1976

Socioeconomic and Medicare Status Differences Between Elderly Church Service and LDS Private Pay Hospital Patients

Edward L. Soper
Brigham Young University - Provo

SOCIOECONOMIC AND MEDICARE STATUS DIFFERENCES BETWEEN ELDERLY CHURCH SERVICE AND LDS PRIVATE PAY HOSPITAL PATIENTS

A Thesis

Presented to

the Department of Health Science

Brigham Young University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Edward L. Soper

April 1976

This thesis by Edward L. Soper is accepted in its present form by the Department of Health Science of Brigham Young University as satisfying the thesis requirements for the degree of Master of Science.

Don D. Shaw, Chairman

Brent Hafen, Committee Member

Dec 12, 1975
Date

Ray Watters, Department Chairman

TABLE OF CONTENTS

LIST OF TABLES

Table

Chapter 1

INTRODUCTION

In 1974 the Medical Welfare Office of the Church of Jesus Christ of Latter-day Saints provided $1.4 million in cash financial assistance for medical expenses to needy members in Utah. (12) Of that amount, $1,327,070 went to assist needy patients on or near the "Wasatch Front" of Utah - an area where membership of the Church, as well as the state population, is concentrated: in 1970, 821,691 or 78 percent of the state's population lived in the four counties in this region. (17)

But a more significant reason for the heavy usage of "medical welfare" funds in this region is the fact that bishops in this area have 1) historically had access to a system of hospitals which, until April 1, 1975, were owned or operated by the Church; and 2) had available a simple method of arranging for the Church proper to pay for hospital expenses of the needy. Bishops have been able to provide indigent members with a payment guarantee in the form of a "Medical Services Request Form," which authorized hospitals to bill the Church central offices for care rendered the holder.

Although central monitoring provided protection against abuses of that system by the hospitals or the patients, the Church, in effect, underwrote all hospital costs not collectible from sources other than the patient.

The presence of this hospital system (the Medical Services Request Form was not honored by non-Church hospitals) and the existence of the form itself led to a relative over-utilization of medical welfare funds in the state of Utah as compared to the rest of the Church. In 1974, 98.5 percent of medical welfare funds were expended in Utah, where only 24.3 percent of the membership resided. (12)

It should be noted that bishops in other areas of the Church - outside the service area of the Church hospital system - were also able to pay for the medical expenses of needy members by simply writing a check on local donated fast offering funds. Should expenses exceed that which was available in the local Church account, additional funds needed could easily be secured from Salt Lake City by merely "overdrawing" the local fast offering fund through use of funds in other accounts. The amount over-drawn would be automatically reimbursed from the local stake or Salt Lake City the next month.

Why, then if all bishops had relatively equal access to funds for the medical expenses of the needy, did medical welfare

(disbursed to the Church hospitals) so greatly exceed medical payments from fast offering funds (paid to non-Church hospitals)? There were a number of factors thought to account for much of the Church hospital utilization, including 1) the ready availability of donated care by staff physicians, who as a condition of appointment were required to rotate onto "Church Service Care" at the hospitals; 2) a greater emphasis, over a longer period of time, on usage of medical welfare in Central Utah, where the Church had been long-established; 3) a relatively greater concentration there of older (age 65 and over) members of the Church; 4) the greater need of these elderly for financial assistance to pay for hospital care.

But this last assumption had been questioned. Since the advent of Medicare, no other group (senior citizens) in the population as a whole had been so well-covered by hospital insurance. Yet an internal study completed in early 1975 showed that 42 percent of all medical welfare expenditures by the Church went to pay for the expenses of the elderly, who constituted only 14 percent of Church membership.

A 1972 study on Church Service outpatients at L.D.S. Hospital revealed that some Salt Lake City stakes had as many as 100 or more elderly members at any given time on medical welfare. (13)

Only five stakes (out of 219 in Utah and 702 in the Church) in Salt Lake City account for on the average, 20 percent of all elderly Church Service patients in the Church.

Therefore, there were two questions that needed to be answered: why did some elderly, who were ostensibly eligible for Medicare, require Church financial assistance, and why the concentration of elderly Church Service patients in Salt Lake City? Therefore, the following problem was proposed.

STATEMENT OF THE PROBLEM

The problem was to determine the kind and degree of differences that existed in the socioeconomic status and access to financial resources of elderly members of the Church of Jesus Christ of Latter-day Saints who required Church financial assistance for payment of hospital bills, versus other elderly members who did not require such assistance. The following subproblems were investigated:

1. To what extent were elderly Church Service patients covered by Medicare?
2. For those covered by Medicare, were "ineligible" or non-covered expenses higher for Church Service than for private pay patients?
3. Among those patients was there any reluctance to enroll for or accept Medicare benefits?
4. Why was the greatest concentration of elderly Church Service patients found in Salt Lake City?

HYPOTHESIS

A null hypothesis to the effect that there would be no significant differences between Church Service and private pay patients on a series of indicators relating to socioeconomic status, to relative access to financial resources, and to attitudes concerning medical care and financing of care when tested. The null hypothesis was not rejected when statistical significance was higher than .05.

Also tested at the same significance level was the null hypothesis that Church Service patients would be equally covered by and have received reimbursement from Medicare, as compared to private pay patients.

DELIMITATIONS

This study dealt only with elderly members of the Church of Jesus Christ of Latter-day Saints who received care at selected hospitals, and for whom records were complete, during the year 1974. Patients at only three hospitals were studied: Latter-day Saints Hospital in Salt Lake City, Utah Valley L.D.S. Hospital in Provo and McKay-Dee Hospital Center in Ogden.

Patients age 65 and over at these hospitals, both inpatients and outpatients, were sampled so as to yield equivalent-size random samples of such patients who were members of the Church and who had received Church financial assistance through a "Medical Services Request Form" versus members of the Church, who as patients, did not receive such financial assistance.

Conclusions of this study cannot, therefore, be extended to all elderly members of the Church, nor to elderly members who received hospital care, nor even to the elderly who received Church assistance for medical care.

Likewise, since the study was, in effect, a one-time measurement of socioeconomic indicators and attitudes, it cannot be used to answer the question, "What causes some elderly members to get into a situation where Church financial assistance is required for medical care?"

However, by identifying the socioeconomic characteristics of elderly member patients in three principal centers of "Mormon-dom," it can provide a guide for teaching financial, career, and other planning so as to avoid those circumstances in later life.

JUSTIFICATION

It has been noted that a significant change occurred in 1974 and 1975 in the system of hospitals formerly owned by the Church

of Jesus Christ of Latter-day Saints. On March 31, 1975, the fifteen hospitals so organized were divested by the Church, and ownership or management transferred to Intermountain Health Care, Inc., a private non-profit management corporation.

Severance of Church ties with the hospitals meant that the system used for handling medical expenses of the needy Church member would need revision. Information was needed to determine what impact this would have upon the hospitals, upon local lay Church leaders, and upon the indigent members. This study was conceived as a partial answer to those questions.

DEFINITIONS

The following terms, most not in common usage, are used in this document and not elsewhere defined:

LDS - Colloquial abbreviation for "Church of Jesus Christ of Latter-day Saints.

Mormon - The colloquial adjective used to describe a member of the Church of Jesus Christ of Latter-day Saints or to refer to the Church or some aspect of it.

Bishop - The presiding officer over the smallest local unit of the Church of Jesus Christ of Latter-day Saints, a ward.

Stake President - The presiding officer over the local Church unit composed of several wards, a stake.

Medical Welfare - The program of financial assistance to those needing medical care that was disbursed directly to hospitals formerly owned by the Church of Jesus Christ of Latter-day Saints.

Medical Welfare Office - The central disbursing point in headquarters of the Church of Jesus Christ of Latter-day Saints.

Fast Offerings - A voluntary financial donation made by many members of the LDS Church on a monthly basis, the purpose of which is to meet the cash needs of the needy poor.

Medical Services Request Form - Internal Church form used by bishops to authorize Church payment of hospital bills of the needy; also called "hospital recommend." Use of this form was discontinued on September 30, 1975; until then it was honored at all hospitals formerly belonging to or managed by the Church of Jesus Christ of Latter-day Saints.

Church Service Patient - A hospital patient (member or non-member of the Church of Jesus Christ of Latter-day Saints) whose hospital expenses are paid in part or full by the Church.

Private Pay Patient - A hospital patient who does not receive financial assistance for hospital expenses from the Church.

Church Service Care - Donated services by a physician or other health care provider to a needy member of the Church.

Medicare - The federally-funded hospital and medical insurance program for the elderly and certain disabled persons.

Medi-Cal - Medicaid (the joint state-federal medical payment program for those under the age of 65) as administered in the state of California.

Poverty Threshold - The federal definition of family or individual socioeconomic status (income) deemed minimal for meeting normal living expenses. The poverty threshold varies according to sex, age, location and other factors, and ranges from $1,487 for an aged single female living in a rural area to $6,907 for a large urban family.

Socioeconomic Differences - The differences in indicators of socioeconomic status, in access to financial resources, and attitudes concerning the financing of medical care on the part of elderly Church Service versus private pay patients.

Medicare Status Differences - The differences in covered status or enrollment and reimbursement received of Church Service versus private pay patients.

Elderly - Those who are age 65 or above.

Chapter 2

REVIEW OF THE LITERATURE

There is no literature, as such, specifically related to characteristics, behavior, or other factors associated with "Church Service" patients. Too little is known about the Church Service patient, often even by the bishop who interviews the needy member and provides the "Medical Services Request," which guarantees payment of hospital-related expenses. Only one previous study, completed by staff at the Latter-day Saints Hospital in Salt Lake City in 1972 is extant. (13)

However, there is a great deal of gerontological literature dealing with the health status and needs of elderly members of the population. Background information, obtained from a brief review of that literature in preparation for carrying out this study, is presented below.

Cicero in his essay, "On Old Age," has Cato say to Laelius, "The Philosopher, himself, could not find old age easy to bear in the depths of poverty." (10)

In Utah in 1972 there were an estimated 87,614 persons age 65 and over. (17) Of these elderly, approximately 16.5

percent or 14,456 persons were below the poverty threshhold (in Cato's "depths of poverty"). (18) And, like Cato, some of them find it difficult to live in poverty.

