Social Surveys and Health Policy
Implications for National Health Insurance

INFORMED JUDGMENTS about the merits of various solutions to the problems of health care delivery in the United States, such as national health insurance, rest on information available about the success or failure of previously enacted programs and the ability to predict the acceptability and impact of new proposals. In this paper we review some contributions that social surveys may make to the formulation of such judgments and provide data from recent national surveys that permit (*a*) some evaluation of the success of precursors to national health insurance—Medicare and Medicaid and (*b*) an overview of the acceptability to consumers of selected national health insurance options.

Banta and Bauman (*1*) point out that although health services research has the potential to influence the health policy decision-making process, such an impact rarely occurs. They cite such reasons as the importance of political rather than technical considerations in policymaking, the absence of a comprehensive health policy, and the poor quality and irrelevance of much health services research. We do not purport to suggest remedies for this considerable range of difficulties. We do, however, provide an example of how one type of often-available data—social surveys of health care consumers—may be used to clarify and inform issues of concern to health policymakers. Elinson (*2*) for example, argues:

> It is probably too much to ask that legislators and administrators defer decision and action on important sociomedical problems until adequate evidence is available. In the first place, there is seldom consensus as to what is 'adequate evidence.' Second, some are more prone to take risks than others. Third, political pressures and humanitarian impulses force or trigger decision and action, even when outcomes are unpredictable. Nevertheless, a persistent rational faith asserts that messes, failures, and unanticipated consequences in general can be reduced if time, effort, and resources are devoted to the prior study, research, and evaluation of proposed solutions of sociomedical problems.

In the literature review that follows, examples of efforts to apply social survey data to evaluate existing and proposed health policy alternatives are summarized. Following that review, data from 1963, 1970, and 1976 national surveys of individual persons' utilization of and attitudes toward medical care are presented in the context of one important currently debated health policy proposal—national health insurance.

Background Literature

Social surveys of people have been employed (*a*) to assess the effects of existing health programs and (*b*) to collect information on the probable outcomes of proposed health policy alternatives. The particular

advantages of using social surveys to address these issues are that (*a*) a consumer's total experience with the health care system can be summarized (*b*) social surveys—unlike clinic records data—enable study of the nonusers as well as the users of the system, and (*c*) attitudes toward the system or toward proposed alternatives can be elicited only by questioning potential participants.

There are, however, also limitations in the use of the social survey method: (*a*) a variety of sources of error may exist in the data, which result, for example, from the method of sampling employed, how the questions are asked, or the response of the person interviewed to the personality or other characteristics of the interviewer, (*b*) the kinds of data of most relevance in health surveys—such as utilization rates, health expenditures, and disability days—may be difficult for respondents to recall accurately, and (*c*) attitudes expressed by respondents may not necessarily be highly correlated with their actual behavior.

Despite these limitations, the social survey method has been used frequently in evaluating health programs enacted during the past 10–15 years. Personal interviews, for example, have been conducted with program recipients, and their experiences and attitudes have been compared with those of nonparticipants. Similarly, data have been collected from other countries and from potential participants concerning the probable effects of the proposed health care innovations. These studies, some of which are summarized here, have been of considerable utility as guides for policy formulation and planning.

Some of the health care programs enacted since

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the early 1960s—such as Medicare and Medicaid—were intended to reduce the financial burden of care-seeking. Others—such as health maintenance organizations (HMOs) and neighborhood health centers —were designed to have an impact on how services were actually delivered. In some evaluations of these programs, the experiences of program participants were compared with those of nonparticipants. Other studies provided trend data on how utilization rates or access measures have changed over time for groups most likely to have been affected by the programs—such as the elderly or low-income persons.

