANS BY HEALTH NEEDS, PROPORTION HAVING HEALTH INSURANCE, AND PREFERENCE FOR PRIVATE OR GROUP PRACTICE

Since health insurance programs are designed to aid people to meet the expenses connected with illness, it seems rather pertinent to inquire into the attitudes of those who, in the past year or two, have had experience with sickness in their homes. Since the question now before the country is whether it should adopt a government-sponsored health program or to further develop and expand the present system, it seems relevant to compare the attitudes of those who have some kind of health insurance with those who have none. Finally, it seemed advisable to compare the attitudes of those who preferred private practice with those who preferred group practice of medicine.

ATTITUDES BY HEALTH NEEDS

Attitudes By Hospital Experience In Past Two Years:

The informants were asked if they or nay member of their family had been a hospital patient in the past year or two. The attitudes of those with hospital experience were compared, as shown in Table 18, with the attitudes of those who had had no hospital experience in the past two years.

Table 18. Attitudes by hospital experience in the past two years

	Hospital Experience				
Attitudes	Yes, self only	Yes, other	Self and other	None	No response
Good idea	51.7	62.0	46.6	47.0	2 cases
Not good idea	30.1	24.1	26.7	32.1	1 case
Uncertain	18.2	13.9	26.7	20.9	1 case
Total percent	100.0	100.0	100.0	100.0	- - - -
Total responding	143	79	15	36	4
No response	10	10	00	00	0

Having had hospitalization experience in the family in the past year or two did not seem to affect the attitudes of the people toward government health plans. The probability that the distribution shown in Table 18 could have occurred by chance was between .10 and .20. When all of those with hospital experience were combined and their attitudes were compared with the attitudes of those who had had no members in the hospital the Chi-square test revealed that the relationship remained unchanged.

Since the distribution was not differentiated by the length of time spent in the hospital, the seriousness of the affliction, nor the cost involved for the family it is not surprising to find a lack of correlation. However, the probability that such an association was due to chance was low enough to suggest further investigation.. Therefore, it seemed pertinent to examine the data on the basis of the total cost of the hospital experience. This was the most relevant information available. This problem will be examined next.

Attitudes By Cost Of Hospitalization:

As was suggested, probably more important than comparing the attitudes of the people by whether or not they had been hospitalized is to compare their attitudes by the cost of that hospitalization. When the attitudes of those with hospital experience in the past two years were compared by the cost of that hospitalization, it was found that there was a definite increase in favorability toward government health plans as the cost of hospitalization increased. The results are shown in Table 19. The distribution was found to be statistically significant (P=.01).[71] The correlation was .37.

---

71 The category, "Federal hospital; all others", was not included in the Chi-square test of significance because of the small number of cases.

Table 19. Attitudes by cost of hospitalization

Attitude	Cost of Hospitalization: Insurance paid part or all	Less than $150	$150-299	$300 and over	Federal hospital; all others	No response
Good idea	38.8	55.7	68.6	72.5	5 cases	4 cases
Not good idea	46.0	21.2	25.7	17.2	1 case	6 cases
Uncertain	16.0	23.1	5.7	10.3	- - - -	1 case
Total percent	100.0	100.0	100.0	100.0	- - - -	- - - -
Total responding	50	104	35	29	6	13
No response	5	5	6	1	2	1

The individuals who indicated that they had health insurance which had paid part or all of their hospital expenses were the only group with a higher proportion opposing government health plans than favoring them. However, it is not to be assumed that all of the people who already have some kind of health insurance are opposed to government plans and those who do not have insurance favor them. Those with health insurance who had had members of the family in the hospital in the past two years were only a small proportion of all of those with health insurance. It should also be pointed out that there were 91 other informants who were hospitalized who also had health insurance. However, they reported the cost of hospitalization, but did not mention that the insurance had paid any of it.

The informants were not asked whether the costs of hospitalization were paid by insurance or if they had met the full expenses themselves. At this point in the interview the respondents were simply asked to give the cost of hospitalization. They were asked later if they had any health insurance. It must be assumed, therefore, that those who simply reported that the insurance paid part or all of the bill either did not know or could not remember how much the bill was. In the event the insurance

company did not pay all of the bill, the informant may have paid the remaining portion without inquiring into the amount paid by the insurance company. On the other hand, it may be that the insurance took care of the entire bill without involving the policy holder. In any event, the cost of hospitalization apparently was of no burden to them or they undoubtedly would have known, at least approximately, how much it was.

It should be pointed out that the hospital costs which were mentioned were, in many cases, only close approximations. One reason for this is the tendency to forget with time. However, in most instances the expenses were large enough that they could be remembered with reasonable ease and accuracy. The categories in Table 19 are large enough to compensate for forgetting. Also, there were 49.0 percent of the people who indicated that the expenses which they reported included the hospital, doctor, and nurse's fees. Approximately half of the respondents indicated that the amount which they reported did not include all of these expenses. However, this discrepancy probably does not affect the results appreciably. The trend is sufficiently pronounced to justify the conclusions.

Attitudes By Informants' Positive Symptoms Of Illness:

It was found that the informants who had the greatest number of positive symptoms indicating need for medical attention also favored most highly a government program of health insurance.[72] As shown in Table 20, there was also a consistent decrease in the proportion opposing such a program as the number of symptoms increased. The trend was further emphasized by a smaller proportion who were uncertain among those with the most symptoms

---

72 For a discussion of the "Symptoms Approach" see: Edgar A. Schuler (Bureau of Agricultural Economics, U. S. Department of Agriculture), Selz C. Mayo (N. C. State College), and Henry B. Makover, M.D. (U. S. Department of Agriculture), "Measuring Needs of Medical Care: An Experiment in Method", Rural Sociology, Vol. XI, No. 2, June, 1946, pp. 152-158.

of illness. The distribution was statistically significant (.05>P>.02), and had a correlation of .20. Although there was practically no difference between the attitudes of those who had only two symptoms or less, the major difference was between those who had two or less and those who had three or more symptoms.

Table 20. Attitudes by informants' positive symptoms of illness

	Number of Symptoms					
Attitude	None	One	Two	Three	Four & over	No response
Good idea	46.2	46.6	45.9	62.1	67.6	4 cases
Not good idea	31.4	33.8	33.8	22.4	22.5	3 cases
Uncertain	22.4	19.6	20.3	15.5	9.9	1 case
Total percent	100.0	100.0	100.0	100.0	100.0	- - - -
Total responding	299	148	74	58	71	8
No response	26	13	12	2	4	2

This indicates that the greater the need for medical attention the more highly the people favored a government-sponsored plan for health care. Since the respondent was giving his own symptoms only, it is possible that the trend would be even more pronounced if the symptoms of illness of the entire family were considered. However, such a comparison did not seem to be feasible in view of the manner in which the data were obtained.

Attitudes By Days Off Due To Illness:

Those informants who indicated that they had been ill during the past six months were asked how many days they had been off work or unable to work, during that period. The results were then compared with the people's attitudes toward a government-sponsored plan for health care. See Table 21.

Table 21. Attitudes by days off due to illness

Attitudes	Days Off None	1-9	10 and over	No response
Good idea	48.8	52.8	57.4	2 cases
Not good idea	30.1	41.5	25.9	- - - -
Uncertain	21.1	5.7	16.7	- - - -
Total percent	100.0	100.0	100.0	- - - -
Total responding	549.	53	54	2
No response	51	3	5	0

The correlation of attitudes with the number of days lost due to illness was .16. The probability that such a distribution could have been due to chance was .05. The low correlation can be accounted for in part by the fact that many house-wives feel that they must keep going in order to attend to the needs of the family even though they may be ill. However, the trend is rather apparent that those who had been disabled for the longest period were also those who were most highly in favor of a government-sponsored plan to provide medical care

ATTITUDES BY PROPORTION HAVING HEALTH INSURANCE

As has been indicated, the people have been convinced of the value of insurance as a method of meeting the costs of medical care. The question which is facing the country is what kind of health insurance --- should it be provided by private companies on a voluntary basis or should it be compulsory and sponsored by the government. It was felt that insight could be gained into this problem by comparing the attitudes of those who already had health insurance under private sponsorship with those who had no health insurance.

The data revealed that there was a positive correlation of .40 between income and having health insurance ($P=<.01$). This indicates that

those who were more apt to need health insurance from a financial standpoint were the ones less likely to have it. The same trend held true among the occupational groups. While there was a greater tendency for the laboring groups to have health insurance than the other occupational groups, the more highly paid laboring groups had a higher proportion with health insurance than did those in the lower income brackets.

When the attitudes of those who had health insurance to pay their doctor and/or hospital bills were compared with the attitudes of those who had no health insurance there were no significant differences found between them. See Table 22. The Chi-square test showed a probability of between .50 and .70 that such a distribution could have been due to chance. In other words, those who already had health insurance from private companies were as highly in favor of government-sponsored health plans as were those who were not insured against the costs of illness.

