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Health care in Montana : A survey of Montana experience and opinion

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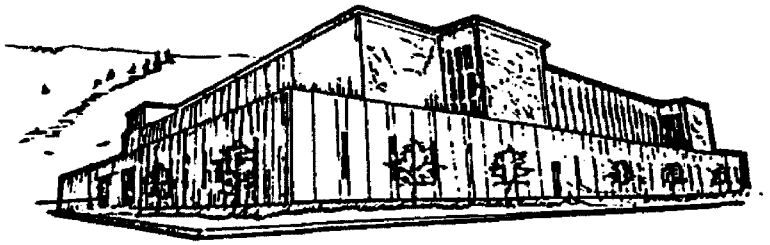

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HEALTH CARE IN MONTANA

A Survey of Montana Experience and Opinion

by

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HEALTH CARE IN MONTANA: A SURVEY OF MONTANA EXPERIENCE AND OPINION

Committee Chair: Dr. Maureen J. Fleming

Health care, including health care reform, quite possibly is, or will be, the most important social issue of the 1990s. The billions spent annually on health care reduces consumers' disposable income, decreases corporate profits, and imposes increasing burdens on American taxpayers. The health care industry, as well, is unquestionably an important, and sometime controversial, part of our national and state economies.

This thesis discusses several aspects of health care in Montana and does so from the perspective of Montana's health care consumers -- the general public. It discusses their situations, experiences, and opinions, as reported in a statewide telephone survey conducted among adult Montanans in August 1992. The research was done at the request of a committee established by former Governor Stan Stephens to study health care in Montana and report to the 1993 Legislature. Some of the more important findings follow.

Eight respondents in ten reported having insurance, mostly through private carriers and most often arranged through the insured's employment. Insurance coverage increased noticeably with age and income, and was lowest among the unemployed. At the same time, roughly two in ten were without coverage. Three in ten were covered at the time of the survey but had been without insurance at some time in their adult lives.

Most Montanans, based on these results, apparently believe that most basic health care services are available to them in their own communities and also make considerable use of health care services. They recognize the avenues for dealing with their potential long-term care needs, but few have done any real preparation for such needs. The results also suggest that most Montanans have relatively healthy lifestyle practices, but the uninsured tend to engage in unhealthy practices somewhat more often, by comparison.

When queried about various options for dealing with health care and reform, Montanans tended to express less public support for options that would directly reduce health care access. And, human nature being what it is, they tended to give more support to options that would put less burden directly on consumers like themselves.

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Health care, including health care reform, is certainly one of the most important social issues of the 1990s. The hundreds of billions spent nationally, in services and insurance, are affecting everyone. The money spent on health care reduces consumers' disposable income, decreases corporate profits, and imposes increasing burdens on American taxpayers. The health care industry, as well, is unquestionably an important part of our national and state economies. It is certainly a growing part and, in some respects, a controversial part as well.

This thesis discusses several aspects of health care in Montana and does so from the perspective of Montana's health care consumers -- the general public. It discusses health insurance coverage in the state, the health care experiences and related practices of Montanans, and Montana public opinion on a number of possible actions for health care reform, as reported in a statewide telephone survey conducted among adult Montanans in August 1992. This survey was considered necessary because of the scarcity of such data for Montana and was commissioned by a committee called Health Care for Montanans, established by former Governor Stan Stephens to study health care in Montana and report to the 1993 Legislature. The survey methodology is discussed in Appendix I, with the survey instrument presented in Appendix II.

I

Review of Literature

With or without documentation, few would challenge the notion that the American public feels passionately about health care, particularly their own health care, one of those most personal and emotional concerns we have as individuals. The public's attention to health care generally, over the years, though, has varied relative to other personal and societal concerns and largely in reaction to their own individual situations and experiences. Such experiences have been affected by the significant changes in health care and in the public and private policies toward it over the years. Not the least of such changes have been the reform efforts in recent years, which have been largely driven by the increasing cost of health care in its broadest and most inclusive sense.

Health care reform in the United States -- including efforts at universal health care coverage, or national health insurance, or national health care financing, or whatever broadly comparable term was in vogue at any particular time -- is certainly not new to the 1990s. Although Teddy Roosevelt is credited with having proposed the first semblance of national health insurance around 1910, many point to the 1940s as the effective start of the struggle for some form of universal coverage (Perry, 1993). Interestingly, in 1949, U.S. Senator James E. Murray of Montana was proposing and discussing many of the issues that are now being discussed, in the early 1990s (Knoll, 1994).

Harry S. Truman, with his plan for compulsory medical insurance, was the first president to put health care reform formally on the nation's agenda. Despite support from organized labor and allied associations, Truman was essentially alone among elected officials in challenging certain precepts of American medicine in the late 1940s. The American Medical Association (AMA) took the lead in successfully opposing Truman, investing heavily in the effort, working with a receptive Congress (under Republican control in 1947 and 1948), and playing to the American public's new Cold War fears of "socialism" (Peterson, 1993). According to some, the medical interests were apparently so effective in defeating comprehensive reform that reform proponents significantly changed their strategy. They worked first on enacting some form of more limited coverage just for the elderly, an effort that was not successful until 1965 with the advent of Medicare (Marmor, 1973). Medicaid, which was intended to bring health care to poor Americans, arrived in 1967.

The 1970s, according to Peterson (1993), may have originally appeared to present a different situation. Medical inflation had changed the dynamics of the reform debate significantly enough that even a Republican president, Richard Nixon, was promoting a version of national health care financing, albeit more a mix of private and public insurance mechanisms. The reform advocates, who, like their historical opponents, were now better organized and held more of a political presence, were able to reject Nixon's plan. They later compelled President Jimmy Carter to reluctantly adopt the mantle of national health insurance, but they were not successful.

Meanwhile, organized medicine had not lost any real political influence since its success in the 1940s and had actually strengthened its alliances with private health insurance carriers and business. These alliances apparently remained healthy well through the 1970s and 1980s.

At the same time, though, and especially since the mid-1960s, the United States was experiencing significant increases in health care spending, not just in terms of the actual amount spent but also as a proportion of individual incomes and of gross national product. Much of the increased spending since 1965 has been increased government spending, both for insurance and for the direct provision of care, largely a result of the advent of Medicare and Medicaid in 1965 and 1967 (Peden and Lee, 1991).

However, increases in private insurance expenditures also contributed significantly to the increased spending overall. In fact, since 1967, private insurance expenditures have risen at a much faster rate than has health care spending overall (Peden and Lee, 1991). The increase in private insurance expenditures initially reflected the dramatic increase in the proportion of the total population covered by private insurance, largely as a result of businesses paying the cost (Peterson, 1993). In time, of course, such increases were compounded by plain rate increases as well.

Business' involvement was initiated at a time when nonwage compensation, like health insurance, was quite appealing to both employers and employees, made attractive by World War II wage and price controls and government protection of labor organizing activity. In time, such benefits became a focus of collective bargaining (Peterson, 1993). In addition, employment-based health insurance has also enjoyed increasingly favorable

tax treatment, through tax subsidies, thus maintaining its attractiveness to both employers and employees. Today, about three American workers in four have employment-based insurance, which has been an important factor in the widespread access of middle- and upper-class working people to comprehensive health insurance and high quality health care. On the other hand, besides reducing government revenues, this same subsidy has played a major role in the explosion of medical costs, including the high cost of insurance, and in the problems small firms have in securing insurance (Burman and Rogers, 1992).

Although the rising costs of health care in the 1970s, and on into the 1980s, worried most business leaders, they still shared the desires of their medical and health insurance allies in looking for private solutions and preventing the government from imposing alternatives. Together, they had the clout to forestall major public sector intervention. Meanwhile, the decline of organized labor had not helped the reform proponents, who some felt were suffering from unwarranted overconfidence about their own clout (Peterson, 1993).

However, by the early 1990s, the business-medical-insurance alliance was already experiencing internal threats to its unity. Today, physicians are no longer speaking with a unified voice. Both the American College of Physicians and the American Academy of Family Physicians, along with more activist physician organizations, have outpaced the AMA in their willingness to accept restructuring of the American health care system, and even the AMA has since joined the call for reform (Peterson, 1993).

Similarly, the movement of health insurance carriers toward cost containment has been eroding the cooperation they previously enjoyed with health care providers, although the insurance industry itself is still quite divided about reform strategies, largely reflective of their respective situations and interests (Peterson, 1993).

And while many businesses, large and small, remain philosophically opposed to government intervention in the health care economy, that view is also not unanimous. Quite a few other businesses, citing concerns about their weakened competitive positions in domestic and international markets as a result of increasing health care costs, either no longer fear or openly invite government efforts of some kind to rationalize health care financing and contain costs. Some leaders have gone so far as to promote the idea of a publicly financed system. Just twenty years ago, this would have been inconceivable. But given 1990s economics, it is increasingly difficult for business to either claim or accept that it should play the primary role of organizing and paying for the health care of American workers or, through cost shifting, the costs of care for the uninsured (Peterson, 1993).

At the same time, the 1990s have seen institutional change in the way all kinds of other interests are mobilized and represented in the national policy-making process. Not the least of such other interests are citizen groups, which have accounted for almost 38 percent of the national membership associations expressing intense interest in the health policy area. In addition, a substantial majority of such citizen groups have opposed past positions of the medical, insurance, and business interests and have favored expanded federal involvement in health and human services (Peterson, 1993).

And what about the general public? Where have they stood? Where do they stand now?

In 1986, Shapiro and Young reviewed data and analyses from a variety of respected public opinion surveys (from 1965 to 1985) and concluded that public concern and support for government assistance in medical care as an entitlement was relatively on par with Social Security and had been quite stable for decades. Support for more government spending and action in this area was consistently high in general, especially because of the elderly and poor, who were perceived to be truly needy. The authors noted that the public appeared to be motivated by compassion and altruism toward all citizens, although some broadly defined private interests could not be ruled out.

The survey data also suggested that the health care changes thus far (mid-1980s) had not had substantial impact on the public's general satisfaction with health care and medical insurance generally (nor their own), save for concerns about high costs. On the other hand, there appeared to be underlying ambivalence that the authors concluded would make the public receptive to more incremental changes of the sort that have occurred in the past with Medicare, Medicaid, federal support for HMOs, and changes in employer-provided plans. They concluded that such policies, along with other credible and persuasive efforts at opinion leadership could move the country closer to some form of national health insurance, albeit with uncertain consequences.

