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ACCEPTANCE OF VOLUNTARY HEALTH INSURANCE IN FOUR RURAL COMMUNITIES OF HAYWOOD COUNTY, NORTH CAROLINA, 1953

By

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I. SUMMARY AND IMPLICATIONS

The acceptance of voluntary health insurance by rural families was studied in four communities of Haywood County, North Carolina. The extent of enrollment in such insurance of different social and economic groups was examined together with situations which encourage health insurance enrollment. Data were obtained by survey method in June, 1953 for the 299 households (1222 individuals) living in the four communities.

The rural areas of Haywood County had very active voluntary health insurance programs, including the health insurance sponsored by the Haywood Community Development Program. This rural group enrollment program was initiated in the four communities studied, as in other rural areas of the county, in 1951. The Community Development Program (described on page 3) provided a particularly active group basis for enrollment along with the several health insurance programs available through group employment plans and those available on an individual basis.

A relatively high proportion of people in the four rural communities were enrolled. Two-thirds of the 299 households reported some health insurance for one or more persons in the household. About three-fifths of all individuals had such insurance.1/ The high proportion of people enrolled in voluntary health insurance in these rural communities serves as a strong challenge to insurance programs in other rural areas.

Social status characteristics of individuals were studied as to their association with insurance enrollment.

Of the age groups, youth 10-14 years and adults 25-44 years were most frequently enrolled while older youth 17-23 years and persons 65 and over were least often enrolled.

Among the occupational groups; skilled workers; professional, proprietors other than farm, sales workers; and semiskilled workers were highest in enrollment with farm operators, farm laborers, and retired least frequently enrolled.

High associations were found between enrollment in health insurance and each of the following social status characteristics: income, home tenure, education of male head, and social participation score of household heads. These associations were positive in direction with those persons having lower status for each of these characteristics least often enrolled in insurance.

1/ As of the end of 1952, it is estimated that about two-fifths of the total population of North Carolina carried voluntary health insurance. Hay, Donald G. and C. Horace Hamilton. Enrollment in Voluntary Health Insurance in North Carolina, 1953. Progress Report Rs-23, Department of Rural Sociology, North Carolina State College, Raleigh, N. C. September, 1954.

While income was found to be a principal factor associated with enrollment in insurance, other socioeconomic characteristics including tenure, education, and social participation evidenced significant association with enrollment. This suggests the usefulness of insurance programs having a varied approach in their efforts to encourage acceptance of health insurance.

All of the group relationship factors examined, other than family cycle, were associated with enrollment in health insurance.

Those households in which the head was in group employment had particularly high incidence of enrollment in comparison to household heads in nongroup work.

In the residence-occupational groups, rural nonfarm residents were higher in enrollment ratios than the farm families. Part-time farmers were in an intermediate position.

There was a consistent association between families living nearest to each other in their acceptance of health insurance. This held both for enrollment and for insurance drop-outs.

The very marked relationship between group employment and insurance enrollment highlights the relative availability of such a practice in an industrial economy. With an increasing number of rural people commuting to nonfarm jobs having group insurance plans, a ready means of enrollment in voluntary health insurance is at hand for them. They, in turn, will doubtless serve as "neighbor" incentives for enrollment among farmers and others in nongroup employment.

One-tenth of all households had dropped health insurance at some time and were not re-enrolled as of the time of the survey. Those households with lower income, farming, and renting their home most frequently had dropped insurance. Characteristics of "drop-outs" then were in consistent agreement with the findings as to people lowest in being enrolled in health insurance. Those in the lower socioeconomic status group and engaged in farming were both less apt to be enrolled and most likely to drop their health insurance. The fact that the incomes of farmers are subject to more year-to-year variation than those of most wage and salary workers makes it more difficult for them to maintain their enrollment. The variable income situation of farmers also makes it especially desirable that they have the benefits of health insurance coverages.

Informal groups including relatives, neighbors, and fellow employees were named most frequently as a source of information about health insurance. In terms of "where do you think you could get the best information," respondents reported the doctor most often.

A frequent suggestion for further improvement in voluntary health insurance was "need for broader coverages" such as having some office and home calls of doctors included as benefits.

The household heads enrolled in health insurance were more familiar with coverages for hospital services in their insurance policies than with surgical care benefits or with coverages for other medical services. Over one-half erred by ten dollars or more in knowledge of their maximum surgical benefits. About four-fifths of the respondents were mistaken as to what their insurance policy provided in medical services other than for surgery. The lack of information of many household heads as to what benefits were available in their health insurance poses a strong challenge for greater educational efforts so that people will be more familiar with what benefits were available and also as to those benefits not available in their insurance.

Employers and the Haywood Community Development Program were frequently reported as motivational influences on initial enrollment in voluntary health insurance. Doctors were reported most often as the source with whom decisions on enrollment would be discussed. It is doubtless important to note that along with the dominance of certain motivational sources there was a number of different influences cited including health care services, health insurance organizations, formal organizations in the communities, informal groups, and mass media. A varied network of recognized forces now operate in these rural localities relative to acceptance of voluntary health insurance.

The predominant role of group enrollment plans on acceptance is repeatedly indicated. Of the 154 male heads of households enrolled in health insurance, over nine-tenths had enrolled on a group basis. Only one of 81 male heads employed where group enrollment was available stated he did not carry the insurance. In only two of these 81 cases, family dependents of the worker were not enrolled. Apparently strong encouragement for enrollment in health insurance exists in these group employment situations along with high interest of the individual worker and his family in having such coverages.

Two-fifths of all male heads with insurance had enrolled on the group basis sponsored by the Haywood Community Development Program. This strong contribution was accentuated in the particular ability of this Community Development Program to enroll two groups generally less available to health insurance -- farmers and low income households. While farmers and other workers in nongroup employment as well as persons in the lower social status groups were still relatively low in enrollment in health insurance in the four rural communities studied, the Community Development Program's success in enrolling many of them is a challenge to further efforts.

The findings of this survey suggest the usefulness of examining several possibilities for furthering enrollment of rural people in voluntary health insurance. The development of organizational channels to more effectively reach nongroup employees continues to be an urgent problem. It may well be worthwhile to study and identify the characteristics of groups which are favorable to member involvement in health insurance. While strong consumer interest in health insurance is apparent, there are many people unfamiliar with insurance details such as coverages available thereby lacking an effective basis for selecting the insurance program most adequate to their needs.

ACCEPTANCE OF VOLUNTARY HEALTH INSURANCE IN FOUR RURAL COMMUNITIES OF HAYWOOD COUNTY, NORTH CAROLINA, 1953

By

Donald G. Hay* and C. Horace Hamilton**

II. INTRODUCTION

Voluntary health insurance has become an important instrument toward the financing of health care services. Although it is widely asserted that continued extension of voluntary health insurance is needed, adequate data are not available on the extent of acceptance of such insurance by different social and economic groups nor as to the ways acceptance of voluntary health insurance is related to occupation, residence, age, income, types of health insurance available, and to other factors and situations which influence human behavior. There is particular interest in problems related to the extension of voluntary health insurance to persons in nongroup employment which includes a high proportion of the rural population.

Interest in enrollment in voluntary health insurance in North Carolina is in keeping with the major recommendations of the North Carolina Hospital and Medical Care Commission of 1944-45: "More Doctors, More Hospitals, More Insurance."2/

A. Purpose of Study

The present study is an exploratory one designed to probe the following questions:

1. How does the rate of acceptance of voluntary health insurance vary among the various social and economic groups in rural areas?

2. How are status and group affiliation factors associated with acceptance or nonacceptance of voluntary health insurance?

This report gives information on these two indicated purposes of the study. An awareness of the acceptance of voluntary health insurance by different social and economic groups is basic to efforts for increased participation of rural people in such insurance programs.

A further objective of this pilot study was to develop and test

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2/ Poe, Clarence (editor) Hospital and Medical Care for All Our People. Raleigh, N. C. (1947)

methods of study of acceptance of an innovation such as voluntary health insurance. An evaluation of methods of study will be presented later in a separate statement.

B. Method of Study

Efforts were made to select rural localities for study which had had a high exposure to voluntary health insurance. Because of the saturation insurance efforts in rural areas of Haywood County, four rural communities[3] were selected in that county for the pilot survey.

Since a particular emphasis was being placed on group influences in relation to acceptance of health insurance, inclusive locality groups were used rather than a sample of rural households over a wider area. The principal objective of the study was to examine relationship of selected factors with acceptance of health insurance rather than to identify the extent of enrollment in health insurance.

While the four rural communities were selected as being generally typical of all rural localities in Haywood County as to farm-nonfarm employment and land use, no claim is made for these four communities being representative of Haywood County nor for any other area of western North Carolina. In terms of area designs of study, these rural communities therefore constituted four limited universes with data obtained on all their units.

Data as to acceptance[4] of voluntary health insurance were obtained for the 299 households (1,222 individuals) in the four rural communities.[5] Information was procured as to enrollment in health insurance, sources of insurance information, motivations relative to health insurance, and use of insurance in paying for health care services together with data on characteristics of the households and individuals.

Data were obtained by an enumerative survey, using a pretested fixed question schedule, in June, 1953. Information was secured from either the male head of the household or from the homemaker. An interviewing design was used of alternately interviewing the male head and the homemaker of the households so as to obtain data including attitudinal information from an equal proportion of male and female household heads. Interviewers included a graduate nurse, a school teacher, and a college student. A training period for the interviewers was held prior to the survey.

3/ The four localities selected for study are termed "communities" throughout this report primarily to agree with their locally accepted identification. In a sociological orientation, these four localities were more "neighborhood" than "community" in character with none of them having a population center with a complete set of trade and other services.

4/ In this study, "acceptance" is defined as the adoption of the practice of voluntary health insurance; i.e. enrollment in health insurance.

5/ For purposes of testing field enumeration methodology, small random samples of households were interviewed in the village of Hazelwood (38 households) and in the city of Waynesville (28 households).

C. Characteristics of the Localities Studied

Hawyood County is in the southwestern part of North Carolina and borders Tennessee on the northwest. Haywood County is in the Blue Ridge province of the Appalachian Highlands. Although the agricultural areas are comparatively level, the county is predominantly hilly to steep with a large part covered by high rugged mountains.

Waynesville, the county seat, (5,295 population); Canton (4,906); and Hazelwood (1,769) are the largest centers in the county and are sites of industrial plants including one of the largest paper mills in the world, furniture factories, sawmills, a large rubber plant, leather products, and cotton textiles. These industrial plants provide employment, and serve as group basis for health insurance enrollment, for many employees living in the open country as well as for those in the centers.

The four rural communities selected for survey were: Francis Cove, Iron Duff, Upper Crabtree, and West Pigeon. These four communities were open country areas as none of them included a village.