Table 22. Attitudes by proportion having health insurance

	Proportion Having Health Insurance			
Attitudes	Yes	No	Uncertain	No response
Good idea	48.7	52.9	- - - -	45.9
Not good idea	30.7	28.2	1 case	49.9
Uncertain	20.6	18.9	1 case	4.2
Total percent	100.0	100.0	- - - -	100.0
Total responding	394	238	2	24
No response	33	25	0	1

ATTITUDES BY PREFERENCE FOR PRIVATE OR GROUP PRIVATE PRACTICE

When the people were asked whether they preferred group practice or if they would rather go to a doctor who practiced alone it was found that 46.1 percent favored group practice, 33.8 percent favored doctors who practiced alone, and 18.7 percent were uncertain. The attitudes of those who preferred group practice were compared with those who preferred

private practice. See Table 23.

Table 23. Attitudes by preference for private or group practice

Attitudes	Preference: Group practice	Private practice	Uncertain	No response
Good idea	53.6	48.2	46.0	1 case
Not good idea	30.8	33.2	23.4	4 cases
Uncertain	15.6	18.6	30.6	1 case
Total percent	100.0	100.0	100.0	- - - -
Total responding	308	220	124	6
No response	23	22	10	4

The distribution was found to be significant (P=.01) with a correlation of .20. However, according to the T test there was no significant difference between the attitudes of those who preferred group practice and those who favored private practice. The significant element in the distribution was found to be the "Uncertain" categories. Those who tended to be uncertain about group and private practice were also uncertain about government health insurance. When the Chi-square test was computed with the "Uncertain" replies taken out it was found that the probability that such a distribution could have been due to chance was between .30 and .50. Therefore, it cannot be concluded that there is any difference between the attitudes of those who preferred group practice and those who favored private practice.

This was undoubtedly a hypothetical situation. For example, it was found that although 46.1 percent favored group practice, more than two out of three (68.9 percent) of the informants and their families went to only one doctor for most of their ills. This may account for the large percentage who were uncertain about group practice. If more of the respondents had had experience with group practice the results may have been considerably changed.

CHAPTER VI

OPINIONS ABOUT GOVERNMENT-SPONSORED PREPAYMENT HEALTH PLANS AND "SOCIALIZED MEDICINE"

The residents of Michigan were asked if they had heard or read of a plan in which the people would pay a certain percentage of their income to the government and in return members of the family would have their doctor and hospital bills paid for by the government.[73] They were then asked what they thought the good and bad points of such a program would be. The first two favorable and unfavorable opinions which were expressed by the individuals were those which were used for the analysis which follows. It was assumed that those which were mentioned first would probably be deemed the most important by the respondent. However, there were only a few instances in which there were more than one or two opinions expressed, and a large percentage of the respondents expressed no opinion.

Those informants who did not spontaneously identify government plans as "socialized medicine" were asked later if they had ever heard of it. Those who replied that they had were asked what they thought were the good and bad points of such a program. Here again, only the first two responses were considered.

OPINIONS ABOUT GOVERNMENT-SPONSORED PREPAYMENT HEALTH PLANS

Favorable Opinions:

Table 24 reveals that the favorable opinion which was most frequently expressed about government-sponsored plans was that "People could get medical care when needed". This implies a certain feeling of insecurity which many of the people had with regard to their ability to obtain adequate medical care. Perhaps they have had trouble in getting medical care

at some time or had put off seeking medical aid when needed because of lack of money. It was found, for example, that the most frequently expressed reason for members of the family not seeing a doctor when they felt that they should was that it was "too expensive". More than one out of every four (26.2 percent) gave this as the main reason.

Table 24. Favorable opinions about government-sponsored prepayment health plans

Favorable opinions	Percent
People could get medical care when needed	21.7
Good for poor people	18.2
Don't have to worry when something happens	11.0
Payroll deduction - hency prepayment plans	9.2
More people would be taken care of	7.0
Lower cost of medical care	6.1
Favor government control or sponsorship	5.6
Good for large families	4.3
Better medical care	3.4
All others	13.5
Total percent	100.0
Total responses*	444

*The first two responses of the informant were considered. However, many only gave one statement and some did not give any.

The second most frequently expressed opinion was that a government-sponsored plan for health care would be "Good for the poor people". This seems to show a concern for the poor people generally whom they feel should be taken care of and not so much a concern for oneself. However, it is likely that some of the people identified themselves as one of those poor people who would be taken care of.

The expression, "Don't have to worry when something happens", is, like the first one, a more personal reason for favoring government-sponsored health insurance. It indicates the feeling that they would be assured of health care under a government system, an assurance which they apparently do not have at the present time.

The opinion that a government-sponsored health plan would be "Payroll deduction - hence prepayment plans" probably indicates a certain amount of indifference as to who sponsores the health insurance, the government or private companies, just as long as it operates on a prepayment basis. It is also interesting to note that 5.6 percent indicated that the reason government health insurance would be a good idea is that they "Favored government control or sponsorship".

Favorable Opinions As Stated By Those Who Favored And Those Who Opposed Government-Sponsored Health Plans:

When the opinions of those who favored government health plans were compared with those who opposed such plans, it was found that persons who favored government plans gave 82.8 percent of the total favorable opinions. See Table 25. Also, individuals favoring government health insurance tended to give more personal reasons for endorsing such a system. Such opinions as "People could get medical care when needed"

Table 25. Favorable opinions as stated by those who favored and those who opposed government-sponsored health plans

	Attitudes	
Favorable opinions	Favor	Oppose
People could get medical care when needed	25.1	9.0
Good for poor people	14.0	37.3
Don't have to worry when something happens	13.0	3.0
Payroll deduction - hence prepayment plans	8.1	11.9
Favor government control or sponsorship	8.1	1.5
Lower cost of medical care	8.1	0.0
More people would be taken care of	5.3	14.9
Good for large families	3.4	7.5
Better medical care	3.7	1.5
All others	11.2	13.4
Total percent	100.0	100.0
Total responses	322	67

and "Don't have to worry when something happens", included 38.1 percent of the responses. Conversely, only 12.0 percent of the responses of those who opposed government health plans were concerned with those statements. The opinions, "Good for poor people" and "More people would be taken care of", comprised 52.2 percent of the responses of those who opposed government plans. This reveals a tendency for them to imply that government health insurance may have some advantages for people other than themselves. They probably recognized the need for better health care for many families but, as indicated by their attitudes, they did not feel that government health insurance was the best method of meeting that need. Evidently, they did not favor such a system for themselves but felt that it may be all right for the poor people and others who were not receiving adequate care.

Those who opposed government health insurance did not give a single response to the effect that it would lower the cost of medical care. Eight percent of the opinions of those who favored government plans were of this kind. There was also a smaller proportion of those opposing a government system who said that they favored government control or sponsorship, and a smaller proportion who felt that government health insurance would provide better medical care. On the other hand, there was a higher proportion who felt that a government plan would have the advantage of being a prepayment plan. A certain proportion recognized that a government system would also be a prepayment plan, but their unfavorable attitude indicates that they preferred to have such a plan sponsored by someone other than the government. There was a larger proportion of those opposing a government program who indicated that it would be a good idea for large families. This is a further indication that they felt that it would be a good idea for people other than themselves.

Unfavorable Opinions:

There was little difference between the number of unfavorable opinions and those which were favorable. There were 444 favorable statements as compared with 431 unfavorable opinions. As shown in Table 26, the major objection to government plans for health care was

Table 26. Unfavorable opinions about government-sponsored health plans

Unfavorable opinions	Percent
Government has too much control now -- too much "red tape"	25.3
People should pay their own bills	15.6
Financial disadvantages -- cost too much -- money mismanaged	11.6
No choice of doctors	8.8
Destroy doctor's initiative and incentive	6.7
Lowered quality of service	6.5
Less personal care and interest	5.3
People would misuse the services	4.2
All others	16.0
Total percent	100.0
Total responses	431

that the"government has too much control now -- too much 'red tape'". This is, of course, connected with the American ideal of laissez faire. However, such an objection to government health insurance, even though it may have some justification, is rather incongruous. The laissez faire system is praised for the freedom which it gives the individual, but at the same time it is criticized because of the "red tape" involved in the administration of its programs.

The second most frequently expressed unfavorable opinion was that "People should pay their own bills". This indicates the influence of unfavorable propaganda about government-sponsored health plans and also the traditional idea of independence prevalent in our culture. The

informants were asked what they felt would be some of the "bad" points of a program in which the people would pay a certain portion of their income to the government and in return members of the family would have their doctor and hospital bills paid for by the government. The tendency may have been for them to recall those statements which they had heard about government health insurance or about other government programs. Such assertions, as how much it would cost the government to provide health care for the people, and the strong emphasis upon being independent are examples.

The opinion that a government system would cost too much or that the money would be mismanaged may be a legitimate objection. However, it should be pointed out that it is concerned with management and not with the services which would be rendered. It is noticeable that only 18.5 percent of the unfavorable opinions were connected with medical service. These opinions included such ideas as a government health program would: "destroy the doctor's initiative and incentive"; "lower the quality of service"; or cause "less personal care and attention". The other unfavorable opinions were concerned primarily with management and administration of the system.

