The Response to Medicare

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IMPLEMENTATION of title XVIII of Public Law 89–97 (Medicare) presented a unique opportunity to study several facets of social change because Medicare is a large-scale innovation in the philosophy and method of payment for health and medical care services for the aged. This paper concerns the response to Medicare by a sample of the older population in five selected Midwestern communities. The focus of this report is on (*a*) awareness of and knowledge about Medicare and (*b*) expressed attitudes toward the program by older people.

Data for this study were collected under the terms of a subcontract with National Analysts, Inc., Philadelphia. Personal interviews were conducted with 2,622 respondents age 60 or older in one metropolitan area, two large cities, and two small cities. The communities were selected to provide information from cities of different sizes with differences in medical care resources such as physician-specialists, nurses, and other professional personnel; facilities, including hospitals, clinics, and nursing homes; and programs, for example, services of visiting nurse associations and local health departments.

The metropolitan area, subsequently referred to as Metropolis, is a city of more than 500,000 population with the full range of medical care resources. Two large cities, Center City and Ozark City, each have a population of approximately 100,000 but differ in the amount and kinds of health resources. Center City has access to a nearby State medical school and affiliated hospital. Two smaller communities, Prairietown and Watertown, are in counties each with a population of about 30,000. Both are centers to which persons come from outlying rural areas for initial medical care. However, Prairietown has more medical care resources than Watertown.

There was very little difference in the distribution of respondents by age or sex in the five communities (table 1). The only statistically significant Negro population, however, was in the metropolitan area. Each of the five communities was divided into segments with approximately the same size population although the size of the segment varied from one community to another. Segments then were selected by random numbers for screening for eligible households. An eligible household was one that had at least one person aged 60 or over who was able to be interviewed and who consented to being interviewed. The proportion of eligible households ranged from 26.4 percent in Center

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City to 38.8 percent in Watertown. The completion rates ranged from 81.4 percent in Metropolis to 87.9 percent in Center City.

Medicare as an Innovation

Much of the literature on social change and the acceptance or rejection of innovations suggests that a wide variety of factors may be important, depending on the nature of the program (*1–3*). Two of the several factors which consistently appear, however, are awareness of the innovation and knowledge about it. Moreover, certain demographic and social factors such as age, sex, and social class—indicators of a combination of influencing factors—frequently are important also (*4*).

There is little question that the provisions of Medicare are innovative in terms of the method of payment for health and medical care services as well as in the range of services and number of persons involved. Furthermore, this program very often has been described, discussed, and debated (*5, 6*), particularly in the mass media. What is more problematic—and the major subject of this paper—is how well the older population was reached by these mass media, what level of factual information was communicated, and what attitudes were formed toward Medicare.

Awareness and Knowledge of Medicare

Our data indicate that the respondents in this survey generally were aware of the program. In response to the question, "Have you heard of Medicare?" which followed a brief introduction about subsidized programs, nearly everyone answered "Yes." The percentages ranged from 98.2 percent in Metropolis to 100 percent in Ozark City. With a range of difference in response this narrow, there would be no appreciable variation by size of community or other independent variable.

However, while awareness of the program was generally high, the amount of specific information about it varied. Respondents were asked whether they agreed or disagreed with three factual statements directly related to individual benefits and one about payment policy not concerning patients. Table 2 shows the percentage of respondents who answered each statement correctly.

For statements related to patient benefits, two-thirds or more of the interviewees gave the correct answer, but there was little consistent variation between communities. Respondents in the two smaller communities, Prairietown and Watertown, generally answered correctly more often than those in Metropolis, but no strong relationship of answers to age distribution or income levels was found. The percentage who stated they did not know the answers to the factual questions also varied little. The "don't know" responses ranged from 5 to 13 percent for the first statement, 11 to 16 percent for the second, and 13 to 21 percent for the third. Within each community, however, correct answers to the three questions varied considerably.