Last, the authors concluded that national health insurance has generally had a good deal of support in principle, but this has not necessarily been support for government-provided insurance or health services.

Blendon and Donelan (1990) drew some related conclusions from another set of poll data, emphasizing four major findings. First, they concluded that Americans considered universal access to health care an important concern, but that it is not as important to them as are other issues (i.e., was not at the time). Second, though they overwhelmingly endorsed major reform of the health care system, Americans remained unsure whether the United States should have a predominantly public or private system of health care financing. Third, the authors concluded that Americans were unwilling to pay more than a modest tax increase to make a universal health plan a reality.

Last, Blendon and Donelan also concluded that Americans are deeply ambivalent about using the welfare system to provide adequate medical care to the nation's poor, as is the case with Medicaid, which is financed and administered through the welfare system. Blendon and Donelan explored this further, noting that various opinion surveys had indicated that Medicaid's health care aspects are popular. They also noted that surveys conducted in 1989 suggested that if the Medicaid program were not seen as part of an unpopular welfare system, public support for expanding the coverage provided for low-income Americans would be stronger.

Health care reform, including national health insurance, emerged as a major election issue in 1991 in the special U. S. Senate election in Pennsylvania, in which Democrat Harrison Wofford campaigned specifically and successfully on the issue. During that campaign, polls indicated, for the first time, that health care was a major concern to voters (or at least to Pennsylvania voters), ranking second only to worries about the general state of the economy (Kelly and Gemeinhardt, 1992).

A more recent analysis of public opinion data (1983 to 1992) by Jacobs, Shapiro, and Schulman (1993), updating the 1986 analysis by Shapiro and Young, concluded that the nation is primed and apparently ready for major reforms in medical care, especially considering a decade of substantial cost increases, a significant number of uninsured Americans, and dramatic efforts that nevertheless failed to stop cost increases or to introduce universal access and basic affordability. The authors cautioned that no consensus had yet developed for any specific approach or plan, but that the public did support certain important principles.

They noted that public support continued for government action to provide medical assistance as an entitlement, and, in recent years, the salience of the issue and the public's desire for government action has grown. The public remains quite satisfied with their own health care generally, save for health care costs, which are the main source of personal and national dissatisfaction with health care; but public dissatisfaction with the nation's health care system has increased.

Americans apparently feel overall reform is needed, and they perceive major health reform as a collective, national issue, not one driven by personal interests. They remain ambivalent, though, about precisely how to change government's role in health care -- supporting reform of that role but uneasy about expanding it. The authors consider this reflective of Americans' long-standing fear of big government and excessive regulation infringing on economic efficiency and individual freedom, and they feel it may have contributed to the repeal of the 1988 catastrophic health care act.

Last, Jacobs, Shapiro, and Schulman also concluded that the public's ambivalence is reflected as well in the varying interpretations of such national survey results. They note, as an example, that public support of developing and paying for a "national health insurance" plan providing universal coverage has been interpreted in several ways: as support for a government-coordinated system, paid by payroll taxes and used to supplement or complement employer-provided insurance; as keeping consumer choice and control; or as support for a Canadian-type system. Despite the various interpretations, the authors believe the public remains divided on various policy options and note the lack of trend data that track opinions over time on the various specific proposals.

On the subject of specific tax increases to support universal health -- in light of Blendon and Donelan's third finding -- Haggerty's (1993) results could be viewed as either supplemental or different, depending on one's definition of a "modest" tax increase. From a nationwide survey for the Kaiser Foundation, it was concluded that the public was expecting significant health reform, was poised for it, and may be prepared to pay for it. Haggerty noted that 69 percent said they would still support the various elements of reform addressed in the survey even if it meant new taxes, and 55 percent would rather see increased tax revenues dedicated to health reform than to deficit reduction. Additionally, that survey found: 58 percent supported a 3 percent sales tax, 79 percent supported a $1 tax hike on a six-pack of beer, 75 percent supported a 20 percent tax on guns and ammunition, and 74 percent supported a $1 tax increase on a pack of cigarettes to help finance health reform.

The emergence of health care as a significantly more prominent issue or concern among the public in recent years has undoubtedly played some role in the proliferation of surveys to determine public opinion on a variety of topics within the realm of health care. Unfortunately, though, despite the numerous national surveys, similar state data remain quite scarce by comparison, especially for Montana. It was largely for this reason that the Montana survey was commissioned.

II

Health Insurance Coverage in Montana

Status and History of Coverage

One does not need survey data to believe that Montanans, like Americans generally, are deeply concerned about affordable and accessible health care. And, from the consumers' perspective, their access to health care and their ability to pay for it, or their ability to take advantage of what may be available, can be significantly affected by whether they have health insurance and the extent of that coverage.

The survey data indicate that, fortunately, most Montanans are covered by some form of health insurance. Further, many Montanans apparently have also been continuously covered throughout their adult lives. At the same time, though, some Montanans remain uninsured, and many more have had to deal with lapses in their coverage.

As indicated in Table 1, about eight respondents in ten (84 percent) reported being insured at the time of the survey. About five in ten (53 percent) claimed to have been continuously covered throughout their adult lives, but almost a third (31 percent) reported that, although they were insured at the time of the survey, they had experienced lapses in their insurance coverage at some time in their adult lives.

TABLE 1

HEALTH INSURANCE STATUS
AMONG ADULT MONTANANS
August 1992
(n=402)

Insured now	84%
Continuous coverage	53%
Periods without insurance	31%
Uninsured	16%

At the same time, however, 16 percent, almost two in ten, were not insured at the time of the survey. As will be discussed later, though, it cannot be assumed that all the uninsured cannot afford or obtain the coverage; apparently some Montanans are voluntarily uninsured.

While the 16 percent may seem a relatively small proportion of Montana's adult population, it translates to well over 90,000 adults in the state (based on 1990 census counts) who could be without any kind of coverage. Moreover, some of these persons undoubtedly have dependents who may also be uninsured.

At the national level, an estimated 17 percent of the total population (including children) were uninsured in 1990, about 16 percent in Montana (EBRI, 1992). By 1991, the national estimate was 13 to 14 percent. Four states -- Connecticut, Pennsylvania, Wisconsin, and Hawaii -- were particularly well covered with under 10 percent uninsured. At the other end, eleven states and the District of Columbia estimated 20 percent or more

of their populations are without health insurance (*Wall Street Journal*, 1993, citing EBRI). These data suggest the Montana survey data are on target and that Montana is about average among the states.

Insurance Coverage among Segments of the Population

Overall Population. Patterns of coverage among Montanans appear to be relatively similar to those found generally in the United States. In both cases, some segments of the population are more likely than others to have coverage and some more likely to be uninsured.

Specifically, among the Montanans interviewed, the incidence of health insurance was higher among those who were older, those with more education, and those with higher incomes. Given this pattern, it's likely no surprise, then, that younger Montanans, those with less formal education, and lower-income Montanans were, by comparison, less likely to have such coverage, along with unemployed persons.

The coverage patterns for the sample population are summarized in Table 2. As the data indicate, insurance coverage increased significantly with age, peaking at 95 percent among the elderly, aged sixty-five and older. Given the existence of Medicare, the high incidence of coverage among the elderly was not unexpected. By contrast, among the youngest adults, those under twenty-five years of age, only about 65 percent were covered by health insurance at the time of the survey, and 35 percent were uninsured.

TABLE 2

HEALTH INSURANCE COVERAGE AMONG SEGMENTS OF MONTANA'S ADULT POPULATION
August 1992

			Insured	Uninsured
Age:	18-24 years (n=48)		65%	35%
	25-34 years (n=64)		75%	25%
	35-44 years (n=107)		87%	13%
	45-64 years (n=108)		88%	12%
	65 years and older (n=74)		95%	5%
Education:	Some high school or less (n=47)		70%	30%
	High school graduate (n=142)		81%	19%
	Some college (n=119)		84%	16%
	College graduate (n=94)		95%	5%
Household income (1991):		Under $15,000 (n=91)	70%	30%
		$15,000-$34,999 (n=153)	85%	15%
		$35,000 and over (n=129)	91%	9%
Labor force status:				
	Employed (n=267)		85%	15%
		Employers, self-employed (n=68)	85%	15%
	Unemployed (n=14)		43%	57%
	Not in labor force (retired, students, etc.) (n=121)		86%	14%
Marital status:		Married (n=233)	91%	9%
		Not married (n=166)	74%	26%
Head of household:		Male (n=295)	86%	14%
		Female (n=105)	77%	23%

Insurance coverage also increased significantly with education and with household income. Income, however, is probably the more influential factor of the two, since it frequently accompanies increased education. Among those with the least formal education, with some high school or less, almost a third were without coverage, with only

about 70 percent insured. That proportion increased with education, peaking with college graduates who, like the elderly, had the highest incidence of coverage at 95 percent.

The patterns reflected by household income were similar. The level of insurance coverage increased from 70 percent among those at the low end of the income scale, with household incomes under $15,000, to 91 percent at the high end, among those with incomes over $35,000.

Marked differences in coverage were also apparent based on the respondent's marital status and the sex of the head of the household in which the respondent lived, with the more "nontraditional" groups having a lower incidence of coverage. Among married respondents, 91 percent reported having health insurance, while only 74 percent of the unmarried respondents were insured. Almost two-thirds of the insured respondents were married, compared to only about a third of the uninsured.

Those living in households headed by men were also slightly more likely to have coverage (86 percent) than were those in households headed by women (77 percent). While that alone is not a significant difference, it is compounded by a slightly higher incidence of lapsed coverage among those in households headed by women. The differences reflect the predominance of husband-wife households in Montana (58 percent of all households overall). Most Montana households headed by men are, in fact, husband-wife households (75 percent), and many are also dual-earner households, suggesting higher income levels generally. Most Montana households headed by women, however, are single parent households; very few are dual-earner households (U.S. Census Bureau; 1990, tables 17 and 30; 1991, table 712; derived).