Unfavorable Opinions As Stated By Those Who Favored And Those Who Opposed Government-Sponsored Health Plans:

Seventy and eight-tenths percent of the unfavorable opinions about government-sponsored prepayment plans for health care were expressed by those who opposed them. The most frequently expressed objection, by both those who favored and those who opposed, was that the "government has too much control now -- too much 'red tape'". See Table 27. This was more frequently expressed by those who opposed government health insurance than those who favored it.

Table 27. Unfavorable opinions as stated by those who favored and those who opposed government-sponsored health plans

Unfavorable opinions	Attitudes	
	Favor	Oppose
Government has too much control now -- too much "red tape"	20.6	29.2
Financial disadvantages -- cost too much -- money mismanaged	15.0	10.4
Less personal care and interest	10.3	2.7
People should pay their own bills	9.3	19.6
Lowered quality of service	9.3	5.4
No choice of doctors	7.5	9.6
Destroy doctor's initiative and incentive	6.5	6.9
People would misuse the services	2.8	3.1
All others	18.7	12.8
Total percent	100.0	100.0
Total responses	107	260

Among those who favored a government-sponsored health plan the second most frequently expressed objection was that of financial disadvantages. Even though they favored such a plan some felt that it might cost too much or that the money might be mismanaged.

The third unfavorable opinion which was most frequently expressed by those who favored a government-sponsored health plan was the first to deal with medical care. Even this statement did not deal with it directly. It was concerned with what was described by the informant as "less personal care and interest". From the standpoint of emotional security of the patient this may be important; however, it probably has little effect upon the quality of medical care. Nevertheless, as far as the people are concerned personal interest is desirable; therefore, it is a legitimate objection to any program which might not provide such personalized attention. This objection was stated by those who opposed government health plans less frequently than any of the other opinions.

The unfavorable opinion which was expressed the second highest number of times by those who opposed government health insurance was that "the people should pay their own bills". As has been indicated, this objection is very general and shows a lack of critical analysis. It is rather illogical to assume that the people could receive "free" medical care. However, they still have the feeling that their government would be "footing the bill" and giving them "free" medicine when they should be paying their own bills. There is a tendency to forget who that government is and who it is that finances the government. This fallacy is promoted by the opponents of government health insurance. However, it should be pointed out that the major proponents have not advocated that the people would be getting something for nothing. Their programs have included definite plans for financing such a system.

OPINIONS ABOUT "SOCIALIZED MEDICINE"

The main objective in inquiring into the opinions of the people toward "socialized medicine" was to study the opinions about the general concept and not about any specific plan. Because of the negative connotation which the term "socialized" has, it seemed desirable to compare the opinions which the people expressed about "socialized medicine" with those which they gave about government prepayment plans for health care. Those who had not previously identified government-sponsored health plans as "socialized medicine" were asked if they had heard of it. Including those who had mentioned it earlier, there were only 204 of the informants who had heard of"socialized medicine". Only those who had heard of "socialized medicine" were asked to give their opinions about it.

Favorable Opinions:

As shown in Table 28, the people expressed essentially the same kinds of favorable opinions toward "socialized medicine" as they did toward government-sponsored prepayment plans for health care. This implies that there was a tendency for many of the people to feel that the two programs would be the same thing. This was also indicated in the remarks of many of the informants. When asked what their opinions about "socialized medicine" were they would oftentimes indicate that they were the same as they had expressed toward government prepayment plans.

Table 28. Favorable opinions about "socialized medicine"

Favorable opinions	Percent
Good for poor people	24.3
People could get medical care when needed	18.9
More people would be taken care of	16.2
Lower cost of medical care, cost standardized	12.2
Don't have to worry when something happens	8.1
Good for large families	5.4
Better medical care	5.4
All others	9.5
Total percent	100.0
Total responses	74
Number of respondents	204

*"Number of respondents" refers to those who had heard of "socialized medicine" and were asked to give their opinions about it. The number of individuals who actually gave opinions was not computed.

One of the major differences between the favorable opinions toward "socialized medicine" and those about government prepayment plans is that in no instance was "socialized medicine" identified as a prepayment plan. There was also no one who indicated that they favored government control or sponsorship when expressing their opinions about "socialized medicine". This is an indication of the negative connotation which the

term "socialized" has to the people. They may favor government control as long as it is not "socialized" control. However, there was a greater tendency for the people to feel that under "socialized medicine" "more people could be taken care of". This is to be expected since the central idea of any "socialized" program is collective ownership for the distribution and production of goods.

It should be pointed out that only 74 opinions were expressed by 204 people who had heard of "socialized medicine". This reveals a lack of familiarity with such a program especially since two opinions were considered for each informant.

Unfavorable Opinions:

There were considerably more unfavorable opinions expressed about "socialized medicine" than there were favorable ones. The unfavorable statements comprised almost two out of three (60.2 percent) of the total responses. This tends to indicate a somewhat more unfavorable attitude toward "socialized medicine" than government prepayment plans, since there was practically no difference in the number of favorable and unfavorable opinions which were expressed about government plans. This is probably indicative of a reaction to a negative term rather than a particular program.

Here again, the opinion expressed most often was that the "Government has too much control now — too much 'red tape'". See Table 29. This statement was rather consistently applied to the idea of a government-sponsored plan and to"socialized medicine" alike. The second most frequently expressed opinion is probably associated with the general stereotype that anything "socialistic" would lack the initiative and incentive associated with competition, free enterprise, and lassez faire.

Table 29. Unfavorable opinions about "socialized medicine"

Unfavorable opinions	Percent
Government has too much control now -- too much "red tape"	18.8
Destroy doctor's initiative and incentive	16.1
Lowered quality of service	11.6
No choice of doctors	10.7
Less personal care and interest	8.9
People should pay their own bills	6.2
Might cost too much	4.5
People would misuse the service	3.6
All others	19.6
Total percent	100.0
Total responses	112
Number of respondents*	204

*"Number of respondents" refers to those who had heard of "socialized medicine" and were asked to give their opinions about it. The number of individuals who actually gave opinions was not computed.

The statement that the quality of service would be lowered is probably not only associated with the foregoing statement but also with the concept which many people have of the inefficiency of government control and administration.

Summary:

The fact that so few people gave opinions is further indication of the lack of information which they had concerning government health insurance and "socialized medicine". The objections to both government health programs and "socialized medicine" pertained primarily to management and administration. Favorable opinions were concerned more with the extension of medical care and the feeling that a government health program would provide that care.

The informants who favored a government health program gave the largest number of favorable statements. Conversely, those who opposed

government health insurance expressed the largest number of unfavorable opinions. While this may be further indicative of the favorable or unfavorable attitudes which were expressed by the respondents, it is also possible that they were trying to justify the attitudes which they had expressed. In most instances the attitudes were expressed rather spontaneously; however, more thought was given to the statements which they made.

CHAPTER VII

SUMMARY AND CONCLUSIONS

SUMMARY

Health insurance developed as a result of a long process of social evolution. It had its beginning in this country approximately 100 years ago. There were essentially two major factors which were important in the development of health insurance. Probably the most important influences were those of the industrial revolution and the great strides in the scientific progress of diagnosing and treating illness.

The industrial revolution had the effect of bringing a general lack of security for the large laboring class of people. Such misfortunes as low wages, lack of personal property, unemployment, industrial accidents, sickness, inflation, and deflation accompanied the industrial revolution. As a result, the people began to seek social security from these adversities.

The scientific advancements in medicine had many effects upon the development of health insurance. A large body of men and women became highly trained and centralized in the more densely populated areas. This centralization was also influenced greatly by the shift from a rural-handicraft economy to an urban-industrial economy. The scientific progress of medicine was also a factor in increasing the cost of medicine. Longer periods of training were required, and modern equipment for diagnosing and treating illness became very expensive. These two factors of cost and centralization had the effect of isolating many people both physically and financially from the modern medical techniques which were being provided. These two factors were also very closely related to the industrial

revolution with which low wages and centralization were associated. The great strides being made in the medical field were also influential in the growing public awareness of the need for adequate medical care. The people began to appreciate the benefits which were being offered by the medical profession, and became more and more aware of the social advantages connected with good health. However, there still remained large groups of people who financially were unable to take advantage of the benefits being offered by scientific medicine.

Before costly medical techniques were developed, and before the social pressure became so strong for adequate medical care, loss of earnings due to sickness and accidents was the major concern, rather than the expenses connected with sickness itself. It was during this time (the latter part of the 19th century) that lumbering, mining, and railroad companies began to offer limited cash benefits to their employees to cushion such losses. It was from these plans that the prepayment health plans as we know them today developed. With the growing concern for medical care, cash benefits began to give way to medical benefits, and commercial companies began to provide these services. Gradually the need for unifying all health activities into a highly integrated and coordinated program was recognized. The government was also becoming interested in public health and began to exert a more dominant influence.

