THE IMPACT OF MEDICARE ON THE DISTRIBUTION OF

PUBLIC HEALTH CARE EXPENDITURES

IN OKLAHOMA

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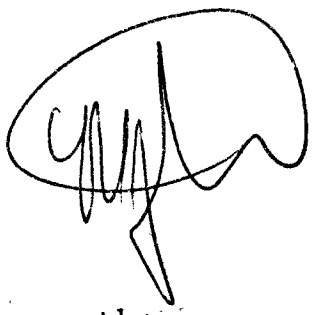

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The purpose of the study is to determine what effect medicare has had on the distribution of public health care expenditures in the state of Oklahoma. The study tests two hypotheses: (1) that there is a significant correlation between medical vendor payments and indigency in Oklahoma or in other words that pre-medicare public health care dollars in Oklahoma were distributed to indigents, and (2) that there is also a significant correlation between medicare expenditures and indigency, but with significant differences in the relative strengths of the correlation coefficients of the variables indicating indigency.

Non-parametric statistical techniques are employed in testing these hypotheses. Specifically, using county data on the number of recipients and the per capita expenditures under medical vendor payments and medicare, rank order correlations were run with selected social and economic characteristics indicative of indigency.

The results of the rank order correlations indicate that indigency is still a factor determining the

distribution of public health care expenditures after medicare was introduced. However, the results also indicate a significant decline in the amount of observed variation in expenditures and recipients, which can be explained by all of the selected social and economic characteristics with the exception of the characteristic age 65 and above.

The sources of indigency data were the 1960 and 1970 Census. The MVP data was obtained from the Oklahoma Department of Public Welfare and the medicare data was obtained from a Department of Health, Education and Welfare publication entitled Medicare: Health Insurance for the Aged; Amounts Reimbursed by State and County, 1969.

The first chapter introduces the problem, purposes and method of procedure of the study. Chapter two presents a detailed history of public health care legislation up to the enactment of medicare. The third chapter gives a view of the ideological and rhetorical problems involved in the passage of health care legislation. Chapter four describes the statistical methods involved and chapter five the results of the statistical tests. An appendix is included which presents suggestions for further research.

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THESIS

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By

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CHAPTER I

INTRODUCTION

Before the enactment of the Social Security Amendments of 1965, public provision for medical care had been provided on the basis of indigency. However, in the years just prior to this legislation (commonly called "Medicare"), there evolved strong support to provide medical care to anyone over the age of sixty-five who desired it, regardless of need. This support was based primarily on the premise that as a group, the aged had high expenditures for medical care and that the majority of the aged had low incomes. The initial Social Security Act of 1935 provided substantial protection against loss of earnings resulting from the labor market. However, many people argued that the monthly social security benefits were not sufficient to cover heavy medical costs, which in 1961 the Secretary of Health, Education and Welfare considered, "the most serious impediment to security in old age."[1]

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[1] Health Insurance for Aged Persons, report submitted to the Committee on Ways and Means, House of Representatives, by the Secretary of Health, Education and Welfare (Washington, July 24, 1961), p. 3.

As early as 1912, programs had been suggested for comprehensive federal health insurance not tied to indigency.[2] However, not until 1965, after years of bitter struggle and rhetorical debate, did such a program become a reality, and even then, it was confined to a relatively small group of the population--the elderly. Medicare established a national health insurance program to provide extensive coverage against the costs of medical care, for all persons aged sixty-five and over.

Purpose

Vigorous opposition to medicare was put forth by organizations such as the American Medical Association (AMA) and various insurance groups who saw the program as an infringement on their freedom. There was also fear that medicare would ultimately lead to "socialized medicine." Some of the strongest arguments, however, indicated the concern that Federal funds would be used to pay the medical expenses of persons who could actually afford to pay for it. There was considerable literature expounding this view. For example, the September 14, 1964, issue of Barron's made the following statement:

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[2]Robert J. Meyers, Medicare (Homewood, Illinois, 1970), p. 42.

> Medicare would thrust bureaucracy into an area already well served by both private enterprise and public charity. At the end of 1962, no fewer than 3 out of 4 Americans 65 or older had some means of meeting their health care costs. For those in want, the resources now available range from general welfare assistance to special aid under the Kerr Mills Act.[3]

The National Underwriter expressed the insurance industry's view in an article on March 16, 1963. In the article, E. J. Faulkner, president of Woodmen Accident & Life, made the following prediction:

> Health insurance is a common ground for all who believe in the superiority of private enterprise. But if the medicare proposal is enacted into law, establishing the principle of federal responsibility for health care irrespective of need, an entering wedge will have been driven that will surely and inexorably lead to a universal compulsory health plan with its inevitable concomitant of socialized medicine.[4]

Thus, the belief was widely held that medicare would change public policy governing the distribution of public health care dollars away from a policy restricting the flow of such funds solely to those persons who were indigent to a policy which would, in effect, provide health care dollars to a substantial number of persons who were financially

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[3]"Dangerous Prescription--Medicare Will Imperil, Not Advance, the Nation's Welfare," Barron's, XLIV (September 14, 1964), p. 1.

[4]"Faulkner Urges Stronger Fight Against Medicare," The National Underwriter (Life Edition), LXVII (March 16, 1963), p. 4.

capable of providing for their own health care needs. The present study attempts to answer the question of whether or not a substantial alteration in the basis on which public health care dollars are distributed did in fact result from the enactment of medicare.

As to why there existed such a plethora of writers prior to the 1965 amendment who felt that medicare would alter the distribution of public health care expenditures, it should be noted that their opinion was consistent both with the legal basis upon which pre-medicare dollars were being distributed and with the wording of the proposed medicare amendment. The principal public provision for health care prior to medicare was in the form of the medical vendor payments programs administered by the various state welfare departments. These programs were established as the result of a 1956 amendment to the social security law which provided health care assistance to "persons eligible for public assistance."[5] Thus, health expenditures, in the form of medical vendor payments (MVP), made need or indigency the sole criterion for eligibility. Given the limitations of the pre-medicare law and the basis upon which the state welfare departments actually operate,

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[5] Complete Social Security Law 1960 (New York, 1960), p. 4039.

it does seem evident that medical vendor payments were being distributed solely on the basis of indigency. That medicare payments were never intended to be restricted solely to indigents may be established by considering the eligibility requirements stated in the proposed law. House Report 6675, Section 1836 makes the health benefits, provided by the law, available to:

> Every individual who--(1) has attained the age of 65, and (2) is a resident of the United States, and is either a citizen or an alien lawfully admitted for permanent residence. . . .[6]

The purpose of this study is to determine what impact, if any, the medicare legislation has had on the distribution of public health care expenditures in the state of Oklahoma. The question of whether or not the enactment of medicare has caused the distribution of public health care dollars to be altered is no longer one that is debatable, but rather, has now become a question for which an empirical answer exists.

Method and Scope

Chapter II contains an historical description of the significant federal health care legislation which led to the enactment of the 1965 amendments establishing medicare.

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[6]U. S. Congress, House Report 6675, 89th Congress, 1st Session (Washington, 1965), p. 14.

Part one of this chapter deals with the legislation prior to the Kerr-Mills program enacted in 1960, which provided a program of medical assistance for older persons who did not receive old-age assistance payments, but who could afford necessary medical care. Part two concerns the legislative action which took place between 1961 and 1965 medicare amendments.

Chapter III deals with the political rhetoric which accompanied the legislative action discussed in the previous chapter. The role of American ideology as it relates to federal involvement in the area of public health care is a major point of discussion. Considerable attention is given to the debates in Congress as well as to the organized external attempts to influence Congress.

Chapter IV concerns the development of the statistical model. To determine how medicare has affected health care expenditures, the study tests two hypotheses: (1) that there is a significant correlation between MVP and indigency in Oklahoma or in other words that pre-medicare public health care dollars in Oklahoma were distributed to indigents, and (2) that there is also a significant correlation between medicare expenditures and indigency, but with significant differences in the relative strengths of the correlation coefficients of the variables indicating indigency.

The variables involved include five characteristics chosen as indicative of indigency: poverty, old age, lack of education, rural residency, and non-white. Using census data for counties in Oklahoma, calculations were made as to what percentage of the population in each county possessed the selected characteristic. These computations were made using 1960 census data for purposes of testing hypothesis I and using 1970 census data for purposes of testing hypothesis II.

The health care data used in testing hypothesis I were computed from data collected from the records of the Oklahoma Department of Public Welfare. Two variables are derived from these MVP data; they are the per capita payments by counties and the percentage of the county population receiving benefits under the medical vendor payments program.

For purposes of testing hypothesis II, the medicare data are taken from Social Security Publication 69-28, entitled Medicare 1969, Reimbursement by State and County.[7] Once again, these data are converted, by county, into per capita payments and per cent of the population receiving benefits. By putting the variables in rank order and employing the

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[7]U.S. Department of Health, Education and Welfare, Medicare: Health Insurance for the Aged; Amounts Reimbursed by State and County, 1969 (Washington, 1971), p. 50.

statistical method known as Spearman's rank order correlation, hypothesis I is tested by determining whether the rank orders of expenditures and the characteristics indicative of indigency are significantly correlated. Hypothesis II is tested in a similar manner using the medicare data and the 1970 census data on the selected variables indicative of indigency. Also presented in this chapter are the statistical data obtained from the various tests and their explanation.

Chapter V presents the resultant conclusions derived from the study, and an appendix contains suggestions for further research.

CHAPTER II

LEGISLATIVE HISTORY

The Early Stages of Public Health Care

Traditionally, health care and protection have been a personal or private matter. Society has intervened, however, in case of destitution and provided such care for the sick as the knowledge and standards of the time permitted.[1] A colonial law which provided that the towns should be responsible for the support of all persons who had resided therein for three months and who were in need because of "sickness, lameness, or the like," was in effect in Connecticut as early as 1673.[2] Similar provisions were made in Massachusetts, New York, and other colonies. In the Midwest, early territorial and state laws imposed the care of the sick poor upon the local government.[3]

George W. Bachman and Lewis Meriam, in a discussion of early health care in their book, The Issue of Compulsory Health Insurance, stated the following:

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[1]Earl E. Muntz, Growth and Trends in Social Security (New York, 1949), p. 65.

[2]Ibid., p. 66.

[3]Ibid.

> The traditional position of the United States in regard to medical care has been that it should not be withheld from an individual requiring it on the ground that he lacked the resources to pay the costs. The existing arrangements for providing free service or services at less than cost are an evolutionary composite of devices not sufficiently planned or properly integrated to be called a system. Going far back in American history one finds such devices as:
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> The physician who attended the poor without compensation.
>
> The local poor authorities who hired a physician to attend the poor or who paid the doctors in the locality fees for attending them.
>
> Voluntary hospitals established and at least partially maintained by private philanthropy that made provision for the care of the poor without charge or at far less than cost.
>
> Public poor authorities or private philanthropic agencies that supplied the funds to permit needy persons to be hospitalized and to receive service in institutions that required payment.
>
> Public hospitals, supported in whole or in part by local taxation, giving services free or at much less than cost.
>
> Free clinics publicly or privately supported.
>
> Publicly supported institutions for the care of special classes of sick people, notably the mentally ill and tubercular.[4]

In the early 1900's programs were implemented to provide aid to the needy aged, the blind, and orphaned children, primarily for living expenses, but they also served medical needs. These programs were generally inadequate and spotty. Medical services were also provided to the needy aged in so-called "almshouses" or "poor farms" that provided

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[4]George W. Bachman and Lewis Meriam, The Issue of Compulsory Health Insurance (Washington, 1948), p. 3.

domiciliary care in most states. In addition to needy aged persons, these facilities also provided a modicum of medical services to the mentally defective and chronically ill who could not otherwise have been taken care of.[5]

Robert J. Meyers considered Germany to have been important in activating interest in public health care for the United States. In the 1880's, Bismarck developed a government health insurance program for the working classes in Germany in an effort to divert them from the potential attractions of Socialism and Marxism. Of this program Meyers says that "there were those in this country who studied the general movement with great interest."[6]

Meyers also credits the Socialist Party in America as the first to nationally advocate government health insurance as early as 1900.[7] However, many feel that Theodore Roosevelt gave American public health care its first serious consideration during the 1912 presidential campaign when he made national health insurance a major element in the Progressive Party platform. Although Roosevelt lost, the idea of government health insurance gained considerable momentum.[8]

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[5]Meyers, p. 3.

[6]Ibid.

[7]Ibid.

[8]Social Security and Medicare Simplified: What You Get For Your Money (New York, 1970), p. 201.

Shortly before World War I, the first agitation for and against the adoption of a compulsory system of medical care insurance developed in the United States. Odin W. Anderson, in an article entitled "Compulsory Medical Care Insurance, 1910 to 1950," observed three distinct periods within this time span. During the first period, 1910-1920, the legislative stage was reached in some states, but no bills were passed. Bills proposing compulsory medical care were poorly prepared and hastily introduced. It ended abruptly as unexpected opposition was effectively introduced.