Respondents were much more aware of those aspects of the act which pertain directly to patient benefits and less sure about policies not directly affecting patients. The "don't know"

Table 1. Age, sex, and race of respondents

Characteristic	Total (N=2,622)	Metropolis (N=870)	Center City (N=575)	Ozark City (N=521)	Prairietown (N=372)	Watertown (N=284)
Age group:						
60–64	28. 7	29. 6	30. 0	25. 8	32. 1	25. 9
65–69	25. 0	25. 8	23. 6	25. 2	25. 6	24. 9
70–74	20. 6	20. 2	20. 1	21. 2	19. 7	21. 8
75–79	14. 0	13. 1	15. 0	14. 8	12. 7	14. 4
80 and over	11. 7	11. 3	11. 3	13. 0	9. 9	13. 0
Sex:						
Male	45. 5	42. 8	44. 5	41. 9	48. 3	50. 2
Female	54. 5	57. 2	55. 5	58. 1	51. 7	49. 8
Race:						
White	95. 5	81. 9	97. 9	98. 2	99. 5	100. 0
Negro	4. 4	17. 9	1. 9	1. 8	. 5	0
Other	. 1	. 2	. 2	0	0	0

Table 2. Knowledge of selected aspects of Medicare

Statement	Percent of respondents who answered correctly [1]				
	Metropolis (N=862)	Center City (N=565)	Ozark City (N=515)	Prairietown (N=371)	Watertown (N=281)
1. Under Medicare, the patient may select any physician he wishes. (Agree)	84.2	85.8	88.3	91.9	95.0
2. Persons 65 and over are eligible for Medicare benefits no matter what their income. (Agree)	82.2	84.2	84.1	83.6	77.9
3. Medicare covers the total cost of the patient's hospital bill. (Disagree)	66.5	77.9	76.2	70.4	73.9
4. The Government can tell the physician how much he can charge for treating Medicare patients. (Disagree)	30.0	36.3	29.0	36.0	30.8

[1] Some respondents did not answer all questions.

response was much higher to the question not pertaining to patients, ranging from 39.8 to 43.1 percent.

This marked difference between correct answers to statement 4 and the others may reflect the degree of visibility in Medicare publicity. Information on patient benefits was described more thoroughly than other aspects of the program.

In terms of six other selected independent variables, summaries of the differences in responses to the four statements follow:

1. *Age.* The relationship between age and knowledge about Medicare is curvilinear. The older age groups, particularly those over 80, gave the fewest correct responses along with those under age 65 who tended also to be less well informed about patient benefits. These results were not unexpected because older age groups typically have less factual knowledge about service programs. For persons under age 65, the trend may have been due more to confusion about provisions of a program in which these respondents did not yet participate.

2. *Sex.* The least important source of variation, sex of respondent, did not affect the responses to the first three statements. However, on statement 4, regarding the Government's influence on how much a physician could charge a patient, men consistently gave more correct answers than women although the percentage difference was small, about 6 percent. What seemed more significant was that slightly more than one-third of the respondents could answer correctly at all.

3. *Race.* Since there were too few Negroes in the other communities to include in the analysis, these comments refer only to Negro respondents in Metropolis. With few exceptions, these data indicate that white respondents generally were better versed on the provisions of Medicare than Negro respondents. We do not believe, however, that race per se was the important aspect, but rather it was the interaction of race with social class level and education. That is, Negroes tended to be clustered in lower class families and to have had less formal education.

4. *Marital status.* Except for a fairly consistent trend that married respondents gave more correct responses than those who were widowed, separated, or divorced and those who were never married, marital status was an unimportant influence on knowledge. Relative isolation appeared to be more important than actual marital status. The level of correct information was higher when couples lived together than when the interviewee lived alone.

5. *Social class.* While social class appeared to be the most influential variable, it is also least clear from these data precisely in what ways it influenced knowledge. At one level, higher social class position is associated with more education, thus greater interest in social policy and greater ability to understand the provisions of programs. These data indicate a modest positive relationship between social class and correct answers although there were a few notable exceptions. In one situation middle class respondents gave the most correct answers, but the upper class gave the fewest and consequently reduced the overall differences between the classes. In another situation the highest rate of correct answers was from lower class respondents.

One could argue that the assumed relation-

ship between social class and education does not hold for this generation of respondents, that is, those aged 60 and over, since the phenomenon of education as a springboard to class position is more recent than two generations. Thus, one could attribute the failure of upper class respondents to answer correctly to some statements to other influences, such as stereotyping of Government programs, anti-Medicare advertising, or other ideological biases.