The first campaign for government health insurance in the United States began about one year after the British Insurance Act of 1911 was passed. In 1912 the American Association for Labor Legislation created the National Committee on Social Insurance. This Committee organized the first national conference on the subject of social insurance. The Committee, with the aid of the American Medical Association, drew up nine standards for a health insurance law. This draft became known as the "Standard Bill".

Compulsory health insurance reached the United States Congress in 1916 in the form of a bill to create a Federal Commission on national insurance for sickness, invalidity and old age. However, it was referred to a committee and soon died out. During the period from 1915 to 1920 there was much activity going on both for and against compulsory health insurance. However, on the whole it was primarily on the state level, rather than the federal level. About 1920 interest waned and the activity died out.

The major groups who opposed government health insurance were the employers, insurance companies, the medical profession, and organized labor — at least the executive council of the A. F. of L. At first, the medical profession actively engaged in promoting government health insurance, as indicated by their interest in the Standard Bill and other activities, but later their position changed.

The event of greatest consequence which developed in the field of health insurance between the first campaign for government health insurance and the recent campaign was the application of group insurance. Group health insurance received widespread acceptance and by 1934, just nine years after it was first begun, 76 percent of all health plans were group insurance plans.

The recent campaign for government health insurance began in 1927 when the Committee on the Costs of Medical Care was appointed to investigate the problem of furnishing good medical care to all of the people. The reports of the Committee were published in 1932. However, there was disagreement among the Committee members. The majority report favored encouraging and experimenting with voluntary insurance financed from private and government sources. They also recommended group practice. The minority report was most strongly opposed to group practice, but also indicated

that health insurance also had many shortcomings. Both groups agreed that there was a need for some kind of health program.

Although health security was the only major form of security omitted from the National Social Security Act of 1935, it became part of the larger social security context and, as such, has received increasing interest. In recent years there have been many bills introduced into the Congress proposing a nation-wide system of compulsory health insurance. Among the most prominent ones are those which were formulated by Senators Wagner and Murray and Representative Dingell. On the other hand, Senators Taft, Smith, Ball, and Donnell, who have opposed compulsory health insurance have introduced bills into the Congress which would expand and further develop the present health system.

Both of the campaigns went through a phase of study and discussion and then into a period of legislative activity. There have also been certain shifts of interest during this development. The first campaign was primarily between individuals and the second was between groups of people. Nevertheless the arguments for and against a government health program have been essentially the same. In both periods the people have been divided into three main groups with respect to their attitudes. In one group are those who have vigorously opposed government health insurance. Another group are those who have taken an extreme position in favor of it. In between are those who have felt that such a program would have certain advantages but that it would also have certain defects which would need to be eliminated before a successful program could be achieved.

There have been many studies of attitudes toward government health insurance. On the whole they have found, with varying degrees of authenticity, that the majority of the people favored a government health program.

CONCLUSIONS

The purpose of this study was to determine the attitudes of a scientifically drawn sample of the adult residents of Michigan toward government-sponsored prepayment plans for health care. The questions which were posed in the beginning of this study will not be treated specifically here, but will be integrated in the general conclusions drawn from the study.

Insurance, per se, as a method of paying medical expenses is not in question by the people of Michigan. A high majority favor it.

Despite the activity which has been waged for and against government health insurance, on the whole, the adult residents of Michigan were found to be unfamiliar with either a generalized program of government health insurance or with a specific plan such as the Wagner-Murray-Dingell Bill. Less than one out of three of the informants had heard of a general government plan, and only one person out of six had heard of the Wagner-Murray-Dingell Bill. In view of the time and money which is being spent on advertising and propaganda about government health insurance this seems to be a rather pertinent finding, for apparently it is not reaching the people.

Even though a large proportion of the informants had not heard of a government-sponsored health plan previous to the interview, a significantly higher percentage favored such a plan than opposed it. On the basis of the information at hand, it is concluded, therefore, that not only were the majority of the people in favor of a government-sponsored prepayment plan for health care, but also that they were probably dissatisfied with the present system of meeting health needs.

It was found that, while there was no specific factor which correlated highly with attitudes toward government-sponsored health plans, attitudes were determined by a complex of factors. There were three main factors which were found to be influential in the determination of the attitudes of the adult residents of Michigan toward government-sponsored prepayment health plans. They are as follows: familiarity with government-sponsored plans for health care, a complex of socio-economic factors related to social class, and actual experience with sickness.

It was found that there was no difference in the percentages of persons approving government health plans between those who had and those who had not heard of such plans. However, among those persons who were familiar with government health insurance there was a larger proportion who were opposed than there was among persons who had not previously been familiar with it. It was concluded, therefore, that the knowledge which the informants had gained had some effect upon their attitudes, although the association was very low. However, the kind of information which they received is not known. Hence, it cannot be concluded that they were opposed to any particular program which is being advocated. It is possible that they were familiar with a certain program of which they did not approve. However, it is just as likely that they were reacting to negative propaganda which they had received.

It has been indicated that no one factor was highly correlated with the attitudes of the adult residents of Michigan toward government-sponsored health plans. However, when the complex of socio-economic factors was taken as a whole, it was found that those who favored government plans were primarily associated with the large laboring groups and the lower socio-economic classes generally. Those factors which seemed to be of first importance in the determination of attitudes were, in order of

greatest to least degree of association, income, union membership, political preference, size of community in which the respondents lived, size of family, occupation, and education.

When broad income groups were considered, it was found that those informants who were in the income groups below $3,000 were those who were most highly in favor of government-sponsored health plans.

Although it is conclusive that members of the A. F. of L. were more highly in favor of government health insurance, sufficient information was not available to explain its position as compared with the other unions.

Democrats were more highly in favor of government health plans than were the members of the other political parties. This is understandable in view of the fact that the Democratic party is associated with the laboring groups, the lower income people, and with more progressive measures.

Although the size of community from which the respondents came was found to be associated with attitudes toward government health plans, the association cannot be considered to be a true linear relationship. The most noticeable relationship was that those in the less densely populated areas (especially those under 2,000 population, where medical facilities are less likely to be readily available) tended to be most highly in favor of government-sponsored prepayment health plans.

With the exception of the families with four members, there was an increase in favorability toward government health insurance as size of family increased. The position of four-member families are explained by the fact that they not only have the highest median income, but also they were at the peak of productivity as far as age is concerned. Family size itself is related to health needs, which increase with the size of the family.

Among the occupational groups, it was found that the laboring groups were those who were most highly in favor of government health insurance. The primary exception was that the attitudes of servants tended to more nearly coincide with the attitudes of those whom they served. Although the correlation between occupational standing and attitudes toward government health plans was not found to be very high, occupation is highly correlated with income, education, and with unmet medical needs which, in turn, correlated with attitudes toward government health insurance.

Although education correlated with the attitudes of the informants toward government health insurance, it was also highly correlated with other socio-economic factors. Therefore, it cannot be concluded that education itself is very influential in determining the attitudes of the respondents. The attitudes were probably more highly associated with other socio-economic factors which are, to a large extent, determined by one's education.

The actual experiences which the people had with illness are probably the most important factors in terms of determining their attitudes toward a government-sponsored health plan. It was found that the greater the number of medical needs, as determined by the number of positive symptoms of illness and the number of days off work or unable to work due to sickness, the more favorable were the attitudes of the informants toward government-sponsored health plans. However, the primary factor associated with favorable attitudes, as far as experience with illness is concerned, was that of personal experience with the expense of hospitalizing family members. The greater the expenses connected with hospitalization the more favorable were the attitudes of the respondents toward government health insurance.

It is concluded, therefore, that while attitudes toward government-sponsored prepayment plans for health care were associated to a certain extent with familiarity with such plans, with the whole complex of socio-economic factors related to one's social class, and with experiences with illness, the primary factors with which attitudes were associated were those of income and expenses connected with illness. Those who had the greatest needs, in terms of financing health care, were those who most highly favored government-sponsored prepayment plans for health care.

The informants' lack of opinions about government-sponsored health plans and "socialized medicine" is further evidence of the lack of familiarity which they had with such plans. However, the favorable opinions which were expressed about government health insurance, as well as "socialized medicine", were concerned primarily with the extension of medical care. The unfavorable opinions were concerned primarily with the management and administration of such programs. The fact that there was a larger number of unfavorable than favorable opinions expressed about "socialized medicine", indicates that the respondents were somewhat less favorable toward it than they were toward government health plans generally, since this was not the case with the opinions about government-sponsored health plans.

It was also found that there was no difference between the attitudes of those who already had some kind of health insurance and those who did not have any health insurance. Those who had health insurance were just as likely to favor a government-sponsored health plan as were those who had no health insurance.

The majority of the respondents favored group practice as compared with private practice. However, there was no difference between the

attitudes of those who favored group practice and those who favored private practice. This was probably due to the fact that too few of them had had actual experience with group practice.

BIBLIOGRAPHY

BOOKS

Avnet, Helen Hershfield. Voluntary Medicine Insurance in the United States: Major Trends and Current Problems. New York: Medical Administration Service Inc., 1944.