This study deals with some of the most basic problems confronting older people. Nancy Anderson, writing in 1973, reported that, "Surveys of older persons and professionals in the field consistently identify income maintenance and health care as priority problems No. 1 and 2." (1)

Physiological deterioration and chronic disease take a heavy toll among those over 65. Many suffer from such life-threatening problems as atherosclerosis, emphsyma, diabetes, cancer and ischemic heart disease. (6,15,19,24)

The typical elderly patient presents, in medical terminology, a picture of numerous and complex etiology. Physical changes that the older person undergoes may include:

1. A decline in the ability to utilize nutrients as effectively as in youth or middle age.
2. Reaction to infection and ability to repair damaged tissue are both affected adversely.
3. The adaptation to demands for sudden activity (e.g., violent exercise) is poor as is the response to changes in heat and cold.
4. Dental caries and gingivities are common and, in the elderly who wear dentures, alveolar absorption interferes with correct fit.
5. Feet develop a variety of diseases or deformities. Even the humble corn can assume major importance.
6. Obesity - developing as it often does in those people with a tendency to "run to fat" - can become a serious handicap.

7. Other major disabilities - some so common as to be thought of as almost a part of the aging process itself, make their appearance at different ages, and to differing degrees - arthritis - arteriosclerosis - hypertension - malignant disease in its various forms - all create problems that frequently increase dependence. (8)

Lack of adequate nutrition is often a problem faced by the elderly. Limited income may restrict the purchase of adequate amounts and right kinds of foods, and provide for no more than meager cooking facilities and refrigeration. A number of other factors may pose obstacles to a good diet: inadequate dentition; decreased appetite; reduced activity and increased fatigue and weakness; lack of incentive to prepare meals; loneliness, unhappiness and anxiety; reduced sense of taste, sight and smell and motor skills; and physiological deterioration. (14)

Given the multiple health problems and obstacles of the elderly, it is no wonder that they utilize a disproportionately large share of medical services in this country. Concomittantly, their medical expenses are higher than for younger people. Whereas young people, that is, those 19 and under, in 1971 had an average of $140 in medical expenses, and the 19 to 64-year old person incurred an average expense of $323, medical expenses of the aged averaged $861 per year. Although this group constituted only 9.9 percent of the total population, 27.4 percent of all health care expenditures were amassed by the elderly. (21)

The rate of increase in health care expenditures for these age groups from 1966 to 1973 was twice as great for the elderly as for those younger.

With the advent of Medicare proportionate out-of-pocket health care expenses of the elderly dropped to about one-half the 1966 level, but because of higher costs of care and increased use of services, the amount the elderly person paid directly in 1973 ($225) was only slightly below that paid in 1966 ($234).

By May 1974 DHEW reported that Medicare paid for 40 percent of the health bill for aged people; yet direct personal payments had risen to $311. In general, the aged were well-covered by insurance: 70 percent of those over 65 were covered by a third party provider, while only 60 percent of those under 65 were so insured. (22)

In 1970 the Social Security Administration reported:

> The annual health bill for the average old person has been calculated at $791, nearly three times that for the lower age groups ($280). The United States currently spends 27 percent of total health expenditures on behalf of the aged, though these comprise only 10 percent of the total population. (20)

Statistics previously cited lead to the suspicion that the financial burden imposed by health on the elderly has since become heavier.

As might be anticipated, that burden was too much for many of the elderly. Data for the 1972-73 fiscal year in Utah

were receiving state financial assistance for health care expenses, as shown in the following table (16):

Table 1

Assistance in Medical Payments
FY 1972-73
State of Utah

Type of Care	No. Assigned	Expenditure	Average Expenditure
Physician Care	583	$ 98,436	$ 168.84
Inpatient Hospital	134	496,735	3,706.98
Outpatient Hospital	383	111,686	291.61
Drugs	2,410	553,140	229.52
Skilled Nursing Homes	729	2,761,897	3,788.61
Intermediate Care Facilities	901	2,085,341	2,314.47
Dental	4,900	50,170	10.24
Health Maintenance Organization	49	233,560	4,766.53
Other	792	10,638	13.43
Medicare Premiums	4,530	331,451	73.17

The higher medical costs for the aged, combined with their lower income, make it particularly difficult for them to be self-sufficient in payment of medical expenses. Medicare has, undoubtedly, allayed that problem to some extent. And nearly all of Utah's aged are covered by Federal Old Age, Survivors and Disability and Health Insurance, (OASDHI).

During the early years of OASDHI, immediately after the depression, few Utahns applied for benefits. Mormon Church leaders had, especially after the Church Security Plan was inaugurated in 1936, cautioned members against "getting something for nothing" - and by 1940, the first year that OASDHI benefits were payable, anticipated benefits still exceeded premiums that had been paid in. In that year only 406 persons in Utah applied for benefits. A decase later, still only 3,700 persons were receiving benefits. By 1960, however, that number had jumped to 27,400, and in 1970 reached 51,327. At that point approximately 96 percent of those eligible were receiving benefits. (17)

The "social security pension" is, according to the Social Security Administration, "to replace partially the income that is lost when a worker retires, becomes fairly disabled or dies . . . and to provide partial protection against the high cost of health care during old age and disability." (23)

Beginning in 1965 Congress gave specific attention to health care expenses of the elderly. In that year the Medicare Amendment was passed, and became law in 1966. This law provided that basic hospital insurance protection, financed through contributions paid while the individual was working, is provided against the cost of inpatient hospital services for all who are eligible for any type of Social Security or Railroad Retirement Pension when they reach age 65. As of 1973, Medicare benefits were extended to persons who, regardless of age, are entitled to a disability pension. Since 1973 workers or their dependents who require kidney dialysis or transplantation are also eligible for benefits.

Eventually all personsl who have worked in the United States become eligible at age 65 for OASDHI, or other retirement benefits and thus for Medicare benefits. The law provides, however, that immigrants and others who do not earn eligibility may voluntarily enroll for hospital insurance by paying the full premium cost (rates vary from year to year). State and other public employee groups do not participate in federal OASDHI, but may be enrolled as a group by their employer on the same basis as those who are eligible for coverage.

Services eligible for Medicare payment include:

(1) Inpatient hospital services up to 90 days in each benefit

period, subject to a deductible and co-insurance payment after the 61st day. (2) Post-hospital extended care services (after three or more days of hospitalization) in an institution or convalescent section of a hospital which qualifies as a skilled nursing facility. After the first 20 days there is also a co-insurance payment. (3) Post-hospital home health services for a maximum of 100 visits during the year following a three-day or more hospital stay.

In Utah, as in many other states, Medicare is actually administered by Blue Cross-Blue Shield. The federal agency reimburses the state insuror at "reasonable cost" plus administrative overhead. Two basic programs of Medicare pay for hospital costs and certain non-hospital costs. The two programs are titled "Hospital Insurance" (HI) and "Supplementary Medical Insurance" (SMI). SMI is a voluntary enrollment program requiring the payment of monthly premiums. After the participant has paid a calendar-year deductible of currently $92 (usually revised upwards annually), the SMI plan covers 80% of reasonable charges or costs for the following services not included in the basic (HI) plan: physician and surgeon services, outpatient hospital services, outpatient physical therapy, limited ambulance services, surgical dressings, splints, casts and many prosthetic devices. SMI also covers radiology and pathology services to

hospital inpatients, and home health services costs after the deductible.

Payments for physician services can be made in one of two ways: (1) A beneficiary may file a claim for reimbursement based on an itemized bill, and receive payment for 80 percent, or (2) the physician may accept an assignment for the billing and receive direct payment for the reasonable charge as his full fee. The patient then pays no more than the deductible and 20 percent of the balance of the reasonable charge.

Since so many enroll for and must pay the monthly premium for SMI, to facilitate payment the government normally withholds the premium from monthly pension checks.

To ensure the quality and effectiveness of Medicare services, congress in 1972 established a peer review system (professional standards review organization or PSRO). These state organizations review selected patient cases for medical necessity, appropriateness and quality of service provided.

SMI recognizes that the patient does not always need hospital care. Studies have shown that:

> On follow-up (on release of geriatric patients from a hospital) four in ten released or rejected patients were judged to need one or more social or medical service; hospitalization had provided only a temporary solution for patients. Few received health or social services; when they did come, these were uncoordinated. (11)

But other patients may not need care of any type, as traditionally defined. A study of indigent persons receiving Medi-Cal benefits in California revealed that:

> Illness and a need for medical attention are not absolutes, but depend on the patient's perception of his symptoms and condition. Some persons accept the "sick role" more reluctantly than others, depending not only on how they feel, but also on a host of other variables - social mores, childhood training, personal knowledge of acceptable health practices, other commitments they may have on that day, how far it is to the doctor's office, how welcome they will be when they arrive there, etc.
>
> Sickness, therefore, is relative, and so is the judgement as to whether or not one should see a doctor. Some patients may see a doctor 100 times and not be over-utilizing, while others may see him only twice a year and be over-utilizing. (3)

The preceding comment is relevant to the utilization of medical services and the financial status of elderly Church Service versus private pay patients. Specific concern was expressed over the relatively high utilization of outpatient care facilities at L.D.S. Hospital in Salt Lake City by the elderly (and non-elderly). As will be seen later, even the clinic staff suggested that as many as half of the patients really did not need medical care; they needed the personal attention and show of concern that was provided to clinic patients. Not receiving love and attention at home, they looked to the clinic as a surrogate friend. That clinic may have tended to attract those who had "nothing better to do," and were less able to find other outlets for needs. Whereas Church

participation, social groups, clubs, and visiting friends usually met the social needs of some elderly, others lacked that social group association.

> A positive relationship between participation and voluntary associations and life satisfaction among the aged is an artifact of the manner in which participants differ from non-participants. Older persons with higher levels of participation are generally in better health, are of higher socio-economic status than are those with lower levels of participation . . . voluntary associations, self-select as members and as participants, persons who are initially more satisfied with their life situations by virtue of their health and status characteristics. (5)

The "success" of the L.D.S. Hospital Church Service clinic has partially been due to fulfillment of the need for such personal service for certain of the elderly. Unless those with unmet social needs can receive loving attention, they degenerate physiologically, as well as socially and emotionally.

