MOTIVATIONS TOWARD HEALTH EXAMINATIONS

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Contents

Foreword

Although it is impossible to list all the people who contributed so generously to the success of this study, I can thank them again for their assistance.

Special mention should be made, however, of the following three groups who were particularly helpful. First there are the many staff members and interviewers of the National Opinion Research Center, especially Ann Brunswick, the Assistant Study Director, who participated in every phase of this study. Jack Feldman and Paul Sheatsley, other NORC study directors, used their experience from other health studies to make many suggestions in the design and the development of the questionnaire. Pearl Zinner and Peter Rosenberg served as field supervisors and coordinators of coding operations. Last but not least, there is Clyde Hart, our director, and Herbert Goldstein, our business manager in Chicago, who shouldered the many administrative responsibilities involved in contract research.

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The third key organization, of course, is the Census Bureau, whose wholehearted cooperation in expediting the preparation of sampling lists and in furnishing punch cards on the personal characteristics of each respondent made this study possible. Special note must be taken of Katherine Capt, Abbott L. Ferriss, and Samuel J.Dennis who supervised the Census participation in the study. Another word of thanks must be given to the New York City Census staff who pretested the supplement Census question for us.

Finally, after recognizing the invaluable help from all these people, I must accept full responsibility for the analysis, conclusions and recommendations included in this report.

PAUL N. BORSKY
Study Director

I. Introduction

A. Background and Objectives of This Study

The U.S. National Health Survey was established by an Act of Congress in 1956, and under this Act, the U.S. Public Health Service was directed to conduct a continuing survey of disease, accidental injuries and impairments in the U.S. To carry out these broad objectives, three general programs have been developed:

1. The Household Survey: The Bureau of the Census, through its National staff of lay interviewers, conducts household interviews every week with a stratified probability sample of U.S. households. From direct questions to family members, information is obtained on such matters as the prevalence of disease, injuries and impairments, the nature and duration of any disability, and on the types of medical care received.

2. Special Studies: A program of special studies is designed to supplement the household survey. It is recognized that the household survey may not be the most efficient or appropriate method for collecting all kinds of health information. For such problems as undiagnosed and non-manifest disease, and for the development of U.S. norms for height, weight, blood pressure levels, hearing and eyesight and other physiological characteristics, actual physical examinations and clinical tests by competent medical personnel are required. In addition, special health studies may involve analytical comparisons of existing hospital, doctor or public health records and household reports.

3. Methodological Studies: In order to evaluate the effectiveness of the different methods used to collect health information and to improve the data collection process, special methodological studies are required.

One of the first special studies to be initiated by the National Health Survey will be a single visit health examination of a representative sample of the national population. The basic plan is to first conduct the regular Census household interview with a cross-section of American households and then persuade a sub-sample of respondents to come for an actual health examination by a special team of doctors and nurses. It will then be possible to establish, for the first time, certain health norms for the American public.

Since an unsatisfactory response rate can nullify the best planned and best conducted sample survey, and prevent any valid generalizations of survey findings, the staff of the National Health Survey early recognized the problem of non-response as a crucial one. Aware that respondent cooperation and non-cooperation involve questions of human motivation and behavior, the Public Health Service asked the National Opinion Research Center of the University of Chicago to investigate the problem. NORC was asked to determine, if possible, the factors which influence willingness to participate in a health examination and to develop recommendations to maximize the participation rate.

B. Other Relevant Research Findings

An indication of the serious magnitude of the non-cooperation problem is revealed by three other recent health surveys. Despite the most intensive persuasion efforts, from 30-40 percent of the public failed to cooperate on a free health examination. Obviously such large non-participation rates would create serious doubts about the validity of the research findings.

A summary of the participation rates achieved in these three limited population studies is presented below.

ACCEPTANCE OF MEDICAL EXAMINATIONS IN THREE POPULATION SURVEYS

	Medically Examined	
	Persons	Percent of Base Population
Hunterdon County (15) (1952-55) (Commission on Chronic Illness) 1/	846	72 (weighted)
Baltimore (7, 13) (1953-55) (Commission on Chronic Illness)	809	63
Pittsburgh (2, 6) (1953-54) (Arthritis Study, U. of Pittsburgh)	429	61

1/ Numbers in parentheses refer to references listed in the bibliography which appears at the end of this report. (Appendix B)

Unfortunately, none of these studies had built into their basic plans any systematic scheme for determining the reasons for cooperation or non-cooperation. Chen & Cobb (6), however, did a post-examination attitude study in the Pittsburgh arthritis survey and were able to gain some insight into the problem. Other researchers have reported subjective impressions and some sociological characteristics of cooperators which provide additional clues about the factors influencing cooperation. Most of these other health examination studies, however, were limited in their scope. Some were directed primarily at assessing the health needs of a local community (1, 7, 10, 11, 12, 15) while others were limited to the study of particular illnesses or conditions (2, 3, 4, 5, 6, 8, 9, 16). The only relevant national study was one conducted by NORC (14) in 1955 under sponsorship of the Health Information Foundation. It consisted of a detailed opinion study of American attitudes toward health needs, doctors and doctor experiences, medical facilities and other related health matters. While the report on this study has not yet been released, we were able to utilize its major findings in formulating the hypotheses for this study. Some of the relevant findings of these prior health examination studies are briefly summarized below.

Hochbaum (9) in reporting on participation in a voluntary chest-X-ray program, concluded that there were three sets of conditions that were most important in determining cooperation in a medical examination. The first is described as a psychological state of readiness, including belief in the possibility of oneself contracting the disease. He distinguishes between real belief and mere verbal endorsement of the value of diagnostic (X-ray) detection. Real belief involves acceptance of the idea that a person can be sick without knowing it, and a feeling that one can benefit from the early detection of disease. Given the psychological state of readiness or the belief in the potential personal benefit from an examination, two other sets of conditions need to be met -- the situational and the environmental. The situational influences include the person's observation of what he suspects may be symptoms of disease, along with the social, medical and campaign pressures which encourage and reinforce the individual's intention to act. The environmental factors are defined as the physical circumstances which facilitate the appointment process. These include the existence of appropriate facilities and knowledge of their whereabouts, as well as the ease and convenience with which the individual can avail himself of these facilities (time of appointment, distance to be traveled, etc.). Hochbaum concluded that these three sets of conditions cut across the usual demographic stratifications of sex, income, education, etc., in influencing decisions to cooperate in health examinations.

Cobb (2) in his study of the prevalence of arthritis and rheumatism in Pittsburgh found that people who do not cooperate in a clinical examination survey usually have had less experience with medical care, rate their own health higher, and less often report the presence of chronic disease. While the non-cooperators do not differ appreciably from those who do cooperate with regard to negative attitudes toward medical personnel and institutions, they more often give "prefer my own doctor" as the principal reason for refusing to participate. This may indicate some distrust of other doctors.

The Baltimore study by the Commission on Chronic Illness (7, 13) concluded that there were five principal motives for cooperation:

1. Conformity to a group pattern
2. Fear of contracting diseases because of family history or specific symptoms
3. Curiosity about the exam procedures
4. Hypochondriasis
5. Special need for good health to stay on one's job

From largely subjective reports of the survey staff, it was also concluded that the following factors were sometimes obstacles to cooperation:

1. Fear of the physical, economic and social consequences of disease
2. Religious or cultist beliefs about medicine
3. Preference for one's own doctor
4. Misinformation or lack of information about the exam
5. Lack of confidence in the effectiveness of the exam
6. Inconvenience in the time or place of the exam
7. Indifference to health matters
8. The cost

Of the other studies that were reviewed for their application to our problem, a degree of consistency was reported on only some of the personal and demographic characteristics of those who cooperate and those who refuse to cooperate on health surveys. Some of the more significant observations can be summarized as follows:

1. Married people are more likely to cooperate in health examinations than unmarried (11, 15, 14).
2. There are no differences in response on the basis of sex (7, 2, 6).

3. Middle-aged are most likely to cooperate (16, 1, 2, 6).
   There is least participation among the older population (15, 10, 11, 2, 6, 7, 14, 9).
4. There was some divergence in the findings about the role of education.
   The better educated are more likely to cooperate in general health programs; the less educated are the least cooperative (15, 14, 11, 16, 12). BUT participation is poorest among the high school educated; participators more often come from the lower and upper education groups (7).
5. There is less participation in the low income group (10, 14, 7, 16, 15).
   There is more participation among the middle income group (12).
6. Proxy (non-self) respondents more often agree to accept the exam and follow through on having it (7). BUT self respondents give more adequate (comprehensive) reports of their health status (15).
7. The findings on the role of reported unmet health needs are likewise inconclusive. Non-participators indicate an awareness of fewer health needs -- in terms of the absence of reported chronic conditions, less illness over a given period, higher rating of their current health and the degree to which they are taking good care of their health (2, 6, 7). However, actual unmet health needs are believed to be greatest among low income -- low socio-economic status groups, who are least cooperative in health programs (10, 12). And the middle socio-economic status group seems to seek most treatment for illness (12).
8. The findings with regard to prior experiences with doctors are also inconclusive. Some evidence suggests that participators and non-participators cannot be differentiated on the basis of having a regular doctor, and/or having used a doctor over a given period, and/or the length of time since last physical exam (1, 11).

Some studies have found considerable use of non-medical personnel for treatment of illness (10), especially among low socio-economic status groups (12). Low socio-economic status groups also report having a regular family doctor less often (10).

As noted before, the Pittsburgh study noted that participators report more previous medical experiences than non-participators (7).

9. Participation in health surveys is greater when others in the respondent's reference group (family, friends, co-workers, etc.) favor participation (16, 9, 14, 7, 12).

Many factors undoubtedly account for the lack of greater agreement among the findings of the various studies. As noted earlier, they were conducted for different purposes and the findings often were not intended to be applicable to a cross-section of the national population. Questions and their wording differed, as did the response categories and the classification categories for respondents. There was no attempt at coordination among the studies. Thus, actually, any degree of agreement is significant. Even where there is disagreement, however, it helps to focus attention on the possible relevant factors influencing decisions to cooperate on a health survey.

II. Study Design

A. Factors That May Influence Decisions to Cooperate on a Health Examination

After evaluating the available information from previous research, and after intensive discussions with members of the National Health Survey staff, the following factors were listed schematically, as possibly relevant to the problem of cooperation:

1. Knowledge, Information and Experience with Medical Matters
   - a. Identification of symptoms, knowledge of treatments and cures
   - b. Exposure to different sources of information on medical matters
     - 1) Sources usually consulted
     - 2) Other sources
   - c. Personal medical history
     - 1) Incidence of disease and accidents
     - 2) Types of treatment
       - a) Self diagnosis
       - b) Doctor visits
       - c) Hospitalizations
       - d) Clinics
       - e) Chiropractors, Naturopaths, etc.
     - 3) Time incapacitated in past year
     - 4) Availability of clinics - membership in medical plans

2. Attitudes, Feelings, Convictions, and Beliefs on Health Matters

a. Importance of good health

1) Effects of illness on living activities (work, career, responsibilities)

2) Effects of personal illness on dependents

b. Satisfaction and concern with personal health status

1) Overall health condition

2) Treatment by doctors, clinics, hospitals

a) Quality

b) Costs

c) Considerateness

3) Belief and concern about presently unmet needs

4) Belief and concern about possibility of future illness

c. Belief in avoidability and control of illness

1) Role of individual effort

a) Good health practice

b) Early professional diagnosis vs. self-diagnosis

(1) Usefulness of early diagnosis
(2) Type of facility -- own doctor, clinic, hospital
(3) Cost and convenience of checkup
(4) Fear of discomfort or pain in examination
(5) Fear of cost or inconvenience of indicated treatment
(6) Fear of worry and concern about possibility of cure
(7) Fear of social disapproval of known illness
(8) Vacillation in taking firm action

c) Early treatment vs. passive fatalistic attitude

(1) Disease matter of chance, can't avoid
(2) Disease a punishment for misdeeds or sins
(3) Body corrects ills if left alone

2) Belief in capability of present medical knowledge to diagnose or treat illness

a) Attitude toward individual doctors, in general and own physician

(1) Quality of services
(2) Considerateness, concern, time and effort, explanation
(3) Costs and convenience

b) Attitudes toward groups of doctors, clinics and hospitals

(1) Quality of service
(2) Considerateness
(3) Costs and convenience
(4) Social implications

c) Attitudes toward government and public health authorities

(1) Role in diagnosis and treatment of individual needs
(2) Role in establishing standards and regulating practices
(3) Role in research and development

3) Belief in possibility of future discoveries and improvement in diagnosis and treatment

d. Public spiritedness-social responsibility

1) General citizenship

a) Voting

b) Attendance at public meetings

c) Communication with officials and editors

2) Participation in civic organizations, school PTA's, religious and welfare work

3) Cooperation with public surveys

a) General market studies

b) Government research studies

e. Decision patterns -- persons and sources consulted

1) Going to a doctor or clinic for diagnosis or treatment

2) Buying drugs or patent medicines

3) Going to a hospital for treatment

f. Conditions for acceptance of public health examination

1) Time

2) Place

3) Identity of doctors and approval of medical society

4) Kind of examination -- items, number of visits, length

5) Personal gain -- release of information toown doctor

6) Baby sitters

7) Reimbursement for transportation costs and time

8) Availability of transportation

9) Offer of examination to all adults in household

3. Personal Characteristics

Age, sex, education, income, type and size residential area, marriage and family status, race, religious preference

From this comprehensive list of factors, a personal interview questionnaire was developed and pretested in the New York City area. It soon became apparent that complete coverage of all of the factors would require a very lengthy interview of approximately two hours. Practical survey experience and budgetary limitations made such a plan impractical, so it was decided to eliminate marginal items and those which could be secured by other means. Appendix A1 includes a copy of the final questionnaire which actually required an average of 60-65 minutes interviewing time. In only 3 percent of the interviews was it possible to complete the questionnaire in less than 40 minutes, while at the other extreme, over two hours were necessary in only about 2 percent of the cases. Table 1 summarizes the actual interviewing time for different respondents.

TABLE 1

DURATION OF NORC INTERVIEWS

Number of Minutes Interviewing	Number of Respondents	Percent Each Class	Percent Cummulative
39 or less	21	2.8	2.8
40-49	93	12.3	15.1
50-54	72	9.5	24.6
55-59	63	8.3	32.9
60-64	136	18.0	50.9
65-69	76	10.0	60.9
70-79	132	17.4	78.3
80-89	66	8.7	87.0
90-104	52	6.9	93.9
105-119	28	3.7	97.6
120 or more	18	2.4	100.0
Total ascertainable	757	100.0	100.0
Number non-ascertainable	5	-	-
Total number respondents	762	-	-

Also included as Appendix A2 is a detailed outline describing the purpose of each question included in the final questionnaire and Appendix A3, the General Instructions to Interviewers, which explains the structure of the questionnaire and the specific field procedures to be used. For the convenience of the more general reader, a summary of the kinds of questions covered by the final questionnaire is presented here.

Questionnaire Design

Questions	Content
1-8	General attitudes toward health and doctors
9-13	Belief in the possibility of becoming ill and its effects
14-20	Knowledge of specific illness and need to see doctor
21-26	Satisfaction with medical facilities and services now as compared to 30 years ago

Questions	Content
27-37	Personal experiences and attitudes toward doctors
38-39	Sources of information and interest in health matters
40-46	General attitudes toward doctors, clinics and the role of government in health matters
47-52	Attitudes toward taking the tests and measurements phase of the survey
53-56	General information about the respondent

Two further observations about the questionnaire itself are important. As will be explained below, each respondent interviewed by NORC was first interviewed by the Census on the regular national health survey.[18] Consequently, information on recent illness, medical attention and personal characteristics is obtained from the Census and need not be repeated on NORC's questionnaire. This arrangement reduced the length of NORC's interview and avoided duplication of Census questioning.

The second observation involves the kind of questions generally asked. In designing a questionnaire, two types of questions are generally used -- the open free-answer and the closed pre-coded. The open question asks the respondent about a general area of interest without suggesting the possible range of alternative answers. For example, the question, "What sort of things would you ask him (your doctor) about?" does not suggest the kinds of things one might ask a doctor. These questions are most useful in determining salience and the range of possible answers when this is not known by the researcher in advance. The major disadvantage of open questions is the uncertainty whether failure to mention an answer spontaneously represents chance forgetfulness or actual disagreement with the answer category. In order to determine the full extent of agreement or disagreement with a given question, a pre-coded question is usually most effective. This type of question clearly states each

possible alternative and directly asks the respondent to select the one answer most closely reflecting his views. For example, the first question, "Would you say your own health, in general, is excellent, good, fair or poor?" clearly poses the range of possible responses, and every person has the same ~~chance~~ opportunity of selecting a given category. Failure to do so can not be attributed to forgetfulness but to a difference in point of view. Fortunately, from our analysis of other NORC health studies and other reports, we were able to learn enough about the kinds of alternate answers one might expect to different questions. This enabled us to use mostly precoded questions in our questionnaire, which not only saved precious interviewing time, since open questions are more time consuming, but also provided more complete statistical data for the analysis.

In order to minimize any respondent bias in reported attitudes toward health, health needs, doctors, etc., explicit instructions were given to each interviewer regarding the kind of introduction to use. (See Page 12 of Appendix A 3- General Instructions and Specifications.) Each respondent upon completion of the original Census interview was given a letter from the Surgeon General thanking him for his cooperation and advising him that he might be called upon in the future to cooperate again in some additional health studies. When the NORC interviewer re-contacted the respondent, he was instructed to introduce himself as an NORC representative, show his Identification Card, if necessary, and hand the respondent another official letter from the Surgeon General. This letter which is included as Appendix A4, stated that NORC was "doing a special study for the Public Health Service --- As part of the U.S. National Health Survey, you -- or some member of your household -- were interviewed not long ago about your health experience. We are now following up to get some different information -- this time, your opinions on certain health matters." The interviewer was further told to avoid specific description of the kinds of questions involved, and particularly, to avoid mention of the health

examination. Reports from interviewers indicate that the suggested approach was effective in practically all instances and that the sequence of questions was begun without further lengthy discussion.

B. Scope of Work and Area Sampling Design

Since the National Health Survey covers all civilian persons in continental U.S., our study should also concern itself with cooperation from all these people. However, the Health Survey staff decided to limit the initial health examinations to adults (18-65 years old), thus reducing our responsibility.

If possible, it would then have been desirable to select for the attitude study a probability sample of adults in the entire U.S. Only through such a sample would it be possible to establish accurately the numerical differences in national attitudes and behavior for different segments of the population. Unfortunately, insufficient funds made such an ideal scheme impossible.

Since there were funds for approximately 800 interviews, it was decided that this exploratory study would not attempt to establish precise national levels of response but would merely seek to identify the more important factors which appear to be influencing cooperation and non-cooperation. Further research would be needed to establish the relative numerical significance of each factor.

One additional limitation in scope of work was arbitrarily made. Since earlier research indicated that the problem of cooperation in rural areas was likely to be significantly different from the problems in urban areas, and since there was very little overlap in rural sampling areas with few cases available for interviewing, it was also decided to eliminate all rural areas from this initial study.

The final sampling design was influenced by one other long range policy consideration. It is the plan of the National Health Survey to continue to use the Census Bureau as its data collection and processing agency. Census interviewers are expected to collect the basic household survey reports on respondent illnesses and accidents and as a final supplementary question, the interviewers will ask the respondent about his willingness to come for a health examination. Consequently, it was desirable to have normal Census procedure followed in this pilot study. It was agreed, therefore, to have the Census conduct its regular household interview and then have NORC re-interview a sub-sample of Census respondents. The Census interviewer would not be told about the impending NORC re-interview, so that no special treatment would be given to the household interviews.

With the above limitations of scope in mind, the most efficient and least biased sampling design would be a probability sub-sample of original Census respondents. But, since the Census sample is drawn from many urban places where NORC does not have any of its regular interviewers, it would be quite expensive to hire and train new people just for this special study. It was decided, therefore, to select the NORC sample from Census respondents who lived in or near NORC sampling areas. Then, regular NORC interviewers could be used. Since the Census used a random method in selecting its primary sampling areas and NORC uses a comparable method in selecting its sampling areas, it was hoped that the "overlap areas" of two independently random samples would furnish a fairly representative sub-sample. As will be seen in the next section all indications are that this assumption is valid.

After the "overlap areas" were identified, it became apparent that there was 100 percent overlap in the large metropolitan areas, a good overlap in the small

metropolitan areas, but only a fair coverage of small urban places. To establish some balance in the sample by size of urban area and geographical region, a quota was assigned to each region-size class, which was proportionate to its true size in the U.S. urban population. Since each weekly Census sample is a representative cross-section in itself, it was decided to base the NORC sample on units of an entire week's assignment in overlap areas. Since overlap was best in large metropolitan areas, only 3-4 weeks of Census assignments were required to fill the quota for these areas. In the small metropolitan and small urban areas, almost eight weeks of assignments were used. In fact, it was not possible to get the desirable number of cases in the small urban places due to the spotty overlap.

The Census completed its initial interview during February and March 1958. NORC re-interviewed its sample approximately one month after the Census interview. From the completed Census questionnaires NORC was given the names, addresses, and sex of each adult between the ages of 18-65. In order to obtain equal numbers of men and women in the NORC sample, and in order to minimize the social influences of any family member on the answers of another, it was decided to select only one adult from each household, alternating the sex of that person on a random basis. Consequently, a man was selected from the first household, a woman from the second, etc. Where more than one adult male or female resided at a house, it was possible, in a limited number of cases, for the interviewer to have more than one eligible respondent. In such cases, the names of all eligible persons were listed on the face sheet of the questionnaire and the interviewer chose one of the eligible persons. In no case was a proxy interview permitted.

As described above, the special NORC sample used in this study consisted of the urban Census respondents living in areas which also happened to be included in the regular national NORC sample. While both the Census and NORC national samples are based on random probability designs, the overlapping areas which are used in this special NORC study were selected in such a fashion that the areas themselves do not constitute a strict probability sample. This posed a dilemma in the analysis of the findings when it was desirable to evaluate the significance of different answers. Usual statistical tests of significant differences can be used validly only on a purely random sample. Since the special NORC sample was based on two overlapping random samples, however, it was decided to use the chi-square test of homogeneity as a guide to distinguishing small chance variations from larger, possibly significant differences. For example, if a difference in answers fails to meet the 5 percent level of significance in a chi-square test, then it is generally assumed that the difference probably is too small to be significant. But, if it does meet the chi-square criteria, the difference is generally considered large enough to be possibly significant. When a series of answers tends to reflect a common tendency, but the size of the differences is too small to meet the chi-square criteria, the report notes the tendency and attempts to relate its consistency with other findings. While this approach is not the ideal, it is believed to be a practical compromise. A more rigorous test of statistical significance can be developed from the answers to the Census supplementary question. The National Health Survey is planning to provide this information after it has evaluated the Census replies.

C. Non-Response Characteristics

In all, 835 interviews were assigned and 762 were completed from March 17 - April 15, 1958 -- a 91 percent completion rate. As Col. 3 of Table 2 indicates, the area distribution of our completed sample compares favorably in most respects with the ideal regional distribution. Only in the case of small urban places, is our sample seriously deficient. Fortunately, thehigh completion rate in these areas prevented the under-reporting in these areas from being worse. This result was not completely fortuitous, because the interviewers in smaller urban places and in the south were urged to make more call backs where respondents were repeatedly "not at home" or had refused. A procedure common to other NORC studies was followed: each time an assigned interview could not be completed within the assigned period, the interviewer sent us a report on the case and awaited directions as to whether he should continue with his attempts to complete the interview. The study director and the field supervisor reviewed each individual case, and if it seemed at all possible that the interview could be obtained, the interviewer was asked to continue his efforts to secure the interview. In many cases a special letter was sent by the study director to the uncooperative respondent, indicating the urgency of his assistance and enclosing a letter signed by the Surgeon General of the U.S. Public Health Service explaining the study. Our interviewer then contacted the respondent again within the next day or so for an interview.

In addition to the incomplete interviews cited above, about 5 percent of the households were never interviewed by the Census Bureau and were not even assigned to NORC. Nothing is known about these unassigned persons and no evaluation of possible bias can be made of their omission from the NORC sample. For the 72 persons 1/

1/ The number shown in Table 2 is 73, but one person was over 65 and incorrectly assigned.

TABLE 2

COMPARISON OF ASSIGNED AND COMPLETED INTERVIEWS WITH THE IDEAL NATIONAL SAMPLE

	Proportions in Ideal National Sample	Completed Interviews Number	Completed Interviews Area Distribution	Interviews Assigned Number Assigned	Interviews Assigned Percent Completed
Total, U.S. urban	100.0%	762	100.0%	835	91.3%
East	31.7	237	31.1	261	90.8
North Central	28.4	231	30.3	253	91.3
South	24.8	156	20.5	165	94.5
West	15.1	138	18.1	156	88.5
Urbanized areas:					
Large metropolitan (over 1,000,000)	42.5	386	50.6	434	88.9
Small metropolitan (under 1,000,000) . . .	32.3	277	36.4	299	92.6
Other urban places	25.2	99	13.0	102	97.1

assigned to NORC but not interviewed, however, a great deal of information is available fortunately from the Census interview. An analysis of these Census data indicates that NORC's completed interviews were in no way seriously biased. Responses to the Census indicate that the cooperation rate may have been overstated by only about 1 percent, but that in all other respects, the respondents and non-respondents were not significantly different.

Before evaluating the Census data it might be of interest to analyze interviewer reports of reasons for non-response. As Table 3 indicates, of the 9 percent who were not interviewed by NORC, only about 4 percent could be construed as basically hostile; the remaining were not contacted for a variety of reasons. Of the persons classified as possibly hostile, less than 2 percent made such direct statements as "I don't want to be bothered," "I don't like prying," or "One interview is enough." The other 2 percent gave vague excuses of "too busy" or were reported as antagonistic by a third party. The remaining 5 percent of our predesignated sample could not be reached for a

TABLE 3

REASONS GIVEN FOR NON-RESPONSE 1/

	Number of Answers	Percent of All Non-Respondents	Percent of All Interviews Assigned
1. Not available because moved and/or whereabouts unknown; deceased.	16	22%	1.9%
2. Not available because temporarily out of town or away from the household (hospitalized, away on a job, breaking up household)	12	17	1.4
3. Not available because too ill, weak, mentally incompetent	4	6	.5
4. No contact because not at home due to long, irregular working hours.	6	8	.7
5. Not interviewed because too busy -- with seeming legitimate reason for "busy-ness": taking care of sick person; going, or working out of town; reports long and late working hours.	9	13	1.1
6. Not interviewed because not interested; too busy, no time, sees no reason for the interview, doesn't show up or call at pre-arranged time (and no reason for "busy-ness") (Never double-coded with "7" below). . .	6	8	.7
7. Antagonistic about being interviewed: "One interview enough," doesn't want to be bothered, doesn't like "prying," suspicious (Never double-coded with "6").	15	21	1.8
8. Respondent reports that spouse or others against the interview (never double-coded with "9")	5	7	.6
9. No contact with respondent--other family member refused access to respondent	6	8	.7
10. Miscellaneous--foreign language barrier.	2	3	.2
11. Don't know, Not ascertainable.	6	8	.7
Totals	87	121%	10.3%

1/ Percentages add up to more than 100% since some respondents gave more than one reason for non-interview.

About 2 percent had moved or died since the Census interview, while the others were either temporarily away, too busy at work, too ill, or too occupied with some other legitimate pursuit to be able to be interviewed.

When non-respondents are divided into two groups, those "not contacted" (categories 11 & 1-4 of Table 3) and those "refusing" our interview (categories 5-10 of Table 3), and their answers to Census regarding willingness to accept a free health examination are analyzed, it becomes apparent that only the hostile "refusals" are less cooperative. As will be shown in Table 8, about 71 percent of all Census respondents indicated willingness to cooperate, and as Table 4 shows, 68 percent of the persons whom NORC could not interview because they could not be contacted, said they were willing to accept a health exam. These small differences are well within sampling variability. In contrast, only 35 percent of the "refusals" indicated a "cooperative" attitude on the health examination. In less than one case out of 100, could this ~~biased~~ less cooperative response have been due to chance sampling differences.

Putting this non-response in perspective, however, it is apparent that the failure to interview 72 Census assignments may have resulted in an overstatement of only 1% in the "cooperativeness" rate. If a full 71 percent of the 31 refusals had indicated a willingness to come for the exam, the number of "yes" answers would have been 22. Since only 11 actually said "Yes," the bias totals 11 answers or only 1.3 percent of the 835 assignments. On this basis, it can be concluded that the NORC sample contains very little bias regarding willingness to cooperate on the health examination.

NORC

TABLE 4

TYPE OF NON-RESPONDENTS AND REPORTED INTENTION TO COOPERATE ON THE HEALTH EXAMINATION

Type of Non-Respondent	Total		Answer to Census: Yes		No	
	Number	Percent	Number	Percent	Number	Percent
No NORC contact	41	100%	28	68%	13	32%
Refusal	31	100%	11	35	20	65
Total	72	100%	39	54%	33	46%

In comparing other personal characteristics of the 72 non-respondents with the 762 NORC respondents, no other significant difference was found. As Table 5 indicates, the small variations in family relationship, race, sex, age, education, etc., are well within small sampling differences. It should be noted, however, that the tendency was for non-respondents to be more often somewhat older, less well educated and women. These characteristics have frequently been found in other studies of non-response.

TABLE 5

NORC

PERCENTAGE DISTRIBUTION OF RESPONDENTS AND NON-RESPONDENTS BY PERSONAL CHARACTERISTICS

	Respondents	Non-Respondents
Number of cases	762	72
Family Relationship		
Head	59%	58%
Wife	32	31
Child (18 years old or over)	5	9
Other	4	2
	100%	100%
Race		
White	86%	83%
Negro	14	14
Other	-	3
	100%	100%
Sex		
Male	50%	44%
Female	50	56
	100%	100%

Table 5 Continued

	Respondents	Non-Respondents
Age		
Under 25 years	10%	6%
25-34	22	22
35-44	26	29
45-54	21	12
55-65	21	31
	100%	100%
Education		
Grade school	26%	30%
High school	51	55
College	23	16
	100%	100%
Employment Status		
Working	63%	63%
Looking for work	1	-
Housekeeping	31	29
School	2	1
Other	3	7
	100%	100%
Marital Status		
Married	77%	71%
Widowed	6	10
Divorced	4	5
Separated	4	4
Never married	9	10
	100%	100%
Income		
Under $3,000	19%	23%
$3,000 - 4,999	27	32
$5,000 - 6,999	27	23
$7,000 and over	27	22
	100%	100%
Last Visit to Doctor		
Less than 6 months ago	58%	52%
6 months less than 2 years	21	17
2 - 5 years	11	15
5 years or more	8	14
Don't know	2	2
	100%	100%
Last Dentist Visit		
Less than 6 months ago	34%	22%
6 months, less than 2 years	25	26
2-5 years	22	18
5 years or more	16	31
Don't know	3	3
	100%	100%
Census Supplement		
Self respondent	62%	62%
Proxy respondent	38	38
	100%	100%

D. Further Evidence on the Reliability of the Sample

Another way of examining the reliability of the NORC sample is to match the answers with those of similar questions used in the 1955 National Health Attitude Survey conducted by NORC (14). As we mentioned earlier, many of our questions were based on this survey. Similarity and dissimilarity in the answers can tell us something about the representativeness of our findings. Three major differences in these two studies should be understood, however, before comparing the data:

1. The two studies were conducted under different conditions, including the lapse of three years between them, and the fact that the interviews in our study were preceded by another Census health interview. This could have sensitized respondents somewhat to questioning about health attitudes.
2. Some questions differed in the exact wording and in their sequence in the interview.
3. There were important differences in the coverage of the two samples. Our present study was limited to the urban population between 18 and 65 years of age. These limitations did not apply to the earlier study. For most items, the answers on the 1955 National study were adjusted to remove rural and older-person responses. However, we could not compensate for the other differences in procedure. This should be kept in mind in the following discussion.

Table 6 presents the items on which the answers from the two studies appeared to be significantly different. As can be seen, the present sample seemed less satisfied with their state of health, less often characterizing it as "excellent." They more often felt that there are things they could do to take better care of their health. They less often felt entirely satisfied with the medical care they have received during the past five years, but on the other hand, fewer of our sample reported that they, or anyone they knew, had ever had a disappointing experience with

TABLE 6

COMPARISON OF SIGNIFICANT DIFFERENCES
IN THE 1955 AND 1958 NORC SURVEYS

	1955 Survey	1958 Survey
Age	100%	100%
Under 35	37	32
35-44	26	26
45 and over	37	42
Race[1/]	100%	100%
White	90	86
Non-white	10	14
Rate own health	100%	100%
Excellent	35	31
Good	39	45
Fair	22	20
Poor	4	4
Care for own health	100%	100%
Take best care	57	46
Could do more	42	53
Don't know	1	1
Feel about last 5 years medical care	100%	100%
Entirely satisfied	90%	81%
Some things not	10	18
Self and anyone know had bad experience with doctor	100%	100%
Yes	34	22
No	66	78
Watch medical programs on Radio/TV	100%	100%
Frequently	21	23
Occasionally	37	43
Hardly ever	40	34
Don't know	2	-

1/ Could not be modified for rural - over 65 segments.

a doctor. In summary, Table 6 suggests that the present sample reflects a greater concern about health and a greater interest in health matters. It also seems that the present sample contained fewer young people. On all other matters, however, the findings on the two studies are substantially alike, giving greater confidence in the

TABLE 7

COMPARISON OF SIMILAR ANSWERS
TO THE 1955 AND 1958 NORC SURVEYS

	1955 Survey	1958 Survey
Education	100%	100%
Grade school	29	26
High school	50	51
College	21	23
Income[1/]	100%	100%
Under $5,000	56	46
$5,000 and over	44	54
Sex	100%	100%
Male	49	50
Female	51	50
Think a person can tell right away that something is wrong when he gets:	100%	100%
Cancer	12	11
Diabetes	22	19
Polio	58	60
Treatment of salaried doctors in relation to private doctors:	100%	100%
Better	3	4
Worse	29	25
About same	55	61
Don't know	13	10
Have had complete physical exam:	100%	100%
Have had complete physical exam	87%	91%
Never had complete physical exam	13	9
Had complete exam:	100%	100%
Less than one year ago	37	41
1-2 years ago	17	19
2-5 years ago	27	25
Over 5 years ago	19	15

1/ Average personal income has increased 13% during the 1955-1958 period according to the U.S. Department of Commerce.

Table 7 Continued

	1955 Survey	1958 Survey
Have ever not gone to doctor because:	100%	100%
Too busy	35	34
Don't like to bother doctor unnecessarily	41	43
Don't want to spend the money unnecessarily	38	41
Don't like being examined	10	7
Doctor might tell me I need some expensive medicine	10	9
Thought doctor couldn't help me	9	6
Don't want family or friends to know I am sick	3	5
Doctor's office so far away	8	6
Doctor might want me to change my ways	8	6
Likelihood fo being sick at least 3-4 days over next year:	100%	100%
Very likely	17	13
Fairly likely	26	32
Not likely	49	50
Don't know	8	5
Think something can be done to prevent being sick 3-4 days:	100%	100%
Yes	29	24
No	66	67
Don't know	5	9
Ease in getting care while sick in bed:	100%	100%
Somebody here or easy to get	79	81
Hard to get somebody	20	17
Don't know	1	2
If employed, while sick in bed could:	100%	100%
Lose all income	32	33
Lose some income	29	24
No income loss	38	41
Don't know	1	2

Table 7 Continued

	1955 Survey	1958 Survey
Other than income loss, being sick in bed would:	100%	100%
Hurt great deal.	7	11
Hurt some.	17	19
Not very serious	75	69
Don't know	1	1
Rate own doctor as compared with most other doctors in U.S.:	100%	100%
Much better.	22	24
A little better.	25	21
About average.	50	46
Not as good.	-	1
Don't know	3	8

reliability of our data. Some of these similarities are presented in Table 7, which except for the personal characteristics of education, income and sex, have not been corrected for the rural and older persons included in the earlier study.

III. Findings

A. Overall Indications of Willingness to Cooperate

According to present plans, the National Health Survey hopes to have the regular Census interviewer introduce the health examination phase of the survey at the end of the household interview and to arrange an appointment with all persons who are willing to cooperate. In order to pretest this procedure realistically and also to provide information on the national patterns of cooperativeness from a full U.S. probability sample, a special supplementary question was added to the entire U.S. household survey for the month of February and March 1958. This question was as follows: "As part of the Health Survey, the Public Health Service will provide a free health examination to some of the people we are interviewing. As you would expect, we cannot learn all we need to know about health just by asking questions--for some things we need actual measurements and tests. The examination will involve only one visit to a nearby place. If you are selected for this special free examination and the time and place are convenient, will you be willing to come? .... How about (each related adult), do you think he will be willing to come?"

Special aspects of this question should be clearly stated. First, the health examination is placed in the context of a supplement to the Health Survey. Second, it is free and requires one visit only to a nearby place. Third, the respondent is asked to assume that the time and place are convenient. Fourth, some respondents are asked to answer for themselves, while others are asked to give proxy answers for other related adults who weren't home at the time of the interview. With these specific conditions in mind, the answers may be considered a first line indication of intent to cooperate on a Public Health Service sponsored health examination. It should not be confused with the actual participation rates cited before, however,

since some persons who say they intend to cooperate may fail to do so because they either change their minds or for other reasons find it difficult to keep an appointment.

At the very end of the NORC interview, after all the general attitudes about health and doctors had been recorded, the respondent was again asked about his belief in the cooperativeness of most people he knows and about his own willingness to accept a health examination.

Question 47 first introduces the question of health examinations and asks about other people, while Question 48 concerns personal cooperativeness. The actual questions were as follows:

Q. 47. As you might expect, the Public Health Service cannot learn all they need to know about health in the nation just by asking questions. For some things they need actual measurements and tests. How do you think most people you know will feel about helping on that part of the survey -- Will they certainly come, probably come or probably not come for these measurements and tests?

Q. 48. If you yourself are asked to come for the tests and measurements part of the survey, will you certainly come, probably come, or probably not come? Why is that?

As the specifications indicate (P. 25, Appendix A-3) the interviewer was told not to try to persuade the respondent in any way, but to provide limited information about the examination in answer to specific questions. If the respondent (R) says, "It depends on the time and place," the instructions were to answer, "Well, assuming the time and place are convenient." If R says, "It depends on the tests they want

to give," the answer was, "Well, you know they'll take the height and weight and check your eyes, heart, lungs and things like that." If R asks about the cost, he was assured the exam would be free.