Cantril, Hadley. Gauging Public Opinion. Princeton: Princeton University Press, 1944.

Davis, Michael M. America Organizes Medicine. New York: Harper and Brothers Publishers, 1941.

Hagood, Margaret J. Statistics for Sociologists. New York: McGraw-Hill Book Company, Inc., 1941.

Hoffman, Frederick L. More Facts and Fallacies of Compulsory Health Insurance. New Jersey: Prudential Press, 1920.

Lazarsfeld, Paul F., Berleson, Bernard, and Gaudet, Hazel. The People's Choice. New York: Columbia University Press, 1948.

McCormick, Thomas C. Elementary Social Statistics. New York: Reynal and Hitchcock, Inc., 1941.

Millis, Harry Alvin. Sickness and Insurance: A Study of The Sickness Problem and Health Insurance. Chicago: The University of Chicago Press, 1937.

Mills, C. Wright. The New Men of Power. New York: Brace and Company, 1948.

Mott, Frederick D., and Roemer, Milton I. Rural Health and Medical Care. New York: McGraw-Hill Book Company, Inc., 1948.

Simons, A. M., and Sinai, Nathan. The Way of Health Insurance. Chicago: The University of Chicago Press, 1932.

Smith, T. Lynn. The Sociology of Rural Life. New York: Harper and Brothers, 1947.

Stieglitz, Edward J. (editor). Geriatric Medicine Diagnosis and Management of Disease In the Aging and In the Aged. Philadelphia: W. B. Saunders Company, 1934.

Williams, Pierce. The Purchase of Medical Care Through Fixed Periodic Payment. New York: National Bureau of Economic Research, Inc., 1932.

ARTICLES AND BULLETINS

"American Institute of Public Opinion (Gallup Poll)". Public Opinion Quarterly. Vol. 7, August 13, 1943.

Collins, Selwy D. Economic Status and Health. Washington: Government Printing Office, U. S. Public Health Bulletin No. 165, 1927.

"Constructive Program for Medical Care". Journal of The American Medical Association. 128:883, July 21, 1945.

"Coordination and Expansion of Federal Government Health Activities". Congressional Record. Vol. 92, Part 4, 79th Congress, 2nd Session, May 3, 1946.

Delphey, Eden V. "Arguments Against The 'Standard Bill' For Compulsory Health Insurance". Journal of the American Medical Association. 68:1500-1, May 19, 1917.

"Doctors Offer Plan for More Medical Aid". Detroit Free Press. February 14, 1949.

"Endorsement of Health Insurance by Health Authorities". Journal of the American Medical Association. 67:832-33, September 9, 1916.

Foster, William Trufant. "Doctors Dollars and Disease". (A pamphlet based on the 28 volumes issued by the Committee on Costs of Medical Care). Public Affairs Committee, Incorporated, 1940.

Garceau, Oliver. "Organized Medicine Enforces Its 'Party Line'". Public Opinion Quarterly. Vol. 4, 1940.

"Health Job in Cabinet Proposed". Detroit News, February 14, 1949.

Hoffer, Charles R. "Health and Health Services in Three Michigan Communities". East Lansing: Michigan State College Agricultural Experiment Station (Section of Sociology and Anthropology), Quarterly Bulletin, Article 31-12, August, 1948.

Hoffer, Charles R. "Health and Health Services for Michigan Farm Families". East Lansing: Michigan State College Agricultural Experiment Station (Section of Sociology and Anthropology), Special Bulletin 352, September, 1948.

Hoffer, Charles R., and Schuler, Edgar A., "Measurement of Health Needs and Health Care". Michigan State College, Social Research Service, Reprinted from American Sociological Review, Vol. XIII, No. 6, December, 1948.

Hoffman, Frederick L. "Compulsory Health Insurance Unnecessary as a Public Health Measure". Journal of the American Medical Association. 68:480, February 10, 1917.

Lambert, Alexander. "Health Insurance and The Medical Profession". Journal of the American Medical Association. 68:257-262, January 27, 1917.

"National Health Act of 1947." Congressional Record. Vol. 93, Part 1, 80th Congress, 1st Session, February 10, 1947.

"National Health Act of 1949", S. 1581, by Senator Taft and others. 81st Congress, 1st Session, April 11, 1949.

"National Health and Disability Insurance Programs -- Message from the President of the United States". Congressional Record. Vol. 93, Part 4, 80th Congress, 1st Session, May 19, 1947.

"National Health Insurance and Public Act", S. 1679, by Senator Thomas and others. 81st Congress, 1st Session, April 11, 1949.

"National Health Insurance". Public Health Economics, Vol. 6, No. 1. School of Public Health, University of Michigan.

"National Health Program". Congressional Record. Vol. 84, Part 10, 76th Congress, 1st Session, August 4, 1939.

"National Health Act of 1945". (Committee Print No. 1). U. S. Senate Committee on Education and Labor. 79th Congress, 1st Session. Washington: Government Printing Office, 1946.

National Resources Planning Board, Family Expenditures in the United States. United States Government Printing Office, Washington, 1941.

"Report of Special Committee", Journal of the American Medical Association. 102:2199-2201, June 30, 1934.

"Reports of Subcommittees of the Council on Health and Public Instruction (Report of the Committee on Social Insurance). Journal of the American Medical Association. 66:1951-1985, June 17, 1916.

Reuss, Carl F. "Farmer Views on the Medical Situation". Pullman: State College of Washington Experiment Station (V Circular No. 20). September, 1944.

Roskelly, R. W. "The Rural Citizen and Medical Care". Pullman: State College of Washington Institute of Agricultural Sciences, Agricultural Experiment Station Bulletin No. 495, December, 1947.

Schuler, Edgar A. (Bureau of Agricultural Economics, U. S. Department of Agriculture), Selz C. Mayo (N. C. State College), and Henry B. Makoner, M.D. (U. S. Department of Agriculture). "Measuring Needs of Medical Care: An Experiment in Method". Rural Sociology. Vol. XI, No. 2, June, 1946.

"Should We Have Health Insurance?" (Poll of experts conducted by Arthur Kornhauser, Bureau of Applied Social Research, Columbia University). The American Magazine. 141:40-41, 116, January, 1946.

"Statement of Dr. E. I. Robinson, President, National Medical Association, Accompanied by Dr. Paul B. Cornelli". National Health Program, Hearings Before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606. Washington: United States Government Printing Office, Part 2, April 18, 1946.

"Statement of Dr. Ernst P. Boas, Chairman of the Physicians Forum". National Health Program, Hearings Before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606. Washington: Government Printing Office, Part 2, April 18, 1946.

"Statement of Dr. John P. Peters, Secretary, Committee of Physicians For the Improvement of Medical Care". National Health Program, Hearings Before the Committee on Education and Labor, United States Senate, 79th Congress, 2nd Session on S. 1606. Washington: United States Government Printing Office, Part 2, April 23, 1946.

"Symposium on Compulsory Health Insurance". Journal of the American Medical Association. 68:801ff, March 10, 1917.

"The American Medical Association Health Program and Prepayment Sickness Insurance Plans". Journal of the American Medical Association. 130:494-496, February 23, 1946.

"The Fortune Survey". Fortune. Vol. 26, No. 21, July, 1942.

"The Nation's Health — a Ten Year Program". A report to the President by Oscar R. Ewing, Federal Security Administrator. Washington: Government Printing Office, September, 1948.

Warren, Dr. B. S. "Health Insurance: Its Relation to the Medical Profession". Journal of the American Medical Association. 67:1966, December 23, 1916.

Warren, Dr. B. S. "Health Insurance: Its Relation to the National Health". Journal of the American Medical Association. 67:1015 ff, September 30, 1916.

"What Do The American People Think About Federal Health Insurance?" (Report of a Nation-Wide Survey of Civilian Adults, Conducted for the Physicians' Committee on Research, Inc. by the National Opinion Research Center). University of Denver, October, 1944.

THESIS

Anderson, Odin W. "The Health Insurance Movement in the United States: A Case Study of the Role of Conflict in the Development and Solution of a Social Problem". Published Doctoral Dissertation. Publication 959, University of Michigan, 1948.

APPENDIX A

STATISTICAL MEASURES

STATISTICAL MEASURES

Throughout the study percentages have been used for ease of comparison. To test the statistical significance[1] of difference between two proportions in different samples a curve constructed to give conservative estimates of the significance was used.[2] In estimating the critical limits of difference between two percentages in the same sample a curve especially constructed for that purpose was used.[3] Both tests will be referred to as the "T test" of significance.

The Chi-square test was used to test the significance of association between two variables, and was applied to the original tables from which the percentages were computed.[4] When a significant association was found the coefficient of contingency (C) was computed to show the amount of correlation actually present.[5] Since the coefficient of contingency understates the amount of correlation present in an inverse proportion to the number of cells in the table, the correction as suggested by McCormick[6] was applied to the values of C.

---

1 For purposes of this study the .05 and the .02 level of significance will be considered to be significant, and the .01 level will be considered to be very significant. In all instances conservative estimates were used.