Households with "farm operator" as the major occupation of the head of the household constituted over two-fifths of all households in the four communities (Table I).[6/] Over one-third were "rural residents," that is, households residing in the open country but whose head did not have farming as a major occupation. Over one-fifth were part-time farmers.

Individuals in the working age group of 20-64 years constituted one-half of the total population in the four communities (Table II). Persons in the older age group of 65 years and over made up about 1 of every 14 individuals.

D. Voluntary Health Insurance Programs in the Localities

In addition to the health insurance programs available through group employment plans and those available on an individual enrollment basis, the four communities were part of the voluntary health insurance activities developed by the Haywood Community Development Program.

This Community Development Program was activated early in 1949. "To find out the major needs of the rural people in Haywood County, and as a way of fulfilling these needs, a Community Development Organization was set up within the county to do this work, with all paid agricultural workers within the county working with the Community Development Organization on the major needs of the county....the ultimate objective of the Community Development Program as set up is 'Better Living for Rural People' with increased farm income as one of the immediate objectives."[7/]

6/ Detailed tables are referred to by Roman numerals and are in Appendix A of this report.

7/ Annual Report of County Agent, Haywood County, 1949, p. 2.

The objectives of this program were later stated as including: '(1) increased income, (2) improved educational opportunity, (3) better rural religious life, (4) full development of community organizations, and (5) improved rural standards of living.' 8/

The Haywood Community Development Program was organized in each of the 26 rural communities of the county. Each organized community has a regular monthly meeting devoted to community problems, projects, and recreation. Officers in each community are: chairman, vice-chairman, secretary, treasurer, and reporter. The county-wide organization of the Community Development Program consists of a chairman, vice-chairman, secretary, treasurer, and reporter together with a twelve member board of Directors equally represented by men and women and also as to open country and village residence. 9/

Group enrollment in voluntary health insurance was a specific undertaking of the Haywood Community Development Program. "The officers and directors of the Community Development Program are very much interested in securing for the rural people of Haywood County the same benefits received by industrial and common-employer groups in the county on group hospital and surgical insurance.

"After much consultation with different insurance companies, the State Insurance Commission, and others, a group plan was finally decided upon and the community officers and leaders put this program across, with a total of 1,444 family and individual policies.

"This is the first time in the history of North Carolina that a rural group has succeeded in getting group hospital and surgical insurance comparable with the employee-employer groups. This was possible only through the hard work of community chairmen and leaders of the county organization.

"It is felt that this will mean much to the health and welfare of the rural people of Haywood County for years to come." 10/

The group enrollment in health insurance through the Haywood Community Development Program started functioning in June, 1951. For the first year, the insurance was carried with a commercial insurance company with coverages for hospital and surgical care. In June, 1952; one of the nonprofit agencies in North Carolina (Hospital Saving Association of Chapel Hill, N. C.) became the insurance carrier for the Community Development Program with Blue Cross Program for hospital care, Blue Shield for surgical services, and some coverages for in-hospital medical expenses other than surgery. 11/

8/ Annual Report of County Agent, Haywood County, 1953, p. 1.

9/ Data on organizational features from Annual Reports of County Agent, Haywood County for 1949 and 1950.

10/ Annual Report of County Agent, Haywood County, 1951.

11/ As of January, 1954, and therefore subsequent to the field survey, Hospital Care Association of Durham, N. C., became the insurance carrier for the Haywood Community Development Program. This nonprofit agency has a Blue Cross program for hospital care and also insurance for surgical care and for some in-hospital medical expenses other than surgery.

This group enrollment program was initiated in the four communities, as in the other rural communities of the county, in 1951. In each community, a local person serves as chairman for the health insurance activity with responsibilities for collecting the periodic premiums quarterly and for furnishing information on such insurance.

The strong local support for this voluntary health insurance program is reflected in each of the communities achieving the necessary 75 percent enrollment of all families in order to quality for the group enrollment arrangements in 1951.

Voluntary health insurance was also carried by people in the communities through several group employment plans. Information as to enrollment of male heads of households and homemakers showed that 18 different industrial companies and other commercial firms served as employment group bases for enrollment. Six of these 18 employer firms accounted for most of the household heads group enrolled where they were employed.

Health insurance on an individual basis was not particularly active. Of the male heads and homemakers carrying health insurance, only 24 or 8 percent of all those insured were participating on an individual enrollment basis. However, these 24 individual enrollees were represented in 17 different health insurance companies. Only one insurance company had as many as four individual enrollees.

One may well conclude that a highly varied program of voluntary health insurance was represented in the communities. However, the health insurance available through the Haywood Community Development Program and through six of the employer firms was the basis of enrollment of most individuals and households carrying insurance.

III. ENROLLMENT IN HEALTH INSURANCE

A. Extent of Enrollment

At the time of the survey (June, 1953), two-thirds of the 299 households in the four rural communities reported health insurance[12] for one or more persons in the household. Nearly three of every five individuals were reported to have such insurance.

Insurance toward costs of hospital care and for physician's services for surgery were the predominant types of coverages (Table 1). The proportions of population enrolled in hospital and surgery coverages are practically identical.

Disability benefits (and/or workmen's compensation) and school accident insurance, as noted earlier, are two types of coverage which are often not included as voluntary health insurance. In the four rural communities, these coverages were usually held along with other types of health insurance. Only 34 (3 percent) of all individuals were enrolled in these two coverages only.

Of the 195 households reporting some enrollment in health insurance, 7 of every 10 had all members of the "main family"[13] enrolled; about 1 of every 6 households had some but not all members of the "main family" covered in the insurance; and in less than 1 of every 6 enrolled households other persons than "main family" members were the individuals having voluntary health insurance coverage. This latter group includes nonfamily households as when a household head was living alone or with nonrelatives only.

B. Factors Related to Enrollment in Health Insurance

In setting up the survey, it was decided to examine the relation of two general types of characteristics, social status and group relationships, as to their relationships to the acceptance of voluntary health insurance. The generalized hypothesis was that acceptance of such insurance is related to status and group relationships.

12/ For this survey voluntary health insurance was defined as embracing all forms of prepaid health care including insurance for hospital, surgical, limited medical care, comprehensive health care, disability, workmen's compensation, and school accidents.

If an individual had any of the given types of health insurance coverage, he was considered to be enrolled in voluntary health insurance. No attempt was made to evaluate the adequacy of health insurance coverage.

If one or more individuals in any household carried any health insurance, the household was considered as enrolled in such insurance.

13/ "Main family" includes those families in which the family head, i.e., male head and homemaker, are also the heads of the household. A family was defined, as in the 1950 Census, as "a group of two or more persons related by blood, marriage, or adoption and living together."

Table 1. ENROLLMENT IN VOLUNTARY HEALTH INSURANCE COVERAGES REPORTED FOR HOUSEHOLDS AND INDIVIDUALS IN FOUR RURAL COMMUNITIES OF HAYWOOD COUNTY, 1953

Types of Health Insurance Coverage	Percent of Households Reporting Enrollment (293 households reporting)	Percent of Individuals Reporting Enrollment (1200 individuals reporting)
Hospital insurance	53	50
Surgical insurance	52	49
Other medical insurance 1/	3	1
Disability benefits insurance 2/	34	11
School accident insurance 3/	25	15
Other health insurance 4/	1	1
Does not have health insurance	36	44

1/ Includes specified benefits for the costs of physician's services in hospitals other than for surgery.
2/ Includes disability cash benefits for accidents and/or sickness available from insurance carriers and coverages for medical and hospital services provided in the North Carolina Workmen's Compensation program.
3/ Includes the accident coverage available for school pupils.
4/ Includes such special insurance coverages as polio care, nursing services, etc.

Several more specific indices of each of these general characteristics were used. The social status factors used were age, sex, household status, occupation, tenure, education, social participation, and income. In the group relationship area, characteristics studied were employment basis, residence-occupation, family cycle, community of residence, social participation, and types of community group affiliation.

1. Social status characteristics - As used here, social status is considered with reference to particular patterns of behavior which involve rights and duties for individuals. For example, the age characteristics of any individual bring into play a whole set of anticipated behaviors both on the individual's part and in terms of other people's reactions to the individual.

The objective at hand, then, is to examine enrollment in voluntary health insurance in relation to social status characteristics of individuals and of households.

Age - Enrollment in health insurance varied[14/] by age of individuals (Table III and Figure 1). The relatively low percent of children under 5 years enrolled will reflect in part the practice followed by many insurance carriers at the time of the survey, of not writing such insurance for infants under two months or even older.

A particularly high coverage was found for children in the 10-14 age group.

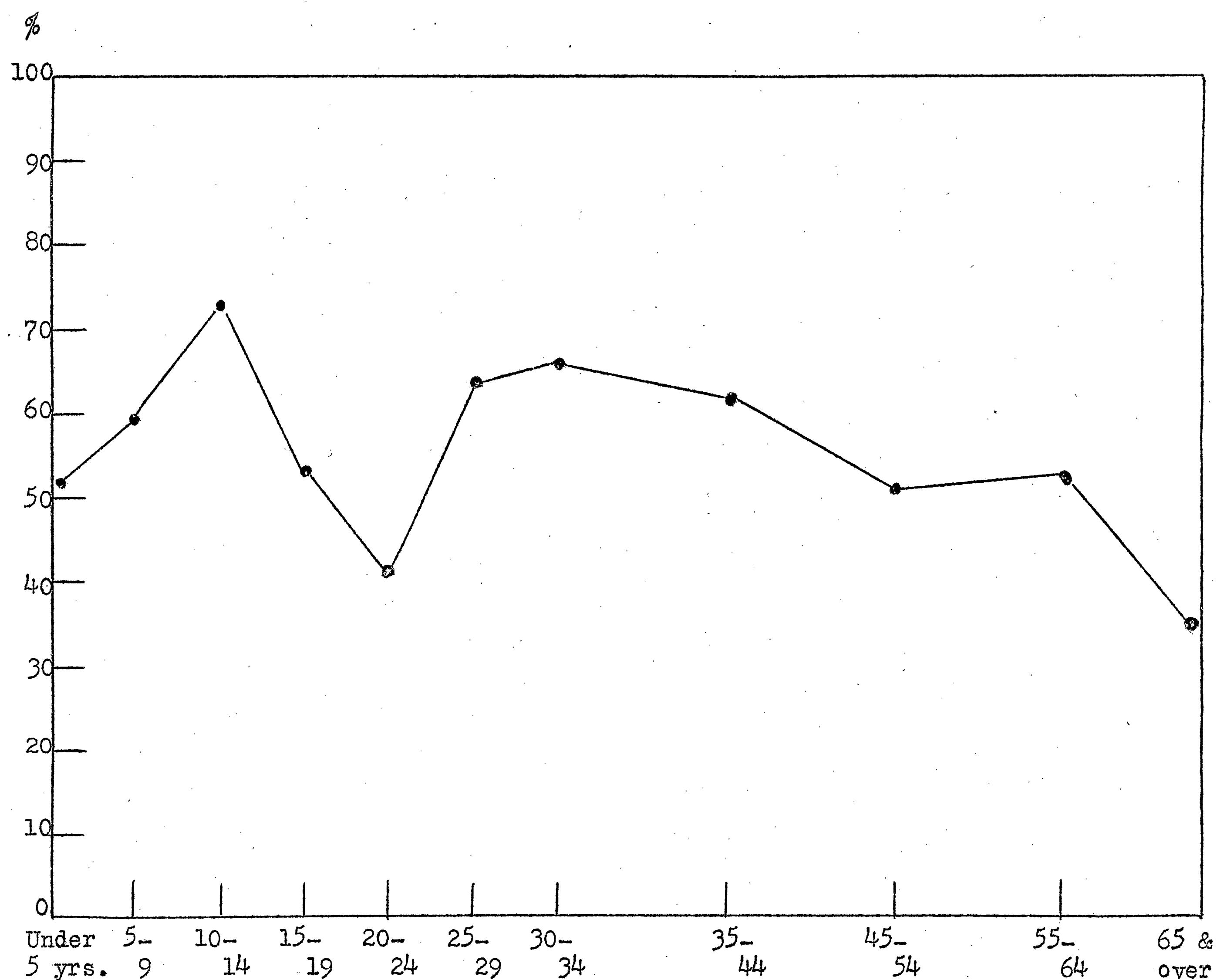
There was a pronounced drop-off in enrollment for older youth -- particularly those 17-23 years. This loss is doubtless contributed to by: (1) the ceiling of 19 or 20 years as age limit for dependents in a family unit coverage and (2) the college and university attendance of young people and their consequent availability to health care programs of these educational institutions. The high loss of enrollment in health insurance of this age group is, however, a serious challenge to insurance programs. A break in any pattern of behavior requires extra effort to re-establish former practices such as being enrolled in insurance.