Data from national household surveys conducted by the National Center for Health Statistics (*3*) and the Center for Health Administration Studies (*4*), for example, show that over time the low-income groups have been reporting more physician visits on an average than the high-income groups. These studies point to Medicare and Medicaid as having contributed to these changes. Similarly, in a 1968–69 household interview survey in metropolitan Baltimore, Md., Medicaid recipients reported more physician visits for illness and preventive reasons on an average than did the rest of the population in that area (*5, 6*). According to Roghmann (*7*), data from surveys conducted in 1967, 1969, and 1971 in Rochester, N.Y., showed that the continuous improvement in access for the poorer segments of that community could be traced to Medicaid and other programs enacted over that period. These changes were also reflected in the changed attitudes of the persons affected by the programs. Medicaid recipients, for example, were much more likely than other groups to indicate that they thought it was easier to get access to a physician than before Medicaid and that the quality of care had improved.

Some researchers argue, however, that inequities in terms of use rates relative to experienced need, where people go for care, and the quality of care actually received may still persist. Donabedian (*8*) summarizes results from a number of social surveys and other studies which point to this conclusion. Olendzki (*9*), in a panel study of welfare cases in New York City, found that for this population—which had generous health benefits before Medicaid—the introduction of Medicaid had little subsequent effect on the use of physicians' services. Issues of quality, effectiveness, coordination, and continuity of the care received remained, however. Davis and Reynolds (*10, 11*), through secondary analyses of recent National Center for Health Statistics survey data, reported that certain groups—the poor who are not eligible for Medicaid and nonwhites, particularly those who reside in the South, for example—still use hospital and physician services at lower rates relative to their experienced need for care than do others. These findings, they suggested, document the necessity for supplementary programs to address the special problems of these population groups. Based on an analysis of 1975–76 national survey data, Aday and associates concluded that low-income groups continue to go to hospital emergency rooms and outpatient departments for care at higher rates than do high-income consumers and are still less likely to have one physician as their regular source of care ("A National Survey of Access to Medical Care," 1977, unpublished.)

In addition to focusing on evaluating the success of existing health policy initiatives, social surveys have been used to anticipate the probable outcomes of proposed alternatives for the financing or delivery of care. Newhouse and associates (*12*), for example, using national survey data collected in 1971 by the Center for Health Administration Studies, developed econometric models to predict the effect of various prototypical coverage and coinsurance options on the demand for medical services. In general, they predicted that any program would greatly increase the demand for ambulatory services, with a resulting increased price for physicians' services, queueing, or less physician time per patient. Some researchers have looked to the experiences of other countries that have enacted changes in their mode of financing or delivering care, comparable to changes proposed in the United States, for some evidence of the probable effect of such programs in the United States (*13, 14*). Consumer attitude studies have been carried out—to assess perceptions of the effectiveness of the current health care system and to obtain clues about consumer preferences for developing models of care (*15–18*). Similarly, a recent national survey of physicians by Colombotos and associates (*19*) provided information on the attitudes of the potential providers of care toward various national health insurance options. We compare the attitudes of the physicians in that study with those of consumers in the findings reported here.

In the analyses that follow, 1963, 1970, and 1976 national survey data are presented to (*a*) examine changes over time for groups that have been the special targets of the Medicaid and Medicare programs and (*b*) provide data from consumers regarding their preferences for particular national health insurance options. These analyses provide current data on the impact of existing programs with respect to whether people actually saw a physician during the past year and the extent to which they perceive the U.S. health

care system as being in a state of "crisis" and what the dimensions of such a perceived crisis might be. Such data provide some idea of the current need for innovations in the delivery system, and the data on consumers' preferences for various national health insurance options provide a guide to which proposals for changes presently being considered may be most acceptable to the potential users of care.

The Data

The data reported here are derived from national surveys of the noninstitutionalized population of the United States conducted by the Center for Health Administration Studies (CHAS) and the National Opinion Research Center of the University of Chicago in 1964, 1971, and 1975–76. In 1964 the response rate was 83 percent; interviews were completed for 2,367 families, including 7,803 persons. In 1971 the population was stratified and differentially sampled according to age, income, and residence. The response rate was 82 percent. The final sample consisted of 3,765 families, including 11,619 persons.