The second period, 1921-1933, was relatively quiet and devoted to study of basic facts and problems. Anderson states that "The third period, beginning in 1933, has been characterized by action similar to that of the first period, but on a much broader base of support and opposition, and in a profoundly different social, political, and economic context."[9]

1910-1920: Aborted State Legislation

The chief group calling attention to the medical care insurance problem during the first period was the American Association of Labor Legislation (AALL). A private

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[9]Odin W. Anderson, "Compulsory Medical Care Insurance, 1910-1950," cited in Eugene Feingold, Medicare: Policy and Politics (San Francisco, 1966), p. 86.

organization whose members included actuaries, lawyers, economists, sociologists, and political scientists, it was primarily interested in the promotion of state workmen's compensation laws. It was extremely successful in this respect and began studying the National Health Insurance legislation that had been adopted in the United Kingdom in 1911. They believed a similar program to be necessary for the United States and considered it in terms of the total population which, according to Meyers, "must have seemed a much more pressing problem to the economic and social planners of the day than the personal needs of the relatively small aged population."[10]

For the next few years the main burden of medical care insurance study and activity was carried on by a Committee on Social Insurance established by the AALL in 1912.[11] This committee drafted two health insurance bills, one in 1912 and another in 1915, which became the model for bills introduced into several state legislatures. State legislatures generally referred these bills to investigating committees for study instead of taking action on them.[12]

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[10]Meyers, p. 4.

[11]Anderson, p. 87.

[12]Meyers, pp. 4-5.

At this point it is interesting to note, particularly in view of later developments in this field, that a committee of the American Medical Association (AMA) worked actively, and even "enthusiastically," with the AALL in offering medical information and advice during the drafting of the bills.[13]

The following statement was made by the AMA's Committee on Social Insurance in regard to the medical profession's proper attitude toward health insurance:

> To work out these problems is a most difficult task. The time to work them out, however, is when the laws are molding, as now, and the time is present when the profession should study earnestly to solve the questions of medical care that will arise under various forms of social insurance. Blind opposition, indignant repudiation, bitter denunciation of these laws is worse than useless; it leads nowhere and it leaves the profession in a position of helplessness as the rising tide of social development sweeps over it.[14]

This attitude by the AMA did not last long and during the medicare debate of the late 1950's and the first half of the 1960's, "the recommended advice in the last sentence was by no means followed."[15]

The AALL bills were introduced in sixteen state legislatures and studied by their investigating committees, but

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[13] Ibid.

[14] Journal of the American Medical Association, LXVIII (June 9, 1917), 1755.

[15] Meyers, p. 5.

the merits of the bills were quickly clouded by tremendous opposition from a wide variety of sources. The AMA completely reversed its position and fought the proposal vigorously. The proponents found the simultaneous opposition of pharmaceutical companies, accident and health insurance companies, most employers and their organizations, as well as the Christian Science religious denomination, to be too much for them. But the crowning blow and a most dismaying discovery for the AALL was the outspoken denunciation by Samuel Gompers, president of the American Federation of Labor.[17] As a result of this overwhelming opposition, New York was the only state to bring the bill to a vote, where it passed the Senate in 1919, but was defeated in the House.

Meyers noted an inverse parallelism in the positions of the AMA and the labor unions on health insurance. In the AMA the upper echelon favored the proposals, while the state medical societies and membership were opposed. On the other hand, the American Federation of Labor's leadership was opposed while most state federations were in favor.[18] In 1920, the vehement officials of state medical societies were instrumental in establishing the AMA's basic policy, which has not been revised and is, expressed in the following resolution:

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[17]Anderson, p. 88.

[18]Meyers, p. 8.

> The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for medical service to be rendered to contributors or their dependents, [which may be] provided, controlled, or regulated by any state or Federal government.[19]

The medicare concept was thereby paralyzed for more than a decade.

1921-1933: A Period of Reflection

During this period a number of conferences took place attended by physicians, members of the public health professions, and economists. In 1927, a private organization called the Committee on the Costs of Medical Care was formed to conduct extensive research in the public health care area and then to make recommendations. Because of the diverse membership there were divisions of opinion as to the role of government. The recommendations of the majority faction of the committee, which were opposed by the AMA, proposed that medical services be furnished largely by organized groups of physicians, pharmacists and associated personnel with the costs placed on a group payment basis through insurance, taxation, or both. Odin Anderson observed that, "The minority group, while agreeing with the majority report

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[19]Anderson, p. 89, stated by the House of Delegates at the annual session of the AMA, New Orleans, 1920.

in many matters, objected to the proposal for group practice and the adoption of insurance plans unless sponsored and controlled by organized medicine."[20]

The AMA's classic editorial response to the majority report reflected its opposition to organized group practice and government involvement:

> The alinement is clear--on the one side the forces representing the great foundations, public health officialdom, social theory--even socialism and communism--inciting to revolution; on the other side, the organized medical profession of this country urging an orderly evolution guided by controlled experimentation which will observe the principles that have been found through the centuries to be necessary to the sound practice of medicine.[21]

The only tangible result of this period was the creation, in 1929, of a voluntary hospital insurance program in Texas. This program later became known as Blue Cross and had the support of both the American Hospital Association and the American College of Surgeons.[22] Blue Cross marked the beginning of private, group hospital insurance in the United States.[23]

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[20] Ibid., p. 90.

[21] Journal of the American Medical Association, XCIX (December 3, 1932), 1952, cited in Feingold, p. 90.

[22] Social Security and Medicare Simplified, p. 203.

[23] Oliver D. Dickerson, Health Insurance (Homewood, Illinois, 1963), p. 152.

1933-1935: The Beginning of Federal Legislation

In the period beginning in 1933, the Federal Government, through committees and legislative activity, reopened the issue of government-sponsored medical care insurance. In 1934, as part of his New Deal, President Franklin D. Roosevelt appointed a top group of government officials to make up the Committee on Economic Security (COEC). As part of Roosevelt's attempt to fight the Great Depression of the 1930's, the organization's purpose was to study and develop an extensive system of social insurance and public assistance and develop draft legislation.[24] Medical care insurance was one of the problem areas considered, but was given short shrift. Edwin E. Witte, executive director of the COEC reported that medical care insurance could not even reach the research stage. He wrote:

> When in 1934 the Committee on Economic Security announced that it was studying health insurance, it was at once subjected to misrepresentation and vilification. In the original social security bill there was one line to the effect that the Social Security Board should study the problem and make a report thereon to Congress. That little line was responsible for so many telegrams to the members of Congress that the entire social security program seem endangered until the Ways and Means Committee, unanimously struck it out of the bill.[25]

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[24]Meyers, p. 10.

[25]Anderson, p. 92.

The Social Security Act of 1935 was the resultant legislation after the health care proposals were omitted. The act established three main assistance programs--for the aged, for the blind, and for dependent children. In 1950, assistance for the totally and permanently disabled was implemented.[26]

Paul H. Douglas in his work, Social Security in the United States, considered the omission of health insurance in the Social Security Act as resulting from four sets of factors. In the first place it was feared that the health care proposals would overload the overall program. In the second place, full details of a proper plan had not been completely worked out. Thirdly, public sentiment had not been sufficiently aroused in favor of it. Finally, there was the "intense, bitter and persistent" opposition of the AMA and most state medical associations.[27]

Legislative Proposals Between 1935 and 1952

The public policy issue regarding personal health services made a distinctive shift during the period between enactment of the Social Security Act in 1936, and the end

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[26]Meyers, p. 13.

[27]Paul H. Douglas, Social Security in the United States (New York, 1939), p. 68.

of the Truman administration in 1952. The issue of government-sponsored health insurance as against no health insurance at all gave way to the issue of a government-sponsored health insurance program versus voluntary health insurance. Voluntary health insurance gained momentum in the 1940's and became regarded as the chief method for paying for family health services.[28] However, Roosevelt had appointed an Inderdepartmental Committee to Coordinate Health and Welfare Activities and its report urged more public health activities and a national health insurance program. Despite the objections of the AMA, a National Health Conference endorsed the report.

In 1939, Senator Robert F. Wagner of New York introduced a national health insurance bill into Congress calling for federal grants to states that would match federal health contributions. The bill died in committee.[29] Meyers considered the Wagner bill to have had two-fold importance: ". . . it revived national interest in health insurance, which had been laid aside during the legislative progress of the Social Security Act; and it demonstrated that the

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[28]Odin W. Anderson, "The Medicare Act: The Public Policy Breakthrough (or Wheeling, Dealing and Healing)," in University of Florida Institute of Gerontology, Medical Care Under Social Security: Potentials and Problems (Gainesville, Florida, 1966), p. 9.

[29]Social Security and Medicare Simplified, p. 9.

compromise of a federal-state grant-in-aid pattern did not [necessarily] result in acceptance."[30]

The next major legislative proposal was the Wagner-Murray-Dingell Bills of 1943, and again in 1949. The bills received public endorsement from President Truman and proposed a national prepaid medical insurance program through the social security system. It proposed broad benefits applying to almost all employees and self-employed persons and provided coverage for social security beneficiaries and their dependents. Hearings were held in several years, but the bills never reached the voting stage in either the House or the Senate.

During the years 1942-1945, the Green-Eliot Bill received consideration. It applied to active workers (not retired workers) who were covered by the Old-Age and Survivors Insurance system and would have been financed by a .5 per cent increase of employer's and employee's social security contribution. The proposal also received no congressional action.[31]

A special program for medical vendor payments with respect to public assistance recipients was proposed by the 1947-48 Advisory Council on Social Security. Reimbursement would

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[30]Meyers, p. 21.

[31]Ibid., pp. 22-24.

be made directly to the providers of medical care and it was recommended by the council that, "medical vendor care payments should be included in the regular assistance programs insofar as they would fall within the maximum individual matchable amounts," and payments could be "averaged out over the entire assistance roll, even though relatively high amounts were paid for a few individuals.[32]

By the late 1940's, the general consensus emerging from opposing factions was that all should have access to medical care irrespective of income and that insurance should be the means. The disagreement centered around the sponsorship and control of the insurance. For example Anderson stated that the ability of private and union health care plans to adapt to the needs of the public would largely determine whether or not a comprehensive national medical care program would be enacted.[33]

Legislative Proposals Between 1952 and 1965

By 1950, great progress had been made in conquering disease and illness. The first result was that people began to live longer. "Second, the tendency toward

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[32] Ibid., p. 26.

[33] Anderson, "Compulsory Medical Care Insurance, 1910-1950," p. 95.

specialized and intensive care made medical costs higher, especially for older persons, who were less able to pay for medical treatment."[34] Despite earlier predictions to the contrary, proponents of national health insurance saw the rapid growth of various forms of private health insurance. They also had seen virtually all of their proposed legislation fail in Congress. Hence efforts became directed away from government health insurance for the entire population and toward the category with the least protection--namely, all of the beneficiaries of the Old-Age, Survivors, and Disability Insurance system (OASDI), with particular consideration given to those over 65.[35] It was argued that those over 65 had the greatest health costs and at the same time the lowest proportion protected by private insurance, however, justification for governmental health care for this segment alone was questioned on the basis of selectively higher costs and the ability of some of the elderly to pay for their own medical care.[36] In the report of the Fifteenth

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[34] Social Security and Medicare Simplified, p. 205.

[35] The technical name for those commonly referred to as "receiving social security."

[36] Meyers, pp. 27-28.

Annual Southern Conference on Gerontology, Odin W. Anderson made the following statement:

> It has been heavily documented that as a group the aged have more illnesses, use health services more, have lower incomes, and so on, than younger elements of the population, and have less health insurance; but the aged are not all below the poverty line, they are not all ill, and they do not all seriously suffer from special disease, and their health insurance coverage [is] increasing.[37]

The 1951 Annual Report of the Social Security Board made the first health-benefits proposals related to OASDI beneficiaries. These proposals were supported by both President Truman and Oscar Ewing, Federal Security Administrator.[38] Senator Murray and Representatives Celler and Dingell introduced the bills which provided for sixty days of hospital care per year to all eligibles (regardless of age). Administration of the initial bill was to have been through state agencies, with reimbursement to hospitals on a reasonable-cost basis. Congress took no action on the Ewing proposal.[39]

The 1956 Amendments to the Social Security Act adopted the remainder of the medical care recommendations of the

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[37]Anderson, "The Medicare Act," p. 10.

[38]The position, Federal Security Administrator, later became entitled Secretary of Health, Education, and Welfare.

[39]Meyers, p. 28.

1947-1948 Advisory Council. "The special separate program for federal participation was established to the extent of 50 per cent of medical vendor payments in excess of the maximum on the average medical vendor payment described previously."[40] These medical vendor payments, administered by the various state welfare departments became the principal public provision for health care prior to Medicare. The declared purpose of the 1956 amendment is contained in section 300, paragraph 4806 of the Complete Social Security Law 1960. The law states, "It is the purpose of this title to promote the health of the Nation by assisting states to extend and broaden their provisions for meeting the costs of medical care for persons eligible for public assistance . . ."[41] Other sections of the law contain the intended requirements for eligibility to receive public assistance. For example, Title I, Section 1A, paragraph 4401 states that grants to states for Old Age Assistance (OAA) would be "for the purpose of enabling each state as far as practicable under the conditions in such state, to furnish financial assistance to aged needy individuals . . ."[42]

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[40] Ibid., p. 39.