In Montana, as nationally, insurance coverage also tends to be particularly correlated with employment. It is, by far, the most common avenue for obtaining health insurance; nationally, about three American workers in four held employment-based insurance (Burman and Rogers, 1992). Thus, it comes as no surprise that, among the Montana respondents, the unemployed were the least likely to have health insurance. Only 43 percent of the unemployed respondents had coverage, compared to 84 percent of the overall sample. Even taking into account the very small subsample of unemployed respondents, this difference is overwhelming.

Employers and Self-Employed. A small subgroup of the larger sample (68 of the 402 respondents) consisted of employers and self-employed persons. While their number was small, too small in many cases for detailed analysis, the data indicate patterns consistent with what is seen generally among employers and employees.

Collectively, the situation among the subgroup of employers and self-employed persons mirrored that of the overall sample, or the population generally. About 85 percent said they were insured at the time of the survey. Sixty-five percent said they had been continuously covered throughout their adult lives, a noticeably higher proportion than for the overall population.

Coverage for their employees, however, was less extensive. Of the employers in the sample, slightly less than half had provided or arranged for insurance for their own employees. Among those employers who had arranged for it, the coverage tended to follow common patterns. Their full-time employees were much more likely to be covered than were their part-time employees, and employers with larger numbers of employees

were somewhat more likely to provide insurance than were those with just a few employees.

Nationally, while a majority of workers receive insurance benefits, the incidence of such coverage as well as the nature of such benefits vary significantly by the size of the business and by industry group. Employees in large firms, on the whole, are more likely to have health insurance than are those in smaller firms. Similar patterns were found those in goods-producing industries compared to those in service-producing industries and, in turn, for the latter compared to those in retail trade businesses, where coverage is much less extensive (Burke and Morton, 1990).

Nature of Insurance Coverage

Among insured respondents, about a fourth (24 percent) reported having coverage through Medicare or Medicaid. The vast majority of insured respondents (76 percent) had private or other coverage, either as their sole coverage or as a supplement to their Medicare coverage.

In most cases (68 percent) the insured respondents said they paid all or part of the insurance premium themselves, as the principal insured or one of them. Twenty-seven percent said the premium was paid by someone else. In many of these cases, though, the respondent was covered as a dependent on a parent's policy.

TABLE 3

NATURE OF THE HEALTH INSURANCE COVERAGE AMONG INSURED MONTANANS
August 1992
(n=337)

Type of health insurance	
Medicare or Medicaid	24%
Private or other	76%
Who pays the health insurance premium	
Respondent/insured pays full premium	36%
Respondent/insured pays part of premium	32%
Someone else pays the insurance premium	27%
Who arranged the health insurance coverage	
Employer or union	50%
Respondent or insured	36%
Other	13%

About two-thirds of the insured respondents reported that dependents in their household were also covered; two dependents was the median among this group.

At least half the insured respondents said their coverage was employment based -- obtained through their own employment or that of the person on whose policy they were covered. For a few, a union was the conduit, but in most of the cases, the employers had arranged for the insurance.

About a third (36 percent) reported that they or the policy holder had arranged their own coverage privately.

Going Without Health Insurance

Slightly more than half the survey respondents reported having continuous insurance coverage throughout their adult lives (Table 1). The rest were either uninsured at the time of the survey (16 percent) or had experienced periods, often quite long periods, without any health insurance (31 percent). These respondents were asked about the length of time they had last been without insurance and why.

About one in five (20 percent) had gone without insurance for only a year or less. The median reported was five years without coverage, with at least a fourth of these respondents (about 28 percent) reporting they had been uninsured for over ten years.

By comparison, a national study reported only about 15 percent had uninsured spells longer than two years (Swartz and McBride, 1990).

As indicated in Table 4, affordability and employment circumstances were cited most often as reasons for not having health insurance. In almost half the cases, both cost and employment factors were cited.

About nine respondents in ten indicated they could not afford to carry the insurance themselves. Also, 13 percent cited the increases in deductibles as a primary reason (thus, presumably, more out-of-pocket expense).

About five in ten indicated that health insurance was not available to them through their employment. For some, it was a change to a job that did not provide insurance; for others, their current employer either did not provide insurance or had discontinued it.

TABLE 4

REASONS FOR NOT HAVING HEALTH INSURANCE
AMONG MONTANANS WHO ARE UNINSURED OR
HAVE EXPERIENCED LAPSES IN COVERAGE
August 1992
(n=190)

Too expensive, could not afford to carry it	89%
Deductible was increased	13%
Changed jobs and no insurance with new job	35%
Employer did not provide insurance or discontinued existing insurance	24%
Insurance company canceled my/our coverage because of a medical problem or condition	8%
Felt I/we could get by without it ("pay as you go")	8%
Benefits were reduced	4%

NOTE: Percentages do not add to 100 because of multiple responses.

Once again, the connection between employment and insurance coverage was prevalent.

A few had other reasons, though, for being without insurance. Roughly one in ten said that their coverage had actually been canceled by the insurance company because of a medical problem or condition they or someone on their policy had developed. And about as many were apparently voluntarily uninsured, feeling they did not need it at the time. Some said they were financially able to cover their expenses.

III

Access to and Use of Basic Health Care Services

Access to Basic Health Care

On the subject of their own access to health care, the survey results suggest that most Montanans, though not all, have access to what they consider basic health care services.

Roughly eight respondents in ten (78 percent) indicated they had a regular doctor at the time of the survey. In most cases, that doctor was located in their own community. Not surprisingly, though, uninsured persons were significantly less likely to have their own doctor; only 57 percent, compared to 82 percent among the insured respondents.

Over three-fourths (79 percent) said they lived within ten miles of a hospital or medical facility of some sort. Still, roughly one in ten (8 percent) said they lived more than twenty-five miles away from such services. This would account for almost 60,000 adults in this state, along with any children in their households. With almost half Montana's population living in rural areas, one might expect this proportion to be higher.

Beyond asking about having a regular doctor and their proximity to some sort of medical facility, the survey did not define "basic" services for the respondents. They were, instead, allowed their own interpretation or perception. When asked about the

availability of such services, eighty-nine percent of the respondents -- almost all -- said that most basic services are available to them in their own communities.

TABLE 5

ACCESS TO BASIC HEALTH CARE AMONG ADULT MONTANANS
August 1992

Have a regular doctor (n=402)	78%
Insured persons (n=337)	82%
Uninsured persons (n=65)	57%
Have a regular doctor in own community (n=402)	62%
Insured persons (n=337)	66%
Uninsured persons (n=65)	43%
Proximity to hospital or medical assistance facility of some type (n=402)	
Within 10 miles of residence	79%
11 to 25 miles from residence	12%
Over 25 miles from residence	8%
Believe most basic health care services are available in own community (n=402)	89%
Need or would like to have other health care services in own community (n=402)	20%

They believe most basic services are available, but not necessarily all. About one respondent in five also indicated a need or desire for other services that were not available in their communities at the time. These "other" services mentioned by the respondents pertained mostly to more specialized treatment services -- such as for cancer, cardiac care, head injuries, trauma, obstetrics-gynecology, and so on. Other responses,

for the most part, referred to the expansion of existing equipment and services in the communities -- such as having a full-time doctor, rather than a part-time doctor, or having another doctor, or more emergency equipment, and so on. Again, given the high proportion of Montana's population living in rural areas of the state, such responses are not unusual. Many of these specialized treatment services, in particular, are typically associated with larger or more urban areas.

Use of Health Care Services

The survey findings summarized in Table 6 indicate that Montanans, not unlike Americans overall, make considerable use generally of health care services.

General Extent of Health Care Use. The vast majority of respondents (78 percent) reported consulting with at least one type of health care professional in 1991 -- most often with a medical doctor (83 percent) or with a nurse or nurse practitioner (42 percent). (Consultations included any kind of consultation or treatment.) Most had five or fewer consultations during the year. Not unexpectedly, given the benefits of insurance coverage, insured respondents were noticeably more likely to report such consultations than were uninsured respondents. Eighty percent of the insured respondents reported having at least one such consultation in 1991, compared to 65 percent among the uninsured.

Roughly six respondents in ten (57 percent) overall reported that someone in their household was using prescription medicines at the time of the survey. Since use of prescription medicines at the least implies consultation with a doctor, and uninsured respondents reported less consultation, it's not surprising that they also reported less use

of prescription medicines by household members -- 45 percent, compared to 59 percent among insured respondents.

TABLE 6

GENERAL USE OF HEALTH CARE SERVICES AMONG ADULT MONTANANS 1990 AND 1991

Consulted with a health care professional during 1991 (n=402)	78%
Insured persons (n=337)	80%
Uninsured persons (n=65)	65%
Types of professionals consulted (n=313):	
Medical doctor	83%
Nurse or nurse practitioner	42%
Chiropractor	19%
Physical therapist	16%
Counselor, psychologist	11%
Other types (naturopath, dentist, optometrist, etc.)	35%
Prescription medicines used (currently) by someone in household (n=402)	57%
Insured households	59%
Uninsured households	45%
Hospitalization of anyone in household during 1991 (n=402)	29%
Insured households	28%
Uninsured households	37%

As would be expected, hospitalizations were considerably less frequent than consultations with health care professionals or prescription medicine use. Twenty-nine percent overall reported that someone in their household had been hospitalized during 1991. Interestingly, though, in this instance, and despite the lack of insurance, the

uninsured respondents reported a slightly higher-than-average incidence of hospitalization at 37 percent, compared to 28 percent among the insured.

Anecdotally, this is often attributed to two general tendencies: a tendency among some persons without their own doctors to turn to hospital emergency rooms for treatment, including routine treatment, and a tendency among many uninsured to defer routine or early attention until their ailments are serious and then entering the hospital through the emergency room for what may be more costly treatment than might have been otherwise.