Persons in the older ages, 65 and over, were less frequently enrolled in health insurance. The proportion enrolled dropped from 53 percent for the 55-64 age group to 38 percent for those 65 years and older.

14/ In this report, differences between percentages are considered "statistically significant" if they are at the 5-percent level of significance. Such differences are referred to as "statistically significant" or as "significant."

For testing significant differences among percentages, the binomial probability graph procedure designed by Mosteller and Tukey was used. See Mosteller, F. and Tukey, J. W. "The Uses and Usefulness of Binomial Probability Paper." Journal of American Statistical Association, 44: 174-212 (June, 1949).

Figure 1. PERCENT OF INDIVIDUALS ENROLLED IN VOLUNTARY HEALTH INSURANCE BY AGE GROUPS IN FOUR RURAL COMMUNITIES, 1953



Sex - There were no significant differences in enrollment between men and women. In the four communities, 58 percent of all men were enrolled and 56 percent of all women were enrolled in health insurance.

Household status - There were no statistically significant differences among male heads, wives of heads, children of heads, or other relatives of heads in enrollment incidence (Table 2). However, "female heads" (widows and other situations where household did not have any male head) and "parents of heads or wives" were relatively low in enrollment. It will be noted that there were only a limited number of cases of these latter groups.

This same association of relation of individual to household head to enrollment was shown when residence-occupation was held constant and also when home tenure was kept constant.

Occupation - Those rural households in which the household head was engaged in skilled and semiskilled occupations ranked highest in being enrolled in health insurance. Of all the employed household heads in the 4 rural communities, farm operators were lowest in health insurance enrollment.

Similar association are indicated between occupation and insurance enrollment of individuals (Table 3). Individuals in skilled work led in enrollment (85 percent) followed by those in semiskilled occupations (75 percent). The "white collar" workers ranked next highest of those gainfully employed (68 percent). As in the cases of households, individuals who were farm operators were relatively low in enrollment percentage (40 percent) followed closely by wage and family farm laborers (38 percent).

Home tenure - Tenure of the head of the household was an important factor in the health insurance enrollment situation. Home ownership was directly and statistically significantly associated with percent of households and individuals enrolled. Among the 207 households in the 4 rural communities owning their home, about three-fourths were enrolled while less than half of the 86 renter households were enrolled (Table 3).

In owner households, 66 percent of all individuals were enrolled while only 37 percent of the individuals from renter households were enrolled.

The association of tenure with insurance was very marked when residence-occupation of household was held constant. (Table IV.) For individuals from farm households, over one-half of the individuals of owner households were enrolled while only 22 percent of those from renter homes were enrolled. For persons from part-time farms, a slightly greater difference by tenure was shown. Among individuals from rural resident households, the tenure differential in enrollment was less but still statistically significant.

Table 2. INDIVIDUAL ENROLLMENT IN VOLUNTARY HEALTH INSURANCE BY HOUSEHOLD STATUS, FOUR RUAL COMMUNITIES, 1953

Household Status	Individuals	
	Total Number Reporting	Percent Enrolled in Health Insurance
Male head	271	57
Wife of head	252	56
Female head 1/	29	45
Child of head and/or wife	584	60
Parent of head or wife	24	29
Other relative of head or wife	60	57
Nonrelative of head	2	a/

1/ "Female head" includes those households having a female head but no male head. Widows accounted for many of such "female head" households.
a/ Insufficient number of cases for determining percentage.

Table 3. ENROLLMENT OF HOUSEHOLDS AND OF INDIVIDUALS IN VOLUNTARY HEALTH INSURANCE BY SELECTED SOCIAL STATUS CHARACTERISTICS, FOUR RURAL COMMUNITIES, 1953

	Households		Individuals	
Social Status Characteristics	Number Reporting	Percent Enrolled in Health Insurance	Number Reporting	Percent Enrolled in Health Insurance
Major Occupation 1/				
Professional; proprietors, managers, & officials; clerical, sales, & kindred workers	17	a/	47	68
Farm operators	145	51	148	40
Skilled workers	58	90	60	85
Semiskilled workers	30	83	48	75
Farm laborers: wage & family	0	---	47	38
Service & unskilled laborers	7	a/	7	a/
Housewives	17	a/	276	52
Retired	14	a/	32	34
Unemployed	0	---	18	a/
In school: student	0	---	309	70
Preschool	0	---	193	50
Home Tenure 2/				
Owner	207	74	789	66
Renter	86	45	396	37
Net Cash Income of Household				
Under $1500	124	39	456	30
$1500-2499	54	76	227	54
$2500-3999	53	91	238	82
$4000 and over	45	100	202	90
Education of Male Head of Household				
Under 7 grades	74	46	353	35
7 - 11 grades	146	74	597	65
12 grades and over	39	87	146	82
Education of Homemaker				
Under 7 grades	65	45	324	38
7 - 11 grades	165	70	655	59
12 grades and over	61	82	164	73
Social Participation 3/ of Household Heads				
Under 10 score	39	33	180	31
10 - 29 score	167	64	660	54
30 score and over	93	81	360	73

a/ Insufficient cases for determining percentages.

1/ "Major occupation" was defined as the gainful employment from which the individual received the largest part of his income during the past twelve months. The major occupation of the household head was used to determine the household "major occupation."

2/ Excludes "other" tenure situations where house was occupied on other than owner or renter basis such as when use of house is part of cash wages of worker, etc. There were 6 "other" tenure households involving 15 individuals.

3/ Based on Chapin Scale for participation in formally organized groups: 1 point for membership, 2 for attendance, 3 for contributions, 4 for committee membership, and 5 for officer.

With income held constant (Table IV) a significant association was found between home tenure of individuals and enrollment in health insurance for those with incomes under $2500. For the upper income households, small but consistent association of tenure and enrollment continued.

When education of male head was held constant (Table IV), tenure was statistically significantly associated for those in the lower education group and there was a small but consistent association of tenure with enrollment for those households with male heads having 7-11 grades of schooling.

With social participation scores of household heads held constant, a statistically significant association was evidenced of tenure with insurance enrollment. Individuals from owner households had higher incidence of enrollment than those of renters when their social participation scores were similarly matched.

Income - A direct and highly significant statistical association was evidenced between income and insurance enrollment in the four rural communities (Table 3). As net cash income for the preceding year went up, there was a higher proportion of households and individuals enrolled in voluntary health insurance. The degree of association of income with enrollment was more marked than for any other status or group relationship factor which was examined.

Under the partial association analysis presented in Table V, a positive and quite marked association of income with enrollment was demonstrated when residence-occupation was held constant. Of the individuals living on full-time farms, 3 of every 10 in households of less than $1500 income were enrolled while over 7 of every 10 with $4000 and up had health insurance. Similar statistically significant differences were found by income groups of those persons in part-time farm and rural resident households.

A positive and statistically significant association of income with health insurance enrollment was evidenced when tenure groups were held constant (Table IV). For individuals from owner households, about 4 of every 10 of those from households having less than $1500 income were enrolled while in the upper income groups ($4000 and over), 9 out of every 10 had health insurance. In the case of tenant households, about 2 in every 10 of those under $1500 had insurance while for those in the upper income group nearly 9 of every 10 were enrolled.

With education of the male head held constant (Table V), there was a consistent and usually significant association of income and enrollment. This association was most marked for individuals where the male head had 12 grades or more schooling.

Education - The extent of formal schooling of the male head and homemaker in the households was found to have a positive and statistically significant association with proportion of households and of individuals enrolled in health insurance (Table 3). The incidence of enrollment was nearly double for households and for individuals where the heads had completed high school as contrasted to where less than 7 grades were completed.

With residence-occupation kept constant (Table VI), education of male head was positively and significantly linked with enrollment. For farm individuals, only a fourth were enrolled where less than 7 grades were completed while for those where male head had completed high school over 6 in every 10 individuals had health insurance. The same marked association was found for education when those individuals from part-time farm and rural resident households were compared.

A positive and significant association of educatiom with health insurance was evidenced when tenure was controlled (Table IV) and also when social participation was kept constant (Table VI).

With income held constant (Table VI), there was a mixed situation in the association of education and enrollment. For lower income groups, under $1500 and $1500-2499; the evidenced linkage of education was generally consistent but small, while for the two highest income groups there was a marked significant association of education with incidence of insurance.

Social Participation - A direct and statistically significant association was found between social participation activity of household heads and incidence of enrollment in health insurance (Table 3). Those households and individuals with lowest participation scores of household heads were less than half as frequently enrolled as those with highest participation.

With residence-occupation held constant (Table VII) and similarly for tenure (Table IV) and also for education (Table V), there was a positive and significant association of the social participation score with acceptance of insurance.

Summary --- Social Status and Enrollment in Health Insurance

All of the specific indices of social status which were examined evidenced an association with extent of health insurance enrollment except sex (Table 4).

Among the age groups, youth 10-14 years and adults 25-44 years were most frequently enrolled in health insurance. Older youth 17-23 years of age and persons in the older age group, 65 years and over, were least often enrolled.