Yet placing the lonely elderly in an environment where they are in contact with other elderly (a nursing home), is not usually the solution. A high rate of mortality is seen in older patients moved into nursing homes, even if relocation is prepared for. This despite the recognition that nursing home patients are often those who are most ill, and likely to die. Still, eight in ten elderly want to live in their own home and fear institutionalization. (2)

But the consequences of providing free care of any type are predictable. Jesus, out of compassion for the hungry

multitude, blessed and brake bread and fed 5,000 souls. Thereupon the crowds sought him to see a repeat of that charity. Christ, chagrined at the realization that the loaves and fishes were more palatable than the Word, said to the crowds which sought him: " . . . Ye seek me, not because ye saw the miracle, but because ye did eat of the loaves, and were filled." (9)

> It should be clear that the cause of today's medical crises has been the inexorable spread of free care throughout our population. The effect is an expanded and altered demand that is incompatible with the existing sick-care delivery system, wasting its medical manpower and threatening the quality and economics of the service it renders. It is grossly unfair to blame that effect on the medical profession. The delivery system functioned fairly well with fee-for-service under which it evolved. It became unbalanced on a so-called "non-system" under the impact of the poorly planned legislation of Medicare-Medicaid with its elimination of fees, and that result should not surprise anyone. Picture what would happen to air transportation if fares were eliminated and travel became a right. What chance would you have of getting anyplace if you really needed to? Even the highly automated telephone service would be staggered by a removal of fees and necessary calls would become practically impossible. The change from "fee" to "free" would disrupt any system in the country, no matter how well organized, and this is particularly true of medicine with its highly personalized sick-care service. (7)

Medical care for the L.D.S. Hospital elderly outpatient is not only free, but it is easy. Except for a periodic (usually at six-month intervals) interview with the bishop, which often was cursory, the patient may have had little contact with the bishop. He often was unaware of the cost of services or how the bill was paid. Billings were made directly to the Medical

Welfare Department of the Church. The Church Service patient was not involved in the financing of health care.

Summary

Without resorting to an exhaustive study of literature, little os which is immediately relevant to the specific types of individuals being studied, it is seen that the elderly as a group are generally poor, fact obstacles to good health, have high health care expenses and want to be independent, but are as human as the rest of us, and need personal attention.

Medicare was developed as a means of reducing the out-of-pocket medical care expenses of the elderly, especially the elderly poor. Despite the existence of Medicare - which does not pay for all medical care expenses - many elderly members of the Church of Jesus Christ of Latter-day Saints have sought hospital inpatient or outpatient care at former Church hospitals, especially at L.D.S. Hospital in Salt Lake City.

In this light, we shall examine the two groups of hospital patients described earlier, identify and define certain of their socio-economic characteristics, and attempt to evaluate the cost and range of services utilized by them.

Chapter 3

PROCEDURES

The Problem

The problem was to determine the kind and degree of differences that existed in the socioeconomic status and access to financial resources of elderly members of the Church of Jesus Christ of Latter-day Saints who required Church financial assistance for payment of hospital bills, versus other elderly members who did not require such assistance.

Population Boundaries

Subjects for this study were chosen from among elderly (age 65 and over) members of the Church of Jesus Christ of Latter-day Saints who received hospital care at the Latter-day Saints Hospital in Salt Lake City, Utah Valley Hospital in Provo, or the McKay-Dee Hospital Center in Ogden, Utah.

Sampling Process

The data presented here was derived from two sources: financial reimbursement data from the file of each patient selected at the indicated hospitals, and interviews with each of the patients so selected.

A decision was made early in the study to identify subjects via hospital records, since this approach would shed light on the central administrative question posed by Church leaders: why was such a high utilization of hospital medical welfare assistance seen among the elderly members of the Church?

Given the rather narrow scope of the study, which formed only one source of information about the total medical welfare program of the Church, recourse to hospital records substantiated by data from central files and personal interviews seemed appropriate. The intent in selecting subjects was to obtain a representative random sample of all elderly members who had received hospital inpatient or outpatient care at three hospitals during 1974, the last year for which payment and other records were complete. Original plans were to assemble a sample of approximately 30 patients in each of the two payment categories to be studied: those who received Church Service care, and those who were admitted and treated on a private pay basis, as are other patients. However, as records were examined at two of the three hospitals, it became apparent that it would be impossible to obtain that large a sample of Church Service patients at each hospital: during 1974 only 9 such patients were treated at Utah Valley Hospital, with only 1 of those being an outpatient; and

at McKay-Dee Hospital only 15, including 3 outpatients, received treatment. Therefore, all Church Service patients at those hospitals were accepted as part of the sample. (The small number of patients meant, of course, that analysis of differences in patients between the three hospitals would be impractical, since the sample size would not have been adequate for making statistically significant comparisons.)

Only at the Latter-day Saints Hospital was a random sample drawn - from the 384 eligible patients whose Church Service "recommends" were on file in the Outpatient Department, and from the 37 1974 inpatients whose records were still available. In the case of the outpatient sample, five percent of all patients were selected by choosing every 19th patient covered in the "recommend" card file. Of these 19, four were later disqualified or dropped from the study: two had moved and could not be traced, one had died and left no relatives for interview; and no hospital or Church membership could be located for the other.

All the patients identified at the other two hospitals, or their relatives, were located and interview schedules were completed. Thus none were disqualified or dropped. The procedure for selecting the non-Church Service, or private pay, samples at each of the three hospitals was more difficult. In all cases except at L.D.S. Hospital where admitting records are maintained in

the same file with payment records, and where patients age 65 and over were easily identified from the files themselves, a two or three-step process was employed.

Each hospital is required to maintain a record of Medicare-eligible patients. Since the hospitals now consider all patients over 65 to be potentially eligible, this meant that all aged patients were identified and included on a quarterly Medicare computer print-out, and classified as to the type of service (in-patient, outpatient or home-care) rendered. A sample size of approximately 15 was sought at each of the three hospitals.

Patients were randomly selected by dividing the inpatient and outpatient registers by 10 and 5 respectively (so as to yield samples roughly proportionate to the total numbers of inpatients versus outpatients in the Church Service samples). Billing records were then searched to determine if reimbursement had been received from third party payors, so that financial records would be complete for each patient. Finally, the original admitting form was reviewed to determine the patient's religious preference and ensure that the patient was, or claimed to be a member of the Church. Originally, 44 patients were identified via this system; this was accomplished after rejecting four random choices whose records revealed they were not LDS. Those 44 were reduced to 41 when three could not be contacted for interviews.

The following table summarizes the composition of the final sample from all three hospitals.

Table 2

Sample Composition

Hospital	Church Service Sample Male	Church Service Sample Female	Private Pay Sample Male	Private Pay Sample Female	Totals
Utah Valley	4	5	5	7	21
McKay-Dee	6	9	8	7	30
Latter-day Saints	7	13	6	8	34
Sub-totals	17	27	19	22	
TOTALS	44		41		85

Research Design

The research design used in this study is often used where a descriptive statement of population characteristics is desired, as opposed to testing a hypothesis over time. In effect, it assumes that an experimental technique common to all participants (the independent variable, or the sum of the events producing the observed socioeconomic status and other measured indicators) has previously been applied. By selecting patients from a common pool of subjects (Church members over 65) in restricted geographical areas, it further assumes that the random selection

process provides at least minimal controls for history and other variance between groups. It is, thus, assumed that the distinguishing variable (the need for Church financial assistance for hospital expenses versus ability to meet such expenses individually) is a product of the differences observed in other variables.

RA: X_1 O_1

RB: X_2 O_2

Where X_1 and X_2 = Experimental variable

O_1 and O_2 = First measurement

Pilot Study

The interview schedule, designed specifically for this study, was pretested with selected families in the Farmington Utah Stake of the Church of Jesus Christ of Latter-day Saints. As a result of this pretest, a number of changes were made in the format and wording of schedule items.

Data Collection Instruments

No formal instrument was used in the collection of financial data from hospital reimbursement records. However, a common format was used, as provided in the appendix of this study.

An interview schedule was constructed so as to elicit answers to questions related to some 22 variables or indicators

of socioeconomic status and attitudes. It was early hypothesized that significant differences, if any, between the two groups studied would relate to the economic situation of the individual, the relative availability of resources for payment of medical bills, the proximity and access to medical care, the type of care needed, the type of care actually sought by the patient, the real or perceived health status of the individual, the relative amount of medical bills, and attitudes towards sources of payment. The total of 76 questions were designed to obtain information in these areas. A copy of the final interview schedule is provided in Appendix B.

Financial data on patients was collected from the hospitals themselves and corroborated by figures in the central file of the Church Service patients at general Church headquarters in Salt Lake City, Utah.

Interviews with each patient identified in the sampling process, or with a relative or friend able to provide answers when the patient was medically unable to respond, were conducted. Three interviewers were personally trained by the researcher, and patients in each of the three areas were assigned randomly to the three interviewers. This approach ensured that some of the patients in each of the hospital areas would be interviewed by each

of the interviewers. The researcher followed up on a random basis to ensure that contact had, indeed, been made with patients.

The only exception to the above interview process occurred in the case of four patients who lived in remote parts of the state; these were personally interviewed by the researcher during a trip into Southern Utah.

Tabulation of Data

The data collection process for financial information was designed so that computer cards could be easily keypunched. The response items on the interview schedule were also designed and numbered such that responses were automatically identified as to card column and row, so as to facilitate keypunching.

Analysis

Data obtained through these two approaches was keypunched and analyzed on an IBM 360 Computer, using standard programs in the SPSS Inventory. Depending on the nature of questions or data, the two-tailed Student T test of means and/or the Chi Square test of frequencies was employed. The null hypothesis in each case was accepted or rejected at the .05 level of probability.

Summary

Following presentation of data and findings, a summary is presented in which these are reported and conclusions made based on significant differences observed between socioeconomic indicators, attitudes, and financial reimbursement data. Recommendations for further research, and implications for Church policy concerning medical welfare are given.

Chapter 4

FINDINGS

Questionnaire

An interview schedule was designed that would permit measurement of certain factors which, it was hypothesized, would impinge upon the ability of elderly members of the Church to pay for medical care.

The following discussion presents, in sequence, a series of postulated influencing or distinguishing factors, with the hypothesized results and actual findings. A summary is presented at the end of the discussion.

Each factor is identified in the tables by an abbreviated form of the variable statement as identified in each question in the survey instrument. Questions and the respective number of respondents are listed. Respondents are identified by "Church Service" versus "Private Pay" categories. Also provided in each table are appropriate statistics and significance levels.

Economic Indicators

It was hypothesized that certain economic factors would (a) affect adversely or positively the individual's ability to meet

medical expenses from his or her own resources, and/or (b) enable the researcher to differentiate between the two classes of elderly persons studied.