A combination of answers to the first offer of the health examination by Census and the second offer by NORC provides a measure of the stability of intention to cooperate. Table 8 summarizes these overall relationships.

TABLE 8

EXPRESSED INTENT TO CENSUS AND NORC ON ACCEPTING A HEALTH EXAMINATION

	Total		Answers to Census: Yes		No		Don't Know		Not Asked	
	No.	%	No.	%	No.	%	No.	%	No.	%
Total.	762	100.0	539	70.7	171	22.5	24	3.1	28	3.7
Answers to NORC										
Certainly Yes. . . .	301	39.5	249	32.7	36	4.7	10	1.3	6	.8
Probably Yes	313	41.1	237	31.1	56	7.4	6	.8	14	1.8
Total Yes.	614	80.6	486	63.8	92	12.1	16	2.1	20	2.6
Probably No.	134	17.6	46	6.0	73	9.6	7	.9	8	1.1
Don't know	14	1.8	7	.9	6	.8	1	.1	-	-
Total No . . . . . or Don't know. .	148	19.4	53	6.9	79	10.4	8	1.0	8	1.1

As can be seen from the top line of Table 8, about 7 out of every 10 persons told the Census that they would accept the examination, 23 percent said "No," and almost 7 percent were either undecided or, due to an oversight by the Census interviewer, were not asked the supplement question. When NORC offered the examination a month later, a total of 8 out of 10 indicated willingness to accept, of which half said, "Certainly" they would accept, and half were a little less certain and said, "Probably yes." In light of the substantial number of "Don't knows" usually found on opinion surveys, it is noteworthy that less than 2 percent answered "Don't know" to this question.

The degree of stability of stated intention is also unusually high. Three out of every four persons maintained their original answer, 64 percent continuing to say "Yes," and 11 percent saying "No" or "Don't know." About 14 percent shifted from "No" or "Don't know" to "Yes," and only half as much, 7 percent changed from "Yes" to "No." It is impossible to state the firmness of intent of the remaining 4 percent who were not asked by Census for their views. That 70 percent of this later group said "Yes" to NORC, however, indicates that their original attitudes could not be too different from the other respondents who were asked by Census to indicate their intentions. Nevertheless, because any allocation of this group among the initial "Yes" or "No" Census categories would have to be arbitrary and open to challenge, it was decided to exclude this group from the subsequent detailed analysis. Likewise, to keep the attitude groups as clearcut as possible, the 24 cases answering "Don't know" to Census were also kept separate. This left the following five different intention groups with sufficient numbers of respondents for detailed analysis:

	Answer to Census	Answer to NORC	Number of Respondents
1.	Yes	Certainly Yes	249
2.	Yes	Probably Yes	237
3.	Yes	No or Don't Know	53
4.	No	Yes	92
5.	No	No or Don't Know	79
6.	(Don't know or Not Asked)	-	52
	Totals	-	762

As indicated earlier, a statement of intention to cooperate is different from actually following through and coming to an examination. An indication of the relationship between intention or making an appointment and actually being examined is provided by the Washington D.C. field test of the health examination.

Utilizing preliminary findings in the national survey of attitudes, procedures were set up for producing examinees at a pilot project for the health examination survey. This pilot project was conducted in Washington, D.C., on a population sample drawn from the population of the metropolitan area especially for the pilot study. Census interviewers gave the regular National Health Survey interview in each sample household, and at its conclusion, asked the supplementary question on the willingness to accept a health examination. The question was asked of just one person from the household in the eligible age range of 18-64 years. The selection of the particular eligible was on the basis of a predetermined procedure for a random choice. No proxy response was accepted on the supplement question and return visits were made to interview the potential examinee in person. If the Census interviewer received a "Yes" answer, she immediately made an appointment for the examinee by calling the survey office. While the Census interviewer was under instructions to explain the content and arrangements for the examination, she was not under instructions to try to persuade those who failed to give their immediate and ready assent. Persuasion efforts were planned for a second-stage visit. Making the appointment included scheduling a taxicab (at no expense to the examinee) for transporting him to the examination center. Some of those who answered "Yes" to the supplemental question were not able or willing to make a definite appointment at the time of the Census interview. These together with those who said "No" were visited subsequently either by an NORC interviewer or by a "Persuader" from the National Health Survey staff.

By inspection of Table 8 with Table 9, it is apparent that the relative number of persons indicating to NORC their willingness to come for an examination (80.6 percent) corresponds quite closely to the proportion of actual appointments in the pilot project (82 percent). However, since the answers in the pilot project were by self-respondents only, it is more appropriate to compare Table 9 with the national data on self

TABLE 9

EXAMINATION APPOINTMENTS AND RESPONSE TO INITIAL INVITATION BY CENSUS INTERVIEWER IN WASHINGTON, D.C. FIELD TEST

	Total		Initial Answer to Census: "Yes"		"No"	
	Number	Percent	Number	Percent	Number	Percent
Total	180	100	142	79	38	21
Appointment made	148	82	135	75	13	7
No appointment made	32	18	7	4	25	14

respondents. Also, since the pilot project population was 32 percent non-white in contrast to 14 percent in the national study, the comparison is best made for white self-respondents only.

TABLE 10

WILLINGNESS TO COOPERATE SHOWN BY WHITE SELF-RESPONDENTS IN THE NATIONAL ATTITUDE SURVEY AND IN THE WASHINGTON, D.C. PILOT PROJCET

	Total		Initial Answer to Census: "Yes"		"No"	
	Number	Percent	Number	Percent	Number	Percent
National Attitude Survey						
Total	393	100	300	76	93	24
NORC: "Yes"	311	79	270	69	41	10
NORC: "No"	82	21	30	7	52	14
Pilot Project, Washington, D.C.						
Total	123	100	92	75	31	25
Appointment made	96	78	86	70	10	8
Appointment not made	27	22	6	5	21	17

From the foregoing table we are encouraged to believe that the question on willingness to accept an exam in the NORC interview closely reflects behavior in making an actual appointment for examination. Accordingly, the attitude factors which show up from the NORC interviews can be taken as initial guidelines in planning for the health examination survey techniques to produce examinees. The next question is the

problem of broken appointments, which, as can be seen from the following table, are considerable. About two out of every ten persons making appointments failed to show up for the actual examination. About 25 percent found it necessary to reschedule appointments, and less than half of these actually kept the second appointment.

In all fairness, the examination was only given during a three week period and it is the subjective estimate of the survey staff that about half of the "no-shows" had legitimate reasons for not keeping their appointments.1/

TABLE 11

APPOINTMENTS AND ACTUAL EXAMINATIONS
IN THE WASHINGTON, D.C. PILOT PROJECT

	Total		Examined		Not Examined	
	Number	Percent	Number	Percent	Number	Percent
Total persons with appointments. .	148	100	119	80	29	20
Original appointments:						
By Census.	131	88	107	72	24	16
By NORC and persuaders	17	12	12	8	5	4
Reappointments after a broken appointment.	37	25	16	11	21	14

1/ If the period of examination had been extended, it is believed the number of "no shows" would have been reduced. If the percent making an appointment is taken as 79 percent (Table 10) and the "no show" rate of 20 percent is assumed, then the "effective appointment" rate is reduced to 63 percent. If a longer examination period is assumed and the "no show" rate is cut in half, then the potential "effective appointment" rate would be raised to 70 percent. This points up the need for greater persuasion efforts.

B. Profiles of Groups Differing in Willingness to Cooperate

An analysis of personal characteristics and basic attitudes toward health clearly differentiate the five groups which were classified by their stated intentions to cooperate or not cooperate on the health examination phase of the survey. As described above, there are two consistent cooperating groups, differing only in degree of certainty of intention, one consistent negative group and two vacillating groups -- one shifting from "Yes" to "No"and the other from "No" to "Yes". For ease of reference, these five groups will henceforth be called the "cooperation" groups. Although some of the attitude differences among these groups are small and not statistically significant by themselves, the fact that so many of them fall in the same direction bolsters confidence that a larger sample would produce significant findings. Additional research is needed, of course, for more definitive and precise appraisals.

There are ten principal attitudinal and personal variables which distinguish the "cooperation" groups and help us understand motivational differences among them. These variables are:

1. Appraisal of own health status
2. Feelings of unmet health needs
3. Interest and concern about health matters
4. Importance of good health and impact of illness on living activities
5. Satisfaction with current health research efforts
6. Belief in avoidability and cure of illness
7. Confidence in doctor's skill and belief in his concern with patient's welfare
8. Attitudes toward clinics and the role of government in health matters
9. Situational and environmental factors in the arrangements for a health examination
10. Personal variables such as age, education and income.

The differences in these ten variables will first be presented as a series of composite profiles for each "cooperation" group. Then, supporting data will be analyzed for each of the variables in subsequent sections.

The most consistent and certain cooperating group represents all persons who said "Yes" to Census and "Certainly yes" to NORC. Approximately 40 percent of all respondents are in this category, and an outstanding characteristic of the group is the greater recognition of unmet medical needs and desire for medical attention. They less often describe their present health as "excellent" and more often say it's "poor." Accordingly, they generally mention having more chronic illness, and more often would like to talk to their doctor about their health. They also evince greater concern about general health matters by more often thinking about, talking about, and reading and listening to health programs on radio and TV.

With regard to current research on causes and cures of disease, they are less satisfied with the amount of effort currently being made and feel more should be done. When questioned about household surveys, such as this study, they usually felt it was "very important" for people to cooperate. More often, they reported the need for "especially good health to do their work well," and in appraising the economic and social impact of an illness on themselves and their family, more often stated the effects would be more serious. Although more of them usually concede the possibility of becoming seriously ill, they also have greater confidence in early diagnosis and the skill and concern of doctors in making them well. They report more personal experiences with care at clinics and more often feel that the government should have a larger role in maintaining the health of the nation. Sex, marital status and recency of latest doctor visit are equal among all "cooperation" groups, but a higher proportion of younger, non-whites, residents of the West and veterans turn out to be more consistent cooperators. Contrary to other research findings this

study also found greater cooperation from the less educated, poorer, and self respondent persons. Since people with lower incomes have actually been found to have greater unmet health needs, their report of greater willingness to cooperate is consistent with their own appraisal of greater personal benefits to be derived from the health examination. Other studies found, in contradiction, less cooperation among the lower socio-economic status groups.

The group answering "Yes" to Census, but only "Probably yes" to NORC, generally scores somewhat below the "Certainly yes" group in its basic health attitudes but above the negative and vacillating groups. There was no appreciable difference between the two cooperating groups regarding satisfaction with medical research efforts, belief in early diagnosis or confidence in doctor skills, but there were consistent tendencies for lesser feelings on other basic attitudes. The "Probably yes" generally regard their present health as better, report fewer chronic conditions and less often desire to see a doctor about their health. They also show somewhat less concern and interest in health matters and less often recognize the potential threat of serious illness. They less often report the need for especially good health and when ill report less serious consequences. The group is also more often critical of the bedside manner and personal treatment of doctors and less often report experiences with clinics. With regard to their feelings about the role of government, they are more positive than the negative or vacillating groups but approve less government action than the "Certainly yes" group. They also are more often younger, better educated, white and have higher incomes than the "Certainly yes" group. It should be repeated that despite these modest differences, this group is more like the "Certainly yes" respondents than the non-cooperators.

A clear tip off on their less certain feelings about cooperating is shown by their belief that fewer other people will probably cooperate on the health exam. They

more often report having questions in their minds about the kinds of tests to be included in the examination and wonder why they were selected for the sample. Finally, they indicate more responsiveness to the approval of the exam by their own doctor, the local medical society or their own spouse.

The consistent non-cooperators, i.e. the group saying "No" to both Census and NORC, are largely composed of persons who express contrary views to the cooperating groups. More of them are well satisfied with the state of their current health, report fewer chronic illness conditions, express satisfaction with current research efforts, and consider it less important to assist studies such as this by cooperating in the study. Fewer of them also express any desire to see a doctor and fewer consider "especially good health" as essential to their work. Likewise, they more often feel that illness in themselves would not be a heavy financial problem or burden to their families. The consistent non-cooperators as a class are also less interested in health matters in their reading, radio listening and TV watching, and fewer of them consider it likely they may encounter illness in the next year. When symptoms appear the group is more complacent and fewer of them claim they would consult a doctor immediately. More of them have reservations about doctors' ability to cure illness, even though they agree with the cooperators that doctors now know more, and have better medicines, than 30 years ago. They more often feel the role of government in health should be restricted and, as a whole, are older, have higher family incomes, and more often are non-veterans.

A good reflection of their negative attitudes is also afforded by the projective question about their belief in the cooperativeness of other people, in which less than 40 percent feel others will come for the examination. When asked why they themselves would not come, they indicated their belief that they would not gain any personal benefits from the exam and that they have other medical facilities readily

available when needed. They reported little knowledge of the tests and that they had few objections to any specific procedures, but showed some general hostility to free clinics. The approval of the exam by their own doctor or spouse was reported as a possible influence on their decision and a procedure requiring the least time and effort was also stated to have the best chances in overcoming their reluctance to cooperate.

The vacillating "Yes-No" response class is of particular interest because other indications seem to imply that success in gaining cooperation really depends on getting an initial "yes" to the request for examination. There were 53 persons who shifted from "yes" to "no." Their attitudes as revealed by our questions tend to represent viewpoints at the extremes. They report less chronic illness than the consistent non-cooperators and seldom desire to talk to a doctor about their health. With regard to satisfaction with current research efforts, they are more like the cooperators and feel more could be done, but, as far as this study is concerned, few of them feel it is important to cooperate in such studies. They feel less need for especially good health to do their work well and report the least impact when illness strikes. Their interest and concern about health matters is the lowest, although their educational background is the highest. They are least likely to feel that the way people live makes a difference in how healthy they are and they more often recommend self-diagnosis for illness. Generally, they have less confidence in doctors' abilities to cure diseases and are least satisfied with doctors' concern and manner in patient care. It is interesting to note that these critical attitudes toward doctors are not based on reported experiences but on the result of impressions of doctors in general. This "Yes-No" group also feels that the role of government in health matters should be restricted. Moreover, they tend to be concentrated at the two extremes with respect to age, income, and education.

Only 21 percent of the "Yes-No" group feel others will cooperate, and when asked why they themselves probably wouldn't come for the examination, they gave such evasive reasons as, "I'm too busy," and "It depends on when and where they are given." Other reasons indicated a feeling that they personally felt little need for the exam, that their participation was not essential to the success of the survey and that they preferred their own doctors for examination. They revealed little awareness of what might be included in the exam, and expressed few specific objections to the procedures they anticipated. Like the "No-No" group, they indicated potential persuasion by their own doctor or spouse and that the least time consuming examination procedures would be most acceptable to them.

The shift from "No" to "Yes" is believed to be partially an artifact of the Census interviewing procedures. NORC always interviewed the sample person directly, but Census, in accordance with the standard practice of the National Health Survey, accepted proxy responses from members of the family. Proxy respondents proved to be more cautious in saying "yes" than those who responded for themselves. Likewise, the "No-Yes" group is the only group with a higher concentration of proxy respondents. While other groups had about one-third proxy respondents, the "No-Yes" group had 54 percent proxies. A separate analysis of these proxy respondents reveals they considered themselves in very good health, and believed in regular doctor visits. It so happens that less than half of these proxy persons had seen a doctor in the past year in comparison with the average of almost two-thirds for all other respondents. It is reasonable to assume, therefore, that the offer of an examination came at the appropriate time to induce a "Yes" response to NORC. It is also reasonable to assume that if they had been asked directly by Census in the initial interview, they would probably have said "Yes" at that time, and would not have been included in the vacillator group.

With respect to basic attitudes the whole "No-Yes" group more nearly resembles the consistent cooperators. They report less chronic illness and better current health, but more often feel the need for additional doctor consultation than the non-cooperators. They are least satisfied with current medical research and almost all of them feel cooperation on this study is important. There is high interest and concern about health matters and when illness strikes, the impact is almost as serious as that reported by the consistent cooperators. The "No-Yes" group feels less threatened by the possibility of becoming seriously ill, but they strongly believe that the way you live is important to your health, and more often believe in regular medical checkups. They are most satisfied and confident in their own doctor's skill and manner but are somewhat critical of doctors in general. As a group, they have had little experience with clinics and more often feel that doctors engaged in group practice are not as good as private doctors. Because so many were proxy respondents, it is understandable that they are mostly men who were at work when the Census called. It is also interesting to note that there are more non-veterans in this group.

A clue to their own cooperative intentions is shown by their belief in three out of four cases that other persons would probably cooperate on the health examination. The reason most often given for cooperating is "desiring to help the government and personal benefit from the exam." Over three-fourths had questions about the kinds of tests to be given and why they were chosen in the sample. In general, they themselves had a good idea of the tests and more of them wanted their own specific conditions checked. Very few of them had any special dislikes of particular tests and more than half of them indicated that approval of their doctor or spouse might influence their decisions.

C. The Effects of Major Variables on Intention to Cooperate on the Health Examination

The previous section presented a series of integrated summaries of the different "cooperating" groups. This section will evaluate the data underlying the attitudinal differences described above.

1. Appraisal of Own Health Status

After the initial introduction, all NORC respondents were asked as their first question, "Would you say your own health, in general, is excellent, good, fair or poor?" As Table 12 indicates, almost a third of all persons rated their present health as "tops" or "excellent;" a fourth felt it was only "fair or poor," and slightly less than half chose the middle ground and rated it as "good." While the differences between the consistent "cooperators" and "non-cooperators" are not great, the latter tend to rate their current health slightly better. The two vacillating groups, however, indicate considerably better health appraisals than all other groups. These tendencies confirm Cobb and Chen's findings (6) previously reported, that non-cooperators tend to rate their health better.

A more sensitive measure of health appraisal is provided by respondent reports on chronic illness. Every Census respondent was asked whether he ever had a series of chronic conditions. Of course, Trussel, Elinson and Levin (15) have shown that respondent reports of having had chronic illness are not conclusive evidence of actual illness or absence of illness, but they are valid measures of self appraisal of one's own health. As Table 13 indicates, almost half of all people could recall no chronic illness; about a fourth reported having only one condition and an almost equal number said they had two or more chronic conditions. The "cooperation" groups, however, answer this question quite differently. The "Yes-Certainly" group reports the most chronic illness, with over a third mentioning several chronic conditions,

TABLE 12

APPRAISAL OF OWN HEALTH STATUS

	All Persons 1/		Census: YES NORC			Census: NO NORC	
	Number	Percent	Certainly	Probably	No-DK	Yes	No-DK
Number Respondents	762	-	249	237	53	92	79
Self rating of health:	-	100%	100%	100%	100%	100%	100%
Excellent	238	31	28	29	40	33	33
Good	343	45	42	49	41	52	38
Fair	149	20	21	20	17	15	27
Poor	32	4	9	2	2	-	2

1/ The totals for all persons in this and all subsequent tables, includes 16 persons who answered "No" and 36 who answered "Yes" to NORC, but were not asked about the health exam or answered "Don't know" to Census. Answers for these persons are not shown separately, but may easily be derived by subtracting the sub-totals for the five analytical groups from the totals for all persons.

while the second highest incidence of illness is mentioned by the "Yes-Probably" group. In contrast, only about 20 percent of the consistent and vacillating "No's" had as much illness. The least number of chronic conditions was reported by the "No-Yes" people, with almost two-thirds stating they had no chronic illness, and only 15 percent saying they had as much as two or more conditions. As will be seen in later discussion, this low report of illness is in part due to the fewer conditions reported for proxy persons and the higher concentration of proxy respondents in this group. When self respondents only are evaluated, the least illness is reported by the "Yes-No" group and the second least by the "No-Yes" persons.

It is interesting to note that very few of the persons reporting chronic illnesses feel that their conditions limit their activity or mobility in any way. When Census asked about such possible limitations, only 9 percent said that the illness imposed any restrictions on usual activity, and only 1 percent felt it limited their mobility. On these questions there was very little difference among "cooperation" groups.

TABLE 13

RESPONDENT REPORTS OF CHRONIC ILLNESS

	All Persons		Census: YES NORC			Census:NO NORC	
	Number	Percent	Certainly	Probably	No-DK	Yes	No-DK
Number Respondents	762	-	249	237	53	92	79
Number Chronic Conditions	-	100%	100%	100%	100%	100%	100%
None	346	46	39	45	53	62	42
One	216	28	26	30	30	23	38
Two or more	200	26	35	25	17	15	20

Another measure of self appraisal of health is reflected in the number of symptoms reported by each respondent. While awareness of conditions depends on a diagnosis which may be made by the person himself or by a doctor, awareness of symptoms does not have this limitation. A person can report having "frequent headaches" or "lumps or discolored patches on skin" without being able to report the illnesses these symptoms may represent. Each respondent was given a card with eleven symptoms, and asked, "Now I'd like you to tell me if you yourself had any of these conditions at any time during the last year or so?" As Table 14 shows, the frequency of "Yes" answers varies considerably from 2 percent being "thirsty all the time" to 40 percent having a "sore throat or running nose." The tendency for "cooperators" to report more symptoms is apparent in Table 14 but is highlighted in Table 15 which summarizes the numbers of symptoms reported. While only 20 percent of the "Yes-Certainly" and 26 percent of the "Yes-Probably" and "No-Yes" groups report "none" of the 11 possible symptoms, 35 percent of the consistent "No-No's" and 32 percent of the "Yes-No's" report no symptoms at all.

TABLE 14

PERCENT OF RESPONDENTS REPORTING SYMPTOMS
DURING PAST YEAR OR SO

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number Respondents	762	249	237	53	92	79
Symptoms						
Coughing for 5 or 6 days	23	26	25	26	18	14
Diarrhea or constipation for several days	17	16	18	19	17	15
Feeling tired all the time	26	27	26	19	25	27
Frequent headaches	17	21	16	13	15	13
Lump or discolored patches on skin	7	8	6	6	5	9
Shortness of breath	12	14	11	9	6	11
Sore throat, running nose	40	39	40	43	40	33
Unexpected loss of 10 pounds	4	5	3	2	5	2
Feeling thirsty all the time	2	2	2	2	2	2
Pains in the chest	9	12	10	4	6	8
Pains in the stomach	12	17	9	17	4	9

TABLE 15

NUMBER OF SYMPTOMS REPORTED DURING PAST YEAR OR SO

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number Respondents	762	249	237	53	92	79
Number Symptoms	100%	100%	100%	100%	100%	100%
None	25	20	26	32	26	35
One	30	31	29	24	37	23
Two	21	23	22	21	16	19
Three-Four	18	18	17	15	19	20
Five or more	6	8	6	8	2	3

All of these findings indicate that "non-cooperators" generally rate their health as better than "cooperators." It is interesting to note that both Hochbaum (9) and Cobb (6) also report this finding in their more limited studies.

2. Feelings of Unmet Health Needs

In a sense, when a person appraises his own health as only "good," "fair" or "poor," there is an implication that there are unmet health needs. On the other hand, a person may feel his health is only "fair," but that he is already making all possible efforts to take the best care of his condition. He may feel that he has no additional unmet needs. Better indications of feelings about possible benefits from additional medical care are afforded by more direct questions included in our study.

The second and third questions of the NORC interview directly concerned beliefs in unmet health needs. The second question was a projective type and asked the respondent to describe the behavior of most people, possibly including himself. It asked, "All in all, do you think that most people take the best possible care of their health, or could they take better care than they do?" The next question explicitly concerned the respondent himself. It asked, "Would you say you take the best care of your own health now, or could you take better care than you do?" Table 16 summarizes the answers to the projective question and Table 17 presents answers to the more direct question.

While only 23 percent believe "most people" take the best possible care of their health, twice as many or almost half of all people feel they themselves take the best care of their own health. Apparently, it is easier to recognize possible shortcomings among others than it is to admit them for oneself. It is significant to note that "cooperators" more often recognize unmet needs or the possibility for better care than the "non-cooperators." On the projective question, both the

TABLE 16

RESPONDENT BELIEFS ABOUT CARE MOST PEOPLE TAKE OF THEIR HEALTH

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number Respondents	762	249	237	53	92	79
Amount of care:	100%	100%	100%	100%	100%	100%
Take best care	23	19	22	36	23	33
Not take best care	74	78	76	58	74	59
Don't know	3	3	2	6	3	8

TABLE 17

RESPONDENT BELIEFS ABOUT CARE TAKEN OF OWN HEALTH

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number Respondents	762	249	237	53	92	79
Amount of care:	100%	100%	100%	100%	100%	100%
Take best care	46	49	43	43	46	56
Not take best care	53	51	56	55	53	40
Don't know	1	-	1	2	1	4

consistent and vacillating "No's" reported less unmet needs, while on the direct personal question, only the consistent "No-No" group indicated less need for additional medical care.

An even more sensitive indicator of unmet health needs is revealed by a somewhat less direct question about possible benefits from a free medical consultation. All persons were asked, "Now, if you had a chance to talk to your doctor for half an hour, at no cost to you, are there any things about your health that you'd like

TABLE 18

RESPONDENT DESIRE TO TALK TO OWN DOCTOR - FREE OF CHARGE

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Reported Feelings:	100%	100%	100%	100%	100%	100%
Desire to talk	40	53	43	28	32	16
No desire to talk	59	47	56	72	67	83
Don't know	1	-	1	-	1	1

to ask him?" Table 18 reveals that only 16 percent of the "No-No" group and 28 percent of the "Yes-No" group have any questions to ask the doctor. In sharp contrast, over half of the most cooperative, "Yes-certainly" group, report unanswered questions. As indicated in the profiles, the "Yes-Probably" and "No-Yes" cooperators feel slightly less need to talk to a doctor, but they feel greater unmet needs than the consistent "No-No" group.

When all respondents who felt they could take better care of their health were asked, "What are some of the things you could do to take better care of your health?" almost half of all persons answering mentioned better personal habits, such as eat better foods, less food, more regularly, get more sleep, more rest, avoid overexertion. About a third answering mentioned "go to a doctor or dentist more regularly," while another 8 percent said "get medical care right away when something is wrong." Other answers were to take medicine or doctor's advice, change smoking and drinking habits, get more exercise and avoid bad weather.

Another indication of the kinds of unmet health needs reported by respondents was given in answer to a follow-up question asked of those people desiring to talk to their doctor. All persons who had questions on their minds, were asked, "What

sort of things would you ask him about?" About half of all persons with questions wanted information about their own specific symptoms or apparently undiagnosed conditions. Another fourth of the answers were in terms of follow-up advice on already diagnosed conditions. Only about 10 percent had general questions about health rules or wanted a general check-up. There were little differences in the types of questions among the five cooperating groups with the exception that almost 75 percent of the questions from the "Yes-No" group (represents only 21 percent of total group, since only a fourth of the group had any questions) concerned specific undiagnosed personal symptoms, in comparison to the 50 percent for all other groups reported above.

Additional insight into the groups without any questions for their doctors is given by answers to the questions, "Why is that (you have nothing about your health that you'd like to ask your doctor)?" About 40 percent of those without any questions answered, "Because I'm healthy," "I don't know of anything wrong with me," or "There's nothing wrong with me." Over a fourth answered, "Because I have regular checkups," or "I have been examined recently." About 10 percent felt they knew how to take care of themselves or could go to their doctor whenever necessary without worrying about cost. The consistent "No-No's" more often reported "having regular checkups or having readily available a doctor," as their reasons for not desiring to talk to their doctor.

These answers clearly indicate that desiring to talk to their doctor reflected a specific feeling of unmet medical needs, while conversely, not desiring to talk to the doctor reflected a satisfaction with their medical care and the absence of personally perceived unmet needs. Further confirmation of these findings is shown in Tables 19-21.

Every person was also asked, "During the last year, have you felt at any time that you should have seen a doctor but didn't?" As Table 19 shows only about 10

TABLE 19

RESPONDENT REPORTS OF NEED TO SEE DOCTOR DURING LAST YEAR -- BUT FAILURE TO DO SO

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Respondent Feelings:	100%	100%	100%	100%	100%	100%
Need to see doctor	25	32	28	13	22	11
No need to see doctor	75	68	72	87	78	89

percent of the non-cooperators reported feeling such unmet needs. In contrast, about a third of the consistent cooperators felt a need to see a doctor. As expected, when those persons who felt like seeing their doctor are asked why they didn't, "Lack of money," and "Lack of seriousness of the symptom," are the most important reasons given. Admission of neglect or carelessness and evasive answers like, "Too busy" represent most of the remaining answers.

To check any possible reluctance to admit personally some unmet health needs, two additional questions were asked. Each respondent was asked, "During the past year has anyone suggested you see a doctor, but you didn't go?" and "Do you ever argue with anyone else in the family about whether one of you should see a doctor?" A "Yes" answer to these questions would at least indicate a difference of opinion with the respondent regarding his health needs.

Table 20 reveals that only 2 out of 10 persons report that others have suggested they see a doctor, and only the consistent "No-No" group reports fewer people urging them to see a doctor. When asked who did the urging, most respondents said their spouse wanted them to go. Table 21 summarizes the answers to the second question on arguments about seeing a doctor. Apparently, this more general question

TABLE 20

OTHERS SUGGESTED RESPONDENT SEE DOCTOR BUT HE FAILED TO DO SO

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Suggestions:	100%	100%	100%	100%	100%	100%
See doctor	20	20	23	17	20	9
Not see doctor	80	80	77	83	80	91

TABLE 21

ARGUMENT WITH FAMILY MEMBERS ABOUT SEEING DOCTOR

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
All Responses	100%	100%	100%	100%	100%	100%
No family	5	6	5	10	1	8
Never argue	65	63	63	67	65	73
Argue about doctor: 1/	30	31	32	23	34	19
Spouse wants me to go	7	4	8	10	5	4
Children want me to go	1	1	1	-	1	-
Other relatives want me to go	1	1	2	2	-	1
I want spouse to go	18	16	18	13	24	15
I want children to go	3	3	4	-	3	-
I want other relatives to go	5	7	4	4	5	3

1/ Types of arguments add to more than total because more than one argument may be reported by each person.

reveals more difference of opinion on family medical needs. About a third of all persons reported such disagreements, with "cooperators" reporting almost twice as many differences than the "non-cooperators." It is interesting to note, in general, that in only one out of eleven arguments did the respondent state that others urged

him to go to a doctor. Likewise, indicating their strong belief in medical examinations, only one out of every sixteen disagreements reported by the "No-Yes" group involved respondent reluctance to see a doctor.

All of these questions clearly support the findings of other research that "cooperators" feel greater unmet health needs than "non-cooperators." These findings of potential personal benefits from additional medical care are perhaps the most crucial in evaluating willingness to participate in a health examination.

3. Interest and Concern About Health Matters

Another key attitudinal variable is the relative importance of health matters to an individual. While feelings of unmet needs are undoubtedly related to interest and concern about health matters, the two attitudes can be separate and distinct. The question of unmet needs is necessarily a very personal attitude, while the question of interest and concern about health topics is a more general one. To what extent do people think about, talk about, read about and listen or watch health education programs. Answers to these questions were sought in a series of items asked of all respondents.

Early in the interview (sixth question) everyone was asked, "Would you say you think about your health fairly often, once in a while or hardly ever?" "Do you talk about your health with your family and friends fairly often, once in a while or hardly ever?" Answers to these questions which are shown in Table 22, reveal a measure of general concern about personal health. About 40 percent, on the average, think about their health fairly often, but this concern is much greater for the "cooperators." While almost half of the most cooperative, "Yes-Certainly" group think about their health "fairly often," only a fourth of the "non-cooperators" report as much concern. The other cooperating groups show somewhat less concern than the "Yes-Certainly" group but definitely more than the "non-cooperators."

TABLE 22

CONCERN ABOUT PERSONAL HEALTH

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
A. Think about own health:	100%	100%	100%	100%	100%	100%
Fairly often	40	49	41	26	36	25
Once in a while	36	33	36	40	39	34
Hardly ever	24	18	23	34	25	41
B. Talk about own health:	100%	100%	100%	100%	100%	100%
Fairly often	15	19	13	11	16	9
Once in a while	32	31	36	32	30	25
Hardly ever	53	50	51	57	54	66

Far fewer persons admit talking about their health to family or friends. Only 15 percent of all persons say they talk about their health "fairly often" and over half say, "hardly ever." It is significant, however, that twice as many "Yes-Certainly" respondents say they often talk about their health than consistent "No-No" persons.

Two questions concerning general interest in health matters were also asked. All persons were queried, "Could you tell me if you read about health matters in newspapers or magazines often, once in a while, or hardly ever?" Everyone answering "hardly ever" was also asked, "Is that because you don't read the newspapers or magazines much or because you usually skip health items?" This second question clearly separates all persons who are really disinterested in health matters. As Table 23 shows only a third of all persons read about health items often, and only a fourth hardly ever read about health. Only the vacillating "Yes-No" group shows any atypical behavior with more of them consciously skipping health articles.

TABLE 23

EXTENT OF READING ABOUT HEALTH MATTERS

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Extent of Reading:	100%	100%	100%	100%	100%	100%
Often	33	34	30	40	34	30
Once in a while	43	41	49	23	48	42
Hardly ever	24	25	21	37	18	28
Why?						
Don't read papers, etc.	13	15	11	19	7	18
Skip health items	11	10	10	18	11	10

The second question concerning radio and TV programs more sharply differentiates the cooperating groups. Every one was asked, "How about radio and television programs dealing with health or medicine...do you listen to those often, once in a while, or hardly ever?" As in the previous question, everyone answering "hardly ever" was asked "Why?" As Table 24 indicates, only a fourth of all people listen "often" to radio or TV health programs, while a third hardly ever listen. The "cooperators," however, show much more interest in health programs than the "non-cooperators." While only 27 percent of the "Yes-Certainly" group say they "hardly ever" listen, about half of the "non-cooperators" say the same. Likewise, while only 13 percent of the "Yes-Certainly" group specifically avoid health programs, almost three times as many "Yes-No's" and twice as many "No-No's" avoid health programs.

TABLE 24

EXTENT OF LISTENING TO RADIO OR TV PROGRAMS ON HEALTH

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Extent of listening:	100%	100%	100%	100%	100%	100%
Often	23	29	18	19	26	19
Once in a while	43	44	48	29	47	34
Hardly ever	34	27	34	52	27	47
Why?						
Avoid all programs	11	12	14	8	9	13
Avoid health programs	19	13	17	36	16	29
None available or other	4	1	3	8	2	5

4. Importance of Good Health and Importance of Illness on Living Activities

Related to concern and interest in health is the relative importance of good health to the life of a person and the seriousness with which he regards an occurrence of illness. As we shall see, the "cooperators" generally regard good health as more important and feel that illness would have a more severe impact on their lives.

All persons were asked, "All in all, in order to do your work well, would you say that it is necessary for you to have especially good health, to have fairly good health or could you do your work well even if you were not feeling so well?" As shown in Table 25, only a third felt they needed "especially good health," while almost half chose the middle ground of "fairly good health." With the exception of the "Yes-No" group, all respondents felt substantially the same on this question. The vacillating group felt much less need for good health; about twice as many felt they could do their work well even if they weren't feeling so well.

TABLE 25

REPORTED HEALTH REQUIRED BY OWN WORK

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Kind of health:	100%	100%	100%	100%	100%	100%
Especially good	32	36	31	17	33	30
Fairly good	49	47	53	47	49	49
Not so good	18	17	16	34	18	18
Don't know	1	-	-	2	-	3

To help measure relative impact of severe illness, respondents were asked about economic and social effects of being seriously ill. Each person was asked this hypothetical question, "Now suppose you had a large medical bill not covered by insurance -- say for $500 or more -- would you have great difficulty in paying it right away, a moderate amount of difficulty or hardly any difficulty at all?"

Table 26 indicates that almost half of all people would have great difficulty in paying a $500 medical bill, but twice as many of the "Yes-Certainly" group in comparison with the "No-No" respondents report such a serious problem. In contrast, about 40 percent of the "non-cooperators" feel they would have hardly any difficulty at all in meeting such a bill. As expected the "Yes-Probably" group reports less impact than the more certain cooperators, but more difficulty than the "non-cooperators."

The same findings are reflected in a question about loss of pay when ill. Everyone was asked, "Now if you were sick in bed for a week -- would you lose all of your income during that time, or only part of it, or wouldn't you lose any income at all if you were sick in bed for a week?" As Table 27 clearly shows, the maximum impact is reported by the "Yes-Certainly" group with 41 percent reporting some loss,

TABLE 26

EXPECTED DIFFICULTY IN PAYING A LARGE MEDICAL BILL

	All Persons	Census:YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Difficulty in payment:	100%	100%	100%	100%	100%	100%
Great	45	56	46	30	34	28
Moderate	31	26	33	32	32	32
Hardly any	24	18	21	38	34	40

TABLE 27

LOSS OF INCOME IF SICK

	All Persons	Census:YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Amount of loss:	100%	100%	100%	100%	100%	100%
All	22	27	18	6	7	6
Some	16	14	18	9	14	10
None	26	21	25	49	50	46
No job	35	36	38	32	28	35
Don't know	1	2	1	4	1	3

the next greatest loss by the "Yes-Probably" with 36 percent having some loss and the lowest impact by the"non-cooperators"who report only 15-16 percent with any income loss.

All persons with jobs were also asked, "In other ways -- other than income, that is -- would it hurt you on your job a great deal or some, or wouldn't it be very serious (if you were sick in bed for a week)?" Table 28 indicates little other effects and only slightly greater impact on the"cooperators."

TABLE 28

WAYS OTHER THAN INCOME JOB WOULD BE HURT BY ILLNESS

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Amount of Harm:	100%	100%	100%	100%	100%	100%
Great deal	7	10	6	6	7	6
Some	12	10	14	9	14	10
Not very serious	46	44	42	55	51	49
No job	35	36	38	32	28	35

Likewise very few people (17 percent) report that they would have great difficulty in getting somebody to take care of them if they were sick in bed for a week. Almost 60 percent say there is somebody at home who could take care of them, and the rest say they could get somebody easily. No differences are reported for the different cooperating groups.

In order to assess the impact of respondent illness on the family, the following question was asked: "And how much trouble would the rest of the family have in taking care of the house if you were sick in bed for a week -- a great deal of trouble, some trouble, or not much at all?" As shown below in Table 29, over half of all persons report "not much trouble," but the "non-cooperators" maintain the persistent pattern of reporting somewhat less trouble and less difficulty resulting from illness. Such findings go a long way in explaining why the "non-cooperators," feeling fewer unmet needs and better health, also have less concern about illness when it strikes.

