Health

NORTH CAROLINA

RURAL HEALTH STUDIES

Acceptance of Voluntary Health Insurance in Sampson County, North Carolina, 1955

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FOREWORD

In launching North Carolina's modern Good Health Program in 1944, Governor J. M. Broughton, in his charge to the Hospital and Medical Care Commission, stated:

"The ultimate purpose of this program should be that no person in North Carolina shall lack adequate hospital care or medical treatment by reason of poverty or low income."

In the final report of the Commission, Dr. Clarence Poe, the Chairman, summarized "the most urgent needs of today" and of the "larger program of tomorrow" as follows:

"More Doctors
More Hospitals
More Insurance"[1]

On the basis of the Poe Report, the State Legislature passed the legislation and appropriated the funds needed: to establish a four-year medical school; to build many new hospitals; to finance partially the hospital care of indigent patients; and to set up a medical student loan fund. The legislation also authorized the Medical Care Commission "to encourage the development of group insurance plans, the Blue Cross Plan, and other plans which provide for insurance for the public against the costs of disease and illness."

In other words, it has been recognized from the beginning that health insurance is needed as a means of financing medical care and, hence, providing a sound basis of support for our new hospitals and doctors. However, in spite of the early strong support given to voluntary health insurance and in spite of a favorable economic situation, more than half of our rural people still do not carry health insurance; and many who have taken out health insurance have dropped it. Also much of the health insurance carried by rural people is limited in coverage and in other ways poorly adapted to their needs.

It is evident that something more needs to be done to improve the health insurance situation for rural people. <u>But what can be done</u>? We believe that the answer to this question must come from a careful study of the facts.

How many rural people have health insurance? What are the characteristics of the people who do not have insurance? What kinds of health insurance do rural people have? Why have so many rural people dropped health insurance? What are the most successful methods of enrolling rural people in health insurance? Can group plans be developed for enrolling rural people? What do rural people think about health insurance? Where do they go to get information about health insurance?

Such are the questions that this and similar reports based on our research are attempting to answer. This progress report is only one of five which presents the results of our recent work. One previous report, based on the Haywood County survey, has been issued. Including the present report, there are to be four others, based on surveys in Sampson, Halifax, Montgomery, and Stokes Counties. Finally, there will be a printed bulletin giving the results of more complete analysis of the data in all five studies.

C. Horace Hamilton, Head
Department of Rural Sociology

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This report is the result of the cooperative effort of many people, including the 297 sample households who furnished information on the acceptance of voluntary health insurance.

C. Horace Hamilton, Ph. D. and Head of the Department of Rural Sociology, North Carolina State College, assisted in the research plans and advised on all phases of the study.

Plans for the study were reviewed by Henry T. Clark, Jr., M. D., Administrator of the Division of Health Affairs, University of North Carolina. Margaret Jarman Hagood, Ph. D., Chief, Farm Population and Rural Life Branch, Agricultural Marketing Service, U. S. Department of Agriculture, also advised on study plans and reviewed this report.

Field interviewers were Mr. Ralph R. Nichols and Mr. Bart Hague of the Agricultural Marketing Service and Mr. Randall F. Autry, Mr. Ralph C. Hodges, and Mrs. Elizabeth F. Matthews all of Sampson County. Mrs. Mary Hoadley and Mrs. Irene Hartman did most of the clerical work including the statistical calculations, and Mrs. Katie G. Latham typed the manuscript.

Mr. Milton H. Woodside, Hospital Administrator of Sampson County Memorial Hospital; Mr. E. J. Morgan, County Agent; and Miss Emily Teague, Home Demonstration Agent, assisted actively in setting up local plans for the study. In addition, Mr. Woodside provided a conference room for training interviewers, and Mr. Morgan and Miss Teague provided office space for the field supervisor. Mrs. Elizabeth Peterson of the Clinton Chamber of Commerce gave valuable assistance in locating qualified interviewers.

Dr. J. Street Brewer of Roseboro and Dr. Amos Johnson of Garland took considerable time from their busy schedules to advise on the study and to give valuable local insights.

The Department of Experimental Statistics of North Carolina State College drew the area sample, advised on tabulation plans, and did the machine tabulations.

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I. SUMMARY AND IMPLICATIONS

The acceptance of voluntary health insurance was studied in Sampson County, North Carolina. The extent of enrollment in health insurance of the various social and economic groups was examined along with the frequency of dropping of such insurance. Various situations which encourage health insurance enrollment were also reviewed. The data were obtained by the survey method in June, 1955, from 297 sample households (1294 individuals).

Sampson County was selected purposefully for study because it was a rural hospital service area in eastern North Carolina which had experienced relatively active enrollment efforts in health insurance in recent years. In 1952 a campaign to enroll people in the "doctor's program" was initiated by a nonprofit agency in cooperation with the county medical society, the local hospital administrator, and other local leaders.

The findings of the study are summarized as follows:

1. Forty-one percent of the households and just over one-third (38 percent) of the main families within these households had some kind of health insurance for one or more members. Insurance was held by 28 percent of the individuals.

2. Two-thirds of the insurance was held on an individual rather than a group basis. Almost two-thirds of the families were insured with a commercial company rather than a nonprofit association. Most of the insurance included both hospital and surgical coverage, about half of which included additonal benefits.

3. The highest percentage of enrollment was found among persons ranging in age from 25 to 54 years.

   Farmers and nonfarm laborers were least likely to have health insurance of all of the occupational groups. Farm owners were more likely to have some insurance than were tenants.

   Home owners were more than twice as likely to have health insurance as were renters.

   City people were more likely to be enrolled than were open country and village residents.

   White families were more than twice as likely to have insurance as were nonwhite families. Forty-five percent of the white families had insurance, and only 22 percent of the nonwhite families were insured. White families were also more likely to have all members of the family enrolled.

Insurance enrollment was much more pronounced in the higher income groups than in the lower, the families whose heads were in the highest educational groups, and those who had the highest social participation scores.

4. Almost half (47 percent) of all families who had ever been enrolled in health insurance had dropped some insurance at one time or another. However, only five families dropped more than one policy. They each dropped two policies. Over half of the families who had ever dropped some insurance were not re-enrolled at the time of the study.