1. Type of Housing. It was hypothesized that private pay patients who were assumed to be more stable economically would be more likely to be living in a private home, whereas Church Service patients would be more likely to live in rented or other types of housing. Although the response to this item on the questionnaire showed a tendency to support that hypothesis, the pattern of responses was far from statistically significant. Therefore, the null hypothesis that there was no difference in the type of housing between Church Service and private pay patients was not rejected. (Table 3)

Table 3

Type Housing

Response	Church Service	Private Pay	Chi Square
1-House	27	30	
2-Apartment	10	7	
3-Room	2	3	
4-Boarding	0	0	
5-Other	5	1	
TOTALS	44	41	3.452

2. Home Finances. It was hypothesized that the private pay patient would be more likely to own his or her home, whereas the Church Service patient would be more likely to be paying rent or on a mortgage. The responses indicated a tendency in that direction, but again were not significant. Therefore, the null hypothesis that there was no difference in the home financing of the two groups of patients was not rejected. (Table 4)

Table 4

Ownership

Response	Church Service	Private Pay	Chi Square
1-Own home	19	25	
2-Renting	13	8	
3-Buying home	6	5	
4-Nursing home, other	6	3	
TOTALS	44	41	2.997

It was also hypothesized that there would be a difference in the amount of mortgage or rent payment and other housing expenses paid by the two groups, with the Church Service patients having higher monthly expenses.

Tables 5 and 5a reveal that the null hypothesis that there would be no monthly housing expenditure difference between

the two groups, was rejected only if responses were broken into two broad categories - expenses below $25 per month versus those over $25 per month. The private pay patient had lower monthly housing expenses.

Table 5

Housing Expenditure ($0 - $100+)

Response	Church Service	Private Pay	Chi Square
1-$0 - $25	19	28	
2-$26 - $50	4	2	
3-$51 - $75	5	3	
4-$76 - $100	7	3	
5-$100+	9	7	
TOTALS	44	41	4.906

Table 5a

Housing Expenditure ($0 - $25+)

Response	Church Service	Private Pay	Chi Square
1-$0 - $25	19	28	
2-$25+	25	13	
TOTALS	44	41	5.354*

* Significant at .025 level.

3. Marital Status. Although it is not true that two can live as cheaply as one, it was hypothesized that given current levels of social security retirement pension, based on a husband and wife living together versus a sole survivor, it would be easier for the married couple to pay medical bills than the single individual. The marital status distribution of respondents in these two samples was not significantly different, however. The null hypothesis was not rejected. (Table 6)

Table 6

Marital Status

Response	Church Service	Private Pay	Chi Square
1-Single	0	1	
2-Married	20	24	
3-Widowed, divorced	24	16	
TOTALS	44	41	2.861

4. Sex. Because a man would have had, or continue to have, greater earning power and social security reimbursement, as compared to a woman; because women generally outnumber men in the over-65 age group; and because previous studies had shown the ratio of women to men Church Service outpatients at Latter-day Saints Hospital to be at least 3 to 1, it was hypothesized

that there would be a greater number of women in the Church Service sample than in the private pay sample. Although the data indicate a tendency to support the hypothesis stated above, the difference in favor of a greater number of women in the Church Service sample was not statistically significant. Therefore, it was impossible to reject the null hypothesis that there were equal proportions of men and women in each group. (Table 7)

Table 7

Sex

Response	Church Service	Private Pay	Chi Square
1-Male	16	19	
2-Female	26	22	
TOTALS	42	41	0.29

5. Age. Because of the relatively recent advent of Medicare eligibility in relationship to the age of older individuals; because of the result of inflationary pressures on respectively smaller pensions for the very elderly; and because of the expected greater medical expenses of that group, it was hypothesized that Church Service patients would tend to be older

than private pay patients. A comparison of ages of those in the two samples, however, showed no significant difference. The null hypothesis that there was no age difference in the two groups was thus not rejected.

Table 8

Age

Response	Church Service	Private Pay	Chi Square
65	3	1	
66	1	1	
67	3	4	
68	2	3	
69	4	2	
70	1	5	
71	4	5	
72	2	2	
74	1	2	
75	5	4	
76	0	2	
77	3	0	
78	3	0	
79	1	1	
80	1	2	
81	2	0	
82	1	0	
83	0	1	
84	1	1	
85	1	0	
87	0	1	
91	1	0	
92	1	0	
94	0	1	
TOTALS	41	38	1.801

6. Education. There traditionally being a strong relationship betwwen income and education, it was therefore hypothesized that the elderly on Church Service would have significantly less formal education than those able to pay hospital expenses privately. Although the data shows a definite trend in that direction, the results are not significant if one looks at the entire range of schooling.

However, when the members of both groups who completed part or all, but no more than a high school education were excluded, and attention was focused on the distal groups (those with a grade school education or less, and those with post-secondary education), differences became highly significant. What was seen was a relatively higher concentration of poorly educated members among the Church Service patients, and a relatively higher number of the well-educated among the private pay patients.

It was interesting to note, however, that two-thirds of the Church Service patients had completed grade school education or more, and one-third had completed high school. About four-fifths of the private pay patients had completed grade school or more, and 40 percent had graduated from high school. The median years of education of the Church Service group was 9.9 years; that of the private pay group, 10.8 years. Although these

Although these figures were lower than those for the population of Utah as a whole, they were not markedly different from average years of schooling of the elderly Utah population. (18)

Table 9

Years of Schooling (1 Year to over 12 Years)

Response	Church Service	Private Pay	Chi Square
1-8 years or below	15	8	
2-9 - 11 years	14	16	
3-12 years	12	9	
4-Over 12 years	3	8	
TOTALS	44	41	4.906

Table 10

Years of Schooling (8 Years or below versus over 12 Years)

Response	Church Service	Private Pay	Chi Square
1-8 years or below	15	8	
2-Over 12 years	3	8	
TOTALS	18	16	6.732*

* Significant at .01 level.

7. Transportation. Since it was hypothesized that the Church Service patient would be poorer than the private pay patient, it was also assumed that he or she would be less likely to own a car. The survey did reveal a significant difference in the number of those in the two groups owning cars. Whereas only about half of the Church Service patients owned a car, 83 percent of the private pay patients had a vehicle. Consequently, the null hypothesis that there would be no difference in the proportion of those owning cars in the two groups was rejected.

Table 11

Car Ownership

Response	Church Service	Private Pay	Chi Square
1-Yes	21	34	
2-No	23	7	
TOTALS	44	41	34.92*

* Significant at .001 level.

8. Perceived Financial Status. Given the fact that the Church Service patient had requested (or for some other reason was receiving) financial assistance from the Church; and because it was assumed that he or she was, indeed, poorer than

the private pay patient, it was hypothesized that Church Service patients perceive their financial status less favorably than do private pay patients: they think of themselves as poorer. The results indicate that although about half of each group think they "have just enough to get along," none of the Church Service patients were willing to state they "have more than enough to meet daily needs," whereas about one-third of the private pay patients saw themselves in that fortunate position. And whereas 48 percent of the Church Service patients "find it impossible to make ends meet," only 10 percent of the private pay patients were that pessimistic. The null hypothesis that there was no difference in the perception of socioeconomic status between the two groups was rejected. (Table 12)

Table 12

Perceived Socioeconomic Status

Response	Church Service	Private Pay	Chi Square
1-Find it impossible to make ends meet.	21	4	
2-Have just enough to get along.	23	23	
3-Have more than enough to meet daily needs.	0	14	
TOTALS	44	41	25.486*

* Significant at .001 level.

9. Employment Status. It was hypothesized that for a variety of reasons (health, age, attitude) the tendency would be for the Church Service patients to be retired or unemployed, whereas private pay patients would continue to be working. The data, however, did not indicate a significant difference in the employment status of the two groups, and the null hypothesis, that there was no difference in employment status, was not rejected.

Table 13

Employment Status

Response	Church Service	Private Pay	Chi Square
1-Employed part-time	5	3	
2-Employed full-time	2	1	
3-Unemployed, but seeking work	1	0	
4-Retired	35	37	
TOTALS	43	41	1.842

Employment History. Likewise, it was hypothesized that the private pay patient would have been more likely to have been employed (as opposed to being a housewife), or in a professional or white collar occupation, as opposed to being unemployed, or in a trade or farming occupation, if a Church Service patient.

However, the data did not reveal significant differences in the employment history of individuals in the two groups, and it was impossible to reject the null hypothesis.

Table 14

Employment History

Response	Church Service	Private Pay	Chi Square
1-Professional	2	2	
2-White collar	3	5	
3-Blue collar	12	10	
4-Farming	9	6	
5-Sales	1	1	
6-Housewife, other	15	14	
7-No response	2	3	
TOTALS	44	41	1.119

10. Income. It appeared that the most obvious difference between the two groups would be income: It was hypothesized that the average monthly income of the private pay group would be higher than that of the Church Service group. For purposes of comparison (since the raw income data was non-parametric), the income of individuals was broken down into three groupings as indicated in Table 15. The difference in distribution among these groupings between the Church Service and private pay patients was highly significant. The null hypothesis was

rejected in favor of the conclusion that the Church Service patient was more likely to have a lower monthly income than the private pay patient.

Table 15

Income

Response	Church Service	Private Pay	Chi Square
1-$0 - $249	17	6	
2-$250 - $499	20	16	
3-$500+	6	19	
TOTALS	43	41	12.373*

* Significant at .005 level.

11. Financial Ability. Although it was hypothesized (see below) that there might be a greater number of private pay patients eligible for Medicare reimbursement of medical expenses, it was still assumed that the majority of all patients would be covered by Medicare. Therefore, an important indicator of financial ability to meet medical expenses would be the ability of the individual to pay the Medicare deductible. It was hypothesized that whereas the private pay patient would from insurance or personal funds be able to meet that expense, such would not be available to the Church Service patient. Responses to this

question on the survey revealed a decided handicap for the Church Service patient. Whereas only 23 percent indicated they could pay the full Medicare deductible without help, 57 percent said they could pay none of it. Private pay patients, on the other hand, were more likely to be able to pay the entire deductible (83 percent) and less likely to be unable to afford that expense (10 percent). The null hypothesis that there was no difference in the ability of patients to pay the Medicare deductible, was rejected.

Table 16

Ability to Afford Deductible

Response	Church Service	Private Pay	Chi Square
1-Yes, could pay all.	10	34	
2-Could pay some, but would need help.	8	2	
3-Could not pay without help.	25	4	
4-Don't know, no response.	1	1	
TOTALS	44	41	31.831*

* Significant at .001 level.

12. Availability of Children as a Resource. Much talk is made, especially within the Church, about the responsibility of children to care for their aged parents. If children of the two

groups under study were equally solicitous of their parents' welfare, it would therefore be possible to compare the value of these resources by 1) counting the number of children or by 2) determining how far distance children lived from their parents.

A count of living children reported by respondents revealed that the number of children (total of questions 19 through 22) for Church Service patients was 3.0; for private pay patients the average number was 3.6. These means were not significantly different, and the null hypothesis was not, therefore, rejected.