2 This curve was constructed by Charles Proctor, a graduate student in Sociology and Anthropology at Michigan State College, and was based on a discussion of the test of significance of difference between two proportions found in John F. Kenney, Mathematics of Statistics, Part 2, New York: D. Van Nostrand Company, Inc., 1947, pp. 119 ff.

3 Hadley Cantril, Gauging Public Opinion, Princeton: Princeton University Press, 1944, p. 299.

4 For a discussion of the Chi-square test of significance see: Margaret J. Hagood, Statistics for Sociologists, New York: Reynal and Hitchcock, Inc., 1941, pp. 501 ff.

5 For a discussion of the coefficient of contingency see: Thomas C. McCormick, Elementary Social Statistics, New York: McGraw-Hill Book Company, Inc., 1941, pp. 203-8.

6 Ibid., p. 207.

APPENDIX B

SCHEDULE

MICHIGAN STATE COLLEGE 6/16/48

SOCIAL RESEARCH SERVICE (CRS)

MICHIGAN HEALTH SURVEY

All information in this schedule is strictly confidential and under the exclusive control of the Social Research Service of Michigan State College. Names of all persons referred to in this schedule will not be quoted or made public in any way.

1-3 Schedule Number:_____ 4-5 County:_____ 1-3_____ 4-5_____

Post Office Address:_____

Sample area:
1-Rural ( ) 2-Village ( ) 3-Metro. area ( ) 4-City ( ) 6_____

Segment number:_____ 7-9_____

Interviewer's initials:_____ 10_____

Code for Row 16, Page 2: Interview Type

Check one

0 - Not an informant
1 - Informant (female head or single male head), Part I (family) and Part III (___)
2 - Informant Part I (self only), II and III (___)
3 - Informant for Part I (family), II and III (___)

Code for Row 18, Page 2: (Person No.)_____

Dates of Calls and Interview

Call Number	Call	Interview Completed	Interview Not completed
First			
Second			
Third			

My name is .... and I'm from Michigan State College. We're making a health survey in homes all over the state of Michigan. Could you give me a few minutes of your time right now? For instance, we want to know if any member of your family has had any of these symptoms in the last six months... But first I need to know what people there are here, and their relation to the head of your family. What is the name of the head of the household? And may I ask his (her, your) age? Who else is there in the family? And his (her) age? What relation is he (she) to the head of the household?

Code for symptoms:
If negative, enter a dash(___)
If positive and untreated (except for home care), enter "1"
If positive and treated by non-M.D., enter "2"
If positive and treated by M. D. or dentist, enter "3"

Code for vaccination and immunization:
If not vaccinated and has not had disease, enter a dash (___)
If vaccinated and has not had disease, enter "1"
If not vaccinated but has had disease, enter "2"
If vaccinated and has had disease, enter "3"
If under minimum or over maximum age indicated, enter "4"

For each symptom reported as positive:
"Did You (he, she) do anything about (for) it or not?"
(If other than home treatment or remedies ask:)
"Was this an M. D. or not?"

MICHIGAN HEALTH SURVEY

All information in this schedule is strictly confidential and under the exclusive control of the [illegible] Michigan State College. Names of all persons referred to in this schedule will not be quoted or made public in any way.

1-3 Schedule Number: ______	1-3 ______
4-5 County: ______	4-5 ______
Post Office Address: ______	
Sample area: 1-Rural ( ) 2-Village ( ) 3-Metro. area ( ) 4-City ( )	6 ______
Segment number: ______	7-8 ______
Interviewer's initials: ______	______

Code for Row 16, Page 2: Interview Type

Check one

0 - Not an informant

1 - Informant (female head or single male head), Part I (family) and Part II ( )

2 - Informant Part I (self only), II and III ( )

3 - Informant for Part I (family), II and III ( )

Code for Row 16, Page 2: (Person No.) ______

Dates of Calls and Interview

Call Number	Call	Interview	
First			
Second			
Third			

My name is ... and I'm from Michigan State College. We're making a health survey [illegible] of Michigan. [illegible] [illegible] [illegible] is the (one) to the [illegible] household.

Code for [illegible]:

[illegible]

Code for vaccination and immunization:

[illegible]

For each symptom reported ask:

"Did you (he) ... anything about (it) it or not?"

(If other than home treatment ... ask:)

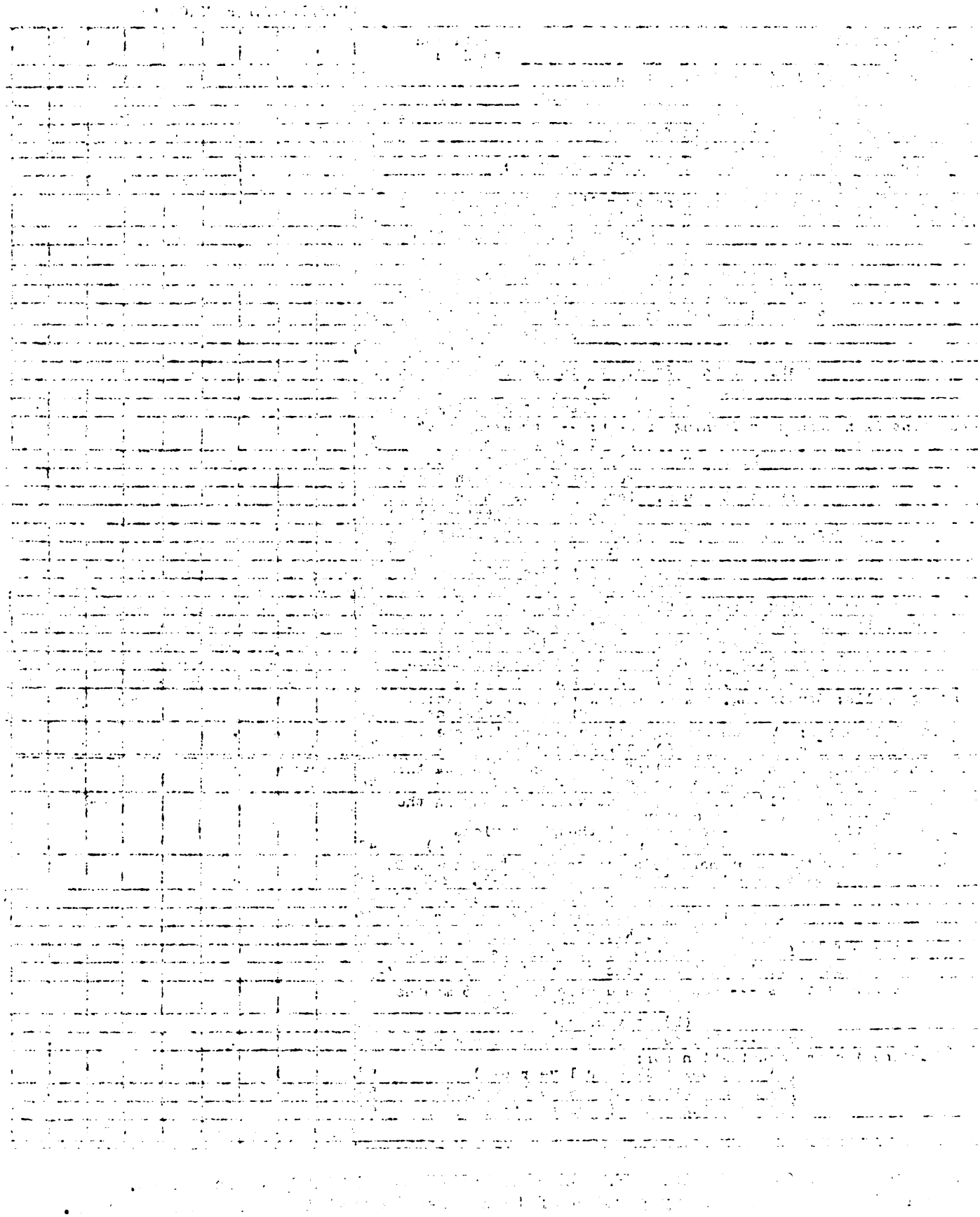
"Was this on M.D. or not"

Copy ... SOCIAL RESEARCH SERVICE, MICHIGAN STATE COLLEGE ... permission to reproduce any portion of this schedule must be obtained in writing.