   The major reason for dropping was dissatisfaction with insurance. The second most frequent reason was financial.

   Only two families indicated that they had had a policy cancelled by the company. However, there were several who stated that they had dropped their insurance because the company cancelled certain benefits or modified the coverage or the premium rate.

5. Health care personnel were listed as the "best source" of information about health insurance far more frequently than were any other sources. They were listed by almost two-thirds of the respondents. Next in line was the insurance agent or company. This was followed by informal groups.

6. Almost half (47 percent) of those families which had ever been enrolled in health insurance had ever used it at some time to pay health care bills.

   Over three-fourths of the respondents who had ever used health insurance expressed satisfaction with it.

7. There was very little evidence of any locally organized support of health insurance during the year preceding the study. Only seven percent of the respondents indicated that certain organizations in their community had actively encouraged acceptance of health insurance.

The findings of this study point up several rather pertinent generalizations:

1. On the whole, those families who could least afford the cost of health care were also least likely to be enrolled in health insurance.

2. Those families who dropped insurance and did not re-enroll were more likely to be those who had the greatest financial need for insurance. Those families also tend to come from those classes in which unmet health needs are generally most prevalent, according to findings of previous studies.

3. Those same classes of families also are less likely to qualify for group enrollment either through an occupational group, because of the nature of their work, or a non-work group, because of their relative lack of participation in local community organizations.

A real challenge to the insurance industry, to the health leaders in general, and to the local organizations in the immediate future lies with these general classes of people.

ACCEPTANCE OF VOLUNTARY HEALTH INSURANCE IN SAMPSON COUNTY, NORTH CAROLINA, 1955

By
Sheldon G. Lowry* and Donald G. Hay**

II. INTRODUCTION

The objectives of the "Good Health Program" were outlined over a decade ago after extensive study and evaluation of the health care needs of the people in North Carolina.[1] However, continued study and evaluation are necessary in order to assess the progress being made toward achieving those objectives and to plan sound programs for the future.

Although voluntary health insurance[2] is recognized as an important means of financing health care services, adequate information has not been available on the acceptance of such insurance by the people of the State.[3] The present study is designed to provide objective information on this question and to analyze the ways in which the acceptance of health insurance is related to occupation, age, income, education, place of residence, color, and other factors and situations which influence human behavior.[4]

Purpose of the Study

The present study is designed to help answer, among others, the following questions:

1. To what extent are the people in rural areas of the state enrolled in voluntary health insurance?

2. What are the major types of health insurance coverage currently in force?

3. What are some of the social and economic factors associated with the acceptance of health insurance?

4. How extensive is the dropping of health insurance, and what are the major reasons for dropping?

5. What do the people consider to be the sources of "best information" on health insurance?

6. How many people have ever used health insurance and how satisfied are they with it?

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7. How active are local organizations in promoting the acceptance of health insurance?

Method of Study

A random sample was drawn to give a representative cross-section of households in Sampson County Memorial Hospital service area.[5] The sample design consisted of geographic strata, each containing the same number of sampling units. The number of sampling units selected in the urban, village, and open country areas was designed to yield the expected proportional distribution of households as found in the 1950 Census. The sampling rate was 1 in 35. The sample resulted in the selection of 297 households (consisting of 1,294 individuals) from the open country, village, and urban areas of the hospital service area.

This hospital area was selected, along with Scotland Neck Community Hospital area, as an area in eastern North Carolina which recently had received high exposure to voluntary health insurance. Areas were selected to represent a variety of situations which, it was believed, would provide a broad background of conditions and experiences for the analysis of the acceptance of health insurance. Hospital service areas were selected for two reasons: (1) it was felt that this type of information would be more meaningful if viewed in terms of a total local situation; and (2) it provided some check data on hospital service area boundaries which were mapped previously.

The data were obtained during the month of June, 1955, by an enumerative survey using a revised version of the interview guide which was used in the Haywood County study in 1953. Information was secured from either the male head or the female head of the household. The male head was interviewed when he was available; otherwise, the female head was interviewed.[6]

The interviewers included two public school teachers, one high school principal, and two sociologists. Some interviewing was also done by the project leaders. A training period for the interviewers was held prior to the survey, and practice interviews were taken by each interviewer before the fieldwork actually began.

Characteristics of the Locality Studied

The Sampson Memorial Hospital service area was selected as one of the areas to be studied. In this instance, the hospital service area is coterminous with the county.

Sampson County is in the southeastern part of North Carolina, and it is the largest county in the state geographically. The area is generally recognized as being in the southern coastal region of the state. The territory is relatively flat with low rolling hills. The total population in 1950 was 49,780.

The largest city in the county is Clinton, which had a population of 4,414 in 1950.[7] However, since the census in 1950 the city boundaries have been expanded, and the current population is reported to be just over 7,000. With the exception of a few smaller centers such as Garland, Roseboro, and Salemburg, the remainder of the population is widely scattered over the entire county.

The Census listed 67 percent of the population of the county as rural farm and 63 percent as white. By comparison, the sample population was comprised of 65 percent rural farm and 66 percent as white. Therefore, it appears that the sample is a fairly accurate representation of the total population.

Sampson County has a meat-packing plant, wearing apparel factories, radio parts factory, a large produce market, and other industries which provide work opportunities for many rural and urban people alike. These industries also provide a group basis for health insurance enrollment. Truck farming is the major type of agriculture in the area.

The Sampson County Memorial Hospital is one of the larger hospitals which has been built in the state with Hill-Burton Funds. It has 100 beds.

Voluntary Health Insurance Programs in Sampson County

Probably more effort has been made in this area to enroll rural people in the so-called doctor's program than in any other area in the state. Apparently the doctor's program was also the only program which had placed concerted effort in enrolling the rural people of Sampson County in groups, at least up to the time of the survey. The enrollment campaign was begun in May of 1952 with an educational program under the sponsorship of one of the nonprofit insurance agencies of North Carolina and with the cooperation of the county medical society, the hospital administrator, and various local leaders, including farmers, school principals, and ministers. The insurance plan was designed especially for low income people, and it included an agreement with the doctors to supply medical services on the basis of a pre-arranged schedule of fees which would be paid by the insurance agency. For policy holders having incomes below certain specified limits, the participating physicians accept the schedule of fees as full payment for services which they render. If such income limits are exceeded, or if services are rendered by a nonparticipating physician, the fee allowances are paid to the physician to be applied as credit toward his charge. The program was entirely voluntary for both doctors and prospective members. Group rates were offered to farm organizations, schools, churches, and other local organizations.