The other approach to measuring family as a resource was to calculate a "child proximity score." Respondents were asked to indicate how many of their children still living resided within about 50 miles, about 100 miles, about 200 miles and over 200 miles. Since it was assumed that the closer a child lived, the more probable it would be that he or she could render assistance when needed, an arbitrary factor of 4, 3, 2, or 1 was used to multiply the number of children reported within the categorical distance indicated. The resulting scores of all individuals in each group (including those with a score of 0 because they had no children) were totalled and divided by the number of subjects so as to provide a mean score. The mean "child proximity score" for the Church Service group was 8.5; for the private pay group, 9.3. These means were not

statistically different. It was therefore impossible to reject the null hypothesis that either group had more or less access to children as a resource solely on the basis of numbers of children or distances which separated them.

Nothwithstanding the number or proximity of children, another measure of their availability as a resource to the elderly parents, was hypothesized to be the frequency of contact between child and parent. It was assumed that Church Service patients would have less contact with their children than private pay patients. (Table 17)

This hypothesis was not borne out by the data. There was no significant difference in the frequency of contact with children reported by respondents in the two groups. The null hypothesis, therefore, was not rejected, and the conclusion reached that data gathered via this study was inadequate to differentiate between the two patient groups on access to children as a resource for assistance in meeting medical expenditures.

Table 17

Frequency of Contact

Response	Church Service	Private Pay	Chi Square
1-Almost daily	14	17	
2-Weekly	10	10	
3-Once or twice a month	7	1	
4-Infrequently	8	8	
5-Never or almost never	1	0	
TOTALS	40	36	5.595

12. Companionship. Along with being married, another measure of the availability of help would be whether the individual were living alone or with others. There was no significant difference in the distribution of responses between the two groups on the question which related to this variable. Therefore, the null hypothesis was not rejected. (Table 18)

Table 18

Living Relationships

Response	Church Service	Private Pay	Chi Square
1-Alone	14	10	
2-With spouse	16	19	
3-With spouse and children	5	5	
4-With child or children	5	3	
5-With others	0	3	
6-Nursing home	4	1	
TOTALS	44	41	6.125

13. Income Sources. It was hypothesized that Church Service patients would be less likely to be receiving income from any of a variety of sources: pensions, income from trusts, annuities, insurance or savings, from real estate, stocks or other investments, or contributions from the family. On the other hand, it was hypothesized that they would be more likely to be receiving public assistance (this ignores, of course, the possible influence of Church teachings on avoidance of the dole). From these various income sources, private pay patients indicated a significantly higher access to income from real estate, stocks or other investments. There was no significant difference in the distribution of those who did or did not receive income from other sources, including public assistance. Therefore, the null

hypothesis was not rejected, except in the case of the indicated investment income source. (Tables 19-23)

Table 19

Pension Availability

Response	Church Service	Private Pay	Chi Square
1-Yes	42	40	
2-No	2	1	
TOTALS	44	41	0.004

Table 20

Savings

Response	Church Service	Private Pay	Chi Square
1-Yes	3	7	
2-No	40	34	
3-Don't know - no response	1	0	
TOTALS	44	41	2.984

Table 21

Investment Income

Response	Church Service	Private Pay	Chi Square
1-Yes	1	13	
2-No	39	28	
3-Don't know, no response	4	0	
TOTALS	44	41	16.006*

* Significant at .001 level.

Table 22

Family Assistance

Response	Church Service	Private Pay	Chi Square
1-Yes	9	7	
2-No	33	34	
3-Don't know, no response	2	0	
TOTALS	44	41	2.162

Table 23

Public Welfare

Response	Church Service	Private Pay	Chi Square
1-Yes	6	5	
2-No	35	35	
3-Don't know, no response	3	1	
TOTALS	44	41	2.907

A similar series of question was asked about access to tangible resources in the event of a medical emergency. Again it was hypothesized that the Church Service patient would be less likely to have a bank or other savings account, an automobile or other vehicle, a house or other property, stocks, bonds or other investments, a business or shares in a business, or other assets. (Tables 24-29)

The data which follows show that (a) there were, indeed, significant differences between the two groups on the availability of savings, vehicles, and property - the majority of Church Service patients did not have such assets, and even where they did exist these people did not feel they could utilize them, whereas private pay patients tended to have such assets, and were able to willingly use them; and (b) very few from either group owned other

types of assets. It was, therefore, possible to reject the null hypothesis as it pertained to assets such as savings, vehicles, and property in favor of the conclusion that these resources were more readily available to the private pay patient. However, primarily because of a lack of cases, it was not possible to reject the null hypothesis as this applied to investments, business or other assets. Very few of the elderly people studied had access to these more "advanced" assets. It is possible, of course, that were these once owned, there could have been a transfer to children or by sale to others. In any event, income from such sources was not significant.

Table 24

Existence of Savings

Response	Church Service	Private Pay	Chi Square
1-Yes, could use.	8	33	
2-Own, couldn't use.	2	2	
3-Don't have.	34	6	
TOTALS	44	41	34.781*

* Significant at .001 level.

Table 25

Existence of Car

Response	Church Service	Private Pay	Chi Square
1-Yes, could use	4	29	
2-Own, couldn't use	14	6	
3-Don't have	26	6	
TOTALS	44	41	34.576*

* Significant at .001 level.

Table 26

House or other Property

Response	Church Service	Private Pay	Chi Square
1-Yes, could use	8	19	
2-Own, couldn't use	8	10	
3-Don't have	28	12	
TOTALS	44	41	0.005*

* Significant at .005 level.

Table 27

Investments

Response	Church Service	Private Pay	Chi Square
1-Yes, could use	0	4	
2-Own, couldn't use	1	1	
3-Don't have	43	36	
TOTALS	44	41	4.52

Table 28

Business Resources

Response	Church Service	Private Pay	Chi Square
1-Yes, could use	0	2	
2-Own, couldn't use	1	0	
3-Don't have	43	39	
TOTALS	44	41	3.093

Table 29

Other Assets

Response	Church Service	Private Pay	Chi Square
1-Yes, could use	0	4	
2-Own, couldn't use	2	2	
3-Don't have	42	35	
TOTALS	44	41	4.536

Finally, an attempt was made to determine whether the family could assist if needed in a medical emergency. It was hypothesized that Church Service patients would be less likely to be able to draw upon resources of the children in times of emergency than would the private pay patients. The richness of response to this question was hidden by the simplicity of answers; many people from both groups expressed an unwillingness to burden the children with their problems. Many guilt feelings were expressed about having asked for help in the past. But when pressed for an answer, it became apparent there was a tendency for the private pay patient to be more willing to ask and more liable to receive help. However, the observed distribution fell barely short of statistical significance, and since the rejection level was set at .05, it was not possible to do so. (Table 30)

Table 30

Availability of Family Help

Response	Church Service	Private Pay	Chi Square
1-Yes	19	27	
2-No	14	11	
3-Could not ask	9	3	
4-Don't know, no response	2	0	
TOTALS	44	41	6.654

14. Medicare Enrollment. One of the principal questions raised at the beginning of this study was whether Church Service patients were, indeed, enrolled for Medicare, both Parts A and B. Given the quoted high eligibility/enrollment figures by the government, why were so many Church elderly receiving medical welfare, and was the amount being paid by the Church greater than that being paid from personal and insurance resources of the private pay patient? The answer to these questions was sought partly through the interview schedule by asking respondents whether they were enrolled for either or both parts of Medicare. (Tables 31, 32)

It was hypothesized that a lower proportion of Church Service patients would be enrolled for both types of Medicare. Responses to the questions, however, confirmed that hypothesis

only for "Part B," which pays for certain clinical and outpatient services. There was no significant difference in the number of those enrolled for "Part A" (hospital benefits): All of the private pay patients claimed to be enrolled and 41 (93 percent) of the 44 Church Service patients said they were enrolled. It might be noted that only one of the Church Service patients disclaimed enrollment; the other two were not sure.

However, only about half (52.3 percent) of Church Service patients claimed to be enrolled for Part B of Medicare, whereas 80.5 percent of the private pay patients said they were enrolled. The difference in distribution on this question was specifically significant. Of the Church Service patients who were not enrolled, over half (52.6 percent) claimed they could not afford the premium ($6.40 per month), and an additional 26.3 percent said they did not know about this part of Medicare. (It should be noted, however, that response distribution to the question on why non-enrollment was not statistically different, principally because of the extremely low number of private pay patients who fell into the non-enrolled category.) (Table 33)

It was thus impossible to reject the null hypothesis that there was no difference between the proportion of Church Service and private pay patients who are enrolled for Medicare, Part A. However, the null hypothesis that there was no difference in

enrollment proportions between the two groups for Part B of Medicare was rejected in favor of the conclusion that private pay patients are more likely to be so enrolled. We were unable to conclude definitely that the failure of Church Service patients to enroll was due to their inability to pay the premium or unawareness of that program. But we were strongly influenced toward that conclusion by the data.

Table 31

Medicare Enrollment

Response	Church Service	Private Pay	Chi Square
1-Yes	41	41	
2-No	1	0	
3-Don't know	2	0	
TOTALS	44	41	2.898

Table 32

Part B. Enrollment

Response	Church Service	Private Pay	Chi Square
1-Yes	23	33	
2-No	15	3	
3-Don't know	6	5	
TOTALS	44	41	9.783

* Significant at .007 level.

Table 33

Why not Enrolled - Part B

Response	Church Service	Private Pay	Chi Square
1-Didn't know about it	5	3	
2-Just haven't enrolled	2	0	
4-Can't afford premium	10	1	
5-Don't believe in it or counselled against it	1	0	
6-Other	1	1	
TOTALS	19	5	4.088

15. Proximity and Access to Medical Care. Most people have a private physician to whom they can go when their

health requires. However, there has traditionally been a heavy utilization of general outpatient services at the Latter-day Saints Hospital by the elderly Church poor in Salt Lake City. It has been claimed that this is because the elderly live in the "central city" and do not have access to physicians. In other areas of the Church, it has been claimed, the mix of lay and professional people is such that bishops have greater access to physicians who are willing to render care on a Church Service basis, doctors are easier for the poor to reach when needed, or because the total Church Service load is less "out there" doctors, in general, are more willing to provide free care to the elderly. The distribution of responses to the question was such that significant differences are noted between the two samples. We are, thus, tempted to conclude that the private pay patient is more likely to have access to a personal physician than is the Church Service patient. But a more detailed analysis of this question reveals that the differences exist primarily in Salt Lake City, as earlier expected. Tables 34 and 35 show that when Church Service patients at L.D.S. Hospital in Salt Lake City are compared against Church Service patients at the other two hospitals, there are significant differences between those sub-groups in access to a private physician. Furthermore, when L.D.S. Hospital Church Service patients are excluded from the Church Service sample, which is then compared with

the sample of private pay patients, the differences between the two groups nearly disappear. The distribution differences become non-significant. In other words, the patients who claim lack of access to private physicians were Church Service patients living in Salt Lake City. The null hypothesis that there were no differences in accessibility to or use of private physicians versus hospitals was rejected.