TABLE 29

IMPACT ON REST OF FAMILY IF RESPONDENT IS ILL

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Impact:	100%	100%	100%	100%	100%	100%
Great deal	12	14	13	19	8	10
Some	23	24	29	6	24	17
Not much	57	53	50	66	64	63
No family	8	9	8	9	4	10

5. Satisfaction with Current Research Efforts

Since the offer of a free health examination is part of a research program, it was believed pertinent to find out how satisfied each respondent was with current medical research efforts. Presumably if a person felt more medical research was urgently needed, he might be more cooperative with the examination phase of the National Health Survey. This hypothesis is substantiated by attitudes presented in Tables 30-32.

Everyone was asked, "Do you think enough is being done to discover the causes of disease?" As expected the consistent "non-cooperators" are the most complacent and satisfied with research efforts. As Table 30 shows, only 16 percent of the "No-No's" feel additional research may be needed, as compared to 34 percent of the "Yes-Certainly" group. The least satisfied group is the "No-Yes" vacillators, with 39 percent reporting more should be done.

TABLE 30

SATISFACTION WITH CURRENT RESEARCH ON CAUSES OF DISEASE

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Feelings about research:	100%	100%	100%	100%	100%	100%
Enough being done	68	66	70	64	61	84
Not enough being done	28	30	26	30	36	11
Don't know	4	4	4	6	3	5

The answers to a question about satisfaction with research on cures of disease are similar to the one on causes. As Table 31 shows, the "No-No's" are the most satisfied, the "No-Yes's," the least satisfied, and the others about the same. In general, over two-thirds feel enough is being done but over three-fourths of the consistent "No's" feel this way.

TABLE 31

SATISFACTION WITH CURRENT RESEARCH ON CURES OF DISEASE

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Feeling about research:	100%	100%	100%	100%	100%	100%
Enough being done	67	66	69	66	55	77
Not enough being done	29	31	26	28	41	18
Don't know	4	3	5	6	4	5

When answers to the more direct question about personal cooperation with research surveys are analyzed, the differences among cooperation groups are highlighted. In order to avoid possible bias from other questions, the following question was kept for last: "How important do you feel it is for people to cooperate on opinion surveys such as this -- very important, fairly important or hardly important at all?" Table 32 shows that the "non-cooperators" more often feel assisting such research is not important. About 9 out of every 10 "Yes-Certainly" respondents felt it was very important to cooperate; 99 percent felt it was at least fairly important. In contrast, only 4 out of 10 "No-No's" felt it was very important and only 8 out of 10 felt it was even fairly important. The "Yes-Probably" and "No-Yes" answers show feelings of somewhat less importance than the most certain cooperators but definitely more importance than the "non-cooperators."

TABLE 32

BELIEF IN IMPORTANCE OF COOPERATING ON HEALTH OPINION SURVEYS

		Census: YES			Census:NO	
	All	NORC			NORC	
	Persons	Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Importance of Cooperation:	100%	100%	100%	100%	100%	100%
Very important	70	90	65	51	66	42
Fairly important	25	9	33	36	32	40
Hardly important	3	1	1	8	2	10
Don't know	2	-	1	5	-	8

6. Belief in Avoidability and Cure of Illness

Underlying both the feeling of unmet health needs and the willingness to accept medical assistance for these needs are a series of interrelated attitudes which we may characterize as the belief in avoidability and cure of illness. An understanding of these attitudes is essential if we are to differentiate the behavior of "cooperators" and "non-cooperators." In order to facilitate the analysis of the complex interrelationships, we will separate schematically five of the attitudes for our evaluation.

First, we will consider some evidence of the knowledge people have of a few major illnesses, and their belief in being able to recognize readily symptoms of illness. Then, we will examine the relationships of beliefs that positive human behavior can influence the health of a person. Next, we will relate beliefs that a person may become seriously ill without knowing it for sometime, and then, the value of early diagnosis and treatment. Finally, we shall look at the extent to which people have respect and confidence in medical science and their doctors capabilities to cure illness and maintain good health. As we shall see, a "cooperator" is more often a person who has more knowledge of symptoms as significant signs of possible illness, who believes that the way he lives can affect the state of his health, who recognizes the possibility of becoming ill without knowing it, who has more confidence in doctors and believes in early diagnosis and treatment of illness.

Everyone was asked to mention as many signs or symptoms of polio, tuberculosis, and diabetes as he could. The questions were so worded as to encourage as many comments as possible. The first question about polio was as follows: "From what you've heard or read, do you happen to know any of the signs or symptoms of polio? (What are they?) Any other ways a person could tell he had polio?" While the

differences are not great between the "cooperators" and the "non-cooperators," there is a persistent tendency for the "non-cooperators" more often to report "no symptoms" at all, or to report fewer symptoms. Since knowledge and education are so obviously related, it is interesting to note again that the consistent "cooperators" and "non-cooperators" do not differ with regard to education and the vacillating "Yes-No" group , represents a group with the highest educational background. Likewise, the less certain "cooperators" also have higher educational training. Consequently, the differences in knowledge of symptoms of these three major illnesses can not be explained by educational differences. They may either represent less knowledge or greater reluctance or indifference to discuss symptoms and health matters.

Table 33 summarizes the answers on knowledge of symptoms. Over a fourth of all persons failed to mention any symptoms of polio or TB, two illnesses which have received widespread publicity. In contrast, half of all people could mention no symptoms of diabetes, a disease which has received less public attention. In all three illnesses, the"non-cooperators"tend to report the least number of symptoms, with the greatest differentiation occurring in the case of diabetes. Almost two-thirds of the consistent "No-No's" mention no symptoms for diabetes as compared to less than half of the "Yes Certainly" group.

As a further check on belief in ready recognition of serious illness, everyone was asked the following question: "Now I'd like to ask you about some particular illnesses. If a person should get (each of eight conditions were separately mentioned) do you think he could tell right away something was wrong by the way he felt or might he not know for some time that something was wrong?" Table 34 indicates for each of the eight conditions, the number of people who feel they can tell right away that they are ill, while Table 35 summarizes for each respondent, the number of illnesses he feels he can tell right away.

TABLE 33

NUMBER OF SYMPTOMS MENTIONED FOR THREE SERIOUS ILLNESSES

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
A. Polio						
Number mentioned:	100%	100%	100%	100%	100%	100%
None	29	29	27	36	33	33
One	13	16	11	9	14	17
Two	23	20	28	26	20	16
Three or more	35	35	34	29	33	34
B. Tuberculosis						
Number mentioned:	100%	100%	100%	100%	100%	100%
None	26	23	27	30	23	25
One	23	21	29	23	13	27
Two	27	27	24	30	37	25
Three or more	24	29	20	17	27	23
C. Diabetes						
Number mentioned:	100%	100%	100%	100%	100%	100%
None	50	47	50	55	47	63
One	17	18	18	15	18	13
Two	17	19	16	21	20	14
Three or more	16	16	16	9	15	10

TABLE 34

NUMBER OF PEOPLE WHO FEEL EACH ILLNESS CAN BE RECOGNIZED RIGHT AWAY

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Illnesses:[1/]						
Arthritis	83%	85%	81%	75%	84%	84%
Asthma	77	78	75	79	79	77
Polio	60	56	60	62	66	53
Heart trouble	35	40	36	21	33	34
Liver trouble	33	34	32	26	33	39
Diabetes	19	22	16	11	20	23
TB	18	21	17	8	24	18
Cancer	11	12	9	11	11	10

1/ Percentages are non-additative, but represent the percentage of 100% who can recognize each illness right away.

TABLE 35

NUMBER OF ILLNESSES RESPONDENT FEELS CAN BE RECOGNIZED RIGHT AWAY

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Number of Illnesses:	100%	100%	100%	100%	100%	100%
None	5.3	4.4	4.6	5.6	4.3	11.4
1-2	24.5	23.7	27.8	30.2	21.7	17.8
3	27.6	27.8	24.6	30.2	26.1	26.5
4-5	31.4	30.9	33.7	32.1	36.0	29.1
6-8	11.2	13.2	9.3	1.9	11.9	15.2
Cumulative Number:	100%	100%	100%	100%	100%	100%
None	5.3	4.4	4.6	5.6	4.3	11.4
2 or less	29.8	28.1	32.4	35.8	26.0	29.2
3 or less	57.4	55.9	57.0	66.0	52.1	55.7
5 or less	88.8	86.8	90.7	98.1	88.1	84.8
8 or less	100.0	100.0	100.0	100.0	100.0	100.0

The range in recognition of different illnesses is quite large, but there are hardly any differences among cooperation groups. Only the "Yes-No" group appears to be less sure of easy recognition of serious illness which appears to be consistent with the poorer report of symptoms cited above. About 80 percent of all people feel that the symptoms of arthritis and asthma can be recognized right away, about a third felt they'd know heart or liver trouble, while only 11 percent felt cancer could be detected as readily. As Table 35 shows, there are no significant differences among the cooperation groups except that while 98 percent of the "Yes-No" group feel they can recognize only five or fewer illnesses, less than 90 percent of the other groups feel that way.

In general, the above evidence is quite inconclusive on the differences in knowledge of symptoms among the cooperating groups. On the specific free answer mentions of symptoms, the cooperators appeared to have more ready answers, but in

reply to the direct question on recognition of eight illnesses, no real differences are apparent.

Somewhat greater differences are evident between the consistent "cooperators" and "non-cooperators" and the vacillators, with respect to the effects of human behavior on health conditions. When everyone was asked, "Do you think the way you live makes a great deal of difference in how healthy you are, makes some difference or hardly any difference at all?" almost two-thirds of the "No-Yes" respondents felt it made a "great deal" of difference in comparison with less than half of the "Yes-No" vacillators. Response among the consistent cooperators and non-cooperators, however, were substantially the same. Table 36 presents these findings.

TABLE 36

BELIEF THE WAY YOU LIVE AFFECTS HEALTHINESS

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of respondents	762	249	237	53	92	79
Effects on health:	100%	100%	100%	100%	100%	100%
Great deal	56	58	51	47	65	58
Some	26	23	30	23	20	24
Hardly any	17	19	18	26	14	13
Don't know	1	-	1	4	1	5

Two additional questions probed the respondent for his beliefs about the possibility of his becoming ill. Presumably, a person who feels greater danger of becoming ill might be more willing to come to a free health examination. As Tables 37 and 38 show the "cooperators" do feel more proneness to becoming ill than the "non-cooperators."

All respondents were first asked, "Looking ahead over the next year, how likely do you think it is that you may be sick in bed for a week all told?" If the answer was "not likely" or "don't know," they were asked, "How about being sick in bed for 3 or 4 days?" The answers to these questions are combined in Table 37. Slightly over half of all people did not think they would be sick in bed during the next year even 3-4 days, but only 51 percent of the "Yes-Certainly" were as optimistic compared to 64 percent of the "No-No's." The vacillators were almost as sanguine as the "No-No" group, with 60 percent forseeing no illness.

The greater optimism of the "non-cooperators" is even more apparent in the answers shown in Table 38. While only 70 percent of the "Yes-Certainly" and 74 percent of the "Yes-Probably" feel it uncertain or unlikely that they will become seriously ill, 84 percent of the consistent"No's"and 87 percent of the vacillating "No's"feel unthreatened by TB, heart disease or arthritis.

TABLE 37

LIKELINESS TO BECOME SICK IN BED FOR A WEEK OR LESS DURING NEXT YEAR

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Likeliness to be Sick:	100%	100%	100%	100%	100%	100%
A week or more	20	36	27	25	30	23
3-4 days	15	13	19	15	10	13
None	55	51	54	60	60	64

Assuming that "cooperators" and "non-cooperators" do not differ greatly in their ability to recognize symptoms, and that "non-cooperators" feel somewhat less threatened by impending illness, the question of confidence in medical science to diagnose and

TABLE 38

LIKELINESS TO GET TB, HEART DISEASE OR ARTHRITIS IN NEXT 5-10 YEARS

	All Persons	Census: YES			Census: NO	
		NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Likeliness:	100%	100%	100%	100%	100%	100%
Very likely	7	9	7	2	3	6
Fairly likely	18	21	19	11	21	10
Hardly likely	67	63	66	70	71	66
Don't know	8	7	8	17	5	18

cure illness remains a crucial one. A general question about people's chances for living a healthy life now as compared to 30 years ago indicates a pervasive confidence in medicine by practically all people. Over 80 percent said the chances for living a healthy life now were "much better;" 9 percent said a "little better;" only 7 percent said "worse" and 2 percent said the "same." This vote of confidence was characteristic of all cooperating groups as shown in Table 39.

TABLE 39

PEOPLE'S CHANCES FOR LIVING A HEALTHY LIFE NOW AS COMPARED TO 30 YEARS AGO

	All Persons	Census; YES			Census: NO	
		NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
People's Chances:	100%	100%	100%	100%	100%	100%
Much better	82	81	83	79	76	84
Little better	9	8	9	7	17	5
Much worse	3	4	2	4	2	5
Little worse	4	5	4	4	1	4
Same	2	2	2	6	4	2

Two follow-up questions about doctors' skill and new medicines also reveal the overwhelming confidence in modern medicine. Table 40 summarizes answers to the following question, "Do you think doctors today know a lot more about treating sickness, a little more, a lot less, or a little less than they did 30 years ago?" Over 9 out of 10 generally answered doctors now know a lot more, but only 83 percent of the "Yes-No" vacillators felt as confident in doctors' skill. When asked, "And do you think the medicines we have today are much better, a little better, or worse than they were 30 years ago?" the same pattern of confidence is apparent. As Table 41 shows only the "Yes-No's" report fewer than 90 percent saying "much better."

TABLE 40

BELIEF DOCTORS TODAY KNOW MORE THAN THEY DID 30 YEARS AGO

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Belief Doctors Know:	100%	100%	100%	100%	100%	100%
A lot more	90	92	91	83	95	87
A little more	8	7	8	13	5	5
Less	1	-	1	2	-	3
The same	1	1	-	2	-	5

How do these general expressions of faith in medical science compare to beliefs in doctors abilities to cure or help specific chronic diseases? To test this question, everybody was asked to rate doctors' capabilities to "completely cure," "help but perhaps not cure" or "not help at all," eleven specific illnesses. Table 42 presents answers for each illness and Table 43 summarizes the number of illnesses

TABLE 41

BELIEF MEDICINES TODAY ARE BETTER THAN 30 YEARS AGO

	All Persons	Census: YES NORC			Census:NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Comparison of Medicines:	100%	100%	100%	100%	100%	100%
Much better	93	93	92	87	98	
Little better	4	4	5	7	2	
Worse	1	1	*	2	-	
Same or Don't know	2	2	3	4	-	

* Less than 1percent.

respondents feel doctors can cure or help. As Table 42 indicates there is considerable variation in beliefs in complete cures, but little difference among illnesses regarding "cure or help" combined. While only 4 percent believe doctors can cure arthritis, 89 percent felt doctors can at least help the condition. At the other extreme, over three-fourths of all people feel piles can be completely cured, and an additional 18 percent feel they can be helped but not cured. While the number of items in Table 42 makes comparisons of the cooperation groups difficult, it is apparent that the non-cooperators have somewhat less faith in doctors, and the "No-Yes" group has the highest confidence in doctors. Table 43 simplifies these comparisons, and it can be seen that while 87-89 percent of the cooperators believe that nine or more illnesses can be cured or helped, only 73 percent of the consistent "No's"and 79 percent of the "Yes-No" group are equally confident.

A direct question was also asked regarding belief in early diagnosis. Each respondent was handed a card with 11 symptoms and asked, "Now on this card is a list of health conditions that people sometimes have. I'll read each one and I'd like

TABLE 42

BELIEF IN DOCTORS' ABILITY TO CURE OR HELP ILLNESS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Cure or Help Illness						
Cure allergy	17%	16%	15%	11%	26%	16%
Help allergy	71	71	74	77	62	66
Cure or help allergy	88%	87%	89%	88%	88%	82%
Cure arthritis	4%	4%	3%	8%	7%	6%
Help arthritis	89	90	92	81	89	80
Cure or help arthritis	93%	94%	95%	89%	96%	86%
Cure asthma	10%	9%	8%	23%	16%	9%
Help asthma	78	82	80	60	77	68
Cure or help asthma	88%	91%	88%	83%	93%	77%
Cure diabetes	15%	18%	11%	17%	14%	18%
Help diabetes	76	73	81	66	77	67
Cure or help diabetes	91%	91%	92%	83%	91%	85%
Cure gall bladder	62%	64%	62%	57%	62%	58%
Help gall bladder	23	22	25	24	16	29
Cure or help gall bladder	85%	86%	87%	81%	78%	87%
Cure heart	13%	13%	10%	17%	22%	14%
Help heart	80	81	83	70	74	77
Cure or help heart	93%	94%	93%	87%	96%	91%
Cure blood pressure	31%	30%	28%	38%	45%	28%
Help blood pressure	63	64	70	51	49	62
Cure or help blood pressure	94%	94%	98%	89%	94%	90%
Cure kidney	46%	44%	46%	43%	54%	41%
Help kidney	41	43	44	38	38	37
Cure or help kidney	87%	87%	90%	81%	92%	78%
Cure piles	76%	75%	75%	76%	84%	73%
Help piles	18	17	23	13	10	18
Cure or help piles	94%	92%	98%	89%	94%	91%
Cure sinus	23%	25%	21%	11%	28%	25%
Help sinus	66	67	69	74	62	51
Cure or help sinus	89%	92%	90%	85%	90%	76%
Cure varicose veins	37%	36%	35%	34%	42%	41%
Help varicose veins	47	50	50	45	39	39
Cure or help varicose veins	84%	86%	85%	79%	81%	80%

TABLE 43

NUMBER OF ILLNESSES DOCTORS CAN CURE OR HELP

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Number:	100%	100%	100%	100%	100%	100%
Six or less	5	5	2	13	4	10
7-8	9	8	10	8	7	17
9 +	86	87	88	79	89	73

you to tell me if you think a person should see a doctor about it immediately, if he should take care of it himself unless it gets worse, or if he should leave it alone." As Table 44 shows, 95 percent believe an immediate doctor visit is warranted when there is a lump or discolored patch on the skin, but only a fourth believe a sore throat requires immediate doctor's care. An inspection of individual symptoms or the cumulative summary at the bottom of the table indicates clearly that the "non-cooperators" do not believe in early diagnosis as much as the "cooperators." While 40 percent of the "Yes-No" and 27 percent of the "No-No" groups believe only six or fewer symptoms warrant immediate doctor visits, 18 percent of the "Yes-Certainly" and 21 percent of the "Yes-Probably" feel this way. The "No-Yes" respondents generally are similar to the consistent "No's" in their reluctance to see a doctor right away. As we shall see shortly, the "No-Yes" group also reports more hostility to doctors and that may partly explain their hesitancy to see a doctor right away.

The previous discussion has shown that "non-cooperators" report somewhat less knowledge of symptoms of disease, although they feel equally confident that they can recognize illness from given symptoms. They feel less threatened by possible illness and feel only slightly less confident in the wonders of drugs and doctors. But when questioned about specific illnesses, the non-cooperators more often doubted

TABLE 44

CONDITIONS WHICH REQUIRE IMMEDIATE DOCTOR VISIT

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Conditions:	100%	100%	100%	100%	100%	100%
Coughing 5-6 days	65	67	66	66	65	57
Diarrhea or constipation several days	61	62	63	49	58	63
Tired all the time	76	78	78	60	72	74
Frequent headaches	81	79	85	74	80	74
Lump or discolored patches on skin	95	95	97	85	96	90
Shortness of breath	80	86	78	60	85	76
Sore throat	27	32	27	15	23	28
Unexpected loss of 10 lbs.	80	82	84	74	74	72
Thirsty all the time	62	64	60	55	70	53
Pains in chest	90	92	92	83	83	87
Pains in stomach	80	81	82	74	76	77
Cumulative Number of Conditions:						
None	1	*	-	-	-	5
6 or less	22	18	21	40	29	27
7 or less	38	34	35	64	38	41
8 or less	55	52	54	74	56	59
9 or less	73	72	72	87	72	75
10 or less	88	87	90	89	90	85
11 or less	100%	100%	100%	100%	100%	100%

whether doctors can help or cure disease and whether doctors need to be seen right away for diagnosis and treatment. All of these attitudes concern intentions or beliefs of what is desirable. The following discussion will examine some evidence of actual reported behavior.

Each person was also asked whether he himself had any of the eleven conditions listed in Table 42 during the last year or so. Then, for each reported condition, he was asked whether he happened to see a doctor about it, and if not, why not. About half of all persons reported no conditions so they could not be tested on

actual behavior. But of the remaining 412 persons who had one or more conditions, Table 45 shows that about half saw a doctor for all conditions, about 16 percent saw a doctor for only some of the items and almost a third saw a doctor for none of the conditions reported. While the "No-No" and "Yes-No" groups tend to show more cases with no doctor visits, the relative differences are too small to be significant. Apparently, when they recognize a condition, all groups equally see a doctor. When asked why they didn't see a doctor, almost two-thirds said they knew what to do about their condition and almost half said they felt the condition wasn't serious enough.

TABLE 45

REPORTED EXPERIENCE IN SEEING DOCTORS FOR ELEVEN CONDITIONS

		Census: YES			Census:NO	
	All	NORC			NORC	
	Persons	Certainly	Probably	No-DK	Yes	No-DK
Number with Conditions	412	140	133	25	47	41
Saw doctor:	100%	100%	100%	100%	100%	100%
For all conditions	54	55	57	44	49	54
For some conditions	16	17	14	28	17	14
For no conditions	30	28	29	28	34	32

Census also asked a question about the last visit to a doctor. When the answer to this question is cross-tabulated by the number of chronic conditions reported to the Census, another behavior test is possible. Table 46 which presents these data also shows little actual behavioral differences among the cooperation groups. Apparently, the "non-cooperators" feel less need to see a doctor, but when they clearly recognize a condition, they equally seek the services of a doctor. Likewise, people with no reported chronic conditions generally have seen a doctor less recently; 44 percent of them have seen a doctor more than a year ago. People with two or more chronic conditions say that only 20 percent of them last saw a doctor 12 months ago or more, while 29 percent of those with only one chronic illness last saw a doctor as long ago as a year or more.

TABLE 46

LAST DOCTOR VISIT BY NUMBER OF REPORTED CHRONIC ILLNESSES

Chronic Illness	Last Visit to Doctor (months)		Census: YES NORC			Census: NO NORC	
		Persons	Certainly	Probably	No-DK	Yes	No-DK
		N= (346)	(98)	(106)	(28)	(57)	(33)
None	- 3	32%	31%	32%	32%	30%	36%
	4-11	24	25	26	32	25	15
	12 +	44	44	42	36	45	49
		100%	100%	100%	100%	100%	100%
		N = (216)	(64)	(71)	(16)	(21)	(30)
One	- 3	47%	41%	48%	44%	48%	56%
	4-11	24	28	18	31	19	27
	12 +	29	31	34	25	33	17
		100%	100%	100%	100%	100%	100%
		N = (200)	(87)	(60)	(9)	(14)	(16)
Two or more	- 3	62%	70%	55%	56%	64%	56%
	4-11	18	12	25	22	22	13
	12 +	20	18	20	22	14	31
		100%	100%	100%	100%	100%	100%
		N = 762)	(249)	(237)	(53)	(92)	(79)
Total	- 3	42%	46%	42%	38%	36%	43%
	4-11	23	21	24	30	23	19
	12 +	35	33	34	32	41	38
		100%	100%	100%	100%	100%	100%

Two additional behavioral questions were asked by NORC pertaining to general physical checkups. In answer to the question, "Have you ever had a complete physical examination?" about 9 out of 10 persons in all groups said "Yes." When asked, "Do you get a complete physical exam regularly every year or two, or just occasionally?" about a third answered, "Every year or two," and about 60 percent said "Just occasionally." As Table 47 shows, there is very little difference among the cooperation groups with respect to their "ever having" a general checkup, but the"non-cooperators" tend to have them somewhat less frequently. When asked, "About how long ago was the last time (you had a checkup)?" over a third said less than a year ago, about a fifth said between 1-3 years ago and only a little less than a fourth said more than three years ago.

TABLE 47

EXPERIENCES WITH PHYSICAL EXAMINATIONS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of respondents	762	249	237	53	92	79
Ever had?	100%	100%	100%	100%	100%	100%
No	9	9	12	8	8	11
Yes	91	91	88	92	92	89
How often?	100%	100%	100%	100%	100%	100%
Every year or two	33	37	26	28	39	34
Just occasionally	58	54	62	64	53	55
Never	9	9	12	8	8	11
Last time?	100%	100%	100%	100%	100%	100%
Less than 1 year	37	40	33	40	44	34
1 year less than 2	17	18	17	11	17	17
2 years less than 3	14	14	12	15	16	10
3 years less than 5	10	8	10	11	10	9
5 years or more	13	11	16	15	5	19
Never	9	9	12	8	8	11

It is interesting to note that while only a third say they believe in having periodic general checkups, more than half report their most recent exam during the past two years. When asked, "Why did you go to the doctor at that time?" their answers indicated that only 13 percent went for a routine checkup, while most of the others had other reasons, such as 34 percent to check other symptoms; 14 percent in connection with job policy; about 5 percent for armed forces exam, feeling run-down, in connection with pregnancy or because a chronic condition required periodic examinations.

In comparing "cooperation" groups, it is interesting to note that the "No-No's" tend to have gone for a checkup less recently than the "Yes-No's" although their stated goal is more often to go "every year or two." More of the "non-cooperators" seem to have had their last checkup more than three years ago.

To get at feelings about preventative checkups, everyone was asked, "And have you ever gone to a doctor for a checkup or examination even though you didn't think you had anything especially wrong with you?" Only about 40% answered "Yes" and, as mentioned in the profiles, over 50 percent of the "No-Yes" group said they have such general checkups. The consistent "No's" reported the fewest general checkups, but the vacillating "Yes-No's" report the second highest number. When asked, "And why did you go to the doctor then?" about 17 percent indicated it was for a real general checkup only, while an equal number said it was in connection with job requirements, that someone had suggested it or because of their concern about age or weight. Again, we should note that the "No-No's" least often go for a general checkup and that only a small minority actually practice preventative medicine.

TABLE 48

EXPERIENCE WITH GENERAL PHYSICAL CHECK-UP
WHEN RESPONDENT BELIEVES THERE IS NOTHING WRONG

		Census: YES			Census: NO	
		NORC			NORC	
	All Persons	Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
	100%	100%	100%	100%	100%	100%
Don't go for checkup	60	63	63	58	48	67
Do go for checkup	40	37	37	42	52	33
Reasons:						
Just for checkup	17%	17%	14%	21%	25%	10%
Job, school requirements	16	15	15	15	16	15
Felt run-down	1	1	2	2	2	-
Somebody suggested it	2	2	2	2	7	-
Because of my age, weight	1	1	1	-	2	3
Other reasons	3	1	3	2	-	5

To summarize our findings on attitudes toward prevention and cure of illness, we can say that non-cooperators tend to report less knowledge of symptoms, but feel equally confident in their own ability to diagnose illness. They feel there is less chance they will become seriously ill and less often feel they need go to the doctor

right away when they have symptoms of illness. They have a little less confidence that doctors can cure or help various diseases, but when they recognize symptoms of serious illness in themselves, they equally seek their doctor's services. Likewise, although there is little difference in reported experience with general physical examinations, the consistent "non-cooperators" less often get a checkup just to make sure they are alright; more often it is related to job and other requirements. The findings that cooperators more often believe in early detection of disease confirms Hochbaum's (9) report, but the findings regarding actual medical experience are less clear. While Cobb (6) found "non-cooperators" had fewer medical experiences, our findings do not fully support it. Of course, our study did not record the number of doctor visits, so that we lack complete data for a validation of Cobb's findings. We did find, however, that both cooperators and non-cooperators go to a doctor when they recognize serious symptoms. Since non-cooperators less often report chronic illness, or perhaps less often recognize having chronic illness, it is possible that they less often use medical services.

7. Confidence in Doctor's Skill and Belief in his Concern with Patient's Welfare

In the previous section brief mention was made of respondent attitudes toward doctors and medicine. In this section, more detailed views of doctors will be presented as well as reports of patient experiences with doctors. While the differences are seldom great, the consistent tendency is for the non-cooperators to have less confidence in doctors and to be more critical of their medical practices.

About 9 out of 10 persons have a regular doctor or clinic they go to when sick. About three-fourths have a regular medical doctor, about 11 percent go to public or private clinics and only 2 percent go to a chiropractor, osteopath or other person for healing. About half of all those who don't have a regular doctor now (7 percent) say they used to have one; only 5 percent say they never had a regular doctor. It is apparent that practically all respondents in our urban sample will have had

TABLE 49

KIND OF REGULAR MEDICAL SERVICE REPORTED BY RESPONDENT

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Kind of Service:	100%	100%	100%	100%	100%	100%
Private medical doctor	75	76	72	74	80	76
Private clinic	5	5	7	4	2	4
Public clinic or hospital	6	7	6	7	7	4
Chiropractor, osteopath, etc.	2	1	3	2	-	2
Have regular service	88%	89%	88%	87%	89%	86%
No regular service	12	11	12	13	11	14

sufficient contacts with doctors to have formed judgments about them. Table 49 summarizes the kind of regular medical care reported by each respondent.

In order to gauge possible indirect influence of other medical services, everyone was also asked, "During the past year, have you or anyone in your family been to a chiropractor, an osteopath, a medical doctor or any other person for treatment or healing?" Answers to this question, which are presented in Table 50, indicate that about 7 percent have used an osteopath, 10 percent a chiropractor, and only 1 percent a faith healer. The rest have used medical doctors, dentists, optometrists, etc. The consistent "cooperators" tend to have used more different services, including chiropractors and osteopaths and medical doctors.

As part of the general evaluation of present medical services with 30 years ago, everyone was asked, "All in all, how much interest do you think doctors take in their patients today compared to 30 years ago -- much more, a little more, much less, or a little less interest than they used to?" As Table 51 indicates, 4 out of 10 "Yes-Certainly" respondents say, "much more" interest, while only half as many "Yes-No" persons rate doctors as high and about 30 percent of the other groups rate doctors as

TABLE 50

KINDS OF MEDICAL SERVICES ACTUALLY USED BY RESPONDENT'S FAMILY DURING PAST YEAR 1/

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Medical doctor	89%	91%	88%	87%	88%	86%
Chiropractor	10	13	8	8	8	5
Osteopath	7	9	9	4	3	7
Dentist, optometrist 2/	10	11	11	16	4	7
Faith healer 2/	1	1	*	-	1	1

1/ Totals do not add to 100% since respondent's family could have used more than one type of service.

2/ Does not necessarily represent total usage, since they are mentioned voluntarily and are not explicitly asked about on the original question.

TABLE 51

DOCTOR'S INTEREST IN PATIENTS NOW COMPARED TO 30 YEARS AGO

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Amount of interest:	100%	100%	100%	100%	100%	100%
Much more	34	41	31	21	34	30
Little more	14	14	13	13	18	15
Much less	14	12	14	15	12	19
Little less	20	17	23	27	19	17
Same	15	14	17	13	12	11
Don't know	3	2	2	11	5	8

favorably. It is interesting to note that the non-cooperators more often are reluctant to rate the considerateness of doctors at all. It should also be recalled as shown in Table 40, that fewer "non-cooperators" especially the vacillators felt that doctors today know a lot more than they used to.

When asked to rate their own doctors, the "non-cooperators" again tend to show more doubt and less confidence. Fewer feel their doctors are better than most other doctors in the U.S., and more refuse even to make a judgment. The vacillating "No-Yes" group, on the other hand, shows the most confidence of all groups, with over 60 percent saying their doctors are "better." Further evidence of general reluctance to be critical is indicated by answers to the question, "Have you been entirely satisfied with the care and treatment you and your family got from doctors during the past five years or so, or were there some things about the care that you were not satisfied with?" About 80 percent said they are entirely satisfied and if anything the "non-cooperators" tend to be more satisfied. When the 19 percent who were "not entirely satisfied" were asked, "Why?" 36 percent of them said, "ineffective treatment," 17 percent said "harmful treatment," 28 percent said "wrong diagnosis," 18 percent said "charged too much" and about 10 percent said "the doctor was rude," "not thorough enough," or "refused to treat(the patient)when called." Table 52 summarizes respondent ratings of their own doctors and Table 53 presents data on the satisfaction with their services.

TABLE 52

OWN DOCTOR COMPARED TO OTHERS IN THE UNITED STATES

		Census: YES			Census:NO	
	All	NORC			NORC	
	Persons	Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Rating:	100%	100%	100%	100%	100%	100%
Much better	24	26	20	17	35	25
Little better	21	21	22	23	26	13
Better	45%	47%	42%	40%	61%	38%
Average	46	46	51	50	31	44
Not as good	1	*	*	-	-	1
Don't know	8	7	7	10	8	17

TABLE 53

SATISFACTION WITH DOCTOR'S SERVICES DURING PAST FIVE YEARS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census:NO NORC Yes	Census:NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Feelings:	100%	100%	100%	100%	100%	100%
Entirely satisfied	81	80	83	81	83	86
Some things not	18	19	16	19	17	14
Don't know	1	1	1	-	-	-

To round out our general questions about bad experiences with doctors, everyone was also asked, "Now could you tell me if you yourself or anyone you know, ever had any bad experiences with a doctor which made you lose some confidence in doctors generally?" Only one out of five answered "Yes" and only one out of 12 reported that they themselves had the bad experience. About 5 percent each reported their spouse or child, another relative or a friend had the bad experience and most of these experiences occurred three or more years ago, with only 4 percent of the respondents reporting a recent experience, less than a year ago. The only appreciable difference among the cooperation groups shown in Table 54 is the fewer number of bad experiences reported by the "Yes-No" group.

Another series of more specific probes attempted to test respondent attitudes toward doctors. Before discussing these questions, however, it might be useful to report on an indirectly provocative question about fear of doctors. Everyone was asked, "Some people say they're afraid of seeing a doctor. What do you suppose they mean by that?" About 70 percent of all persons said, "They're afraid they may have an incurable disease," and about 10 percent each said, "They're afraid of pain," or "They're afraid of what the treatment will involve" or "They're afraid of the expense." Very small differences are reported in Table 55 by the different cooperating groups.

TABLE 54

BAD EXPERIENCES WITH DOCTORS THAT RESULTED IN GENERAL LOSS OF CONFIDENCE

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Respondent reports:	100%	100%	100%	100%	100%	100%
No bad experiences	78	74	81	89	79	78
Have had bad experiences	22	26	19	11	21	22
Who had experience?						
Respondent	8	10	8	5	7	8
Spouse or child	5	3	4	4	6	12
Other relative	5	7	3	2	7	2
Friend	4	6	4	-	1	-
How long ago?						
- 1 year	4	4	3	2	1	5
1-3 years	5	6	6	3	5	3
3-10 years	7	10	4	4	8	5
10 + years	6	6	6	2	7	9

TABLE 55

REASONS WHY PEOPLE SAY THEY ARE AFRAID TO SEE A DOCTOR

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of respondents:	762	249	237	53	92	79
Reasons[1/]						
May have incurable disease	71	67	73	77	74	70
Pain of treatment	13	11	15	14	14	11
Expense	11	11	11	10	15	10
Kind of treatment required	11	10	11	8	13	11
Lack of sympathy from doctor	7	8	8	4	10	4
Doctor may want to change habits	2	2	2	2	4	1
Silly to be afraid	6	8	3	4	9	6

1/ Percentages do not add to 100% because same person gave more than one reason.

Another effort to elicit reasons for not seeing a doctor involved 18 specific probes. Each person was presented with a list of reasons some people give for not seeing a doctor, and asked to agree or disagree with each statement. The actual question was, "Now here are some reasons people give for not seeing a doctor. For each one I'd like you to tell me whether you yourself have ever felt this way?" As Table 56 indicates, the differences among cooperation groups are generally small. The consistent non-cooperators, however, more often feel, "Regular exams make you worry," "If you feel alright, the chances are you are alright," and "A person understands his own health best." All of these attitudes indicate a "let well enough alone" feeling. The "Yes-No" group more often felt that "If I'm sick I can get better by myself" and "Doctors can't help me" or "The doctor might hurt me."

TABLE 56

REASONS GIVEN FOR NOT SEEING A DOCTOR

		Census: YES			Census:NO	
	All Persons	NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Something comes up	34[1/]	33	37	30	35	27
Doctor's office is too far away	5	5	6	8	5	4
Waste of time waiting for doctor	15	14	16	17	15	15
If feel alright, are alright	65	60	67	64	64	73
Not bother unless sick	43	46	45	40	36	47
Don't think doctors can help	6	4	6	11	1	8
Don't learn much from checkups	7	7	8	8	3	4
Get better myself if I'm sick	12	9	12	19	12	14
Person knows health better	21	20	20	15	28	25
Disease is punishment for sins	5	7	2	6	2	8
Regular exam makes worry	15	14	14	17	13	24
Don't like doctors	11	11	12	8	13	11
Doctor might hurt me	7	6	7	11	7	6
Doctor might try to change my ways	6	10	5	2	7	2
Doctor might want to put me in a hospital	8	9	10	6	9	5
Don't want family to know I'm sick	5	6	4	2	2	6
Not spend money if OK	41	44	41	49	39	38
Doctor may suggest expensive treatment	9	10	9	4	10	5

1/ Percentages are non-additative but represent the percentage of 100 percent agreeing with each statement.

The last question on attitudes toward doctors involved 15 specific criticisms of doctors, with which each respondent was asked to agree or disagree and to indicate whether he ever had a doctor with such a characteristic. The actual question was as follows: "Now here are some things people sometimes don't like about doctors. I'd like to know whether you personally think they are true of most doctors, true of some doctors or true of hardly any?" For each item believed to be true of "some" or "most" doctors, the respondent was asked, "Have you yourself ever had a doctor like this?" As Table 57 shows, the non-cooperative "Yes-No" group is generally more critical, while the "No-Yes" group is least critical. The extreme cooperative and non-cooperative groups report little difference in attitudes. It is also interesting to note that very few of the criticisms are believed to be true of the respondent's own doctor or based on first-hand experience. Even the "Yes-No" group reports no differences in actual experience.

In conclusion, our findings agree with those of Cobb (6) that there are very little differences among cooperators and non-cooperators with respect to attitudes toward doctors. Doctors are generally held in such high esteem that seldom will a majority agree with a criticism of a doctor, and at most a third will criticize their own doctor. On direct question, only 18 percent said they were sometimes not entirely satisfied with their medical care and treatment.