Children of household heads, male heads, wives, relative of heads other than parents, and children were most frequently enrolled as compared with female heads of households or with the parents of household heads.

Table 4. SUMMARY OF ASSOCIATIONS BETWEEN SOCIAL STATUS CHARACTERISTICS OF INDIVIDUALS AND THEIR ENROLLMENT IN VOLUNTARY HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Social Status Characteristics	Group Differentials in Enrollment 1/			
	High Group	Percent	Low Group	Percent
Age	10-14 yrs.	74	20-24 yrs.	41
	25-44 yrs.	74	65 yrs. & over	38
Sex	(No significant differences) 2/			
Household Status	Male heads	57	Female heads	45
	Wives	56	Parents of heads	29
	Children	60		
Occupation	Skilled	85	Farm operators	40
	Semiskilled	75	Farm laborers	38
	Professional, prop., mgrs., sales	68	Retired	34
Tenure	Owner	66	Renter	37
Income	$4000 & over	90	Under $1500	30
Education of Male Heads	12 grades & over	82	Under 7 grades	35
Social Participation of Household Heads	30 score & over	73	Under 10 score	31

1/ Differences in proportions between groups were at the five percent or less level.

2/ Differences in proportions between groups were <u>not</u> at the five percent level.

Among the occupational groups, skilled workers; professional, proprietors other than farm, salesworkers; and semiskilled workers were highest in enrollment ratios. Farm operators, farm laborers, and retired persons least frequently had voluntary health insurance.

Highly significant statistical associations were found between extent of enrollment in health insurance and each of the following social status characteristics: income, home tenure, education of male head, and the social participation score of household heads. These associations were positive in direction with individuals having the lower status on each of these characteristics being least frequently enrolled in health insurance.

2. Group relationship characteristics - The group affiliations of individuals, and particularly household heads, were considered to play a very important role on the acceptance of health insurance. This role was assumed to function in two important ways: (1) groups including industrial plants and other work groups serve as the basis of insurance enrollment and (2) participation in groups is an important carrier of ideas about insurance.

As indicated earlier, group relationship characteristics studied were employment basis, residence-occupation, family cycle, community of residence, social participation, and types of community group affiliation.

Employment Basis - Those households in which the heads worked for a firm having five or more employees had health insurance most frequently (91 percent) as contrasted to where the head was farming, self-employed, or in a firm having less than five employees (49 percent). The work group then showed a particularly active role in the acceptance of health insurance.

Residence-Occupation - The three broad residence-occupation categories of (1) open country—farm, (2) open country—part-time farm, and (3) open country—rural resident[15] — indentify somewhat distinctive groupings as to availability of household head to nonfarm employment. Nonfarm work, in turn, is generally recognized as most favorable to providing a work group basis for health insurance enrollment.

There are probably differences in these three residence-occupation groups in information interaction relative to insurance. Nonfarm jobs, as compared with farming, usually involve more contact with other people and provide opportunities to exchange ideas and points of view relative to such a practice as health insurance.

15/ Household heads residing in the open country who did not have farming as either a major or part-time occupation.

Enrollment in voluntary health insurance differed significantly with residence-occupation of the households (Table 5). Rural resident households were most frequently enrolled (80 percent) followed by those in part-time farming (67 percent) and with households having the head engaged in farming as major occupation being less (52 percent) often enrolled in insurance.

In the case of individuals, the same significant association obtained between residence-occupation and enrollment.

A direct and usually significant difference in insurance enrollment between farm and rural resident individuals was demonstrated when each of the following characteristics was individually held constant: tenure, income, education, and social participation (Tables IV - VI). Usually part-time farm persons were in an intermediate position in the percentage accepting insurance.

Family Cycle - Households in the "all adult" stage of the family cycle, -- that is, with husband and wife only and the wife 40 years old or older, -- were lowest, but not statistically significantly, in enrollment in health insurance (Table 5). There was a generally similar pattern of enrollment incidence for households in other family cycle stages.

Community of Residence - Among the four communities, there was a range in enrollment from about one-half of all households in the community ranking lowest to four-fifths of all households in the community which had the highest ratio of households enrolled. Examination of the distribution of households in each of these four communities by residence-occupation, income, and education indicated that variance in enrollment ratios of the communities was apparently a consequence of the household distribution by these characteristics. As indicated earlier, these factors showed a consistent and significant association with acceptance of insurance.

Role of nearest household - As indicated in methods of study, inclusive locality groups were used in this survey since emphasis was placed on examining group influences in relation to acceptance of health insurance.

Limited sociometric analyses were made of the role of nearest households in the enrollment situation. At the time of the field survey, a map was made for each of the four communities with respondent household located in place. These households were then later identified on each map by the following insurance acceptance categories: (1) one or more household members enrolled in health insurance, (2) household has not enrolled in insurance, and (3) household member has dropped health insurance and household not re-enrolled.

After all households were identified on the map according to this three-way enrollment classification, they were checked as to the enrollment category of nearest household. The "nearest household" was determined in terms of road distance between dwellings.

Table 5. ENROLLMENT OF HOUSEHOLDS AND OF INDIVIDUALS IN VOLUNTARY HEALTH INSURANCE BY GROUP RELATIONSHIP CHARACTERISTICS, FOUR RURAL COMMUNITIES, 1953

Group Relationship Characteristics	Households		Individuals	
	Number Reporting	Percent Enrolled in Health Insurance	Number Reporting	Percent Enrolled in Health Insurance
Employment Basis of Household Head				
Nongroup employment	185	49		
Farm operator	145	51		
Nonfarm, self employed	15	a/		
Nonfarm, work for someone else, nongroup1/	8	a/		
Housewives	17	a/		
Group employment2/	99	91		
Residence-Occupation of Household Head				
Open country--farm	128	52	495	41
Open country--part-time farm	66	67	284	56
Open country--rural resident	105	80	421	74
Family Cycle of Main Family				
Husband and wife - no children, wife under 40 years	10	a/		
Husband and wife - oldest child under 6 years	30	70		
Husband and wife - oldest child 6-13 years	65	66		
Husband and wife - oldest child 14-17 years	83	72		
Husband and wife - no children, wife 40 years and over	70	64		
All other households	39	49		
Social Partifipation of Household Heads				
(See Table 3)				

a/ Insufficient cases for determining percentages.
1/ Work for someone else in nonfarm work but less than 5 persons employed by firm.
2/ Employed in groups of five or more persons. These were all nonfarm work situations in the localities surveyed.

There was a marked tendency in the four communities for households to be in agreement with nearest household as to acceptance of voluntary health insurance.

Of the households enrolled in insurance, about 8 in every 10 had a nearest household also enrolled. For those households which had not enrolled in insurance, nearly 7 in every 10 had nearest household similarly not enrolled. Finally for those households who had dropped health insurance and not currently re-enrolled, over 6 of every 10 had nearest household not enrolled in insurance.

Social Participation - The role of organizations as a communication channel for information concerning health insurance and the place of organizations, particularly the Haywood Community Development Program[16] as an enrollment basis are both involved in the indices of social participation.

As indicated in the examination of social status characteristics, a direct and statistically significant association was evidenced between social participation score of male head and homemaker and incidence of enrollment in health insurance (Table 4).

Types of community group affiliation - A pronounced association, as would be expected, was found between affiliation in the Haywood Community Development Program and enrollment. Of those households in which male head and/or homemaker were participating in the Community Development Program, about four-fifths were enrolled while only a little over one-half of households affiliated in organizations other than the Community Development Program were enrolled.

Summary ---- Group Relationships and Enrollment in Health Insurance

Group relationship factors, other than family cycle, were associated with extent of enrollment in voluntary health insurance. (Table 6.)

Households in which the head was in group employment had particularly higher incidence of insurance enrollment as compared to where the head was in nongroup employment.

Among the residence-occupational groups, the rural resident was statistically significantly higher in enrollment ratios than were farm individuals and households. Part-time farmers were in an intermediate position.

There was a consistent tendency for households to be in agreement as to acceptance of health insurance with the nearest located households. This held for enrollment, nonenrollment, and for those who had dropped such insurance.

16/ The Haywood Community Development Program was the only organization reported serving as a nonwork group for enrollment in health insurance in the 4 communities.

Table 6. SUMMARY OF ASSOCIATIONS BETWEEN GROUP RELATIONSHIP CHARACTERISTICS OF INDIVIDUALS AND THEIR ENROLLMENT IN VOLUNTARY HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Group Relationship Characteristics	Group Differentials in Enrollment 1/			
	High Group	Percent	Low Group	Percent
Employment Basis	Group employment	91	Nongroup employment	49
Residence-Occupation	Rural Resident	74	Farm	41
Family Cycle	(No significant differences) 2/			
Social Participation of Household Heads	30 score and over	73	Under 10 score	31

1/ See footnote 1/ Table 4.
2/ See footnote 2/ Table 4.

C. Extent of Dropping of Health Insurance

Household respondents were asked, "Have you folks ever dropped any health insurance?" This question was broadly interpreted by many of the persons interviewed to include those situations in which there was a change of insurance carrier for group enrollment. As indicated earlier, there was a change of insurance carriers in 1952 for the Community Development Program sponsored health insurance.

While about three of every ten households reported having dropped health insurance at one time or another,17/ two-thirds of those having dropped insurance were enrolled in some health insurance at the time of the survey. Only one-third of the households reporting having dropped such insurance were not currently enrolled.18/ While this indicated relatively high interest in and continued acceptance of health insurance in that such a high proportion of those dropping were re-enrollees, it is still a challenge to insurance programs that one-tenth of all households in the 4 communities were dropouts.

Identification of characteristics of households dropping health insurance contributes to knowledge of how insurance is dropped.

As examination of selected features of re-enrollee and dropout households indicates some interesting differentials (Table VIII). Comparison of these two groups is in consistent agreement with findings already presented as to differentials of enrolled or nonenrolled households.

Among the residence-occupation groups, rural residents were relatively high for re-enrollees and low for dropouts while both farm and part-time farm households were low in re-enrollees and relatively high in dropouts. No explanation is now available for part-time farm being more similar to farm than to rural residents in dropping of insurance.

Owners were over twice as high as renters in proportion re-enrolled with these tenure categories reversed for dropouts as renters were here twice as frequently represented.

Among the income groups, the lowest income households were less than half as often represented for re-enrollees compared with the higher income ones. The two lowest income groups were in turn highest in proportion of dropouts.

17/ Of the households dropping of health insurance, about one-fourth (27 percent) reported "change of insurance carrier of a group" as the reason for dropping. Four-fifths of those households dropping insurance because of a change in carrier re-enrolled in health insurance.

18/ Throughout this report, "re-enrollees" is used to refer to those households reporting dropping of insurance, but again enrolled at the time of survey. "Dropouts" is used to refer to households who had dropped insurance and were not again enrolled as of June, 1953.