III. ENROLLMENT IN HEALTH INSURANCE

The principle of health insurance is well accepted in this country. However, there is still considerable disparity between the acceptance of health insurance as a principle and the actual enrollment in such insurance. This section of the study was designed to show the extent of enrollment and to point up those social and economic factors which tend to be related to enrollment.

Extent of Enrollment

At the time of the survey (June, 1955), 41 percent of the 297 households and just over one-third (38 percent) of the main families[8] within each household reported having health insurance for one or more persons in the family. Of the 112 families reporting some enrollment in health insurance, over three-fourths had all members of the family enrolled, and about one-fourth had some but not all members enrolled. Less than one-third (28 percent) of the 1,294 individuals in the study had health insurance of some kind.

Ninety percent of the families which were enrolled had only one policy. Eight families had 2 policies, two had 3 policies, and one had 4 policies. In general, those families with more than one policy were not duplicating their coverage, but rather they were either providing comparable insurance for members of the family not covered by the one policy, or they had policies to provide additional benefits not covered by other policies.

Type of Coverage

The most common type of coverage reported was hospital and surgical together. This tendency is clearly shown in the following data:

Type of Coverage	Percent of Enrolled Families
Hospital and Surgical	47
Hospital, Surgical and Other	45
Hospital Only	5
Disability Only and/or Workmen's Compensation Only	4
Surgical Only	0

Ninety-two percent of the families with insurance reported that they had both types. Almost half of those families also had other benefits in addition to hospital and surgical coverage. There was no surgical insurance by itself, and only 5 percent of the families reported

having had hospital coverage only. Another 4 percent indicated that they had disability benefits but no other coverage.

Enrollment Basis

Over two-thirds of the 112 families with insurance stated that their insurance was obtained on an individual rather than a group basis. Over one-fourth indicated that they had group insurance only. The remainder (5 percent) reported a combination of group and individual insurance.

Enrollment Basis	Percent of Enrolled Families
Individual	68
Group	27
Group and Individual	5

By far the majority of group policies were obtained as a member of a work group. Out of 37 families reporting being enrolled in group insurance, 28 were enrolled as a member of a work group. Other kinds of groups which were listed most frequently were the Grange and Home Demonstration clubs.

Type of Carrier

The following data reveal that families were insured far more frequently with commercial insurance companies than they were with nonprofit agencies:

Type of Carrier	Percent of Enrolled Families
Commercial Insurance Companies	61
Nonprofit Agencies (Blue Cross)	34
Both	5

Almost two-thirds of the families indicated that they were insured with a commercial insurance company; one-third were enrolled with a nonprofit agency; and 5 percent said they had policies from both types of insurance carriers. While 80 percent of the commercial insurance was obtained on an individual basis, about half of the nonprofit insurance was obtained on an individual and half on a group basis.

Year of First Enrollment

As revealed below, there has been a decided increase in first enrollments in health insurance in Sampson County in recent years.

Year of First Enrollment	Percent of Families Ever Enrolled
1954-1955	22
1952-1953	21
1950-1951	23
1948-1949	16
1947-before	18

The major increase in enrollment began between 1948 and 1950 and has remained rather constant ever since. This upswing in enrollment seems to coincide with the building of the Sampson Memorial Hospital in Clinton, which was completed in September of 1950. Although only 7 families gave the building of the hospital as a reason for taking out health insurance, there has been more enrollment activity in the area since the hospital was begun than at any other time. Two-thirds of the 152 families who had ever been enrolled at the time of the study enrolled for the first time since 1949. Only 12 percent enrolled for the first time prior to 1946. Proportionately twice as many high income families were enrolled for the first time prior to 1948 as were low income families. The respective percentages were 14 and 28.

Factors Related to Enrollment

One of the primary concerns of the study was to investigate the relationship of insurance enrollment to various social and economic characteristics of the families involved. These characteristics not only influence the financial availability of health insurance, but also the acceptance of insurance by the people regardless of whether or not it is within reach financially. Some of the characteristics, such as age and others, also influence the availability of health insurance in terms of the willingness of insurance companies to insure the people. The two classes of characteristics are so closely interwoven that it is unrealistic to assign a greater weight to one or the other of them.

Age. The relationship of age to insurance enrollment was as follows:

Age	Total Number of Individuals Reporting	Percent of Individuals Enrolled in Health Insurance
Total	1,278	28
Under 6 years	196	27
6-17	376	23
18-24	114	21
25-34	158	34
35-44	152	38
45-54	119	34
55-64	90	29
65-over	73	23

The highest percentage of enrollment was found among persons ranging in age from 25 to 54 years. Over one-third of the individuals in these age groups had some kind of health insurance. Beyond age 55 there was a gradual tapering off in enrollment. Roughly one-fourth of the individuals below 25 years of age were enrolled.

Relationship to Head of Household. The rates of enrollment for male heads and female heads were almost identical. Thirty-five percent of the former and 33 percent of the latter were enrolled. For children of the household heads and all other relatives living in the household, the enrollment rate was only 23 percent. Only one of the 4 unrelated individuals living in the household had any health insurance.

Occupation. As would be expected, of all the occupational groups, the families of farmers and nonfarm laborers were least likely to have any type of health insurance.[9] See Table 1 below. In fact, the unemployed, retired, and those who were unable to work were as likely to have health insurance as were farmers and nonfarm laborers. The highest frequency of insurance enrollment was found among the professional, managerial groups, and the clerical and kindred workers. Next to them were the skilled and semi-skilled workers. The same general trend existed for the percentage of individuals enrolled as was found for the families.

Home Tenure. Home owners were more than twice as likely to have some insurance as were renters. Fifty percent of the home owners had some kind of health insurance compared with 23 percent of the renters. Furthermore, thirty-nine percent of the individuals in owner households were insured, whereas only 17 percent of the individuals in renter households were insured. See Table 1.