8. Attitudes Toward Clinics and the Role of Government in Health Matters

Since the sponsor of the free health examination is the U.S. Public Health Service, the possibility was recognized that hostility or bias toward clinics or government health operations might influence willingness to cooperate on the examination. Consequently, a section of the interview was devoted to recording respondent attitudes on these topics. As the following analysis will indicate, "non-cooperators" have had less experience with clinics but show no marked hostility

TABLE 57

PERCENT OF RESPONDENTS AGREEING WITH EACH CRITICISM OF DOCTORS

A. Doctors In General

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Don't give chance to tell trouble	41%	45%	40%	55%	38%	39%
Not enough personal interest	55	58	57	55	50	46
Not enough free time for needy	55	54	57	62	49	52
Not tell you things ought to know	42	45	46	42	30	47
Give better care to regular patients	47	49	46	43	45	48
Not set appointments right	55	56	55	62	41	53
Give unnecessary medicine	30	31	31	38	18	30
Don't like consult other doctors	37	37	37	42	34	39
Too old fashioned	15	14	19	15	8	15
Work too fast-make mistakes	34	37	33	34	23	32
Not careful or gentle enough	17	18	16	32	12	16
Hurt when examining	13	14	12	19	12	14
More interested in money	39	43	37	36	36	38
Suggest unnecessary visits	35	39	33	36	27	33
Charge too much money	46	46	46	55	42	46

B. Own Doctor

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Don't give chance to tell trouble	15	15	18	13	9	13
Not enough personal interest	21	25	22	17	16	13
Not enough free time for needy	8	11	8	9	2	4
Not tell you things ought to know	11	12	14	15	5	9
Give better care to regular patients	13	15	15	6	11	10
Not set appointments right	31	34	33	34	23	27
Give unnecessary medicine	8	9	9	4	6	9
Don't like consult other doctors	6	7	9	4	2	8
Too old fashioned	2	2	4	-	-	1
Work too fast-make mistakes	8	10	9	8	7	4
Not careful or gentle enough	6	6	5	8	3	2
Hurt when examining	6	6	5	9	5	4
More interested in money	10	12	8	8	11	11
Suggest unnecessary visits	14	15	14	11	13	16
Charge too much money	17	18	18	15	15	14

toward them. They do show definite biased feelings ~~of bias~~, however, toward the role of government in public health matters. The "non-cooperators" more often feel that the government should limit its concern and activities in the field of national health. This antagonism could definitely influence attitudes toward cooperation.

Table 49 has already shown that only 4 percent of the "No-No's" use a public clinic regularly as compared to 7 percent of the "Yes-Certainly" group. To broaden our record of respondent contacts with clinics, everyone was asked, "During the last five years or so, have you ever received any care or treatment at any clinic or medical center?" All those answering "No" were further asked, "Have you ever received any care or treatment at a clinic or medical center?" Finally, all persons with any experience were asked directly, "Were you always entirely satisfied with the care and treatment they gave you, or were there some things you were not so satisfied with?"

As Table 58 indicates, only half as many "No-No's" and three-fourths as many "Yes-No's" ever had any direct experience with clinics. About equal numbers have used public and private clinics, but more of the consistent "No's" have used private clinics. While almost a third of the "Yes-Certainly" group report treatment or care at public clinics, only 12 percent of the "No-No's" report such experiences. When asked about satisfaction with the services, a high degree of satisfaction was noted by all groups, with the "No-Yes" group reporting the highest approval.

In order to gauge the indirect impact of any unfavorable experiences with clinics by friends or relatives, everyone was asked, "Has anyone you know ever had an experience with a public clinic which gave you a poor opinion of that service?" Only about one out of 10 persons in all "cooperation" groups reported knowing of any unfavorable experiences and most of them were reported by friends and acquaintances. When all persons with reports of some unsatisfactory treatment were asked to describe their criticisms in their own words, about equal numbers mentioned ineffective or

TABLE 58

RESPONDENT EXPERIENCES WITH CLINICS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Experience with Clinics	100%	100%	100%	100%	100%	100%
Never had any	50	38	53	55	57	70
Had care in past five years	34	41	35	26	32	22
Had care more than 5 years ago	16	21	12	19	11	8
Ever had care	50%	62%	47%	45%	43%	30%
Kind of Clinics						
Public	26%	30%	25%	21%	23%	17%
Private	23	30	22	24	19	12
Don't know	1	2	-	-	1	1
Satisfaction with Care	100%	100%	100%	100%	100%	100%
Entirely satisfied	76	77	73	74	87	78
Not entirely satisfied	24	23	27	26	13	22

unnecessary treatment, harmful treatment, improper diagnosis, the crowded understaffed facilities and lack of personal interest in patient welfare."

Since almost half of the experiences had been at private clinics, a direct question was also asked about possible prejudice towards salaried doctors. Everyone was asked, "As you probably know, some doctors are hired by groups or business firms to practice medicine on a salaried basis. From what you've read or heard, do you think most doctors who work for a salary are likely to treat their patients better, worse, or about the same as private doctors who charge fees?" Almost 60 percent of all people felt the treatment would be the same; only about one out of four felt they would be treated worse, and only the "No-Yes" group showed somewhat more bias (32 percent). Table 59 summarizes the attitudes towards salaried doctors.

TABLE 59

CARE OF PATIENTS BY SALARIED DOCTORS COMPARED TO DOCTORS CHARGING FEES

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Care by Salaried Doctors:	100%	100%	100%	100%	100%	100%
Better	4	5	3	4	4	8
Worse	25	22	25	23	32	20
Same	61	63	63	58	55	57
Don't know	10	10	9	15	9	15

As a final test of attitudes toward clinics, a series of loaded criticisms were presented to each respondent, and he was asked to say whether he felt the unfavorable statements were true or not. The actual question was, "Now, I'd like to read you some things people sometimes dislike about public clinics. For each one I'd like you to tell me whether you think it is generally true or not true about public clinics?" As Table 60 shows, less than a majority of all groups agree with most criticisms and only in the case of "waiting too long" do as many as 60 percent say "it's true."

As far as the evidence is concerned, respondents report few bad experiences and very few criticisms of public clinics. The fact that only half as many "non-cooperators" have had any experiences with clinics, however, may be a significant finding. It may be that there is reluctance to criticize clinics and that there are some underlying differences in attitudes toward clinics. Our evidence, however, does not support such a thesis.

A few special questions were also asked about the Public Health Service and the role of government in health matters, and the consensus shows that the "cooperators" more often approve of government concerning itself in public health matters.

TABLE 60

THINGS DISLIKED ABOUT PUBLIC CLINICS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
All Criticisms						
Doctors not experienced or well trained	20%	22%	18%	21%	20%	19%
Too busy to give you personal attention	40	40	37	47	37	42
Don't have up to date equipment	10	10	9	4	9	9
Not concerned about patient's feelings	23	24	20	24	18	25
Have to wait too long until doctor sees you	61	59	62	76	58	62
Sent to different doctor every time	38	39	38	43	35	35
Doctors don't try hard enough because you don't pay	13	16	12	9	12	14
Doctors not considerate or gentle when examining you	16	17	16	17	13	15
Make you feel they're doing you a favor	21	21	22	23	20	23

Everyone was asked, "As you may know, the Public Health Service carries on several different kinds of programs -- like studies on illnesses, aid for building new hospitals, and helping communities with their health problems. Are you entirely satisfied with the job now being done by the public health people, or are there some things you feel they could do better?" About 55 percent of all people said they were "entirely satisfied," 26 percent felt they "could do better," and 19 percent answered, "don't know." The differences among the cooperating groups were negligible indicating little open hostility to the P.H.S.

When a series of loaded questions about the role of government in health matters was asked, however, the "non-cooperators" definitely felt government should be more restricted. A third of the "Yes-No" and over a fifth of the consistent "No" group

TABLE 61

ATTITUDES TOWARD THE ROLE OF GOVERNMENT IN HEALTH MATTERS

	All Persons	Census: YES NORC			Census: NO NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Attitudes						
Disagree "Health is no business of government"	88%	91%	90%	77%	91%	78%
Agree "All doctors should work for government"	12	17	11	8	8	9
Agree "Government should test all new vaccines"	89	91	92	77	94	80
Disagree "Government should not provide free service to needy"	89	93	89	91	87	84
Disagree "Government should not set up own labs"	80	86	78	68	83	66
Disagree "Government should not provide any health insurance"	63	73	62	43	65	53
Agree "Government should give private hospitals money for research"	80	82	84	72	76	71
Agree "Government should make health studies"	94	96	96	89	98	85

agreed, that "the people's health is no business of the government," compared to less than 10 percent of the cooperating groups.

9. Situational and Environmental Factors in the Arrangements for a Health Examination

Hochbaum (9) defined situational factors, in part, as the social, medical and campaign pressures which encourage and reinforce the individual's intention to act, and he defined environmental factors as the physical circumstances surrounding the appointment process. In addition to feelings about potential personal benefits, Hochbaum considered the situational and environmental factors most important in influencing public cooperation. In wording the Census question about cooperating on

the health survey, an effort was made to neutralize or eliminate effects of the environmental factors. Every person was told to assume that, "The examination will involve only one visit to a nearby place, that is a special free examination and the time and place are convenient." In the NORC interview, however, a special attempt was made to ascertain the influence of different situational and environmental factors. As we shall see, there are indications that by varying the conditions of the examination, greater cooperation may be secured from reluctant respondents.

To find out whether or not each person felt most people would be sympathetic to a health examination, and whether the respondent felt his attitude had general social approval, he was first asked, "As you might expect the P.H.S. cannot learn all they need to know about health in the nation just by asking questions. For some things they need actual measurements and tests. How do you think most people you know will feel about helping out on that part of the survey -- Will they certainly come, probably come, or probably not come for these measurements and tests?" As Table 62 indicates, both the cooperators and non-cooperators felt most people agreed with their own opposite views. While over 80% of the "Yes-Certainly" group felt others would cooperate, only 21% of the "Yes-No's" and 33% of the "No-Nos" felt this way. Each group felt its view was supported by most other people.

TABLE 62

RESPONDENT BELIEF IN THE WILLINGNESS OF OTHER PEOPLE TO COOPERATE ON A HEALTH EXAMINATION

		Census: YES			Census:NO	
	All Persons	NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
All Beliefs:	100%	100%	100%	100%	100%	100%
Certainly come	12	27	4	-	11	1
Probably come	56	56	72	21	61	32
Probably not come	27	14	22	66	25	48
Don't know	5	3	2	13	3	19

An effort was also made to gauge the potential persuasiveness of different prestige groups. Everyone was asked, "If you knew that your own doctor (the local medical society, your religious advisor, the local newspaper, radio or TV station, or your spouse or friends) approved of your coming, would you be more likely to come, would you be less likely to come or wouldn't it make any difference in your coming for the tests and measurements?" Answers to these questions, which are presented in Table 63, indicate that only 1-2 percent say that approval by these prestige groups would make it less likely they would come, but from half to three-quarters of the people say it would make no difference. The most influential groups are the respondent's own spouse or friends or his own doctor. The least effective are the newspapers, radio or TV stations, religious adivsors and local medical societies. The vacillating "Yes-No" group shows more susceptibility to persuasion than the consistent "No-No" group, with about 4 out of 10 vacillators saying they would probably come if their own spouse, friends or doctor gave his approval. In contrast, at most a fourth of the "No-No's" say they would be persuaded to come if their spouse approved, and only a fifth say they might come if their own doctor gives his blessing.

When asked directly, "Why?" they themselves would cooperate or not cooperate, the respondents' answers confirm some of the previous deduc ions made from analysis of other indirect answers. About half of the cooperators say they would come principally to help the government and cooperate with PHS. The second most frequest reason given is "to find out about my own health." The "Yes-Probably" and "No-Yes" groups more often have questions about the time, place and kinds of tests. Summaries of these answers are given in Table 64.

The non-cooperators, on the other hand, gave evasive answers like, "I'm too busy," or "It depends on when or where the tests are given." The persistent "No-No's" more often said, "I'm healthy" or "I have other facilities available," indicating a feeling of lack of need. They also indicated preferences for their own

TABLE 63

REPORTED PERSUASIVE EFFECTS OF APPROVAL OF EXAMINATION BY OTHERS

Type of Person	Effects	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents		762	249	237	53	92	79
		100%	100%	100%	100%	100%	100%
Own Doctor	More likely	42	39	50	38	48	21
	Less likely	*	-	-	2	1	1
	No difference	56	61	48	58	49	70
	Don't know	2	*	2	2	2	8
		100%	100%	100%	100%	100%	100%
Local Medical Society	More likely	34	35	42	21	38	11
	Less likely	1	*	*	2	-	1
	No difference	63	64	57	66	62	80
	Don't know	2	1	1	11	-	8
		100%	100%	100%	100%	100%	100%
Religious Advisor	More likely	24	28	27	15	29	11
	Less likely	1	-	*	-	2	3
	No difference	74	72	71	81	68	81
	Don't know	1	-	2	4	1	5
		100%	100%	100%	100%	100%	100%
Newspaper, Radio, TV	More likely	20	25	23	2	25	4
	Less likely	2	1	1	-	4	1
	No difference	77	74	75	94	70	90
	Don't know	1	*	1	4	1	5
		100%	100%	100%	100%	100%	100%
Spouse or Friends	More likely	47	45	54	42	59	25
	Less likely	1	2	*	-	-	1
	No difference	51	53	45	58	40	70
	Don't know	1	-	1	-	1	4

* Less than 1 percent.

TABLE 63

REPORTED PERSUASIVE EFFECTS OF APPROVAL OF EXAMINATION BY OTHERS

Type of Person	Effects	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents		762	249	237	53	92	79
		100%	100%	100%	100%	100%	100%
Own Doctor	More likely	42	39	50	38	48	21
	Less likely	*	-	-	2	1	1
	No difference	56	61	48	58	49	70
	Don't know	2	*	2	2	2	8
		100%	100%	100%	100%	100%	100%
Local Medical Society	More likely	34	35	42	21	38	11
	Less likely	1	*	*	2	-	1
	No difference	63	64	57	66	62	80
	Don't know	2	1	1	11	-	8
		100%	100%	100%	100%	100%	100%
Religious Advisor	More likely	24	28	27	15	29	11
	Less likely	1	-	*	-	2	3
	No difference	74	72	71	81	68	81
	Don't know	1	-	2	4	1	5
		100%	100%	100%	100%	100%	100%
Newspaper, Radio, TV	More likely	20	25	23	2	25	4
	Less likely	2	1	1	-	4	1
	No difference	77	74	75	94	70	90
	Don't know	1	*	1	4	1	5
		100%	100%	100%	100%	100%	100%
Spouse or Friends	More likely	47	45	54	42	59	25
	Less likely	1	2	*	-	-	1
	No difference	51	53	45	58	40	70
	Don't know	1	-	1	-	1	4

* Less than 1 percent.

TABLE 64

REASONS GIVEN BY COOPERATORS FOR WILLINGNESS TO COME FOR EXAMINATION[1/]

	Census:YES NORC		Census:NO NORC
	Certainly	Probably	Yes
Number of Respondents	249	237	92
Reasons:			
To help the government . . .	58%	47%	58%
Personal health benefits . .	50	31	25
Depends on when and where tests are given.	5	27	24
Depends on kind of tests . .	4	7	4

1/ Answers do not add to 100% because more than one reason may be given.

doctor, dislike of free examinations and a feeling that "they don't need me - get someone else." The less certain "Yes-No" group more often said it depended on the time and place, but also indicated that they felt less personal need and benefit from the exam. Other reasons were similar to the "No-No" group.

TABLE 65

REASONS GIVEN FOR NOT COOPERATING ON THE HEALTH EXAM

	Census: YES NORC No-DK	Census: NO NORC No-DK
Number of Respondents	53	79
Reasons:		
I'm too busy.	29%	19%
Depends on when and where . .	20	5
I'm healthy	10	15
They don't need me.	10	8
I don't go to free clinics. .	6	11
I have other medical facilities.	4	24
I prefer my own doctor. . . .	4	9
I would need a replacement at home	8	*

In order to probe the kind of preconceptions people had about the tests, everyone was asked, "Before you yourself decided on coming, would you have any questions about the tests you'd want to find out about?"

Almost two-thirds of all people had some questions, but less than half of the "No-No's" had any specific questions. It is also interesting that the most cooperation "Yes-Certainly" group also had few questions. Apparently, for the extreme groups, cooperation did not depend primarily on the nature of the tests. Most of the questions concerned the kind of tests, why the respondent was selected, when, where and how long the tests would take. Table 66 presents these data.

TABLE 66

QUESTIONS RESPONDENTS WANT ANSWERED BEFORE DECIDING ON COMING

		Census:YES			Census:NO	
	All Persons	NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Questions[1]						
None	36%	45%	28%	42%	24%	55%
Describe tests	50	44	55	45	62	32
Why was I selected	16	12	18	21	20	13
Time required for tests	6	4	7	2	10	5
When and where tests given	5	4	6	8	3	4

1/ Percentages do not add to 100 percent because more than one answer may be given by a respondent.

To find out further what stereotypes the respondents may have of the kinds of tests being planned, they were asked, "What sort of tests do you think they would give you?" Over a third of all respondents and almost a half of the "No-No's" had no idea of the tests at all. The items most frequently mentioned, however, were heart and lung examination, urinalysis, blood tests and X-rays. The non-cooperators appeared to be less informed of the specific tests included in the survey.

TABLE 67

RESPONDENT BELIEFS OF THE KIND OF TESTS INCLUDED IN SURVEY[1/]

	All Persons	Census: YES NORC			Census NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Kind of Tests:						
No idea	34%	28%	37%	38%	28%	47%
Heart exam	35	40	33	32	37	24
Lung exam	32	30	34	32	40	24
Blood tests	25	31	22	15	24	15
Urinalysis	21	24	20	11	17	19
X-Ray	19	22	17	17	14	24
Height, Weight, Eyes, Ears	18	22	17	17	20	9
Overall checkup	23	27	22	13	20	19

1/ Percentages do not add to 100percent because more than one answer may be given.

Lack of specific awareness of the kinds of tests offered is also indicated by answers to two additional questions. Everyone was asked, "Is there anything you'd especially like them to check about your own health?" and "Is there anything you'd rather they did not do in such an examination?"

Almost two-thirds of all people said there was nothing in particular they wanted checked, and over 80 percent said there was nothing they'd rather not have examined. The non-cooperators more often showed their total indifference. Almost 90 percent of the "No-No's" and 80 percent of the "Yes-No's" said they had no particular thing they wanted examined. About 10 percent of the "Yes-No's" and 30 percent of the "No-No's" volunteered a statement that they had no need for the examination at all. Table 68 presents the answers to these questions.

The final series of questions concerned respondent reactions to a variety of environmental arrangements under which the examination could be given. Each person was told, "In planning for the tests, we are interested in finding out what arrangements will make it easier for the greatest number of people to come. I am going to

TABLE 68

THINGS RESPONDENT WOULD LIKE OR NOT LIKE TO HAVE CHECKED IN THE EXAMINATION

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
A. Things Liked Checked						
None	64%	52%	62%	78%	68%	88%
Heart	10	11	10	10	11	2
Cancer	6	7	7	6	7	-
Lungs	6	5	6	2	10	3
General physical	6	8	6	4	7	2
Specific symptoms	12	17	12	2	10	6
B. Things Not liked Checked						
None	83%	88%	81%	83%	82%	76%
Pelvic, Internal	4	3	3	4	3	5
Blood tests	3	3	5	2	3	-
Miscellaneous	4	5	3	-	7	3
Don't want to be guinea pig	2	1	3	-	4	-
Don't need examination	4	*	-	9	1	28
Other vague and irrelevant	6	3	6	11	3	18

read you some of the different ways the exam can be arranged and for each one I would like you to tell me if you will certainly come, if you will probably come, or if you probably won't come?" It should be clearly understood that the "probably come" answers by the non-cooperators do not necessarily mean a reversed decision to come for an examination but rather that the particular arrangement would be more agreeable and would be most conducive to influencing a changed decision. Some non-cooperators kept volunteering the comment, "That would be best, but I still wouldn't come." This underlines the above statement that a "Yes" answer to this question merely reflects the comparative convenience of a particular arrangement if the respondent decided to come, but does not necessarily indicate a decision to come.

As Table 69 indicates, almost 90 percent of all respondents prefer: a) a short travel time of 15-20 minutes, b) a brief examination of a half hour, c) their own

TABLE 69

WILLINGNESS TO COME FOR EXAMINATION UNDER DIFFERENT ARRANGEMENTS

Arrangements	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census:NO NORC Yes	Census:NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
A. Travel time						
5-10 minutes	89%	100%	100%	62%	99%	33%
15-20 minutes	87	99	98	58	97	29
One hour	63	88	65	13	67	11
B. Time of Day						
Morning during week	57%	71%	67%	36%	58%	5%
Afternoon during week	58	72	64	26	72	9
Evening during week	69	84	74	42	77	24
Saturday morning	65	78	74	30	72	17
Saturday afternoon	65	80	72	28	72	17
C. Length of Exam						
½ hour	89%	99%	99%	68%	99%	34%
1 hour	84	99	93	55	96	24
1½ hours	75	96	81	30	85	18
Second visit	82	98	90	45	92	23
D. Place of Examination						
Hospital or medical center	87%	99%	97%	62%	98%	30%
Church or school	79	94	88	47	87	23
Special trailer parked outside	74	88	82	47	87	24
Local doctor's office	88	99	99	59	100	33
E. Person Giving Exam						
Own doctor	89%	97%	98%	72%	97%	48%
Other local doctor	83	97	94	49	92	23
Specialist approved by AMA	88	100	99	57	99	32
F. Financial Considerations						
Taxicab fare is paid	83%	97%	93%	55%	89%	24%
Not appropriate	(5)	(2)	(5)	(8)	(9)	(3)
Baby sitter paid	32	35	36	28	26	10
Not appropriate	(62)	(65)	(62)	(55)	(72)	(60)
Paid for time at exam	82	95	90	58	89	32
Not appropriate	(5)	(4)	(6)	(4)	(8)	(1)

Table 69 Continued

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census:NO NORC Yes	Census:NO NORC No-DK
G. Person Examined						
All grown-ups only	79%	88%	87%	62%	91%	28%
Not appropriate	(9)	(11)	(8)	(9)	(4)	(10)
Grown-ups and children	54	59	60	47	60	19
Not appropriate	(39)	(40)	(39)	(36)	(38)	(43)
Only you	86	99	98	57	97	29
H. Personal Modesty						
Undress completely	82%	96%	91%	51%	95%	27%
Undress above waist	86	99	96	57	99	30
Wear coverall gown	88	100	98	62	98	34
I. Voluntary Mention of Other Arrangements						
Want definite appointment	1%	1%	1%	2%	1%	1%
Give choice of times	3	3	4	4	2	-
Specified hour-not working hour	9	11	10	11	9	1
If other people I know go	1	*	*	2	2	-

In contrast, only about 10 percent of the non-cooperators would consider coming if they had to travel an hour or more. Likewise, only a fourth of the "Yes-No's" would come during the afternoon, and only a half if their exam were given at a trailer or church or if the doctor were a local physician other than their own. Showing the greatest resistence to cooperating, only 5 percent of the "No-No's" say they might come if the exam is given during the morning and only 10-15 percent agree if it is given during an afternoon. About a fourth say they might agree to come if the place of examination is at a church or trailer, or if the physician is a local doctor other than the respondent's doctor. When asked if they would prefer any other arrangements not already mentioned, almost 20 percent of the "Yes-No's" volunteered that a convenient time would be important. Table 69 summarizes these data.

10. Personal Variables

Of the eleven personal variables on which information was collected, seven partially separate the cooperators from the non-cooperators, while four are about the same in all groups. All of the personal variables, however, show less relationship to the respondent's intention to cooperate than the psychological factors discussed in prior sections. The following groups are more cooperative: Non-whites, younger and middle aged, self respondents, veterans and in the lower income groups, living in Southern or Western urban centers. In contrast, the more educated tend to be less cooperative. Practically no differences, however, are found regarding sex, family relationship, marital status, or labor force status.

Our findings with respect to age and sex are consistent with other research reports. But findings regarding self respondent, income, education, and marital status differ from the findings of other investigations. It is difficult to explain these differences, but the lack of comparability among survey designs and procedures must be remembered as a possible explanation. The present study is the first national urban research program designed to measure specifically the differences among cooperators and non-cooperators. Of course, it is to be expected that there would be differences with other studies which are more limited in geographic coverage. Likewise the differences in the contents and contexts of the studies are legitimate sources of variation.

a) Sex, Family Relationships, Marital Status and Labor Force Status

Table 70 summarizes the data on personal variables which are substantially the same for cooperators and non-cooperators. As indicated in the discussion of profiles of cooperators and non-cooperators, the "No-Yes" group happened to have a concentration of proxy respondents. Consequently, they also show more males who were working away from home at the time of the Census interview. These differences,

TABLE 70

PERSONAL VARIABLES WHICH ARE ABOUT THE SAME FOR COOPERATORS AND NON-COOPERATORS

Items	All Persons	Census: YES			Census: NO	
		NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Sex:	100%	100%	100%	100%	100%	100%
Male	50	48	46	55	62	49
Female	50	52	54	45	38	51
Family Relationship:	100%	100%	100%	100%	100%	100%
Head	59	62	56	58	63	56
Wife	32	30	37	32	27	32
Child	5	3	4	6	6	6
Other relative	3	4	2	2	4	4
Unrelated	1	1	1	2	-	2
Marital Status:	100%	100%	100%	100%	100%	100%
Married	77	74	78	73	83	79
Widowed	6	7	8	6	3	6
Divorced	4	7	2	4	2	5
Separated	4	7	1	4	4	-
Never married	9	5	11	13	8	10
Labor Force Status:	100%	100%	100%	100%	100%	100%
Working	63	60	61	64	67	66
Looking for work	1	2	1	-	1	1
Keeping house	31	33	34	32	23	28
School	2	1	3	-	2	1
Other	3	4	1	4	7	4

however, are believed to be merely an artifact of the Census survey procedures and not substantive findings.

b) Race, Age and Income

Table 71 presents three of the personal variables which partially distinguish cooperators from non-cooperators. While 23 percent of the consistent "Yes-Certainly" group are non-white, only 5 percent of the consistent "No-No's", and 11 percent of the "Yes-No's" are non-white. One can only conjecture why non-white respondents tend to be more cooperative, but that they are is quite apparent.

TABLE 71

RACE, AGE AND INCOME DISTINGUISH COOPERATORS AND NON-COOPERATORS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
Race:	100%	100%	100%	100%	100%	100%
White	86	77	87	89	94	95
Non-white	14	23	13	11	6	5
Age:	100%	100%	100%	100%	100%	100%
18-34	32	27	36	38	34	19
35-49	36	41	37	28	37	27
50 +	32	32	27	34	29	54
Income:	100%	100%	100%	100%	100%	100%
- $3,000	19	25	20	25	11	13
$3,000 - $5,000	27	30	25	27	32	23
$5,000 - $7,000	27	27	29	13	26	26
$7,000 +	27	18	26	35	31	38

Likewise, confirming other health examination studies, the cooperators generally are younger and middle-aged, while the non-cooperators tend to be older persons. While only 32 percent of the "Yes-Certainly" group and 27 percent of the "Yes-Probably" group are 50 years or older, 54 percent of the consistent "No-No's" are in the older bracket. The vacillating "Yes-No's", on the other hand, have a greater concentration of younger 18-34 year-olds.

Contrary to other findings, our respondents indicate that the non-cooperators are more often the well-to-do, with higher incomes. While only 18 percent of the "Yes-Certainly" and 26 percent of the "Yes-Probably" cooperators reported incomes of $7,000 or more, 38 percent of the "No-No's" and 35 percent of the "Yes-No's" reported such high incomes. This finding is more consistent with our other reports of perceived unmet needs. The cooperators more often report recognition of greater unmet needs and the personal benefits of a free health exam. These feelings would be expected

among lower income groups. The non-cooperators, with higher incomes, as one would expect, report fewer unmet needs and more often report the ready availability of other medical facilities to meet their health requirements.

c) Veteran Status

As Table 72 shows, veterans more often are cooperators, while non-veterans more often are non-cooperators. It is possible that their military service has made them identify themselves more clearly with government operations and, therefore, they are more cooperative. While 71 percent of the veterans are in the consistent "Yes" group only 59 percent of the non-veterans are in this group. Likewise, twice as many consistent "No's" are reported by the non-veterans.

TABLE 72

VETERANS STATUS FOR MALE COOPERATORS AND NON-COOPERATORS

	All Respondents		Census: YES NORC				Census: NO NORC	
Males	Number	Percent	Certainly	Probably	Total Yes	No-DK	Yes	No-DK
Veterans	162	100%	35%	36%	71%	9%	13%	7%
Non-Veterans	193	100%	32	27	59	8	19	14

Since the "No-No's" were older people, with probably fewer opportunities for military service, it was believed possible that the veteran-non-veteran factor might really be a reflection of the age differential. Consequently, all males were classified by both veteran status and age and their intentions to cooperate were compared for equal age groups. As Table 73 shows, the tendency is clear, that veterans are more cooperative in all age categories. Likewise, while the differences are small, there are more non-veterans in the "No-No" group in all three age categories.

TABLE 73

VETERAN AND AGE STATUS FOR MALE COOPERATORS AND NON-COOPERATORS

Age	Veteran Status	All Respondents		Census: YES NORC				Census: NO NORC	
		Number	Percent	Certainly	Probably	Total Yes	No-DK	Yes	No-DK
18-34	Veterans.	64	100%	30%	42%	72%	12%	11%	5%
	Non-Veterans.	36	100%	25	28	53	14	25	8
35-49	Veterans.	69	100%	36	35	71	7	15	7
	Non-Veterans.	69	100%	36	30	66	5	20	9
50 +	Veterans.	29	100%	45	24	69	3	14	14
	Non-Veterans.	88	100%	33	24	57	8	15	20

d) Self and Proxy Respondents

As mentioned earlier, normal Census procedure permits an adult member of a family to answer questions for another family member who is not at home at the time of the interview. Persons for whom answers are given by another family member are called proxy respondents. As Table 74 indicates, proxy respondents represented about one-third of all cooperation and non-cooperation groups with the exception of the "No-Yes" group which had 54 percent proxies. As we shall see in Table 75, this concentration of proxies undoubtedly helps to explain the switch from a proxy "No" to a self response of "Yes." While 79 percent of the Census self-respondents said they were willing to cooperate themselves, only 71 percent of the proxies were believed to be cooperative by other members of their families. Likewise, while 20 percent of the proxies who had been said to be non-cooperative said they would be cooperative when answering for themselves, only 9 percent of the self respondents switched from negative to positive views. It is interesting to note that when NORC answers are compared (all self respondents), 83 percent of the Census proxies say "Yes" for themselves compared to 80 percent of the Census self-respondents. For all practical purposes, these answers are the same.

TABLE 74

DISTRIBUTION OF SELF AND PROXY RESPONDENTS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
All Respondents	100%	100%	100%	100%	100%	100%
Self respondent	64	68	68	64	46	71
Proxy respondent	36	32	32	36	54	39

TABLE 75

DISTRIBUTION OF COOPERATORS AND NON-COOPERATORS BY SELF AND PROXY RESPONDENTS

Intention to Cooperate Census	NORC	Self Respondent	Proxy Respondent
Total	Total	461	249
Yes	Yes	71%	63%
Yes	No	8	8
No	Yes	9	20
No	No	12	9
		100%	100%

Self and proxy respondents were also compared for a number of personal variables. Consistent with the Hunterdon findings,(15) self respondents rated their health as poorer and reported more chronic illnesses. Self-respondents were also more often older, female, with lower family incomes, less education and with more recent visits to a doctor.

In general, the profiles for cooperators and non-cooperators are comparable for both self and proxy respondents. In the consistent "Yes-Yes" group, both the self and proxy respondents report lower health ratings and more chronic illnesses than the respective "No-No" groups. Both consistent cooperator groups also have

more younger and middle aged persons, with lower educational backgrounds. Both, likewise, report the lowest income levels and about two-thirds say they have seen a doctor within the past year.

The consistent "No-No's" generally reflect opposite tendencies. The "No-No" self-respondents report only slightly better health ratings and fewer chronic illnesses than the "Yes-Yes" self-respondents, but the "No-No" proxies report the least amount of chronic illness, 70 percent of them reporting no chronic conditions. Both proxy and self "No-No's" are the oldest respondents, with a little more education than the consistent "Yes" groups. While the "No-No's" who are self respondents report the highest family income with 43 percent having $7,000 or more per year, the proxy "No-No's" have the second lowest income levels. Likewise, there are conflicting tendencies regarding recency of doctor visits. About 72 percent of the "No-No" self-respondents have been to a doctor within the past year, while only 47 percent of the proxies have seen a doctor as recently.

The vacillating "Yes-No's" and "No-Yes's" report similar characteristics on a number of items. Both vacillating proxy groups report very good health ratings, young respondents, with more college training and higher income levels. But the "No-Yes" proxies have less chronic ailments and report the least recent doctor visits. The "Yes-No" proxies more often report at least one chronic ailment and most recently have seen a doctor within the past year. As mentioned earlier, this difference in recency of doctor visit is considered an important difference between the two groups.

The "No-Yes" self-respondents rate their health poorer than the "Yes-No" self-respondents but both groups report few chronic conditions. Both also report somewhat older age groups than their respective proxy groups, but while the "No-Yes" self-respondents report a concentration of only high school persons, the "Yes-No" self-respondents report the most college educated among the self-respondents. The "Yes-No" self-respondents also report more low income and fewer middle income families and

TABLE 76

CHARACTERISTICS OF SELF AND PROXY RESPONDENTS

	Total		Census: YES				Census: NO			
			NORC: YES		NORC: NO		NORC: YES		NORC: NO	
	Self	Proxy	Self	Proxy	Self	Proxy	Self	Proxy	Self	Proxy
Number of Respondents	483	279	329	157	34	19	42	50	56	23
Current Health Ratings:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Excellent	28	37	25	36	41	37	26	38	32	35
Good	45	45	47	41	38	47	50	54	36	44
Fair	21	16	21	20	18	16	24	8	30	17
Poor	6	2	7	3	3	-	-	-	2	4
Chronic Illness:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	41	53	39	48	59	42	52	70	30	70
One	29	28	28	27	21	47	24	22	43	26
Two	30	19	33	25	20	11	24	8	27	4
Age:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
18-34	33	31	33	29	35	42	33	34	20	17
35-49	33	43	36	45	27	32	31	42	23	35
50 +	34	26	31	26	38	26	36	24	57	48
Education:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grade school	28	23	30	24	44	16	14	23	25	18
High school	52	49	52	52	27	42	67	46	57	59
College	20	28	18	24	29	42	19	31	18	23
Sex:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Male	32	82	30	82	35	90	38	82	36	83
Female	68	18	70	18	65	10	62	18	64	17
Income:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
- $5,000	50	39	54	43	61	37	50	36	35	39
$5,000 - $6,999	24	33	25	33	9	21	21	31	22	39
$7,000 - $9,999	15	18	15	16	12	37	12	18	18	11
$10,000 +	11	10	6	8	18	5	17	15	25	11
Last visit to doctor:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
- 1 year	69	60	69	63	62	79	74	48	72	47
1 year	12	19	13	18	12	5	14	21	4	26
2 years +	19	21	18	19	26	16	12	31	24	27

unlike the proxy "Yes-No's" they have seen a doctor less recently. These conflicting trends in personal characteristics for proxy and self-respondents indicate that the basic health attitudes which are expressed to NORC by each person for himself are more important in determining shifts from cooperation to non-cooperation.

e) Geographic Region and Size of Urban Community

While the differences are not large, residents of the South and West tend to be more cooperative than residents of the east. Residents of the Midwest also tend to be somewhat more cooperative, but the differences are too small to be statistically significant. As Table 77 shows, only 75 percent of the Easterners say they would cooperate on the health exam compared to 86 percent of the Westerners and 83 percent of the Southern urban population. A chi-square test of homogeneity indicates that the east-west difference could have occurred by chance in less than one sample out of one hundred, while the east-south difference could have occurred by chance in less than five samples out of one hundred.

Since the cooperation in the south and west is not significantly different and since cooperation in both is greater than the east, residents of the south and west are combined in the more detailed analyses which follow. Likewise, in order to secure sufficient numbers of persons in each comparison group, the previous combinations of Census and NORC intentions to cooperate are dropped and only a dichotomy of NORC answers is used. All persons who told NORC's interviewer that he "certainly" or "probably would come" are classified as "cooperators" and all doubtful or negative answers are grouped as "non-cooperators." Of course, it should be reemphasized that the relatively small samples of respondents in some categories makes numerical comparisons note too random.

Table 77 also indicates little difference in cooperativeness between large or small urban areas. The tendency is for large metropolitan areas to be somewhat less cooperative but the differences are small and could be due to chance. This confirms other sociologists' observations that differences between large and small urban areas are disappearing. Since the principal variation in cooperation is by regional group,

TABLE 77

INTENTION TO COOPERATE ON HEALTH EXAM
REPORTED TO NORC BY REGION AND SIZE OF URBAN AREA

	All Respondents		Cooperators	Non-Cooperators
	Number	Percent		
Region:				
East	237	100%	75%	25%
Midwest	231	100%	81	19
South	156	100%	83	17
West	138	100%	86	14
Urban Size				
Large metropolitan (over 1,000,000)	386	100%	78%	22%
Small metropolitan (under 1,000,000)	277	100%	84	16
Other urban places	99	100%	82	18

further detailed study was devoted to comparisons of attitudes and characteristics of different regional "cooperation" and "non-cooperation" groups.

