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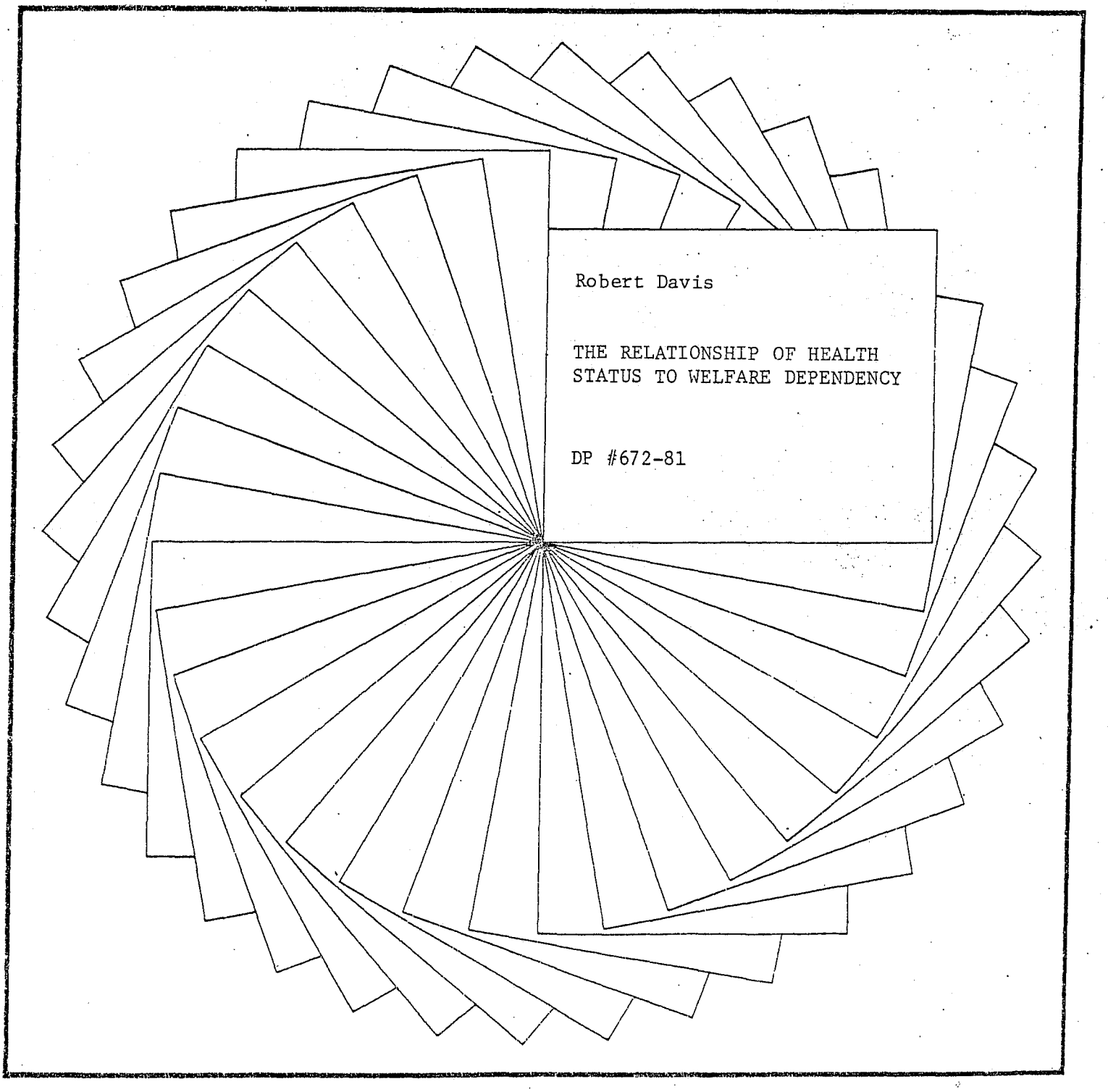

The Relationship of Health Status to Welfare Dependency

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ABSTRACT

This paper is designed to advise government policymakers on appropriate health policy initiatives for improving the overall health status of the poor, thereby reducing welfare dependency. The analysis proceeds from a general discussion of the growth of public and private health care spending to the nature of medical care given to the poor, and concludes with a critical examination of government policy toward medical care for the poor. Unpublished data from the 1977 Health Interview Survey of the National Center of Health Statistics and 1975 AFDC recipient data from the Department of Health and Human Services provide the basis for much of the analysis. The conclusion recommends that a more rational, data-based health policy be implemented by government policymakers. That policy could make use of information on behavorial ~~control~~ measures, (environmental control measures) and health care services to improve the health status of the nation's poor.