IV. THE PROCESS OF ACCEPTING VOLUNTARY HEALTH INSURANCE

Examination of the prevailing routes of accepting or rejecting health insurance is useful in identifying factors which assist or which serve as barriers to enrolling in such insurance.

Two general areas in the acceptance process were studied: (1) perception of health insurance and (2) motivations.

Since it was assumed that the decision-making role concerning health insurance lies primarily with the adult heads of households, information as to the acceptance process was obtained only for the male heads and the homemakers.

A. Perception of Health Insurance

The examination of perceptual aspects in the acceptance of voluntary health insurance included: (1) sources of information on insurance, (2) expectations of insurance, and (3) familiarity with insurance provisions.

1. Sources of information - The household respondents were asked, "In general, where do you get your ideas and information about health insurance?" About 1 in every 8 did not name any source. Of those who named one or more sources (Table 7) "informal groups" was cited most frequently (45 percent). These "informal groups" included a range of situations all of which were characterized by relatively intimate and unstructured types of interaction including friends, neighbors, relatives, fellow workers, people who were enrolled in health insurance, community activities, and "general talk." Mass media including newspapers, magazines, radio, and pamphlets were next most frequently cited by (34 percent). Other sources in order of frequency of reporting were: formal groups such as meetings of Community Development Program and other organizations (19 percent), health care services including doctor, public health department, and hospital (15 percent), insurance agents or companies (14 percent), and other sources (14 percent).

It will be noted that the informational work of a particular organization or program that used radio, newspapers, or other media of communication is not necessarily identified by the above question.

Respondents were then asked, "Where do you think you could get the best information?" The responses to this question represented a shift to more person-to-person interaction than those for the preceding and more general questions. Doctors were most frequently reported (30 percent) as a source for the best information. Other sources in order of frequency of mention were insurance agents or companies (23 percent), hospitals (13 percent), public health departments (11 percent), formal group meetings (7 percent), and people who were enrolled in insurance (6 percent).

Table 7. DISTRIBUTION OF HOUSEHOLDS BY REPORTED SOURCES OF INFORMATION ON HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Sources of Information	Percent of Households Reporting	
	Sources of Information on Insurance (259 households reporting)	Sources of Best Information on Insurance (227 households reporting)
Mass media 1/	34	3
Informal groups 2/	45	10
Formal groups 3/	19	7
Health care services 4/	15	54
Health insurance organization 5/	14	23
Other sources 6/	14	4

1/ Mass media includes pamphlets, bulletins, newspapers, magazines, radio and television.
2/ Informal groups include relatives, neighbors, other friends, people enrolled in insurance, and fellow employees.
3/ Formal groups include Community Development Program, Home Demonstration Clubs, county agent, and other formal groups.
4/ Health care services include doctor, hospital, and public health department.
5/ Health insurance organization includes insurance agent or company.
6/ Other sources include own experience, insurance policies, and employer.

No consistent or significant differentials in reporting of sources of "best information" on insurance were evidenced by residence-occupation, income, education of male head, or social participation of household heads (Table IX).

The respondents were asked, "Do you feel that you need more information about health insurance?" One-half indicated they needed more information, 4 of every 10 reported "no," and less than 1 in every 10 were "undecided" as to their need for more information.

Reported need for more information did not vary by residence-occupation, income, or by educational status of the male head (Table X). Respondents from low social participation households were highest in reporting need for more insurance information.

2. Expectations of health insurance

What consumers expect to achieve from voluntary health insurance is very useful in identifying the recognized role of such a practice.

Benefits preferred - From a list of five specific types of benefits, the respondents were asked to check three "which you regard as most important" in possible coverages of voluntary health insurance.

Coverage for hospital use was most frequently cited for surgery by 7 in every 10, for doctor calls in home and office by over one-half, cash disability benefits by one-half, and coverage for special duty nursing by one-fourth.

Since insurance benefits for hospital service and for surgical care are most frequent coverages available in existing insurance programs in the areas of study, these dominant expectancies would be anticipated. The relatively high interest expressed in insurance coverage for doctor calls at home and office and the considerable mention of coverage for special duty nursing apparently derives from other than existing programs. This suggests the question--are rural people highly interested in having health insurance coverages for broad types of health care services?

Anticipated Impact of Health Insurance on Use of Health Care Services -

The impact of health insurance on use of health care services was generally probed by these questions: "Do you believe that having health insurance influences a person's use of a doctor including a surgeon?" and "Do you believe that having such insurance influences a person's use of a hospital?" It will be recognized that several different situations could contribute to expressed responses including observations of other people's behavior and the prevailing expectancies of friends and acquaintances.

Slightly over one-half of the respondents indicated that having such insurance influences a person's use of these health care services (52 percent in case of use of doctors and 53 percent for hospitals).

For those persons reporting insurance influenced use of services, the question was asked, "In what ways?" Nearly all (95 percent for case of doctors and 97 percent for hospitals) of such respondents believed that insurance tended to increase the use of these services.

3. Familiarity with health insurance provisions - There is widespread interest in the extent to which people understand the health insurance in which they are enrolled. Two general areas were examined in the survey: (1) familiarity of enrollees with insurance premium arrangements and (2) familiarity with coverages of current insurance.

In order to check as to the familiarity of enrolled household respondents with their health insurance, information as to premium arrangements and insurance coverages was obtained from all the group insurance carriers with clients in the four rural communities. Such information was not obtained for health insurance carried on an individual enrollment basis.

Data as to insurance arrangements and coverages of clients of group insurance based on their insurance contracts, hereinafter called "policy arrangements," were then compared with the arrangements and coverages as reported by respondents during the survey, hereinafter termed "reported arrangements," to determine their familiarity with their health insurance.

Familiarity with premium arrangements - Sources of payment of health insurance premiums, methods of paying premiums, and frequency of premium payments were the particular types of arrangements concerning premiums which were examined as to familiarity of respondents.

There was a consistent, although not statistically significant, tendency for higher familiarity of these premium arrangements for the group carried insurance involving the homemaker than for the male head (Table 8).

As to the source of premium payments including full payment by enrollee, full payment by employer, or payment jointly by employer and enrollee; about two-thirds of the respondents reported arrangement for the male head was in agreement with the policy arrangements.

The farm household respondents were more frequently (91 percent) familiar with source of premiums than were part-time farm (54 percent) or rural resident respondents (48 percent). As will be indicated later, the part-time farm and rural resident enrollees were most frequently insured in a work group arrangement and apparently the homemaker of such households, who constituted one-half of the respondents as shown earlier, is less fully informed than is the covered employee, usually the male head, of the source of premium payments. There were no evident differentials in familiarity with source of insurance premiums by educational status of male head or by net cash income of the household.

Table 8. DISTRIBUTION OF HOUSEHOLDS WITH GROUP ENROLLMENT IN HEALTH INSURANCE BY FAMILIARITY WITH INSURANCE PREMIUM ARRANGEMENTS FOR MALE HEADS AND HOMEMAKERS, FOUR RURAL COMMUNITIES, 1953

Health Insurance Premium Arrangements	Percent of Enrolled Households Reporting Enrollment Arrangements	
	Male Head (121 households reporting)	Homemaker (137 households reporting)
Source of Insurance Premiums[1]		
Policy and reported arrangements agree	64	72
Policy and reported arrangements agree in part but not fully[2]	2	2
Policy and reported arrangements disagree	33	26
Method of Payment for Health Insurance[3]		
Policy and reported arrangements agree	83	93
Policy and reported arrangements agree in part but not fully[2]	0	1
Policy and reported arrangements disagree	17	7
Frequency of Premium Payment[4]		
Policy and reported arrangements agree	83	84
Policy and reported arrangements agree in part but not fully[2]	4	3
Policy and reported arrangements disagree	13	13

1/ Respondents were asked: "What arrangements do you have for paying health insurance premiums (for male head and for homemaker): Pay all of it ourselves, employer pays total cost, employer and employee jointly, and other."

2/ Includes where individual has more than one group insurance policy and the policy and reported arrangements are in agreement for one policy but not for all policies.

3/ Method of payment categories were: cash payment by mail, cash payment at insurance company office, paid to collector on call, payroll deductions, checkoffs on sale of farm products, paid by other group method, and other.

4/ Frequency of premium payments were: annually, semi-annually, quarterly, monthly, and other.

Over 8 of every 10 group enrolled household respondents were familiar with the method of payment for insurance for male head called for in their insurance contract (Table 8) and over 9 of every 10 were familiar with such arrangements in insurance for the homemaker.

In the case of health insurance covering the male head, 8 of every 10 respondents were familiar with the policy arrangements as to the frequency of premium payments.

Familiarity with health insurance coverages - The extent of familiarity of the respondents of group-enrolled households in the four rural communities of Haywood County with the coverages in their health insurance was examined (Table 9). Respondents' familiarity with coverages in the health insurance policy or contract varied considerably by specific types of benefits. They were more often familiar with the coverages for hospital services and for disability benefits than they were with the surgery care coverages or medical services other than surgery. In the case of surgery, over one-half of the respondents reported maxiumum surgical benefits in the case of both the male head and homemaker which varied by $10 or more from the maximums specified in their group contract or policy.

B. Motivations Concerning Health Insurance

In examining some of the motivations relative to acceptance of health insurance, a genetic or developmental approach was used. Emphasis was placed on situational characteristics, including group influences, associated with enrollment or rejection of health insurance.

It will, of course, be recognized that an individual's perception of insurance, including those aspects just noted, has important impacts on his motivations toward health insurance.

The areas probed as to motivations in acceptance of health insurance were: (1) motivational influences, (2) enrollment situations, (3) use of insurance, and (4) recognized strengths and weaknesses of voluntary health insurance.

1. Motivational influences - An effort was made to identify recognized influences which motivated respondents to accept or reject voluntary health insurance. This examination was developed by asking for information as to particular situations involving acceptance decisions and as to recognized factors bearing on acceptance of health insurance.

Influences on first enrollment in health insurance - Respondents for those households which were currantly enrolled or which had been enrolled and later dropped out were asked a series of questions as to their initial contacts concerning health insurance:

"What started you to thinking about taking out your first health insurance?"
"What sources of information did you depend on?"
"With whom did you talk about it?"
"What finally made you decide to take out your first health insurance?"