[41] Complete Social Security Law 1960, p. 4039.

[42] Ibid., p. 3821.

Other titles included "Aid to the Blind,"[43] "Aid to Families with Dependent Children,"[44] and "Aid to the Disabled."[45] These titles also imposed the requirement of need. The basis upon which need was to be established was stated by the law in that, "the state agency shall in determining need take into consideration any . . . income and resources of the individual."[46] This requirement applied to all four categories of public assistance.

The administration of the separate federal medical vendor payments turned out to be complex and difficult. In 1958, amendments were made to the Social Security Law which removed the provision for the maximum matchable limit for individual payments. Instead, a matchable limit was placed on the average statewide total payment. Specifically, a state plan would be able to have federal matching funds to cover all medical vendor payments, regardless of the size of the individual MVP cases, so long as the average of all the cash payments plus medical vendor payments did not exceed the new prescribed average matchable maximum.[47]

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[43] Ibid., p. 3986.

[44] Ibid., p. 3957.

[45] Ibid., p. 3999.

[46] Ibid., pp. 3987, 3958, 4000, 3823.

[47] Meyers, p. 39.

Pressure increased for a health insurance program for aged persons particularly in the area of hospital costs.[48] Public hearings were held in 1959 and 1960 by the Committee on Ways and Means to hear several proposals to amend the Social Security Act. Representative Aime J. Forand (D., R. I.) introduced a bill (H. R. 4700) to provide "insurance against the costs of hospital, nursing-home, and surgical services for persons eligible for old-age and survivors insurance benefits."[49] The bill was favored by representatives of organized labor, social workers, the American Nurses Association and a few physician's groups. Opposition came from the AMA, business groups, and the insurance industry.[50]

The AMA and the American Hospital Association (AHA) saw inherent dangers in the possible implementation of a medical program for such a large segment of the population as was proposed by the Forand bill. A joint resolution by the AMA and AHA stated that they would mobilize their "full resources" to accelerate the implementation of adequate health care programs for needy persons--particulary the

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[48] Ibid.

[49] Wilber J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," Social Security Bulletin, XXVIII (Washington, September, 1965), p. 4.

[50] Eugene Feingold, Medicare: Policy and Politics (San Francisco, 1966), pp. 102-103.

aged needy. Their joint opposition to the Forand bill was based on the fact that its provisions were "not designed especially to assist the needy, since they apply to all Social Security beneficiaries and exlude the majority of the needy persons who are not eligible for Social Security benefits."[51]

The Committee on Ways and Means concluded that Federal action was necessary on the problem of meeting health costs in old age, but did not recommend adoption of the proposal for hospital insurance under the social security system. Instead, liberalizations in the existing Federal-State public assistance programs were recommended. This proposal was modified by the Senate Finance Committee and resulted in a new program called Medical Assistance for the Aged (MAA). Before this legislation was passed an additional program was proposed by Senator Clinton P. Anderson (D., N. Mex.), Senator John F. Kennedy (D., Mass.), and eight other senators. This program, which would provide hospital insurance for persons aged sixty-eight and over who were eligible for OASDI benefits, was defeated by a vote of fifty-one to forty-four.

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[51] Hospitals, XXXIV (January 1, 1960), p. 58.

The medical assistance legislation, however, received bipartisan support and was enacted on September 13, 1960, as part of H. R. 12580.[52] Often referred to as the "Kerr-Mills" program, after the two congressional sponsors of the bill, the medical assistance legislation made matching grants available to the states which were intended "for the purpose of enabling each state to furnish medical assistance on behalf of aged individuals who are not recipients of old age assistance but whose income and resources are insufficient to meet the costs of necessary medical services."[53]

The new medical care legislation reverted back to the 1947-48 Advisory Council proposal to have special additional federal matching for medical vendor payments, which was adopted in 1956 and eliminated in 1958 due to its complex nature. The MAA legislation was more liberal than other public assistance programs in not permitting a "length of residence" requirement. It was reasonably liberal in establishing limits to income and states were not permitted to require premiums or enrollment fees. The MAA program also differed from the other public assistance programs in that there was no maximum on the matchable amounts, either

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[52]Cohen and Ball, p. 4.

[53]Complete Social Security Law 1960, p. 3821.

individually or for the aggregate. Medical services included:

> . . . the services of hospitals, skilled nursing homes, physician, dentists, private duty nurses, physical therapists, and other categories such as osteopaths, chiropractors, and optometrists, and any other services authorized under state law. The only requirement as to services provided . . . was that some type of both institutional and non-institutional services should be provided. The only exclusion of medical services was with respect to services furnished in nonmedical public institutions and in mental and tuberculosis hospitals . . .[54]

It is obvious that the intent of the law, with regard to medical vendor payments, was to make need or indigency the sole criterion for eligibility. That the state welfare officials administering the program carried out the intent of the law was indicated by the procedures which an applicant was required to go through in order to be placed on the welfare roles and thereby become eligible for MVP. Specifically, the applicant had to fill out a detailed questionnaire which was witnessed and notarized. The welfare agency then conducted a thorough investigation of each applicant so as to verify the validity of the statements made in the application. Only then was the applicant permitted to receive benefits.

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[54]Meyers, p. 41.

Medicare Legislation

In 1961, despite Kennedy's very narrow victory and a divided Congress, there was increasing expectation of some successful federal action on health care for the aged. On February 9, President Kennedy proposed to Congress a broad program of federal insurance to provide health care services to the aged. The proposal was contained in bills introduced by Representative King (D., Calif.), Senator Anderson (D., N. Mex.), and Senator Javits (R., N. Y.).

These bills had been preceded a month earlier by the largest national conference ever assembled on the problems of the aged. More than 2,500 delegates from more than 300 national voluntary organizations attended the meeting which was called the "White House Conference on Aging."[55] The recommendations emanating from this conference in regard to health care for the aged covered a broad spectrum including voluntary health insurance, extended public assistance and many others. However, a majority of the delegates voted that the Social Security mechanism should be the basic means of financing health care for the aged.[56]

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[55]Anderson, "The Medicare Act," pp. 18-19.

[56]"John F. Kennedy: State of the Union Message," New York Times, CXI (January 12, 1962), p. 12c, cited in Medical Care Under Social Security: Potentials and Problems, p. 19.

The 1961 legislative proposal was studied in executive sessions of both the House Ways and Means Committee and the Senate Finance Committee, but no action was taken on it. It should be noted that this proposal and subsequent ones between 1961 and 1964, were often referred to as "Medicare." However, this was a misnomer since these proposals only provided for hospitalization and related benefits rather than medical care.[57]

In 1962, despite the House decision to table the King-Anderson hospital insurance proposal, Senator Anderson and other Senate Democratic leaders decided to force a vote on a House-passed public welfare reform bill by attaching an amendment which contained the essence of a health service program for the aged. Some Senate Democrats did not like the unusual procedure, but Anderson was confident of Senate victory and hoped the tally would demonstrate Congressional support for the program. The Senate voted fifty-two to forty-eight against the measure. The Wall Street Journal stated that "The defeat was all the more humiliating for Mr. Kennedy because it was by no means necessary even to have a Senate vote on the issue this year. Even if the Senate's vote July 17 had gone the other way, there would

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[57]Meyers, pp. 43-44.

have been no final Congressional approval this year of the President's proposal. . ."[58]

Although the Senate vote did not kill the King-Anderson bill, it cast serious doubts on the Kennedy Administration's ability to pass this type of legislation. No further action was taken on the proposal by the Eighty-seventh Congress.[59]

The Eighty-eighth Congress

President Kennedy continued to urge Congress to enact a program of health insurance for the aged under the Social Security Act. In his State of the Union Message of January 14, 1963, he stated his wishes for a new health program and elaborated on this theme in his special message on a Health Program, submitted to Congress on February 7. In his special Message on Elderly Citizens of Our Nation on February 21, Kennedy recommended not only the enactment of a program of hospital insurance for the elderly but also numerous improvements in the OASDI program, such as increases in benefit amounts and in the contribution and benefit base.[60]

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[58]"President's Plan for Medical Care Killed by Senate," Wall Street Journal, XLII (July 18, 1962), 2.

[59]Anderson, "The Medicare Act," p. 21.

[60]Cohen and Ball, p. 4.

The King-Anderson bill was again introduced on February 21, 1963. It differed from the previous bill in that the new bill did not include the option for private insurance. Anderson explained that the option had raised administrative difficulties and at the same time had not placated the opposition to the social-security approach.[61] However, the health care programs were not the top priority of Congress. Kennedy's tax proposals kept the Ways and Means Committee occupied until mid-summer, when civil-rights legislation displaced everything else following the outburst of civil rights demonstrations. Although the House Ways and Means Committee began holding public hearings on the subject by the end of the year, no legislative action was taken in 1963.[62]

The Congressional stalemate still existed when President Johnson stated his support of health services for the aged through OASDI (social security) in his annual message to Congress in January, 1964).[63] Interested organizations continued to air their views. A subcommittee of the Special Senate Committee on Aging issued a report which was highly critical of the Kerr-Mills program.

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[61]Feingold, p. 125. [62]Meyers, p. 45.

[63]Anderson, "The Medicare Act," p. 22.

The twelve-man private organization, National Committee on Health Care, proposed to the Ways and Means Committee a compromise employing both government and private hospital insurance, with the government insurance to be financed by a specifically designated social-secrity tax. The AMA denounced the report as providing nothing new "except for a few gimmicks."[64]

Johnson predicted enactment and was anxious for something to emerge from the Ways and Means Committee so that action could be taken before Congress adjourned for the national party conventions in July and August. But the Senate was tied up with a civil-rights filibuster and chances for the enactment of medicare before the convention faded.[65]

It should be noted that at this time Congressman Mills, Chairman of the Ways and Means Committee, was attempting to weaken the charge that the Kerr-Mills program was inadequate by proposing increased federal grants to states that would ease rules for eligibility and provide broader services. He also suggested increased cash benefits for social security recipients to offset the 7 per cent increase in the cost of living since 1958. Mills presumed that the higher social-security contribution, which would be required

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[64]Feingold, pp. 129-130. [65]Ibid., pp. 130-131.

to finance the higher benefits, would result in taxpayer resistance to further increases that would be required by Medicare. But Mills was not successful in getting his committee to agree on the Kerr-Mills liberalization efforts. The increased cash benefits were approved, however, and on July 7, the committee reported out a bill (H. R. 11865) which provided a 5 per cent increase in cash benefits.[66] The bill passed the House by a vote of 388 to 8. An amendment to add hospital insurance for the aged under the social security program was added to the bill in the Senate, despite the fact that the majority of the conference committee, which the bill had to go through, were opposed to medicare. Also, a deadlock in the conference committee would jeopardize the cash benefits proposal, which would not be a wise move by Congressmen in an election year. The bill was sent to the Senate Finance Committee for a public hearing. Extensive debates took place and medicare proponents such as HEW Secretary Anthony Celebrezze and former HEW Secretary Ribicoff pointed out the shortcomings of the House bill in its original form.[67]

The amendment to provide a hospital insurance program was adopted by a vote of forty-nine to forty-four, and the next day the Senate subsequently passed the entire social

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[66] Ibid., p. 131.

[67] Ibid., pp. 132-133.

security bill by a vote of sixty to twenty-eight and returned it to the House. The bill then had to go before a joint conference committee which would endeavor to reach a compromise. However, the majority of the conferees from both houses were opposed to medicare and despite the fact that the Senate conferees were honor bound to support the bill as passed by the Senate, a compromise on the medicare issue failed. The stalemate lasted until October 3, 1964, when both the medicare and cash increase legislation of H. R. 11865 died with the adjournment of the Eighty-eighth Congress.[68]

Senator Goldwater's opposition to medicare was clearly indicated when he interrupted his Presidential campaign to fly to Washington and vote against it. He also utilized the opportunity to attack the democrats for letting the increased cash benefit legislation die. Johnson promised that medicare would head his list of "must" legislation if he were elected. The stage seemed to be set for medicare to become a major issue in the Presidential campaign. The AMA spent $1.5 million on an advertising campaign which praised the Kerr-Mills law.[69] However, despite all of this activity, the

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[68]Cohen and Ball, p. 5.

[69]Feingold, pp. 136-137.

medicare issue was not particularly stressed during the campaign, while others such as the Vietnam War took precedence.[70]

1965 Congressional Action

Johnson won the November 3, election and the Democrats increased their margin in the House by thirty-eight votes. This made the new House Democratic by better than two to one, while the Senate added another seat to its previous two to one Democratic majority.[71] Although passage of a health care bill for the aged in the Eighty-ninth Congress was not a foregone conclusion, the atmosphere was considerably changed in favor of a new wave of such legislation. The Ways and Means Committee stalemate had been broken up by a reshuffling of its membership which made it sympathetic to medicare.[72] "The improvements in OASDI that had failed to be enacted three months earlier because the Conference Committee did not agree on the hospital insurance provisions of H. R. 11865 were considered to be non-controversial."[73]

On January 4, 1965, the Administration's proposals for hospital insurance and improvements in the OASDI program

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[71]Feingold, p. 137.