In the most recent study, besides the probability sample of the noninstitutionalized population, there were special additional samples of persons experiencing episodes of illness, rural Southern blacks, and Spanish-speaking persons living in the Southwest. These samples were merged and appropriately weighted to provide estimates for the total U.S. population. Unlike the previous studies in which information was collected on all family members in the sample households, in the 1975–76 survey only one randomly selected adult (17 years of age or older) and one child (if there was a child present in the family) were selected for detailed interviews. The total number of individual interviews completed was 7,787, based on interviews in 5,432 families. The response rate for this study was 85 percent.

Infants under 1 year of age and family members who died during the survey year are excluded from these analyses.

The physician contacts in all 3 years—1963, 1970, and 1976—included seeing either a medical doctor (or osteopathic physician) or his nurse or technician at the patient's home; physician's office or private clinic; hospital outpatient department or emergency room; industrial, school, camp, or college health service; or any other clinic, such as a board of health clinic or neighborhood health center. Excluded were telephone calls and visits by a physician to a hospital inpatient. To obtain the physician visit information in 1963 and 1970, we aggregated visits for various reasons—including major and minor illnesses—reported throughout the study year. In 1976, respondents were asked simply to recall their visits to a physician or his agent during the 12 months before the interview. This latter procedure may tend to underestimate the total volume of use, particularly for persons who consult physicians infrequently.

In 1976 the randomly selected adults in the sample were asked whether they agreed or disagreed with the statement: "There is a crisis in health care today in the United States." Respondents who said they "agreed" or "strongly agreed" with the statement were included in the "percent agreeing" category.

Data on levels of dissatisfaction with various aspects of care illuminate the dimensions of the crisis reported to exist by large proportions of the population. In 1976 persons in the sample were asked a series of detailed questions about the actual cost, convenience, and so on of their most recent visit to a physician and then asked to indicate how satisfied they were with the aspects of this particular encounter. People who were less than "completely" or "mostly" satisfied, that is, "moderately," "slightly," or "not at all satisfied," were characterized as "dissatisfied." In 1970 a series of questions were also asked about respondents' attitudes toward the form that any national health insurance program should take. Only responses for persons under 65 years old are reported here, because these persons are the ones most likely to be affected by any pervasive changes in the organization or financing of care. The precise wording of both the 1976 and the 1970 series of questions appears in the appropriate tables in the section on "Findings" that follows.

The poverty level cutoffs for the several time periods are generally based on cutting points for describing low-income families. These cutting points, developed by the Social Security Administration (*20–22*), were multiplied by 1.25 so that a larger proportion of the marginal poor would be included in the below poverty level group.

Insurance coverage is based on whether the respondent reported having "any kind of medical, surgical, or hospital plan that meets any part of a doctor's bill or hospital expenses." This question refers only to private, voluntary health insurance coverage—not Medicare or Medicaid eligibility.

Standard errors for the estimates are presented in parentheses in each table. We computed these standard errors by using the standard error formula for proportion estimates, assuming a simple random sample, and then multiplying the result by the square root of the design effect associated with the

complex, multistage samples used in each time period. That formula is:

$$\text{Standard error of estimate} = \sqrt{\frac{PQ}{N}} \cdot \sqrt{DEFF} \text{ where}$$

P = actual proportion reported in table
$Q = 1 - P$
N = unweighted number of observations upon which proportion is based
$DEFF$ = design effect associated with particular sample.

Andersen and associates (*4*) discuss this approach. Any differences reported in the text that follows represent estimated differences that are significant at a probability level of 80 percent or higher (1.3 standard errors).