In general, the eastern respondents consistently more often reported the attitudes and characteristics of "non-cooperators" and the non-cooperative easterners usually reported these characteristics most frequently. There were some exceptions to this generalization and they shall be discussed below. Table 78, which presents the most important regional differences, is divided into six sections for convenience of analysis. These are:

a) Reports of current health status

b) Feelings of unmet health needs

c) Belief in the avoidability and cure of illnesses

d) Attitudes toward doctors

e) Attitudes toward the health examination

f) Selected personal characteristics

TABLE 78

SOME CHARACTERISTICS OF COOPERATORS AND NON-COOPERATORS BY GEOGRAPHIC REGION

	All Respondents			Cooperators			Non-Cooperators		
	East	Mid-west	South and West	East	Mid-west	South and West	East	Mid-west	South and West
Number of Respondents	237	231	294	177	188	249	60	43	45
1. Current Health Status									
Self-rating of own health	100%	100%	100%	100%	100%	100%	100%	100%	100%
Excellent	38	27	30	36	26	29	42	29	32
Good	38	49	48	40	48	49	32	54	40
Fair	20	22	17	19	24	16	21	17	26
Poor	4	2	5	5	2	6	5	-	2
Presence of Chronic Illness	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	56	43	40	58	41	38	50	51	49
Some	44	57	60	42	59	62	50	49	51
2. Unmet Health Needs									
Self care for health	100%	100%	100%	100%	100%	100%	100%	100%	100%
Best possible	60	50	33	58	51	34	65	46	28
Could do more	39	48	67	42	47	66	32	49	72
Don't know	1	2	-	-	2	-	3	5	-
Consult own doctor free of charge	100%	100%	100%	100%	100%	100%	100%	100%	100%
Desirous	35	45	41	41	50	44	18	22	28
Not desirous	65	55	59	59	50	56	82	78	72
3. Belief in Avoidability and Cure of Illness									
Way you live affects health									
Great deal	63	51	54	66	52	53	57	46	60
Some	25	24	27	24	26	27	25	17	25
Hardly any	12	25	19	10	22	20	18	37	15
Cumulative Number of Symptoms Could Tell if Sick									
None	7	6	4	6	6	5	10	7	2
Less than 4	53	62	59	53	61	58	53	63	60
Less than 6	88	88	91	88	89	90	87	80	96
8 or less	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 78 Continued

	All Respondents			Cooperators			Non-Cooperators		
	East	Mid-west	South and West	East	Mid-west	South and West	East	Mid-west	South and West
No. conditions should see doctor right away	100%	100%	100%	100%	100%	100%	100%	100%	100%
6 or less conditions	23	25	19	21	22	18	28	32	28
7 - 8	33	29	34	36	28	34	27	34	30
9 - 11	44	46	47	43	50	48	45	34	42
No. conditions doctor can help or cure	100%	100%	100%	100%	100%	100%	100%	100%	100%
6 or less conditions	7	6	2	5	5	2	15	12	4
7 - 9	25	22	22	24	20	21	27	25	24
10-11	68	72	76	71	75	77	58	63	72
4. Attitudes Towards 1/ Doctors									
No chance to tell trouble	33	39	41	35	39	40	25	42	45
Not enough personal interest	44	59	54	47	61	55	38	51	49
Give unnecessary medicine	22	25	32	22	25	31	22	24	40
Require unnecessary visits	24	33	34	26	34	35	17	33	31
Not set appointments right	42	55	56	43	55	56	40	55	57
More interested in money	30	33	46	33	32	45	20	34	47
Not get other doctors opinions	22	34	31	21	35	30	25	29	32
Work too fast - make mistakes	22	35	31	25	36	31	15	32	32
Not gentle enough	8	18	17	8	18	16	8	17	23
5. Attitudes Toward Health Examination 1/									
More likely to come if exam is approved by:									
Own doctor	44	44	40	49	49	41	28	22	32
Local medical society	31	37	34	36	44	36	17	7	23
Friends or spouse	48	47	47	53	52	50	35	27	34
Religious advisor	29	26	19	33	30	20	17	10	13
Newspaper or TV	22	23	17	28	28	19	2	2	9

1/ Each percentage represents the number of people agreeing with each category.

Table 78 Continued

	All Respondents			Cooperators			Non-Cooperators		
	East	Mid-west	South and West	East	Mid-west	South and West	East	Mid-west	South and West
Willingness to come under different arrangements 1/									
Travel 1 hour	57	65	65	72	78	74	10	10	15
Exam of ½ hour	72	73	78	89	86	88	22	15	26
Pay for cab	78	82	87	92	94	95	37	28	38
Pay for time	75	82	88	86	93	95	42	32	51
At a trailer	66	74	82	79	84	89	30	28	40
Given by own doctor	87	87	93	96	97	98	63	43	65
Given by specialist	84	87	93	99	99	98	37	35	59
Given to all adults	80	78	80	96	98	87	43	35	41
6. Personal Characteristics									
Age	100%	100%	100%	100%	100%	100%	100%	100%	100%
18-34	30	29	35	32	31	34	23	22	44
35-49	39	35	36	42	38	37	32	20	28
50 +	31	36	29	26	31	29	45	58	28
Education	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grade school	28	30	22	27	32	21	31	24	25
High school	56	46	50	57	48	51	54	37	45
College	16	24	28	16	20	28	15	39	30
Income	100%	100%	100%	100%	100%	100%	100%	100%	100%
- $3,000	15	17	24	15	18	24	12	13	28
$3,000 - $4,999	29	29	25	31	28	24	24	29	28
$5,000 - $6,999	29	23	28	29	25	30	29	16	14
$7,000 +	27	31	23	25	29	22	35	42	30

Reflecting the attitudes of "non-cooperators," in general, eastern residents rate their own health as better than mid-western or southern and western respondents. About 40 percent of the easterners say their health is "excellent" compared to 27 percent and 30 percent for the other two regional groups. The biggest differences are between ratings of "excellent" and "good," with little variability in the "fair" or "poor" classifications. The same regional pattern is evident in comparisons of "cooperators" and "non-cooperators," with eastern "non-cooperators" reporting better health than other regional "non-cooperators" and all regional "cooperators" reporting somewhat poorer health than their respective "non-cooperating" groups. Underlying these

attitudinal differences is the objective fact that there are more medical facilities generally available in the eastern states.

Reports of chronic illness, next shown in Table 78, parallel the findings of health ratings. Eastern residents more often report no chronic illness, and "non-cooperators" generally tend to report less chronic illness. While 56 percent of the easterners reported no chronic conditions, only 40 percent of the southern-western and 43 percent of the midwestern residents said they were as healthy. The reversal of this pattern in the east, where 8 percent fewer eastern "cooperators" report chronic illness than the eastern "non-cooperators" may be due to chance variability. With only 60 eastern non-cooperators reporting, a chance variation of ±14 percent could be expected in 5 cases out of 100.

Eastern residents are also consistently more confident that they are already taking the best possible care of themselves and report fewer unanswered questions about their own health. Almost twice as many easterners said that they are taking the best possible care of their health as compared to southern-westerners. About 60 percent of the easterners felt fully satisfied with their health care as compared to 33 percent of the southern-westerners and 50 percent of the mid-westerners. The identical pattern is found in "cooperator-non-cooperator" comparisons; the eastern "non-cooperators" are the most satisfied and feel the least unmet needs, while the other regional groups feel less satisfied or feel greater need for additional health care. The "cooperator" and "non-cooperator" differences, however, are again not statistically significant, but answers to the next question shown on Table 78 bring these attitudes into sharper focus. When asked if they had anything they would like to talk about to their own doctor free of charge, only 35 percent of the easterners said "Yes" compared to 45 percent of the midwesterners and 41 percent of the southern-westerners. Likewise, each of the regional "cooperator" groups more often feel the need to talk to their doctor than the comparable "non-cooperators" do. While the differences are not significant among the cooperator groups, the eastern "cooperators" tend to report the

least need, and more than twice as many eastern"cooperators"feel this unmet need as compared to the eastern"non-cooperators."

With respect to belief in the avoidability and cure of illness, the easterners, to a limited extent, reflect greater belief in man's capacity to exert some control over his health. Almost two-thirds of them feel that the way you live makes a "great deal" of difference in your health as compared to about half of the residents in other regions. The"cooperators"generally feel this way more often than the"non-cooperators." Likewise, easterners more often feel confident they can self-diagnose illnes. Of the eight symptoms given, 62 percent of the midwesterners and 59 percent of the southern-westerners felt they could recognize only four or fewer symptoms, while only 53 percent of the easterners said they could recognize so few symptoms.

When actual behavior is compared, however, very insignificant differences are observed. About equal numbers from all regions have gone for a general checkup when they had no symptoms. Likewise, when they recognize certain serious symptoms in themselves, equal numbers go to see a doctor right away. Of course, "non-cooperators" feel they need see a doctor right away for fewer symptoms than "cooperators."

Southern and western residents indicate somewhat greater confidence in the ability of doctors to cure or help 11 specific conditions, but they are more critical of doctors with respect to their personal manners and ethical practice. While 76 percent of the southern and western residents feel that doctors can help or cure 10 or 11 different illnesses, only 68 percent of the easterners are as confident in doctors' skills. As expected, the "cooperators" are more hopeful of their doctors' ability than the "non-cooperators," but the east vs. south-west differentials remain. On nine different specific criticisms of doctors, however, the eastern respondents show greater satisfaction with doctors' manners and ethics. Over 50 percent of the southerners and westerners feel that some doctors "don't take enough personal interest in patients" or "don't make enough of an effort to set appointments right," as

compared to about 40 percent of the easterners. Likewise, almost 50 percent of the southern-western group feel that doctors are "most interested in making money," and "charge too much," while only 38 percent of the easterners feel this way. About 10 percent more southern and western persons also feel that doctors "give unnecessary medicine," "are reluctant to get other doctors' opinions," "require unnecessary visits," "work too fast" and "aren't gentle enough" in their handling patients. Indicative, however, that these hostile attitudes toward doctors are not too crucial in decisions to cooperate on a health exam is the greater concentration of criticism among "cooperators." Most of these criticisms are not based on personal experiences with the respondent's own doctor, but are based on stereotypes of doctors, in general.

In response to a series of questions on the possible influence of different prestige groups on their decisions to cooperate, all regions showed about the same effects. The only difference appears to be the effect of approval by religious advisors, with more easterners indicating such approval might persuade them to cooperate. It is again significant to note that the support of their own doctor, spouse or friends is most effective in persuading "non-cooperators" to come for an exam. The least effect is produced by sponsorship of newspapers, radio or TV media.

Some regional differences are also noted in the effects of different arrangements on willingness to come for an examination. The greatest variation is reported by southern and western "non-cooperators," with more of them saying they might come if they have to "travel one hour," if they are "paid for their time," if the "exam is given in a trailer by a specialist". The least change in attitude is reported by the midwestern "non-cooperators," and very small differences are reported by "cooperators."

With respect to demographic variables, eastern respondents tended to be somewhat older, to have less college training, and to have higher incomes than the southern-western respondents. Eastern "non-cooperators" more often reported more

residents to be 50 years or over, fewer with college education and more with incomes of $5,000 or over. When each age group was analyzed separately, an interesting tendency was noted. Younger respondents were equally cooperative in all regions; middle-aged mid-westerners and southern-westerners were slightly more cooperative, but older persons, 50 years or more of age, were much more cooperative. About 85 percent of these older southern and westerners agreed to cooperate compared to only 65 percent of the older easterners and 70 percent of the mid-westerners.

In summary, we have seen that easterners are less cooperative than residents of other regions and that on most important variables they report attitudes and characteristics of "non-cooperators" in general. They report better health, less unmet health needs, more confidence in self-diagnoses and less in doctors abilities to help or cure illness. They are somewhat older, have less education and have higher family incomes. With respect to reactions to different arrangements for the exam, they appear to be more inflexible in their opposition.

f) Current Health Status

In the previous discussion of cooperating groups, it has been shown that "non-cooperators" more often report better health and fewer chronic illnesses than "cooperators." In this section, we shall describe the differential attitudinal and personal profiles of respondents according to their relative reported health conditions. The question of how to rank ~~older~~ order people according to their reported health levels presented some interesting problems. We considered using the respondent's own subjective ratings, or some system of weighting the number of reported illnesses according to a scale of seriousness. Both of these schemes, however, involve too many subjective assumptions. Ideally, the best system should be based on a doctor's evaluation of results obtained on a uniform series of clinical tests and measurements. Recognizing that these data are not yet available, however, it was decided that the second best alternative would be the number of chronic ailments

reported. In our sample, there are almost 350 respondents reporting no chronic conditions, so it was further considered desirable to sub-divide this large group by some objective criterion. In our previous discussion, we found that there was very little difference in the number of times a person consults a doctor once he is aware of having certain symptoms or conditions. It was assumed, therefore, that persons without a chronic illness who saw a doctor during the past 11 months might be considered in somewhat poorer health than persons who hadn't seen a doctor in the past year. This assumption is further supported by the finding that all groups report about the same numbers going for a checkup when there was nothing specifically bothering them. It follows, then, that those going to the doctor more recently, might have had more illness than those not going to a doctor during the past year. Using this additional criterion of recency of doctor visit for the no-chronic illness group, we derived four health status categories, with approximately equal numbers of respondents.

Table 79 presents these health status groups by stated willingness to cooperate on the health exam. While the differences are generally small, it is apparent that the most cooperative are the most ill and those who saw a doctor recently, while the least cooperative, are those with only one chronic ailment, and those without any chronic condition who haven't seen a doctor in the past year.

Table 80 includes comparisons of selected attitudinal and personal variables for each of the four health status groups, cross-tabulated by intentions to cooperate on the health exam. Since there are generally less than 50 interviews in each of the non-cooperator health groups, responses for each non-cooperator group are subject to greater sampling error and valid comparisons are difficult to make. With this general limitation in mind, we shall first discuss the broader differences among the health status groups and then shall briefly describe some of the varying tendencies of the "cooperator" and "non-cooperator" groups, which cut across health status classifications.

TABLE 79

WILLINGNESS TO COOPERATE BY HEALTH STATUS GROUPS

Health Status		All Respondents Number	All Respondents Percent	Cooperators Number	Cooperators Percent	Non-Cooperators Number	Non-Cooperators Percent
I	No chronic-Not see doctor in past year.	164	100%	129	79%	35	21%
II	No chronic-Saw doctor in past year	182	100%	150	83	32	17
III	One chronic illness	216	100%	164	76	52	24
IV	Two or more chronic illnesses	200	100%	171	86	29	14

As one would expect, persons with two or more chronic conditions generally rate their health subjectively as poorer than those in better health groups. About 41 percent of the persons reporting the most illness (category IV in Table 79) rated their health as only either "fair" or "poor" in comparison to about 14 percent for those with no chronic conditions. Likewise, it is not surprising that the "most ill" are among the least satisfied with the care they are taking of their health, and are most desirous of talking to their doctors about their health problems. It is also consistent with this greater feeling of unmet health needs that more often they feel like seeing a doctor but for a variety of reasons don't. It is interesting to note, however, that this group also feels most threatened by the possibility of becoming seriously ill of T.B., heart or arthritis conditions and are also less confident in self diagnosis. They equally feel with other health groups, however, that they should see a doctor right away when they recognize having certain selected symptoms or conditions and in actual practice, they also say equally they saw a doctor when they recognized these conditions in themselves. Their attitudes on seeing a doctor and in trusting doctor's abilities to help or cure disease are also the same in all health groups. In personal characteristics, they are generally the oldest, are more often women, have less education and lower family incomes.

The second most cooperative health group, category II in Table 79, is generally different from category IV, which we have just described, and more like health status group I, which also reports no chronic illnesses. Both groups II and I rate their health about equally better than the other two health groups. Group II, however, feels less satisfied with the care it is taking of its health, while group I is most satisfied with its health care. When asked whether they'd like to talk to their doctor, or whether they ever felt like seeing their doctor and didn't, equally low numbers of groups I and II answer "yes." The reason generally given is, "I'm healthy and don't need to see the doctor." Likewise, both groups equally feel the same likelihood they may become seriously ill. The more cooperative group II feels a little less confident in self diagnosis and actually more often saw the doctor for all symptoms and conditions which they recognized as having. But with respect to verbal belief in seeing a doctor when one is ill, both groups equally say they should see a doctor right away when they are sick, and equal numbers say they trust their doctor's ability to help or cure illness. Likewise, they equally say they go for check-ups when they have no special symptoms or illness. With respect to attitudes toward check-ups and behavior of doctors, there are no substantial differences between the two no-chronic illness groups. Their personal characteristics, however, are quite different. Group II, the more cooperative, is younger and has somewhat higher incomes, while Group I is older, more often men, with less education and less income.

Persons reporting only one chronic illness, Group III in Table 80, present a picture common to "non-cooperators." They generally rate their health higher than the more seriously ill Group IV, are more satisfied with the care of their health, less often want to talk to a doctor about their health, or ever felt like seeing a doctor but didn't. They also feel it is less likely they will become seriously ill, but at the verbal level, are about equal with other groups in saying they should see a doctor right away when they recognize certain symptoms. In actual practice, they

about equal group IV but are less than Group II in the number of times they actually saw a doctor for all conditions they reported having. In personal characteristics, we find Group III is younger than Group IV, is about equally male and female, has more people with higher education and more often has people in the middle income range of $5,000-$7,000.

Indicative of the pervasive effects of such basic attitudes as concern about unmet health needs, belief in early diagnosis, and proneness to illness, "cooperators" regardless of health status, exhibit different characteristics from "non-cooperators." "Non-cooperators" generally rate their health as better, and express less desire to talk to a doctor or having ever felt like talking to one but not having done so. The reason usually given is that they feel healthy and in no need to see a doctor. They also feel less threatened by possible illness and less often feel they may get TB, heart or arthritis ailments. "Non-cooperators" in health groups I and III also are more confident in self diagnosis and less often say they should see a doctor right away. Likewise, they less often feel a doctor can help or cure illness but on general attitudes towards doctors, they split; "non cooperator" groups with chronic illness are generally more critical but "non-cooperators" without chronic ailments are a little less critical of doctors. Non-cooperators are also usually older, have more women in groups III and IV and more men in group II, have more education and higher incomes.

g) Educational Levels

The formal educational background of a person has usually been found to be one of the key variables in most attitude studies. As reported in the introduction, other researchers have found a tendency for "cooperators" to be better educated than "non-cooperators." Our findings are somewhat in conflict with these earlier studies. No significant educational difference is found between consistent "cooperators" and "non-cooperators." But, as Table 81 shows, the less certain cooperators

TABLE 80

SOME ATTITUDES AND CHARACTERISTICS
OF COOPERATORS AND NON-COOPERATORS BY HEALTH STATUS

	Totals				Cooperators				Non-Cooperators			
	Health Status				Health Status				Health Status			
	I	II	III	IV	I	II	III	IV	I	II	III	IV
Number Respondents	164	182	216	200	129	150	164	171	35	32	52	29
1. Current Health Rating	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Excellent	38	40	32	17	36	39	32	17	46	47	31	17
Good	48	46	45	42	50	47	45	43	40	44	42	35
Fair	13	13	21	29	13	13	21	27	14	9	23	41
Poor	1	1	2	12	1	1	2	13	-	-	4	7
2. Unmet Health Needs												
Self Care for Health	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Best possible	53	39	50	44	52	41	46	46	57	25	62	38
Could do more	46	59	50	56	47	58	54	54	40	66	38	62
Don't know	1	2	-	-	1	1	*	-	3	9	-	-
Consult Doctor Free of Charge	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Desirous	34	32	43	50	37	36	48	55	23	12	27	24
Not desirous	66	68	57	50	63	64	52	45	77	88	73	76
Felt Like Seeing Doctor But Didn't	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Yes	21	22	24	34	25	25	28	34	6	6	12	31
No	79	78	76	66	75	75	72	66	94	94	88	69
3. Belief in Avoidability and Cure of Illness												
Way you Live Affects Health	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Great deal	61	55	55	54	59	54	59	54	69	63	42	52
Some	24	23	26	28	26	23	26	29	17	22	25	27
Hardly any	15	22	19	18	15	23	15	17	14	15	33	21
Likely Get TB Heart, Arthritis Illness	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Likely	23	20	20	35	27	21	23	36	8	13	14	31
Not likely	65	75	71	56	65	74	72	55	66	78	67	62
Don't know	12	5	9	9	8	5	5	9	26	9	19	7

Table 80 Continued

	Totals				Cooperators				Non-Cooperators			
	Health Status				Health Status				Health Status			
	I	II	III	IV	I	II	III	IV	I	II	III	IV
Cumulative Number Symptoms Could Tell if Sick												
Less than 2	12	12	15	13	10	13	14	15	20	9	19	3
Less than 4	52	56	62	61	51	54	61	63	54	62	63	48
Less than 6	88	90	90	88	88	89	90	91	88	94	90	76
Less than 9	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. Conditions Should See Doctor Right Away	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
6 or less	22	20	23	24	19	19	20	23	34	28	35	28
7-8	35	32	30	33	36	32	31	33	31	31	27	31
9-11	43	48	47	43	45	49	49	44	35	41	38	41
Of Conditions Actually Had - Saw Doctor for:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
All	40	65	56	54	42	67	57	54	30	50	55	48
Some	12	14	16	18	12	12	16	18	10	30	15	24
None	48	21	28	28	46	21	27	28	60	20	30	28
No. Conditions Doctor Can Help or Cure	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
6 or less	7	5	6	2	6	3	3	2	9	12	15	3
7-9	22	23	22	24	23	23	20	23	20	22	27	31
10-11	71	72	72	74	71	74	77	75	71	66	58	66
Ever got Checkup-Feeling O.K.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Yes	44	47	36	34	46	45	37	34	34	53	33	28
No	56	53	64	66	54	55	63	66	66	47	67	72
Reasons for Not Seeing a Doctor												
Regular exam makes worry	18	13	18	12	14	13	16	12	31	12	23	14
Not bother doctor unless sick	39	45	41	48	39	49	39	46	40	28	48	55
Not spend money if feel OK	41	37	41	45	35	45	40	45	46	22	46	45
Understand health better than doctor	22	24	19	18	23	25	20	16	26	12	17	28
Doctor can't help me	6	4	7	5	5	4	6	4	11	3	10	14
Can get better without doctor	10	14	13	8	7	15	13	7	23	13	14	17
If feel OK, Are OK	68	62	66	61	66	61	68	57	77	62	67	83

Table 80 Continued

	Total				Cooperators				Non-Cooperators			
	Health Status				Health Status				Health Status			
	I	II	III	IV	I	II	III	IV	I	II	III	IV
4. Attitudes towards Doctors												
No chance to tell trouble	32	38	40	40	31	40	41	40	37	28	39	38
Not enough personal interest	50	51	54	54	50	52	57	57	49	50	44	38
Give unnecessary medicine	24	28	26	30	25	30	24	29	23	22	31	38
Don't tell you things ought to	31	39	39	41	34	40	40	41	23	34	37	41
Require unnecessary visits	34	28	33	27	36	30	34	28	29	16	31	21
More interested in money	37	32	42	36	38	34	42	37	34	22	40	28
Work too fast - make mistakes	27	26	29	34	27	26	33	34	29	25	17	24
5. Personal Characteristics												
Age:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
18-34	27	42	33	26	29	41	35	26	20	47	27	28
35-49	37	36	38	35	38	37	43	37	34	28	23	24
50 +	36	22	29	39	33	22	22	37	46	25	50	48
Sex:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Male	60	50	51	42	59	49	52	42	66	53	44	41
Female	40	50	49	58	41	51	48	58	34	47	56	59
Education:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grade school	33	22	22	29	30	24	22	29	43	12	24	31
High school	49	54	53	47	52	52	56	48	40	62	43	41
College	18	24	25	24	18	24	22	23	17	25	33	28
Income:	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
- $3,000	23	14	16	23	22	15	17	24	27	7	21	14
$3,000 - $4,999	27	29	26	28	26	27	26	29	32	39	20	18
$5,000 - $6,999	26	23	33	25	27	24	35	27	19	18	24	18
$7,000 +	24	34	25	24	25	34	22	20	22	36	35	50

and the vacillators do report statistically higher educational levels than the consistent respondents. While the average educational achievement for all persons was about 50 percent with high school training and about 25 percent with grade school or college experience, the consistent "cooperators" report about a third with grade

school or college experience, the consistent "cooperators" report about a third with grade school and only 15 percent with college background. Likewise, the consistent "No-No's" have only 4-5 percent more persons who have high school or college training and such small differences could easily reflect merely sampling variability.

The "Yes-Probably" group, however, reports 9 percent more college trained people than the "Yes-Certainly" group; the "No-Yes" respondents have 11 percent more college people and the "Yes-No" vacillators report the most college educated people, 19 percent more than the "Yes-Certainly" group. A chi-square test of significance indicates that reports of higher education by the "Yes-Probably" group could have occurred by chance in only 2 out of 100 samples and the differences between the vacillators and the "Yes-Certainly" group could have occurred by chance in less than one case out of 100. Clearly these are significant differences.

When consistent and vacillating cooperators are combined, however, the above educational differences offset one another and no significant variation can be observed in the educational levels of"cooperators"and "non-cooperators." The first comparisons in Table 83 indicate that college trained people are only 4 percent less cooperative than high schoolers and only 2 percent different from grade school educated respondents.

To further test the influence of education on the decision process of cooperating on a health exam, all of the more significant attitudinal and personal variables were cross-tabulated by cooperator group and education. These comparisons are shown in Tables 82 and 83.

Grade school and college educated persons reveal many contradictory patterns of attitudes. In general, grade school trained respondents exhibit the more important characteristics of cooperators and college experienced persons reflect opposite views. But these patterns are not entirely consistent. Grade school persons more often describe their health as poorer, but report no difference in the number of chronic

TABLE 81

WILLINGNESS TO COOPERATE BY EDUCATION LEVEL

		Census: YES			Census: NO	
	All Persons	NORC			NORC	
		Certainly	Probably	No-DK	Yes	No-DK
Number of Respondents	762	249	237	53	92	79
Education:	100%	100%	100%	100%	100%	100%
Grade school	26	32	24	34	19	23
High school	51	53	52	32	55	58
College	23	15	24	34	26	19

TABLE 82

SOME ATTITUDES AND CHARACTERISTICS OF COOPERATORS AND NON-COOPERATORS BY EDUCATIONAL LEVEL

	Totals			Cooperators			Non-Cooperators		
Item	Grade School	High School	College	Grade School	High School	College	Grade School	High School	College
Number of Respondents 1/	197	383	174	157	315	135	40	68	39
1. Current Health Status									
Self Health Rating:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Excellent	21	29	48	21	27	49	22	37	44
Good	39	49	43	41	50	41	32	41	49
Fair	30	20	8	28	20	9	38	22	5
Poor	10	2	1	10	3	1	8	-	2
No. Chronic Conditions	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	47	46	42	47	45	44	47	50	36
One	24	30	30	22	29	27	30	32	44
Two or more	29	24	28	31	26	29	23	18	20
2. Unmet Health Needs									
Most People Care for Health:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Best possible	28	22	20	25	21	19	43	29	26
Could do more	67	76	77	70	78	79	52	63	69
Don't know	5	2	3	5	1	2	5	8	5

1/ Eight persons failed to give their educational level and, therefore, are not included in this anslysis.

Table 82 Continued

Item	Totals			Cooperators			Non-Cooperators		
	Grade School	High School	College	Grade School	High School	College	Grade School	High School	College
Self Care for Health:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Best possible	59	45	34	56	45	36	70	46	28
Could do more	41	54	64	43	55	63	30	51	67
Don't know	*	1	2	1	*	1	-	3	5
Consult Doctor Free of Charge	100%	100%	100%	100%	100%	100%	100%	100%	100%
Desirous	45	41	36	49	45	41	28	22	18
Not desirous	55	59	64	51	55	59	72	78	82
3. Belief in Avoidability and Cure of Illness									
Way you live affects health:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Great deal	49	57	61	50	56	64	47	62	51
Some	24	25	27	23	27	26	28	16	31
Hardly any	27	18	12	27	17	10	25	22	18
Likely get TB, Heart or Arthritis	100%	100%	100%	100%	100%	100%	100%	100%	100%
Likely	36	19	23	39	22	22	25	6	-
Not likely	49	72	75	48	71	77	52	78	88
Don't know	15	9	2	13	7	1	23	16	12
Cumulative No. Symptoms Could Tell if Sick									
None	8	6	3	7	6	3	10	6	5
Less than 4	57	55	64	55	55	67	65	56	54
Less than 6	85	91	90	84	92	90	87	87	90
Less than 9	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cumulative No. Conditions Should See Doctor Right Away									
Less than 7	18	23	26	15	22	22	28	29	41
Less than 10	62	75	80	57	76	79	82	71	85
Less than 12	100%	100%	100%	100%	100%	100%	100%	100%	100%
Of Conditions Actually Had Saw Doctor For:	100%	100%	100%	100%	100%	100%	100%	100%	100%
All	60	52	52	64	52	52	45	49	52
Some	15	17	15	15	18	11	15	15	29
None	25	31	33	21	30	37	40	36	19

Table 82 Continued

Item	Totals			Cooperators			Non-Cooperators		
	Grade School	High School	College	Grade School	High School	College	Grade School	High School	College
Reasons for Not Seeing Doctor									
Not bother doctor unless sick	58%	42%	31%	55%	42%	31%	68%	37%	28%
Regular exam makes worry	27	13	8	27	11	6	28	19	15
Don't like doctors	17	11	5	17	12	5	15	10	3
Not spend money if feel OK	51	39	34	47	40	37	68	32	26
Understand own health best	38	15	11	38	15	12	35	18	8
Disease is punishment	12	3	-	11	3	-	18	4	-
Don't think doctors can help	12	9	2	10	3	2	20	6	5
Waste time waiting for doctor	16	11	2 1	17	10	21	15	12	21
Can get better without doctor	18	8	13	15	8	12	28	9	18
If feel OK are OK	74	64	58	71	63	55	85	66	67
4. Knowledge and Interest In Health Matters									
No. Polio Symptoms Reported	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	50	25	15	49	24	14	58	28	18
1-2	32	38	37	32	38	38	30	37	33
3	14	23	29	14	25	29	12	16	28
4 +	4	14	19	5	13	19	-	19	21
No. TB Symptoms Reported	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	42	22	16	40	23	15	53	18	18
1-2	44	52	49	46	51	49	40	60	49
3	10	16	19	10	15	21	7	18	15
4 +	4	10	16	4	11	15	-	4	18
No. Diabetes Symptoms Reported	100%	100%	100%	100%	100%	100%	100%	100%	100%
None	60	48	44	60	45	41	63	59	54
1-2	29	38	29	30	40	31	27	32	23
3	9	10	17	8	11	19	10	6	8
4 +	2	4	10	2	4	9	-	3	15
Extent of Reading About Health	100%	100%	100%	100%	100%	100%	100%	100%	100%
Often	27	32	41	24	33	42	37	25	36
Once in a while	35	49	40	38	51	43	25	45	28
Hardly ever	38	19	19	38	16	15	38	30	36
Don't read papers, etc.	26	10	4	25	8	3	30	15	10
Skip health items	12	9	15	13	8	12	8	15	26

Table 82 Continued

Item	Totals			Cooperators			Non-Cooperators		
	Grade School	High School	College	Grade School	High School	College	Grade School	High School	College
Extent of Radio and TV Listening	100%	100%	100%	100%	100%	100%	100%	100%	100%
Often	26	24	17	25	20	19	27	17	8
Once in a while	45	44	40	50	46	42	25	34	36
Hardly ever	29	32	43	25	28	39	48	49	56
Avoid all programs	11	10	14	11	10	16	10	13	8
Avoid health	17	18	25	13	15	21	33	33	38
None available, etc.	1	4	4	1	3	2	5	3	10
5. Attitudes toward Doctors									
Not enough personal interest	42	56	57	43	59	57	38	43	59
Not tell all need to know	40	37	35	42	38	36	33	32	36
Require unnecessary visits	38	28	27	41	29	27	25	26	26
More interested in money	42	35	35	43	37	34	35	28	38
Doctors charge too much	44	41	42	43	40	39	40	44	54
Doctors hurt you	14	10	7	13	10	7	18	7	8
Work too fast, make mistakes	35	28	26	37	29	26	30	20	28
6. Attitudes Toward Government Role in Health									
Should test all vaccines	89	92	84	91	94	88	82	87	69
Should give free doctor service to needy	93	94	85	92	94	85	95	93	85
Should set up own labs for research	88	89	79	89	88	84	85	83	62
Should provide health insurance	81	74	51	82	75	55	80	67	36
Should give money to private hospitals for research	84	79	76	87	80	79	70	74	64
Should make studies of nation's health	91	95	95	94	97	97	83	87	87
7. Personal Characteristics									
Race:	100%	100%	100%	100%	100%	100%	100%	100%	100%
White	77	88	94	74	86	95	88	96	92
Non-white	23	12	6	26	14	5	12	4	8
Sex:	100%	100%	100%	100%	100%	100%	100%	100%	100%
Male	54	45	55	55	45	53	50	46	62
Female	46	55	45	45	55	47	50	54	38

Table 82 Continued

Item	Totals			Cooperators			Non-Cooperators		
	Grade School	High School	Col-lege	Grade School	High School	Col-lege	Grade School	High School	Col-lege
Age:	100%	100%	100%	100%	100%	100%	100%	100%	100%
18-34	11	38	42	13	37	44	5	40	38
35-49	35	41	30	37	44	31	25	29	26
50 +	54	21	28	50	19	25	70	31	36
Income:	100%	100%	100%	100%	100%	100%	100%	100%	100%
- $3,000	33	17	7	33	18	8	34	14	5
$3,000 - $4,999	34	27	20	35	26	21	33	28	17
$5,000 - $6,999	18	33	24	18	34	26	15	28	14
$7,000 +	15	23	49	14	22	45	18	30	64

TABLE 83

EDUCATIONAL LEVELS BY SELECTED PERSONAL CHARACTERISTICS

	Total		Grade School		High School		College	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Cooperation								
Total Cooperators	607	80	157	80	315	82	135	78
Total Non-Cooperators	147	20	40	20	68	18	39	22
Total Respondents	754	100%	197	100%	383	100%	174	100%
Race								
White	650	100	151	23	335	52	164	25
Non-White	104	100	46	44	48	46	10	10
Total	754	100%	197	26%	483	51%	174	23%
White-Cooperators	514	79	116	77	270	81	128	78
-Non-Cooperators	136	21	35	23	65	19	36	22
Total	650	100%	151	100%	335	100%	164	100%
Non-White-Cooperators	93	89	41	89	45	94	7	70
Non-Cooperators	11	11	5	11	3	6	3	30
Total	104	100%	46	100%	48	100%	10	100%
Sex								
Male	375	100	106	28	174	47	95	25
Female	379	100	91	24	209	55	79	21
Male-Cooperators	300	80	86	81	143	82	71	75
Non-Cooperators	75	20	20	19	31	18	24	25
Total	375	100%	106	100%	174	100%	95	100%
Female-Cooperators	307	81	71	78	172	82	64	81
-Non-Cooperators	72	19	20	22	37	18	15	19
	379	100%	91	100%	209	100%	79	100%

Table 83 Continued

	Total		Grade School		High School		College	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age								
18-34	241	100	22	9	145	60	74	31
35-49	277	100	68	24	157	57	52	19
50 +	236	100	107	46	81	34	48	20
18-34-Cooperators	197	82	20	90	118	81	59	80
Non-Cooperators	44	18	2	10	27	19	15	20
Total	241	100%	22	100%	145	100%	74	100%
35-49-Cooperators	237	86	58	85	137	87	42	81
-Non-Cooperators	40	14	10	15	20	13	10	19
Total	277	100%	68	100%	157	100%	52	100%
50 + -Cooperators	173	73	79	74	60	74	34	71
-Non-Cooperators	63	27	28	26	21	26	14	29
Total	236	100%	107	100%	81	100%	48	100%
Income								
-$3,000	137	100	63	46	62	45	12	9
$3,000-$4,999	197	100	66	33	98	50	33	17
$5,000-$6,999	195	100	34	17	122	63	39	44
$7,000 +	195	100	29	15	86	44	80	41
-$3,000-Cooperators	114	83	50	79	54	87	10	83
-Non-Cooperators	23	17	13	21	8	13	2	17
Total	137	100%	63	100%	62	100%	12	100%
$3,000-$4,999-Cooperators	161	82	53	80	81	83	27	82
-Non-Cooperators	36	18	13	20	17	17	6	18
Total	197	100%	66	100%	98	100%	33	100%
$5,000-$6,999-Cooperators	167	86	28	82	105	86	34	87
-Non-Cooperators	28	14	6	18	17	14	5	13
Total	195	100%	34	100%	122	100%	39	100%
$7,000 + -Cooperators	147	75	22	76	68	79	57	71
-Non-Cooperators	48	25	7	24	18	21	23	29
Total	195	100%	29	100%	86	100%	80	100%

ailments. They are most satisfied they are taking the best care of themselves, but are most anxious to talk to a doctor about their health. They feel that the way they live is less important to their health status, but they say they are more likely to become seriously ill in the near future. They are more confident in their ability to

self diagnose, least often feel they should see a doctor right away, generally are less confident and more critical of doctors' abilities and patient ethics, but they actually went to a doctor more often when they recognized having certain symptoms and conditions. As expected, they report less knowledge of symptoms of TB, polio and diabetes and less often read about health matters. This doesn't reflect lack of interest in health matters, however, but merely that they less often read the newspapers. They more often report watching or listening to health programs on radio or TV. It is highly important to note that they are consistently more favorably disposed toward the government extending its role in public health matters. With respect to personal characteristics, grade school persons are more often non-whites, more often men who are older and have less income.

College educated persons usually report opposite characteristics to those cited above for grade school respondents. They more often rate their health as "excellent," but also feel they usually can do more to improve their health. That this dissatisfaction with the care of their health is not too serious is revealed by their very low desire to talk to their own doctor about their health. They more often recognize that the way they live makes a great deal of difference to their health, but they feel they are less likely to become seriously ill in the near future. Although they have more knowledge of symptoms, and are least confident in being able to recognize illness by themselves, they less often feel they should go to a doctor right away when they have symptoms of illness. Likewise, in actual behavior, they less often saw a doctor for all conditions they reported as having. While they are generally less critical of doctors, they more often feel doctors take less personal interest in patients than they should. Consistently, they more often want to restrict the role of government in health matters, even in such traditional areas as providing free care for the needy. In personal characteristics, they are more often white males who are younger and have higher incomes.

When"cooperators" and "non-cooperators" are compared for equal education groups, college trained"non-cooperators" more often report the extreme attitudes usually associated with non-cooperation. There is no difference with respect to health ratings, but "cooperators" at all education levels report more chronic illness. "Non-cooperators" are generally more satisfied with their care of their health and less often feel a need to talk to their doctor. The "cooperators" with only grade school education are most anxious to talk to their doctors, while the college trained "non-cooperators" are least desirous of doing this. While grade school and high school educated "cooperators" and"non-cooperators" equally feel the way they live is important to their health, college trained "non-cooperators" more often feel the way they live is less important. "Non-cooperators," however, generally feel less threatened by illness and the college trained feel least likely to become seriously ill. While the "non-cooperators" report less knowledge of symptoms and show the least interest in health matters, they less often feel they should see a doctor right away after recognizing a symptom. As expected, the college "non-cooperators" more often skip radio and TV health programs and least often feel they should see a doctor right away. But in actual practice, while grade and high school"non-cooperators"usually saw their doctors less often after reporting an illness, the college "non-cooperators" more often saw a doctor for some of the conditions and less often saw a doctor for none of the reported illnesses. On the crucial attitude toward the role of government in health affairs,"non-cooperators" approve of less government interference and college "non-cooperators"are least approving of all.

As Table 83 indicates, there are no differences in the cooperativeness among white persons by educational level, but college trained non-whites are more uncooperative than less educated non-whites. In less than 3 cases out of 100 could the difference be due to chance sampling variance. With respect to sex, there is some tendency for male college persons to be more non-cooperative but the difference is too small to be statistically significant. Older persons are clearly less cooperative,

but for equal age categories, there are no sizable differences in cooperation among educational groups. Likewise, the wealthier prove consistently less cooperative, but for equal income groups, there are no differences among educational levels.