Health Status and Its Relationship to Welfare Dependency

> The notion persists that the finest medical care available--in fact, better than what most people can afford--is provided free to poor people in hospital clinics and even in private doctors' offices by top-notch physicians who allot a portion of their time to charitable work. According to a popular saying, you have to be either very rich or very, very poor to get first rate medical care.
>
> But the poor know better. The most significant and unassailable truth, supported by raw and disquieting facts, is that the poor have a far higher rate of sickness and death in all the diseases that are preventable and treatable by good medical care....
>
> The truth is that sometimes excellent, sometimes shoddy, but always piecemeal medical care is delivered fitfully and distributed badly to the poor, under conditions that make a coordinated, personal medical approach impossible even for the most conscientious physicians. Moreover, these conditions are so surrounded with indignities and inconveniences that poor people, even when they are informed about the value of prompt and sustained medical care, characteristically come for medical help at the last moment--often too late.
>
> Irving Block, The Health of the Poor, 1970

In 1964 the United States embarked on the greatest expansion of spending for health and medical care in its history. With the creation of Medicare, which provided comprehensive medical care for those over 65, the federal dollar began to be used to bring medical care to those who could not otherwise secure it. In the 16 years since, government efforts to improve access to medical care have included expanded and extended Social Security benefits and increased cash and in-kind assistance through two other programs, Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI).

THE GROWTH OF PUBLIC AND PRIVATE HEALTH CARE SPENDING

Between 1950 and 1978 total expenditures from public and private sources for health and medical care increased dramatically, from $12 million to $187

million, an increase of $175 million. Health care expenditures increased 13.7 percent, or $22.5 billion, from fiscal year 1977 to 1978 (Table 1). This rise represents a slower annual rate of growth in health care expenditures than in the previous year. Table 1 shows that the percentage of total health care spending provided by the public sector rose from 25.5 percent to 40.8 percent over the 28 years for which data are presented. In 1978 the proportion of total health care spending provided by private sources was 59 percent, compared to the 41 percent provided by the public sector. These percentages are about the same as those for the previous year and interrupt the trend of a slow but steady shifting of health care spending from the private sector to the public sector that has been observed since Medicare began paying benefits in the mid-1960s.

In 1965, 25 percent of total health care expenditures were met by payments from the public sector. By 1976, public spending had reached a high of 42 percent of the total, and private spending dropped to 58 percent. Approximately one-third of public sector health care spending in fiscal year 1978 was for aged and disabled Medicare beneficiaries. The $25.2 billion spent under that program represented a 17 percent increase over the figure for 1977. After Medicare, the second largest single component of public spending for health care was "public assistance (vendor medical payments)," which consisted primarily of Medicaid payments.[1] Payments in this category, which amounted to $20.1 billion, accounted for 26 percent of the total and were 11 percent higher than in 1977 (see Table 1).

Table 2 shows that the percentage of public assistance committed to medical payments jumped from 12 percent in 1960 to 34 percent by 1978. In fiscal year 1978 the proportion of federal aid allotted for medical

Table 1

Health and Medical Care: Expenditures from Public and Private Sources, Selected Fiscal Years, 1950-78 (in millions of dollars)

Type of expenditure	1950	1955	1960	1965	1970	1974	1975	1976	1977	1978
Total	$12,027.3	$17,329.6	$25,856.2	$38,892.3	$69,201.1	$106,056.6	$123,568.7	$139,727.7	$164,507.1	$186,975.9
Public expenditures	3,065.3	4,420.6	6,395.2	9,535.3	25,391.1	41,521.9	51,235.7	58,950.7	67,264.1	76,197.9
Health and medical services	2,470.2	3,862.3	5,346.3	7,641.2	22,661.4	37,756.0	46,558.0	53,710.7	62,053.1	70,405.9
Public assistance (vendor medical payments)	51.3	211.9	492.7	1,367.1	5,212.8	10,371.9	12,984.2	15,616.0	18,179.0	20,095.0
Private expenditures	8,962.0	12,909.0	19,461.0	29,357.0	43,810.0	64,534.7	72,333.0	80,777.0	97,243.0	110,778.0
Health and medical services	8,710.0	12,529.0	18,816.0	28,028.0	41,329.0	61,309.6	69,053.0	77,400.0	93,732.0	107,278.0
Total expenditures as % of GNP	4.5%	4.6%	5.2%	5.9%	7.2%	7.8%	8.5%	8.6%	9.0%	9.2%
Public expenditures as % of total	25.5%	25.5%	24.7%	24.5%	36.7%	39.1%	41.5%	42.2%	40.9%	40.8%

Source: Statistical Abstract of the U.S., 1980.