Table 9. DISTRIBUTION OF HOUSEHOLDS WITH GROUP ENROLLMENT IN HEALTH INSURANCE BY FAMILIARITY WITH INSURANCE COVERAGES FOR MALE HEADS AND HOMEMAKERS, FOUR RURAL COMMUNITIES, 1953

Health Insurance Coverages	Percent of Enrolled Households Reporting Insurance Coverages	
	Male Head (102 households reporting)	Homemaker (111 households reporting)
Hospital Coverage		
Policy and reported coverages agree1/	76	79
Policy and reported coverages disagree2/	24	21
Surgery Coverage		
Policy and reported coverages agree3/	40	44
Policy and reported coverages disagree4/	60	56
Maternity Coverage5/		
Policy and reported coverage agree	---	67
Policy and reported coverage disagree	---	33
Coverages for Medical Services6/		
Policy and reported coverages agree	21	19
Policy and reported coverages agree in part but not fully	29	30
Policy and reported coverages disagree	50	51
Coverage for Disability Benefits7/		
Policy and reported coverages agree8/	68	93
Policy and reported coverages agree in part but not fully9/	4	1
Policy and reported coverages disagree10/	28	6

1/ Daily room benefit in hospital agrees or varies by less than $1.
2/ Daily room benefit in hospital varies by $1 or more.
3/ Maximum for any surgical service agrees or varies by less than $10.
4/ Maximum for any surgical service varies by $10 or more.
5/ Any coverage for maternity care in insurance of homemaker.
6/ Medical services other than surgery included: outpatient care, office calls to doctor, home calls by doctor, physical examination other than for sickness or accident, and other.
7/ Disability benefits included cash payments to insured other than workmen's compensation for injuries due to accidents and/or for sickness.
8/ Maximum cash payment for accidental injury agrees or varies by less than $10 and weekly benefit for sickness agrees or varies by less than $1.
9/ Maximum cash payment for accidental injury agrees or varies by less than $10 while weekly benefit for sickness varies by $1 or more _or_ maximum cash payment for accidental injury varies by $10 or more, while weekly benefit agrees or varies by less than $1.
10/ Maximum cash payment for accidental injury varies by $10 or more and weekly benefit for sickness varies by $1 or more.

The responses to these first contact questions indicated the respective role of different sources as reported by the respondents (Table 10). Employers, recognized need for use of health care services, and the Haywood Community Development Program were the predominant influences in "starting thinking about the first health insurance."

Examination of some characteristics of households reporting these predominant influences on initial enrollment indicates the high impact of the Community Development Program among farm households (Table XI). This Program was a principal influence among farmers while the employer was most frequently reported by rural residents and part-time farm households. The role of the Community Development Program in the initial thinking about health insurance among all income, education, and participation groups is also indicated. The Community Program was cited particularly often by the lowest income households. There was a consistent tendency for "employer" to be more frequently reported by the upper social status groupings. On the other hand, "need for using health care services" as a recognized motivational influence on thinking about insurance was consistently reported most often by the lower social status groups as identified by income, education, and social participation.

The employers, Community Development Program, and insurance agents or companies were the "sources of information depended on" by most of the respondents (Table 10). A wide range of contacts were reported for "with whom did you talk about it?" The interacting at informal group levels was here indicated with "friends" being most often cited. Again the employer and also the insurance agent or insurance company were prominent sources of contact.

As for recognized influences on finally deciding to take out health insurance, the respondents most usually cited "need for using health care services." The anticipated role of health insurance in terms of use of health services was thus a chief criterion in the enrollment decision.

<u>Influences on decision-making</u> - All respondents were asked: "In your making up a decision on enrolling in health insurance, with whom did (would) you discuss the idea?" It will of course be recognized that this was a hypothetical question for those persons not enrolled in such insurance.

Health care services, particularly doctors, and health insurance organizations were the two dominant sources reported with whom the enrollment decision had been or would be discussed (Table 11). Informal groups, and most frequently relatives, were reported by several respondents.

The pre-eminent role of doctors as a reported influence on health insurance enrollment decisions for all three residential groups and for each of the social status groupings is evidenced (Table XII). Except for rare times when insurance agent or company is most often cited, the doctor is reported most frequently by all status groups as the person "with whom you did (would) discuss" the decision to enroll in health insurance.

Table 10. DISTRIBUTION OF ENROLLED HOUSEHOLDS BY INFLUENCES ON FIRST ENROLLMENT IN HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Influences[1] on First Enrollment	Percent Reporting Influences on First Enrollment (198 households reporting)			
	What started thinking about insurance?	Sources of information depended on?	With whom talk about insurance?	What finally made you decide to enroll?
None Reported	1	1	5	0
Mass Media	1	7	0	1
Informal Groups	6	10	30	3
Relatives	3	1	9	1
Other friends, neighbors	3	8	21	2
People enrolled in health insurance	0	1	0	0
Formal Groups	26	23	12	8
County agent	2	5	4	1
Community Development Program	22	15	5	7
Labor unions	1	1	0	0
Other formal groups	1	2	3	0
Health Care Services	1	6	5	1
Doctor	1	5	3	1
Hospital	0	1	2	0
Public health depts.	0	0	0	0
Health Insurance Organization	5	17	26	3
Ins. agent or company	4	13	17	2
Community insurance collector[2]	1	4	9	1
Employer	34	35	18	11
Recognized Advantages	28	1	1	75
Need for using health care services	25	0	1	63
Believed health ins. a "good thing"	3	1	0	12
Other	1	2	3	1

1/ It will be recognized that the influence of particular individuals or groups functioning through other channels is not separately identified. For example, the county agent was particularly active in the Community Development Program. Several local doctors and the hospital administrators were also active in the health insurance activities of the Community Development Program.

2/ The community insurance collector is an elected representative of the local community who collects the quarterly premiums for the group insurance provided through the Haywood Community Development Program.

Table 11. DISTRIBUTION OF HOUSEHOLDS BY REPORTED INFLUENCE ON DECISION RELATIVE TO HEALTH INSURANCE ENROLLMENT, FOUR RURAL COMMUNITIES, 1953

Decision-Making Influences	Percent of Households (266 households reporting)
Mass Media	1
Informal Groups	15
Relatives	8
Other friends, neighbors	4
People enrolled in health insurance	3
Formal Groups	8
County Agent	4
Community Development Program	3
Labor unions	1
Other formal groups	0
Health Care Services	37
Doctor	29
Hospital	5
Public health department	3
Health Insurance Organization	33
Insurance agent or company	21
Community insurance collector	12
Employer	6
Other	2
Lawyer	2

Differentials in frequency of reporting of the four selected influences by lower and upper status groups were comparatively rare. There was a generally consistent pattern of "relatives" being more often cited by lower than by upper status groups.

The relatively strong role of the Community Development Program among farm households in health insurance decisions is again indicated. One-fourth of the farm respondents cited this Program while only 2 of every 10 part-time farmers and less than 1 of every 10 rural residents reported it as an influende on insurance decisions.

Group influences - The role of specific types of formal organizations in encouraging or discouraging acceptance of health insurance was examined.

The respondent was handed a list of formal organizations previously identified as being active in the four rural communities. The question was then asked "Have any of these organizations been active during the last year in encouraging or discouraging acceptance of voluntary health insurance?" Specified categories of response were: encourage, discourage, and no expressed attitudes.

The Community Development Program was cited most frequently (reported by 89 percent of the households) of all organizations as encouraging acceptance of health insurance (Table 12).

Home Demonstration Club, which is the Agricultural Extension Service organization for adult women, was mentioned by over four-fifths of the respondents as encouraging health insurance. About one-half reported encouragement from general farm organizations and farmers co-operatives and one-third of the respondents reported the church as encouraging health insurance.

It is noteworthy that none of the respondents reported that any formal organization discouraged acceptance of insurance.

As noted earlier, informal groups were often cited as sources of information relative to insurance. Their role as carriers of information was further probed with the question, "Have you heard any complaints or criticisms of voluntary health insurance among your relatives, neighbors, and friends?" Nine-tenths of all respondents reported "no" while the remaining one-tenth said they had heard criticisms from such informal and face-to-face contacts.

Enrollment situations as motivational influences - The situational aspects of health insurance enrollment are doubtless of great importance in influencing acceptance or rejection of such insurance.

Information obtained as to the enrollment situations included year of first enrollment, individual or group basis of enrollment, occupation, and type of carrier. Information on these items was obtained for both male heads and for homemakers. Data for male heads only are presented here since the enrollment pattern for homemakers is largely the same as for the male heads.

Table 12. DISTRIBUTION OF HOUSEHOLDS REPORTING INFLUENCE OF FORMAL ORGANIZATIONS ON ENCOURAGING OR DISCOURAGING ACCEPTANCE OF HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Types of Formal Organizations	Percent of Households Reporting Organization		
	Encouraged Acceptance	Discouraged Acceptance	No Expressed Attitude
Church	32	0	68
Farm Bureau and/or Grange	55	0	45
Farmers Co-operative	48	0	52
Home Demonstration Club	84	0	16
Community Development Program	89	0	11

While it is self-evident that such situational data are useful in a descriptive analysis of the health insurance status of the four rural communities, their examination here is primarily for leads as to factors involved in the enrollment process and particularly as to motivational influences.

Year of first enrollment - The length of time which voluntary health insurance has been active in a community doubtless conditions the acceptance of such a practice. While about four-fifths of the health insurance held by male heads was enrolled in within the past ten years, it is rather surprising that one-fifth reported enrolling in such insurance over ten years ago. It will be noted that the year of highest enrollment, 1951, was when the program of health insurance carried by the Community Development Program was initiated in Haywood County. (Table 13)

Basis of Enrollment - The prominent role of group affiliation as the basis used for subscribing to voluntary health insurance was very impressive in the 4 communities. Of the 154 male heads enrolled in such insurance, over 9 of every 10 had enrolled on a group basis. The employment group in turn was the predominant group arrangement with upwards of three of every five so enrolled.

The very strong contribution of the Haywood Community Development Program to health insurance enrollment is demonstrated in that about two-fifths of all male heads having insurance enrolled on the group basis provided by the Community Development Program.

Only about one in every seven enrollees had enrolled on an individual basis. The reader will note that these proportions are not cumulative to 100 percent since the information was obtained in terms of how the male head had enrolled in health insurance he now held. The comparatively few cases of enrollment in two or more types of health insurance carriers accounts for some heads having more than one basis of enrollment.

The relative role of the individual basis of insurance enrollment and of a group basis in reaching male heads of differing social status is presented in Table 14. While there were only a few male heads enrolled on an individual basis, there were no indications of this enrollment basis being selective of particular status groups.

Of the two types of group situations for insurance enrollment, the Haywood Community Development Program showed marked ability to enroll male heads who were farm operators and in the lower income groups. As would be expected, the employment groups were very strongly represented by skilled and semiskilled workers having health insurance.