PART I MEDICAL NEEDS

(H,W,S,D,P,L,B,SS,GC,N)

Head of Household Full Name: _____ Relation to Head										
Leave Blank (Code for relation to head)	11									
Indicate sex in each column: 1-Male 2-Female	12									
Indicate age in each column (01 - 99)	13-14									
Leave Blank (Code for No. in family)	15									
Code for Informant 0-1-2-3	16									
Enter "1" for each person present at interview:	17									
Code for person's number	18	1	2	3	4	5	6	7	8	9
Unexplained Loss of Weight: Persons over 18: 10 lbs. or more in last 6 mo. Persons under 18: any unexplained loss of weight	19									
Continued Loss of Appetite	20									
Unexplained Tiredness: regularly	21									
Running Ear or Ears: watery, bloody, pus	22									
Poor Vision: for distant or close work, e.g. reading	23									
Repeated Nosebleeds Not Due to Blow or Injury	24									
Persistent Headaches	25									
Toothache	26									
Unable to Chew Food: teeth "sore" or missing	27									
Sore Mouth: due to plates or bridges	28									
Repeated or Frequent Bleeding Gums	29									
Persistent Skin Rashes or Itching of Skin: -- "breaking out" (One week or more)	30									
Lumps or Discolored Patches on Skin	31									
Persistent Pains in Chest	32									
Persistent Cough: (except colds in chest)	33									
Coughing or Spitting Blood	34									
Severe Shortness of Breath: after doing light work	35									
Asthma or Hayfever	36									
Repeated or Persistent Backache	37									
Persistent Pains in the Joints	38									
Open or Running Sores or Ulcers That do not Heal	39									
Repeated or Persistent Swelling of Ankles: (Two weeks or more)	40									
Repeated Vomiting: (Several days or more)	41									
Repeated or Prolonged Pains in Stomach or Anywhere in Abdomen	42									
"Rupture", Hernia, or Wearing of Truss	43									
Fainting Spells: Stuttering: Stammering: Nervous Breakdown: Fits: Convulsions	44									
Accidental Injuries: broken bones, head or severe injuries, accidental poisoning, snake bites, etc.	45									
For each person with one or more "1's" in column, "Do you think --- needs to see a doctor?" 1-Y, 2-N	46									
For each person with "1" in row 46, "What would you say is the main reason --- hasn't seen a doctor?" 1-Lack of time 2-Symptoms not thought serious 3-Too expensive 4-Other (specify on reverse side)	47									
For each person with one or more "3's" in column, "Did the M.D. advise --- to go to a hospital?" 1-Y, 2-N	48									
Did he (she) go? 1-Y, 2-N	49									
Leave blank (individual health care code)	50									
Leave blank (total No. of positive symptoms)	51									
Enter "1" if not working now due to illness or injury	52									
Total days off in last 6 months due to illness	53-54									
Number of times --- has seen a doctor in last 6 months (a) at doctor's office	55									
(b) at your home	56									
Times --- has seen dentist in last 6 months	57									
Vaccination or Immunization for: (a) Smallpox (all over 1 year old)	58									
(b) Diphtheria (6 months to 16 years)	59									
(c) Whooping cough (6 months to 16 years)	60									
		1	2	3	4	5	6	7	8	9



PART II

PRACTICES AND OPINIONS REGARDING HEALTH SERVICES

Schedule No.

Now there are all kinds of doctors just like there are all kinds of other people. Some people like what one doctor does. Others like what another doctor does. Suppose you think about the experiences you have had with different doctors. Just think of one or two you have liked best - we are not interested in their names - and tell me what you especially liked about them. 1-3_____

A _____ 4_____

B _____ 5_____

Do you have any other comments?

C _____ 6_____

Now think of one or two you didn't like so well. What didn't you like about them?

A _____ 7_____

B _____ 8_____

Anything else?

C _____ 9_____

A. You just mentioned when we were talking about the doctors you liked that one thing you thought was important was that (A)_____.
Do you feel that that is pretty typical of doctors in general, or not?
1-Typical ( ) 2-Not typical ( ) 3-Uncertain ( ) 10_____

B. Well, how about your statement that (B)_____.
Is it typical?
1-Typical ( ) 2-Not typical ( ) 3-Uncertain ( ) 11_____

C. You also said that (C)_____. Do you feel that that's typical?
1-Typical ( ) 2-Not typical ( ) 3-Uncertain ( ) 12_____

A. I think that covers the things you said you liked about the one or two doctors you liked best. Now here are one or two things you mentioned about doctors you didn't care as much for. You said (A)_____.
(Mention only items which are not clearly the opposite of those named in Questions 4, 5, and 6.) Do you feel that that is pretty typical of doctors in general, or not?
1-Typical ( ) 2-Not typical ( ) 3-Uncertain ( ) 13_____

B. How about your statement that (B)_____. Do you feel that thattis typical of doctors in general, or not?
1-Typical ( ) 2-Not typical ( ) 3-Uncertain ( ) 14_____

C. You also said that (C)_____. Is that typical?
1-Typical ( ) 2-Not typical ( ) 3-Uncertain ( ) 15_____

Do you have any other feeling about doctors in general, either one way or the other?

_____ 16_____

_____ 17_____

_____

On the whole, have you been satisfied with the help you have received from doctors, or not?
1-Satisfied ( ) 2-Not satisfied ( ) 3-Uncertain ( ) 4-Had no help( ) 18_____

(If "2" to 18) What sort of things aren't you satisfied with?_____ 19_____

_____

So far as you know are your friends and relatives satisfied with the help they have received from doctors, or have you heard them make complaints?
1-Satisfied ( ) 2-Made complaints ( ) 3-Uncertain ( ) 20_____

(If "made complaints") What sort of things have you heard them say? 21_____

_____

_____

_____

Have you (and the members of your family) always been able to get a doctor's help when you needed it, or have you had trouble in getting a doctor's help? 22_____
1-Always get one ( ) 2-Had trouble ( ) 3-Uncertain ( ) 4-Haven't tried( )

(If 2 is checked on 22) When was the last time this happened? 23_____
1-Year _____ 2-Month _____

Would you mind telling me about it?
(Probe for: A. Who needed a doctor. _____ 24_____

B. Why couldn't a doctor come. _____ 25_____

C. What did you do about it. _____ 26_____

D. What were the results.) _____ 27_____

In your experience do you think that we have enough doctors or do we need more general M.D.'s or more specialists; or both?
1-Have enough ( ) 2-General M.D.'s ( ) 3-Specialists ( ) 4-Both ( ) 28_____
5-Uncertain ( ) 6-Need more good doctors ( )

(If 2 or 3) Why do you feel that way? _____ 29_____

_____

(If "more needed" in 29) Do you feel that this problem is so serious that something ought to be done about it?
1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 30_____

How about other communities (towns): do you think they have enough or are more needed?
1-Enough ( ) 2-More needed ( ) 3-Uncertain ( ) 31_____

If some community (town) needed more doctors do you have any idea how it could get them?
Don't know ( ) 32_____

_____

_____

In some communities doctors have organized into a group so they can work together in diagnosing and treating illnesses. Have you heard about such plans?
1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 33_____

Would you prefer such a group plan or would you prefer to go to a doctor who practices alone?
1-Group ( ) 2-One doctor ( ) 3-Uncertain ( ) 34_____

Have you (or any members of your family) ever gone to an osteopath or other doctor who was not an M. D.?
1-Yes, self only ( ) 2-Yes, other members( ) 3-Self and others ( ) 35_____
4-No ( ) 5-Uncertain ( )

(If "yes" to question 35) Was he an osteopath, chiropractor, or other kind of doctor?
1-Osteopath ( ) 2-Chiropractor ( )
3-Other (specify) _____ 36_____

When was the last time you (or some member of the family) went to him?
1-Within the last year ( ) 2-Before the last year ( ) 3-Uncertain ( ) 37_____

What kind of trouble did you (or members of your family) have the last time you went to him? 38_____
_____

_____

How do you think the training of osteopaths compares with the training of M.D.'s? 39_____

_____

_____

How do you feel about using doctors who are not M.D.'s, such as osteopaths? 40_____
1-Would use only M.D. ( ) 2-Would use only non-M.D. ( )
3-Would use non-M.D. for certain things ( ) 4-Uncertain ( )

HOSPITAL SERVICES

Now I'd like to ask a few questions about hospitalization. Have you (or any member of your family) been a hospital patient within the past year or two? 41_____
1-Yes, self only ( ) 2-Yes, other members ( ) 3-Self and others ( )
4-No ( )

(If "yes" to question 42)
Would you mind telling me about how much that cost you the last time it happened? _____ 42_____

Does this amou t include Doctor, hospital and nursing expense or not?
1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 43_____

In general, how do you feel about the medical and surgical services which the doctors gave you (or other members of the family) while in the hospital? 44_____

_____

_____

In general, how do you feel about the accommodations and services which were provided by the hospital? _____ 45_____

_____

_____

PAYMENT FOR MEDICAL SERVICES

Next I'd like to ask some questions about payment for medical service. Do you (or any members of your family) carry insurance to pay for all or part of:

A. Hospital bills? 1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 46_____

B. Fees for surgery? 1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 47_____

C. Doctors' fees other than surgery? 1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 48_____

(If "yes" to 46, 47, or 48) Which members are covered?