Table 2

Medical Vendor Payments[a] (through Medicaid) as a Percentage of Federal, State, and Local Public Assistance Programs, 1960-1978 (in millions of dollars)

Fiscal Year	Total			Federal			State and Local		
	Public Aid	Medical Payments	% Medical	Public Aid	Medical Payments	% Medical	Public Aid	Medical Payments	% Medical
1960	$4,101	$ 493	12.0	$ 2,117	$ 200	9.4	$1,984	$ 293	14.8
1970	16,488	5,213	31.6	9,649	2,607	27.0	6,839	2,606	38.1
1971	21,262	6,278	29.5	12,990	3,374	26.0	8,272	2,904	35.1
1972	26,078	7,751	29.7	16,291	4,166	25.6	9,787	3,585	36.6
1973	28,691	9,208	32.1	18,061	4,997	27.7	10,630	4,211	39.6
1974	31,521	10,372	32.9	20,388	5,833	28.6	11,133	4,539	40.8
1975	40,707	12,984	31.9	27,205	7,056	25.9	13,502	5,928	43.9
1976	47,985	15,617	32.5	32,527	8,897	27.4	15,458	6,720	43.5
1977	52,894	18,179	34.4	35,399	9,713	27.4	17,495	8,466	48.4
1978, prel.	59,620	20,095	33.7	40,979	10,638	26.0	18,641	9,457	50.7

Source: Social Security Bulletin, May 1980, and earlier issues.

[a]Medical vendor payments are those made directly to suppliers of medical care.

payments was almost half (26 percent) that of state and local programs (51 percent). However, data in Table 3 indicate that in fiscal year 1978 the federal government spent more than twice as much for health care as did state and local governments--$52.5 billion, compared with $23.7 billion. In fiscal year 1965, before the impact of Medicare and Medicaid was felt, the ratio of federal to state and local outlays for health care was about 50-50. Since that time, as noted earlier, the federal government has been responsible for a continually increasing rate of public spending for health care. Finally, the nation's total health care expenditures (public and private) as a proportion of the nation's output of all goods and services (GNP) continued to rise during the 1970s, reaching a high of 9.2 percent in 1978 (Table 1).

An expressed or implicit goal of much of the health policy responsible for increasing public expenditures for health care was to "improve people's access to the medical care system." There is evidence that sizable gains have been made in the use of medical care services by the poor (National Center for Health Statistics, 1978). Despite the increased public expenditures for health care and subsequent increases in the overall physician utilization rates for those with the lowest incomes, the poor (especially welfare recipients)[2] may still be at a disadvantage in terms of overall health status.

THE NATURE OF MEDICAL CARE GIVEN TO THE POOR

Using as a starting point the foregoing statistics, this paper is oriented toward policy. It is designed to advise government policymakers

Table 3

Health and Medical Care: Expenditures from Public Sources, by Sources of Funds, Selected Fiscal Year, 1950-78 (in millions of dollars)

Type of expenditures	1950	1955	1960	1965	1970	1974	1975	1976	1977	1978
	federal expenditures									
Total	$1,361.8	$1,947.6	$2,917.6	$4,624.7	$16,600.2	$27,498.9	$34,125.8	$40,564.0	$46,094.4	$52,512.4
Health and medical services	1,059.6	1,657.3	2,174.8	3,074.6	14,494.4	24,928.1	31,047.1	36,920.0	42,512.0	48,329.4
OASDHI (Medicare)	. . . .	. . . .	. . . .	. . . .	7,149.2	11,347.5	14,781.4	17,777.4	21,543.0	25,204.0
Public assistance (vendor medical payments)	. . . .	23.3	199.8	555.0	2,607.1	5,833.2	7,056.4	8,896.5	9,713.0	10,638.0
	state and local expenditures									
Total	$1,703.6	$2,472.9	$3,477.5	$4,910.5	$8,790.0	$14,023.0	$17,109.9	$18,386.7	$21,169.7	$23,685.5
Health and medical services	1,410.6	2,204.9	3,171.5	4,566.5	8,166.9	12,828.0	15,510.9	16,790.7	19,541.1	22,076.5
Temporary disability insurance (Medical benefits)	2.2	20.0	40.2	50.9	62.6	70.7	72.9	75.5	75.7	74.8
Public assistance (vendor medical payments)	51.3	188.6	292.9	812.1	2,605.6	4,538.7	5,927.8	6,719.5	8,466.0	9,457.0