11. Health Exam Pretest in Washington, D.C.

The second phase of the experimental special studies, as mentioned previously, was a pilot project in the Washington, D.C. area. Here, the actual medical procedures and tests which will be employed in the National Health Examinations were given a trial run. There was also an opportunity to study the actual behavior of people confronted with the offer of a free health exam. It was possible to get a measure of the consistency between verbal intent and actual behavior, and to supplement our investigation into the factors associated with willingness and unwillingness to cooperate in the health exam.

For this pilot study, a special sample was drawn from the metropolitan Washington, D.C. area which reduced the numbers of government and non-white respondents and, thereby, selected respondents which resembled more closely the national population. Even so, the proportion of non-whites proved higher than expected.

Census interviewers conducted the regular National Health Survey interview in each sample household, and at its conclusion, asked the supplementary question on willingness to accept a health examination. The question was asked of just one person from each household in the eligible age range of 18-64 years. Departing from the usual Census procedure, however, everyone was interviewed personally and no proxy responses were accepted.

Whenever the respondent indicated that he was willing to participate in the health exam, an appointment was made on the spot, together with arrangements for a free taxi pick-up, etc. When, for some reason, the Census interviewer failed to secure an appointment, the case was turned over to NORC and a week or so later, our hour-long interview on health attitudes and opinions was conducted.

TABLE 84

PERSONAL CHARACTERISTICS OF EXAMINED AND NOT EXAMINED PERSONS IN WASHINGTON, D.C.

	All D.C.		Examined		Not Examined	
	Number	Percent	Number	Percent	Number	Percent
Number of Respondents	180	100%	119	66%	61	34%
Race		100%		100%		100%
White	123	68	74	62	49	80
Non-white	57	32	45	38	12	20
Sex		100%		100%		100%
Males	74	41	51	43	23	38
Females	106	59	68	57	38	62
Age		100%		100%		100%
- 25	32	18	23	19	9	15
25-44	90	50	63	53	27	44
45-64	58	32	33	28	25	41
Education		100%		100%		100%
Grammar school	46	26	27	23	19	32
High school	89	51	58	50	31	52
College +	41	23	31	27	10	16
Income		100%		100%		100%
- $3,000	42	24	31	27	11	18
$3,000-$6,999	92	52	59	51	33	55
$7,000 +	42	24	26	22	16	27

special convincing to commit themselves to an appointment and men would seem to require more persistent follow-up to assure their attendance for the examination.

Our trends reflected in the Washington data are for the refusal rate to increase in the college educated group, in the older group, and in the higher income groups, all characteristics of non-cooperators.

Table 85 compares the health opinions and attitudes among the Washington NORC sample with the national consistent non-cooperators. These findings are presented below in terms of the nine variables which have been found most related to intentions to cooperate:

1. The Washington data support the national findings that non-cooperators have a higher appraisal of their own health, greater satisfaction with their state of health and with the care they are now taking of their health. Fewer concede the possibility of their becoming seriously ill over the next 5-10 years, and fewer recognize the likelihood of being sick in bed even 3-4 days next year.

2. The Washington data also agree with the general findings that non-cooperators report fewer unmet health needs, as evidenced in their less frequent mention of chronic illness or symptoms and less frequent desire to discuss their health with a doctor. In Washington, the cooperators more often reported a recent visit to the doctor than did non-cooperators. It would seem that this related more to greater awareness of health needs than to confidence in doctor's care.

3. There is general agreement, but not complete consistency, that non-cooperators evidence less concern and interest in health matters. The Washington sample less often think and talk about their health and report less radio listening and televiewing of health programs than the national average. However, their listening and televiewing rate was higher than among the national non-cooperator groups and their reason for not listening to or watching health programs more often is that they just don't spend much time with TV or radio listening and not that they skip health programs. Furthermore there was apparent contradiction in their reports of reading health articles in newspapers and magazines. The Washington sample rates somewhat higher than the national on this matter. Thus the Washington experience does not bear out fully the indications that non-cooperators have a lesser interest in health matters.

4. The Washington data also support the national findings in that non-cooperators report that ill health has less impact on their jobs and family welfare and finances.

5. Concern for research efforts seems to fall into a somewhat different pattern in the Washington sample. When speaking in broad generalities, the Washington respondents indicate more dissatisfaction with current research efforts than the national non-cooperators and they show more support for the government role in research. Yet when they were questioned about the importance of their own cooperation on health surveys such as this, they agreed with the general pattern of non-cooperators that it was not of great importance to cooperate.

6. While the Washington respondents less often believed that the way they lived made a great deal of difference in their healthiness, they tended to be more confident in the abilities of doctors to help or cure illness and more often recognized the need for immediate doctor's attention when a given symptom occurred.

7. The Washington data are in agreement with the national finding on non-cooperators being much more critical of doctors for their lack of personal interest in their patients. However, there was no other attitude on which the Washington non-cooperators were consistently more critical of doctors.

8. The Washington respondents do not appear to have had more experience with clinics than cooperators as shown in the national survey, but they do register more criticism in their attitudes toward clinic procedures. On the other hand, they are more frequently satisfied with what the Public Health Service is doing and are more sympathetic to the government's role in research.

9. In Washington, only a small number of people were asked for their reactions to a variety of conditions under which the examination could be given.

This was so because in Washington only those who indicated in the NORC interview that they probably would not come to the exam were then questioned further about circumstances under which they might come. Realizing that the following discussion is based on only 19 respondents, we found that "spouse and friends" would be the most influential persons for inducing cooperation; that the respondent's own doctor, and even specialists approved by the AMA, were preferred; that inviting all the grown-ups and children in a household to come and wearing a coverall gown were the more desired alternatives. None of the other circumstances were endorsed by more than 10 percent of the group.

Fortunately, the Washington experience provided us with more than verbal intentions and by looking at our results, we can learn something about the extent to which non-cooperators can be influenced. About 4 out of every 10 persons who failed to make an initial appointment with Census were eventually convinced to make an appointment by either the indirect effects of the NORC interviews or by a direct discussion with a persuader. About 1 out of every 10, for one reason or another, failed to show up for the examination, leaving a net gain of almost 30 percent who actually took the exam but had initially refused. This is a sizeable conversion rate.

The Washington experience also gave us some additional information about people's motives for cooperating in the examination. At the conclusion of the medical exam, each participant was asked a series of questions about his reasons for coming, his suggestions for improving the appointment making procedures, and his reactions to the exam itself. These questions formed the Exit Interview.

The most frequently reported motive for coming to the exam was the personal advantage derived from it -- checking up on your health. But it seems that this motive is not so dominant among the respondents who had been less willing to cooperate.

Although our numbers were small, we were able to separate the eleven respondents who had been interviewed by NORC before making their appointment for the exam, and compare their responses with the 109 who had made their appointments immediately with the Census interviewer. Considering the NORC respondents as representing those less willing to come for the exam, we find that for the less willing, concern about civil and social responsibility is as strong a motive as the personal benefits involved.

The exit interviews revealed very little criticism of the exam procedures, even on questions which asked directly for it. It was evident that the special care which the examining personnel took to overcome impressions of a clinic as impersonal, and making you wait too long, paid off. Respondents noted with particular satisfaction the amount of personal and courteous attention they had received.

TABLE 85

COMPARISON OF ATTITUDES AND OPINIONS TOWARD HEALTH
BY WASHINGTON AND NATIONAL NON-COOPERATORS

	All National		National Consistent Non-Cooperators		Washington Non-Cooperators	
	Number	Percent	Number	Percent	Number	Percent
Number of Respondents. . . .	762 1/	100%	79	100%	31	100%
Presence of Chronic Illness						
None	346	46	33	42	16	52
One.	216	28	30	38	8	26
Two or more.	200	26	16	20	7	22
Self Rating of Own Health						
Excellent.	238	31	26	33	17	55
Good	343	45	30	38	10	32
Fair	149	20	21	27	4	13
Poor	32	4	2	2	-	-
Like to Consult Own Doctor Free of Charge						
Desirous	307	40	13	16	6	20
Not desirous	453	60	65	84	24	80

1/ Numbers do not always add to 762 because some respondents failed to answer particular questions.

Table 85 Continued

	All National		National Consistent Non-Cooperators		Washington Non-Cooperators	
	Number	Percent	Number	Percent	Number	Percent
Satisfied with Medical Research						
On Causes: Yes	521	69	66	84	20	65
No	209	27	9	11	10	32
Don't know	32	4	4	5	1	3
On Cures: Yes	509	67	61	77	19	61
No	218	29	14	18	11	36
Don't know	34	4	4	5	1	3
Kind of Health Required by Own Work						
Especially good health	244	32	24	30	10	32
Fairly good health	376	49	39	49	12	39
Not so well	136	18	14	18	7	23
Don't know, no answer	6	1	2	3	2	6
Trouble for Family if You are Sick						
Great deal	92	12	8	10	2	7
Some	177	23	13	17	5	16
Not much	432	57	50	63	20	64
No family, No answer	61	8	8	10	4	13
Think About Health						
Fairly often	303	40	20	25	9	29
Once in a while	271	36	27	34	9	29
Hardly ever	182	24	29	37	13	42
Don't know	4	*	3	4	-	-
Talk About Health						
Fairly often	111	15	7	9	1	3
Once in a while	241	32	20	25	9	29
Hardly ever	405	53	50	63	21	68
Don't know	2	*	2	3	-	-
Read About Health Matters in Newspapers and Magazines						
Often	250	33	24	30	14	45
Once in a while	329	43	33	42	12	39
Hardly ever	181	24	21	27	5	16
Don't know	1	*	1	1	-	-
Listen or Watch Health Programs on Radio or TV						
Often	176	23	15	19	7	22
Once in a while	329	43	27	34	12	39
Hardly ever	256	34	37	47	12	39
Why Listen or Watch Hardly Ever?						
Avoid all programs	86	11	10	13	5	16
Avoid health	144	19	23	29	5	16
None available	25	4	3	5	2	6

Table 85 Continued

	All National		National Consistent Non-Cooperators		Washington Non-Cooperators	
	Number	Percent	Number	Percent	Number	Percent
The Way You Live Affects Your Healthiness:						
A great deal	426	56	46	58	14	45
Some	194	26	19	24	12	39
Hardly any	133	17	10	13	5	16
Don't know	9	1	4	5	-	-
Likely to Get TB, Heart Disease or Arthritis 5-10 Years						
Very likely	54	7	5	6	-	-
Fairly likely	134	18	8	10	4	13
Hardly likely	507	67	52	66	25	81
Don't know, no answer	67	8	14	18	2	6
From List of 11 Symptoms Should See Doctor Immediately About:						
6 or less symptoms	170	22	21	27	6	19
7 or 8 symptoms	245	32	25	32	13	42
9-11 symptoms	347	46	33	41	12	39
Reasons for Not Wanting A Checkup from Doctor 2/						
Makes you worry	116	15	19	24	1	3
Get better by self	88	12	11	14	5	16
Are O.K. if feel O.K.	492	65	58	73	21	68
Doctor might hurt	52	7	5	6	4	13
Doctor can't help	42	6	6	8	1	3
Criticisms of Doctors 2/						
Don't let you tell exact trouble	287	38	24	30	-	-
Don't take enough personal interest	399	52	33	42	15	48
Aren't careful or gentle enough	110	14	7	9	6	19
Charge too much	320	42	30	38	13	42
Role of Government in Health						
Government: Has no business in health	69	9	10	13	2	6
Should test all vaccines	680	89	62	80	25	81
Should give free doctor's services to needy	679	89	66	84	26	84
Should provide health insurance	482	63	42	53	19	61
Should give money for research in private institutions	606	80	56	71	27	87
Should make studies on the nation's health	717	94	67	85	30	97
Should set up its own laboratories for research	607	80	52	66	27	87

2/ Percentages do not add to 100 since every question was asked separately and percentages represent extent of agreement with each statement.

Table 85 Continued

Personal Characteristics	All National		National Consistent Non-Cooperators		Washington Non-Cooperators	
	Number	Percent	Number	Percent	Number	Percent
Race						
White	655	86	75	95	26	84
Non-white	107	14	4	5	5	16
Sex						
Males	382	50	39	49	7	23
Females	380	50	40	51	24	77
Age						
- 25	75	10	4	5	5	16
25-44	364	48	25	32	13	42
45-64	323	42	50	63	13	42

IV Summary of Conclusions and Recommendations

A. Conclusions

A study of a national sample of the adult urban population indicates that the following types of people are more willing to cooperate on a free health examination: the non-white, younger and middle-aged, veterans, and lower income groups. Also, persons are more apt to commit themselves to cooperate on a health examination than to commit other members of their family.

Four basic attitudes and beliefs were demonstrated to be even more closely related to examination behavior than personal characteristics. These were:

1. Underlying attitudes and beliefs on health.
2. Beliefs as to the potential personal benefits to be derived from the health exam.
3. Beliefs as to the importance of furthering medical research
4. Belief as to the reasonableness and appropriateness of the examination procedures and arrangements.

Each of these attitudes and beliefs is described briefly below:

1. Underlying Health Attitudes and Beliefs

Underlying the degree of receptivity to a free medical examination are five general health attitudes and beliefs. Cooperators more often report agreement with these attitudes and beliefs, while non-cooperators generally report contrary beliefs.

a) The importance of good personal health as an objective in life. Cooperators more often believe that especially good health is essential to do one's work well, and, therefore, strive to maintain good health. Likewise, illness more often presents them with serious social and economic problems.

b) Interest and concern in health matters. Cooperators more often believe that the way one lives has a direct influence on one's health. They are also more interested in discussing, reading and listening to educational health programs.

c) Belief of personal susceptibility to illness. Cooperators more often admit the likelihood that they will be sick in bed during the next year and grant the possibility that they may become seriously ill in the next few years.

d) Belief of the need for professional diagnosis and care of illness. Cooperators show less confidence in self-diagnosis and more often feel they can become sick without being immediately aware of it. They also more often feel they should see a doctor right away for professional diagnosis and treatment upon appearance of a symptom.

e) Belief in the ability of modern medicine to cure or help illness. Cooperators more often believe that doctors have the know-how and facilities to cure or help relieve illness and disease.

2. Belief as to the Potential Personal Benefits to be Derived from the Health Exam

Cooperators usually state that they expect to benefit directly from the results of the examination. Underlying this strong personal motivation are the following three beliefs:

a) Dissatisfaction with personal efforts to care for health. Cooperators more often feel they could do more to take better care of their health.

b) Recognition of some personally unmet health needs which are susceptible to medical care. Cooperators more often report a desire to talk to their doctors about their health, and more often admit having felt the need to see a doctor without actually doing so for a variety of reasons.

c) Confidence in the skill and personal approach of their own doctor and doctors generally. Based on their personal experiences and on what they've heard or read, cooperators generally are more confident in their own doctors and in doctors generally. Non-cooperators report more criticisms of doctors and more often indicate a distrust of strange doctors by

limiting their willingness to come for the exam to the case where their own doctor gives it.

3. Belief in Importance of Aiding Medical Research

The most frequent reason given for agreeing to cooperate on the health exam is a desire to help the government in its research efforts. Underlying this motive are the following three different attitudes and beliefs:

a) Recognition of the need for additional medical research efforts. Cooperators are least satisfied with current efforts at finding causes and cures of disease. In addition, most people believe that research efforts will eventually succeed in discovering new cures for disease.

b) Recognition of the responsibility of government in maintaining the nation's health. Cooperators more often approve of government taking an active role in health research and in programs to promote the nation's health.

c) Recognition of personal responsibility in assisting medical research programs. Cooperators more often feel it is very important for them personally to cooperate on health research programs. Non-cooperators more often question whether their cooperation is essential to the success of the program.

4. Approval of the Reasonableness and Appropriateness of Examination Procedures and Arrangements

This is the last of the major conclusions and involves the convenience and approval of the arrangements for the examination.

a) Items of convenience. These include such considerations as: (1) Travel time, (2) duration of examination, (3) time of appointment, (4) place of exam, (5) mode of transportation provided, (6) persons offered exam, (7) type of doctors giving exam, and (8) kind of tests and procedures

APPENDIX A

NHS - NORC Form-1

Form Approved
Budget Bureau
No. 68-5804
Expires 6-30-58

NATIONAL OPINION RESEARCH CENTER
University of Chicago

FACE SHEET

NORC Respondent No. 1- 2- 3- 4-

Interviewer_____

ADDRESS_____ TEL. NO._____
(Street)

_____
(City)

HOUSEHOLD ENUMERATION OF ELIGIBLE RESPONDENTS

RESP. NO.	RESPONDENTS NAME	SEX	AGE

NHS PREVIOUS INTERVIEW: TIME_____ DATE_____

Best time to contact: TIME_____

Call	Date	Time	RECORD OF CALLS Result of Call	Completed Resp. No.
1st				
2nd				
3rd				
Later				

For Office Use Only

IDEN Code	PSU No.	Segment No.	Serial No.

NORC
Survey 410

Good (afternoon, evening) I'm from the National Opinion Research Center. As this letter says, the Public Health Service has asked us to do a special study for them and to ask you some additional questions. The first one is --

1. Would you say your own health, in general, is excellent, good, fair or poor?

Excellent	5-1
Good.	2
Fair.	3
Poor.	4
Don't know.	5

---

2. All in all, do you think that most people take the best possible care of their health, or could they take better care than they do?

Take best care.	6-1
Could take better care. . .	2
Don't know.	3

---

3. Would you say you take the best possible care of your own health now, or could you take better care of your health than you do?

Best possible care.	7-1
Could do more	2*
Don't know.	3

*A. IF "COULD DO MORE": What are some of the things you could do to take better care of your health? 8-

---

4. Do you think the way you live makes a great deal of difference in how healthy you are, makes some difference or hardly any difference at all?

Great deal.	9-1
Some difference	2
Hardly any.	3
Don't know.	4

5. Now, if you had a chance to talk to your doctor for half an hour, at no cost to you, are there any things about your health that you'd like to ask him?

Yes	10-1*
No	2**
Don't know	3

*A. IF "YES": What sort of things would you ask him about?

11-

**B. IF"NO": Why is that?

12-

---

6. A. Would you say you think about your health fairly often, once in a while or hardly ever?

B. Do you talk about your health with your family and friends fairly often, once in a while, or hardly ever?

	A. Think About	B. Talk About
Fairly often	13-1	14-1
Once in a while	2	2
Hardly ever	3	3
Don't know	4	4

7. During the last year, have you felt at any time that you should have seen a doctor, but didn't?

Yes	15-1*
No.	2
Don't know.	3

*IF "YES", ASK BOTH "A" & "B"

A. Was it anything that kept you from doing your regular work, or were you able to continue your usual activities?

Kept from doing	15-5
Able to continue.	6
Don't know.	7

B. Why didn't you see a doctor?

16-

---

8. A. Looking ahead over the next year, how likely do you think it is that you may be sick in bed for about a week all told -- very likely, only fairly likely, or not likely at all?

Very likely	17-1**
Fairly likely	2**
Not likely.	3*
Don't know.	4*

*B. IF "NOT LIKELY" OR "DON'T KNOW": How about being sick in bed for 3 or 4 days -- Would you say it is very likely, only fairly likely, or not likely at all?

Very likely	18-1**
Fairly likely	2**
Not likely.	3
Don't know.	4**

**IF "VERY LIKELY" OR "FAIRLY LIKELY" ON "A" OR "B" OR "DON'T KNOW" ON "B", ASK "C"

C. Do you think there's anything you could do to prevent that?

Yes	18-6
No.	7
Don't know.	8

---

9. And how likely does it seem to you that you might get tuberculosis, arthritis or a heart attack in the next 5 or 10 years -- Very likely, fairly likely or hardly likely at all?

Very likely	19-1
Fairly likely	2
Hardly likely	3
Don't know.	4

10. All in all, in order to do your work well, would you say that it is necessary for you to have especially good health, to have fairly good health, or could you do your work well even if you were not feeling so well?

Especially good	20-1
Fairly good	2
Not so well	3
Don't know.	4

---

11. A. Now, if you were sick in bed for a week, would there be somebody who's living here to take care of you, or could you get somebody in pretty easily or would it be hard to get somebody?

Somebody here	21-1
Get someone easily. . . .	2
Hard to get somebody. . .	3
Don't know.	4

B. By the way, do you have a job outside your home?

Yes	22-R*
No.	1

*IF "YES", ASK "C" & "D"

C. Would you lose all of your income during that time, or only part of it, or wouldn't you lose any income at all if you were sick in bed for a week?

Lose all income	22-3
Lose some income.	4
No income loss.	5
Don't know.	6

D. In other ways -- other than income, that is -- would it hurt you on your job a great deal, or some, or wouldn't it be very serious (if you were sick in bed for a week)?

Hurt great deal	22-8
Hurt some	9
Not very serious.	0
Don't know.	X

---

12. And how much trouble would the rest of the family have in taking care of the house if you were sick in bed for a week -- A great deal of trouble, some trouble, or not much at all?

Great deal.	23-1
Some trouble.	2
Not much at all	3
No family	4
Don't know.	5

---

13. Now suppose you had a large medical bill not covered by insurance -- say for $500 or more -- Would you have great difficulty in paying it right away, a moderate amount of difficulty, or hardly any difficulty at all?

Great difficulty.	24-1
Moderate amount	2
Hardly any.	3
Don't know.	4

14. Now I'd like to ask you about some particular illnesses. If a person should get (each condition) do you think he could tell right away something was wrong by the way he felt or might he not know for some time that something was wrong? How about (next condition)?

	Can tell Right Away		
	Yes	No	Don't Know
Diabetes.	25-1	2	3
Cancer.	26-1	2	3
Asthma.	27-1	2	3
Liver trouble	28-5	6	7
Arthritis or rheumatism	29-5	6	7
Polio	30-5	6	7
Tuberculosis.	31-9	0	X
Heart trouble	32-9	0	X

---

15. From what you've heard or read, do you happen to know any of the signs or symptoms of polio? (What are they?) Any other ways a person could tell he had polio?

33-

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16. How about T.B. (tuberculosis) -- Do you happen to know any of the signs or symptoms of T.B.? (What are they?) Any other ways a person could tell he might have T.B.?

34-

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17. And how about diabetes -- What are its signs or symptoms? Any other ways a person could tell he might have diabetes?

35-

18. Now on this card is a list of health conditions that people sometimes have. I'll read each one and I'd like you to tell me if you think a person should see a doctor about it immediatley, if he should take care of it himself unless it gets worse, or if he should leave it alone? First, how about "coughing for 5 or 6 days?" /How about (next condition)?/

	See Doctor	Cure Self	Leave Alone	Don't Know
1. Coughing for 5 or 6 days.	36-1	2	3	4
2. Diarrhea or constipation for several days . .	37-1	2	3	4
3. Feeling tired all the time.	38-1	2	2	4
4. Frequent headaches.	39-5	6	7	8
5. Lump or discolored patches on skin.	40-5	6	7	8
6. Shortness of breath	41-5	6	7	8
7. Sore throat, running nose	42-1	2	3	4
8. Unexpected loss of 10 pounds.	43-1	2	3	4
9. Feeling thirsty all the time.	44-1	2	3	4
10. Pains in the chest.	45-5	6	7	8
11. Pains in the stomach.	46-5	6	7	8

19. A. Now, on the other side of that card (HAVE RESPONDENT TURN CARD OVER) -- I'd like you to tell me if you yourself had any of these conditions at any time during the last year or so? (Circle under "A" all those mentioned.) The first one is "coughing for 5 or 6 days"?

*B. FOR EACH CONDITION MENTIONED IN "A", ASK: Did you happen to see a doctor about (condition) in the past year? (Circle one of the three codes under "B")

	A. Have Had	B. Saw Doctor	No Doctor	Don't Know
1. Coughing for 5 or 6 days	47-1*	2	3**	4
2. Diarrhea or constipation for several days	48-1*	2	3**	4
3. Feeling tired all the time	49-1*	2	3**	4
4. Frequent headaches	50-1*	2	3**	4
5. Lump or discolored patches on skin	51-1*	2	3**	4
6. Shortness of breath	52-5*	6	7**	8
7. Sore throat, running nose	53-5*	6	7**	8
8. Unexpected loss of 10 pounds	54-5*	6	7**	8
9. Feeling thirsty all the time	55-5*	6	7**	8
10. Pains in the chest	56-5*	6	7**	8
11. Pains in the stomach	57-1*	2	3**	4
12. Allergy	58-1*	2	3**	4
13. Arthritis, rheumatism	59-1*	2	3**	4
14. Asthma	60-1*	2	3**	4
15. Diabetes	61-1*	2	3**	4
16. Gall bladder or liver trouble	62-5*	6	7**	8
17. Heart trouble	63-5*	6	7**	8
18. High blood pressure	64-5*	6	7**	8
19. Kidney trouble	65-5*	6	7**	8
20. Piles	66-5*	6	7**	8
21. Sinus trouble	67-1*	2	3**	4
22. Varicose veins	68-1*	2	3**	4
None of them	68-X	-	-	-

**IF HAD CONDITION AND DID NOT SEE DOCTOR, ASK "C"

C. How is it that you didn't see a doctor about (conditions with Code 3 or 7 circled)? (Write number of each condition before answer.)

69-

20. Now, if a person had an "allergy," do you think a doctor could cure it completely, could he help it but perhaps not cure it, or couldn't he help it at all? How about (next condition)?

	Complete Cure	Help Not Cure	Couldn't Help	Don't Know
1. Allergy	70-1	2	3	4
2. Arthritis or rheumatism	71-1	2	3	4
3. Asthma	72-1	2	3	4
4. Diabetes	73-1	2	3	4
5. Gall bladder trouble	74-1	2	3	4
6. Heart trouble	75-5	6	7	8
7. High blood pressure	76-5	6	7	8
8. Kidney trouble	77-5	6	7	8
9. Piles	78-5	6	7	8
10. Sinus trouble	79-5	6	7	8
11. Varicose veins	80-5	6	7	8

21. Compared to 30 years ago, do you think people's chances for living a healthy life are much better, a little better, much worse, or a little worse than they used to be?

Much better	5-1
Little better	2
Much worse	3
Little worse	4
About the same	5
Don't know	6

22. All in all, how much interest do you think doctors take in their patients today compared to 30 years ago -- much more, a little more, much less, or a little less interest than they used to?

Much more	6-1
Little more	2
Much less	3
Little less	4
About the same	5
Don't know	6

23. Do you think doctors today know a lot more about treating sicknesses, a little more, a lot less, or a little less than they did 30 years ago?

A lot more	7-1
Little more	2
Lot less	3
Little less	4
About the same	5
Don't know	6

1- 2- 3- 4-

24. And do you think the medicines we have today are much better, a little better, or worse than they were 30 years ago?

Much better.	8-1
Little better.	2
Worse.	3
About the same	4
Don't know.	5

---

25. Do you think enough is being done in this country to discover the causes of disease?

Yes.	8-7
No	8
Don't know	9

---

26. And do you think enough is being done to discover new cures for disease?

Yes.	9-1
No	2
Don't know	3

---

27. And have you ever had a complete physical examination?

Yes	10-1*
No.	2

*IF "YES", ASK "A", "B" & "C"

A. Do you get a complete physical exam regularly every year or two, or just occasionally?

Every year or two	10-4
Just occasionally	5
Don't know.	6

B. About how long ago was the last time?

Less than 1 year.	11-1
1 year, less than 2	2
2 years, less than 3. . . .	3
3 years, less than 5. . . .	4
5 years, less than 10 . . .	5
10 years or more.	6

C. Why did you go to the doctor at that time?

12-

28. And have you ever gone to a doctor for a check-up or examination even though you didn't think you had anything especially wrong with you?

Yes	13-1*
No	2

*IF "YES", ASK "A" & "B"

A. About how long ago was this?

Less than 1 year	13-4
1 year, less than 2	5
2 years, less than 3	6
3 years, less than 5	7
5 years, less than 10	8
10 years or more	9

B. And why did you go to the doctor then?

14-

---

29. Now here are some reasons people give for not seeing a doctor. For each one, I'd like you to tell me whether you yourself have ever felt this way. (Some people say (read statement). Have you ever felt this way?)

	Yes	No	Don't Know
A. I mean to go but something always seems to come up	15-1	2	3
B. I don't like to bother the doctor unless I'm sick	16-1	2	3
C. Regular exams just make you worry -- it's like looking for trouble	17-1	2	3
D. I don't like doctors and avoid them as much as possible	18-1	2	3
E. I don't want to spend the money if I'm feeling all right	19-1	2	3
F. A person understands his own health better than most doctors do	20-4	5	6
G. I don't like being examined -- the doctor might hurt me or make me feel uncomfortable	21-4	5	6
H. The doctor might tell me I needed some expensive medicine or treatment	22-4	5	6
I. Disease is a punishment for our sins and can't be avoided	23-4	5	6
J. I don't think doctors can help me any	24-4	5	6
K. I don't want my family or friends to know I'm sick	25-7	8	9
L. The doctor's office is so far away	26-7	8	9
M. I don't want to waste so much time waiting for the doctor to see me	27-7	8	9
N. The doctor might want me to change my ways, like rest more or stop smoking	28-7	8	9
O. If I'm sick, I can get better by myself without any doctor	29-7	8	9
P. The doctor might want to put me in a hospital	30-9	0	X
Q. You don't learn much about your health from regular check-ups	31-9	0	X
R. If you feel alright, the chances are you are alright	32-9	0	X

30. During the last year, has anyone suggested you see a doctor, but you didn't go?

Yes	33-1*
No.	2

*IF "YES", ASK "A" & "B"

A. Who was that?

Spouse.	33-4
Other relative.	5
Friend, acquaintance. . .	6
Other (specify)_____	7

B. Why didn't you go?

34-

---

31. Do you ever argue with anyone else in the family about whether one of you should see a doctor?

Yes	35-1*
No.	2
No family	3
Don't know.	4

*A. IF "YES": Who wants who to go to the doctor?

35-

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32. Do you have a doctor or clinic you usually go to when you're sick?

Yes	36-1*
No.	2**

*A. IF "YES": What kind of doctor (clinic) is he (it)?

**B. IF "NO": Have you ever had a regular doctor whom you'd go to when you were sick?

Yes	36-4
No.	5

33. During the past year, have you or anyone in your family been to:

	Yes	No	Don't Know
A. A chiropractor	37-1	2	3
B. An osteopath	5	6	7
C. A medical doctor	9	0	X
D. Any other person for treatment or healing (specify type) _____	38-1	2	3

34. Some people say they're afraid of seeing a doctor. What do you suppose they mean by that?

39-

35. Now could you tell me if you yourself, or anyone you know, ever had any bad experience with a doctor which made you lose some confidence in doctors generally?

Yes	40-1*
No	2

*IF "YES", ASK "A", "B", & "C"

A. Who had that experience?

Respondent	40-4
Spouse or child	5
Other relative	6
Friend, acquaintance	7

B. About how long ago was that (the last time)?

Less than 1 year ago	41-1
1 year, less than 3	2
3 years, less than 5	3
5 years, less than 10	4
10 years, less than 25	5
25 years or more	6

C. What was it that made you lose some confidence in doctors?

42-

36. And how would you rate your doctor in comparing him with most other doctors in the United States -- Would you say he is much better than most, or a little better than most, about average or not as good as most?

Much better	43-1
A little better	2
About average	3
Not as good	4
Don't know.	5

---

37. Have you been entirely satisfied with the care and treatment you and your family got from doctors during the past five years or so, or were there some things about the care that you were not satisfied with?

Entirely satisfied. . . .	43-7
Some things not	8*
Don't know.	9

*A. IF "SOME THINGS NOT": What was that?

44-

---

38. Could you tell me if you read about health matters in newspapers or magazines often, once in a while or hardly ever?

Often	45-1
Once in a while	2
Hardly ever	3*
Don't know.	4

*A. IF "HARDLY EVER": Is that because you don't read the newspapers or magazines much or because you usually skip the health items?

Don't read papers, magazines	45-6
Skip health items	7
Other reason (specify). .	8
Don't know.	9

---

39. How about radio and television programs dealing with health or medicine -- Do you listen to those often, once in a while, or hardly ever?

Often	46-1
Once in a while	2
Hardly ever	3*
Don't know.	4

*A. IF "HARDLY EVER": Is that because you don't listen to radio or television very much, or because you don't tune in on health programs?

Don't listen much	46-6
Don't tune in health. . .	7
Other (specify)	8
Don't know.	9

40. A. Now here are some things people sometimes don't like about doctors. I'd like to know whether you personally think they are true of most doctors, true of some doctors, or true of hardly any. For example (Read "A") -- Do you think that's true of most doctors, true of some doctors, or true of hardly any?

*B. FOR EACH "ASTERISKED" ANSWER, ASK: Have you yourself ever had a doctor like this?

	A.				B.		
	Most	Some	Hardly Any	Don't Know	Yes	No	Don't Know
a. They don't give you a chance to tell them exactly what your trouble is .	47-1*	2*	3	4	6	7	8
b. They don't take enough personal interest in you	48-1*	2*	3	4	6	7	8
c. They don't give enough free time to people who need it.	49-1*	2*	3	4	6	7	8
d. Doctors like to give you medicine even if you don't need it	50-1*	2*	3	4	6	7	8
e. Doctors don't like to get other doctors' opinions about a condition	51-1*	2*	3	4	6	7	8
f. Doctors give better care to their regular patients than to people they don't know so well	52-1*	2*	3	4	6	7	8
g. They don't tell you the things you ought to know	53-1*	2*	3	4	6	7	8
h. Doctors don't set appointments right -- you have to wait too long to see them.	54-1*	2*	3	4	6	7	8
i. Doctors want you to come back for additional visits even if you don't need to	55-1*	2*	3	4	6	7	8
j. Doctors are more interested in making a lot of money than in finding out what is really wrong with you . . .	56-1*	2*	3	4	6	7	8
k. Doctors hurt you when they examine you and make you feel worse than when you came in.	57-1*	2*	3	4	6	7	8
l. Doctors take advantage and charge you more than they should	58-1*	2*	3	4	6	7	8
m. Doctors are too old fashioned and don't keep up with modern medicine.	59-1*	2*	3	4	6	7	8
n. Doctors work too fast and make mistakes in finding out what's wrong with you.	60-1*	2*	3	4	6	7	8
o. Doctors aren't careful and gentle enough when they examine you. . . .	61-1*	2*	3	4	6	7	8

41. A. During the last five years or so, have you received any care or treatment at any clinic or medical center?

Yes	62-1**
No.	2*
Don't know.	3

*B. IF "NO": Have you ever received any care or treatment at a clinic or medical center?

Yes	62-5**
No.	6
Don't know.	7

**IF "YES" TO "A" OR "B", ASK "C" & "D"

C. Was it a public or private one?

Public.	62-9
Private	0
Don't know.	X

D. Were you always entirely satisfied with the care and treatment they gave you, or were there some things you were not so satisfied with?

Entirely satisfied. . . .	63-1
Not satisfied	2***
Don't know.	3

***E. IF "NOT SATISFIED": What was the trouble?

64-

---

42. Has anyone you know ever had an experience with a public clinic which gave you a poor opinion of that service?

Yes	65-1*
No.	2
Don't know.	3

*IF "YES", ASK "A" & "B"

A. Who was that?

Spouse, child	65-5
Other relative.	6
Friend.	7
Other (specify)_____	8
Don't know.	9

B. What was the trouble?

66-

43. As you probably know, some doctors are hired by groups or business firms, to practice medicine on a salaried basis. From what you've read or heard, do you think most doctors who work for a salary are likely to treat their patients better, or worse, or about the same as private doctors who charge fees?

Better.	67-1*
Worse	2*
About the same.	3
Don't know.	4

*A. IF "BETTER" OR "WORSE": In what way do they treat their patients (better, worse) than private doctors?

68-

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44. Now I'd like to read you some things people sometimes dislike about public clinics. For each one, I'd like you to tell me whether you think it is generally true or not true about public clinics:

	True	Not True	Don't Know
A. The doctors are not as experienced or well trained . .	69-1	2	3
B. They are too busy to give you personal attention . . .	70-1	2	3
C. They don't have up to date equipment	71-1	2	3
D. They aren't concerned about the patient's feelings . .	72-4	5	6
E. You have to wait a long time until a doctor sees you .	73-4	5	6
F. You are sent to a different doctor every time.	74-4	5	6
G. The doctors don't try hard enough because you don't pay them for their services.	75-7	8	9
H. They're not as considerate or gentle when they examine you.	76-7	8	9
I. They make you feel as if they are doing you a favor to see you	77-7	8	9

45. As you may know, the Public Health Service carries on several different kinds of programs -- like studies on illnesses, aid for building new hospitals and helping communities with their health problems. Are you entirely satisfied with the job now being done by the public health people, or are there some things you feel they dould do better?

Entirely satisfied.	78-1
Could do better	2*
Don't know.	3

*A. IF "COULD DO BETTER": What are some of the things you think they could do?

79-

80-

---

46. Now here are some different statements about the government and health. I'd like you to tell me whether you agree or disagree with each one. Now first, "The people's health is no . . ." -- Do you agree or disagree?

	Agree	Disagree	Don't Know
A. The people's health is no business of the government	5-1	2	3
B. All doctors should work for the government and be paid a salary	6-1	2	3
C. The government should test all new vaccines and medicines for safety	7-1	2	3
D. The government should not provide free doctors' services for the needy.	8-4	5	6
E. The government should not set up its own laboratories for research.	9-4	5	6
F. The government should not privide any health insurance for the people to help pay for doctor and hospital bills.	10-4	5	6
G. The government should give private hospitals and universities money for research.	11-7	8	9
H. The government should make studies and publish information on the nation's health	12-7	8	9

47. As you might expect, the Public Health Service cannot learn all they need to know about health in the nation just by asking questions. For some things they need actual measurements and tests. How do you think most people you know will feel about helping on that part of the survey -- Will they certainly come, probably come or probably not come for these measurements and tests?

Certainly come.	13-1
Probably come	2
Probably not come	3
Don't know.	4

---

48. Before you yourself decided on coming, would you have any questions about the tests you'd want to find out about?

Yes	14-1*
No.	2
Don't know.	3

*A. IF "YES": What are they? 15-

---

49. A. What sort of tests do you think they would give you? (Any others?) 16-

B. Is there anything you'd especially like them to check about your own health? 17-

C. Is there anything you'd rather they did not do in such an examination? 18-

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47. As you might expect, the Public Health Service cannot learn all they need to know about health in the nation just by asking questions. For some things they need actual measurements and tests. How do you think most people you know will feel about helping on that part of the survey -- Will they certainly come, probably come or probably not come for these measurements and tests?