Other research, though, has more carefully documented the experiences among many uninsured persons nationally. First, data have shown that uninsured persons are unlikely to seek medical care until their health deteriorates significantly and, thus, tend to be sicker upon admission to a hospital (Aukerman, 1991; and Hadley, *et. al.*, 1991). Thus, conditions that could have been treated cost-effectively become chronic and more expensive. Further, once admitted, uninsured patients, compared to the insured, tend to have a slightly shorter hospital stay with slightly fewer high-cost or high-discretion procedures applied in treatment (Hadley, *et. al.*, 1991). Unfortunately, they were also somewhat more likely to die while hospitalized or to die from complications arising from limited access to health care (Hadley, *et. al.*, 1991; and Aukerman, 1991). Physician involvement also apparently differs depending on the insurance status of the patient. Specifically, research indicated: the more specialized the physician, the less contact with the uninsured (for example, pediatricians and general practitioners had more contact than

did internists and surgeons); and self-employed physicians were less likely to deal with the uninsured than were employed physicians (Blumenthal and Rizzo, 1991).

Health Care Expenditures. Respondents were also asked to estimate their total household expenditures, out of pocket, for prescription medicines, doctor services, and hospital services. Table 7 summarizes this information, noting first the percentage of households having such out-of-pocket expenditures and the median estimated expenditure for those households. The median reflects the "middle" figure in the distribution -- that is, presumably half the households spent less, and half spent more than the median amount.

These data, however, should be interpreted and used with caution. Because the interviews were conducted by telephone, respondents were not asked to consult their records in estimating their expenditures. They were asked for their own best estimates of their expenditures, although some did voluntarily check their records. Further, they were given cost ranges to select rather than being asked to give single dollar amounts. Thus, the medians noted were derived from grouped data. Nevertheless, while the expenditure data may not be as precise as one would like, they do still provide some information for comparisons.

Most Montana households overall, as suggested by the survey data, apparently had expenditures for prescription medicines during 1991 and for doctor services during 1990-1991. Roughly half had hospital expenditures during the two-year period.

Overall, only about 14 percent reported no out-of-pocket expenditures for prescription medications during 1991 for their households. Eighty-four percent reported

such expenditures, with a median expenditure of $130 (roughly $10 per month). Almost a fourth reported expenditures over $250 (more than $20 per month).

TABLE 7

MONTANA HOUSEHOLDS WITH OUT-OF-POCKET HEALTH CARE EXPENDITURES IN 1990 AND 1991

	All Respondents (n=402)	Insured Persons (n=337)	Uninsured Persons (n=65)
Expenditures for prescription medicines, 1991			
Percentage of households	84%	86%	72%
Median total expenditure	$130	$135	$ 95
Expenditures for doctor services, 1990-1991			
Percentage of households	93%	95%	85%
Median total expenditure	$575	$560	$725
Expenditures for hospital services, 1990-1991			
Percentage of households	56%	54%	66%
Median total expenditure	$710	$710	$710

Even fewer (6 percent) said their households had no out-of-pocket expenditures for doctor services during the two-year period of 1990-1991. Among the 93 percent that reported such expenditures, the median was about $575. At the high end, about two in ten (21 percent) reported totals over $1,500 (or more than $60 a month).

Hospital expenditures were less common. A little over half (56 percent) had such expenditures during the two-year period. The median expenditure was $710, but about one in ten averaged over $100 per month, or more than $2,500 total.

Among the insured respondents, the incidence of expenditures was virtually the same. By comparison, though -- among the uninsured respondents -- noticeably fewer reported household expenditures for prescription medicines and for doctor services, which would not be unexpected, especially since such expenditures would reflect some routine or preventive care or early treatment. However, noticeably more uninsured respondents reported having hospital expenditures -- roughly seven in ten. The earlier discussions regarding use of health care among uninsured persons, based on both the anecdotal information and the research, would have application here as well.

The expenditure data indicate generally, as common experience would confirm, that hospitalization, on average, is comparatively more costly than doctor services, though less frequent, and that both of these are considerably but expectedly more costly than prescription medicines.

Given the cautions expressed earlier about the expenditure data, but assuming they are relatively realistic, they might also help in understanding the situation among uninsured persons, not all of whom are involuntarily uninsured and not all of whom obviously do not pay for their treatment. The lower incidence and lower median expenditure for prescription medicines among the uninsured certainly coincide with the somewhat lower likelihood of doctor consultations noted earlier, especially when it comes to routine or preventive consultations.

While the uninsured also have a somewhat lower incidence of expenditures for doctor services, their median expenditure is significantly higher. As stated earlier, the

tendency to put off treatment until a condition becomes more serious means what could have been treated cost-effectively instead becomes an expensive treatment.

In the case of hospital expenditures, again as noted earlier, while the incidence is higher, the median expenditure is still comparable. This may well be a case of a higher number of "visits" that are less expensive compared to the those incurred by insured persons who would only be in the hospital for more serious treatments.

Without more reliable and detailed expenditure data, of course, any further generalizations are not warranted.

IV

Related Health Care Concerns

There are, of course, any number of related concerns and issues in the health care arena. The survey certainly was not intended to address all pertinent issues, but did touch on two important aspects -- long-term health care and health-related lifestyle practices.

Long-Term Health Care

With continuing advances in longevity generally, coupled with the significant medical advances that compound that longevity, increasing attention is being focused on long-term care needs. This survey asked Montanans more specifically about preparing for such long-term care. In a nutshell, though, while they acknowledge the importance of such preparation and appear to recognize certain avenues for dealing with it, they, like many Americans, have done little real preparation.

When asked how they would fund their own long-term care in the future, should they need such care, most -- about six in ten overall -- said they would rely either on long-term care insurance (37 percent) or on their own personal savings (24 percent). Fifteen percent, or almost two in ten, acknowledged that they would probably have to rely on some sort of public assistance. Another 5 percent indicated that they would most likely be relying on some combination of the three.

TABLE 8

LONG-TERM HEALTH CARE PREPARATION AMONG ADULT MONTANANS
August 1992

Planned funding of own long-term health care (n=402)	
Insurance	37%
Personal savings	24%
Public assistance	15%
Combination of above	5%
Other sources/responses	19%
Have already made plans for own possible long-term health care needs (n=402)	27%
Steps taken so far regarding own long-term health care needs (n=402)[a]	
Purchased long-term care insurance	16%
Discussed family's role	15%
Set aside personal savings	10%
Looked into various public and private services	9%
Other	3%

[a]Responses add to more than the 27% noted in previous item because of multiple responses.

Only 27 percent of the respondents, however, indicated that they had actually done anything in the way of planning for their own possible long-term care needs. Even fewer had done something substantial -- 16 percent had actually purchased long-term care insurance, and 10 percent said they had set aside personal savings for this purpose. Fifteen percent said they and their family had at least discussed the family's role in their own long-term care, and 9 percent said they had looked into various long-term care programs and services, both public and private. (It should be noted, though, that multiple responses were allowed, and some of the respondents had cited more than one action.)

Health-Related Lifestyle Practices

An increasing body of evidence shows that lifestyle practices -- such as smoking or tobacco use, alcohol consumption, and exercise -- can have a profound impact on health and consequently on the need for health care. The survey findings suggest that Montanans have some pretty respectable lifestyle practices.

Most Montanans apparently exercise or engage in physical activity somewhat regularly, do not smoke, drink only moderately or not at all, use their seat belts, and have consciously improved their dietary habits.

While this picture might seem too good to be true, similar patterns have shown up at the national level, and there's no evidence or reason to suggest the experience reported by Montanans is an aberration (***The Polling Report***, 1993; citing Louis Harris and Associates for Baxter International, December 1992 poll).

Roughly eight respondents in ten said they engage in exercise or some other form of strenuous activity on a regular basis. Most said they did so about three or four times a week or more. Walking was, by far, the single most frequently cited activity (54 percent). Other frequently mentioned activities were use of weight training or exercise equipment or aerobics (20 percent total), and jogging (11 percent). A few said their daily work was their strenuous activity, citing construction work, farm or ranch work, and the like.

Overall, only 25 percent of the respondents admitted to smoking or any other kind of tobacco use. While 75 percent disclaimed any current use, a third overall said they had used tobacco in the past but no longer did. Compared with insured persons, the

uninsured respondents were nearly twice as likely to be smokers or other users of tobacco. Forty-three percent admitted to current tobacco use, compared to only 22 percent among the insured.

TABLE 9

HEALTH-RELATED LIFESTYLE PRACTICES AMONG ADULT MONTANANS
August 1992

	All Respondents (n=402)	Insured Persons (n=337)	Uninsured Persons (n=65)
Engage in exercise or strenuous physical activity on a regular basis	79%	79%	80%
Smoke or use other tobacco products	25%	22%	43%
Do not smoke or use tobacco products	75%	78%	57%
Drink alcoholic beverages	74%	74%	72%
Often	14%	12%	23%
Seldom or only sometimes	60%	62%	49%
Do not drink alcoholic beverages	26%	26%	28%
Use seat belt in vehicle	91%	92%	83%
Often or always	69%	70%	61%
Sometimes use	22%	22%	22%
Have made changes to improve eating habits and diet	59%	60%	51%

A similar pattern appeared in the reported use of alcoholic beverages. Overall, roughly one respondent in four (26 percent) claimed to be a nondrinker, while the majority (60 percent) said they drink only moderately or infrequently. Among the uninsured, while about as many (28 percent) said they were nondrinkers, there were

proportionately more frequent drinkers. Twenty-three percent of the uninsured said they drink often, compared to only 12 percent among the insured respondents.

The uninsured also reported using seat belts slightly less often than did insured persons, although few respondents would admit to never buckling up. Overall, only 9 percent admitted they never use their seat belts, while 69 percent claimed they often did. Insured persons exhibited similar patterns. Among the uninsured, though, while 61 percent said they often buckle up, 17 percent admitted no seat belt use.

Overall, about six respondents in ten claimed to have improved their eating habits, citing concerns about fat and cholesterol as influential factors in their changes. Here, as with other lifestyle measures, uninsured persons were somewhat less likely to practice the healthier alternative. About five in ten indicated they had made dietary improvements.

While most Montanans appear to engage in relatively healthy lifestyles, there is a discouraging note as well. The uninsured respondents, as a group, were somewhat less likely to use their seat belts or to have improved their diets. Moreover, they showed a somewhat higher propensity for tobacco and alcohol use. All of these practices could certainly lead to their needing health care, perhaps considerable and expensive health care, but care for which they have no insurance.

V

Options for Dealing with Health Care and Reform

In addition to queries about lifestyle, expenditures, insurance status, and so on, Montanans were also asked how they felt about several important health care policy issues, especially several that would impact access and cost containment. The options presented were not meant to be all-inclusive, by any means, but were the ones for which the Governor's committee wanted some reading of public opinion. And in instances where similar issues have been raised in national polls, the results have been comparable.