[72]Anderson, "The Medicare Act," p. 23.

[73]Cohen and Ball, p. 5.

were introduced by Representative King as H. R. 1. The companion bill was introduced by Senator Anderson as S.1 and contained the following major provisions which did not include coverage of physicians' services:

1. Hospital insurance for the aged.
2. A general increase of 7 per cent in cash benefits.
3. An increase to $5,600 in the contribution and benefit base.
4. An increase in the contribution schedule.
5. Coverage of self-employed doctors.
6. Coverage of tips.
7. Extension of the period for filing application for lump-sum death payments.
8. Automatic recomputation of benefits.[74]

The AMA had become aware of the new pro-health insurance atmosphere created by the Presidential election and proposed a program, not related to social security, called "Eldercare" which provided "that federal and state funds be used to help persons sixty-five years of age and over and below certain incomes to purchase comprehensive health insurance benefits from voluntary health insurance."[75] The AMA insisted that the King-Anderson bill was "inadequate" and that the "Eldercare" plan was more comprehensive and more equitable, despite the tactical omission of physicians' services.[76]

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[74] Ibid.

[75] Anderson, "The Medicare Act," p. 24.

[76] Ibid.

On January 27, the Committee on Ways and Means began executive sessions to consider the King-Anderson bill, the "Eldercare" bill and a third proposal. H. R. 42351, introduced by Representative Byrnes (R., Wis.) which was supported by five of the eight Republican Committee members. "It would have established a Federal health insurance program for the aged, financed from Federal general revenues and from premiums paid by participants. Enrollment would have been voluntary, and premium amounts would have been scaled to the amount of the participants OASDI benefits."[77] The Byrnes proposal provided a full range of health benefits, while the King-Anderson bill was directed merely at hospital and related benefits.

After two months of deliberations, Chairman Mills introduced H. R. 6675, which attempted to incorporate the essential features of all three proposals. Two related health insurance programs were provided by the new bill: The first was a basic program which would provide protection against hospital and related health costs under the social security system. This program was similar to the King-Anderson bill, but unlike that bill, the Committee's bill called for financing by an earnings tax which would be identified separately from

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[77]Cohen and Ball, p. 5.

the present social security taxes. The second health program for the aged to be provided in the Committee's bill, "was a voluntary program of protection against the cost of physicians and certain other medical and health services not covered under the basic program. The supplementary program was to be financed by premiums from enrollees and a matching amount paid by the Federal Government from Federal tax revenues."[78]

The administration supported the combined approach of Hospital Insurance and the new Supplementary Medical Insurance program (SMI), which had come as a surprise to virtually everyone outside of the Committee.[79] The Committee's reasoning behind the recommendations was stated in its report as follows:

> Although your committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal progam as to both persons who can qualify and protection afforded is required.
>
> Therefore, a threefold approach to meet this national problem has been developed. First, since your committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your committee recommends

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[78] Ibid., pp. 5-6.

[79] Meyers, p. 55.

> more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. In addition, your committee recommends . . . a strengthening of the medical assistance provisions of the Social Security Act so that adequate medical aid may be provided for needy people.[80]

The usual procedure of a "closed rule" was followed when the bill came before the House for consideration on March 29. This meant that no amendments were permitted, however motions could be made to recommit the bill. Congressman Byrnes made such a motion in an effort to have his health benefits proposal substituted for the dual proposal; however, the motion was rejected by a vote of 236 to 191. In the final vote on April 8, the House passed the bill, without amendment, by a vote of 313 to 115.[81]

At the end of April, the Senate Finance Committee began hearings on H. R. 6675, and the first witness, HEW Secretary Celebrezze praised the bill. He did recommend, however, that the bill be amended so that it would cover the fees of certain medical specialists in the basic plan, even though they were covered under the supplementary plan.[82]

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[80] Social Security Amendments of 1965: Report of the Committee on Ways and Means on H. R. 6675, House Report No. 6675, 89th Congress, 1st Session (1965), p. 20.

[81] Meyers, pp. 58-59.

[82] Feingold, pp. 143-144.

Testimony was centered on the health insurance aspect throughout the hearings, with heaviest opposition coming largely from the AMA and various state and local medical societies. However, some medical groups testified in favor of the health insurance provisions of the bill.

Secretary Celebrezze's proposal was resolved in early June when it was approved by the Senate Finance Committee in the form of an amendment by Senator Douglas (D., Ill.). Another issue was posed by Senator Long (D., La.), which proposed "that the medicare program be changed from a program offering limited benefits at the same cost for all the aged to one concerned primarily with catastrophic illness, offering broader benefits at a cost based on the recipient's income."[83] On June 23, the Long proposal was defeated by a vote of ten to seven; however, in its place Long proposed another motion which provided for an additional sixty days of hospital care and other benefits if the patient paid part of the cost. This proposal was accepted and on the following day the Committee approved H. R. 6675 by a vote of twelve to five.[84]

On the Senate floor the only direct test of the bill was a motion by Senator Curtis to kill only the medicare

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[83] Ibid., p. 145.

[84] Ibid., pp. 146-147.

portion of the bill; however, the move failed by a vote of sixty-four to twenty-six. On July 9, H. R. 6675 was passed by the Senate, with a number of minor amendments, by a vote of sixty-eight to twenty-one.[85]

Unlike the great differences between the House and Senate bills in 1964, the situation in 1965 was entirely different. In the Conference Committee the Senate provisions for hospital insurance were followed except for a few changes. For example, the maximum number of hospital days per spell of illness was changed to ninety days and the maximum number of home health service visits would not be covered under the basic hospital plan but under the SMI system. The minor Senate revisions for the SMI program were accepted in the Conference Committee.[86] The House approved the Conference Committee report on July 27 by a vote of 307-116 and on the following day the Senate approved the report by a vote of 70-24.[87]

In a meeting with President Johnson on July 29, eleven AMA leaders agreed to cooperate in administering medicare. The representatives said the meeting had helped to alleviate many of their suspicions regarding federal intentions toward

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[85] Ibid., p. 147.

[86] Meyers, pp. 61-62.

[87] Cohen and Ball, p. 9.

the medical profession. They were to be involved in making rules and regulations for the medicare program and they were to have an opportunity to make recommendations on any regulations considered for enactment.

On July 30, 1965, Johnson signed the medicare bill at the Truman Library in Independence, Missouri, and H. R. 6675 became Public Law 89-97. Hence, the legislative battle over the enactment of medicare had come to an end.[88]

Summary of the Law

Wilber J. Cohen and Robert Ball, in an article in the Social Security Bulletin summarized the major provisions of medicare health insurance for the aged as follows:

> Public Law 89-97 adds to the Social Security Act a new title XVIII establishing two related health insurance programs for persons aged 65 and over: (1) a hospital insurance plan providing protection against the costs of hospital and related care, and (2) a medical insurance plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the hospital insurance plan.
>
> The hospital insurance plan is financed through a separate earnings tax and a separate trust fund. Benefits for persons who are currently aged 65 and over who are not insured under the social security or the railroad retirement systems will be financed out of Federal general revenues.
>
> Enrollment in the medical insurance plan is voluntary, and the plan is financed by a small monthly premium ($6 a month initially--$3 paid by enrollees and an equal amount paid by the Federal Government from general revenues).[89]

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[88]Feingold, pp. 147-148. [89]Cohen and Ball, pp. 9-10.

CHAPTER III

IDEOLOGY AND RHETORIC

The American Ideology

Since most immigrants to early America came from England, the earliest ideas and programs for the aged and indigent in America were basically the same as those of the English system. In both countries beggars were whipped and driven to other towns. Many new immigrants who could not afford passage to America lost their freedom by becoming indentured servants. All types of indigents were housed together in workhouses and almshouses which became the main method of caring for the aged and the poor.

It was partly from these beginnings that America developed an ideology in which individualism coupled with a strong suspicion of centralized authority became the dominant force. This ideology originated with America's criticism of the English monarchy,which led to the American Revolution and according to Paul A. Brinker, "has been with us ever since."[1] With regard to welfare, early Americans viewed public "doles"

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[1]Paul A. Brinker, Economic Insecurity and Social Security (New York, 1968), p. 18.

or "handouts" with contempt. The Puritan ethic regarding the sanctity of work was so strong that it was generally felt that the acceptance of government funds was detrimental to one's morals.[2]

Despite considerable poverty and the fact that early methods of caring for the poor were inadequate, the American ideology of individualism prevailed. Oscar Handlin considered this idelogical element unique to America and he felt that the concept of individualism had become so well "entrenched" by the beginning of the twentieth century that any type of social action was feared as a threat to "personal liberty."[3] Roy Lubove, in his book entitled The Struggle for Social Security 1900-1935, observed that attitudes of "self-sufficiency and superiority of voluntary institutions: became obstructions to the adaptation of existing institutions to changing economic and social conditions. He also noted that "nowhere did the rigidities of the voluntary creed prove more disastrous than in the area of social welfare legislation."[4]

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[2]Max J. Skidmore, Medicare and the Rhetoric of Reconciliation (University of Alabama, 1970), p. 5.

[3]Roy Lubove, The Struggle for Social Security 1900-1935 (Cambridge, Massachusetts, 1968), p. vii.

[4]Ibid., p. 2.

However, New Deal social reform resulting from the depression was felt by many writers to have marked the end of America's traditional ideology regarding public welfare. In reference to the social security insurance program, Lubove says that "its commitment to rationalization posed an unprecedented challenge to treasured assumptions concerning the role of voluntary institutions in a democratic society."[5] In an article entitled "Sharing Prosperity: Income Policy Options in an Affluent Society," Elizabeth Wickanden considered social reforms to have created complete shifts of values and ideas. She considered these shifts to be "political realities." However, despite the fact that traditional values had "little relevance" to the present, they provided comfort from what Wickenden called a "fear of past insecurities projected into an unknown future."[6]

Thus it seems that while certain attitudes did change in regard to public welfare, basic values and ideological concepts did not. During the years of the Great Depression, more and more people came to realize that economic well being for all could not be guaranteed through economic

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[5] Ibid., p. 3.

[6] Elizabeth Wickenden, "Sharing Prosperity: Income Policy Options in an Affluent Society," Towards Freedom from Want, edited by Sar A. Levitan, Wilbur J. Cohen, Robert J. Lampman (Madison, Wisconsin, 1968), p. 17.

individualism and political liberties alone. Max J. Skidmore believed that this awareness, rather than a change in the traditional concepts of individual responsibility, served "to permit American acceptance of increased governmental welfare activities."[8] Although the rigidness of ideological concepts often served to thwart the development of needed social welfare reforms, Skidmore observed that the programs that were established have been generally accepted "without greatly altering the main currents of an ideology that would seem to require their rejection."[9]

David Potter noted both a major transformation and a fundamental continuity, stating that while the "tactics" changed, the basic principle did not.[10] He observed that Roosevelt shifted the emphasis from freedom as "immunity to control" to freedom as "immunity to social privation." Thus, he was completely in accord with the American ideology when he declared his four freedoms--"freedom of speech, freedom of religion, freedom from want, and freedom from fear."[11]

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[8]Skidmore, p. 3.

[9]Ibid.

[10]David M. Potter, People of Plenty (Chicago, 1954), p. 123, cited in Skidmore, p. 4.

[11]Ibid., p. 138.

During World War II, Karl Mannheim's study of American society indicated divergent strains of culture. In Diagnosis of Our Time he made the following statement:

> Though no longer the country of the Herbert Hoover type of rugged individualism, the United States is still a country where the state and its functionaries are held in low esteem, in which the controls of the community are loose, where powerful urges of self assertiveness and demands for freedom from all restrictions characterize a generation becoming only slowly aware of the dependence of liberties on self-imposed renunciations. The United States is a country where being "agin the Government," an element of which is necessary for any successful Democracy, is still so strong as to aggravate class and party conflict.[12]

In view of this ideology, a paradox can be noted in the public's acceptance of the New Deal, which occurred when a large section of the American population, in Manheim's words, began to "think realistically."[13]

Another writer, Hace Sorel Tishler, says that "the social welfare reforms constituted a reinterpretation of self-reliance rather than a rejection of it. . . ."[14] He feels that the continuity which existed along with the changes is an important aspect of American social welfare history. If social welfare change is measured in terms of

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[12]Karl Manhiem, Diagnosis of Our Time (New York, 1944), p. vii, cited in Skidmore, p. 5.

[13]Ibid.

[14]Hace Sorel Tishler, Self-Reliance and Social Security 1870-1917 (Post Washington, New York, 1971), p. viii.

outright rejection of self-reliance there is little or no change at all. Tishler considers it significant that most Americans were compelled to "reassure" themselves that each new acceptance of a welfare reform,rather than weaken the individual's self-reliance, would in fact enhance it. However, it is equally significant that despite strong ideological faith in the Protestant ethic, we have managed to make accommodations "which to an earlier generation would have seemed like a betrayal."[15]

The historian Henry Steele Commager discusses the American case in The American Mind, saying that it is not surprising that a people as "sentimental and conservative" as the Americans would not give up their traditional principles. On the other hand, it would also not be expected that a people as "ingenious and adaptable" as the Americans would abandon their "necessary practices." "They were neither to be frightened away from their symbols, nor reasoned out of their habits."[16]

Although the revolutionary aspects of the New Deal were debatable, there is little argument, says Skidmore, that

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[15] Ibid.