Farm Tenure. For purposes of comparison, nonfarm occupations were included with the farm tenure classes. There was a tendency for farm owners and those engaged in nonfarm occupations to be enrolled in health insurance in greater proportions than the sharetenants and sharecroppers (see Table 1). The rate of enrollment for nonfarm people and for farm owners was more than double the rate for tenants and laborers both in the proportion of families with one or more members enrolled and the proportion of individuals which were enrolled.

Place of Residence. A greater proportion of city families had some health insurance than did either the village or the open country families (see Table 1). In fact, the proportion of families and of individuals with insurance was about half again as high in the city as it was in the village and open country.

Another trend which should be pointed out is that the open country, part-time farmers were more likely to have health insurance than were the full-time farmers and the open country, nonfarm residents. The part-time farmers were comparable to the city residents in this regard.

Color. White families were more than twice as likely to have

TABLE 1

ENROLLMENT OF FAMILIES AND INDIVIDUALS IN HEALTH INSURANCE BY SELECTED FAMILY CHARACTERISTICS, SAMPSON COUNTY, 1955

Family Characteristics	Number of Families Reporting	Percent of Families Enrolled	Number of Individuals Reporting	Percent of Individuals Enrolled
Total	297	38	1294	72
Occupation of Head				
Professional, managerial, clerical, sales and kindred workers	43	63	166	54
Skilled and semi-skilled	30	43	141	31
Nonfarm laborer	33	33	144	27
Farmer	169	32	779	23
Unable to work, retired, unemployed	21	33	42	26
Home Tenure				
Owner	163	50	647	39
Renter	133	23	642	17
Farm Tenure				
Nonfarm	93	42	390	33
Farm owner	102	47	423	37
Tenants and Laborers	80	20	419	15
Residence				
Open country	238	35	1097	26
Village	14	36	46	28
City	45	53	149	46
Color				
White	204	45	852	35
Nonwhite	93	22	440	15

(Continued)

TABLE 1

ENROLLMENT OF FAMILIES AND INDIVIDUALS IN HEALTH INSURANCE BY SELECTED FAMILY CHARACTERISTICS, SAMPSON COUNTY, 1955

(Continued)

Family Characteristics	Number of Families Reporting	Percent of Families Enrolled	Number of Individuals Reporting	Percent of Individuals Enrolled
Income				
Under $500	111	23	514	17
$500 - $1,499	72	31	320	22
$1,500 - $2,499	28	57	109	44
$2,500 - $3,999	24	75	105	59
$4,000 - over	18	83	74	74
Education of Male Head				
Under 7 grades	116	17	575	15
7 - 9	78	49	334	29
10 -12	55	67	208	60
13 - over	19	63	68	60
Education of Female Head				
Under 7 grades	82	10	364	7
7 - 9	91	38	446	26
10 - 12	88	51	360	45
13 - over	27	67	95	55
Social Participation of Family Heads				
Under 10	44	14	216	11
10 - 29	207	37	881	27
30 - over	45	64	191	55

insurance as were nonwhite families. See Table 1. The percentage of white individuals enrolled was also more than double that of nonwhite individuals.

Income. Insurance enrollment was much more pronounced among the higher income groups (Table 1). The percentage of families with one or more members enrolled increased from 23 percent for those with incomes below $500 to 83 percent for those with incomes of $4,000 and over. The percentage of individuals enrolled increased from 17 percent in the lowest to 74 percent in the highest income group.

Education of Household Heads. There was a definite association between education of household heads and enrollment of family members in health insurance (Table 1). Seventeen percent of the families whose male heads had less than 7 years of schooling had some health insurance. Enrollment increased to about two-thirds in those families whose male heads had 10 or more years of education. The same general trend existed when education of the female heads was considered. The enrollment ranged from 10 percent in the lowest educational level to 67 percent in the highest. Comparable trends were found for the enrollment of individuals also.

Social Participation of Household Heads. There was a marked difference between the proportion of families enrolled in insurance in the highest social participation class and those in the lowest.[10] See Table 1. Only 14 percent of the families in the lowest group has insurance as compared with 64 percent in the highest. This pronounced trend was also found in individual enrollment. Individuals whose household heads were in the highest participation group were enrolled proportionately five times more frequently than were individuals whose heads were in the lowest group.

Types of Organizations in Which Household Heads Participate. Only 14 of the 297 household heads reported that they did not participate in any organization. Thirteen of these said that no one in the family had any health insurance. On the other hand, 39 percent of those who did participate in various organizations also reported having some insurance. Even though the number of cases of nonparticipants was rather small, the difference in enrollment between participants and nonparticipants was large enough to be significant according to the chi square test. The results point up a possible trend which is worthy of further investigation.

Very few household heads participated in any community organization without also participating in a church. On the contrary, 170 heads of separate households participated in a church but no other organization. Of the participators, those who were active only in the church were a little less likely to have insurance than those who participated in other organizations in addition to the church. This finding has some implications for the role of church in the temporal affairs of its members.

Distance to the Nearest Doctor. Distance to the nearest doctor showed a slight relationship to enrollment in insurance. The major difference, however, was between those less than one mile from a doctor and those one mile or more. The latter group was less likely to be enrolled. It is quite likely that the difference found here was due more to rural-urban residence than to distance per se.

Distance to the Nearest Hospital. Distance to the nearest hospital was also associated with insurance enrollment. Here again, the tendency undoubtedly was due more to rural-urban residence than to distance. The percentage of families with some insurance increased from 33 percent for those 22 miles or more distance to 54 percent for those less than 1 mile away. Distance seemed to have little, if any, effect upon the proportion of families with all members enrolled as compared with those families with only part of the family enrolled.

IV. DROPPING OF HEALTH INSURANCE

The dropping of health insurance offers some measure of the acceptance of such insurance. However, dropping by itself does not reveal the whole picture, since people drop insurance for a variety of reasons. Therefore, in addition to obtaining the reasons for dropping, the re-enrollment rates were studied also in order to obtain a more adequate measure of the magnitude of dropping.[11] Obviously the family which drops a policy and later enrolls in another policy is exhibiting a different attitude toward insurance from a family which drops and does not re-enroll. Of course, in order to obtain an accurate measure of re-enrollment it would be necessary to study the re-enrollment trends over a period of time rather than at any given time, as was done here. Nevertheless, the data from cross-sectional studies do offer sufficient indication of over-all trends to justify their use.