The Findings

As discussed earlier, one piece of evidence cited quite frequently to document the impact of Medicare and Medicaid on access is the increase in the proportion of low-income persons seeing a physician during the year. Table 1 shows a small increase between 1963 and 1970 in the proportion of the population overall seeing a physician. From 1970 to 1976 the proportion seeing a physician at least once rose substantially (from 68 to 76 percent). A corresponding trend can be observed for the National Center for Health Statistics data over the same period (*3*). Although this shift may be observed for both income groups, a greater increase occurred for the below poverty level population. Despite the gains by the poor in previous years, in 1976 the proportion of those below the poverty level who saw a physician was still somewhat lower than the proportion of those above the poverty level.

Examination of changes over time for particular age groups permits an assessment of the impact on target populations who might be expected to benefit most from Medicare and Medicaid—the elderly and low-income children, respectively, for example. The greatest increases in the percentage of those over 65 seeing a physician occurred during the period immediately after the enactment of Medicare—1963 to 1970. Since 1970, physician contact rates have remained relatively stable for the over-65 group. The proportion of low-income children seeing a physician increased substantially from 1970 to 1976, however. This increase may reflect the somewhat later enactment of Medicaid legislation in many States, the effects of which were manifested somewhat later than those of the Medicare program. Low-income children continue to be less likely to see a physician than their higher income counterparts, although the gap had narrowed considerably by 1976.

Table 1. Percentage of respondents who saw a physician in 1963, 1970, and 1976, by poverty level and age groups, United States

Poverty level and age groups (years)	*Percent seeing a physician*		
	1963	*1970*	*1976*
Above poverty level	70 (1.0)	70 (1.4)	77 (0.8)
1–15	76 (1.7)	71 (2.5)	76 (1.5)
16–44	68 (1.5)	69 (2.2)	77 (1.2)
45–64	67 (2.1)	69 (3.1)	77 (1.7)
65 and over	70 (3.9)	81 (3.9)	82 (2.2)
Below poverty level	54 (2.3)	59 (2.3)	71 (2.1)
1–15	48 (3.7)	46 (3.7)	68 (3.2)
16–44	55 (4.1)	59 (4.3)	70 (2.8)
45–65	62 (6.2)	68 (5.8)	76 (4.1)
65 and over	65 (5.9)	71 (4.8)	72 (3.9)
Total percent	65 (0.8)	68 (1.1)	76 (0.7)

NOTE: Numbers in parentheses are standard errors of the estimates.

The preceding data suggest that there has been a general increase in the proportion of the U.S. population seeing a physician, that low-income persons particularly have increased their use rates, and that the results for particular age and income categories indicate that Medicare and Medicaid may be responsible for the strengthening of this trend for the target groups served by those programs.

As Roghmann (*7*) points out, utilization data do not always bear out that a crisis exists in the health care system, as perceived by health care consumers. The following table, for example, demonstrates that a large proportion of the population (83 percent) perceives a crisis, even though, as shown in table 1, the proportion of persons seeing a physician is higher than ever before. Relatively similarly proportions of low- and high-income persons perceive a crisis, and no systematic variation among age groups is apparent.

Poverty level and age group (years)	*Percent perceiving a crisis in 1976* [1]	
Above poverty level:	83 (1.0)	
16–44	84 (1.3)	82 (1.1)
45–64	81 (1.8)	
65 and over.....	85 (2.6)	
Below poverty level	85 (2.6)	
16–44	87 (2.9)	87 (2.4)
45–64	87 (4.0)	
65 and over	82 (4.2)	
Total percent	83 (0.9)	

[1] Numbers in parentheses are standard errors of the estimates.