Health Care Access

Generally speaking, there was less public support for options that would reduce health care access. In fact, respondents favored more, rather than less, access to health care, and only one in ten did not agree with the notion that access to basic health care is a fundamental right for all citizens.

Of all the explicit access-related options presented in the survey, employer-provided health insurance garnered the most public support. A substantial majority, 83 percent, favored incentives for employers to offer coverage or make it available (though not necessarily pay for it). Nearly that many respondents, 72 percent, thought employers should be required to offer coverage. Similarly, in a national survey, 63 percent agreed that "all employers, even small business owners, should be required to provide health

insurance for their workers;" 33 percent were opposed (***The Polling Report***, 1993; citing the **NBC News/*Wall Street Journal* Poll, March 1993).**

Almost three-fourths (72 percent) supported adoption of a national health care plan as a means of improving overall access, and about six in ten (61 percent) favored expansion of Medicare and Medicaid to achieve that goal.

Interestingly, when offered three related options, nearly half the respondents (46 percent) actually said they would pay higher taxes in order to increase access, rather than to leave things as they are (34 percent) or to reduce access (3 percent).

Health Care Costs

Human nature being what it is, respondents tended to support options that would provide the greatest access while putting less burden directly on the average consumer -- i.e., themselves.

The largest majority, 80 percent, endorsed limits on malpractice liability, which are more often seen as benefitting doctors and other providers rather than affecting consumer access. Almost as many (79 percent) favored limits on the fees charged by health care providers -- i.e., what they and other consumers could be charged for the health care services they receive. By contrast, though, many fewer respondents (45 percent) supported limits on the insurance reimbursements on behalf of the insured consumers, which would directly impact them.

TABLE 10

MONTANA PUBLIC SUPPORT FOR SELECTED HEALTH CARE POLICY OPTIONS
August 1992
(n=402)

Health care access:	
Access to basic health care is a fundamental right for all citizens	91%
Incentives for employers to provide health insurance	83%
Establish State trust fund to provide coverage for uninsured or underinsured persons	73%
Require employers to provide health insurance	72%
Adopt a national health care plan	72%
Expand Medicare and Medicaid	61%
Increase access through higher taxes, versus reducing access	46%
Maintain current access, versus increasing access through higher taxes	34%
Controlling health care costs:	
Limit malpractice liability	80%
Limit health care fees and charges	79%
Require preventive programs and actions	74%
National health care system	68%
Establish federal funding priorities for health care services	57%
Disallow Medicare benefits for persons who can afford to pay their own expenses or insurance	55%
State-operated health care system	46%
Limit insurance payments	45%
Limit access to health care	15%

Once again, raised in the context of cost containment, the general idea of a national health care system received majority support. Sixty-eight percent favored it as

a cost-cutting measure, compared with the 72 percent who supported it as a means of improving access.

Despite the support for a national system, support was mixed for health care systems at the state level. When asked about developing a Montana-operated health care system as a means of controlling costs, only 46 percent indicated support. Yet nearly three-fourths (73 percent) endorsed the general idea of a state-level "safety net" or trust fund to provide just insurance coverage for uninsured or underinsured Montanans.

Here again, strategies that limited access garnered little support. In fact, only 15 percent of respondents endorsed the idea of limiting access to control costs. But two cost control measures with some impact on access did receive majority support. Just over half (55 percent) thought Medicare benefits should be disallowed for persons who can afford to pay their own expenses or insurance -- i.e., a kind of means test to qualify for such benefits. Slightly more respondents (57 percent) favored setting priorities on federally funded health care services.

VI

Concluding Observations and Recommendations

Virtually no one disagrees that health care reform is needed, and it's always tempting to reach for a few succinct concluding comments and recommendations, but health care reform is a deeply complex issue. It is, in fact, both complicated and risky. Reforms must protect not only the public welfare but also the public purse.

Given the variety of topics in this survey, the coverage was not extensive enough to warrant firm conclusions or any specific or detailed recommendations for health care reform. However, a few general suggestions or observations may be offered.

Universal Coverage. Any significant health care reform undoubtedly will acknowledge the popular view that access to some basic level of health care is a right that should be afforded all citizens. Implied in this, of course, is that this "right" be secure, that it cannot be denied or taken from them, regardless of their income or their employment situation or their health. Whatever the arrangement -- whether some form of universal insurance, or actual unrestricted access to some basic level of services, or some kind of combination of these -- there is considerable general evidence to suggest a real sensitivity to policies that might negatively impact access to health care or the security of that access. In this survey, among the various options that would impact health care, those policies that would ensure, enhance, or guarantee access generally received considerable support, as contrasted with those that would reduce or limit access.

Cost Containment. Universal coverage, secure coverage, is not without a price, of course, and another foundation of any health care reform will unquestionably be cost containment at the very least. Therein, of course, lies one of the major tradeoffs or compromises -- between security and cost, between guaranteeing secure access or coverage to all and dealing with the cost of such universal coverage or access. Human nature being what it is, it should surprise no one that people tend to be more concerned about the security of their access and less enthralled with bearing the full cost of it. But though they may be less enthused, certainly, they are not necessarily opposed to assuming some of this burden. Many indicated support for efforts that are often touted as cost saving in the long run, such as required preventive or wellness activity, funding priorities for services, etc. Higher taxes were less appealing, by comparison, but more so than reduced access. Thus, while few would disagree that costs must be controlled, the significant question, on which there is less agreement, is how.

Shared Compromise. The results could also be construed generally to suggest that the public, as consumers, would put emphasis on sharing the costs, but not just among themselves. That is, the compromises and sacrifices, monetary and otherwise, that will be called for must also be shared by the other major players -- the health care providers and the health care insurers. For example, the public apparently supports limits on malpractice liability, which would certainly benefit providers, but also wants to see limits on health care fees charged by those providers.

Employment-Based Insurance. Most insurance coverage is employment based (among at least half the insured in this survey), and even a good share of the uninsured

are themselves employed. Thus, despite the protestations of many businesses about the costs of providing insurance for employees, this is one already well-established avenue for expanding coverage. The reality is that employment-based insurance will undoubtedly be part of any health care reform, and it is an avenue that is strongly supported by the public.

Further, though, there are currently problems with employment-based insurance that will need to be resolved. Any reform should undoubtedly include what's referred to as "portability," which means a worker's insurance will move with him/her if a job change occurs. Thus, the worker would not be subject to "job lock," would not have to feel compelled to stay with a job simply because it provides health insurance he/she would lose upon leaving and might not be able to replace at another job.

Flexibility, or One Size Does NOT Fit All. Given the American tradition of free choice, and the fact that one seldom finds unanimity of public opinion, common sense, if nothing else, would suggest that any reform plan would do well to allow for some flexibility. That is, it should, to some extent, allow consumers to fashion a mix of coverage and cost to accommodate their own needs (or desires) and resources.

As this survey suggests, and as experience confirms, health care reform involves difficult tradeoffs, apparently contradictory public demands at times, and certainly no pat answers. There are uncertain expectations, which can foster both optimism and apprehension. And while important policy matters should certainly not be dictated solely by public opinion, neither can policy makers afford to develop policy without acknowledging and understanding the complexity and power of public opinion. Such

polls as these can help them understand the environment within which reform must be undertaken and the obstacles and opportunities they will face.

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APPENDIX I

Survey Methodology

This research was done originally and primarily at the request of a committee called Health Care for Montanans, which was established by former Governor Stephens to study health care in Montana and report to the 1993 Legislature. This survey was only one part of that committee's work.

The concern of the Governor's committee in underwriting the research was primarily to develop a descriptive report on the status of Montana's population relative to health insurance coverage (and noncoverage), access to and use of health care, and related practices; and to determine the degree of public support for a number of options for dealing with health care.

The information was compiled through a statewide survey conducted in August 1992. The survey plan and the survey questionnaire were developed by the author, with consultation from the committee through a designated representative. For a variety of reasons, not the least of which was cost, the survey and the questionnaire were designed for telephone administration. The telephone interviews were conducted by the Bureau of Business and Economic Research under the author's direction.

The survey was conducted with a random sample of 402 adult Montanans, selected through the Bureau's two-stage random sampling procedure. Initially, a computerized, random digit telephone sampling program is used to generate a random sample of telephone numbers that appropriately reflects the geographic distribution of the population being surveyed. Then, once the interviewer makes contact with a household, a second random sampling procedure is used to select one adult member of the household to be interviewed. This latter procedure takes into account the total number of adults in the household and the mix of males and females. The two-stage procedure is used to assure that the sample is a representative cross-section of the study population.

Overall, the sample size reflects a 73 percent response rate. The nonresponse was about 27 percent, but not all refusals. Outright refusals accounted for about half the nonresponse; all were initial refusals before the interview could begin. The rest of the nonresponse included two broken interviews but were mostly cases where the potential respondent was identified but the interviewers were never able to establish contact for the following reasons: the individual was temporarily away from his/her residence during the interview period and could not be reached by telephone, the individual had a physical or mental condition that precluded a telephone interview, the individual was hospitalized or otherwise incapacitated, or the individual was never reachable at his/her residence (or any other telephone number) during the interview period despite numerous varied attempts.

The data, then, are estimates that were derived from the sample survey. Because random sampling was used, there could be chance variations in the sample that could cause the results to vary slightly from the "true" values -- the results that would be

obtained by interviewing all adult residents of Montana. However, the range of possible values -- that is, the confidence interval or "error margin" for the results -- can be estimated with a certain level of confidence. In survey research, particularly among surveys of this kind among the general population, a confidence level of 95 percent is customarily used, and a confidence interval or "error margin" of plus or minus 5 percentage points is common.

For this survey generally, assuming a standard confidence level of 95 percent, the sample size of 402 is sufficient for an overall confidence interval, or error margin, of plus or minus 5 percentage points. Thus, for any set of results for the overall sample, the maximum possible error due to random sampling would be plus/minus 5 percentage points. That maximum error margin, however, could be less depending on the particular value being evaluated (as shown by the table below).