[16] Henry Steele Commager, The American Mind (New Haven: 1950), p. 315, cited in Skidmore, p. 7.

"its pragmatism and its general disregard of ideology were typical American responses to crises situations."[17]

The fear of reducing individual responsibility was lessened somewhat by including private insurance principles in the Social Security Act. This prevented a complete departure from traditional beliefs. On the other hand, those portions of the law designed to help the needy required no such rationalization. These programs were deemed government "charity," whereas the general program was considered "insurance."

However, the elimination of the belief that those who are not materially successful are necessarily "lazy" or "weak" has not been so easily achieved.[18] Max Lerner discusses this concept in his work, America as a Civilization. This belief was so deeply ingrained in the American mind that even victims of the Great Depression could wonder if those who had not been driven into poverty might be right and the fault might not, after all, be their own.[19] "It is this outlook," says Lerner, "that has made 'relief' so

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[17]Skidmore, p. 8.

[18]Ibid., pp. 8-9.

[19]Max Lerner, America as a Civilization (New York, 1957), cited in Skidmore, p. 9.

vulnerable a target for those who decried the retreat from the ancient virtues."[20]

However, despite this strong belief in individual responsibility there has been a steady growth in programs that have been accepted even though they deny the validity of the belief.[21] Ida C. Merriam, an official of the Social Security Administration, writes that over the past fifty years the trend overshadowing all others has been to develop an institutional mechanism which would assure a regular and assured income to nonearning groups.[22]

The Social Security Act partially came about as "an attempt to reconcile a continued belief in individual responsibility with the acceptance of the inadequacies of the doctrine of individual sufficiency for modern society."[23]

In similar studies conducted by Art Gallaher in 1940 and 1955, an ironic change in attitudes toward welfare was observed. In the first study the idea of "cash without work" was a most offensive principle to the individuals studied. The distribution of food and clothing to those in need was

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[20] Ibid.

[21] Skidmore, p. 9.

[22] Ida C. Merriam, "Trends in Public Welfare and Their Implications," American Economic Review, XLVII (May, 1957), p. 480.

[23] Skidmore, p. 10.

not questioned, due to its resemblance to local charity gifts. However, the second study revealed that the critical attitude was now against the distribution of a service or commodity, while cash payments were approved and became a "firmly accepted principle." The persons in the study explained that a cash supplement gave them the freedom to spend as they wished, while a service abridged this freedom. Skidmore felt that this change in attitude could be explained in that many of those interviewed had grown up in an era of increasing welfare programs and governmental controls. No longer was their major concern the accumulation of land and surplus cash, as a hedge against old age, but rather how much present spending potential they could achieve. Many of them had the attitude that the government would take care of them when they got old.

Gallaher observed in his study that programs providing for old persons had the greatest effects in easing their guilt of being burdens upon their children. However, despite the advantages of security, the belief that it was less "honorable" to depend on the government still caused much uneasiness.[24] He found that the most severe critics of the

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[24] Ibid., pp. 14-16.

pensions under OAA were the older persons who were economic successes and resented "seeing those who, in their eyes, had been poor workers receiving the same amount as those who had worked hard, but who had suffered misfortunes."[25]

On the other hand, payments within the OASDI's "social security" program did not receive this opposition, as the "charity" programs did. Social security was regarded as "earned" retirement and therefore within the confines of their belief. Thus, by employing a mechanism which took the form of a gigantic insurance plan, the pitfalls of programs giving people "something for nothing" were avoided.[26] In The Symbols of Government, Thurman W. Arnold points out that programs established in the semblance of an insurance company permitted Americans to live at peace with their traditional ideology and at the same time provided support to a vast class of people which he felt had been limitedly supported in a "haphazard" way.[27]

In 1953, Columbia University's American Assembly studied economic security and agreed that "striving for security is part of the temper of our time."[28] The report of the

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[25] Ibid., p. 17.

[26] Ibid.

[27] Thurman W. Arnold, The Symbols of Government (New York, 1962), p. 121.

[28] American Assembly, Economic Security for Americans (New York, 1970), p. 7.

meeting indicated that the Assembly could find no reason why a reasonable standard of protection against "security exigencies" would threaten any of the "traditional American virtues," particularly the will to work and the will to save.[29]

Skidmore concludes that there is still some antagonism between security and individual initiative. He states that "the fears of those who believe the search for security to be inimical to continued economic progress may have abated somewhat, but they have not been eliminated even when faced with the coincidence of economic growth and a general preoccupation with security."[30]

The Process of Rhetorical Reconciliation

In general, arguments by both supporters and opponents of a national health program were based upon the same traditional concepts, symbols, and cliches. There was endless debate concerning "compulsion," "socialism," "quality of care," the "health and financial condition" of the aged, the "fiscal nature" of the proposal, and the program's "compatibility (or incompatibility) with American ideals."[31]

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[29] Ibid., p. 8.

[30] Skidmore, p. 18.

[31] Ibid., p. 100.

The "American tradition" argument contained two points that were used most extensively by both sides during attempts at "rhetorical reconciliation." First, H. R. 6675 was espoused by proponents as a purely "American" plan.[32] Senator Russell Long described the bill as the "democratic way of achieving social progress,"[33] and supporters said the bill was a contrast to plans for "socialized medicine" in other countries. In other words, medicare was presented as being uniquely American. Opponents denied this since the bill provided coverage not only to those who were in need but also to those who were able to pay. Senator Curtis exemplified the opposition argument that limiting public provision for medical care to the needy was in keeping with American tradition. "It is not socialism for us to be charitable . . ." he said; "however, to pay the medical bills and hospital bills of individuals over sixty-five who are well able to provide the same for themselves is not charity. It is not indeed. It is socialism."[34]

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[32] Ibid., p. 163.

[33] Congressional Record, III, Part 11, Senate, 89th Congress, first session (Washington, July 6, 1965), p. 15602.

[34] Congressional Record, III, Part 12, Senate, 89th Congress, 1st session (Washington, July 8, 1965), p. 15870.

During the course of the health care controversy the imprecise term "socialism" was often used but seldom defined. Although there was virtually no agreement as to what it was, both proponents and opponents expressed unwavering hostility toward socialism. Opponents argued that medicare was itself socialistic,or at the very least, a "foot-in-the-door" that would inevitably lead to socialism. Proponents of public health programs likewise agreed that they would reject any program that they could agree was socialistic. However, this agreement had little effect since both sides argued their position citing the same facts and employing the same "logical" processes. Opposing factions tended to maintain the same "values and presuppositions" and established their positions in accordance with them. By accepting the relevance of the same symbols, the ideological orientations, at least on the surface, were similar and often the same.[35]

The AMA accused the proposed public health programs of being socialistic in nature,and utilized virtually every media of mass communication to denounce them.[36] The AMA preferred a voluntary system of health care,and in a pamphlet

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[35]Skidmore, p. 103.

[36]"Medical Association Launches New Drive Attacking 'Socialized Medicine,'" Advertising Age, XXXII (April 24, 1961), 84.

entitled "It's Your Decision," suggested that voluntary insurance was available to those who could afford it, while public assistance was available for those who needed help in paying for medical care. Referring to the proposed legislation, other critics charged that the bill "with its limited services, its compulsion, its deleterious effect on the quality of care, its expense, its inequity, 'would mean socialized health care . . . immediately for all those over 65 eligible for social security and eventually for every man, woman, and child in America.'"[37]

Medicare opponents frequently used the British National Health Service as an example of the inferior medical care that would result from such a system. Referring to the failure of the British system, those in opposition predicted that an American program of public health care would first encourage the use of medical services by many who really did not need them. This would cause overcrowding in existing facilities and result in poorer care for those really in need of medical care. Second, the Government's payment for medical care would result in government control over the services provided. Thirdly, the physicians's incentive to serve his patients would be lessened if medicare were implemented.

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[37]Skidmore, p. 103.

For all three reasons, "the doctor-patient relationship [would] be disturbed."[38] Those in favor of medicare denied that it would lower the quality of medical care and emphasized the safeguards that were written into the bill. They disagreed with the unfavorable evaluation of the British system and asserted that medicare need not lead to a similar, nor to a more extensive, medical care program for the entire population.[39]

Cecil R. King, one of the authors of the bill, refuted the AMA's charge that the bill provided "blanket authorization for the Federal Government to control the providers of services."[40] The text of the bill actually states that the Secretary would be permitted to do only that which is "specifically provided" in the law. According to King, "This exercise in logic--in which a statutory limitation to do only what is 'specifically provided' becomes a 'blanket authorization' to exercise power without limit--illustrates clearly the AMA's approach to the problem: the approach of a calculated attempt to distort the meaning of the bill."[41] With regard to the AMA's concern over the decline in the

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[38]Eugene Feingold, Medicare: Policy and Politics, p. 261.

[39]Ibid., pp. 261-262.

[40]Cecil R. King, "My Bill Will Not Damage the Quality of Medical Care," Feingold, p. 285.

[41]Ibid.

quality of medical care, King says that "the AMA is not really interested in looking at the merits of the case, nor in being logically consistent, for it later predicts with horror that 'Government would be preoccupied with efforts to regulate quality.'"[42]

It should be noted that arguments often reach the point where the principles of democratic theory became points of argument. A good example is an exchange between Senator Carl Curtis (R., Neb.) and Senator John O. Pastore (D., R.I.) which is found in the Congressional Record of the 87th Congress, July 5, 1962. Senator Pastore asked Senator Curtis, ". . . if the people of the United States want this program, after they embark on it, to pay for more than hospitalization, what is wrong with that, if they want to pay for it?" Senator Curtis said in reply that such a majority view would be wrong, "because it will ruin the free practice of medicine in this country."[43]

Senator Gordon Allot (R., Colo.) made the following statement to Congress: "Nor is public approval proof that a plan is good; this is particularly true in medical care."[44]

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[42] Ibid., p. 292.

[43] Congressional Record, CVIII, Part 9, 87th Congress, 2nd session (Washington, July 5, 1962), p. 12790.

[44] Congressional Record, CVIII, Part 10, 87th Congress, (Washington, July 13, 1962), p. 13573.

However, in the same argument he later contradicted himself by saying:

> . . . it is difficult for me to understand how this legislative body can even consider such a proposal as the one we have before us today, unless we too are now willing to subscribe to the theory that this Government knows best what our people "need," and, unless we are no longer interested in what they "want."[45]

These arguments would seem to indicate that a system or theory was sound only when it could be used to support one's position, but not otherwise.

In the rhetorical battle concerning the need of services by the aged and their ability to pay, proponents of medicare offered numerous statistics to support their arguments. Those in favor of medicare considered the illness problem of the aged to be an important point. For example, a National Health Survey Report conducted from 1957 to 1959, indicated that 77 per cent of all persons sixty-five and over, not in institutions, had had one or more chronic conditions and 42 per cent had been limited in their activity.[46] In 1957-1958, a Health Information Foundation study showed that per capita gross private medical expenditures were at least twice as large for persons aged sixty-five and over than for persons under

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[45] Ibid., p. 13581.

[46] Health Insurance for Aged Persons, p. 4.

sixty-five.[47] Statistics were introduced to show that health costs were also rising. A report by the Senate Aging Committee indicated that between 1950 and 1960, there was a 47 per cent increase in the medical care price index. This was considerably larger than the 23 per cent increase experienced by the over-all Consumer Price Index. Per diem hospital costs were shown to have increased from less than $10 to $32, since 1946.

As for hospital insurance, according to a Congressional Quarterly Special Report entitled Medical Care for the Aged, 48.8 per cent of those sixty-five and over had no coverage in 1960; 20.9 per cent had less than 75 per cent of their hospital expenses covered; and only 30.3 per cent of the elderly had more than 75 per cent of their hospital bills covered by insurance.[48]

Another point of argument for supporters of medicare was the growing number of elderly persons as a percentage of the total population. Proponents argued that by 1962, persons aged sixty-five and over numbered seventeen million. From 1950 to 1960, the total United States population expanded

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[47] Ibid., p. 21.

[48] Medical Care for the Aged, Congressional Quarterly Special Report (Washington, August, 1963), p. 17.

by 18.5 per cent while the elderly population increased by 34.7 per cent. Aged persons were expected to constitute a steady 12 per cent of the total United States population.[49]

Although there was little dispute that the elderly had a greater need for medical services, the main differences were of emphasis. While supporters presented the above data as evidence of illness among the aged, the opponents of medicare stressed the proportion of the elderly who were not ill.[50] The AMA argued that "most older people are in fact, in good health."[51] They were susceptible to the same diseases as any other group, and the AMA pointed out that "there are no diseases of the aged; there are simply diseases among the aged."[52] In an article used as testimony before the House Ways and Means Committee, "The Health Problems of Older People Cannot Be Solved Through Legislation," the AMA stated that although there is a great deal of chronic illness among older people, it is generally misunderstood what "chronic illness" really is. Although it refers to a recurrent condition or one that persists over a period of time, the term "chronic"

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[49] Ibid.