Table 13. DISTRIBUTION OF ENROLLED HOUSEHOLDS BY REPORTED YEAR OF MALE HEADS' ENROLLMENT IN VOLUNTARY HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Year of Enrollment	Male Head Enrolled in Health Insurance	
	Number	Percent
Total Reporting	142	100
1953	10	7
1952	22	16
1951	30	21
1950	23	16
1949	4	3
1948	7	5
1947	3	2
1946	10	7
1945	3	2
1944	0	0
1943 or earlier	30	21

Table 14. MALE HEADS OF HOUSEHOLDS ENROLLED IN VOLUNTARY HEALTH INSURANCE BY BASIS OF ENROLLMENT AND BY SELECTED SOCIAL STATUS CHARACTERISTICS, FOUR RURAL COMMUNITIES, 1953

Social Status Characteristics	Basis of Health Insurance Enrollment					
		Group Enrollment Basis				
	Indiv. Basis Only	Group Employment	CDP1/	Indiv. & Group Employed	Indiv. and CDP1/	Group Employment & CDP1/
Major Occupation						
Farm operators	5	12	79	0	4	0
Skilled workers	7	76	2	9	0	7
Semiskilled workers	4	75	8	8	4	0
Residence-Occupation						
Open country--farm	6	12	81	0	2	0
Open country--part-time farm	9	58	18	9	3	3
Open country--rural resident	6	78	6	4	3	3
Home Tenure						
Owner	7	48	37	3	2	2
Renter	3	66	24	3	3	0
Net Cash Income of Household						
Under $1500	6	28	67	0	0	0
$1500 - 2499	4	36	50	7	0	4
$2500 - 3999	7	68	7	7	7	2
$4000 - and over	10	74	8	3	3	3
Education of Male Head						
Under 7 grades	4	47	40	4	2	4
7 - 11 grades	6	54	32	5	2	2
12 grades and over	13	58	19	3	6	0
Social Participation of Household Head						
Under 10 score	a/	a/	a/	a/	a/	a/
10 - 29 score	1	65	25	5	1	1
30 score and over	13	32	46	3	5	2

a/ Insufficient cases for determining percentages.
1/ Community Development Program.

The ability of the Haywood Community Development Program sponsored insurance to reach farmers and those with low income has strong implications for voluntary health insurance programs. It indicates marked strength of an active type of rural organization reaching farmers and other nongroup employed persons.

Occupation - The strong role of the employment group in furthering health insurance enrollment is indicated in that about 6 of every 10 male heads had enrolled while engaged in "nonfarm work for someone else." One-third were farming when they enrolled and about 1 in every 20 were "self-employed nonfarm" when they took out currently held health insurance.

Of all 81 male heads employed in industrial plants or firms offering employee group enrollment, only one reported he did not carry such insurance for himself.

All but two of these 81 male heads also reported carrying employment group sponsored health insurance for their eligible family members.

This high impact of employment group on insurance enrollment both of the employee and of his dependents suggests several factors are active, including high interest of the individuals in such insurance and strong encouragement for enrollment.

Type of Carrier - The male head enrollees were evenly divided in their insurance carriers between nonprofit agencies, Blue Cross and Blue Shield, (55 percent) and the commercial insurance companies (56 percent). A few of the male heads carried insurance with more than one type of carrier which explains that the above proportions do not cumulate to 100 percent.

Use of health insurance as a motivational influence - For those households who were currently enrolled in health insurance, respondents were asked, "Have you folks ever used your health insurance?" Nearly two-thirds of those enrolled in insurance reported having used such insurance.

Of the households enrolled and also having used their health insurance, 9 of every 10 had used it in paying towards doctors' charges and a slightly higher proportion (96 percent) had used their insurance in paying toward a hospital bill.

Satisfactions with Use of Health Insurance - Satisfactions with the "use which you folks have made of your health insurance in paying hospital or doctors' bills" was reported by about 9 of every 10 households who had used their insurance.

"Financial security" was most frequently cited as a chief advantage by those persons who were fully satisfied with their use of insurance (Table 15).

Table 15. DISTRIBUTION OF HOUSEHOLDS REPORTING CHIEF ADVANTAGE OF THEIR USE OF HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Chief Advantage of Use of Health Insurance	Percent of Households[a] (114 households reporting)
Financial security[1]	72
Other security[2]	18
Increases availability of health care services[3]	13
Method of individual financing of health care[4]	7
Other advantage[5]	5
No advantages reported	1

a/ Percentages total more than 100 since some respondents reported more than one advantage.
1/ Includes specific reported advantages of: paid bills, have money when you need it, help when unable to pay, helps keep bills paid, paid part of bills, cuts expense in sickness, paid bills easily and promptly, helps poor people, keeps from going broke.
2/ Includes specific reported advantages of: helps in time of sickness, helps in difficulties or emergencies, and provides peace of mind.
3/ Includes specific reported advantages of: takes care of your health, can go to hospital or doctor immediately, obtain operation, helps one obtain needed treatment, means for better health, and good service at hospital.
4/ Includes specific reported advantages of: savings for sickness, savings to pay hospital or doctor, good investment, and provides benefits already paid for.
5/ Includes specific reported advantages of: just well satisfied, coverage was good, other folks were satisfied, and does all it claims it would.

2. Recognized advantages and disadvantages of voluntary health insurance - The reasons people have for accepting or rejecting health insurance are of key usefulness in revealing motives. These attitudes are deliberately reviewed following the earlier examination of situational aspects of enrollment on the basis that attitudes largely develop from overt behaviors and experiences rather than the reverse.

Main Advantages of Health Insurance - The question was asked all respondents "As you see it, what are the main advantages of health insurance?"

Financial security was the main advantage reported most frequently--by about 6 of every 10 respondents (Table 16). Other security advantages were reported by 2 in every 10. The general area of security was reported then by 9 of every 10 respondents thus placing security as the predominantly recognized main advantage of health insurance. The insurance role of spreading risk was cited very infrequently--by one percent of all respondents.

Main Disadvantages of Health Insurance - A corollary question as to disadvantages was asked: "As you see it, what are the main disadvantages or weaknesses, if any, to health insurance?"

The respondents reported disadvantages with insurance much less frequently than in the case of advantages with only one in every four reporting any main disadvantages (Table 17). Need for broader coverages was cited most frequently as a main disadvantage--being reported by 1 of every 10 respondents.

Are There Important Changes Needed in Health Insurance? - In order to obtain an indication of felt desires for changes in insurance, all respondents were asked, "Are there important changes that you think should be made in voluntary health insurance?" One-half reported "no." Over one-fifth reported "yes." Nearly 3 of every 10 respondents reported "don't know."

Personal Satisfaction With Health Insurance - An indication of the personal commitment to voluntary health insurance of the household heads interviewed was obtained with the question: "In general, how satisfied are you with your (existing) voluntary health insurance?"

A very high frequency of satisfaction was reported. Seven of every 10 indicated "very satisfied," 19 percent were fairly satisfied, 7 percent indicated "no opinion," and 3 percent were "not satisfied." Among the contributing factors to this high satisfaction expression with voluntary health insurance, field observations indicate that the following are probably quite important: (1) the very strong local support for health insurance in each of the four communities including that provided by the Community Development Program and industrial employers, (2) the high value placed on health insurance as a security practice, and (3) reluctance of respondents to criticize adversely a community-accepted value in interviews with strangers.

Table 16. DISTRIBUTION OF HOUSEHOLDS REPORTING MAIN ADVANTAGES OF HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Main Advantages of Health Insurance	Percent of Households a/ (280 households reporting)
Financial security 1/	58
Other security 2/	21
Increases availability of health care services 3/	12
Method of individual financing of health care 4/	12
Insurance spreads risk 5/	1
Other advantages 6/	5
No advantages reported	4

a/ Percentages total more than 100 since some respondents reported more than one advantage.
1/ See footnote 1/ Table 15.
2/ See footnote 2/ Table 15.
3/ See footnote 3/ Table 15.
4/ See footnote 4/ Table 15.
5/ Includes the specified advantages of staggers the bills, spreads sickness bill.
6/ See footnote 5/ Table 15.

Table 17. DISTRIBUTION OF HOUSEHOLDS REPORTING MAIN DISADVANTAGES OF HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Main Disadvantages of Health Insurance	Percent of Households[a] (280 households reporting)
Need broader coverages[1]	9
Financial burden of insurance[2]	8
Difficulties with insurance[3]	6
Abuse of insurance[4]	5
Other disadvantages	1
No disadvantages reported	74

a/ Percentages total more than 100 since some respondents reported more than one disadvantage.

1/ Includes specific reported disadvantage of: need to cover all doctor services, all hospital and doctor bills, dental care, pre-existing conditions, people 65 years and over and all sickness and accident.

2/ Includes specific reported disadvantage of: premiums too expensive, income too low to pay premiums, difficult to pay premiums regularly, and premiums too expensive in relation to benefits.

3/ Includes specific reported disadvantage of: policies are misrepresented, loopholes in policy keep client from collecting, some insurance companies unreliable, difficult to settle claims, companies cancel policies.

4/ Includes specific reported disadvantage of: people go to doctor or hospital too quickly when insured, doctors may charge more if people insured, and doctors may urge people to come who don't need medical care, and hospital costs have increased with insurance.

APPENDIX A - TABLES

Table I. CHARACTERISTICS OF HOUSEHOLDS IN FOUR RURAL COMMUNITIES OF HAYWOOD COUNTY, 1953

Characteristics of Households	Distribution of Households	
	Number	Percent
Residence-Occupation,[1/] Number Reporting	299	100
Open Country--Farming	128	43
Open Country--Part-time farming	66	22
Open Country--Rural Resident	105	35
Tenure,[2/] Number Reporting	299	100
Owner	207	69
Renter	86	29
Other	6	2
Net Cash Income, Number Reporting	276	100
Under $1500	124	45
$1500 - 2499	54	20
$2500 - 3999	53	19
$4000 and over	45	16
Education of Male Head of Household, Number Reporting	259	100
Less than 7th grade	74	29
7 - 11 grades	146	56
12th grade and over	39	15
Social Participation Score of Household Head,[3/] Number Reporting	299	100
Under 10 score	39	13
10 - 29 score	167	56
30 score and over	93	31
Household Respondent,[4/] Number Reporting	299	100
Male head	148	49
Wife of male head	119	40
Female household head	32	11

1/ Based on residence (open country or village) and on major occupation of household head.
2/ Based on home tenure.
3/ Based on Chapin Scale for participation in formally organized groups: 1 point for membership, 2 for attendance, 3 for contributions, 4 for committee membership, and 5 for officer.
4/ Household member interviewed.