Certainly come.	13-1
Probably come	2
Probably not come	3
Don't know.	4

---

48. A. If you yourself are asked to come for the tests and measurements part of the survey, will you certainly come, probably come, or probably not come?

Certainly come.	13-6
Probably come	7
Probably not come	8
Don't know.	9

B. Why is that?

---

49. Before you decided on coming, would you have any questions about the tests you'd want to find out about?

Yes	14-1*
No.	2
Don't know.	3

*A. IF "YES": What are they?

15-

---

50. A. What sort of tests do you think they would give you? (Any others?)

16-

B. Is there anything you'd especially like them to check about your own health?

17-

C. Is there anything you'd rather they did not do in such an examination?

18-

50. A. Now if you yourself are asked to come for the tests and measurements part of the survey, will you certainly come, probably come, or probably not come?

Certainly come.	13-6**
Probably come	7**
Probably not come	8*
Don't know.	9*

*
**ASK EVERYBODY

B. Why is that?

*IF "PROBABLY NOT COME" OR "DON'T KNOW", SKIP PART C AND ASK Q. 51-55

**IF "CERTAINLY COME" OR "PROBABLY COME", ASK PART C, THEN SKIP Q. 51-52 AND ASK Q. 53-55

C. Now, my instructions are to arrange an appointment with a (man)(woman) from this house for the tests and measurements part of the survey -- and I guess that's you. We are planning to give these tests during the second and third weeks of June -- that is, from Monday June 9 to Saturday June 21.

For your convenience we have arranged for a taxicab to bring you to our offices and to take you home. The entire examination will take about an hour, and in order to help us schedule the appointments, I wonder if you could tell me just when you would be available to come.

(1) First, could you come on Monday the 9th of June?

IF "YES", ASK (2) - (4)

(2) Could you come in the morning from 8:30 to 11 A.M.?
(3) Could you come in the afternoon from 1 to 5:30 P.M.?
(4) Could you come in the evening from 6:30 to 9 P.M.?

(How about Tuesday the 10th of June? etc.)

	Day			Time of Day						Day			Time of Day					
				Morning		Afternoon		Evening					Morning		Afternoon		Evening	
	June	Yes	No	Yes	No	Yes	No	Yes	No	June	Yes	No	Yes	No	Yes	No	Yes	No
Monday	9	1	2	1	2	1	2	1	2	16	1	2	1	2	1	2	1	2
Tuesday	10	1	2	1	2	1	2	1	2	17	1	2	1	2	1	2	1	2
Wednesday	11	1	2	1	2	1	2	1	2	18	1	2	1	2	1	2	1	2
Thursday	12	1	2	1	2	1	2	1	2	19	1	2	1	2	1	2	1	2
Friday	13	1	2	1	2	1	2	1	2	20	1	2	1	2	1	2	1	2
Saturday	14	1	2	1	2	1	2	1	2	21	1	2	1	2	1	2	1	2

NOTE: IF "NO" TO ALL DAYS LISTED ABOVE, ASK: "When would you be able to come?

_____

		More Likely	Less Likely	No Difference	Don't Know
51.	A. If you knew that your own doctor approved of your coming, would you be more likely to come, would you be less likely to come or wouldn't it make any difference in your coming for the tests and measurements?	19-1	2	3	4
	B. If you knew the local medical society approved of your coming, would you be more likely to come, would you be less likely to come, or wouldn't it make any difference in your coming for the examination?	20-1	2	3	4
	C. How about your religious advisor -- If he approved, would you be more likely to come?	21-1	2	3	4
	D. How about the local newspaper or radio-TV station -- If they approved, would you be more likely to come?	22-1	2	3	4
	E. Last, if your (spouse) or friends approved, would you be more likely to come?	23-1	2	3	4

52. In planning for the tests, we are interested in finding out what arrangements will make it easier for the greatest number of people to come. I am going to read you some of the different ways the exam can be arranged and for each one I would like you to tell me if you will certainly come, if you will probably come, or if you probably won't come. The first one is (read A-1).

		Will Certainly Come	Will Probably Come	Probably Won't Come	Not Appropriate	Don't Know
A.	1. If it is given at: A place just 5-10 minutes from your home	24-1	2	3	4	5
	2. A place just 15-20 minutes from your home	25-1	2	3	4	5
	3. A place an hour from your home	26-1	2	3	4	5
B.	1. What if it is given on a morning during the week. .	27-1	2	3	4	5
	2. On an afternoon during the week	28-1	2	3	4	5
	3. On an evening during the week	29-1	2	3	4	5
	4. On a Saturday morning. . . .	30-1	2	3	4	5
	5. On a Saturday afternoon. . .	31-1	2	3	4	5

Question 52 continued	Will Certainly Come	Will Probably Come	Probably Won't Come	Not Appropriate	Don't Know
C. 1. If your taxicab fare is paid	32-6	7	8	9	0
2. If a baby sitter were paid for when needed.	33-6	7	8	9	0
3. If you were paid for the time spent at the examination.	34-6	7	8	9	0
D. 1. What if it was at a hospital or medical center	35-1	2	3	4	5
2. If it was at a church or school	36-1	2	3	4	5
3. At a special trailer unit parked outside	37-1	2	3	4	5
4. At a local doctor's office .	38-1	2	3	4	5
E. 1. If your own doctor gave the exam	39-6	7	8	9	0
2. If some other local doctors gave the exam.	40-6	7	8	9	0
3. If some specialists approved by the American Medical Association gave the exam.	41-6	7	8	9	0
F. 1. If the exam took only about half an hour	42-1	2	3	4	5
2. If the exam took about an hour.	43-1	2	3	4	5
3. If the exam took an hour and a half	44-1	2	3	4	5
4. If a second visit were also necessary to get a more complete exam.	45-1	2	3	4	5
G. 1. If all the grown-ups in your home were offered the exam	46-6	7	8	9	0
2. If the children were also offered the exam	47-6	7	8	9	0
3. If only you were selected for the exam	48-6	7	8	9	0
H. 1. If you were asked to undress completely	49-1	2	3	4	5
2. If you were asked to undress above the waist.	50-1	2	3	4	5
3. If you could wear a coverall gown	51-1	2	3	4	5

I. Would any (other) arrangement make it (more) possible for you to come?

*IF "YES": What is that?

Yes 52-1*
No. 2
Don't know. 3

Now here are just a few different questions and we'll be through.

53. Before the Census interviewer asked you about your own health -- Had you ever been interviewed before?

Yes	54-1
No	2
Don't know	3

54. How important do you feel it is for people to cooperate on opinion surveys such as this, very important, fairly important or hardly important at all?

Very important	55-1
Fairly important	2
Hardly important	3
Don't know	4

55. And in what countries were your parents born?

Mother_____

Father_____ 59-

60-

61-

62-

63-

64-

I wonder if I could (use your telephone to) (go outside to) call the office and get a definite appointment for you while I'm here. (Of course, I'll pay you for the call.)

Date:_____ Time began:_____ Time finished:_____

Used in National

Now here are just a few different questions and we'll be through.

---

53. Before the Census interviewer asked you about your own health -- Had you ever been interviewed before?

Yes	54-1
No.	2
Don't know.	3

---

54. How important do you feel it is for people to cooperate on opinion surveys such as this, very important, fairly important or hardly important at all?

Very important.	55-1
Fairly important.	2
Hardly important.	3
Don't know.	4

---

55. A. By the way, what is your religious preference?

Protestant.	56-1*
Catholic.	2
Jewish.	3
Other (specify)	4
None.	5

*B. IF "PROTESTANT": What denomination?

C. How often do you attend church (synagogue) services?

Once a week or more . . .	57-1
1-3 times a month	2
Less than once a month. .	3
Never	4

D. Quite apart from church (synagogue) going, how important would you say religion is to you -- very important, fairly important, or not important at all?

Very important.	58-1
Fairly important.	2
Not important at all. . .	3
Don't know.	4

---

56. And in what countries were your parents born?

59-

Mother_____ 60-

Father_____ 61-

62-

63-

Date:_____ Time began:_____ Time finished:_____ 64-

Appendix A-2

OUTLINE
STRUCTURE AND RATIONALE OF QUESTIONNAIRE

Question Number	Contents	Use
1	Rating of health	Satisfaction overall health
2	Care of health - most people	Importance of health
3	Care of health - self	Concern of own unmet needs
4	Effect of living activities on health	Role of good health practice
5	Free chance to talk to doctor	Concern of own unmet needs
6	Think and talk about health	Importance of health
7	Should see doctor - didn't	Early diagnosis
8	Possibility of getting sick and avoiding	Role of individual effort
9	Possibility of getting specific illnesses	Belief in possible future illness
10	Importance of health to work	Importance of health
11	Specific effects of illness on activities	Importance of good health
12	General effect of illness on family	Importance of good health
13	Financial ability to pay large bill	Importance of good health
14	Immediate detection of ill health	Need for professional diagnosis
15-17	Knowledge of Polio, TB, Diabetes	Identification of symptoms
18	See doctor or not	Belief in early diagnosis
19	Experience with illness - past year	Belief in early diagnosis
20	Can cure or not	Belief in medical knowledge
21-24	Chances good health - now vs. 30 years ago	Belief in present medical knowledge to diagnose and treat illness
25-26	Satisfaction with research	Concern for health matters
27	Experience with check-ups	Belief in early diagnosis
28	Experience with check-ups, no illness	Belief in early diagnosis
29	Reasons for not getting check-up	Belief in early diagnosis and treatment
30	Friends suggested seeing doctor	Attitude toward doctors
31	Argue with someone in family to see doctor	Belief in unmet needs
32	Have regular doctor or clinic	Availability of services
33	Experience with medical people other than doctor	Availability of services
34	Fear of seeing doctors	Attitude toward doctors

Question Number	Contents	Use
35	Unfavorable experience with doctor	Attitude toward doctors
36	Rating of own doctor	Attitude toward doctors
37	Satisfaction with doctor's services	Attitude toward doctors
38	Read about health in newspapers or in magazines	Exposure to media
39	Hear and see about health on radio and TV	Exposure to media
40	Statements about doctors	Attitudes toward doctors and examinations
41	Experience with clinics	Attitude toward clinics
42	Unfavorable experience with clinics	Attitude toward clinics
43	Quality of services by salaried doctors	Attitude toward clinics
44	Dislikes about clinics	Attitude toward clinics
45	Satisfaction with Public Health Service	Attitude toward Public Health
46	Statements about Government and health	Attitude toward Government and health
47	Most people's willingness to take Public Health exam	Acceptance of Public Health exam
48	Personal willingness to take exam	Acceptance of Public Health exam
49	General questions about exam	Acceptance of Public Health exam
50	Conception of contents of exam	Acceptance of Public Health exam
51	Effects of prestige people on decision	Acceptance of Public Health exam
52	Specific conditions of exam	Acceptance of Public Health exam
53	Experience with interviews	Public spiritness
54	Importance of social studies, polls	Public spiritness
56	Parent's birthplace	Demographic data

A-4

This is to introduce a representative of the National Opinion Research Center of the University of Chicago, doing a special study for the Public Health Service, U. S. Department of Health, Education, and Welfare.

As part of the U. S. National Health Survey, you—or some member of your household—were interviewed not long ago about your health experience. We are now following up to get some different information—this time, your opinion on certain health matters.

Anything you tell us will, of course, be held in confidence. It will be used only after being combined with what other people tell us and in a way that no person or family can be identified. Your cooperation will be very much appreciated.

Leroy E. Burney

Leroy E. Burney
Surgeon General

APPENDIX C

Suggested Questions to be Used for Screening Potential Non-Cooperators

The following four questions were initially selected as sensitive indicators of potential non-cooperators.

A. If you had a chance to talk to your own doctor for half an hour at no cost to you, are there any things about your health you'd like to ask him?

B. As you might expect, the Public Health Service cannot learn all they need to know about health in the nation just by asking questions. For some things they need actual measurements and tests. How do you think most people you know will feel about helping on that part of the survey -- Will they certainly come, probably come or probably not come for these measurements and tests?

IF "PROBABLY NOT COME": Why is that?

C. Could you tell me how often you listen to radio or TV programs dealing with health or medicine -- often, once in a while or hardly ever?

D. By the way, how important do you feel it is for people to cooperate on surveys such as this -- very important, fairly important, or hardly important at all?

From an examination of the marginal tabulations, it was decided to dichotomize all answers to these four questions as follows:

A_1 Desire to talk to doctor

A_2 No desire or don't know if desire to talk to doctor

B_1 Most people will certainly or probably come

B_2 Most people will probably not come or don't know if they will come

C_1 Listen to health programs "often" or "once in a while."

C_2 Listen to health programs "hardly ever" or "don't know."

TABLE 86

COOPERATION GROUPS FILTERED BY FOUR SCREENING QUESTIONS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Responsents	762	249	237	53	92	79
A_1 B_1 C_1 D_1	143	84	38	1	10	2
A_1 B_1 C_1 D_2	22	3	13	-	4	-
A_1 B_1 C_2 D_1	38	21	10	1	4	-
A_1 B_2 C_1 D_1	44	16	12	6	6	3
A_2 B_1 C_1 D_1	140	56	47	2	23	5
A_1 B_1 C_2 D_2	22	5	14	-	2	-
A_1 B_2 C_1 D_2	10	-	3	4	1	-
A_1 B_2 C_2 D_1	18	3	10	1	1	3
A_2 B_1 C_1 D_2	62	9	26	3	12	10
A_2 B_1 C_2 D_1	62	22	20	2	6	6
A_2 B_2 C_1 D_1	51	14	10	5	8	10
A_1 B_2 C_2 D_2	10	-	1	2	1	5
A_2 B_1 C_2 D_2	30	7	11	2	5	3
A_2 B_2 C_1 D_2	34	1	8	5	3	12
A_2 B_2 C_2 D_1	34	7	7	9	2	4
A_2 B_2 C_2 D_2	42	1	7	10	4	16
Number Respondents						
4 No's	42	1	7	10	4	16
3 No's	108	15	27	18	11	24
2 No's	225	53	83	15	30	29
1 No	244	96	82	9	37	8
4 Yes's	143	84	38	1	10	2
	762	249	237	53	92	79
Percent Respondents						
4 No's	5%	*%	3%	19%	4%	20%
3 No's	14	6	11	34	12	30
2 No's	30	21	35	28	33	37
1 No	32	39	35	17	40	10
4 Yes's	19	34	16	2	11	3

D_1 Feel it is "very important" for people to cooperate

D_2 Feel it is "fairly important," "hardly important" or "don't know"

These eight dichotomous answers were then cross-tabulated into 16 groups as shown in Table 86.

As can be seen, any three "no" responses would filter only 50 percent of the consistent "No-No's", 53 percent of the "Yes-No's", but also 27 percent of the "Yes-Certainly" and 49 percent of the "Yes-Probably" groups. If any two "no's" are taken as the filtering criteria, the number of "non-cooperators" is increased to 87 percent for the "No-No's" and 81 percent for the "Yes-No's" but the number of "Yes-Yes's" are also increased considerably. Upon inspection of the "Yes-Yes's" included in the screening, it was discovered that question C contributed most of the false positives. Table 87 shows the cross-tabulations of Questions A, B and D only.

As Table 87 shows, if respondents with any two "No's" are screened by these questions, about three-fourths of the non-cooperators are segregated, and only 16 percent of the "Yes-Certainly" and 31 percent of the "Yes-Probably" are falsely selected. The combined "Yes-Yes" false positives would amount to only 23 percent and if the "No-Yes" group is also added to the "Yes-Yes" group, the total false positives would represent only 25 percent of the cooperators. Since the vacillating "No-Yes" and less certain "Yes-Probably" groups may include respondents who could benefit from a more skilled persuader's efforts, the number of false positives is not believed to be too great.

TABLE 87

COOPERATION GROUPS FILTERED BY THREE SCREENING QUESTIONS

	All Persons	Census: YES NORC Certainly	Census: YES NORC Probably	Census: YES NORC No-DK	Census: NO NORC Yes	Census: NO NORC No-DK
Number of Respondents	762	249	237	53	92	79
A_2 B_2 D_2	76	2	15	15	7	28
A_2 B_2 D_1	85	21	17	14	10	14
A_2 B_1 D_2	92	16	37	5	17	13
A_1 B_2 D_2	20	-	4	6	2	5
A_2 B_1 D_1	202	78	67	4	29	11
A_1 B_2 D_1	62	19	22	7	7	6
A_1 B_1 D_2	44	8	27	-	6	-
A_1 B_1 D_1	181	105	48	2	14	2
Number Respondents	762	249	237	53	92	79
3 No's	76	2	15	15	7	28
2 No's	197	37	58	25	29	32
1 No	308	105	116	11	42	17
3 Yes's	181	105	48	2	14	2
Percent Respondents	100%	100%	100%	100%	100%	100%
3 No's	10	1	6	28	8	35
2 No's	26	15	25	47	31	41
1 No	40	42	49	21	46	21
3 Yes's	24	42	20	4	15	3

Appendix A-3

NORC-410-3
3-15-58

GENERAL INSTRUCTIONS

AND

SPECIFICATIONS

NATIONAL OPINION RESEARCH CENTER
University of Chicago

Please read this material first
before studying other materials

I

MATERIALS AND PREPARATION

1. SURVEY NUMBER

This is Survey 410. Please refer to it by that number in filling out your forms and in correspondence with the office.

2. ADDRESS CORRESPONDENCE TO NEW YORK

The New York office (Pearl Zinner, Field Supervisor) is in charge of the interviewing on this survey.

If you should not be able to complete an assignment, or if you need additional materials of any kind, or if you have any questions about this survey, write or wire NATIONAL OPINION RESEARCH CENTER, 100 FIFTH AVENUE, NEW YORK 11, NEW YORK.

3. TIME LIMIT

It is our aim to complete all interviewing on this study by the end of April. It should be noted that there will be two series of different interviews in this survey -- an initial household interview with the entire sample, and a brief follow-up interview with a smaller sub-sample.

The assignment that is included in this mailing concerns the initial household interview. In general, a week is being allowed to complete about six interviews, and we expect to complete all initial household interviews by early April. Since the number of assigned interviews differs for each interviewer, individual deadlines have already been given on the advance notices. If additional time is required, please request an extension. We urge you, however, to work as much and as fast as you conveniently can.

The second series of follow-up interviews will be selected from the initial respondents, and assignments and instructions will be mailed to you shortly. Interviewing on this phase will begin about April 14 and should be completed by April 30. Most of these follow-up interviews will be by telephone and will require only a few minutes conversation. Where phones are not available and, in a few other instances, home visits will be necessary. Detailed individual instructions will be sent you as soon as the sub-sample has been selected. In no instance should you advise a respondent that he may be interviewed again. The preliminary notice of the follow-up interviewing is for your information only.

4. ASSIGNMENT SHEETS AND MAPS

Each household to be interviewed has been assigned a number. On the face sheet attached to each questionnaire has been listed this household number along with the address and the names of the eligible respondents living there. Only one adult will be interviewed from each household and you will make your selection from the eligibles listed on the Face Sheet. The household number has also been listed on the pink Assignment Tally Sheet. Each Assignment Tally Sheet with its list of household numbers constitutes one assignment.

Attached to the pink Assignment Tally Sheet is a map to help you locate your assigned homes.

The number of households included on each Assignment Tally Sheet will vary. In our advance notices we gave you the approximate number of cases that would be assigned to you. As will be explained in a following section, the actual number of cases included in each assignment may differ from the initially expected number. The number listed on your Assignment Tally Sheet, however, constitutes your actual assignment. Most interviewers will receive only one assignment but in cases where more than one assignment has been planned, advance notices have already been given.

Use your Tally Sheet to keep track of your completed interviews, and be sure to write in the last column of the tally sheet the respondent number of each completed interview. (See section on "How to Proceed" for discussion of respondent numbers.) When you have done all of the interviews listed on the tally sheet, return it to us with the completed interviews.

5. RETURN OF COMPLETED INTERVIEWS

Mail an envelope to New York every week -- Friday night or Saturday -- with as many questionnaires as you have completed. Please note that no postage is needed on these envelopes. Postage is paid by the office when the envelope arrives. Also include your week's Time and Expense report and any Unavailable Sheets which are required.

After completing all interviews listed on your pink Assignment Tally Sheet, return it to us. Also be sure to return the map describing the assigned area.

After completing all assignments (some interviewers have been notified that they will receive more than one assignment) please send us your Interviewer Report Form, summarizing your reactions to the first phase of the survey, and any extra questionnaires you have left.

Do not return any instructions, or the cards or any other unused materials except questionnaires.

6. PROGRESS REPORTS AND UNAVAILABLE SHEETS

The blue Unavailable Sheet (NORC 410-6) is the form to be used to notify New York of a refusal, a break-off or a failure to secure an interview after repeated callbacks over a two-week period. It should be used as follows:

a) Refusal or Break-off

In the event that one of your assigned respondents refuses point blank to let you interview him, or breaks off the interview before you have asked all the necessary questions and refuses to arrange another appointment to complete the interview, an Unavailable Sheet must be filled out immediately and sent to New York.

Do not regard a temporary, "I'm too busy" as a point blank refusal. Remember that there are no substitutes for the designated households and that you must make every effort to overcome any hostility or resistance that you may encounter. Try to arrange for another appointment at a more convenient time before you regard the refusal as final.

The information on the Refusal Sheet is needed for two reasons. First, we will be following up every single refusal with a letter or telegram from the office. To make this follow-up most effective, we want to know why the person refused, and something about his circumstances.

You will receive carbon copies of such letters, and can then go back and try the case once more; or if your own experience with the case may for some reason have been an unpleasant one, we will try to assign some other interviewer to the follow-up.

The second reason we need this information about refusals is to help us evaluate the degree of bias they may have introduced into our sample. If we find that particular types of persons, in particular socio-economic situations or in particular areas of the country, refuse in disproportionate numbers, we can make allowances for that fact in interpreting our data.

Since most interviewers will have no refusals or break-offs at all, and others may have several of them, we have sent you what we think should be an ample supply, on the average, of the blue Unavailable Sheets. If you find that you need more, write the office for additional forms (NORC 410-6).

b) Report of Temporary Unavailability

If you determine that a respondent is ill or out of town and may be available by April 15, retain the pink assignment sheet and questionnaire with its Face Sheet for later use. Two weeks after receiving an assignment, however, fill in a blue Unavailable Sheet for these dealyed interviews to advise us of your contacts and arrangements for an interview.

If after two weeks of repeated efforts to contact a respondent, you are unable to arrange for an interview, fill out the blue Unavailable Sheet explaining the situation and send it to us. Continue your efforts to locate the respondent, however, until we notify you to stop.

If you cannot find the respondent or anyone in the household at home, it is usually a good idea to inquire at a neighbor's house about the respondent's whereabouts. It is also advisable to schedule your visits at different hours during the afternoon and evening. We can only repeat that since there are no substitutions for each household, every effort must be made to complete your assigned interviews.

7. INTERVIEWER'S QUESTIONNAIRE

One of your questionnaires has been stamped "Interviewer's Questionnaire." Please fill out this questionnaire with your own opinions and answers as soon as you finish reading these instructions for the first time -- before you obtain any interviews at all.

Put the completed Interviewer's Questionnaire in the enclosed stamped envelope and return it to the New York office immediately. This will serve as an acknowledgment on your part of receipt of these materials.

8. OTHER MATERIALS

Also enclosed are the following materials:

a) T&E Reports (Time and Expense) -- Remember to enter the NORC Respondent Number in the column labeled "S.U. No.", and return a T& E with each week's mailing of completed questionnaires.

b) Interviewers Report -- to be filled out after all assignments are completed.

c) Letter from Public Health Service and NORC Brochure -- to be used as directed in your introduction to the respondent.

d) Envelopes -- to be used in returning materials to us.

9. HOW TO PREPARE FOR THIS ASSIGNMENT

a) First, continue reading carefully the following instructions and specifications referring to the questionnaire and other forms which are mentioned as you do so.

b) Then fill out your Interviewer's Questionnaire and return it to New York immediately in the enclosed small envelope.

c) Next, conduct a practice interview with some member of the family. Do not bother to report his answers on a questionnaire. The prupose of this practice interview is simply to accustom you to asking the questions, recognizing inadequate responses, and to get a "feel" for the interview. Refer to the specifications, as necessary, while you conduct this interview.

d) Finally, go over the map of the assigned area and arrange your schedule of contacts according to the time suggested for each household on the Face Sheets of the questionnaires.

II

BACKGROUND AND PURPOSE OF SURVEY

10. OBJECTIVES

This survey, which is sponsored by the United States Public Health Service, is one of the methodological studies related to the National Health Survey. Each week the Bureau of the Census, acting as an agent of the USPHS, interviews a national cross-section of the population on a National Health Survey. It ascertains the amount, duration and effects of illness and disability in each household. From these interviews accurate trends in reported illnesses can be charted and the efforts of public and private health organizations can be directed where the needs are the greatest.

It is known, however, from the experience of a few local health surveys that health information reported in an interview is not always complete or accurate. Some illnesses are not reported because the respondent may be unaware that he has them, and others may be incorrectly reported because the respondent may be misinformed about his condition.

In order to verify illnesses reported in the interviews and to secure certain additional statistical information on such items as height, weight, vision, hearing,

etc., the USPHS is planning to have a team of doctors give a series of standard tests and measurements to a sub-sample of adults already interviewed on its National Health Survey.

But it is also known from the experience of those local surveys cited above, that substantial segments of the public will refuse to participate in such a health examination, even when it is free. Such nonparticipation can seriously affect the findings of a medical survey, and it is imperative that the number of noncooperators be reduced to a minimum. This is where the National Opinion Research Center methodological study fits into the picture.

It is the purpose of our study to find out the kinds of people who are willing or unwilling to accept a free health examination. It is our objective to isolate the variables which may contribute toward willingness or unwillingness to cooperate on the tests and measurements phase of the National Health Survey. From such findings the USPHS can plan its procedures to minimize the amount of noncooperation.

Naturally, no respondent should be informed of the purposes of this study. If he were aware of our objectives, he might color his responses to rationalize his feelings about the proposed tests and measurements. As will be described in a later section on "Introduction to Respondent," we merely describe our interview as a "special study for the Public Health Service" without explaining any of the questions that are to follow. The information contained in these instructions is for you alone, to help you do a better job of interviewing.

11. SELECTION OF THE SAMPLE

Since one of the major objectives of the test and measurements phase of the National Health Survey is to compare data obtained by personal interviewing with data obtained by a medical examination, it is necessary ot offer the health examination to the same people who were interviewed by the Census Bureau. Consequently, the Census sample was evaluated and all localities which were within reach of NORC interviewers were selected for our special study.

It is important to remember that each household assigned to you has already been interviewed by the Census Bureau for reported illnesses, hospitalizations and disability of all members in the household. Not all members of a household, however, are interviewed directly by the Census. If a person was personally interviewed by the Census, the respondent number listed on the Face Sheet next to his name will be circled. If his health condition was reported by another member of the household, his respondent number will not be circled. This information may be useful to you in your approach to the respondent.

Since the selection of our sample of households is based on the completion of successful interviews by the Census, it was impossible for us to know in advance how many interviews would be assigned to each interviewer. In order to send you advance warning cards, we estimated an average of six households per assignment. In actual practice, vacant homes or Census inability to contact respondents reduces this quota in some cases. Other assignments may be greater than 6 interviews because the Census quota contained more than 6 households. We prepared your actual assignments as soon as we received the Census listing sheets.

Since the Census sample is a random selection of households, and since we are only assigning one interview to each household, it is necessary for us to specify

the sex of the respondent in each household. This is being done in a random fashion, with a male and female respondent being selected from alternating households. Where there is more than one adult of the same sex in a household, each is listed on the Face Sheet of the questionnaire. You may select one respondent from those listed on the Face Sheet. No other substitution is permitted.

There is one other limitation in the selection of our sample. For policy reasons, the USPHS has asked us to limit our sample to adults between the ages of 18-65. If a person is older or younger, he should not be interviewed. On the Face Sheet, we are listing the ages reported by the Census for each "eligible" respondent. If the age of a person listed on the Face Sheet seems to be in error and you feel he may be ineligible, ascertain his age before you proceed with the interview. Say to him, "By the way, could you tell me how old you are? You see my instructions are to interview only people in certain age groups."

It has already been mentioned, but we can repeat it here, "There is no substitution for the eligible respondents." Each household listed on each Face Sheet is a sample case from which one respondent must be interviewed. Schedule your contacts carefully and make every effort to reach one of the designated respondents from every household.

12. HOW TO PROCEED

a) Locate the addresses of the households assigned to you by checking the Face Sheets and the map enclosed.

b) Check each Face Sheet for the following information:

1) Address of household
2) Names, sex and ages of eligible respondents
3) Respondent numbers assigned to each eligible respondent. Note the first three digits, which designate the household, are common for all members listed on a Face Sheet, but the fourth digit is different.
4) Previous interview experience with Census. If he was interviewed himself, his fourth digit of the respondent number will be circled.
5) Time of previous Census interview and time suggested as "best time to contact." Use this information in planning your house visits.
6) Telephone number of household.

c) Schedule your initial contacts:

1) Check whether respondents were interviewed themselves by the Census. If they were, then the time of actual Census interview or suggested "best time" will be useful information to be used in your planning.
2) Check age and sex. If the respondent is an older woman, she is more likely to be at home during the morning or afternoon.
3) Allow approximately an hour for each interview. Some will require less time, others somewhat more time depending on the amount of free comments, etc.
4) Remember only one adult between the ages of 18-64 may be selected from the names listed on the Face Sheet.

If for any reason a questionnaire is spoiled, be sure to copy all of the information on the Face Sheet on the blank questionnaire which you plan to use.

d) Record each contact with a household on the Face Sheet. If no one is at home on your initial contact, ask the neighbors about the respondent's whereabouts. If necessary, use the phone number, when it is listed on the Face Sheet, to arrange for an interview.

e) Record the four digit respondent number on the following forms after completing the interview:

1) On top of the Face Sheet. (The first three digits, designating the household, have already been entered. You must enter the fourth.)
2) On the "Record of Calls" section of the Face Sheet.
3) On the Assignment Tally Sheet
4) on the T&E report (under S.U. No.).

f) Sign your name on the Face Sheet and indicate the date and time spent on the interview on the last page of the questionnaire.

g) Read the interview and check the answers as soon as possible after the interview. In this way, you can call back if you find you have failed to ask a question or record an answer properly. You will also be able to make sure the questionnaire has all been filled in accurately and completely and that your writing is legible.

h) Return completed questionnaires and T&E reports every week.

i) After two weeks, fill out an "Unavailable Sheet" for each assigned household which has not been interviewed.

III

BASIC INTERVIEWING RULES

13. A BRUSH-UP ON BASIC INTERVIEWING RULES

Before taking up the actual questionnaire, and the special problems you may encounter on this survey, it may be worthwhile to review quickly some of our basic interviewing rules which will be important on this study.

We assume that all of you are thoroughly familiar with these rules, but repeating them here may provide you with useful reminders.

14. DON'T EXPLAIN QUESTIONS, EXCEPT AS AUTHORIZED

While you may sometimes have to re-phrase questions slightly to fit the particular case, our general rule still applies that the interviewer must not explain the meaning or intent of the question.

The later specifications will sometimes instruct you to make necessary explanations or may provide you with alternative phrases to use, but unless such explanations are authorized in the "Spex," don't explain. If the person can't answer on the basis of the wording, just code him "Don't know" and write in what he says.

15. ASK ALL QUESTIONS IN THE ORDER IN WHICH THEY APPEAR

Don't skip any questions and come back to them later. Never go back and change a prior answer in the light of a later response. The order in which the questions are asked can easily influence replies, and we must be sure that all respondents hear the questions in the same order.

16. IN GENERAL, ONLY ONE CODE CAN BE CIRCLED ON EACH QUESTION

There are a few exceptions in which more than one answer can be coded, and these are noted in the Specifications. On all of the others, however, you are to circle only one code.

17. DON'T ACCEPT "DON'T KNOW" ANSWERS WITHOUT PROBING

On opinion questions, there are no right or wrong answers, and you should probe for the respondent's attitude, "in general, taking everything into consideration;" and then circle the one code that comes closest to his opinion.

On factual questions, such as the date of a particular experience, even a rough guess by the respondent is more useful to us than a "Don't know" answer. Encourage the respondent to answer as best he can, using such probes as, "Well, just roughly" or "Could you tell me approximately?"

18. RECORD COMMENTS ON PRE-CODED QUESTIONS

In answering precoded questions, respondents often make comments or remarks which qualify their opinions, or give reasons for their answers, or emphasize the positiveness or uncertainty of their views.

Such volunteered comments are immensely useful to us in interpreting and evaluating the percentaged results, and it is up to you to record them verbatim, using the white space on the questionnaire or the back of a page. Do not ask the respondent to comment, but do be alert to record any remarks that he volunteers. Do not bother to record comments which merely repeat the precoded response. For example, there is no point in recording verbatim "No, I disagree" if there is a code to circle for "Disagree." We regret that there will not always be as much space as you will need to record these comments, but feel free to use the margins and any other available space you can find, but clearly specify the question or sub-question to which the comment is pertinent.

19. PROBE FOR COMPLETE AND SPECIFIC FREE ANSWERS

There are a great many free answer questions, of the "Why?" or "In what way?" type on this questionnaire. The following specifications will generally advise you as to what kinds of answers are acceptable, and what kinds require further probing.

If the person's first response is vague, brief, ambiguous or off the point (as many of them are), take the time to ask him to consider the question carefully, to clarify or elaborate on his opinion. Repeating the question or using such probes as "How do you mean?" or "Could you give me an example?" or "What do you have in mind when you say (such and such)?" usually elicits a more complete and specific reply.

20. DISCOURAGE IRRELEVANT CONVERSATION

You have a lot of questions to ask, and the sooner you get through, the better for all concerned. If you do not adopt a businesslike manner you are very likely to find yourself spending three or four hours with talkative respondents.

This does not mean that you should hurry the respondent or discourage him from giving full consideration to the questions. It does mean that once you have his answer, you should proceed immediately to the next question and do the most efficient job of getting his answer to that one.

Don't get involved in a discussion of health or illness, and discourage long-winded stories, repetitions, etc., by interjecting "I see. . Now the question is. . .," or by repeating the question you just asked.

21. REVIEW YOUR INSTRUCTIONS

By doing so, you may very likely catch some error or misunderstanding which would otherwise persist throughout your whole assignment. When you have completed two or three interviews, sit down and read again these general instructions and specifications.

These materials are necessarily lengthy and detailed, and hard to grasp in one sitting. After you have actually done a couple of interviews, they will mean a great deal more to you.

22. INTERVIEW RESPONDENTS ALONE

As in most public opinion surveys, we want the respondent's own unbiased answers to our questions. It is hard to get such answers if someone else is listening to the interview. Third parties, furthermore, often distract you with interruptions, or otherwise complicate and lengthen the interview process.

Therefore, make clear to the respondent and any third person that this is a confidential interview, and that the respondent's answers will not be revealed to any other member of the family or to anyone else. If the third person persists in staying on, just say firmly, "I'm sorry, that's one of the rules they give me."

If there is no other place to go, and a third person must inevitably be in the same room with you, try to distract that person with some NORC literature; discourage any comments or interruptions, and make clear to the respondent that you want his own unprompted answers.

> Never under any circumstances allow someone you must interview later (such as a neighbor) to overhear a prior interview.

23. QUESTIONS ANSWERED BEFORE YOU GET TO THEM

In any comprehensive interview dealing with a single subject, it is almost a certainty that the answers to a few questions will have been volunteered or will have become obvious by the time you get to them. This interview will be no exception, though we do believe that its careful organization has considerably reduced the likelihood of such occurrences.

Nevertheless, we ask you to follow the rule: Ask every question, even if you know the answer. There are several reasons for this rule, but we will mention only one of them, and that is you never can be sure you have the answer already or that respondents will be consistent in their answers.

You can easily avoid embarrassment simply by prefacing the awkward questions with some such phrase as: "Now you may already have answered this, but the next question is. . ." or "Let's see. I guess I know what you'll say on this one, but the question is. . ." Respondents understand that you are working with a questionnaire, and if they have anticipated one of your questions, they are often proud to learn of it and don't at all mind repeating their opinion.

24. THE CARD

There are two questions (18 & 19) which require the use of a card. When you reach Q. 18 hand the respondent the card and follow the introduction printed on the questionnaire.

25. AIM FOR VERBATIM RECORDING

On all NORC surveys we ask you to record the respondent's answers to free answer questions word-for-word, and you should endeavor to do so on the present study. We have tried to anticipate the amount of space you will need to do so, but occasionally we were unable to allow as much free answer space as would be desirable. If you cannot squeeze in all the verbatim material in the space allotted for any question, feel free to use the margins and any other available space you can find -- but be sure to clearly label anything that does not appear in the proper spot. Above all, don't let a shortage of space stop you from probing for clear, complete and relevant responses. If necessary, summarize the vague answers but keep on probing and record fully the clear and relevant answers.

Indicate your probes. Whenever you probe to clarify responses or to encourage the respondent to express himself, indicate precisely when you probed by using the probe symbol "X". Don't forget to record whatever the respondent said or did, which prompted you to probe. Always record the results of your probe. In short, you should always have something recorded before and after each "X."

26. CIRCLE CODE CATEGORIES CLEARLY

When you ask a precoded question, please mark your circles carefully so that there is no confusion as to the code you intended to circle. For example, Q. 1 will be coded in Col. 5 of an IBM card (after your interviews are received in the office). If a respondent indicates that he feels his health is "excellent" you should circle code number 1. Your circle should not enclose Column 5 along with Code 1.

This way:

Excellent. . . .	5-(1)
Good	2
Fair	3
Poor	4
Don't know . . .	5

Not this way:

Excellent. . . .	(5-1
Good	2)
Fair	3
Poor	4
Don't know . . .	5

Note also that in some questions, the possible codes for a given question read across in a horizontal line as for example in Q. 14:

	Can Tell Right Away		
	Yes	No	Don't Know
Diabetes.	25-1	2	3
Cancer.	26-1	2	3
Asthma.	27-1	2	3
etc.			

In a number of questions, as in Q. 3-A, an IBM column number and a dash, but no code number appears to the right of a free answer space. This is for office use only for coding the free answers and the space to the right of the dash should always be left blank.

IV

THE QUESTIONNAIRE

27. BIRD'S EYE VIEW

One of the major problems involved in devising a standard questionnaire is the arrangement of questions in a natural sequence. Certain questions frequently stimulate a typical pattern of thought and unless the questionnaire is organized to correspond with the natural flow of answers, interviewing problems are increased. In analyzing the pretest interviews, great care was taken to determine these normal patterns of response and to adapt them in the design of the questionnaire.