Table 2 shows the primary dimension of the perceived crisis. The out-of-pocket cost of care ranked as the least satisfactory aspect of respondents'

Table 2. Percentage of respondents dissatisfied with various aspects of their most recent physician visit, United States, 1976

Aspects of care [1]	Percent dissatisfied [2]
Cost: The out-of-pocket cost of the medical care received [3]	37 (1.1)
Office waiting time: The amount of time you had to wait to see the doctor, once there	28 (0.8)
Information: The information provided about what was wrong with you or what was being done for you	18 (0.7)
Getting to care:	
The cost of getting to the doctor's office	13 (0.6)
The amount of time it took you to get to the doctor's office	12 (0.6)
Quality of care: The quality of care you felt was provided at that visit	13 (0.6)
Doctor courtesy: The courtesy and consideration shown you by the doctors	8 (0.5)
Nurse courtesy: The courtesy and consideration shown you by the nurse or nurses there [4]	7 (0.5)

[1] Listed in order of percentage dissatisfied, from largest to smallest percentages.
[2] Includes those "moderately," "slightly," or "not at all satisfied."
[3] Respondents who reported no out-of-pocket cost for the visit were not asked this question.
[4] Respondents who had no contact with a nurse were not asked this question.
NOTE: Numbers in parentheses are standard errors of the estimates.

experiences with obtaining medical care. Almost 40 percent of the respondents were dissatisfied with the out-of-pocket cost of medical care. Office waiting time ranked second as the greatest source of dissatisfaction with care-seeking. Complaints concerning the amount of information given by physicians about the treatment they were providing was the next most-often criticized aspect of care, followed by problems associated with actually getting to the physician's office and the quality of medical care being delivered. The least dissatisfaction was expressed with the courtesy and consideration shown the patient by physicians and nurses. This rank ordering of levels of dissatisfaction with various aspects of care-seeking parallels quite closely the relative importance of the various dimensions of the crisis consumers perceived in 1970 also (*15*).

These analyses suggest that although access to medical care has improved as a result of Federal initiatives since the mid-1960s, much dissatisfaction still exists among consumers. The out-of-pocket cost of care continues to be a major source of this consumer discontent. Based on the data summarized in table 2, we review consumer preferences for various options to reduce the financial burden of care. For persons under 65 years of age, we compare those in the best position financially to cover their outlays for medical care—the above poverty level people with private insurance coverage (who comprise about two-thirds of the under-65 age group)—with all others.

Although these data are several years old, it is likely that, as with the perceived dimensions of the health care crisis, consumer attitudes with respect to these questions have remained relatively unchanged. For example, in the 1970 national survey respondents were asked whether they agreed or disagreed with the statement that "Universal government health insurance is necessary because private health insurance has not done an adequate job." Forty-nine percent agreed with this statement. In 1976 a similar proportion (46 percent) indicated that they were *not* "happy with the coverage provided by medical insurance plans." Another limitation we recognize in the kinds of data reported here, however, is that if the questions were phrased differently, perhaps different responses would have been forthcoming. Available findings from other studies that asked similar questions with somewhat different wording are included in the following section also.

Davis (*23*) emphasizes that a number of important issues must be resolved before the adoption of any form of national health insurance. Who should be covered, what should be covered, how should it be financed, and how the providers should be paid are examples of some of the questions that must be answered. Data collected in the 1970 survey concerning consumers' attitudes toward various national health insurance options are considered in the context of these questions, related to existing proposals before the Congress, and, when available, compared with physicians' attitudes toward national health insurance reported in the Colombotos study described earlier (*19*).

The bills currently before the Congress vary in the extent of coverage to everyone in the population. The Kennedy-Corman bill would provide coverage to all U.S. residents through a program administered by the Federal Government and financed by special taxes on earned and unearned income and by general Federal revenues. Other proposals such as the American Hospital Association-supported Ullman bill and the Ford Administration's Comprehensive Health Insurance Plan (CHIP) base coverage to some extent on ability to pay, with benefits extended to employed persons and the medically indigent who could not otherwise afford care (*24*). The responses to question 1 in table 3 suggest consumer

preferences for the options reflected in these various bills. The Kennedy-Corman proposal, for example, is most similar to extending a Medicare-type program to everyone, while the Ullman and CHIP bills place more emphasis on categorical provisions for people who cannot afford to pay for insurance.