Extent of Dropping

Almost half (47 percent) of the families who were ever enrolled in health insurance had dropped some insurance at one time or another. Over half of those who had dropped were not re-enrolled at the time of the study. In other words, over one-fourth of the families who had ever held any health insurance had dropped and not re-enrolled.

Only two families reported that their insurance had been cancelled by the company. However, a number of families reported that they had dropped their insurance due to the restriction of certain benefits or the raising of premiums.

Only 5 families had ever dropped more than one policy. These 5 families had dropped two policies each.

Over half of the families which dropped did so one year or less from the time they enrolled. Seventy-nine percent of the families who dropped insurance dropped their policies within two years of the time they enrolled. Only 21 percent held their policies as long as three years or more.

There was no pronounced trend with regard to the type of coverage which was dropped. In relation to the type of coverage ever in force, there seemed to be a very slight tendency for hospital coverage by itself and hospital and surgical coverage together to be dropped a little more than hospital and surgical coverage combined with other benefits. Further study needs to be made of this trend. If it is found to be valid, it would seem to indicate a desire for more complete coverage on the part of the policy holder.

Reasons for Dropping

When all dropped policies were considered, the most frequent reason for dropping was dissatisfaction with insurance. (See Table 2.) One-third of the policies were dropped for this reason.

The most common expressions of dissatisfaction were such statements as "inadequate benefits," "it wouldn't pay off," "too much red tape," "couldn't use it without paying own money first," and "misinformed about the policy." This study made no attempt to check the validity of these statements.

The second most frequent reason which was given for dropping was financial reason. The comments were directed both at the cost of insurance and at the family's own financial circumstances. Such comments as the following were made: "the premium increased," "it was too expensive," "we stopped borrowing," "we were too much in debt," "we couldn't pay the premiums."

Change of employment was the next most common reason given for dropping. It was reported for 16 percent of the dropped policies. Other reasons which were listed may be seen in Table 2.

There was some evidence, though not conclusive, that insurance purchased on an individual basis was dropped proportionately more than insurance purchased on a group basis. For example, of the insurance that had ever been in force, 54 percent of the individual policies had been dropped as compared with 44 percent of the group policies.

In very few instances did any of the families talk to anyone about dropping their policies. Eighty-three percent did not talk with anyone. There was a slightly greater tendency for nonwhite people to discuss their dropping with someone than for white people. However, the tendency was not pronounced.

Factors Related to Dropping

Occupation. Clerical and kindred workers and nonfarm laborers were more inclined to drop health insurance than were the other occupational groups. Skilled and semi-skilled workers and farmers were least likely to drop insurance. The number of cases of dropping was so small in certain of the occupational classes that it was difficult to pin point trends in re-enrollment. However, it appeared that the professional and managerial groups and the clerical and kindred workers were most likely to re-enroll.

Home Tenure. Proportionately more renters had dropped some health insurance than had home owners. (See Table 3.) Of even greater importance, however, is the fact that renters were not only more inclined to drop insurance, but they also had a greater tendency not to

TABLE 2

REASONS FOR DROPPING VOLUNTARY HEALTH INSURANCE, SAMPSON COUNTY, 1955

Reasons for Dropping*	Percent of Dropped Policies
Total	100**
Dissatisfaction with the insurance (dissatisfied with use of insurance, inadequate benefits, wouldn't pay off, too much red tape, couldn't use it without paying own money first, misinformed about the policy)	34
Financial reasons (increase in premium, too expensive, stopped borrowing, too much in debt, couldn't pay premiums)	23
Change in employment (quit working, changed place of work, changed jobs, moved away, joined service)	16
Dropped to take other policy	10
Missed paying premium (neglect)	5
Dropped insurance on individual basis for group basis	1
Other (group wouldn't join, death of family member, never needed it, personal reasons)	10

*Two policies which were cancelled are not included in this table.

**Percentages do not add up exactly to 100 due to rounding off to whole numbers.

TABLE 3

DROPPING OF HEALTH INSURANCE BY FAMILIES IN SAMPSON COUNTY BY SELECTED FAMILY CHARACTERISTICS, 1955

Characteristics of Families	Number of Families Ever Enrolled	Percent of Families Ever Enrolled		
		Who Ever Dropped	Re-enrolled	Not Re-enrolled
All Families	152	47	20	26*
Home Tenure				
Owners	97	40	24	16
Renters	54	57	13	44
Farm Tenure				
Nonfarm	54	54	26	28
Farm Owners	57	39	23	16
Tenants and Laborers	30	60	13	47
Color				
White	115	45	25	20
Nonwhite	37	51	5	46
Income				
Under $500	38	47	16	32
$500 - $1,499	39	51	8	44
$1,500 - $2,499	20	50	30	20
$2,500 - Over	36	31	22	8
Education of Male Head				
Under 7 grades	41	59	7	51
7 - 9	44	41	27	14
10-12	40	40	33	7
13- Over	16	44	19	25
Education of Female Head				
Under 7 grades	18	67	11	56
7 - 9	49	43	14	29
10-12	56	48	29	20
13- Over	22	45	27	18
Social Participation Score				
Under 10	17	65	0	65
10-29	100	47	24	23
30-Over	34	35	21	15

*Due to rounding errors the "Re-enrolled" and "Not Re-enrolled" do not always add up exactly to the percent who ever dropped.

re-enroll. Forty-four percent of the renters who had ever enrolled were dropouts[11] at the time of the survey as compared with 16 percent of the home owners. To state it another way, 77 percent of the renters who had ever dropped were not re-enrolled, whereas 41 percent of the home owners who had ever dropped were not re-enrolled at the time of the study.

Farm Tenure. Sharecroppers, sharetenants, and farm laborers dropped health insurance in greater proportion than did any of the other tenure classes (Table 3). Tenants (sharecroppers and sharetenants) and farm laborers also had the lowest re-enrollment rate. Seventy-eight percent who had ever dropped were not re-enrolled at the time of the study. The comparable figures for farm owners and nonfarm occupations were 41 percent and 52 percent, respectively.