Table 34

Access to Private Physician

Response	Church Service	Private Pay	Chi Square
1-Yes	24	37	
2-No	19	4	
TOTALS	43	41	10.840*

* Significant at .001 level.

Table 35

Source of Routine Medical Care Sought by Elderly Church Service Patients, by Hospital

Response	Church Service	Private Pay	Chi Square
1-Physician	17	6	
2-Hospital and Other	9	13	
TOTALS	26	19	4.990*

* Significant at .05 level.

But the interesting question, which must be left at this point to speculation, is whether the dependence of Church Service patients in Salt Lake City is, indeed, a function of the lack of physician care, or whether it represents a dependence on free outpatient services (which are unavailable at the other hospitals). As indicated elsewhere in this paper, it is possible either that the elderly poor Church member (and the priesthood leader) in Salt Lake City over-utilize the free care available, or the elderly poor in other communities are being denied needed care because such services are lacking.

Additional insight into this question was sought by looking at the length of time persons had resided in the particular neighborhood where now found. It was hypothesized that if services

offered by the hospital and/or particular neighborhoods (because of low income rentals) attracted the elderly poor, Church Service patients would report a shorter period of residence than private pay patients because the Church poor would gravitate to these areas. Two questions were asked relative to this concern: Whether the individual was born in the same area (thus determining relative in-migration between the two groups), and number of years residence in the immediate neighborhood. The observed distribution between the two groups was not significantly different for either question, and it was not possible to reject the null hypothesis. Church Service patients do not seem to be more likely to move to a particular neighborhood than do private pay patients. (Tables 36, 37)

Table 36

Birthplace

Response	Church Service	Private Pay	Chi Square
1-Same city	6	10	
2-Same county	5	6	
3-Same state	24	17	
4-Same country	6	7	
5-Other country	3	1	
TOTALS	44	41	3.261

Table 37

Years in Neighborhood

Response	Church Service	Private Pay	Chi Square
1- 0-10 Years	14	12	
2- 10+ Years	30	29	
TOTALS	44	41	.054

16. Type of Medical Care Needed and Sought. It was hypothesized that the need of the Church Service patient for Church financial assistance would be, at least in part, a function of illness and the type of care needed, and would result in a difference in the type of medical care sought. The following information was gleaned from a series of questions relative to these variables.

a. Illness. Inability to hold employment, a resulting drop in income, and higher medical expenses could be the result of a relatively poorer state of health. It was hypothe sized that the Church Service patient might have more illness than the private pay patient, and thus be more likely to require outside financial assistance. The survey did, indeed, reveal that there was a difference in the state of health as measured by days of illness between the two groups: Church Service patients

were significantly "sicker" than private pay patients. Two-thirds of the Church Service group reported having 20 or more days of bedridden illness during the previous year; only one-third of the private pay patients reported such illness. It was, therefore, possible to reject the null hypothesis. (Table 38)

Table 38

Frequency of Illness

Response	Church Service	Private Pay	Chi Square
1-No sickness	2	1	
2-Less than 10 days	4	10	
3-Between 10 and 20 days	8	15	
4-More than 20 days	30	15	
TOTALS	44	41	9.942*

* Significant at .02 level.

Responses to the question on frequency of visits to a physician (including a hospital physician) tended to substantiate the previous conclusion. The null hypothesis, that there would be no difference in the number of visits annually to a physician, was tested and rejected. Table thirty-nine presents data which lead to the conclusion that a greater proportion of Church Service

patients claim to have visited a physician more frequently than once a month in the previous year than private pay patients.

Table 39

Physician/Hospital Visits

Response	Church Service	Private Pay	Chi Square
1 - 12 or less	28	35	
2 - 13 or more	16	7	
TOTALS	44	42	3.967*

* Significant at .05 level.

It should be noted, although the findings were not tested, that the high frequency visits were attributable primarily to patients being treated at the L.D.S. Hospital Outpatient Clinic. Eleven of the 16 patients reporting 13 or more visits were from this portion of the sample. The greatest utilization of services, therefore, appeared to be at this outpatient clinic.

Another method of measuring the health status of individuals in the study was handled through asking whether the respondent was taking medications, and if so, what for. It was hypothesized that those with a poor health status would be more likely to be taking medications and for more than one reason;

those who were relatively healthier would be less likely to be taking medications and if so, probably for a single purpose, such as hypertension, heart disorder, or other. The null hypothesis, that there would be no difference in the proportion of those not taking medications or taking medications for a single cause versus those taking medications for multiple etiology, was tested and rejected.

Table forty presents data leading to the rejection of the null hypothesis that the Church Service patient was no more likely to be taking medications and for multiple problems than was the private pay patient. We therefore conclude, on the basis of the various data presented, that the Church Service patient is relatively less healthy than the private pay patient. This alone could go far to explain the need for Church assistance among these individuals: being sicker and requiring relatively more medical care, their expenses were higher and exceeded available income and other assets.

Table 40

Medications

Response	Church Service	Private Pay	Chi Square
1-3, 5 Not taking or for single problem	15	27	
4-For multiple problems	29	15	
TOTALS	44	42	7.773*

* Significant at .01 level.

17. Payment of Medical Bills. The series of questions asked relating to the source of reimbursement for medical expenses also provided information on access to and use of various financial resources for the payment of medical expenses.

It was hypothesized that one of the differences between Church Service and private pay patients would be the total amount of out-of-pocket expenditures for medical care. One reason that the Church Service patient required Church financial assistance might have been the large expenditure in relation to income. We have already seen that the income of these individuals is significantly less than the private pay patient. Tables forty-one to forty-seven indicate the number of respondents reporting payment of medical bills by various sources of financial assistance,

ranging from Medicare to government welfare and the Church. Other than table forty-seven (Church Payment of Medical Bills), which would naturally distinguish the two groups from each other, significant differences existed, and the null hypothesis was rejected only in the proportions of those obtaining reimbursement from insurance and from children for medical bills. The responses reveal that a major difference between Church Service and private pay patients exists in the ownership of health insurance. Whereas 71 percent of the private pay patients had a portion of their medical expenses paid by insurance, only 18 percent of the Church Service patients had assistance from this source. It is assumed that these figures reflect not only reimbursement received, but the very existence of insurance in force.

On the other hand, a significantly higher proportion of the Church Service patients had received financial assistance from their family or children for medical expenses. It might naturally be assumed that this difference was, at least in part, a result of need on the part of Church Service patients, whereas private pay patients were able to pay their medical expenses without the necessity of asking for family help. However, this question became involved in some rather complex attitude differences, which will be discussed below.

In conclusion, therefore, we rejected the null hypothesis that no difference existed in the proportion of Church Service versus private pay patients who have medical bills paid by health insurance or family. Instead, we concluded that private pay patients were more likely to have received family assistance.

Table 41

Payment by Medicare

Response	Church Service	Private Pay	Chi Square
1-Yes	41	40	
2-No	2	1	
3-Don't know	1	0	
TOTALS	44	41	1.241

Table 42

Payment by Insurance

Response	Church Service	Private Pay	Chi Square
1-Yes	8	29	
2-No	35	12	
3-Don't know	1	0	
TOTALS	44	41	24.098*

* Significant at .001 level.

Table 43

Payment by Family

Response	Church Service	Private Pay	Chi Square
1-Yes	14	3	
2-No	29	38	
3-Don't know	1	0	
TOTALS	44	41	9.232*

* Significant at .01 level.

Table 44

Payment by Welfare

Response	Church Service	Private Pay	Chi Square
1-Yes	3	2	
2-No	41	39	
TOTALS	44	41	0.006

Table 45

Payment by Church

Response	Church Service	Private Pay	Chi Square
1-Yes	43	0	
2-No	1	41	
TOTALS	44	41	77.228*

* Significant at .001 level.

Attitudes

It was hypothesized that there would be attitude differences between the two types of patients on a number of topics related to using financial assistance for payment of medical bills, and the type of care sought. It was thought that the Church Service patient would be more likely to be opposed to accepting Medicare and family help than the private pay patient. On the other hand, the Church Service patient, probably because he or she would come from a low-income background would be more willing to incur debt to pay for medical bills, to accept government welfare or Church assistance, and to turn to unlicensed practitioners for relief from health problems. Tables forty-eight through fifty-three are related to these hypotheses.

It has already been noted that the research data was inadequate to determine attitude differences between Church Service and private pay patients concerning Medicare. We are thus unable to reject the null hypothesis that there is no attitude difference on the part of Church Service versus private pay patients towards acceptance of Medicare reimbursement for medical expenses.

In like manner, although there is a slight tendency for responses to indicate a slight more favorable attitude on the part of Church Service patients towards going into debt for medical bills, the difference in the responses was not significant. We are unable to reject that null hypothesis. This is true also of attitudes towards asking children to help: There was no significant difference in the distribution of responses on this item.

Table 46

Approval of Borrowing

Response	Church Service	Private Pay	Chi Square
1-Yes	7	8	
2-No	33	28	
3-Don't know	4	5	
TOTALS	44	41	0.482

Table 47

Approval of Family Help

Response	Church Service	Private Pay	Chi Square
1-Yes	30	27	
2-No	10	11	
3-Don't know	4	3	
TOTALS	44	41	0.2428

Table 48

Welfare (Government) Assistance

Response	Church Service	Private Pay	Chi Square
1-Yes	15	14	
2-No	22	27	
3-Don't know	7	0	
TOTALS	44	41	7.448*

* Significant at .02 level.

Table 49

Approval of Church Help

Response	Church Service	Private Pay	Chi Square
1-Yes	40	30	
2-No	2	10	
3-Don't know	2	1	
TOTALS	44	41	6.998*

* Significant at .03 level.