In general, the questionnaire is divided into the following nine sections:

Section	Questions	Content
1	1-8	General attitudes toward health and doctors
2	9-13	Belief in the possibility of becoming ill and its effects
3	14-20	Knowledge of specific illness and need to see doctor
4	21-26	Satisfaction with medical facilities and services now as compared to 30 years ago
5	27-37	Personal experiences and attitudes toward doctors
6	38-39	Sources of information on health matters
7	40-46	General attitudes toward doctors, clinics and the role of government in health matters
8	47-52	Attitudes toward taking the tests and measurements phase of the survey
9	53-56	General information about respondent

28. YOUR APPROACH TO THE RESPONDENT

a) General Rules

Most respondents are somewhat curious about the "purpose" of an interview and will usually ask about it some time or other during the interview. A simple approach which has been effectively used on literally hundreds of NORC surveys involves three steps:

1) Introduce yourself
2) Explain that you're working on an opinion survey and want some of the respondent's ideas
3) Go immediately to the first question as an illustration of the kinds of questions asked.

Usually such brief statement is sufficient to start the interview. You do not ask him whether he wants to be interviewed, or whether he has the time to be interviewed. You do not tell him what the survey is specifically about. You do not go into details about NORC unless he is curious or suspicious. Your aim is to forestall any hesitancy on his part by getting immediately to the most interesting thing -- the questions -- and to avoid wasting time in lengthy explanations. You will find that most of your respondents will answer Q. 1, start thinking about Q. 2, and very often will go through the entire interview without once raising the question of whom you represent and why you want their answers. In such cases, when you complete the interview, make your farewell and leave promptly.

b) Specific Suggestions

The introduction printed on top of Page 1 has been thoroughly pretested and will work in most cases. Since you have the names of eligible respondents, you may start your introduction as follows:

"Good(afternoon, evening) I'm from the National Opinion Research Center. Are you (name of eligible respondent)? or is (name(s) of eligible respondent(s)) at home?'

If the person answering the door is not one of the eligible respondents and if an eligible respondent is not at home, try to arrange for a convenient time when he is expected to be home.

If the person answering the door is one of the eligible respondents, or if he is at home, continue your introduction as follows:

Hand the respondent the Public Health Service letter and say, "As this letter says, the Public Health Service has asked us to do a special study for them and to ask you some questions. The first one is. . ."

Usually the respondent won't even take the time to read the "letter," but will start answering the questions and go through the interview.

If he wants to read it or keep the copy, permit him to do so. As soon as he's finished say, "Well, the first question is. . .," and try to start the interview.

If he wants to know more about the survey, tell him, "It's a study about your ideas about health matters. Now the first question is. . ." Try to avoid any specific description of the kinds of questions involved. Tell him, "Well, let's start it and you'll see. The first question is. . ."

If he wants to see your identification, show him your I.D. card.

If he wants to know more about NORC, tell him, "The National Opinion Research Center is a non-profit research organization which is part of the University of Chicago. We do all sorts of social research projects." If he wants more information, show him the NORC brochure.

Of course, the job of introduction and approach in this particular survey is made much easier because many of the respondents remember favorably the recent Census interviewer.

29. SPEX FOR EACH QUESTION

The following instructions discuss each numbered question separately. They tell you the general purpose of each question, the kinds of answers to probe further and alerts you to anything in the question wording, answer categories or recording of answers that may pose a problem.

NORC RESPONDENT NUMBER. Be sure to copy the respondent's number from the botton of the Face Sheet and insert it at the top of the Face Sheet.

QUESTION 1: This is an easy opener in which we are interested in the respondent's subjective evaluation of his own state of health. Don't try to define what is meant by "excellent," "good," "fair," or "poor" health. Let the respondent himself choose which one best describes his state of health -- not in terms of any specific disorders, but in terms of his overall evaluation. Just repeat the question, "Well, in general, would you say. . .?" And remember that the question inquires about the "general" state of health, not how the respondent feels at a particular time. If necessary, repeat that we are interested in how he rates his health in general.

QUESTION 2: This is another question asked of the entire sample, to get the respondent's evaluations of how well people in general care for their health. This is the only point that needs watching here -- that we are asking about "people in general," "on the whole," etc., and repeat the question accordingly until one of the two answer categories is selected.

QUESTION 3: This is comparable to Q. 2 except that here we are asking about the way the respondent himself cares for his health. And Q. 3 also has an additional free answer question for part of the sample. If he says, "I do the best I can," ask him, "Well, is there anything you could do to take better care of your health than you do?" Remember, we aren't asking about "his best efforts," but the best level of care.

If he asks, "What do you mean by the 'best possible care?'" answer, "Well, is there anything else you could do to take better care of your health, or are you doing all that is possible to take care of your health?"

Repeat the question if necessary, until the respondent selects one of the two offered responses. Then ask "A" of those who state they "Could do more" to take care of their health (Code 2 is circled).

Note that "A" asks what more the respondent could do, not "Why" he cannot or does not take the best care of his health. Probe until you get the respondent's specific ideas as to the things he could be doing, or should be doing, but which he is not doing.

QUESTION 4: This question is asked of everybody. We are interested in the respondent's ideas about whether living conditions and activities can have an effect on health. The key words to emphasize are "the way you live." If he asks, "What do you mean by the way you live?" answer, "Well, the things you do every day and the way you do them."

QUESTION 5: This question is intended to reveal some of the respondent's concerns about his health. Note the conditions of the question: a chance to talk to his own doctor for half an hour, at no cost -- "Are there any things about your own health that you'd like to ask him?" If the respondent thinks of any questions at all even if they are not of his own health, he'd like to ask (no matter how trivial or far-fetched) circle Code 1, "Yes" and ask the sub-question "A." If he has no questions at all about his own health, circle Code 2 "No" and ask sub-part "B."

Please probe for specific answers to "A." The person's first response may often be some vague reply such as "My health in general" or "I would ask him about cancer" or "How to take care of myself." Sometimes the respondent won't be able to answer any more specifically than this, but don't accept such replies without probing" "Well, what in particular would you want to know?" or "What special questions would you want to ask him, about (whatever was mentioned)?"

"B" will also require frequent probing, since respondents may often just repeat their reply to Q. 5 itself: "I have no particular questions I'd want to ask." All such replies must be probed to the point of the questions, which is why the respondent has no questions to ask the doctor. Sometimes your probes will not be very successful, but more often than not your "Why is that?" will bring out such interesting reasons as "My health is fine" or "Doctors don't know very much" or "I don't like to discuss my health with anybody."

QUESTION 6: This is another measure of the respondent's concern about his own health. "A" refers to "thinking about" and "B" to "talking about." Both parts are asked of everybody. Be sure to circle one code for "A" and another for "B."

If the respondent qualifies his answer to "A" by mentioning a particular time when he thought about his health fairly often, record his comments, repeat the question, "Well, in general, would you say. . .?"

If he qualifies his answer on "B" however, distinguishing between family and friends ("with my family fairly often, but only occasionally with friends"), code to the greater frequency (fairly often).

QUESTION 7: The respondent is asked whether he himself, at any time during the past year, has felt he should have seen a doctor when he didn't. Note that Parts "A" and "B" are asked of those who answer "YES" (Code 1 circled).

"A" asks about the effect of the illness on the respondent's usual activities in terms of two precoded answer categroies. "B" is an open-ended question asking why the respondent didn't see the doctor.

If he says, "I did some of it, but not all of it," or "I didn't do it as well," code "Kept from doing." We are interested in whether he was able to continue his usual work in his usual manner or not.

Be careful of two types of inadequate answers to "B." One is the irrelevant reply, "I finally did go." In such cases, probe: "Well, why didn't you go when you first thought you should?" The other is the repetitious response, "I didn't want to go," "I put it off," etc. Here your probe is: "Why didn't you want to go? Why did you put it off?"

QUESTION 8: This question asks the respondent to report what he thinks the chances are of his being "sick in bed" for a given number of days during the next twelve months. The respondent may say, "You never know," or "I hope not," so reassure him, if necessary, that obviously nobody can say for sure, that we just want to know his best guess in the matter. Press him for an answer in terms of one of the three alternatives and then ask either or both of the sub-questions.

Note that "A," which is asked of everybody, is concerned with being sick in bed for a total of a week or more not necessarily at one time, but cumulatively totaling a week. "B" is asked only of those who felt it was not likely, or that they "didn't know" on "A" and asks about the likelihood of a shorter period of illness -- 3 or 4 days during the next 12 months.

Then "C" is asked of everybody except those who report "no likelihood" of being sick at all during the next year (Code 3 circled under "B."). Here we are interested in whether he feels the expected illness is inevitable or whether he can do something to avoid it.

QUESTION 9: Here we want to find out how the respondent views the possibility of future illness -- the likelihood of his getting any of the three specific diseases over the next 5-10 years.

Of course, the respondent may indicate -- either in answering this question or perhaps even earlier in the interview -- that he already has one (or more) of the three named diseases. In that case, question him about the likelihood of his getting the ones (or one) he does not have.

QUESTION 10: You will notice that this interview omits any question about the respondent's occupation. But in Q. 10, we are getting his subjective report of the degree of good health which his work demands. We are not concerned with what the respondent does, he is to answer the question in tersm of what he sees as his usual work or responsibilities. Thus the question is asked of everybody. Does he have to have especially good health to carry on his responsibilities (Circle Code 1) or can he carry on adequately when he is in less than top form (circle Code 2) or when he is under par (circle Code 3)?

The key words, to be read slowly and emphasized, are "especially good health" and "fairly good health." And notice too that we are again asking about the general "all in all" aspects of this situation, rather than the once in a while or exceptional case.

By "do your work well," we mean satisfactory or acceptable. It need not be the very best performance, but it must be good enough to get by.

QUESTION 11: This question is composed of four parts and is a series designed to learn something about the impact of illness on the respondent and his family. Note that parts "A" and "B" are asked of everybody, "C" and "D" only of employed persons who work for pay.

In "A" we want to know how easily the respondent, if ill, could get personal care. If the respondent mentions more than one source of care -- e.g., "My husband's here and my mother would come," code to the highest category and circle Code 1.

In "B", we are interested in paid work -- any mention of volunteer work or service should be coded as "No" under "B."

Most people can answer this series of questions fairly readily, but you may occasionally have trouble with answers that are qualified in terms of the time that illness takes place. A housewife might say, "My mother always visits us during the summer, but if it was some other time it would be very difficult." In such a case, ask the respondent to answer in terms of, "In general. . .there be somebody. . ."

In Part D, we are interested in employer-employee relationships and whether illness would prejudice the employer's attitudes toward the respondent.

QUESTION 12: Now we want to find out about the effects of illness on the respondent's family. We want to know about the effect other than financial or economic that the respondent's illness would have on the management of the household. If the answer is in terms of the money needed to run the household, say "Well, aside from that, I want to know in terms of the general running of household matters. . ." and repeat the question.

This is also the first question so far in the interview which is dependent on the respondent's having a family with whom he lives. For those who indicate that they have no family, circle Code 4 and go on to the next question. And in those cases where the respondent may already have indicated that he has no family, preface your reading of the question with, "This may not apply to you, but the next question is . . ." and in every case read the question to determine definitely if the respondent lives alone, without a family.

QUESTION 13: How much does the respondent need to be concerned with the financial aspects of illness? Thus, this question stipulates "a large medical bill not covered by insurance." If you are questioned about when is "right away," explain that we do not mean anyone particular time but rather the usual time in which the respondent pays his bills,"let's say, within a month."

QUESTION 14: The respondent is asked to judge whether or not each of these illnesses is detectable right away or if a person might not "know for some time that something was wrong." Read each of the eight illnesses one at a time, starting off by inserting "diabetes" in your first reading of the question. Repeat the two alternative answers each time you introduce the next illness -- "How about . . ., do you think a person could tell right away something was wrong by the way he felt, or might he not know it for some time?"

Note that we are not asking whether the person could know exactly what was the matter -- that is, if he could diagnose the condition, but only if he could tell if anything at all were the matter with him if he had the given condition.

One difficulty you may run into here is the reply that "Sometimes you might know and sometimes you could have it a while without knowing." This is particularly true of "heart trouble," when the respondent says, "Well, if he had an attack he'd know, otherwise he might not know for some time." The point here again is that we want the respondent to answer in terms of "in general," of what happens more often. So preface the question, "Well, in general. . ." or "What do you think is more often the case -- can he tell. . .?"

QUESTIONS 15-17: This is a series of questions to tap the respondent's knowledge about three particular diseases. "Signs or symptoms" is explained by the probe questions, "Any other ways a person could tell he had (illness)?" Record answers word for word and keep probing for all the symptoms a respondent can name. Keep on probing for additional symptoms until it is clear that the respondent cannot possibly remember any others.

Don't accept vague answers like, "He wouldn't feel good" or "he'd be in pain." Probe to find out: "How do you mean that?" or "What kind of pain do you have in mind?"

QUESTION 18: Hand the respondent the correct side of the card as you come to Q. 18. Read the instructions slowly and carefully to fix in the respondent's mind the three alternatives: see a doctor about it immediately, take care of it himself, or leave it alone. Then proceed down the list circling one of the four possible codes for each item. Do not skip any item and get the respondent's opinion on one before proceeding to the next.

Do not explain any of the items beyond what is on the card. If the respondent wants to know, "Is it painful?" "How long has he had it?" "Has he had it before?" "Is it an older person?", etc., tell him to answer just on the basis of what the card says, using his own best judgment as to what would generally be the case. Use the customary probes to clarify qualified answers: "In general," "The average person," "The way it seems to you," etc. If the respondent says he just can't decide, circle the code for "Don't know" and go on to the next item.

Periodically as you go down the list, repeat the three alternatives in full: "Should he see a doctor about that right away, should he take care of it himself unless it gets worse, or should he leave it along?" And of course, each time you read off the next condition remind the respondent of the three alternatives or as much of them as you have time, before he indicates his reply.

Be sure to circle the code numbers carefully, so that each line has one code and only one code circled on it.

QUESTION 19: Ask the respondent to turn over the card he used on Q. 18, and ask Q. 19-A. Make sure he understands that you are inquiring only about conditions he has had during the last twelve months. Read each condition and circle Code 1 or 5 if he says he had the condition. You will note that we have added a number of conditions to those previously listed for Q. 18. If, after looking at every item, he says he has had none of them last year, circle Code X at the bottom of the list. Take his own word for any conditions he mentions even if you think he may be wrong. Don't explain any which he doesn't understand.

"B" is asked each time the respondent indicates he had a condition during the past year -- that is, concurrently with "A" rather than going through the entire list for "A" and then for "B." For example, if he feels tired all the time, ask "B" immediately, "Did you happen to see. . ."

"C" however, is asked after the entire list has been checked for occurrence of illness. It is asked about only those conditions which the respondent indicates he has had (Code 1 or 5 circled in Col. A) and for which he did not contact a doctor (Code 3 or 7 circled in Col. B).

Note that in Part "A" you will be entering a code only if the respondent had the condition. There is nothing to record if the respondent did not have it. On "B", if a respondent had a condition, or has currently, and saw a doctor about it some time ago, but not last year, code "No doctor." If he says,"I called him, but didn't see him," code "Saw doctor," (Code 2 or 6).

QUESTION 20: Now we have a shorter list of illnesses asking for the respondent's belief in the effectiveness of medical care. Read the introduction slowly so that the respondent grasps the distinctions between the three answer categories: doctor can cure completely, the doctor can help it but perhaps he cannot cure it, the doctor cannot help it at all.

Be sure you get one opinion about each of the 11 conditions listed.

If you get a qualified response, like: "If the person goes to the doctor in time," "It depends on what's causing it," etc., probe for what the respondent thinks is most often or "in general" the case when a person has that condition.

QUESTIONS 21-24: This is a series of questions to get at the respondent's feelings about medical progress and his satisfaction with medical services. Remind the respondent, if necessary, that we are interested again in how he feels about these matters "in general."

The wording of these questions should be self-explanatory. On Q. 21, if a respondent challenges the meaning of "a healthy life," tell him it is whatever that means to him.

In Q. 22, if the respondent wants to know what we mean by "much interest," answer, "You know, how much concern does he show in his patients, much more. . ." Note the categories of Questions 22-23 are different from Q. 21, and in Q. 24, "Much worse and a little worse" are combined into one category.

QUESTIONS 25 & 26: These two questions inquire about the respondent's satisfaction with what is being done to discover the causes and cures of disease.

The only point to bear in mind here is that we are considering general research on disease, not the diagnosis and treatment of individual cases. If the respondent indicates that he has misunderstood this meaning, say "I mean new discoveries about how certain diseases start."

QUESTION 27: If anyone doesn't understand "complete physical examination," explain" "That is, a thorough medical check-up." But accept the respondent's own interpretation of what these phrases mean. If he thinks he's had one, code "Yes,"

If the answer is "No," you omit the sub-questions and go directly to Q. 28. But if the code "Yes," you must ask all three sub-questions. On "A" record all verbatim comments, as well as circling the proper category.

Some people will answer irrelevantly in terms of where they got the check-up or what the exam involved: "I was working at the plant" or "It was just a complete examination, covered everything." Obviously, these do not tell us the reason or occasion for the examination. We want to know whether he went because it was some requirement, or whether he felt sick, or whether he just wanted to get a check-up.

QUESTION 28: The instructions given above for Q. 27 also apply to this question. In this case, however, we are asking specifically about getting an examination when there were no particular symptoms provoking it. You may find that an answer to Q. 27-C in some cases will also answer Q. 28 -- that is, the respondent will explain that there was no reason for his going to the doctor at that time except for a general check-up.

In such a case, follow the general rule of asking the question, preceded by such a comment as, "I guess you've answered this already, but the next question is. . ."

QUESTION 29: It is important that you read this introduction slowly and carefully to the respondent, since there are 18 items about which he is to answer. We want to know whether each of these 18 reasons has ever kept the respondent from seeing a doctor. Precede the first few items by some statement as, "How about . . ., did this ever keep you from seeing a doctor?" And repeat thispreface from time to time so that you are sure the respondent at all times knows just what you are asking him.

Be sure, too, to circle the code in the appropriate column and that there is only one code circled on each line. On an itemized question of this length it is not difficult to get your lines mixed up. We have tried to overcome this difficulty somewhat by putting an extra space between each series of five items. This spacing is designed to simplify recording of responses and has no other bearing on the meaning of the questions.

QUESTION 30: Here we want to know if anyone the respondent knows has suggested during the past year that he see a doctor but he didn't go. Those who say this has not happened go right on to Q. 31.

For those who reply "Yes," ask both "A" and "B." Multiple coding is permitted on "A" if more than one person is mentioned and the answer fits more than one code category. If he mentions, "the druggist or a nurse" who may not be a friend, circle Code 7 and specify who it was.

In "B" be sure to probe for specific reasons why he didn't or didn't want to go to the doctor.

QUESTION 31: In this case, "family" refers to any relative of the respondent. Again, let the respondent interpret the question in his own fashion. Don't attempt to explain what is meant by "argue," but in circling the codes, you should interpret "argue" freely. For example, if the respondent says "We disagree about it, but we don't really argue," or "I kid my husband about it. It's not really arguing," code "Yes." In short, any disagreement should be considered as "Argue."

The sub-question "A" was always well understood on the pretest, but probe as necessary to find out which family member usually resists going to the doctor, and which member does the urging. We are interested both in who is involved in the argument and the reasons the respondent gives for his own position in the argument.

An answer of "They sometimes have colds" does not tell us who is involved in the two sides of the argument, which side is reluctant to go, and why the respondent takes the position he does in the argument.

QUESTION 32: Note that we are asking about the doctor the respondent "usually" goes to when he's sick; he needn't be called in every time. If the person says he's never sick, obviously the answer is "No." If he says he regularly goes to a particular clinic, but that there are several doctors there who may take care of him, code "Yes" and indicate the clinic in "A."

Under "A," the "kind of doctor" doesn't have to be a family doctor or general practitioner. He can be a specialist, an osteopath or any kind of doctor; just whomever the respondent usually goes to when he's sick. Find out the type of "doctor" the respondent goes to.

If you code "Yes" to Q. 32, you ask "A," record the information, and then go on to Q. 33. If you code "No" to Q. 32, you omit "A" but ask "B."

QUESTION 33: Here we are interested in the types of practitioners the respondent or his family may consult on health matters. It need only have been one visit during the past year to comprise a "Yes" reply.

In reading off the three different types of practitioners listed in the question, make no comparisons either favorable or unfavorable between the different categories.

"A" asks about a visit to a "chiropractor." If you are questioned about what this means, define it as "someone who has a special way of treating sickness by adjusting the spine. He usually has the initials D.C. after his name."

If you are asked for a definition of "osteopath" in "B," explain it as "A person who usually treats illness by giving heat treatments and massages. He usually has the initials D.O. after his name."

"C" is self-explanatory and includes specialists as well as general practitioners. Note, however, that it does not include doctors who are not medical doctors -- e.g., dentist, podiatrist, chiropodist. If you are in doubt as to whether a particular person is a medical doctor, write out the description under "D."

"D" covers all practitioners not previously mentioned and will pick up particularly such people as naturopaths and faith healers.

QUESTION 34: This is a completely open-ended question to see what are the most salient aspects of "fear of the doctor." There will be no difficulty in understanding the question. However, you will need to be very sensitive in probing as far as you can go to get specific and complete replies. Thus you will always probe to find out "Why are they afraid of that?" and "Are there any other things people might have in mind when they say that they are afraid of seeing a doctor?"

The pretest revealed that a particularly frequent reply to this question is, "They're afraid the doctor will find something really wrong with them" or "He might tell them something they don't want to know about." Record all these replies verbatim but be sure to probe for "What is it about finding out they're sick that they're afraid of?" "Is there anything else?"

QUESTION 35: Interpret this question literally. "Have you yourself, or anyone you know" (not necessarily a close friend or relative but on the other hand, someone the person knows or knew; not a case he read about in the papers) "ever" (even a long time ago) "had a bad experience" (not necessarily as a patient, but any experience) "with a doctor" (any doctor of whatever kind) "which made you lose some confidence" (even a little bit) "in doctors generally" (not just in that particular doctor, but some loss of confidence in all doctors, generally).

Give the respondent all the time he needs to think back; don't hurry him. Repeat the question if he doesn't seem to understand it completely. Obviously, the question is "loaded" for a "Yes" answer, and if the respondent can think of any such experience, either his own or someone else's, circle Code 1 and ask all three sub-questions.

"A" is one of the few questions on which you can circle more than one code. If the respondent recalls more than one such experience, by people in different code categories, circle all of the codes that apply on "A." For example, "Yes I did about 10 years ago, and then recently this fellow that handled my wife's case" should be coded both 1 and 2.

"B," however, can receive only one code, and if more than one experience was mentioned, should be asked in terms of the highest category -- i.e., respondent first, spouse next, then relative, etc.

Report fully on "C," as far as space permits. The thing to probe for is what the respondent didn't like about the doctor; what the doctor did or didn't do that made him lose some confidence in doctors generally. This should be answered in terms of any earlier experiences with doctors as well as in terms of the most recent experience coded in "B."

QUESTION 36: This question asks for a comparison of the respondent's doctor in relation to "most other doctors in the United States." Repeat this part of the question, if necessary, to make sure the respondent understands, and don't accept such replies as "Well, he's the best around here" or "I don't know much about doctors in other places." Press for an answer in terms of this doctor vs. other American doctors generally, based on the respondent's own impression of the matter.

If he says, "I have no regular doctor," answer, "Well, I mean the doctor you would go to if you were sick."

QUESTION 37: We are anxious to pick up any dissatisfaction at all on Q. 37. So give the respondent time to think, and encourage him by saying, "Even little things." If there were any things he was not entirely satisfied with, in the medical care and treatment received by either himself or anyone in his family circle Code 8 and ask "A."

If any respondent replies that no one in his family has been sick and/or has been to a doctor in the past 5 years, circle Code 7 for "entirely satisfied" and record the comment. Note, however, that this question may apply even if the respondent or his family had no medical care at all, but had need of it. In that case, probe to ascertain whether he is in fact satisfied or "dissatisfied" with doctors because of the care he did not get by repeating the question.

As usual, on "A" probe for complete and specific answers. Don't stop with such vague replies as "They didn't do a very good job," "I thought the doctor could have done better," etc.

QUESTION 38: Let the respondent interpret "health matters" in whatever way he chooses. Don't explain the term. Furthermore, don't try to define what is meant by "often" or "once in a while." If the respondent says, "I read them sometimes" or "It depends," ask him for a choice among the prescribed categories, and if he can't decide or continues to qualify, code him as "don't know." Of course, a reply of "Never" would be coded as "Hardly ever" since we don't have a separate code for it.

"A" is asked of those who "hardly ever" (or never) read newspaper articles about health. If the respondent volunteers some reason other than the two suggested (for example, "There's no health column in the local paper"), circle Code 8 and write in what he says.

QUESTION 39: Similar to the previous question, this one deals with radio and television programs concerning health. As usual, let the respondent interpret the question as he will. If he thinks that a particular program deals with health, accept his answer even if you are dubious. The same general rules apply to this question and its sub-part as to Q. 38.

QUESTION 40: You will notice that all these statements are critical of doctors, "Things people sometimes don't like about doctors." Read this part of the instruction to the respondent slowly and with emphasis, so that the respondent is perfectly clear that we are asking about criticisms. And about halfway through the list add, "And here are some more things people sometimes don't like about doctors" and continue with your statements. Of course each statement must be followed by the question, "Do you think that's true of most doctors, true of some doctors, or true of hardly any doctors?"

Sometimes a respondent may just say "No" or "That's true" to a statement. In the first case, you would probe by repeating the relevant part of the question: "Well, would you say it is true of 'some' or 'hardly any' doctors?" And in the second case where the respondent signifies general agreement, repeat: "Well, would you say that's true of 'most' or 'some' doctors?"

And if the respondent qualifies his response in any way, get him to select one of the trhee answer categories, but be sure to record verbatim his comment. You may use the reverse side of the page for this if necessary, but please indicate the appropriate item that the comment is about.

Notice that "B" is asked concurrently with "A," that is, as soon as the respondent agrees that either "most" doctors or "some" doctors behave in the way the statement describes, ask, "Have you yourself ever had a doctor like this?"

Remember, you will read each item "A" through "O" one at a time to the respondent, circling his answer on one before proceeding to the next. You will have one code from 1-4 circled on every line -- in answer to "A," and where either Code 1 or 2 is circled, one code under "B" must also be circled on that same line.

Since this is a long list, enter your codes carefully checking that you are on the right line. As in Q. 29, we have separated the items into groups of five, in order to assist you to accurately enter the answers.

QUESTION 41: Here we are interested in finding out which respondents have had care in a clinic or medical center, the kind of place it was, and how satisfactory the care was. We are defining clinic and medical center broadly to include almost everything except care at private doctor's office and in-patient hospital care. For example, we will consider appropriate here veterans services, union and company health services, medical centers of health insurance plans, out-patient hospital clinics and the like.

"A" asks the respondent if he has had any of this kind of medical care during the last 5 years or so. If he has (Code 1 circled), go on to "C" and "D." If he has not (Code 2 circled), ask "B" before deciding whether to continue with the question.

Please note that we are treating the "Don't know" answer category a little differently on this question. If you have a respondent who says he can't remember if he had clinic or medical center care during the past 5 years, consider this a "No" answer, circle Code 2, and ask him part "B."

If the respondent says he does not know what you mean by medical center, explain that you are talking about "Any place where several doctors share an office and work together" and find out whether or not he has had this care.

In other words, avoid using the "Don't know" category as far as possible.

On "B" we ask those who have not had a clinic or medical center experience in the last 5 years, whether they have ever received this kind of care. Those who have not go directly on to Q. 42. Those who say "Yes" on "B" are also asked "C" and "D."

Thus, "C" and "D" are asked of everyone who has at any time been to a clinic or medical center. On "C" a public clinic would be any government connected (like veterans) or totally supported (city hospital clinic) place.

"E" is asked only of those answering "C" and "D" who were "not entirely satisfied" with their experience (Code 2 circled on Col. 63). This is an open-ended question, so be sure to probe for a specific and complete answer as to what the respondent was not satisfied with.

QUESTION 42: This question asks about clinic experiences that any acquaintance, friend or relative may have had, which affected the respondent's own attitudes toward public clinics. It is comparable to Q. 35 which was asked in much the same terms regarding experiences with doctors.

As on the earlier question, the wording is broad, and geared to encourage a "Yes" answer so we can ask the sub-questions. If anyone the person knows ever had any experience with a public clinic which gave the respondent a poor opinion of that clinic, code "Yes" and ask "A" and "B." Give the respondent all the time he needs to think back, and repeat portions of the question as necessary to encourage him or help him understand.

More than one code can be circled on "A" if the person mentions several people who fit different categories. On "B," probe as necessary to the point of the question: what the clinic did which gave the respondent a poor opinion of it.

QUESTION 43: This may be a difficult question, so read it slowly and repeat it if necessary, to be sure the respondent understands. In reading the question, emphasize doctors who "work for a salary." Explain, if necessary, that "on a salaried basis" meant "the group or business they work for pays them a salary, and they themselves don't charge their patients anything." As usual, emphasize that you just want the respondent's own impression of the matter, even if he doesn't have any first-hand knowledge.

On "A" probe for the reasons salaried doctors would treat their patients better or worse. Respondents will sometimes answer in terms of their own experience: "I knew a lot of them in the Army and they were worse," or "My husband has one at his plant and he says he treats you fine." Such responses don't tell us why salaried doctors are better or worse. Probes like these might prove helpful: "What is it that you like (dislike) about them?" or "What do they do that's better (worse)?"

QUESTION 44: This question contains nine statements of criticism about public clinics on which you are inviting the respondent to agree or disagree. Find out for each item whether the respondent thinks it is "generally true or not true of most public clinics?"

Avoid "don't know" answers. Some people will say they don't know anything about public clinics so can't answer the question. Others may answer, "I guess that's true of some clinics, but I don't know how many." Remind the respondent that you just want his general impression as to whether the statement is true of most public clinics -- his "best guess" if necessary. A convenient probe might be: "Well, do you think that happens often in a public clinic?"

Be alert to double negatives. On "H" the answer may be "No they're not." This is an agreement with the statement that doctors are not considerate and should be coded 7 for "True."

QUESTION 45: Here again, we are interested in the respondent's overall impressions -- this time of the Public Health Service. We know that hardly any people have information about the various functions of the PHS. However, they may have attitudes and opinions without having much information. Therefore, this question is designed to elicit any critical impressions or compalints the respondent may have about the Public Health Service. So do not spend time elaborating the functions of the Health Service. Re-read the question if necessary.

"A" is the key question here. For those who are critical of the Public Health Service (Code 2 circled in Col. 78) we want to know what exactly they are disappointed about.

In both this question and the one following we have purposefully been vague as to what level of government and health service we are asking about. It is to be interpreted to include any and/or all levels the respondent has in mind -- local, state, or federal health services.

QUESTION 46: This is a direct question about the respondent's attitudes toward the role of government in health matters. All levels of government are included for the respondent's consideration.

Many of the questions are purposely "loaded" to elicit extreme reactions. Be careful not to show your personal approval or disapproval at any of the answers. Be alert to double-negatives. In part "D," for example, an answer of "No, they

shouldn't" is an agreement with the statement, "the government should not provide doctors' services for the needy." There are eight parts to this question and only one code must be entered for each part.

QUESTION 47: This is the first of a crucial series of direct questions on the test and measurements phase of the survey. In this question, we want to know about the respondent's overall impressions of the willingness or unwillingness of most people to come for the tests.

If the respondent says, "I don't know what most people will do," answer, "Of course, no one can be sure, but just from what you believe about people you know, do you think they will certainly come. . ."

If he says, "It depends on the time and place" or "If I have the time," answer, "Well, assuming the time and place are convenient, do you think. . ."

If he says, "It depends on the tests they want to give," answer, "Well, you know they'll take the height and weight and check eyes, heart and lungs and things like that. Do you think most people. . ."

If he wants to know if there will be a charge, assure him it will be free.

Be sure to record all these qualifications and questions the respondent has verbatim, but probe for a selection of one of the three categories.

QUESTION 48: This question is like Q. 47 but applies to the respondent's own willingness to come. The comments made on Q. 47 also apply here.

"B" is asked of all persons, after one code has been circled in "A." Try to get specific reasons for the answer to "A." What in particular did he have in mind when he made his selection in "A." Since this is a free answer, the items the respondent mentions are an indication of the things most important to him. Probe for anything else to be certain the answer is complete.

QUESTION 49: Some of the answers to this question may be volunteered in the previous question. Use the usual explanation, "This may have already been mentioned, but the next question is. . ." We want to know of any concerns or even vague doubts about the nature of the tests which the respondent may have.

If he asks, "What do you mean?" answer, "Well, do you have any questions about the sort of tests they would give you?"

If he answers the question in terms of results of the tests, record the answer and ask: "Are there any questions you would have about the sort of tests they'll give you?" If the respondent has no questions about the tests themselves, circle Code 2.

"A" is asked only if the respondent answered "Yes" to the first question (Code 1 is circled). Probe for anything else to get a full answer.

QUESTION 50: This is the last of the free answer questions about the tests and measurements part of the survey. It is designed to uncover the respondent's expectations and preferences with regard to the exam, and contains three parts. Each of the 3 parts is asked of every respondent.

"A" is designed to find out just what assumptions the respondent is making about the tests.

"B" is intended to find out any special interests or concerns the respondent has, probably about his own health, that he would like answered by the tests.

And "C" will be useful in finding out what things may make people want to stay away from the tests.

Of course, the respondent's answer may spontaneously overlap two or more parts of the question. Just record it as it comes and be sure to probe for any part that is missing, and "anything else?"

Since this question is of great importance to the USPHS people in planning their health tests, be sure to probe for as full a reply as possible on all three parts.

QUESTION 51: There are five parts to this question and one code must be entered for each part -- every respondent is asked all 5 parts. We are interested in the possible sources of influence on a person's decision to come for the tests. Be sure to record any volunteered comments, because they may help us to evaluate answers to Q. 47 and 48.

If he wants to know, "What is the medical society?" tell him, "That's the group most doctors around here belong to."

If he wants to know what we mean by "religious advisor," answer, "You know, your pastor, priest or rabbi."

If he says, "I know he wouldn't approve" to one of the categories, answer, "Well, just suppose he did, would you be more likely to come?"

QUESTION 52: This is perhaps the most important single question in the interview. It presents a series of alternative arrangements in which the tests may be given, and whether they would influence the respondent's willingness to come.

There are nine parts to the question and everybody is asked all 9 parts. Read the introduction slowly and be certain that all three alternatives -- "Will certainly come;""will probably come" and "probably won't come" are understood. The "not appropriate" applies to Part "C-2," where there are no children in the household, and to Part "G," if there are no other grown-ups or children in the house.

Remember to enter one code in each row. Each part is divided into a number of alternatives and an answer must be secured to each alternative. Repeat the answer categories every once in a while to make certain the respondent knows what the choices are. For example, on "B-1" say, "What if it is given on a morning during the week, will you certainly come, will you probably come, or do you feel you probably won't come?"

If he says, "It makes no difference," answer, "Well, then will you certainly come, will you probably come, or do you feel you probably won't come?"

Part "A" deals with time and distance of travel.

Part "B" deals with the day of the week and time of the day. If he says, "On some mornings I'm off," answer, "If it was on that morning, would you. . ."

"C" deals with costs. Remember the exam is free. If he says, "There are no taxi cabs here," answer, "Well, if your transportation cost is paid. . ." If he says, "I have no children," code "Not appropriate." If he asks, "How much would they pay me for my time?" answer, "Well, I don't know exactly how much. But suppose it made up for the money you lost by coming. . ."

"D" deals with the kind of place in which the tests could be administered. If he questions the adequacy of equipment in a trailer, etc., assure him, "Well you know they'll be specially designed and scientifically equipped."

"E" deals with the people who might give the tests. If he says, "You mean the local AMA?" answer, "I'm sure the local AMA approves the tests, but I believe the doctors are approved by the National offices of the AMA."

"F" deals with the length of the exam.

"G" deals with the people offered the tests. If there are no children or other grown-ups, code "Not appropriate."

"H" deals with the possible feelings of modesty. If he asks, "What is a coverall gown?" answer, "It covers your whole body."

"I" is the last catch-all part of the question. If the respondent has said he "Probably won't come" to most parts of the question, leave the parenthetical phrase out and ask, "Would any arrangement make it possible for you to come?"

If the respondent has indicated he "probably would come" under certain arrangements, use the parenthetical phrases.

If the answer to "I" is "Yes," circle Code 1 and ask "What is that?" Probe for specific arrangements that would make it possible for him to come.

QUESTION 53: This is the first of the concluding set of questions dealing with selected respondent characteristics. On the initial Census interview, questions were asked about age, education and other personal characteristics, so they are not repeated here.

In this question, we want to know whether the respondent was ever interviewed on a survey before the Census interview. In some cases the respondent will tell you he, himself was not interviewed by the Census (his respondent number on the Face Sheet is not circled). In this case, rephrase the question as follows, "Well, have you ever been interviewed before by another interviewer?"

Remember, we are not considering a "job interview" in this question, but are including all kinds of household interviews both commercial and non-commercial. We are also not including the regular decennial Census of Population.

QUESTION 54: This question concerns his overall attitudes toward social surveys and interview studies.

If he wants to know what we mean by "opinion" surveys, tell him, "Well any interview where they ask you about your ideas and feelings."

As in other precoded questions, we are interested in his general, overall attitudes, not any specific experiences.

QUESTION 55: This is a four-part question, with Parts "A," "C" and "D" asked of everybody, and "B" asked of all "Protestants." It concerns the religious preference of the respondent and the importance of religion in his life.

We use the term "religious preference" because a person may not belong to any organized church or congregation but still identifies himself with a particular group.

The major faiths have been prelisted, but if the respondent adheres to a faith not listed, circle Code 4 (Other) and enter the name of his religious preference.

"B" is asked only of all "Protestants," and should not give you any difficulty. Get the specific name of his denomination.

"C" refers to his usual attendance, not just his present behavior. Use the regular probes, "In general," etc., to get the overall pattern of behavior.

"D" is asked of everybody and "synagogue" is used for members of the Jewish faith.

QUESTION 56: This deals with the countries in which the respondent's father and mother were born. In cases where a particular town has been shifted from one country to another in recent years, use the present country as the country of birth. If they were born in the United States, just enter USA.

Be sure to enter your name on the face sheet, and the date and time of interview on the last page.

If you have any problems be sure to let the New York office know about them.

GOOD LUCK!

Paul N. Borsky
Study Director