Residence. City people were a little more inclined to drop health insurance than were open country residents. On the other hand, city residents were much more likely to re-enroll. Almost two-thirds of the open country families who had ever dropped were not re-enrolled at the time of the study. About one-third of the city people had not re-enrolled. Open country, nonfarm residents also had a comparatively high dropout rate.

Color. The percentage of people who had ever dropped any health insurance was slightly higher for nonwhite than for white families. The greatest difference was in the proportion who did not re-enroll. Proportionately many more whites were re-enrolled when the study was made. See Table 3.

Income. The rates of dropping of health insurance were almost identical for income groups below $2,500 (Table 3). However, beyond this point there was a sharp decline in the dropping of insurance. Likewise, of those who had ever dropped the tendency was for the high income people to re-enroll in greater proportions than the low income groups.

Education of Household Heads. When the education of the household heads was considered in relation to the dropping of health insurance, it was found that those families whose heads had the lowest education were more likely to drop insurance. (See Table 3.) The major difference was between those who had completed less than 7 grades of schooling and those with 7 or more grades. There was also a greater tendency for this lowest group to remain out once they had dropped. The over-all trend was consistent even though there were minor fluctuations when the education of the male head was considered.

Social Participation of Household Heads. The families whose heads had the lowest social participation scores dropped health insurance in greater proportions than did the families with higher scores. The families with the lowest scores were also much less likely to re-enroll once they had dropped their insurance. See Table 3.

Distance to Doctor and Hospital. There was no clear relationship between the dropping of health insurance and distance to the

nearest doctor or hospital. Among those who had dropped some health insurance, there was a tendency for those within one mile of a hospital to re-enroll in greater proportions than those beyond one mile. However, the number of cases involved were too few to be conclusive. Even if such a trend actually existed, it would probably be due more to rural-urban residence and occupation than to distance per se.

V. ATTITUDES AND IDEAS ABOUT HEALTH INSURANCE

The perception which people have of health insurance is a rather important influence on their acceptance or rejection of such insurance. The respondents' perception of health insurance was investigated in an exploratory manner in terms of what they expect of it and the advantages and disadvantages of health insurance from their point of view.

Opinions Concerning Health Insurance

Services Which Need Coverage. The informants were presented a list of 8 types of insurance coverage and asked to indicate which they felt should be covered by health insurance. They were also instructed to add additional items which they felt should be covered.

As would be expected, some informants checked all of the suggested types of coverage, and some checked only a few of the items. Table 4 shows that hospital and surgery were the types of coverage most frequently checked. These items were checked by over 90 percent of the respondents. In view of the development of health insurance benefits over the past few years, it was not surprising to find these two types of coverage heading the list.

Maternity care and cash disability benefits were next in line, and they were followed by special nurses and doctors' calls (other than surgery). Dental benefits and physical exams ranked at the bottom of the list.

After checking the types of benefits which they thought should be covered by insurance, the informants were asked to specify which one they felt was most important. Again, hospital and surgical benefits were clearly in the majority. Hospital coverage was mentioned by half of the respondents and surgical by almost one-third. The two items together were mentioned by 82 percent of the people. Cash disability benefits were next. They were mentioned by 10 percent of the people. Other benefits were listed rather infrequently or not at all.

When the respondents were asked to list the "next most important" coverage, surgery was first (46 percent) and hospitalization was second (25 percent). Cash disability and doctor services other than surgery were listed next. These two benefits received almost the same proportion of choices, 9 percent and 8 percent, respectively. Other benefits were mentioned even less frequently.

The respondents were also asked to indicate which type of coverage they felt was least important. Dental care and physical exams were the benefits most frequently checked. They were followed by special

TABLE 4

TYPES OF HEALTH INSURANCE COVERAGE PREFERRED
BY 297 FAMILIES IN SAMPSON COUNTY, 1955

Type of Coverage	Percent of Families Reporting			
	Health Service "Which Should Be Covered by Health Insurance"	Most Important Coverage	Next Important Coverage	Least Important Coverage
Hospital	94	52	25	0
Surgery	91	30	46	*
Maternity Care	69	3	5	7
Cash Disab. Benefits	66	10	9	2
Special Nurses	59	*	4	11
Doctor (Non-surgical)	50	4	8	11
Dental	32	0	*	36
Physical Exam	26	*	1	31
Other Coverage	*	0	0	0
All Are Important	—	—	—	2

*Less than 1 percent.

duty nurses and doctor's calls (non-surgical), although these last two benefits were mentioned somewhat less frequently.

Anticipated Impact of Health Insurance on the Use of Health Care Services. Over two-thirds of the informants felt that when people take out insurance they will not use doctors or hospitals any more nor any less than they did prior to having insurance. Less than one-third (30 percent) indicated that they felt that people had a tendency to use doctors and hospitals more when they have insurance. Less than one percent felt that people would use these services less.

Recognized Needs of Selected Groups. As would be expected, most (77 percent) of the informants felt that the low income people needed health insurance more than the other income groups. However, there were some who felt that since all groups need medical care, one group is as likely as another to need health insurance.

There was little agreement as to the age group which needs health insurance the most. There was a greater tendency to check all age groups rather than to single out any particular age group. Thirty-five percent felt that one age group was as likely to need it as another. The single age group which was checked most frequently was from 19 to 64 years. The reasoning seemed to be primarily concerned with the fact that they are the breadwinning group and, therefore, need more security.

Desirability of $50 or $100 Deductible Health Insurance. Although deductible automobile insurance is widely accepted and used, it seemed difficult for many informants to conceive of this type of insurance being applied in the field of health. It is true, a price cannot be fixed on the life or health of a human being in the same way that it can an automobile. However, health and medical care costs are sufficiently stable as to permit relatively accurate prediction for a given population over a given period of time. Even so, almost two-thirds of the informants felt that they would not like deductible health insurance.