Table 50

Approval of Non-Licensed Care

Response	Church Service	Private Pay	Chi Square
1-Yes	4	1	
2-No	40	40	
TOTALS	44	41	0.708

Table 51

Physiological Results of Quack Treatment

Response	Church Service	Private Pay	Chi Square
1-Yes	1	0	
2-No	2	0	
3-Not sure or don't know	1	1	
TOTALS	4	1	1.875

On the other hand, significant differences did exist in the distribution of responses to questions related to government and Church assistance. Not only was the Church Service patient significantly more willing to "ask the bishop for help," but he or she was also less opposed to accepting government assistance. Interestingly, the difference in responses was not in the proportion of those willing to apply for Welfare assistance, but rather in the number of those who were opposed versus those undecided. The Church Service patient appears to be less sure about being opposed to government Welfare than the private pay patient. Although it was hypothesized that the Church Service patient would be more likely to turn to "quacks" for medical assistance, the positive responses to this question were so few that it was impossible to perform a statistical test. Virtually none of the respondents from either group

indicated a willingness to use unlicensed practitioners for medical care. As a result, it was also impossible to determine whether the respondents felt that their medical problems had, indeed, been solved by the unlicensed practitioner.

Financial Data

Once the initial sample of patients was identified, a review was made of the hospital patient records, billings, and reimbursement data. Reimbursement totals for all visits, whether inpatient or outpatient, during the period of time under study (1974) were obtained for each patient. That information is reproduced in Appendix A.

The financial data was then examined, arranged in tabular form, and statistically tested to determine or contribute towards answers to the following questions:

a. Was there any significant difference between the groups on eligibility for and enrollment with the two parts of Medicare?
b. For those covered by Medicare, was a significantly higher proportion of the total hospital bill paid by the Church (for Church Service patients) than paid by non-Church payors, including the patient (for private pay patients)?
c. What differences, if any, existed between the cost of care provided the elderly Church Service patient versus the private pay patient?

1. Medicare Status. One method of determining Medicare coverage on a patient is to look for Medicare reimbursement on the hospital bill. This does not, of course, indicate whether

the individual is enrolled; it merely tells us that (1) the patient had eligible charges, and (2) the hospital billed Medicare. Table fifty-four shows that while there were differences in the proportions of Church Service versus private pay patients from which the hospital received reimbursement, (1) these differences were non-significant, but (2) there was a greater tendency for the Church Service patient to be a beneficiary of Medicare than for the private pay patient. This finding is, of course, contrary to our hypothesis that a greater proportion of private pay than Church Service patients would have a portion of their bill paid by Medicare, and the null hypothesis was not rejected.

Table 52

Medicare Reimbursement

Response	Church Service	Private Pay	Chi Square
Reimbursement received	37	31	
Reimbursement received	7	10	
TOTALS	44	41	0.867

A convenient way to look at Medicare coverage was to examine patient records at the L.D.S. Hospital Outpatient Clinic. At no other location were the records of patients maintained in an integrated system. Unfortunately, only Church Service patients were covered at this clinic. Table fifty-three illustrates that of the 376 active patients over 65, 361 or 96 percent were covered by Medicare. Since this figure is at least as high as that claimed in Social Security Administration literature for the country as a whole, we can assume that Church Service patients were, contrary to what was hypothesized, nearly universally covered by Medicare. The data might indicate that they are, in fact, more consistently enrolled than are the private pay patients; the null hypothesis was not, however, rejected. (Table 53)

2. Costs of Hospital Care. The question was frequently raised by those responsible for Church Medical Welfare whether the cost for services rendered to Church Service patients by hospitals were greater than those rendered to private pay patients. Charges to the Church Service patient could have been higher if (1) the medical problems of Church Service patients were more serious than those of private pay patients, (2) the type and amount of services rendered by the hospital to the Church Service patient, regardless of the relative degree of illness, were greater than to the private pay patient, and/or (3) the hospital systematically

Table 53

Medicare Status of Elderly Outpatients on Active Church Service, L.D.S. Hospital

Age		MALE Total	MALE Enrolled	FEMALE Total	FEMALE Enrolled	TOTAL Enrolled	
65-74	No.	34	33	237	231	271	264
	%		97.0		97.4		97.4
75-84	No.	5	5	84	81	89	86
	%		100.0		96.4		96.6
85-94	No.	1	1	13	11	13	11
	%		100.0		83.3		84.6
95+	No.	0	0	3	0	3	0
	%	0	0		0		0
TOTALS		40	39	337	323	376	361
	%		97.5		95.8		96.0

billed Church Service patients at a higher rate. The third alternative, of course, was ruled out.

In order to test the null hypothesis that there was no difference in the cost of service to Church Service versus private pay patients, the billing for each patient was compared against the mean billing for all patients, and transformed into nominal data by determining whether that billing was less than or exceeded the mean. This data was arranged in a 2 x 2 contingency table and was tested by the Chi Square test.

Tables fifty-four and fifty-five revealed that in both categories of care charges to the Church Service patient significantly exceeded those to the private pay patient. Although it is not possible to determine the cause of this difference, the null hypothesis was rejected in favor of the conclusion that hospital expenses of Church Service patients, whether treated on an outpatient or inpatient basis, exceeded those of the private pay patient. (Refer to Tables fifty-four and fifty-five on the following page for the presentation of data.)

Table 54

Number of Inpatients, by Type, whose Bills were
Less than or Exceeded the Mean Bill ($1,424)
for all Inpatients

	Church Service	Private Pay	Chi Square
Above mean bill	11	6	
Below mean bill	13	26	
TOTALS	24	32	4.719*

* Significant at .05 level.

Table 55

Number of Outpatients, by Type, whose Bills were
Less than or Exceeded the Mean Bill ($435)
for all Outpatients

	Church Service	Private Pay	Chi Square
Above mean bill	7	0	
Below mean bill	13	10	
TOTALS	20	10	4.59*

* Significant at .05 level.

This conclusion illuminated interview findings, which revealed that the Church Service patient perceived himself or herself to be in relatively poorer health than the private pay patient. In defense of the hospitals it must be suggested that the difference in charges was at least in part explained by differences in the type and amount of health care needed on the basis of the patient's medical condition. In other words, the Church Service patient may have been "sicker" than the private pay patient, and thus, required a greater volume and duration of care. This does not exclude the possibility, of course, that unneeded services may have been rendered to the Church Service patient by the hospitals. This point touches on the relative utilization of services by elderly Church Service patients at each of the hospitals. Hospital care was not only more expensive for the Church Service patient, but it occurred more frequently than may have been necessary. An analysis was made of the volume of patient visits to outpatient facilities at each of the three hospitals studied. Table fifty-six shows that the average number of visits differed greatly between the hospitals. For all practical purposes, there were no outpatient visits at the Utah Valley and McKay-Dee Hospitals.

Table 56

Average Number of Outpatient Visits by Elderly
Church Service Patients during 1974 by Hospital

	Utah Valley	McKay-Dee	L.D.S.*
Total Patient Visits	6	8	3,424
No. Patients	1	4	323
Mean Visits	6.0	2.0	10.6

* Based on random 10 percent sample, 32 patients.

It would appear that not only did the average L.D.S. Hospital elderly Church Service patient require more visits to achieve desired results than did those at the other hospitals, but that they required medical care more often than do either Church Service or private pay patients who received their services from private physicians. An informal survey taken in May 1975 in Salt Lake City, revealed that six physicians surveyed at the Salt Lake Clinic reported seeing the average elderly patient only two to three times a year. This was true whether the patient was paying the bill personally or was on a Church Service basis. Some patients, of course, were seen much more frequently when the severity of their condition required. However the differences in the calculated

mean number of visits at L.D.S. Hospital and the reported number at the clinic would seem to be highly significant.

Table fifty-seven clearly shows that a much-used service has been provided elderly poor at L.D.S. Hospital. Virtually all outpatient Church Service care in the three hospitals studied was provided at that one hospital.

Table 57

Active and Inactive Status Elderly Church Service Patients, by Hospital

Hospital	Patient Status		
	Active	Inactive	Totals
L.D.S. Hospital	376	574	950
McKay-Dee Hospital	11	8	19
Utah Valley Hospital	3	4	7
TOTALS	390	586	976

The question has repeatedly been raised as to whether such a volume is needed and justified. This question is, however, difficult to answer.

A review of billing records for the 376 elderly holding active (currently valid) Medical Services Request forms at L.D.S.

Hospital reveals that 25 or 6.6 percent had not incurred charges during the period studied. Although some of these persons undoubtedly held tightly to their "hospital recommend" for security purposes and did not (during the period studied) require care, it should be remembered that such "hospital recommends" are often sent by the bishop in advance of care, so that the patient's future eligibility will be established.

This question was raised in an interview with Dr. Rich Cannon, Outpatient Clinic Director, who reported that perhaps one-half of the patients regularly seen did not really require medical care. (4) Many of the elderly needed attention and love - evidence of concern - which was being effectively dispensed by the supremely considerate and sensitive clinic staff. Illustrative is the story of an elderly widow, who that morning, reportedly, tenderly laid her hand on the arm of a nurse, and with tears in her eyes said, "I love to come here. I know everyone, and you are so very kind. I look forward to my visits."

The evidence (low volume of care at other hospitals which do not cater to the needs of the Church Service patient, failure on the part of some elderly to call for care when eligible, and personal anecdotes) seem to indicate that many of the elderly really do not need the type care offered at the L.D.S. Hospital Outpatient Clinic - but because it is available, it is utilized.

The higher cost of care for the Church Service outpatient reflects, in part, the type of service being rendered at L.D.S. Hospital versus that provided by the other hospitals. The average elderly Church Service patient studied at this hospital was provided with some one to 16 prescriptions per visit (mean number of prescriptions 8.3), at an average cost to the Church of $22.08 per patient per visit.

Private pay elderly outpatients, on the other hand, are given fewer prescriptions, averaging 2.8 per visit, at a lower cost, $8.17. Further, fewer such private pay patients look to the hospital for outpatient services, preferring to seek private physician care. Whereas the L.D.S. Hospital provided general outpatient care to approximately 350 elderly Church Service patients in 1974, during the same period very few private pay elderly were given such care (essentially because there is no general outpatient clinic except for the Church Service patients).

These findings may be summarized then, by stating that although the exact reasons for differences in the average billings of Church Service versus private pay patients cannot be accurately determined, the evidence would indicate that (1) there is a difference in health status of these two groups, in favor of the private pay patient; (2) outpatient services provided the Church Service patient at L.D.S. Hospital, though less costly than

inpatient care, are more expensive than outpatient care at the other hospitals and probably more (because of higher level) than private medical care for the elderly patient in Salt Lake City; and (3) there is probably over-utilization of outpatient services by the elderly poor in Salt Lake City.

3. Medicare versus other Reimbursement. The final question to be answered in this section deals with the relative extent to which Medicare reimbursement is received for private pay versus Church Service patients. The null hypothesis that there would be no difference in the proportion of Church Service versus private pay billings reimbursed by Medicare as opposed to all other sources of reimbursement, was tested and rejected as indicated.