A large number of respondents thought that Medicare should be kept as it is (41 percent) or extended only to people who cannot afford private health insurance (35 percent). Only 17 percent of those responding thought that everyone in the country—regardless of financial situation—should be eligible for it. Most likely to suggest that the program be kept as it is were those who currently were best protected from the financial risks of care, the above poverty level people who already had private insurance coverage. Others were more likely to think that the program should be extended to the population as a whole (23 percent) or to persons who cannot afford private coverage (42 percent).

A second question of concern in formulating any national health insurance proposal is what types of services should be covered by the plan. The Kennedy-Corman bill, for example, provides broad coverage for physician, hospital, dental, and drug expenses, and no cost sharing is required of the patient. The Ullman and CHIP proposals provide for a similar range of services to be covered, but more limits are placed on the enrollee in terms of the extent of benefits available and the consumer share of the cost of coverage. The AMA-sponsored Fulton bill does not provide coverage for prescription drugs, and the Long-Ribicoff bill covers only physician and hospital expenses associated with catastrophic illnesses.

The responses to question 2 (table 3) point up that among those favoring keeping or extending Medicare in some fashion, slightly more (53 percent) thought that benefits should be expanded to include all hospital, physician, drug, and dental expenses rather than kept at the present level (46 percent). Few thought that the benefits currently provided should be cut. Most in favor of extending benefits were persons in a less favorable position financially than the insured nonpoor.

A related issue of concern in the national health insurance debate is how the program will be financed. Proposed sources of funds include employee-employer premium payments, payroll taxes (like the current Social Security tax that supports Medicare), general Federal revenues (through increases in income taxes), or tax credits for insurance premiums. In some proposals the private insurance carriers would have primary responsibility for administering the program, and in others the Federal Government would be the primary fiscal overseer. The Kennedy-Corman bill, for example, provides for special payroll and income taxes, with a Federal board to administer the program. The Ullman and CHIP proposals, on the other hand, emphasize the role of private insurance carriers, with the largest sources of revenues coming from employer-employee premiums. The AMA-supported bill also provides for employee-employer premiums and tax credits for premium payments to private carriers for low-income and self-employed persons. The Long-Ribicoff catastrophic plan provides for a mix of federally administered and privately insured coverage supported through payroll taxes on employers and general tax revenues.

The responses to questions 3 and 4 (table 3) are indicative of the mode of financing that may be most favored by consumers. More than half of those who thought Medicare should be extended in some fashion (56 percent) favored some charge to the people getting the coverage. Only 7 percent thought that income taxes should be raised to provide the necessary funding for the program. Another 37 percent thought it appropriate to increase Social Security payroll taxes to pay for the premiums. The above poverty level people with insurance coverage were more likely than the rest of the population to favor charging premiums than increasing Social Security taxes.

As an alternative to the Medicare approach, the population was queried about having the government reimburse families through tax credits, for example, for the amounts they spent on health insurance (question 4, table 3). About one-third of the population favored the reimbursement approach, one-third the Medicare approach, and one-third did not support either approach. The above poverty level people with insurance coverage were more likely to favor a reimbursement system over extending Medicare, and other persons found these proposals equally acceptable.

Concerning provider attitudes, Colombotos and associates (*19*) reported that physicians tended to favor a national health insurance plan that would be administered by private carriers instead of the Federal Government, would be supported by people who buy private health insurance, and would have a tax credit incentive.

A final issue to be considered concerning the national health insurance debate is how physicians will be reimbursed for the services they provide. The Kennedy-Corman bill encourages the development

of a system for reimbursing providers using a fixed per capita payment for persons enrolled in the plan. Most of the other proposals provide for reimbursement according to the usual, customary, or reasonable fees charged by providers—with some regulation of the amounts actually charged.

Although the question for which responses are reported (question 5, table 3) does not capture the political options exactly, about half of the respondents thought that physicians would provide better care if they were reimbursed on the basis of units of service provided rather than in terms of some kind of fixed fee. A large proportion (41 percent), however, thought that how a physician was paid had little effect on the kind of care he rendered, but relatively few (9 percent) believed that physicians on salary would provide the best care. However, the above poverty level insured population was somewhat less likely to favor the salary method of reimbursement than was the rest of the population.