Source: Statistical Abstract of the U.S., 1980.

on appropriate health policy initiatives to improve the health status of the poor, thereby reducing welfare dependency. Generally, a positive relationship between increased access to care and improved health is assumed to exist. Recent literature suggests, however, that "above a certain level, medical care itself bears little relationship to general health" (Diehr et al., 1979, p. 998). Many health practitioners are coming to believe that what really influences health status is the quality of the physical and social environment, and one's personal health habits and lifestyle (Callahan, 1980). Newacheck et al. (1980) seem to make a similar point in noting that the expansion of the medical care system runs contrary to the true health care needs of the chronically ill. The authors looked at selected measures of health status from the 1977 Health Interview Survey--restricted activity days, bed disability days, and limitation of activity due to chronic conditions--in an attempt to assess the contribution of chronic disabilities to the health gap between the poor and the nonpoor. They concluded (p. 1174) that:

> Our three major findings are as follows: One, all of the gap in long-term disability between low-income and other income groups is attributable to a greater prevalence of chronic disabilities among the poor. Two, most of the gap in short-term disability also is attributable to chronic disabilities; this gap nearly disappears when we adjust for the differences in prevalence and severity of chronic disabilities among the two income groups. Three, current health care policy, which is focused on acute care for short-term conditions, does not meet the special needs of the chronically ill poor, and we suggest directions for needed reforms [emphasis added].

A ten-year panel study of welfare recipients in New York City (Olendzki, 1974) concluded that Medicaid primarily benefited the younger, less sick poor and not the aged and the most ill, for whom the greatest barriers against actually getting to care persisted. Anderson (1975),

on the basis of an analysis of a 1970 nationwide survey of health care utilization and access, argued that the most important factor contributing to continued "inequity" in the utilization of physician services by the poor was that they did not have a regular source of medical care to provide routine advice and treatment. Similarly, Alpert et al. (1969, p. 57) observed that "persons on public welfare are most likely to lack a stable relationship with either a regular hospital clinic or private physician." Herman (1972, p. 17) noted that "because few hospital clinics are organized to provide immediate care, emergency departments are increasingly being used by poor patients for this purpose." Other studies using explicit social indicators of "access" concluded that the poor continue to use services at a lower rate relative to their need for care than do the nonpoor, and that organizational, rather than explicitly financial, barriers may be causing these differences to persist (Aday, 1976, Taylor et al., 1975).

Benham and Benham (1975) used person-based data from national surveys in 1963 and 1970 on three health status indicators to determine the effect on health status of increased access to medical care. They found a negative relationship, concluding that "groups with increased access to medical care apparently become sicker." Diehr et al. (1979), on the basis of data from the 1971 Seattle Prepaid Health Care project, also failed to support the assumed positive relationship between access and improved health. These investigators conclude that "increased access to care (as provided by this project) was associated with lower perceived health status, more symptoms, and more perceived limitations on activities."

The general lack of support for a positive relationship between access and improved health in the current literature suggests that instances in which improved access is beneficial to the poor may carry less weight than originally believed by government policymakers. Without a model of the impact of increased access to care on different aspects of health, it is difficult to draw definitive or consistent conclusions about changes in health. However, the pessimistic view is consistent with a number of other studies, discussed below, which indicate that improved access is not likely to influence such population-based measures of health status as disability days or sympton reporting.

Examination of two basic health indicators--restricted activity days and bed disability days--used in the 1977 Health Interview Survey of the National Center for Health Statistics shows that about 75 percent of the "health gap" between the poor and nonpoor populations is attributable to greater prevalence and severity of "activity-limiting chronic conditions" among low-income[3] persons. The data also indicate that the impact of "activity-limited chronic conditions" is not equally distributed throughout the low income population. Approximately 25 percent of low income families appear to bear the greatest burden of illness; the majority of the poor do not suffer from disabling chronic conditions and report disability day levels similar to those of the nonpoor (Newacheck et al., 1980).