What this says, generally, is that if all adults in the state had been interviewed, the chances are 95 in 100 (or we are 95 percent confident) that those results (the "true" values) would not differ from the survey results by more than 5 percentage points either way. It also indicates, generally, that if, for example, the difference between two positions or responses is more than 10 percentage points total, the difference is probably "real," or at least more than just possible sampling "error"; or if the difference is less than 10 percentage points, we cannot say that the difference is not the result of possible sampling error.

In estimating the specific confidence interval or error margin for a specific question or set of results, or a particular subsample, the following are taken into account:

the particular value (the percentage reported in the survey results) that is being considered; the size of the sample or subsample; and the confidence level desired or selected for the survey results.

Assuming the 95 percent confidence level discussed, the estimated confidence intervals for selected sample/subsample sizes and survey values (percentages) in this report are:

Sample Size (n)	Percentage Reported in Table				
	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
50	8	11	13	14	14
65	7	10	11	12	12
82	7	9	10	11	11
100	6	9	10	10	10
200	4	6	6	7	7
255	4	5	6	6	6
300	3	5	6	6	6
337	3	4	5	5	5
400	3	4	5	5	5
800	2	3	3	3	4

This means, then, that the chances are 95 in 100 that the value being estimated (the "true" value that exists for the entire study population) lies within a range equal to the reported percentage plus or minus (+/-) the number of percentage points shown above.

To illustrate: The data in Table 1 indicate that 16 percent of the respondents said they were not insured at the time of the survey. Given the size of the statewide sample (n=402), the estimated confidence interval (or error margin) for that response is about +/- 4 percentage points. Thus, we could say we are 95 percent certain (confident) that the true value, had we surveyed all adults in the state, would fall within the range of 12-20 percent (16 percent +/- 4 percentage points).

APPENDIX II

Survey Questionnaire

QUESTIONNAIRE NO.

HEALTH CARE SURVEY
1992

RESPONDENT ID NO.

Bureau of Business and Economic Research
University of Montana
Missoula, Montana 59812
(406) 243-5113

HCS92

TELEPHONE NUMBER: _____

TELEPHONE SHEET NUMBER: _____

INTERVIEW DATE: _____

TIME INTERVIEW BEGAN: _____

LENGTH OF INTERVIEW (MINUTES): _____

INTERVIEWER ID NUMBER: _____

X1. EXACT TIME NOW: _____

X2. INTRODUCTION *(USE ONLY IF NEEDED -- E.G., IF RESPONDENT WAS NOT INFORMANT.)*

Hello, my name is (YOUR FIRST AND LAST NAME). I'm calling from the University of Montana (here) in Missoula. We're doing a statewide survey for the Bureau of Business and Economic Research on various health care issues.

X3. ***THE FOLLOWING MUST BE READ TO RESPONDENT:***

Before we start, I want to assure you that this interview is completely confidential and voluntary. If we should come to a question that you don't want to answer, just let me know and we'll go on to the next question.

A1. First, for classification purposes... what is the name of the city, town, or community you live in now, or live closest to?

IF MORE THAN ONE PLACE OF RESIDENCE: (X) Where is your primary place of residence?

_____
NAME OF CITY/TOWN/COMMUNITY

A2. How many years, altogether, have you lived in Montana? _____ YEARS

A3. What is the zip code for your street address where you live? ZIP CODE: _____

A4. What is your age, as of your last birthday? AGE: _____YEARS

A5. And your marital status at this time -- married, or not married? (1)....MARRIED (2)....NOT MARRIED

A6. Not counting yourself, how many dependents do you have, whether they live with you or not?

_____ DEPENDENTS

A7. And who is the head of your household? ((X) What is that person's relationship to you?)

(1)....RESPONDENT (R) IS HEAD

(X)....OTHER PERSON ***(SPECIFY RELATIONSHIP TO R):***

_____

B1. As for your current job status -- are you working now, temporarily laid off, unemployed, retired, a student, (a homemaker), or what? *(CHECK ALL THAT APPLY.)*

01....WORKING NOW

02....EMPLOYED, BUT ON SICK LEAVE/VACATION NOW

→ ***GO TO B3, NEXT PAGE***

03....TEMP LAID OFF, UNEMPLOYED

04....PERMANENTLY DISABLED

05....RETIRED

06....STUDENT

07....HOMEMAKER

08....OTHER _____

B2. Are you doing any work for pay at the present time?

1....YES

2....NO → ***GO TO C1 ON PAGE 5***

B3. About how many hours do you work at your (main) job in an average week?

_____ HOURS PER WEEK (AVERAGE)

B4. Are you <u>self-employed</u>, are you employed by <u>someone else</u>, are you an <u>owner-employee</u> of a professional corporation, or what?

1....SELF-EMPLOYED

2....EMPLOYED BY SOMEONE ELSE

GO TO C1 ON PAGE 5

3....PC OWNER-EMPLOYEE

X....OTHER: _____

GO TO C1 ON PAGE 5

B5. Does your business, or do you yourself, have any employees?

1....YES

2....NO → ***GO TO C1, PAGE 5***

B6. Approximately how many <u>full-time</u> employees does your business have, and about how many <u>part-time</u> employees? (A rough estimate is fine.)

	FULL-TIME EMPLOYEES	PART-TIME EMPLOYEES
(B6) NUMBER OF EMPLOYEES	_____	_____
(B7) PERCENT (or NUMBER) COVERED BY INSURANCE . . . ***(RECORD % SIGN IF PERCENT IS GIVEN.)***	_____	_____

ASK B7 FOR THE TYPE(S) OF EMPLOYEES R HAS (IF BOTH, ASK <u>TWICE</u>):

B7. About how many, or what <u>percent</u>, of your (full-time / part-time) employees are covered by health insurance? *(RECORD ABOVE.)*

B8. Does your business <u>provide</u> health insurance coverage, or make it available, to any of your employees?

1....YES

2....NO → ***GO TO C1, PAGE 5*** →

B9. Does that health insurance plan include coverage for the employees' families? (1)....YES (2)....NO

B10. There are various ways that employees can share the cost of their insurance coverage.

They can pay part or all of the monthly premium,... or they might pay part of the cost through a deductible or through co-payments, and so on.

At this time, do your employees pay any part of the cost of their insurance coverage, or not?

1....EMPLOYEES PAY PART	2....DO NOT PAY
	GO TO C1, NEXT PAGE →

B11. In what way, or ways, do they pay part of the cost?

Do they pay.....

		YES	NO	DK
(A)	Part of the insurance premium?	1	2	8
(B)	All of the insurance premium?	1	2	8
(C)	A deductible or co-payment?	1	2	8
(D)	In some other way?	1	2	8

(IF "YES", SPECIFY HOW): ((X) What is that other way?)

_____

_____

C1. Now, about <u>your</u> health insurance situation.... Do <u>you</u> currently have health insurance coverage yourself?

1....YES

2....NO → ***GO TO C8, PAGE 7***

C2. Are you the only person covered by your health insurance, or are other members of your family also covered by your insurance?

1....ONLY R IS COVERED

2....OTHERS ALSO COVERED

C2a. <u>Not</u> counting yourself, how many <u>other</u> persons are also covered by your health insurance? _____ PERSONS COVERED

C3. Who pays the premium for your health insurance -- .... ***(READ ALL OPTIONS.)***

(1)....Do <u>you</u> pay the <u>full</u> premium yourself; or

(2)....Do you pay <u>part</u> of the premium; or

(3)....Does <u>someone else</u> pay the <u>full</u> premium;

(X)....Or what? ***(SPECIFY):*** _____

_____

C4. And who arranged for the health insurance coverage -- .... ***(READ ALL OPTIONS.)***

(1)....Did <u>you</u> arrange for the health insurance coverage yourself; or

(2)....Did your <u>employer</u> arrange for it, or already have the health insurance plan when you went to work there;

(X)....Or what? ***(SPECIFY):*** _____

_____

C5. Now a question about Medicare, the federal health insurance program for disabled persons and persons aged sixty-five (65) and over -- are you.....

(1)....currently enrolled in Medicare,

(2)....eligible for Medicare but not enrolled, or

(3)....not eligible yet for Medicare?

(X)....OTHER *(SPECIFY):* _____

C6. And what about Medicaid, the other federal health insurance assistance program -- are you.....

(1)....currently enrolled in Medicaid,

(2)....eligible for Medicaid but not enrolled, or

(3)....not eligible for Medicaid?

(X)....OTHER *(SPECIFY):* _____

C7. To the best of your recollection, in your adult life, have you always been covered by health insurance, or has there been any time when you did not have health insurance, not even Medicaid or Medicare?

1.....ALWAYS COVERED	2.....NOT ALWAYS COVERED
GO TO D1, ON PAGE 8	*GO TO C8, NEXT PAGE* ——▸

C , how long (did you go / have you gone) without health how many months or how many years (was it / has it been)? ***EARS.)***

IF R HAS HAD MORE THAN ONE TIME WITHOUT INSURANCE: (X) Tell me about the last time you were without health insurance -- how many months, or years, was that?

_____ MONTHS	OR	_____ YEARS

C9. I'm going to read you some of the various reasons people have cited for not having health insurance. As I read each one, please tell me if that (applied / applies) in your case, or not.

The (first / next) reason is..... -- does that reason apply in your case, or not?

		YES; APPLIES	NO; DOES NOT	DON'T KNOW
(A)	My employer stopped carrying or providing health insurance	1	2	8
(B)	I couldn't afford the insurance, it was too expensive	1	2	8
(C)	I changed jobs and my new employer did not carry or provide health insurance	1	2	8
(D)	The insurance company canceled my health insurance because of a medical situation or problem	1	2	8
(E)	The benefits in my policy were reduced	1	2	8
(F)	The deductibles were increased in my policy . . .	1	2	8

C10. Are there any other reasons you (did not / do not) have health insurance coverage? ((X) What are those other reasons?)

_____

_____

_____

IF MORE THAN ONE REASON (TOTAL) CITED IN C9-C10:

C11. Of those reasons that you said apply to you, what would you say (was / is) your main reason for not having health insurance coverage. ***(RECORD LETTER OR NUMBER OF REASON.)***

_____

D1. Now we'd like to ask about access to health care. How do you feel about the idea that...

Access to basic health care is a fundamental right for all citizens.