According to Colombotos' study, physicians did not favor reimbursement through fixed annual salaries or per capita payments per patient. They were most in favor of being reimbursed according to their

Table 3. Percentage of adults under age 65 agreeing with respective national health insurance options, by poverty level and insurance coverage, United States, 1970

Questions concerning national health insurance	Percent agreeing		
	Above poverty level with insurance coverage	All others	Total population
1. As you probably know, Medicare is the government-sponsored health insurance for people 65 and over. It is paid for mainly through Social Security taxes on workers and employers. By increasing the taxes that workers and employers have to pay, Medicare could cover other people in the population as well. Do you favor—			
Doing away with the program	7 (1.9)	4 (1.5)	6 (1.3)
Keeping it as it is	45 (3.6)	31 (3.5)	41 (2.5)
Extending it to cover people under 65 who cannot afford their own health insurance	33 (3.4)	42 (3.7)	35 (2.5)
Extending it to cover all people in the country	15 (2.6)	23 (3.1)	17 (2.0)
2. Medicare currently pays for a large part of hospital bills and some doctors' bills for people 65 and over. It could pay for all their medical care, including prescribed drugs and dental care, by increasing Social Security or income taxes or by charging extra premiums. Are you in favor of [1]—			
Keeping Medicare benefits as they are now	49 (3.7)	37 (3.7)	46 (2.7)
Increasing benefits to include all hospital, doctor, drug and dental expenses	49 (3.7)	61 (3.7)	53 (2.7)
Cutting back on what Medicare now pays for	2 (0.9)	2 (1.0)	2 (0.7)
3. What, in your opinion, is the best way to pay for covering more people under Medicare? [2]—			
By increasing the Social Security taxes paid by workers and their employers	35 (4.9)	41 (4.5)	37 (3.3)
By raising income taxes	6 (2.3)	9 (2.6)	7 (1.7)
By charging premiums to the people getting coverage	59 (5.0)	50 (4.6)	56 (3.4)
4. An alternative to extending Medicare to other groups in the population is for the government to reimburse families for what they spend themselves on health insurance, say up to $500 a year. The *lower* the family income, the *more* the government would contribute. Do you favor—			
The government paying families for health insurance costs	34 (3.5)	36 (3.7)	35 (2.5)
Extending Medicare	26 (3.2)	37 (3.7)	29 (2.4)
Do not support either approach	39 (3.6)	27 (3.4)	36 (2.6)
5. Do you think doctors will provide better care for everyone if they are paid—			
A flat monthly salary	8 (2.0)	13 (2.5)	9 (1.5)
According to the amount of treatment they give their patients	49 (3.6)	50 (3.8)	50 (2.6)
How a doctor is paid doesn't affect the kind of care he provides	43 (3.6)	37 (3.6)	41 (2.6)

[1] Persons who said the program should be done away with were not asked this question.
[2] Persons who said the program should be kept as it is or done away with were not asked this question.
NOTE: Numbers in parentheses are standard errors of the estimates.

customary fees but were not unfavorably disposed to being paid a fixed fee for each service, assuming that the fee had been determined by a committee on which physicians were represented.

Since 1970 a number of public opinion polls have included questions concerning consumers' and physicians' attitudes toward various national health insurance options (*25, 26*). For example, in 1974, the results of a Harris poll suggested that 54 percent of the U.S. population favored "a comprehensive health insurance program [that combined] federal government, employer, and employee contributions into one health insurance system that would cover all medical and health expenses." A 1972 Gallup poll question intended to more directly reflect the major bills being considered showed that 22 percent of the population favored "a universal system of health insurance covering everybody and paid for by the federal government out of money raised by taxes"; 40 percent favored "a system of compulsory health insurance covering everybody who has a job and his or her family, with employers and employees sharing the costs, and the federal government providing health insurance only for people who do not have jobs"; 30 percent, however, preferred to keep "the present care system of voluntary health and medical care"; and another 8 percent reported that they did not know which option was the "best."