One of the background characteristics of the average welfare mother is the prevalence of various chronic illnesses (Goodwin, 1972, p. 114).

The health of a sample of welfare women who participated in a 1979 Supported Work program was described as "generally poor." Several of these women were under treatment for injury or illness, and others indicated stress-related symptoms including nervousness, high blood pressure, obesity, taking Valium, and drug or alcohol use problems (Danziger, 1980, p. 41). Prior to the program, most of this sample of women had been welfare recipients for from 5 to 17 years.

The children of welfare mothers are also plagued with various chronic illnesses resulting from inadequate prenatal care. A former Secretary of the Department of Health and Human Services (Health, Education, and Welfare) relates the following incident in support of this assertion:

> A year ago, I visited a school in the South Bronx, an elementary school in which every kid was on welfare. I asked the principal and the guidance counselor what they'd do if they had more money. And they said, "Do you mean $20,000 more for 627 kids?" And I said, "Sure." They said they'd hire a nurse to inform mothers in the neighborhood who become pregnant how to take care of themselves because so many of those kids had learning problems related to prenatal care (Inglehart, 1978).

One could infer from these observations, then, that individuals and families who receive public assistance for health and medical reasons make up a substantial portion of the 25 percent of the low income population that suffers from chronic illnesses. As can be seen in Table 4, illness or injury accounted for 10 percent (329,147) of entry into the rolls ("most recent opening") of AFDC cases in 1975. Another 1 percent (36,643) of the cases were opened because of increased need for medical care, or because the family's assets were reduced due to medical costs. Loss of income due to death of a household member accounted for the opening of 51,751, or 1.5 percent, of AFDC cases.

Table 4

AFDC Families Entering the Rolls for Health or Medical Reasons in 1975

Area	Total Families	Loss of Income of Household Member Due to: Illness or Injury	Loss of Income of Household Member Due to: Death	Increased Need for Medical Care	Assets Reduced Due to Medical Costs	Total Families Entering for Health or Medical Reasons
U.S. Totals						
Number	3,419,671	329,147	51,751	25,311	11,332	3,837,212
Percentage	100.0	9.6	1.5	.7	.3	12.1
HEW Region						
Region I	207,260	8.5%	1.3%	.3%	.1%	10.2%
Region II	535,303	11.4	1.6	.1	.1	13.2
Region III	365,124	15.5	1.0	.3	.2	17.0
Region IV	524,728	10.8	2.1	1.5	.5	14.9
Region V	739,928	7.0	1.3	.6	.6	9.5
Region VI	263,484	10.5	1.5	1.0	.2	13.2
Region VII	146,263	9.4	2.2	.5	.5	12.6
Region VIII	67,091	7.7	1.3	1.2	.0	10.2
Region IX	481,033	6.3	1.5	1.2	.3	9.3
Region X	89,487	10.0	1.1	1.2	.2	12.5
State						
Arizona	20,790	12.2%	3.9%	*	*	16.1%
California	440,863	5.9	1.3	1.1	.3	8.6
Colorado	33,386	7.3	.9	.3	*	8.5
Florida	80,669	6.1	1.0	.2	.3	7.5
Georgia	113,253	9.2	1.2	.8	*	11.2
Illinois	218,949	8.7	1.2	.5	1.4	11.8
Indiana	50,788	6.1	1.1	.2	.5	7.9
Iowa	27,646	9.0	.6	.8	.8	11.2
Kansas	21,646	10.2	.5	1.4	.2	12.3
Kentucky	52,951	12.2	3.0	.6	.2	13.3
Louisiana	68,267	13.2	1.0	.9	.1	15.2
Maine	24,444	9.9	3.2	.3	.1	13.5
Massachusetts	113,093	7.6	1.1	.5	.1	9.3
Michigan	193,506	5.2	1.7	.3	.3	7.5
Minnesota	44,107	5.2	.7	.2	.1	6.2
Mississippi	54,522	13.0	3.4	.9	.1	17.4
Missouri	85,507	8.5	3.4	.2	.6	12.7
New Jersey	131,558	6.3	1.2	*	.4	7.9
New York	357,728	9.7	1.2	.1	*	11.0
N. Carolina	61,572	13.0	1.9	1.1	.3	16.3
N. Dakota	4,399	6.6	2.0	3.1	.5	12.2
Ohio	177,966	6.5	.9	1.0	.3	8.7
Pennsylvania	181,311	14.8	.8	.1	.2	15.9
Puerto Rico	45,225	39.8	5.6	*	*	44.4
S. Carolina	43,813	17.0	4.4	1.7	.6	23.1
Tennessee	67,392	10.2	2.2	1.4	.1	13.9
Texas	112,155	8.0	1.2	.6	.2	9.0
Virginia	55,370	9.7	2.2	.3	.3	12.5
West Virginia	21,475	15.2	1.4	.6	.1	17.1

* = no sample cases.