All things considered, would you say you strongly agree with that idea, somewhat agree,... somewhat disagree, or strongly disagree.

(1)....STRONGLY AGREE
(2)....SOMEWHAT AGREE
(3)....SOMEWHAT DISAGREE
(4)....STRONGLY DISAGREE
(X)....OTHER *(SPECIFY):* _____

D2. There's been talk about changing the health care system, so that more people can have access to health care. As I read some options for changing the health care system, please tell me if you're inclined to favor or oppose each one.

The (first / next) option is __(INSERT ITEM)__ -- would you be strongly in favor of that, somewhat in favor,... somewhat opposed, or strongly opposed?

		FAVOR STR	FAVOR SOME	OPPOSE SOME	OPPOSE STR	DON'T KNOW
(A)	To expand government programs, like Medicaid and Medicare	1	2	3	4	8
(B)	To adopt a national health care program	1	2	3	4	8
(C)	To require employers to provide basic health insurance for their employees	1	2	3	4	8
(D)	To provide incentives for employers to provide basic health insurance for their employees . .	1	2	3	4	8

D3. Is there some other change you would make to the current system in order to provide access to health care for more people? ((X) What other changes would you make?)

_____

_____

_____

_____

D4. Thinking about the types of health care you generally expect to receive from your health care system -- is it your impression,.... given what you would expect to receive,.... that the present health care system is too expensive, is about right, or is actually very inexpensive?

(1)....TOO EXPENSIVE
(2)....ABOUT RIGHT
(3)....VERY INEXPENSIVE
(X)....OTHER *(SPECIFY):* _____

D5. And, considering, instead, the types of health care services actually provided by your health care system -- is it your impression,.... given what is actually provided,.... that the system is too expensive, is about right, or is actually very inexpensive?

1....TOO EXPENSIVE	2....ABOUT RIGHT	3....VERY INEXPENSIVE
	GO TO D7, NEXT PAGE	*GO TO D7, NEXT PAGE* ——→

OTHER *(SPECIFY)*: _____

GO TO D7, NEXT PAGE ——→

D6. I'm going to read some of the reasons we've heard,... about why the health care system is too expensive,... and then I'd like you to tell me which one or two of these you think are the main reasons.

(ROTATED START: BEGIN WITH ITEM MARKED, GO THROUGH ENTIRE LIST, ENDING WITH "SOMETHING ELSE" OPTION EACH TIME.)

Is the system too expensive because ....

(A) Insurance rates are too high; (or)

(B) Hospital costs are too high; (or)

(C) The fees charged by doctors and other health care professionals are too high; (or)

(D) Administrative and paperwork costs are too high; (or)

(E) Insurance company profits are too high; (or)

(X) Or is there something else that you think is a main reason for the health care system being too expensive? *(SPECIFY)*

_____

_____

_____

_____

D7. There's been a lot of talk about controlling the costs of health care, and we'd like your opinion of a few ways to do this.

The (first / next) option is __(INSERT ITEM)__ -- would you be strongly in favor of that, somewhat in favor,... somewhat opposed, or strongly opposed?

		FAVOR STR	FAVOR SOME	OPPOSE SOME	OPPOSE STR	DON'T KNOW
(A)	To set cost limits on actual health care charges	1	2	3	4	8
(B)	To set cost limits on what the insurance will pay	1	2	3	4	8
(C)	To change to a national health care system, to nationalize the system	1	2	3	4	8
(D)	To set up state-run health care systems	1	2	3	4	8
(E)	To limit access to health care	1	2	3	4	8
(F)	To require people to take part in prevention programs	1	2	3	4	8
(G)	To set limits on the malpractice liability of doctors, nurse practitioners, and other health care professionals	1	2	3	4	8

D8. Is there something else you would do to control health care costs over the next ten years or so? ((X) What is that specifically?)

_____

_____

_____

_____

E1. In your view, who generally is helped the most by the federal government's various health care programs -- is it your impression that children tend to be the ones helped most by these programs,... or that senior citizens are helped most,... that single parents are,... that unemployed persons are,... or that some other group tends to be helped most by such programs generally?

(1)....CHILDREN

(2)....SENIOR CITIZENS

(3)....SINGLE PARENTS

(4)....UNEMPLOYED PERSONS

(X)....OTHER *(SPECIFY):* _____

E2. What is your feeling about the overall amount the federal government spends for its health care programs -- considering everything the federal government spends money on, do you feel the federal government is spending too much on health care,... that it's spending about the right amount,... or that it should be spending more?

(1)....TOO MUCH (2)....ABOUT RIGHT AMOUNT (3)....TOO LITTLE; SHOULD SPEND MORE

(X)....OTHER *(SPECIFY):* _____

E3. Is it your impression that the federal government makes good use of the money it spends on health care, or that it does not make good use of that money?

(1)....MAKES GOOD USE OF $ (2)....DOES NOT MAKE GOOD USE OF $

(X)....OTHER *(SPECIFY):* _____

E4. If you could choose how to allocate the federal government's funding for health care, what services would you fund?

_____

_____

_____

_____

E5. How would you feel about the federal government setting priorities for funding various health care services -- some would be at a high priority level for funding, some at a low priority level, and the others would fall in between. Generally speaking, would you say you'd be strongly in favor, somewhat in favor,... somewhat opposed, or strongly opposed to setting funding priorities for health care services?

(1)....STRONGLY FAVOR (3)....SOMEWHAT OPPOSE

(2)....SOMEWHAT FAVOR (4)....STRONGLY OPPOSE

(X)....OTHER *(SPECIFY):* _____

E6. If you were the one to choose priority levels for funding various health care services -- what two or three programs or services would you give the highest priority to?

_____

_____

_____

_____

E7. And, if you were setting the priority levels when it came to the particular groups of persons who are helped by federal health care programs -- such as children, senior citizens, single parents, unemployed persons, and so on -- what one or two groups of persons would you give the highest priority to?

(1)....CHILDREN
(2)....SENIOR CITIZENS
(3)....SINGLE PARENTS
(4)....UNEMPLOYED PERSONS
(X)....OTHER *(SPECIFY):* _____

E8. What is your feeling about the federal government... providing Medicare benefits... for persons who are over age 65 (sixty-five)... but can afford their own health insurance, or can afford to pay for their health care services --

Would you say you would be strongly in favor, somewhat in favor,... somewhat opposed, or strongly opposed to providing Medicare benefits to such persons?

(1)....STRONGLY FAVOR
(2)....SOMEWHAT FAVOR
(3)....SOMEWHAT OPPOSE
(4)....STRONGLY OPPOSE
(X)....OTHER *(SPECIFY):* _____

E9. Now I'm going to name some prevention programs -- and for each, please tell me if you think the federal government should increase the funding for it, or decrease the funding, or leave it as it is?

The (first / next) program is __(INSERT ITEM)__ -- do you think the funding for that should be increased, or decreased, or left as it is now?

		INCR	DECR	AS IS	DK
(A)	Immunizations for children	1	3	2	8
(B)	Flu shots for people of all ages	1	3	2	8
(C)	Preventive prescription drugs	1	3	2	8
(D)	Health screening	1	3	2	8

E10. If you had to choose between....

(1)....Reducing people's access to health care; or
(2)....Paying higher taxes in order to increase people's access to health care; or
(3)....Keeping things as they are now....

Which would you be inclined to do? *(RECORD ABOVE OR IN 'OTHER' BELOW.)*

(X)....OTHER *(SPECIFY):* _____

E11. If it became necessary to reduce health care services -- what two or three health care services would you either reduce or eliminate altogether?

_____

_____

_____

_____

E12. And if it became absolutely necessary to increase taxes in order to support health care services -- which of the following tax options would you favor?

The (first / next) option is to __(INSERT ITEM)__ -- would you be strongly in favor of that, somewhat in favor,... somewhat opposed, or strongly opposed?

		FAVOR STR	FAVOR SOME	OPPOSE SOME	OPPOSE STR	DON'T KNOW
(A)	Increase federal income taxes to support health care	1	2	3	4	8
(B)	Increase state income taxes to support health care	1	2	3	4	8
(C)	Increase taxes on tobacco and alcohol to support health care	1	2	3	4	8
(D)	Increase state gambling taxes to support health care	1	2	3	4	8

E13. Now, suppose the State of Montana had a trust fund,... that would provide basic health care benefits for people who are either not insured or are underinsured -- we'd like your opinion of some funding options for this.

The (first / next) option is __(INSERT ITEM)__ -- would you be strongly in favor of that, somewhat in favor,... somewhat opposed, or strongly opposed?

		FAVOR STR	FAVOR SOME	OPPOSE SOME	OPPOSE STR	DON'T KNOW
(A)	To require contributions from employers who do not provide insurance now	1	2	3	4	8
(B)	To require employers to contribute for their seasonal and part-time employees	1	2	3	4	8
(C)	To require shared contributions from both the employer and the employees	1	2	3	4	8

E14. Again, assuming Montana had such a health care trust fund, we'd like to know your opinion of selected options for controlling health care costs for the fund.

The (first / next) option is __(INSERT ITEM)__ -- would you be strongly in favor of that, somewhat in favor,... somewhat opposed, or strongly opposed?

		FAVOR STR	FAVOR SOME	OPPOSE SOME	OPPOSE STR	DON'T KNOW
(A)	To put a cap on the deductibles	1	2	3	4	8
(B)	To set a limit on the malpractice insurance premiums that doctors and others pay	1	2	3	4	8
(C)	To put a limit on the malpractice damages that could be awarded	1	2	3	4	8
(D)	To put a limit on the percentage or the amount an attorney makes on the malpractice lawsuits	1	2	3	4	8

E15. Overall, how would you feel about the State of Montana setting up such a trust fund -- to provide health care coverage for people who are either not insured or are underinsured --

All things considered, would you say you would be strongly in favor, somewhat in favor,... somewhat opposed, or strongly opposed to setting up such a health care trust fund?

(1)....STRONGLY FAVOR
(2)....SOMEWHAT FAVOR
(3)....SOMEWHAT OPPOSE
(4)....STRONGLY OPPOSE
(X)....OTHER ***(SPECIFY):*** _____

F1. Now, a few questions about long-term health care or extended care. First, has any member of your household or immediate family received long-term health care in the past, or is anyone receiving such long-term care now?