[50] Feingold, p. 26.

[51] American Medical Association, "The Health Problems of Older People Cannot be Solved Through Legislation," in Feingold, p. 30.

[52] Ibid.

does not necessarily imply disability. For example, persons with impaired hearing or diabetes are chronically ill, but they may function normally. The AMA detailed this point due to the opposition's interpretation that because the aged as a group have a higher incidence of chronic illness, most older people are sick and debilitated.[53]

Supporters of medicare used the low income of aged persons as one of their strongest points of argument. The Bureau of the Census reported in 1960 that 52 per cent of the persons 65 and over, not including those in institutions, had cash incomes below $1000.[54] However, opponents considered both the resources of the aged and the demands that were made on those resources; hence, their ability to pay became a point of major controversy.[55] Arthur Kemp, Leonard W. Martin, and Cynthia Harkness, directors of the Economic Research Department of the AMA, wrote an article which tended to minimize the economic plight of the aged. They agreed that the low income statistics of the aged were relevant, provided one assumes that income is an adequate measure of financial status. However, the AMA considered additional statistics and stated the following:

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[53] Ibid.

[54] Health Insurance for Aged Persons, p. 14.

[55] Feingold, p. 35.

> The implication can be questioned if one points out an equally accurate statistic, namely, that in 1957 almost one-half of all persons over 14 years of age also had incomes of $1000 or less per year. Looking further, one finds that 47% of all persons between the ages of 14 and 65 had incomes of $1000 or less per year in 1957. Yet, it also is true that the median family income in 1957 was approximately $5000 per year. . . .[56]

Included in the same article were figures concerning the assets of the aged taken from the Federal Reserve Board's annual Survey of Consumer Finances. The examination revealed that almost three out of every four persons aged sixty-five and over owned liquid assets in some form and that between 1949 and 1958, persons aged sixty-five and over had accumulated liquid assets faster than any other age group. On the other hand, for persons fifty-five to sixty-four years of age, the percentage of those owning liquid assets dropped to 71 per cent in 1958, while there was a rise in the average for all groups between the ages of eighteen and sixty-four years from 71 to 73 per cent. In 1949, 30 per cent of those over sixty-five had liquid assets of $2000 or more; in 1958, this figure had risen to 40 per cent. It was also noted in the article that the age group sixty-five and over had a greater proportion

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[56]Arthur Kemp, Leonard W. Martin, and Cynthia Harkness, "Some Observations on Financial Assets of the Aged and Forand-type Legislation," Journal of the American Medical Association, CLXXI (October, 1959), pp. 1228-1231, in Feingold, p. 35.

of the liquid assets in the categories $500 or more, $2000 or more, and $5000 or more, than any other age group.[57]

Supporters argued that medicare would help younger workers pay in advance for hospital-benefits protection in their old age and at the same time relieve them from paying the heavy hospital costs of their parents. Opponents disagreed with this and claimed that it was unfair to compel younger workers, with their large family responsibilities, and low earnings, to pay the health care expenses of the current older generation, many of whom were still employed at high salaries or had large "unearned" incomes.[58]

Senator Curtis confronted HEW Secretary Celebrezze concerning this problem during hearings before the Senate Finance Committee. Curtis argued that the added burden which the medicare program would place on already overloaded taxpayers was an important point to consider "when we start in on a program to pay hospital and medical bills for people who may be a lot more able to pay their own bills than the rank and file of social security taxpayers."[59] Curtis said that he did not object to paying the medical expenses of those

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[57] Ibid.

[58] Robert J. Meyers, Medicare, pp. 32-33.

[59] House Report 6675, p. 135.

of low income, but he said to Celebrezze, "I cannot understand your reasoning in saying that these people," who are already heavily burdened with living expenses, payments, taxes, and their own medical costs, "should pay a hospital and medical bill for somebody, say, who has an income in retirement of $10,000 a year."[60]

On October 15, 1962, the AMA issued a press release giving its interpretation of data released to it from a study conducted by the University of Michigan Survey Research Center. Statistics which were interpreted to lend support to the AMA position were as follows: (1) The median value of total assets of those under age 65 was $4,839 in 1960, while assets for families with the head of the family 65 or over were $8,349. (2) In a home with the family head over 65, the median value of equity was $4,559, almost four and one-half times as much as the $1,028 reported for younger families. (3) The median value of liquid assets for the over-65 family was $1,012, almost two and one-half times as great as the $460 of those under 65. (4) Seventy-four per cent of the aged families had no personal debt while only 34 per cent of the younger families had no personal debt and 86 per cent of the aged had no installment debt, compared to

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[60] Ibid., p. 136.

48 per cent of all other age groups.[61] George M. Fister, M.D., president of the AMA in 1962, stated in an October 15 press release that it is misleading to use income alone as a test of economic condition, as it ignores the substantial tax relief given those over 65 through "double tax exemptions, retirement income credit, full medical expense deductions and exemption of benefits from social security, railroad retirement and other pensions, annuities and dividends, as well as size of family and other factors."[62]

However, a spokesman for the University of Michigan Survey Research Center, in an interview with a New York Times reporter, said that its staff had not seen the AMA press release in advance of its publication, and though the Center was responsible for the data, it was not responsible for the AMA's charge that those sixty-five and over were on the average substantially better off than younger Americans. In fact, the Center argued that the AMA's conclusion was open to question because the aged were being compared to a group aged eighteen to sixty-four years which included a large number of recent school graduates and young families trying to establish

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[61] American Medical Association, "The Aged as a Group Are Substantially Better Off Than Younger Americans," in Feingold, pp. 51-52.

[62] Ibid., p. 53.

a household and raise children.[63] The Center's spokesman pointed out that "even a comparison with only those over forty-five would overlook the fact that most of the aged have completed asset accumulation, a process in which the others were still engaged."[64] The Center released its own interpretation of the data nine days later.

The Center's press release indicated that 71 per cent of the aged had a disposable income below $3,000 in 1961, while 10 per cent had more than $4,000. Also, while lower incomes are permanent among the aged, they are commonly temporary among younger families. Although the elderly group had average assets similar to the group fifty-five to sixty-four years old, 34 per cent of those sixty-five and over had practically no liquid assets at all, against 28 per cent in the younger group. Of the sixty-five-and-over group, 23 per cent had net worth (including home ownership and investments with debt deducted therefrom) under $1,000, as against 14 per cent in the fifty-five-to sixty-four-year-old age group.[65]

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[63]Feingold, p. 36. [64]Ibid.

[65]The Economic Condition of the Aged," Survey Research Center, University of Michigan, in Feingold, p. 54.

Dorothy McCamman noted that the rhetorical battle over medicare involved numerous instances of data distortion which she termed the "numbers game." She particularly noted the failure to count the "zero" income of the 24 per cent of the married women over sixty-five who had no income in 1960. In reference to the manipulation of figures to make the aged appear better off, she says, "the aged are a low income group and it is high time to stop juggling figures in the attempt to prove otherwise."[66]

In the years just prior to the passage of medicare, rhetorical devices of basic ideological themes (private enterprise, American tradition, socialism, etc.) had diminished considerably and were replaced by factual discussion and technical amendments. It had been generally accepted by most congressmen that medicare was inevitable, reducing the elements of controversy and thus making strenuous debating efforts hardly worthwhile.[67]

Skidmore gives the process of "rhetorical reconciliation" credit for permitting such a program as medicare to come about in America, and explains that through rhetorical

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[66]Dorothy McCamman, "Incomes of the Aged and the Numbers Game," in Feingold, p. 44.

[67]Skidmore, p. 162.

reconciliation practices can be accepted that violate the "ideological tenets of political and civil liberties" just as easily as those which violate the principles of laissez-faire economics.[68] His work on the development of medicare concludes with the statement that "The major reconciliation of opposites that permits the American to live at peace with practices directly contrary to his ideology, is largely rhetorical."[69] Apparently, Skidmore feels that through sharply reasoned arguments we can lead ourselves to accept beliefs which we initially felt to be contrary to our basic ideology by convincing ourselves that these beliefs are not in conflict with our ideology.

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[68] Ibid., p. 175.

[69] Ibid., p. 176.

CHAPTER IV

THE MODEL

Hypotheses To Be Tested

To test the hypothesis that pre-medicare public health care dollars were distributed to indigents in Oklahoma (i.e., that there is a significant correlation between MVP and variables indicative of indigency), the first step was to calculate the per capita amount spent on medical vendor payments in each of the state's seventy-seven counties in a given year. Next, the rank order of these per capita expenditures was established. Then five separate characteristics were chosen as indicators of indigency. They are (1) percentage of the population with income below poverty level, (2) percentage of the population aged sixty-five and above, (3) median school years completed for persons over twenty-five years of age, (4) percentage of the population with rural residency, (5) percentage of the population non-white. The rationale for selecting these variables will be discussed in greater detail later in the chapter. For the next step, the percentage of each county - population possessing a specified characterisic indicative of indigency

was calculated. This procedure was repeated for each of five different characteristics indicative of indigency. The next step was to compute a Spearman rank-order correlation between the ranks of each of the selected indicators of indigency and per capita expenditures under the medical vendor payments program. The final step consisted of computing Kendall's coefficient of concordance so as to ascertain whether the rank order of the per capita expenditures under the medical vendor payments program was correlated with the rank orders of the selected social and economic characteristics taken together.

Essentially the same process described above was repeated so as to ascertain whether the rank order of the percentage of each county's population receiving medical vendor payments was significantly correlated with each of the rank orders of the selected social and economic characteristics indicative of indigency. Again, Kendall's coefficient of concordance was also calculated.

To test the second hypothesis, that there was also a significant correlation under medicare, but with significant differences in the relative strengths of the correlation coefficients of the five variables, rank orders were determined for county data on the per capita expenditures made under medicare and on the per cent of the population

receiving medicare payments in the same manner as described above. These rank orders were then correlated with each of the rank orders of the selected social and economic characteristics indicative of indigency, and Kendall's coefficient was calculated.

Sources of Data

The pre-medicare data were computed from records of the Oklahoma Department of Public Welfare. The data included medical vendor payments made on behalf of public assistance recipients and those persons eligible for Medical Assistance to the Aged under the Kerr-Mills Act. The medical vendor payments data are for the year 1961, and the social and economic characteristics data with which the medical vendor payments are correlated are taken from the 1960 census. The medicare data are taken from social security publication 69-28, entitled Medicare: Health Insurance for the Aged; Amounts Reimbursed by State and County, 1969. These data on medicare are correlated with social and economic characteristics data which are taken from the 1970 census.

Statistical Techniques

A non-parametric statistical technique for testing the hypotheses was chosen, due to the probable existence of

multicollinearity between the selected social and economic characteristics. This condition would exist if the five independent variables are correlated with each other.[1] A non-parametric technique is superior to a parametric technique whenever any of the necessary conditions for the parametric technique fail to be met, provided both conditions for the non-parametric technique are met.[2] Specifically, the condition of additivity is not met under conditions of multicollinearity. Although there are other methods by which one can compensate for multicollinearity, the non-parametric technique offers additional advantages. For example, it could be argued that poverty data does not have a normal distribution and is therefore not homoscedastic (has unequal variances).[3] In addition, the non-parametric technique avoids the possibility of drawing any inferences as to the cause-and-effect relationship between the variables.

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[1]Ralph E. Beals, Statistics for Economists (Chicago, 1972), p. 295.

[2]James V. Bradley, Distribution-Free Statistical Tests (Englewood Cliffs, 1968), p. 15.

[3]Sidney Siegel, Nonparametric Statistics for the Behavioral Sciences (New York, 1956), p. 19.

Similar Studies

As to why inter-county comparisons are used as the basis for determining the distribution of public health care expenditures, the answer is basically that a finer breakdown of data is not readily available. However, with reference to this point, it should be noted that at least one existing study employs essentially the same technique for essentially the same purpose. Lora S. Collins has a study entitled "Public Assistance Expenditures in the United States," which is contained in The Brookings Institute's Studies in the Economics of Income Maintenance.[4] As the title indicates, the Collins study deals with total public assistance expenditures, rather than with the medical vendor payments portion of public assistance expenditures. Nevertheless, there are significant similarities between the Collins study and the present study. In the first place, Collins states that the intent of her study is to attempt, "to identify empirically some quantitative determinants of assistance expenditure levels in 1960."[5] To do this she has calculated a multiple

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[4]Lora S. Collins, "Public Assistance Expenditures in the United States," Studies in the Economics of Income Maintenance, edited by Otto Eckstein (Washington, 1967), pp. 97-173.

[5]Ibid., p. 98.

regression in which public assistance expenditures are made a function of certain selected social and economic characteristics. It is significant to note that the four selected characteristics of indigency used in the Collins study are used in the present study,which also includes median years of school completed. In addition, the Collins study and the present study use the same technique for treating observed variations in expenditures and the number of recipients. That is, both studies convert the data into per capita expenditures and into the proportion of the population receiving payments. Finally, the Collins study uses inter-state comparisons as the basis for determining the distribution of public assistance expenditures. Thus, the Collins study does not employ as fine a breakdown of expenditures as the present study, which uses an inter-county comparison.