Source: U.S. Department of Health and Human Services, Demographic and Program Statistics, "Aid to Families with Dependent Children: 1975 Recipient Characteristics Study, Part 1." September, 1977.

Interestingly, HEW Region III, which consists primarily of Southern border states (see Table 5), had the greatest proportion (15.5%, Table 4) of recent AFDC cases opened due to loss of income of a household member because of illness or injury. HEW Region IX (Arizona, California, Guam, Hawaii, and Nevada) had the smallest proportion, with only 6 percent of the AFDC cases most recent openings due to illness or injury. In four regions (II, IV, V, and X), illness or injury of a household member accounted for at least 10 percent of AFDC openings in 1975.

In Puerto Rico, 40 percent of the entry of AFDC cases were due to illness or injury, with another 6 percent entered because of death of a household member. South Carolina, West Virginia, Pennsylvania, North Carolina, Mississippi, Louisiana, Kentucky, and Arizona represent states with fairly larger proportions (12 to 17 percent) of their AFDC entries due to loss of income of household member because of illness or injury. Finally, it is worthy of note that approximately 12 of every 100 most recent entries for AFDC families in 1975 were for health and medical reasons.

A primary characteristic of the chronic conditions listed in Table 6 is that they are usually degenerative, with episodes of remission and acute flare-up. Table 6 indicates that activity-limiting chronic conditions are much more prevalent among lower income families than among the general population--the ratio is approximately two low income persons affected for every one person in the general population for five of the first six conditions, which account for the majority of all people

Table 5

Proportion of AFDC Cases Opened for Health or Medical Reasons by HHS, 1975[a]

REGION I (Boston)		REGION VI (Dallas)	
Connecticut		Arkansas	
Maine		Louisiana	
Massachusetts	10.2%	New Mexico	13.2%
New Hampshire		Oklahoma	
Rhode Island		Texas	
Vermont			
REGION II (New York)		REGION VII (Kansas City)	
New Jersey		Iowa	
New York	13.2	Kansas	12.6
Puerto Rico		Missouri	
Virgin Islands		Nebraska	
REGION III (Philadelphia)		REGION VIII (Denver)	
Delaware		Colorado	
District of Columbia		Montana	
Maryland		North Dakota	10.2
Pennsylvania	17.0	South Dakota	
Virginia		Utah	
West Virginia		Wyoming	
REGION IV (Atlanta)		REGION IX (San Francisco)	
Alabama		Arizona	
Florida		California	9.3
Georgia		Guam	
Kentucky	14.9	Hawaii	
Mississippi		Nevada	
North Carolina			
South Carolina			
Tennessee			
REGION V (Chicago)		REGION X (Seattle)	
Illinois		Alaska	
Indiana		Idaho	12.5
Michigan	9.5	Oregon	
Minnesota		Washington	
Ohio			
Wisconsin			

Source: See Table 4.

[a]Loss of income of a household member due to death is included in total.

Table 6

Prevalence of the Ten Leading Causes of Limited Activity Due to Chronic Health Conditions, by Income, 1977

Main Cause of Activity Limitation	Number of Persons Limited in Activity per 1,000	
	All Incomes	Income Less than $6,000
1. Heart disease	17.6	36.9
2. Arthritis and rheumatism	16.3	38.8
3. Impairments of the back or spine	9.4	14.7
4. Impairments of the lower extremities or hips	7.2	14.6
5. Other musculoskeletal disorders	6.8	7.3
6. Hypertensive disease	5.2	12.4
7. Asthma	4.8	7.5
8. Diabetes	3.3	7.2
9. Senility	3.3	9.4
10. Emphysema	3.3	7.3

Source: Unpublished data from the Health Interview Survey, National Center for Health Statistics. Data are based on household interviews of the civilian, noninstitutionalized population.

limited in activity, both for the population as a whole and for the low income population.