An alternative explanation—and one which seems more reasonable at this preliminary stage of data collection—is that the poor showing by upper class respondents may be indicative of the degree to which Medicare was an important element in their health care programs. It is reasonable to assume that those who are more dependent upon Medicare would be more likely to probe deeper into Medicare literature.

6. *Perceived health status.* During the interview each respondent was asked to rate his own health status. We hypothesized that persons in poor health would be more concerned about health-related matters and, therefore, more likely to be motivated to learn about the provisions of Medicare. In fact, just the reverse was found in these data. When health status was relevant, a relatively consistent, positive relationship was found between knowledge (correct responses) and perceived good health. The explanation, apparently, lies in the greater mobility of healthy older people and their subsequently greater exposure to sources of information including informal conversations with others (7).

Expressed Attitudes Toward Medicare

Considering the extensive exposure to sources of knowledge about Medicare and, for some respondents, subsequent experience with it, assessing the attitudes of the population toward Medicare seemed important. The first question concerning attitude asked of all respondents who had heard of Medicare was "Do you think Medicare is a good idea?" Table 3 shows the distribution of responses to this question.

Again, a substantial majority—ranging from two-thirds to nearly three-fourths—expressed a favorable attitude toward the program. However, many interviewees were unable to express a definite opinion. Ten percent or less of all interviewees did not think Medicare was a good idea.

Favorable responses to the first question about Medicare varied according to age, sex, and social class position of the respondent. In the smaller communities—Ozark City, Prairietown, and Watertown—the older age groups, particularly those over 80, tended to be less favorable. In part this lower rate of favorable response is related to the finding that men were consistently more favorable toward Medicare than women, who have the largest proportion of respondents in the oldest age group. For social class, there is a curvilinear relationship in the three largest communities, that is, the middle and working classes generally expressed a more favorable attitude toward Medicare than either the upper or lower classes. In the two smallest communities, the lower class expressed the most favorable attitude.

The relationship between social class and attitude may be clarified by the responses to "Why don't (or do) you think it is a good idea?" In the three largest cities, upper class respondents most often cited loss of independence as their main objection—perhaps also tied closely to the predominant ideology about how health care services should be provided. There were too few lower class respondents with negative attitudes in the large cities to make any assessment.

However, in the two smallest communities the major objection cited by lower class respondents was they "couldn't afford it (Medi-

Table 3. Responses to "Do you think Medicare is a good idea?"

Response	Total (N=2,614) [1]	Metropolis (N=869)	Center City (N=575)	Ozark City (N=520)	Prairietown (N=372)	Watertown (N=278)
Yes	69.9	73.9	66.9	70.1	69.9	68.8
No	8.5	6.9	10.1	9.7	7.8	7.8
Don't know	21.6	19.2	22.9	20.2	22.3	23.3

[1] Some respondents did not answer the question.

Table 4. Expressed attitudes toward Medicare

Statement	Percent of respondents who agreed [1]				
	Metropolis (N=849)	Center City (N=558)	Ozark City (N=512)	Prairietown (N=368)	Watertown (N=281)
1. Medicare will improve the health care given to older people	82. 8	78. 2	83. 5	84. 2	82. 2
2. Most older people do not need Medicare	18. 4	15. 1	16. 7	19. 0	13. 8
3. Medicare should be for people under age 65 also	47. 0	33. 3	46. 8	37. 4	39. 7
4. Medicare is leading us directly into socialized medicine	33. 2	33. 1	33. 2	28. 9	38. 7

[1] Some respondents did not answer all questions.

care)." This response was inconsistent since in these two communities most lower class respondents eligible for Medicare also participated in part B, the voluntary insurance portion of the act. In the larger cities participation in part B varied directly with social class position.

Favorable response by the majority of respondents was related to two beliefs. The response most often cited by respondents was that Medicare ". . . assures medical care for all who need it." The second most frequently cited response was that Medicare ". . . provides money to pay medical bills." These responses were consistent and stable, irrespective of age, sex, class, or community. The stability of these responses may be illustrated further by the answers to a second series of four statements assessing opinions about Medicare.