Recognized Advantages and Disadvantages of Health Insurance

Main Advantages. In responding to what they considered to be the main advantages of health insurance, the majority of the respondents reported financial security. Other comments included such things as: it increases availability of health care services and facilities; it "provides peace of mind"; it is a means for better health; and you can get good service at the hospital. Many of the comments had financial implications, but they were not definitely spelled out. One percent of the respondents gave noncommital replies, and another one percent stated that there were no advantages to health insurance.

Main Disadvantages. One-third of the respondents indicated that there were no disadvantages to health insurance. Another one-third

listed difficulties with the insurance companies or their policies as the main disadvantage. The following are some of the more common criticisms which were made: the policies are misrepresented; there are loopholes in the policies to keep people from collecting; the insurance companies are unreliable; it is difficult to get the company to settle claims; and the company cancels policies.

The next most frequent comment involved financial disadvantages relating either to the cost of the insurance or the level of the family income. Ten percent indicated that there were no disadvantages provided certain qualifications were met. Other disadvantages which were reported included abuses of insurance by the people who over-use it and by doctors who pad the bills when they know you have insurance.

Personal Satisfactions. Obviously many individuals could not say whether or not they were personally satisfied with insurance, since they had never had any experience with it. Twenty-two percent of the respondents fell into this category. Of those who reacted to the question, almost two-thirds said they were very satisfied with health insurance. Almost one-third said they were fairly satisfied, and only 7 percent said they were not satisfied.

Changes Suggested in Insurance. Forty percent of the respondents felt that some changes should be made in health insurance. By far the majority of the respondents mentioned changes involving improved practices of insurance companies. Forty-two percent suggested changes that fell into this category. The next two major changes were mentioned with almost equal frequency. The first involved financial changes, and the second related to the extension of coverage. The former, which was primarily concerned with the cost of premiums, was reported by 29 percent of the respondents. The latter included some rather specific suggestions such as "insurance should cover all doctor's calls," "outpatient service," and "all hospital treatment." This group of suggestions was mentioned by 24 percent of the informants.

VI. INFLUENCES WHICH MOTIVATE ACCEPTANCE OF HEALTH INSURANCE

Among the primary concerns in studying the acceptance of health insurance are the influences which induce people to take out their very first policy. Those first contacts and influences are of major importance in determining the initial acceptance or rejection of insurance by the people. Once a family is enrolled, their attitudes become modified and conditioned by their experiences with the particular insurance in which they have enrolled.

In order to obtain further insight into the acceptance of health insurance, the study included a section on some of the influences which motivate acceptance or rejection of health insurance. This section of the study contained information on the sources from which the people obtain information about health insurance and the influences which motivate their first enrollment in insurance. Also, some information was obtained from those family heads who had never had any health insurance concerning their reasons for not enrolling. This section concluded with a brief summary of the use of health insurance and the satisfaction of the people with their use of such insurance.

Sources of Information About Health Insurance

Each informant was handed a card with a list of 19 possible sources of information on health insurance. He was asked to check all of those from which he receives helpful information about health insurance. A place was also provided for listing additional sources which did not appear on the list.

Six percent of the people reported that they received no information. The largest proportion of the people (30 percent) stated that they received information from two sources. The second largest proportion (17 percent) checked three sources. A rather surprising finding was the rather large number of sources which many of the families used. One-fourth of the families reported that they received helpful information from six or more different sources. Five percent reported nine or more sources. All sources were later grouped as shown in Table 5.

The most frequently mentioned sources were health care personnel. They were mentioned by over three-fourths (78 percent) of the informants. See Table 5. Next in line were informal groups such as relatives, friends, neighbors, and fellow workers. They were mentioned as sources by about half of the respondents. The insurance agent or company was listed by 45 percent. Others which were listed are shown in Table 5.

The informant was then asked to go back over the sources he had

TABLE 5

SOURCES OF INFORMATION ON HEALTH INSURANCE
USED BY SAMPSON COUNTY FAMILIES, 1955

Sources of Information	Percent of Families Reporting		
	Sources Used	Sources of Best Information	Next Best Source
Number of Families Reporting	297	283	281
Health Care Personnel*	78	60	53
Insurance Agent or Company	45	15	7
Informal Groups**	49	8	15
Formal Groups***	17	4	4
Mass Media	22	2	3
Employer	9	1	1
Others	3	1	2
None--No Source Given	6	8	14

*Health care personnel include physician, hospital personnel, public health department personnel, and druggist.

**Informal groups include relatives, neighbors, other friends, and fellow workers.

***Formal groups include organizations and agencies and their leaders, such as school teachers, county agents, ministers, and others.

checked and indicate where he thought he could get the best information about health insurance. (See Table 5.) Health care personnel were listed far more frequently than any other source. Almost two-thirds of the informants listed them as the best source of information. Next in line was the health insurance agent, which was listed by 15 percent. Informal groups were in third place. They were mentioned by only 8 percent of the people.

When the "next best sources" were considered, health care personnel were still first choice, informal groups were second, and the health insurance agent was third.

It seems obvious that the people not only place their faith in the medical and health care profession for matters of a strictly medical nature, but also in areas related to health care which are not directly medical in nature. This fact offers a challenge to the health care profession in terms of future educational efforts in the area of payment for health care. It appears likely that this confidence in the profession will be maintained as long as the people receive objective facts and information concerning health insurance and related matters.

Influences on First Enrollment

In order to assess the influences which stimulated the people to take their first insurance, they were asked what started them to thinking about their first health insurance. Illness or anticipated health needs and the influence of the insurance agent were the replies most frequently given. Each of these influences was reported by just over one-fifth of the respondents.

The next most frequently cited influences involved the desire for financial security and the general feeling that "insurance is a good thing." The former was mentioned by 16 percent, and the latter by 14 percent of the respondents. In addition to the above influences, stimulus also came from informal groups, group enrollment situations, employers, and others; however, these influences were mentioned much less frequently.

The data indicate that the health insurance agent was not only one of the major influences in starting people to think about enrolling in insurance, but he was also the major source of information which was used in deciding upon the insurance. Over half of the respondents reported that they received their information from an insurance agent. The next most frequent source of information was informal groups, which was mentioned by only 15 percent of the people.