GOVERNMENT POLICY TOWARD MEDICAL CARE FOR THE POOR

What these findings may imply, then, is that government policy-makers should recognize the marked degree to which chronic conditions affect the health status of welfare recipients. Ultimately this should be an important consideration in the allocation of resources to meet the health needs of this population.

How well does present government policy fit the needs of low income families in general, and welfare families in particular? The evidence reviewed from the literature concerning the persistent and widening health gap suggests not very well. Current government programs, such as Medicare and Medicaid, are designed primarily to pay for acute care received in hospitals and in physicians' offices, and do not match the needs of the low income chronically ill. The problem is essentially that there is no concept of continuing management of chronic illness built into government-financed medical care. For example, under Medicaid, more than 30 percent of the dollars go to inpatient hospital services, and a substantial proportion of these dollars goes to county hospitals and other public institutions to which low income people, including chronically ill welfare recipients, often gain admittance through the Emergency Room. On this point, Newacheck et al. (1980, p. 1174) note:

> These people, unfortunately, end up in the most expensive institution in the medical care system--the hospital--which was created to deal with severe acute illness, when what they need most of all is continuing management of chronic illness, a service that hospitals are not well suited to provide.

The relative importance of organizational solutions for improving the health care of low income populations seems clear. The major federal policy efforts to date have focused on changes in the financing of medical care (in the present Medicare and Medicaid, or introduction of some kind of National Health Insurance). The analyses reported here suggest the importance of formulating public policy which simultaneously considers the financial and organizational aspects of providing health care to low-income populations. The search for a new policy direction might begin with a greater responsiveness to the culture or subculture of low income communities, along with involvement of those to be serviced. The impact of social variables--income status, race, ethnicity, family caring and employment patterns, roles of women, awareness and perception, attitudes and beliefs, etc.--on use of health services should be recognized as an important factor in understanding the community and its reaction to a health program.

The most far-reaching challenge to governmental health policymakers in the 1980s is to include a balanced picture of poor people's health status and the factors that endanger and promote good health in government policy initiatives. To meet that challenge will require more appropriate measures of health status than the ones heretofore used. It will also require balanced collection and presentation of data concerning the three

principal ways that modern society can protect and improve health status; through influences on behavior, through environmental control measures, and through health care services (Breslow, 1981).

Concern about only the third element--health care services and anxiety over their cost--has largely dominated government health care policy in the past. Shifting the focus of health policy from a concern with health care resources (number of hospital beds, physicians, etc.), use of health care services (hospital admissions and physician visits), and financial aspects of health care services (fee-for-service payments to individual hospitals and other providers) to the first two elements--behavior and environmental factors in health (excessive intake of calories, sugar, and salt; and/or exposure to chemicals, noise, etc.)--would make it possible to obtain a coherent and comprehensive view of the health status of the poor along with information about the three main factors influencing it. Socially desirable moves to improve the health status of the poor generally, and welfare recipients particularly, would then appear, in perspective, to guide us toward a more rational health policy.

In sum, it seems safe to say that if we are interested in addressing the continuing gap between the health status of poor or low-income families and those not poor, it is no exaggeration to say that current government policy makes little sense. We promote the reporting and analysis of the services, providers, and dollars involved in health care at the expense of data concerning health-related behavior and features of the environment. We direct the increasing proportion of the gross national

product that is devoted to health care services toward acute rather than chronic illness. We reward hospitalizing people rather than providing incentives to medical care delivery organizations to develop continuing care appropriate to the needs of the poor. Finally, we implement programs to improve access of the poor to medical care, under the assumption that this will improve their health, when increasing access to health care may not be an effective way to improve health.

Many leaders in the field of health are coming to realize that the nation's financial investment in health care for the poor and ill is probably not being well made. For government policymakers, the quest of the 1980s will be to develop a more rational, data-based health policy that makes systematic use of behavioral influences, environmental control measures, and health care services to improve the health status of the nation's poor.

NOTES

[1]Medicaid is basically a health insurance subsidy for low-income persons, financed jointly with state and federal funds. Administered by each state within broad federal guidelines, Medicaid permits eligibles to seek medical care in the private health care sector along with all other consumer/patients. Government funds, however, pay for the services obtained.

[2]Welfare recipients were entitled to free medical care before and after Medicaid.

[3]Based on the official poverty threshold of $6,191 for a nonfarm family of four during 1977.

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