A. Hospital: 1-All members ( ) 2-Head only ( )
3-Other (specify)_____ 4-Uncertain ( ) 49_____

B. Surgery: 1-All members ( ) 2-Head only ( )
3-Other (specify)_____ 4-Uncertain ( ) 50_____

C. Doctors' fees: 1-All members ( ) 2-Head only ( )
3-Other (specify)_____ 4-Uncertain ( ) 51_____

What is the name of the insurance company?
1-Blue Cross or Blue Shield ( ) 2-Fraternal ( ) 3-Uncertain ( ) 52_____
4-Other (specify) _____

Have you (or any members of your family) ever carried hospital insurance and dropped it? 1-Yes, self ( ) 2-Yes, other members ( ) 3-Self and others ( ) 53_____
4-No ( ) 5-Uncertain ( )
(If "yes") Why? _____

_____

Was it Blue Cross (or Blue Shield)? 54_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If informant does not have hospital insurance) Would it be possible for you to get Blue Cross insurance if you wanted to?
1-Yes ( ) 2-No ( ) 3-Uncertain ( ) 55_____

In general, do you think insurance plans for paying hospital and doctor bills are a good idea, or not?
1-A good idea ( ) 2-Not a good idea ( ) 3-Uncertain ( ) 56_____

Have you heard or read about a plan in which people would pay a certain percentage of their income to the government and in return members of the family would have their doctor and hospital bills paid for by the government?
1-Yes ( ) 2-Yes, socialized medicine ( ) 57_____
3-No ( ) 4-Uncertain ( )

(If "no", even if you haven't heard about it before,) do you think that it's a good idea, or not? 58_____
1-A good idea ( ) 2-A good idea, with reservations ( )
3-Not a good idea ( ) 4-Uncertain ( )

Why do you feel that way?
Do you feel that there are any (good) (bad) points?

Good points _____ 59_____
_____
_____ 60_____
_____

Bad points _____ 61_____
_____
_____ 62_____
_____

(If not mentioned above, ask) Have you heard or read about the Murray, Wagner, Dingell Bill? 63_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If not mentioned above, ask) Have you heard or read about "socialized medicine"? 64_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If "yes") What do you feel are its good points? _____ 65_____
_____
_____ 66_____

What are its bad points? _____ 67_____
_____
_____ 68_____

COMMUNITY AND PUBLIC HEALTH

Now I would like to ask you a question or two about Public Health Service. Have you (or any members of your family) been personally examined or advised by a public health nurse or officer within the past year? 69_____
1-Yes, self only ( ) 2-Yes, other members ( ) 3-Self and others ( )
4-No ( ) 5-Uncertain ( )

Do you feel that this community has any major health problem? 70_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If "yes" to 70) What is it? _____
_____
_____

In some places representatives of different organizations have gotten together in a committee or council to develop plans for improving health in the community. Have you heard of anything like that? 71_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If "yes" tp 71) Do you think representatives of the organizations in this community ought to organize some kind of a health committee or council? 72_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )
4-One in community now ( )

Have you heard or read of the Michigan State Medical Society? 73_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If "yes") In general do you feel that it works mostly for Doctors' interests, the interest of people in general, or for both? 74_____
1-Doctors' interests ( ) 2-Interest of people ( )
3-Interests of both ( ) 4-Neither ( ) 5-Uncertain ( )

In general how do you feel about what it does? 75_____
1-Like ( ) 2-Dislike ( ) 3-Unaertain ( )

Code for No. 16 (Symptoms page) 76_____

Give number of informant (From symptoms page line 18) 77_____

PART III CONTROL ITEMS

Schedule No. 1-3_____

Code for No. 16 (Symptoms page) 4_____

Give number of informant (From symptoms page line 18) 5_____

HEALTH CONTROL ITEM

Do you have a certain doctor to whom you (and members of your family) go for most of your ills? 6_____
1-Yes ( ) 2-No, go to more than one ( )
3-No, have no doctor ( ) 4-Uncertain ( )

(If "1" or "2" to 6) Is he an M.D. (are they M.D.'s)? 7_____
1-Yes ( ) 2-None M D.'s ( ) 3-One M D. ( )
4-Uncertain ( ) 5-Other _____

(If "none M D.'s" to 7) What kind of doctor (s) is he (are they)? 8_____

_____

(If "yes" to 6) In what town is his office located?_____ 9-10-11_____

How far is it to his office? (Check code in miles) 12_____
1-1 to 5 ( ) 2-6 to 10 ( ) 3-11 to 15 ( ) 4-16 to 20 ( )
5-21 to 25 ( ) 6-26 to 30 ( ) 7-Over 30 ( )

OTHER CONTROL ITEMS

(If single person answering for self only, go to 14)

Who is the main earner of your family? 13_____
1-Informant ( ) 2-Other person (specify relation to informant)_____( )

Are you (is he) (is she) employed? 14_____
1-Yes ( ) 2-No ( )

(If "no") Why aren't you (isn't she) (isn't he) employed right now?_____ 15_____

_____

What kind of work did you (did he) (did she) do when you were working (when he was working) (when she was working) (when he was living)? 16_____

_____

(If "yes") What kind of work do you (does she) do? 17_____

Job_____

Industry_____

("What sort of place work at?")
("What do they make or do there?")

Are you (Is the family's breadwinner) a member of any union? 18_____
1-Yes ( ) 2-No ( )

(If "yes") Is that CIO, A F of L, or independent? 19_____
1-CIO ( ) 2-AFL ( ) 3-Independent ( ) 4-Uncertain ( )

Do you remember the name of the last school you went to?_____

What was the last grade or year you completed in school? 20_____
1-No schooling ( ) 5-Some high ( )
2-1-4 years grammar ( ) 6-Completed high ( )
3-5-7 years grammar ( ) 7-Some college ( )
4-Completed grammar ( ) 8-Completed college ( )

(If married female head responding) What was the last grade or year your husband completed in school? 21_____
1-No schooling ( ) 5-Some high ( )
2-1-4 years grammar ( ) 6-Completed high ( )
3-5-7 years grammar ( ) 7-Some college ( )
4-Completed grammar ( ) 8-Completed college ( )

(If Open Country)
About how many miles is it to the nearest town having a doctor? 22_____
0-Town or city ( ) 1-1 to 5 ( ) 2-6 to 10 ( ) 3-11 to 15 ( )
4-16 to 20 ( ) 5-21 to 25 ( ) 6-26 to 30 ( ) 7-over 30 ( )

Do you live on a farm? 23_____
0-Town or city ( ) 1-Yes ( ) 2-No ( )

(If "yes") Did you (the head) work 100 or more days off the farm during the past year? 24_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

Do you or your family rent or own the place where you live? 25_____
1-Rent ( ) 2-Own ( ) 3-Other (specify)_____

Is there a telephone in your home (place where you live)? 26_____
1-Yes ( ) 2-No ( )

(If "yes") Is it listed either in your name or your family's name? 27_____
1-Yes ( ) 2-No ( )

Do you happen to have a car (in your family)? 28_____
1-Yes ( ) 2-No ( )

Do you have running water in the place where you live? 29_____
1-Yes ( ) 2-No ( )

Do you have an inside toilet in the place where you live? 30_____
1-Yes ( ) 2-No ( )

Do you read a daily newspaper? 31_____
1-Yes ( ) 2-NO ( )

Do you have a radio? 32_____
1-Yes ( ) 2-No ( )
If "yes": What one radio station do you listen to most?_____

_____ 33-34_____

Have you ever heard a 5-minute health news radio program called "Tell Me Doctor"? 35_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

(If yes) Do you happen to know, is or that program a service of the Michigan State Medical Society, or not? 36_____
1-Yes ( ) 2-No ( ) 3-Uncertain ( )

About how many times a week do you listen to it? 37_____
1-3 or more ( ) 2-Once or twice ( )
3-Less than once a week ( ) 4-Practically never ( )

About how often do you go to church or religious services? 38_____
1-Once a week or oftener ( ) 2-1 to 3 times a month ( )
3-Occasionally ( ) 4-Never ( )

What denomination do you consider yourself? _____ 39_____

Did you (or any member of your family) serve in any of the United States Armed Forces during World War II? 40_____
1-Yes, self only ( ) 2-Yes, other members ( ) 3-Self and others( )
4-No ( ) 5-Uncertain ( )

Do you remember <u>for certain</u> whether or not you voted in the 1944 Presidential election? 41_____
1-Yes, voted ( ) 2-No, didn't vote ( )
3-No, too young to vote ( ) 4-Uncertain ( )

In general, which of the political parties do you favor in the Presidential election this fall? 42_____
1-Republican ( ) 2-Democratic ( )
3-Other (specify) _____( ) 4-Uncertain ( )

Would you look at this card and tell me the <u>letter</u> opposite the figure that comes closest to your total family (for individual, <u>your</u> personal) income this last year? Is it A, B, C, or what? 43_____

(0) A-Under $1,000 ( )
(1) B-$1,000 up to $2,000 ( )
(2) C-$2,000 up to $3,000 ( )
(3) D-$3,000 up to $4,000 ( )
(4) E-$4,000 up to $5,000 ( )
(5) F-$5,000 up to $7,500 ( )
(6) G-$7,500 up to $10,000 ( )
(7) H-$10,000 or more ( )

Code for economic level 1-A ( ) 2-B ( ) 3-C ( ) 4-D ( ) 44_____

Leave blank (code for population of community) 45_____