When it came to indicating what finally made them decide to take the insurance, the major emphasis shifted from the influence of other individuals and groups to what the people considered to be some of the major values of the insurance and their need for it. For example, 30 percent listed anticipated health needs; 18 percent

indicated financial security; and another 18 percent mentioned that they believed that insurance was a good thing. Interestingly enough, 13 percent frankly indicated that their decision was based on the influence of the insurance agent.

Although there was an upsurge in health insurance enrollment at the time the hospital was built in Clinton, only 5 percent of the respondents stated that the building of the hospital influenced their decision to take insurance.

Those family heads who had never had any health insurance were asked if they had ever considered taking any. Half of these respondents said that they had considered it and half said that they had not. Of those who had considered it, by far the most common reason given for not taking insurance was financial. Almost two-thirds (61 percent) of the respondents said that financial reasons were the main ones. One-fourth said that they had simply postponed or put off enrolling. The remainder were scattered over a group of miscellaneous reasons.

Those persons who stated that they had never considered taking health insurance were asked the reason why. Financial reasons and "postponed" were still in first place, only in reverse order this time. One-fifth gave the former, and one-half gave the latter as the main reason. It should also be pointed out that 12 percent said they had no need of insurance. Another 9 percent stated that they lacked confidence in insurance, the agents, or insurance companies.

As a matter of interest, 89 percent of those household heads who had never had any health insurance had incomes below $1,500. Only 2 percent had an income of $4,000 or above.

Of all the informants, only 20 (7 percent) stated that there had been some organizations in their community which had been active in encouraging acceptance of health insurance during the past year. The Grange was the most frequently cited organization, with seven of the informants mentioning it. Home Demonstration Clubs were mentioned four times, churches twice, and the Farm Bureau only once. Other miscellaneous groups were also mentioned.

The information thus obtained reveals that, even though insurance enrollment in the area has maintained a fairly constant rate over the past few years, apparently very little activity was channeled through the existing organizational structure of the communities involved. At least, little activity was recognized at the lay level.

Use of Health Insurance

Of those families which had ever been enrolled in health insurance, almost half (47 percent) had ever used it. Of course, it should be remembered that two-thirds of those families who had ever enrolled in insurance did so for the first time since 1949, and 43 percent

enrolled since 1951. Therefore, some families had a longer period of time in which to use their insurance.

Most of those who had used their insurance had done so within the past three or four years. Of those who had used their insurance, 70 percent had done so most recently within the past 3 years and 80 percent had used it within the past 4 years, that is, since 1951.

Over three-fourths of the respondents who had ever used health insurance stated that they had been satisfied with their use of insurance. Six percent said that they had not been satisfied, and an additional six percent said that they had been satisfied with one claim but not with another. Thirteen percent said they were only partly satisfied.

APPENDIX A: FOOTNOTES

1. Clarence Poe (Editor), Hospital and Medical Care for All Our People, Raleigh, N. C., 1947.

2. Health Insurance. Health insurance was defined to include all forms of prepaid medical care insurance such as hospitalization, surgery, limited medical, comprehensive benefits, disability insurance, and health riders on other kinds of insurance policies such as on life or automobile policies. Workmen's compensation and insurance for school accidents were not included in the study.

If an individual had any of the given types of health insurance coverage, he was considered to be enrolled in voluntary health insurance. If one or more individuals in a household carried any health insurance, the household was considered to be enrolled. Although some analysis was made as to whether or not all household members were covered, no attempt was made to evaluate the adequacy of the coverage.

3. Acceptance of Health Insurance. There are actually two aspects of health insurance: (1) the approval of the principle without necessarily desiring insurance for one's own use; and (2) the adoption of health insurance for oneself or one's family. The former is strictly attitudinal, whereas the latter involves some action on the part of the respondent. The present study includes aspects of both of these levels of acceptance.

4. For a report of the first study in this series, see: Donald G. Hay and C. Horace Hamilton, Acceptance of Voluntary Health Insurance in Four Rural Communities of Haywood County, N. C., 1953, Progress Report Rs-24, N. C. Agricultural Experiment Station, September, 1954.

In 1955, the study was continued in two additional areas: Sampson County Memorial Hospital area and Scotland Neck Community Hospital area. For a report of the study in the Scotland Neck area, see: Donald G. Hay and Sheldon G. Lowry, Acceptance of Voluntary Health Insurance in Scotland Neck Community Hospital Area, North Carolina, 1955, North Carolina Agricultural Experiment Station, Progress Report Rs-27, July, 1957.

5. The sample was drawn by the Department of Experimental Statistics at North Carolina State College.

6. The Haywood County study referred to in footnote 4 revealed little, if any, difference in the reliability of the responses of male and female heads. In that study male and female heads were interviewed alternately. While it is agreed that this is a methodological problem which needs further study, the present procedure seems to be justified in this type of study.

7. United States Census of Population, 1950.

8. Main Family. The term, main family, was used to approximate a family unit as frequently defined for health insurance purposes. According to the 1950 Census, a family was defined as "a group of two or more persons related by blood, marriage, or adoption and living together." Several limitations were placed on the Census definition in order to determine the main family in each household. (1) The main families were designated as those in which the family heads, male or female, were also the heads of the household. (2) The main family was further restricted to include only those children of the male and/or female head who were unmarried and under 18 years of age at the time of the study. (3) In households in which there was only a single individual, that person was considered to constitute a main family, even though such an individual would not qualify for a family health insurance policy. (The number of cases of such households was very small.)

Throughout the report, the term "family" is used to refer to "main family" as here defined. Furthermore, by definition, main family heads and household heads are coterminous.

9. Occupation. Unless otherwise specified, occupation refers to the major occupation of the person involved, that is, that gainful employment from which the individual received the largest part of his income during the past year.

10. Social Participation. The social participation score was based on the Chapin Scale for participation in formally organized groups. The score was arrived at by giving 1 point for membership, 2 for attendance, 3 for contributions, 4 for committee membership, and 5 for being an officer. These values were then added for each organization in which the individual participated.

11. Re-enrollee. A re-enrollee is one who has dropped some health insurance and who was enrolled at the time of the study.

Dropout. This refers to those families or individuals who have dropped some health insurance and who were not enrolled at the time of the study.