Table II. CHARACTERISTICS OF INDIVIDUALS IN FOUR RURAL COMMUNITIES OF HAYWOOD COUNTY, 1953

Characteristics of Individuals	Distribution of Individuals	
	Number	Percent
Age, Number Reporting	1220	100
Under 5 years	134	11
5 - 19 years	409	34
20 - 24 years	73	6
25 - 44 years	308	25
45 - 64 years	211	17
65 years and over	85	7
Sex, Number Reporting	1222	100
Male	624	51
Female	598	49
Occupation, Number Reporting	1198	100
Professional	12	1
Proprietors other than farm managers and officials	10	1
Clerical, sales, and kindred workers	25	2
Farm operators	148	12
Skilled workers	60	5
Semiskilled workers	48	4
Service and domestic workers	14	1
Farm laborers, wage	2	0
Farm laborers, unpaid family	45	4
Unskilled workers other than farm	6	1
Housewives	276	23
Unemployed	18	1
Retired	32	3
In school, students	309	26
Preschool	193	16

Table III. PERCENT OF INDIVIDUALS ENROLLED IN VOLUNTARY HEALTH INSURANCE BY AGE GROUPS IN FOUR RURAL COMMUNITIES, 1953

Age Groups	Individuals	
	Total Number Reporting	Percent Enrolled in Health Insurance
TOTAL	1220	57
Under 5 years	134	52
5 - 9 years	143	60
10 - 14 years	147	74
15 - 19 years	119	54
20 - 24 years	73	41
25 - 29 years	72	64
30 - 34 years	86	66
35 - 44 years	150	63
45 - 54 years	120	52
55 - 64 years	91	53
65 years and over	85	38

Table IV. INDIVIDUAL ENROLLMENT IN VOLUNTARY HEALTH INSURANCE BY TENURE AND BY RESIDENCE-OCCUPATION, INCOME, EDUCATION, AND SOCIAL PARTICIPATION OF HOUSEHOLDS, FOUR RURAL COMMUNITIES, 1953

Tenure, Residence-Occupation, Social Participation, and Income	Individuals	
	Total Number Reporting	Percent Enrolled in Health Insurance
Tenure and Residence-Occupation		
Owners		
Farmers	303	53
Part-time farmers	219	64
Rural residents	267	82
Renters		
Farmers	191	22
Part-time farmers	65	28
Rural residents	140	62
Tenure and Income		
Owners		
Under $1500	224	42
$1500 - 2499	162	57
$2500 - 3999	182	82
$4000 and over	167	90
Renters		
Under $1500	224	19
$1500 - 2499	62	45
$2500 - 3999	52	81
$4000 and over	35	89
Tenure and Education of Male Head		
Owners		
Under 7 grades	147	59
7 - 11 grades	430	66
12 grades and over	133	84
Renters		
Under 7 grades	203	18
7 - 11 grades	163	63
12 grades and over	4	a/
Tenure and Social Participation		
Owners		
Under 10 score	67	55
10 - 29 score	426	61
30 score and over	296	75
Renters		
Under 10 score	110	16
10 - 29 score	226	41
30 score and over	60	62

a/ Insufficient cases for determining percentages.

Table V. INDIVIDUAL ENROLLMENT IN VOLUNTARY HEALTH INSURANCE BY INCOME AND BY RESIDENCE-OCCUPATION, EDUCATION, AND SOCIAL PARTICIPATION, FOUR RURAL COMMUNITIES, 1953

Income, Residence-Occupation, Education, & Social Participation	Individuals	
	Total Number Reporting	Percent Enrolled in Health Insurance
Income and Residence-Occupation		
Under $1500		
Farm	305	32
Part-time farm	78	12
Rural resident	73	45
$1500 - 2499		
Farm	66	56
Part-time farm	62	31
Rural resident	99	68
$2500 - 3999		
Farm	31	74
Part-time farm	69	88
Rural resident	138	80
$4000 and over		
Farm	31	74
Part-time farm	75	92
Rural resident	96	94
Income and Education of Male Head		
Under $1500		
Less than 7 grades	85	40
7 - 11 grades	127	61
12 grades and over	16	56
$1500 - 2499		
Less than 7 grades	77	42
7 - 11 grades	120	60
12 grades and over	25	56
$2500 - 3999		
Less than 7 grades	144	22
7 - 11 grades	216	56
12 grades and over	42	88
$4000 and over		
Less than 7 grades	47	53
7 - 11 grades	105	87
12 grades and over	58	95

Table VI. INDIVIDUAL ENROLLMENT IN VOLUNTARY HEALTH INSURANCE BY EDUCATION OF MALE HEAD AND BY RESIDENCE-OCCUPATION AND SOCIAL PARTICIPATION, FOUR RURAL COMMUNITIES, 1953

Education, Residence-Occupation and Social Participation	Individuals	
	Total Number Reporting	Percent Enrolled in Health Insurance
Education and Residence-Occupation		
Under 7 grades		
Farm	178	26
Part-time farm	69	26
Rural Resident	106	56
7 - 11 grades		
Farm	239	52
Part-time farm	146	60
Rural Resident	212	84
12 grades and over		
Farm	35	63
Part-time farm	56	84
Rural Resident	55	91
Education and Income		
Under 7 grades		
Under $1500	85	40
$1500 - 2499	77	42
$2500 - 3999	144	22
$4000 and over	47	53
7 - 11 grades		
Under $1500	127	61
$1500 - 2499	120	60
$2500 - 3999	216	56
$4000 and over	105	87
12 grades and over		
Under $1500	16	56
$1500 - 2499	25	56
$2500 - 3999	42	88
$4000 and over	58	95
Education and Social Participation		
Under 7 grades		
Under 10 score	95	18
10 - 29 score	190	40
30 score and over	68	46
7 - 11 grades		
Under 10 score	62	56
10 - 29 score	323	58
30 score and over	212	78
12 grades and over		
Under 10 score	0	--
10 - 29 score	68	79
30 score and over	78	83

Table VII. INDIVIDUAL ENROLLMENT IN VOLUNTARY HEALTH INSURANCE BY SOCIAL PARTICIPATION AND BY RESIDENCE-OCCUPATION, FOUR RURAL COMMUNITIES, 1953

Social Participation and Residence-Occupation	Individuals	
	Total Number Reporting	Percent Enrolled in Health Insurance
<u>Social Participation of Household Heads and Residence-Occupation</u>		
Under 10 score		
Open country—farm	85	19
Open country—part-time farm	29	3
Open country—rural resident	66	58
10 - 29 score		
Open country—farm	237	30
Open country—part-time farm	166	55
Open country—rural resident	257	76
30 score and over		
Open country—farm	173	68
Open country—part-time farm	89	73
Open country—rural resident	98	82

Table VIII. CHARACTERISTICS OF HOUSEHOLDS WHO HAVE DROPPED HEALTH INSURANCE, FOUR RURAL COMMUNITIES, 1953

Characteristics of Household	Total Number of Households Reporting	Households Reporting Dropping Ins.	
		Percent Enrolled at Time of Survey	Percent Not Enrolled In Health Ins.
Residence-Occupation			
Open country--farm	127	18	10
Open country--part-time farm	66	15	12
Open country--rural resident	105	23	9
Home Tenure			
Owner	206	23	7
Renter	86	10	15
Net Cash Income			
Under $1500	124	12	14
$1500 - 2499	53	24	13
$2500 - 3999	53	30	6
$4000 and over	45	20	0

Table IX. BEST SOURCES OF INFORMATION REPORTED ON HEALTH INSURANCE BY HOUSEHOLD CHARACTERISTICS OF RESPONDENTS, FOUR RURAL COMMUNITIES, 1953

Characteristics of Households	Percent Households Reporting Best Sources of Information					
	Mass Media	Informal Groups	Formal Groups	Health Care Services	Health Insurance Organizations	Other Sources
Residence-Occupation						
Open country--farm	4	11	8	55	19	2
Open country--part-time farm	2	6	6	47	33	6
Open country--rural resident	1	10	5	56	22	6
Net Cash Income						
Under $1500	5	12	11	52	18	2
$1500 - 2499	2	7	7	59	20	4
$2500 - 3999	2	2	0	50	39	4
$4000 and over	0	13	3	49	28	8
Education of Male Head						
Under 7 grades	4	4	10	58	19	5
7 - 11 grades	2	7	14	47	25	6
12 grades and over	8	17	3	44	25	3
Social Participation Household Heads						
Under 10 score	0	16	12	56	16	0
10 - 29 score	3	10	6	50	27	5
30 score and over	3	8	6	60	18	5

Table X. HOUSEHOLD RESPONDENTS REPORTING NEED FOR MORE INFORMATION ABOUT HEALTH INSURANCE BY HOUSEHOLD CHARACTERISTICS, FOUR RURAL COMMUNITIES, 1953

Characteristics of Households	Household Respondents	
	Total Number Reporting	Percent Reporting Need For More Information
Residence-Occupation		
Open country--farm	127	51
Open country--part-time farm	65	54
Open country--rural resident	105	49
Net Cash Income		
Under $1500	122	47
$1500 - 2499	54	44
$2500 - 3999	53	51
$4000 and over	45	42
Education of Male Head		
Under 7 grades	75	57
7 - 11 grades	144	48
12 grades and over	39	49
Social Participation of Household Heads		
Under 10 score	39	56
10 - 29 score	166	52
30 score and over	92	46

Table XI. CHARACTERISTICS OF ENROLLED HOUSEHOLDS REPORTING SELECTED INFLUENCES ON "THINKING ABOUT YOUR FIRST HEALTH INSURANCE," FOUR RURAL COMMUNITIES, 1953

Characteristics of Households	Total No. Households Reporting	Percent Households Reporting Influence on "Thinking About Your First Hlth. Ins."		
		Community Development Program	Employer	Need for Using Health Care Services
Residence-Occupation				
Open country—farm	56	50	12	38
Open country—part-time farm	36	33	42	25
Open country—rural resident	70	6	66	29
Net Cash Income				
Under $1500	47	40	21	38
$1500 - 2499	21	a/	a/	a/
$2500 - 3999	39	13	62	26
$4000 and over	37	11	73	16
Education of Male Head				
Under 7 grades	27	22	37	41
7— 11 grades	80	32	49	19
12 grades and over	28	25	50	25
Social Participation Household Heads				
Under 10 score	13	a/	a/	a/
10 - 29 score	46	35	9	56
30 score and over	64	36	31	33

a/ Insufficient cases for determining percentages.

Table XII. CHARACTERISTICS OF HOUSEHOLDS REPORTING SELECTED INFLUENCES ON DECISIONS RELATIVE TO HEALTH INSURANCE ENROLLMENT, FOUR RURAL COMMUNITIES, 1953

Characteristics of Households	Total No. Households Reporting	Percent Households Reporting Influence on Health Insurance Decision			
		Relatives	Doctor	Insurance Agent or Company	Community Insurance Collector
Residence-Occupation					
Open country—farm	69	12	39	25	25
Open country—part-time farm	41	5	42	34	20
Open country—rural resident	75	16	44	32	8
Net Cash Income					
Under $1500	70	13	41	26	20
$1500 - 2499	36	11	31	31	28
$2500 - 3999	33	15	48	24	12
$4000 and over	31	3	48	48	0
Education of Male Head					
Under 7 grades	44	11	34	39	16
7 - 11 grades	91	11	47	22	20
12 grades and over	27	7	33	48	11
Social Participation Household Heads					
Under 10 score	23	a/	a/	a/	a/
10 - 29 score	101	15	38	33	15
30 score and over	61	8	49	28	15

a/ Insufficient cases for determining percentages.