These statements and the percentage of persons who agreed are shown in table 4. Thus, respondents in this survey overwhelmingly felt that Medicare would lead to improving the quality (or perhaps, better, increasing the quantity) of health care for their age group. Further, these respondents rejected the negative statement that Medicare was not needed for older persons. On the other two items—basically having to do with the possible outcomes of the present Medicare program—the interviewees were more cautious, as shown by the sharp drop in the number of persons who agreed.

Moreover, there is some question whether the term "socialized medicine" was accurately understood since the percentage who replied "don't know" was highest for this statement, ranging from 27.8 to 39.7 compared with 9.6 to 12.8 for statement 1, 9.4 to 14.1 for statement 2, and 18.1 to 21.7 for statement 3. If one ignores the "don't knows," the percentage who agreed is approximately equal to the percentage who disagreed on statements 3 and 4.

Agreement that Medicare will lead to socialized medicine did not always imply a negative value judgment. Upper class white respondents viewed socialized medicine negatively while lower class, especially Negro, respondents tended to view it positively.

Responses to the questions involving opinions also varied by independent criteria of age, sex, race, marital status, and social class, but to a lesser degree than to knowledge items. Summaries of the relationships of opinions to the five factors follow.

1. *Age.* More of the respondents in the 60–64 age group generally agreed with all the statements, particularly in Metropolis. The oldest age group, those over 80, frequently agreed also with the statements, particularly 3 and 4. Again, the degree of understanding of the term "socialized medicine" may be questioned.

2. *Sex.* Where differences in the answers of men and women appeared, generally men in the larger communities more often agreed with the statement. In the smaller communities, Prairietown and Watertown, women more often agreed with a negative statement. Consequently, men were more consistently favorable toward Medicare and toward expanding it.

3. *Race.* Race was not a significant determinant, in part because only the metropolitan area had a large enough number of nonwhite persons to make any analysis and, in part, because only on statements 3 and 4 were there any sig-

nificant differences. In this case, Negroes more often than white persons agreed that Medicare should be expanded and that it would lead to socialized medicine.

4. *Marital status.* Separated or divorced respondents tended to agree least with statements 1 and 2 and to agree most with statements 3 and 4. To a lesser extent this tendency was partly true also for widowed respondents. There was some inconsistency in that these respondents felt that older people needed Medicare and that it should be extended to other age groups. However, they did not feel Medicare will improve the level of health care. That this was largely uninformed opinion was indicated by the fact that respondents not living with their spouses had least knowledge about Medicare.

5. *Social class.* The most stable relationship shown by social class was that the lower class more often agreed that Medicare would improve the health care, that it was needed by older people, and that it should be extended to other age groups. Responses of the upper classes were just the reverse and, in addition, most often agreed that Medicare was leading to socialized medicine.

Summary and Conclusions

In determining the response to Medicare in terms of (*a*) awareness and knowledge about the program and (*b*) expressed attitudes toward it, data were collected in household interviews with respondents aged 60 and over in five Midwestern communities. The results indicated a thorough awareness of the program and a substantially positive attitude toward it. Variations in amount of knowledge and attitude, however, were traced independently to factors associated with social class, that is, ideological commitment and access to resources. Thus, the lower classes, especially the Negroes in the metropolitan area, and persons living with their spouse were more favorably inclined toward the program while the upper classes and those living alone were less enthusiastic.

Despite these differences—which illustrate again that those with the least knowledge are often more strongly opposed to change—the important conclusion is that the overall response to Medicare, as an innovation in methods of payment for health and medical care services, was positive.

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New Center to Study Economics of Health Care

A center for study of economic and other aspects of health care is to be jointly established by Northwestern University and the American Hospital Association's Hospital Research and Educational Trust.

The new Health Services Research Center, the first of its kind to be established, will conduct and stimulate research on such problems as staffing, financing, planning, organization, administration, and evaluation of health services. Development of cost-reducing methods of reorganizing the delivery of health services was recommended by the Department of Health, Education, and Welfare in "A Report to the President on Medical Care Prices."