Social and Economic Characteristics

The selected social and economic characteristics used in the present study are low income, old age, lack of education, rural residence, and non-white.

Low Income

Low income, the first variable used to indicate indigency, was established as a basic standard of indigency

by the Council of Economic Advisors in their 1964 report. The report states, "For our society today a consensus on an approximate standard [of poverty] can be found."[6] The best single "standard" according to the Council is low income. Poverty was defined as being "the condition of a family whose income from all resources was $3,000."[7]

Thus, an income of $3,000 or below was equated with poverty by the Council. For the pre-medicare expenditures, then, a figure of $3,000 or below is used as the indicator of low income. However, since inflation affects the poor as well as the more affluent, the medicare data are correlated with a higher income figure. That is to say, the 1970 poverty threshold established by the Census Bureau is $3,743 for a non-farm family of four, and it is this figure which is used as the indicator of low income in analyzing the distribution of medicare expenditures.[8]

As has already been indicated, in the present study low income is not used as the sole indicator of indigency.

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[6] Economic Report of the President (Washington, 1964), p. 57.

[7] Ibid., p. 58.

[8] "General Social and Economic Characteristics, Oklahoma," Census of the Population, 1970 (Washington, 1972), Appendix, p. 30.

The inclusion of variables in addition to low income is fairly common. For example, Mollie Orshansky in "Counting the Poor: Another Look at the Poverty Profile," argues for the inclusion of additional variables.[9] Moreover, an article by Harold Watts,entitled "The Isoprop Index: An Approach to the Determination of Poverty Thresholds," is based on the contention that low income is an inadequate indicator of indigency.[10] Thus there is evidence suggesting that any study concerned with indigency should not rely on low income as its sole indicator.

With regard to the additional social and economic characteristics employed in the present study, there are a number of articles which seek to establish these variables as being indicative of indigency. A brief summary of a few of these articles is presented.

Old Age

With respect to old age and the poor, Robert Lampman, in a study done for the Joint Economic Committee of Congress,

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[9]Mollie Orshansky, "Counting the Poor: Another Look at the Poverty Profile," Social Security Bulletin (January, 1965).

[10]Harold W. Watts, "The Isoprop Index: An Approach to the Determination of Poverty Income Thresholds," The Journal of Human Resources, II (Winter, 1967), 3-18.

entitled The Low Income Population and Economic Growth, has estimated that 25 per cent of all low-income persons are 65 years of age or older. According to Lampman, since persons 65 and older constitute only 8.5 per cent of the total population, "It seems clear that old age is an important causal factor with regard to low income."[11]

The Council of Economic Advisors has a higher estimate of that proportion of the poor which is made up of persons 65 and older. Their figure is 34 per cent. Moreover, the Council estimated that persons 65 and over make up 2 1/2 times as great a proportion of poor families as they do for all families.[12]

The Conference on Economic Progress, in Key Policies for Full Employment (using a $4,000 figure as the poverty line for multiple member families and $2,000 for unattached persons), estimated that 80 per cent of all unattached persons 65 and over are impoverished and that 64 per cent of multiple-member families with heads 65 and over are impoverished.[13]

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[11]R. J. Lampman, The Low Income Population and Economic Growth, Joint Economic Committee, Congress of the United States, Study Paper No. 12 (Washington, 1959), p. 7.

[12]Economic Report of the President, p. 62.

[13]Conference on Economic Progress, Key Policies for Full Employment (Washington, 1962), p. 48.

In a second publication, Poverty and Deprivation in the United States, the same group (using the same definition of poverty) contends that 23.3 per cent of all the poor persons in the United States are aged 65 or above.[14]

Lack of Education

The Lampman study also isolated the impact of a lack of education. Specifically, the study concludes that "about 2/3 of low income families are headed by persons with no education beyond grammar school." Lampman concludes that lack of education "is certainly an independent cause of low income."[15]

The A. Phillip Randolph Institute, in A Freedom Budget for All Americans, estimates that a full 40 per cent of all the poverty in the U. S. is due to inadequate employment opportunity, and that training and education are the appropriate remedies.[16]

The Council of Economic Advisors estimates that 37 per cent of all families with no more than eight years of

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[14]Conference on Economic Progress, Poverty and Deprivation in the U. S. (Washington, 1962), p. 71.

[15]Lampman, p. 9.

[16]A. Phillip Randolph Institute, A Freedom Budget for All Americans (New York, 1966), p. 41.

education are impoverished, and that 60 per cent of all impoverished families are headed by individuals with eight years or less education. The Council goes on to state, "The severely handicapping influence of lack of education is clear. The incidence of poverty drops as educational attainments rise for non-white as well as white families at all ages."[17]

Walter Fogel,in an article entitled "The Effects of Low Educational Attainment on Income," has employed bivariate regression to test whether median income is correlated with median years of school completed for males twenty-five years of age and over. His results were as follows: for persons in his sample with Spanish surnames,annual income was found to increase by $529 with each year of school completed,and for the entire sample the figure was $449.[18]

Using a poverty boundary of $4,000 for multiple-member families, and $2,000 for unattached individuals, the Conference on Economic Progress estimated that 65 per cent of the multiple-person families which were impoverished had heads

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[17] Economic Report of the President, p. 66.

[18] Walter Fogel, "The Effect of Low Educational Attainment on Income," The Journal of Human Resources, I (Fall, 1966), 34.

with eight or less years of education, while 80 per cent of the impoverished unattached individuals had eight or fewer years education.[19]

Leon Keyserling, in Progress or Poverty, states that "among both families and unattached individuals, there is a very high correlation between the amount of education and the amount of poverty. In 1963, about 44 per cent of the more than 7 million families whose heads had less than eight years of elementary education lived in poverty."[20]

Rural Residence

With respect to the use of rural residency as an indicator of indigency, Robert Lampman estimates that approximately 25 per cent of all low-income persons had rural residence.[21] The Council of Economic Advisors estimates that while only 8 per cent of the total population has rural farm residency, 16 per cent of those impoverished have rural farm residency.[22] According to Leon Keyserling, more than 43 per cent of farm

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[19]Conference on Economic Progress, Key Policies for Full Employment, p. 48.

[20]Leon H. Keyserling, Progress or Poverty, Conference on Economic Progress (Washington, 1964), p. 40.

[21]Lampman, p. 7.

[22]Economic Report of the President, p. 63.

families live in poverty, as compared to 17 per cent of all non-farm families.[23]

Non-White

That non-whites are more apt to be poor is indicated by the Keyserling study, which found that more than 43 per cent of all non-white families in the United States lived in poverty in 1963, whereas less than 16 per cent of all white families lived in poverty. Keyserling goes on to state that the contrast is even greater for the most abject forms of poverty: more than 9 per cent of all non-white families had income less than $1,000, compared with 3 per cent of all white families.[24]

The A. Phillip Randolph Institute states that in 1964, 37.3 per cent of non-whites lived in poverty with annual incomes less than $3,000, whereas the proportion of white families with income less than $3,000 was 15.4 per cent. Moreover, about 14 per cent of the non-white families had income between $1,000 and $2,000, whereas only 5.4 per cent of the white families had income in this range, and 7.7 per cent of non-white families had income less than $1,000, contrasted with only 2.7 per cent for white families.[25]

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[23] Keyserling, p. 56. [24] Ibid., p. 37.

[25] A. Phillip Randolph Institute, p. 19.

Finally, Robert Lampman points out that while non-white families constitute only 10 per cent of all families, they constitute 22 per cent of all indigent families.[26] And Matthew Kessler in the Economic Status of Non-White Workers estimates that the proportion of non-white families with income less than $3,000 is 2 1/2 times as great as the proportion of white families with income less than $3,000.[27]

Results of the Statistical Analysis

As discussed above, in the present study the rank orders of the per capita payments and the proportion of the population receiving benefits under the medical vendor payments program are correlated with selected social and economic characteristics. Similarly, the rank orders of the per capita payments and the proportion of the population receiving benefits under medicare are correlated with the same selected social and economic characteristics. It is thus possible to ascertain whether there is a significant difference between the two sets of rank order correlations.

Medical Vendor Payments

Tables I and II below describe the result of the rank order correlations with respect to medical vendor payments.

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[26] Lampman, p. 8.

[27] M. A. Kessler, Economic Status of Non-White Workers, 1955-62, U. S. Department of Labor, Special Labor Force Report, No. 33 (Washington, 1963), p. 8.

In Table I the r value of +.78 for per cent of the population with an income below poverty level indicates that poverty income is positively correlated to MVP. This means that as the proportion of the population with poverty income increases, per capita expenditures increase. The T value of 10.8 means that there is a significant correlation between poverty income and per capita expenditures at the .01 level of significance. In other words, there is less than one chance in 100 that there is no correlation between the two variables. The r^2 term is the coefficient of determination. It measures the per cent of the variation in one variable associated with variation in the second variable. In this case, inter-county variation in the per cent of the population with income below the poverty level explains 61 per cent of the inter-county variation in the allocation of per capita expenditures under MVP.

In the case of per cent of the population age 65 and above, the +.53 value of r indicates a direct relationship (as per cent age 65 and over increases, MVP also increases), and the T value of 5.3 indicates that there is a significant correlation; however, the correlation is not as high as in the case of poverty income. The .28 value of r^2 means that only 28 per cent of the variation in MVP per capita expenditures can be explained by old age.

TABLE I

RANK ORDER CORRELATION OF PER CAPITA EXPENDITURES ON MEDICAL VENDOR PAYMENTS WITH SELECTED SOCIAL AND ECONOMIC CHARACTERISTICS

1950 Population Characteristics (by county)	r	y^2	t(df 75)	Level of Significance
% with income below poverty level	.78	.61	10.8	.01
% age 65 and above	.53	.28	5.3	.01
Median school years completed (persons over 25	-.77	.59	-10.5	.01
% with rural residency	.21	.04	1.9	.05
% non-white	.44	.19	4.2	.01

The -.77 value of r indicates that there is an indirect correlation between median years of school completed and MVP expenditures. In other words, as the number of years of school completed increases, per capita expenditures decrease. The -10.5 value of T indicates a significantly high negative correlation and the r^2 value of .59 means that 59 per cent of the variation in MVP expenditures can be explained by variation in the median school years completed.

The +.21 r value of rural residency indicates a positive correlation (as per cent rural increases, MVP increases) with

MVP, but the low T value of 1.9 means that the correlation is significant only at the lower .05 level of significance. It is significant, however, and there is less than a 5 per cent chance that there is no correlation between the two variables. The r^2 value of .04 means that 4 per cent of the variation in per capita MVP is explained by variation in the per cent of the population with rural residency or in other words, 94 per cent of the variation in MVP is <u>not explained</u> by rural residence.

There is a positive correlation between the per cent of the population non-white and per capita MVP (as per cent of the population non-white increases, MVP increases) and the 4.2 value of T indicates that the correlation between these two variables is significant at the .01 level. Nineteen per cent of the variation in per capita MVP expenditures can be explained by variation in per cent non-white.

Hence, all of the variables indicative of indigency are significant in explaining MVP per capita expenditures.

Table II, which shows the rank order correlation of the per cent of the population receiving benefits under MVP with the selected variables indicative of indigency, can be observed in exactly the same manner. Again all variables indicative of indigency are positively correlated to per cent of the population receiving MVP except for median

school years completed, just as under Table I. Again, the T values indicated correlations at the .01 level of significance for all variables except rural residency, which was correlated at the .05 level of significance, as in Table I.

TABLE II

RANK ORDER CORRELATION OF THE % OF THE POPULATION RECEIVING BENEFITS UNDER MEDICAL VENDOR PAYMENTS WITH SELECTED SOCIAL AND ECONOMIC CHARACTERISTICS

1960 Population Characteristics (by county)	r	y^2	t(df 75)	Level of Significance
% with income below poverty level	.80	.64	11.7	.01
% age 65 and above	.52	.27	5.2	.01
Median school years completed (persons over 25)	-.79	.62	-11.3	.01
% with rural residency	.25	.06	2.3	.05
% non-white	.42	.18	4.1	.01

Again, the T values indicated correlations at the .01 level of significance for all variables except rural residency, which was correlated at the .05 level of significance, as in Table I. As in Table I, variations in poverty income and median school years completed are most important in explaining

variation in the allocation of MVP. Again, non-white explains only a small portion of the variation, and rural residency is the weakest variable in explaining variation in MVP payments.

The next statistical procedure was to compute Kendall's Coefficient of Concordance. The results were .6 for both the per capita payment and the per cent of the population receiving MVP benefits. These results indicate that the rank orders of the selected variables used to indicate indigency and the rank orders of expenditures and recipients under the medical vendor payments program were significantly correlated. Specifically, the tests of significance revealed that the probability that the ranks are unrelated is .001, or in other words, in an infinite series the chances are one in one thousand that the ranks are not correlated.