According to a 1971 Gallup poll of physicians, a surprising 51 percent said they would favor the passage of "some form of national health insurance." As with the Colombotos study, however, the overwhelming majority of physicians (75 percent) preferred that such a program be administered by private insurance companies rather than by the Federal Government.

Summary and Discussion

The preceding analyses are intended to demonstrate the application of social survey data to the evaluation of existing health programs and to the rank ordering of priorities concerning the design of future health policy initiatives.

The data suggest that Medicare and Medicaid have enabled the recipients of those programs to increase their access to the health care system. Further, even though more people are seeing physicians than ever before, a large number of people report that they perceive the American health care system as being in a state of crisis. The out-of-pocket cost of medical care continues to be the greatest source of dissatisfaction among American health care consumers.

National health insurance represents an approach to reducing this persistent financial burden of care-seeking. However, there is no consensus concerning the precise form that such a program should take. When consumers were asked about their preferences for various options that might be incorporated in any national health insurance program, they tended to favor somewhat more conservative and less comprehensive alternatives. For example, the majority of people were not in favor of extending Medicare-type coverage to everyone if it meant that taxes to support such an extension would correspondingly increase. Similarly, a large number (46 percent) thought it unnecessary to extend benefits beyond the present level, although a majority (53 percent) favored expanding coverage to include drugs and dental services. The majority favored charging premiums to people who actually received services to cover the increased costs of expanded coverage. They also thought that physicians would probably deliver better care if they were reimbursed according to the number of services they provided rather than being paid a fixed salary independent of the amount of care rendered.

People who could best afford these more limited options—the above poverty level people with voluntary insurance coverage, for example—were most in favor of them. Persons who were not as well off financially were more in favor of extending government-subsidized coverage.

A survey of physicians' attitudes toward national health insurance suggested that the providers of care tended to favor a system administered by private insurance carriers and, assuming the poor were covered by Federal subsidy, financed by people who buy private health insurance, rather than through a Social Security tax-type system. They also favored a method of physician reimbursement based upon the units of service they provided rather than upon some fixed annual salary or per capita fee.

Further findings from recent public opinion polls concerning national health insurance tend to support these same conclusions about patient and provider attitudes.

In general, social surveys can assist public policy by investigating results of ongoing programs, priorities of the population concerning problems that programs might address, and people's assessment of alternative means to attain policy objectives. Illustrations from a series of national studies suggest that (*a*) access to medical care as measured by number of physician visits has improved, particularly for the elderly and low-income population, (*b*) nonetheless, they con-

tinue to perceive that the health care system is in crisis and to identify out-of-pocket costs and availability of primary care services as major problems, and (*c*) despite this sense of crisis they do not appear anxious to endorse dramatic changes in the way health services are currently organized and financed.

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SYNOPSIS

ADAY, LU ANN (Center for Health Administration Studies, Chicago), ANDERSEN, RONALD, and ANDERSON, ODIN W.: *Social surveys and health policy: implications for national health insurance. Public Health Reports, Vol. 92, November-December 1977, pp. 508–517.*

The authors explore the utility of applying social survey data (a) to evaluate the impact of existing health programs and (b) to rank-order priorities concerning future health care policies. Based on national survey data from 1963, 1970, and 1976, they concluded that although Medicare and Medicaid have enabled more people to see a physician than ever before, a large proportion of the population still registers dissatisfaction with the health care they received—particularly with respect to their out-of-pocket costs for obtaining it. However, national health insurance options favored by the majority of the population—particularly those who can best afford the cost of care—suggest preferences for programs that incorporate some mix of existing modes of financing rather than those that provide for substantial restructuring of the current system.