1....YES

2....NO → ***GO TO F3, NEXT PAGE*** →

F2. As for where that long-term care has taken place, or is taking place -- has it been . . .

		YES	NO	DK
(A)	In a nursing home?	1	2	8
(B)	In a personal care home or group home?	1	2	8
(C)	In your home or in that family member's own home?	1	2	8
(D)	In some other place, or facility?	1	2	8

((X) What type of place is that?) _____

F3. Have you made any plans for <u>your</u> <u>own</u> possible long-term care needs?

1....YES

2....NO

GO TO F5, BELOW

F4. Have you done any of the following -- for example, have you . . .

		YES	NO	DK
(A)	Purchased insurance for long-term care?	1	2	8
(B)	Established a savings account for long-term care?	1	2	8
(C)	Discussed your family's role in your long-term care?	1	2	8
(D)	Checked out available <u>public</u> programs for long-term care? . .	1	2	8
(E)	Checked out available <u>private</u> services for long-term care? .	1	2	8
(F)	Done anything else to plan for possible long-term care? . . .	1	2	8

(SPECIFY): _____

F5. If you needed long-term health care yourself, how would you expect it to be paid for -- would it <u>most</u> <u>likely</u> be paid for through . . .

(1)....Your own personal savings, or

(2)....Insurance for long-term care, or

(3)....Public health care assistance or programs,

(X)....Or some other way? ***(SPECIFY):*** _____

_____

G1. The next questions are about your own health care experiences..... First, were you seen by, or did you receive medical advice or information from, any of the following types of health care professionals in 1990 or 1991.

The (first / next) one is __(INSERT ITEM)__ -- at any time in 1990 or 1991, were you seen by, or did you receive any medical advice or information from __(REPEAT ITEM)__ ?

		YES	NO	DK
(A)	A medical doctor or physician	1	2	8
(B)	A nurse or nurse practitioner	1	2	8
(C)	A physical therapist	1	2	8
(D)	A chiropractor	1	2	8
(E)	A psychologist or other type of counselor	1	2	8
(F)	Any other health care professional	1	2	8

(SPECIFY): _____

G2. And just during 1991 -- were you seen by, or did you receive medical advice or information from, any kind of health care professional at any time during 1991?

1....YES → G2a. About how many times, altogether, during 1991? _____ TIMES

2....NO

G3. Do you currently have a regular doctor -- a doctor you usually go to if you need a doctor?

1....YES

2....NO → *GO TO G6 NEXT PAGE* →

G4. Is that doctor located in your own community, in a different community, in another county, or what?

(1)....OWN COMMUNITY (2)....DIFFERENT (3)....OTHER COUNTY

G5. About how many miles is it from your residence to your doctor's location? → _____ MILES

IF R CANNOT GIVE MILES, ASK: (X) Well, would you say it's.....

(1)....Within 5 miles?
(2)....Within 10 miles?
(3)....Within 25 miles?
(4)....Or over 25 miles?

G6. And about how many miles is it from your residence to the closest hospital or medical-assistance facility? _____ MILES

IF R CANNOT GIVE MILES, ASK: (X) Well, would you say it's.....

(1)....Within 5 miles?
(2)....Within 10 miles?
(3)....Within 25 miles?
(4)....Or over 25 miles?

G7. Is that facility a hospital or a medical-assistance facility?

(1)....HOSPITAL
(2)....MEDICAL-ASSISTANCE FACILITY (MAF)
(X)....OTHER *(SPECIFY):* _____

_____

G8. Did you, or did anyone in your household, spend any time as a patient in a hospital or a medical-assistance facility during 1991?

(1)....YES
(2)....NO
(X)....OTHER *(SPECIFY):* _____

G9. Do you, or does any other member of your household, currently take any prescription medications?

1....YES → G9a. About how many separate medications do you, or does that person, currently take?

_____ MEDICATIONS

2....NO

G10. During 1991, about how much, altogether, did your household spend on prescription medications? I'll read you the categories, and you tell me which one applies to your household. In 1991, altogether, did your household spend . . .

(1)....Less than 50 dollars on prescription medications, or
(2)....Between 50 and 100 dollars,
(3)....Between 100 and 250 dollars,
(4)....More than 250 dollars,
(X)....Or nothing at all?

G11. Now, during the last two years -- during 1990 and 1991 -- approximately how much, altogether, would you say was spent on medical doctors' or physicians' services? I'll read you the categories, and you tell me which one applies to your household. In 1990 and 1991, altogether, did your household spend . . .

(1)....Less than 300 dollars on doctors' or physicians services, or

(2)....Between 300 and 750 dollars,

(3)....Between 750 and 1,500 dollars,

(4)....Between 1,500 and 2,500 dollars,

(5)....More than 2,500 dollars,

(X)....Or nothing at all?

G12. And, about how much, altogether, was spent on hospital services during 1990 and 1991? I'll read the categories, and just tell me which one applies to your household. In 1990 and 1991, altogether, did your household spend . . .

(1)....Less than 300 dollars on hospital services, or

(2)....Between 300 and 1,000 dollars,

(3)....Between 1,000 and 2,500 dollars,

(4)....Between 2,500 and 5,000 dollars,

(5)....More than 5,000 dollars,

(X)....Or nothing at all?

G13. When you think of the quality of all the health care services you may have received during 1990 and 1991 -- all things considered, would you say the quality of those services, overall, was... excellent, good,... only fair, or poor?

1....EXCELLENT

2....GOOD

GO TO G14, NEXT PAGE ——▸

OTHER: _____

GO TO G14, NEXT PAGE ——▸

3....ONLY FAIR

4....POOR

G13a. What makes you feel that the quality of those services was (only fair / poor)?

_____

_____

G14. Now, thinking about what you consider basic health care services -- is it your impression that most basic health care services are available there in your own community, or that most are not available in your community?

(1)....ARE AVAILABLE (2)....NOT AVAILABLE

OTHER *(SPECIFY)*: _____

_____

G15. Are there any particular health care services that you need, or that you feel should be available in your community, that are not available in your community now?

1....YES

2....NO

GO TO H1, BELOW

G15a. What are those health care services?

_____

_____

_____

H1. When it comes to health-related activities -- are there any kinds of exercise or physical activity that you do somewhat regularly -- for example, any walking, jogging, weight training, aerobics, swimming, or things like that?

1....YES

2....NO → *GO TO H3, NEXT PAGE* →

H1a. About how many times a week would you say you usually do some kind of regular physical activity or exercise?

(NUMBER): _____ TIMES PER WEEK

H2. What kinds of physical activity or exercise do you usually do? *(RECORD ALL RESPONSES.)*

(1)....AEROBICS (4)....WALKING

(2)....JOGGING (5)....WEIGHT TRAINING, WEIGHT LIFTING

(3)....SWIMMING

OTHER *(SPECIFY)*: _____

_____

H3. Have you ever smoked or used tobacco products?

1....YES → H3a. Do you smoke or use tobacco products at all <u>now</u>?

(1)....YES (2)....NO

2....NO

H4. Do you ever drink beer, wine, or other alcoholic beverages?

1....YES

2....NO

GO TO H5, BELOW

H4a. Would you say you drink alcoholic beverages... very often, somewhat often,... only occasionally, or hardly ever?

(1)....VERY OFTEN (3)....ONLY OCCASIONALLY

(2)....SOMEWHAT OFTEN (4)....HARDLY EVER

OTHER ***(SPECIFY):*** _____

H5. Do you ever wear your seat belt when you're in an automobile or other vehicle?

1....YES

2....NO → ***GO TO H6, NEXT PAGE*** →

H5a. Would you say you wear a seat belt... <u>very</u> often, <u>somewhat</u> often,... only occasionally, or hardly ever?

(1)....VERY OFTEN, (ALMOST) ALWAYS (3)....ONLY OCCASIONALLY

(2)....SOMEWHAT OFTEN (4)....HARDLY EVER

OTHER ***(SPECIFY):*** _____

H6. Have you made, or are you making, any changes in your eating patterns for health-related reasons?

1....YES	2....NO
	GO TO A8, BELOW

H7. What kinds of changes have you made, or are you making? ***(RECORD ALL RESPONSES.)***

(1)....LESS CHOLESTEROL; REDUCING CHOLESTEROL

(2)....LESS FAT/SATURATED FAT; REDUCING FAT

(3)....LESS SALT; REDUCING SALT

(4)....MORE FIBER; INCREASING FIBER

(5)....LESS SUGAR; REDUCING SUGAR

OTHER ***(SPECIFY):*** _____

_____

To finish up, just a couple of questions for classification purposes . . .

A8. What is the highest grade of school, or year of college, you completed?

GRADES OF SCHOOL													YEARS OF COLLEGE	
00	01	02	03	04	05	06	07	08	09	10	11	12	1 2 3	4 5+
													GO TO A9 NEXT PAGE	

A8a. Did you get a high school diploma or pass a high school equivalency test?

5....YES 4....NO

A8b. Do you have a bachelor's degree?

7....YES 6....NO

FINISH ON NEXT PAGE ——————→

A9. Last of all, we need to be able to classify all the households we interview by broad income categories -- that would be all the income you (and the others in your household) received for 1991, ...from all sources, not just from wages, ...and before taxes and other deductions.

We don't need the exact figure -- I'll read the categories and you tell me which one it falls into. Was your total household income for 1991 . . . .

(1)....less than 10 thousand dollars,

(2)....between 10 thousand and 15 thousand,

(3)....between 15 and 20 thousand,

(4)....between 20 and 35 thousand,

(5)....between 35 and 50 thousand, or

(6)....50 thousand dollars or more?

8....DON'T KNOW; CAN'T RECALL

9....REFUSED; NO RESPONSE

X4. END: Those are all the questions I have. Thank you for taking the time to participate in this survey -- we appreciate your willingness to help.

X5. EXACT TIME NOW: _____

DO NOT ASK (COMPLETE DURING EDITING): _____

A10. SEX OF RESPONDENT: (1)....MALE (2)....FEMALE

A11. SEX OF HOUSEHOLD HEAD: (1)....MALE (2)....FEMALE

(IF MALE-FEMALE "SHARE" HOH -- RECORD MALE)