Medicare

Tables III and IV summarize the results of the rank order correlations with respect to medicare. The per cent of the population with income below poverty level is positively correlated ($r = +.39$) with per capita expenditures under medicare. The T value of 3.7 indicates that the correlation is significant at the .01 level. As in the case of MVP expenditures, this means that there is less than one chance in 100 that there is no correlation between low

income and per capita expenditures under medicare. The .15 value of r^2 means that only 15 per cent of the variation in per capita expenditures under medicare can be explained by variation in per cent of the population with an income below poverty level.

TABLE III

RANK ORDER CORRELATION OF PER CAPITA EXPENDITURES ON MEDICARE PAYMENTS WITH SELECTED SOCIAL AND ECONOMIC CHARACTERISTICS

1970 Population Characteristics (by county)	r	y^2	t(df 75)	Level of Significance
% with income below poverty level	.39	.15	3.7	.01
% age 65 and above	.85	.72	14.2	.01
Median school years completed (persons over 25)	-.21	.04	-1.7	.05
% with rural residency	.30	.09	2.7	.05
% non-white	-.05	.00	-0.5	NS*

*Not significant.

As one might logically anticipate, the correlation with the greatest level of significance under per capita medicare expenditures is per cent of the population aged sixty-five and above. Changes in the variable explain 72 per cent of the change in medicare expenditures.

As under MVP, median school years completed has a negative correlation with expenditures; however, the -1.7 value of T indicates that the correlation is, only significant at the lower .05 level of significance. With $r = -.21$ yielding $r^2 = .04$, only 4 per cent of the change in medicare expenditures can be explained by changes in median school years completed.

Rural residency has a low-positive correlation, but it is significantly correlated at the lower .05 level of significance. Changes in rural residency explain only 9 per cent of the change in medicare expenditures.

While the proportion of non-white had a positive correlation with per capita expenditures under MVP, per cent non-white is negatively correlated with per capita expenditures under medicare. However, the T value of -0.5 indicates that there is not a significant correlation between the two variables. The r^2 of .00 reaffirms this--virtually none of the variation in per capita medicare expenditures can be explained by variation in per cent of the population non-white.

Table IV reveals that, like per capita expenditures, all of the variables indicative of indigency are similarly correlated to per cent of the population receiving medicare benefits. The values of T indicate that the rank of poverty

income was significantly correlated with per cent of the population receiving benefits under medicare at the .01 level.

TABLE IV

RANK ORDER CORRELATION OF THE % OF THE POPULATION RECEIVING BENEFITS UNDER MEDICARE WITH SELECTED SOCIAL AND ECONOMIC CHARACTERISTICS

1970 Population Characteristics (by county)	r	y^2	t(df 75)	Level of Significance
% with income below poverty level	.44	.19	4.3	.01
% age 65 and above	.97	.93	33.1	.01
Median school years completed (persons over 25)	-.12	.01	-1.1	.05
% with rural residency	.31	.09	2.8	.05
% non-white	-.03	.00	-0.3	NS*

*Not significant.

Again, the variable age sixty-five and above had the highest correlation with a T value of 33.1,which is significant at the .01 level. Median school years completed and per cent with rural residency were both significant at the lower .05 level. Per cent of the population non-white again did not have a significant correlation,and the .00 level of r^2 indicates that virtually none of the variation in per cent

of the population receiving benefits can be explained by variation in the non-white proportion of the population. Hence, all of the variables, with the exception of per cent non-white, are significantly correlated to the per cent of the population receiving benefits under medicare, meaning that indigency is still a significant factor in explaining medicare expenditures. The following chapter will discuss this point in greater detail.

The coefficients of concordance for expenditures and recipients under medicare with the selected social and economic characteristics were .27 and .18, respectively. The test for significance of these coefficients indicates that the probability of the ranks being unrelated is .01, which is to say, in an infinite series, the chances of the ranks being uncorrelated are 1 in 100.

CHAPTER V

CONCLUSIONS

A comparison of the results of the correlations involving the MVP data with the results of the correlations involving the medicare data is contained in Table V. In order to make the comparison, a test of significant differences was performed for the r values of each variable indicative of indigency, using the following formula:

$$T = \frac{r_v - r_m}{\sigma_{D_r}}$$

where v = MVP
m = medicare payments

The term σ_{D_r} (standard error of the difference between the rank order correlations) was computed, using the following formula:

$$\sigma_{D_r} = \sqrt{\left(\frac{1}{\sqrt{77-1}}\right)^2 + \left(\frac{1}{\sqrt{77-1}}\right)^2} = .16$$

If the so calculated T value is greater than 1.96, there is a significant difference between the two coefficients of rank correlation at the .05 level. If T is greater than 2.576, the two correlation coefficients are significantly different at a 1 per cent level.

TABLE V

TEST FOR SIGNIFICANT DIFFERENCES BETWEEN
MVP AND MEDICARE EXPENDITURES

	MVP			Medicare				
	r	r^2	r^2 average	r	r^2	r^2 average	T*	Change
Poverty Income								
Per capita expenditures	.78	.61	.63	.39	.15	.17	2.41	decrease
% receiving benefits	.80	.64		.44	.19		2.16	
Age 65 and over								
Per capita expenditures	.53	.28	.28	.85	.72	.83	1.97	increase
% receiving benefits	.52	.27		.97	.93		2.76	
Median school years completed								
Per capita expenditures	-.77	.59	.61	-.21	.04	.03	3.48	decrease
% receiving benefits	-.79	.62		-.12	.01		4.25	
Rural residency								
Per capita expenditures	.21	.04	.05	.30	.09	.09	.55	none
% receiving benefits	.25	.06		.31	.09		.31	
Non-white								
Per capita expenditures	.44	.19	.19	-.05	.00	.00	3.02	decrease
% receiving benefits	.42	.18		-.03	.00		2.76	

*T value greater than 1.96 means that there is a significant difference at a 5 per cent level, between correlation coefficients.

For example,

$$T = \frac{.78 - .39}{.162} = \frac{.39}{.162} = 2.41$$

in the case of the correlations between per capita expenditures and persons with income below the poverty level. Since $2.41 > 1.96$, it can be concluded that .78 differs significantly from .39, and hence there has been a significant decrease in the correlation between poverty income and health care expenditures. In other words, income below the poverty level has a significantly lesser effect in explaining expenditures under medicare than it did under MVP.

The r values under per cent of the population receiving benefits yield a T value of 2.16, which gives the same conclusion.

In comparing values of r^2, the average value of 63 per cent under MVP dropped to 17 per cent under medicare. This means that under MVP, poverty income accounted for 60 per cent of the observed variation in expenditures, whereas under medicare, poverty income accounted for only 17 per cent of the observed variation. Hence, the effect of poverty income on dollars spent has significantly decreased.

For the correlations between per capita payments and persons aged sixty-five and over, T was found to equal 1.97. Since $1.97 > 1.96$, the effect of the per cent age sixty-five and over has increased significantly from MVP to medicare.

Again, the same result was found by testing the differences in the r terms associated with the per cent of the population receiving payments and the per cent of the population aged sixty-five and over. The average r^2 value has increased considerably,from 28 per cent to 83 per cent. This means that under MVP,old age accounted for only 28 per cent of the observed variation, whereas under medicare,old age accounted for 72 or 93 per cent (average of 83 per cent) of the observed variation. Hence, the effect of old age on health care expenditures has significantly increased.

For the correlation between median years of school completed and per capita payments, T equals 3.48,and hence -.77 differs significantly from -.21. It may therefore be concluded that under MVP there is a good negative correlation, while under medicare there is significantly less negative correlation. The same results were found under per cent of the population receiving payments. The average r^2 values have decreased from 61 per cent to 3 per cent. Thus, education accounted for 61 per cent of the observed variation under MVP, but under medicare education accounted for only 3 per cent of the observed variation. This means that there has been a very significant decrease in the effect of education on health care expenditures.

A very low T value, .55, was observed for the correlation between rural residency and the proportion receiving per capita payments. In this case,.55 $\angle$ 1.96,and hence there was no significant difference between .21 and .30. The test using per cent of the population receiving payment again produced the same results. The r^2 values increased only slightly,from 5 per cent to 9 per cent, which would also lend support to the indication that there has not been a significant change in the effect of rural residency on the expenditure of health care dollars.

For non-white versus per capita expenditures under the two programs, T was found to equal 3.02; hence there is a significant difference between .44 and -.05. Hence, there has been a significant decrease in the correlation between non-white and per capita expenditures. Again the same results were found by testing under the per cent of the population receiving payments. Under MVP, non-white accounted for 19 per cent of the observed variation,whereas, under medicare the proportion non-white did not account for any of the variation in expenditures. Thus, there has been a significant decrease in the effect of non-white in explaining health care expenditures. In fact there is no correlation under Medicare,while there was under MVP.

In summary, while the majority of the r^2 terms were lower for Medicare payments, all of the selected social and economic characteristics (except the proportion of the population non-white) were correlated with expenditures and number of recipients under medicare at least at the .05 level of significance. In other words, the data indicate that, with the exception of the proportion of the population which is non-white, all of the selected social and economic characteristics indicative of indigency were significantly correlated with expenditures and number of recipients under medicare. Since the same social and economic characteristics were also significantly correlated with MVP expenditures and recipients, this suggests that indigency is a significant determinant of the distribution of public health care funds under both the medicare and the medical vendor payments programs. It is also true that the correlation associated with the proportion of persons sixty-five and above was significantly greater in the case of medicare than in the case of MVP. Moreover, the coefficients of determination (r^2) for the remaining characteristics were significantly smaller in the case of medicare than in the case of MVP. This would suggest that indigency is more significant in explaining variation in MVP than it is in explaining variation in medicare expenditures.

Thus, there has been a significant change in the basis for allocation of health care dollars. However, indigency is still a significant factor, although its effect has lessened under medicare. The variable age sixty-five and above, on the other hand, has assumed greater importance in explaining variation in expenditures and recipients under medicare than was true under MVP. It would appear that the fears expressed by the critics of the law--that a substantial proportion of medicare dollars would go to non-indigents--were largely unfounded,since indigency variables are still significantly correlated with health care dollars. If it can be shown that a significant number of persons age sixty-five and above are not indigent, these findings would suggest that because of ideological or other reasons a number of those eligible are not taking advantage of medicare. The appendix presents suggestions for further research which would attempt to determine why some of those eligible do not use medicare.

APPENDIX

SUGGESTIONS FOR FURTHER RESEARCH

Jerry Nelson, Assistant Manager of the Social Security District Office, Oklahoma City, Oklahoma, stated that during the first year following the enactment of medicare, only 88 per cent of those eligible enrolled for the voluntary program. However, in 1971, 93 per cent of those eligible were enrolled.[1] Since the present study concludes that indigency is still a determinate in the distribution of medicare dollars, these figures raise two questions: (1) whether or not there is a substantial number of non-indigents eligible for medicare who are not availing themselves of the law; (2) if so, why are they not taking advantage of the program?

These questions would provide an interesting topic for a more in-depth study of medicare. Since this type of research requires the testing of attitudes, a survey technique is suggested to obtain this information. From records of the Oklahoma State Hospital Association, one hospital could be chosen in each State Economic Area. A random sample of

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[1]Statement by Jerry Nelson, Assistant Manager of the Social Security District Office, Oklahoma City, Oklahoma, July 31, 1972.

persons age sixty-five and over could be sent a survey questionnaire to try to determine how they paid for their medical care and what their attitudes toward medicare are. Questions should be designed so that those who are not availing themselves of medicare fall into one of the following categories: (1) those who have sufficient resources to pay cash for medical services; (2) those who have sufficient insurance coverage through their employer or other private insurance program; (3) those who are impoverished but have not enrolled because of ignorance of the program or intimidation; (4) adherence to the "Protestant Ethic" or other conscientious objection to such a program as medicare; (5) those who find the mechanics of enrollment too much trouble.

SAMPLE SURVEY QUESTIONNAIRE

1. Name_____.
2. Age_____.
3. County of Residence_____.
4. Date of last hospital visit or medical treatment_____.
5. Method of payment: [check method(s) used]
   Medicare_____.
   Medicaid_____
   Private Insurance_____
   Employer Insurance_____
   Cash Payment_____
6. Are you enrolled for Medicare? Yes_____ No_____.

   If answer to above question is no, please indicate reason(s) below:

   I have adequate personal finances to pay medical costs___.

   I have adequate private insurance_____.

   I am adequately covered through my employer_____.

   I have no knowledge of Medicare_____.

   I find enrollment too much trouble_____.

   I do not know how or where to enroll_____.

   I am not enrolled in Medicare because it is against my personal beliefs_____.

   Other (please state):_____.
7. Do you feel that all Americans (every man, woman, and child) should receive free medical care from the government? Yes_____No_____.
8. Do you feel that only persons who cannot afford to pay medical expenses should receive free medical care? Yes_____No_____.
9. Do you feel that the current Medicare system is adequate? Yes_____No_____.
10. Do you feel that it is right for younger taxpayers to pay the medical costs of all persons age 65 and over? Yes_____No_____.

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