Table fifty-eight compares reimbursement of all types between the three hospitals and by the type of patient. Equal reimbursement from Medicare for Church Service versus private pay patients was achieved only by the Utah Valley Hospital. The McKay-Dee and L.D.S. Hospitals were not as successful in obtaining comparable levels of Medicare reimbursement for the Church Service patient.

Table 58

Total Amounts, Mean and Percent, Medicare Versus Other Reimbursement by Hospital and Type of Service for all Elderly

Hospital	Type Care	Number of Patients	Total Billing	Medicare Amount	Medicare Percent	All Other# Amount	All Other# Percent	Patient Mean Total
Utah Valley	Church Service	9	$ 11,963	$ 10,759	89.9	$ 1,204	10.1	$ 1,329
	Private Pay	11	11,195	10,052	89.8	1,143	10.2	1,120
McKay-Dee	Church Service	13*	11,456	9,519	83.1+	1,937	16.9	881
	Private Pay	15	9,319	8,199	88.0+	1,120	12.0	621
L.D.S.	Church Service	20	17,814	14,044	78.8+	3,770	21.2	891
	Private Pay	15	17,418	15,883	91.2+	1,535	8.8	1,161
All	Church Service	42	$ 41,233	$ 34,322	83.2+	$ 6,911	16.8	$ 1,084
	Private Pay	41	$ 37,932	$ 34,134	89.9+	$ 3,798	10.1	$ 925

*Excluded are two long-term intensive care (cardiac) patients whose length of stay exhausted Medicare eligibility and whose billing was, thus, not representative of other patients.

#In the case of Church Service patients, this column represents Church Medical Welfare reimbursement.

+ T-score differences in mean proportion of Medicare reimbursement by significance at .05 level or above.

Another test of reimbursement levels was performed by categorizing each type of patient as to whether the Medicare reimbursement level was below or in excess of the median level for all patients, and then performing a Chi Square test on the resulting distribution. This was done for all inpatients and all outpatients separately. The results are shown in Tables fifty-nine and sixty.

Table 59

Medicare as a Proportion of all Reimbursement
Inpatients

Proportion of Bill paid by Medicare	Church Service	Private Pay	Chi Square
Less than .85	16	9	
.85 or More	10	18	
TOTALS	26	27	3.901*

* Significant at .05 level.

Table 60

Medicare as a Proportion of all Reimbursement
Outpatients

Proportion of Bill paid by Medicare	Church Service	Private Pay	Chi Square
Less than .50	15	8	
.50 or more	3	6	
TOTALS	18	14	5.198*

* Significant at .02 level.

In each case the distribution of patients by financial classification differed significantly, providing a second justification for rejecting the null hypothesis in favor of the conclusion that higher levels of Medicare reimbursement are obtained for private pay than for Church Service patients.

It was not within the scope of this study to determine why the significant billing differences existed at McKay-Dee Hospital, where nearly all the patients were provided with inpatient care. However, the billing differences at L.D.S. Hospital are explained relatively easily because of the existence of the outpatient clinic.

L.D.S. Hospital outpatient services are not totally eligible for Medicare reimbursement; pharmaceuticals are

excluded, for example. It was noted previously that outpatients at this hospital received a relatively higher number of prescriptions per visit than do other outpatients.

The net result of the Medicare exclusions and relatively greater utilization of outpatient services by the elderly needy Church member produces the excess billing to the Church. Thus, the cost to the Church of subsidizing this clinic is at least as great as the difference between average billings at the other two hospitals versus L.D.S. Hospital, or $23,000 to $34,000 per year.

Further, it can be presumed that Church costs could be further reduced were these elderly patients to have access to private care as needed, as apparently do the needy elderly in Ogden and Provo. It was noted that respondents to the interview schedule from the latter two cities show a significantly greater tendency to look to private care than do those in Salt Lake City. It is suggested that the very existence of the "free" clinic at L.D.S. Hospital is at least partly the cause of this tendency to look to the hospital for care. Were such services to be unavailable, the elderly would find care elsewhere, and it can only be presumed that the quantity of unneeded or marginal care would be reduced. Net savings to the Church, without reducing the volume or quality of care needed by the elderly, could be substantial.

On the other hand, the dependence of the elderly upon the L.D.S. Hospital would make extremely traumatic any abrupt closure of outpatient services paid for by the Church. A transitional period of "weaning away" would be needed.

Chapter 5

SUMMARY

Socioeconomic Differences between Church Service and Private Pay Patient Groups

Data obtained in interviews with members of both patient groups reveal that there existed significant differences at the .05 level or above between the groups on certain indicators of socio-economic status. These have been discussed in detail in the previous chapter, but can be summarized as follows:

1. Church Service patients were more likely than private patients to:
   a. Have higher housing expenses.
   b. Have an eighth grade or lower education.
   c. See themselves as having financial difficulties.
2. Church Service patients were less likely than private pay patients to:
   a. Own a car or other vehicle.
   b. Have cash income over $250 per month.
   c. Receive property or other investment income.
   d. Have cash savings.
   e. Own their own home.

At the same time, the two groups sampled were not significantly different as concerning:

1. Type of housing.
2. Marital status.
3. Sex.
4. Age.
5. Employment history or status.
6. Number of and contact with children.
7. Sources of income and financial resources (except for investment income and the existence of a home, car, or savings account).

Attitude, Medical Care and Health Status Differences

It was discovered that there were significant attitude and behavioral differences at the .05 level or above between the two groups as follows:

1. Church Service patients were more likely than private pay patients to have suffered serious illness, to be taking medications and for more varied reasons, and to utilize the hospital rather than a private physician for medical care. They tended to make more visits for care than private pay patients.

2. Church Service patients were more likely to approve of the family and the Church providing financial help for medical expenses, and less certain than private patients about whether it was proper to accept state welfare assistance.

3. Church Service patients were less likely to have access to or utilize the services of a private physician, to be

enrolled for Part B (SMI) of Medicare or to be able to afford the Medicare deductible, or to have obtained insurance reimbursement for past medical expenses.

Differences at .05 Level or Above in Hospital Expense and Payments

Information obtained from hospital billing and reimbursement records indicated the following:

1. Hospital costs to Church Service patients were greater than to private pay patients for either inpatient or outpatient services.

2. Church Service hospital patients were at least as likely as private pay patients to have been eligible for and had Medicare reimbursement to the hospital when all patients are considered. Relatively fewer Church Service than private pay outpatients were determined to be eligible for Medicare reimbursement but differences were still less than statistically significant.

3. Average Medicare reimbursement to two of the hospitals tends to be less for the Church Service patient than for the private pay patient, with expense to the Church being correspondingly higher.

4. Supplementary data seem to indicate that Church Service outpatients at L.D.S. Hospital make a greater number of clinic visits per unit of time than do similar patients at the other hospitals or at private clinics, and tend to utilize a greater number of prescriptions at greater cost.

Conclusions

The information presented above allows the following conclusions to be made:

1. Some elderly members of the Church were found in a precarious economic situation, partly because of inadequate income due to the death of a spouse and loss of Social Security income, and to low lifetime earnings. Many of those who were unable to personally or through other available resources, meet medical expenses in later years, did not or were not able to accumulate assets, such as an owned home, a savings account, or insurance programs. As a result, they required Church financial assistance to meet hospital expenses. These persons differed from those who did not need Church financial assistance in that they had higher average housing expenses; more had a lower education; and fewer owned a car, home, other property, or private or group hospital insurance. They tended to have more illness, made more visits for medical care, and were less likely

to have a private physician. They were more approving of taking family or Church financial help and not as opposed to accepting government welfare.

2. Elderly Church Service patients studied in this research project were covered by Medicare to at least as great a degree as were private pay patients.

3. Church Service patients incurred greater hospital expense, on the average, than did private pay patients. This was true for both inpatients and outpatients. They also incurred more expenses that were not reimbursable and/or not collected at two of the hospitals. The net result of these conditions was an excess billing to the Church of many thousands of dollars.

4. Church Service patients were equally willing to enroll for Medicare, but did not do so in the case of Part B (SMI). Those who were not enrolled disclaimed knowledge of this voluntary program or claimed they lacked funds to pay the monthly premium. There was no reluctance to receiving earned benefits.

5. More (a great majority) of Church Service patients were found in Salt Lake City because of a combination of factors, the most important of which seemed to be, the provision of "free" care at the L.D.S. Hospital Outpatient Clinic.

Discussion

The findings suggest that the system of medical welfare in the Church, wherein payments were made to hospitals centrally, was inadequate to control for possibly unneeded and unwarranted medical expenses for the elderly poor. This was especially true where hospitals (or others) might wish to provide a direct service, payment for which was not a personal responsibility of the needy elderly. Whether because the poor could not resist utilizing free services that were available, whether that service filled an unmet non-medical need, or because hospital personnel provided care more liberally to those for whom the Church paid than to other payors, the result was that the Church faced expenditures above those incurred in areas where such services were unavailable.

Interviews with the patients, discussions with hospital personnel, and visits with priesthood leaders lent credence to the belief that prevention of financial dependence would have been better than cure. Perhaps if those who became the needy poor had been helped to more adequately plan their retirement finances, to find and hold a better-paying job, to have purchased a home in employed years, and to have received attention needed following retirement and/or the death of a loved one, the health and attitude of the elderly would have been improved. Expenses to the Church might have

consequently been reduced. The current study is quite limited in concluding the cause of the plight of the elderly poor in the Church. This study concerned itself with the "here and now" of select hospital patients and not with the events which led to their need for financial assistance from the Church.

At the same time, we are unable to determine to what extent unneeded services were actually being provided at the L.D.S. Hospital Outpatient Clinic versus the possibility that the elderly poor were going without needed care in other communities. And, as has been mentioned earlier, the conclusions of this study are limited by the communities and individuals studied.

Recommendations

Finally, as a means of resolving some of the problems noted above, it was recommended that the Church alter its present medical welfare system from one in which medical bills are paid centrally to one where the individual patient and his or her priesthood leader are aware of and actually pay the medical care bill. Such a program would place the burden of financial responsibility on the individual where it has always belonged. It would also enhance the individual and priesthood line of responsibility, wherein the individual looks to his or her own resources first for payment, then to the family, and finally to the Church through proper priesthood channels. The proper channel, of course, would be the bishop.

The suggested program would differ little from the one in existence at the time of this study, except that instead of the hospital or the medical care provider billing the central Church Medical Welfare office, the bill would be sent to the individual. If and when the individual needed assistance in paying medical expenses, he or she could then turn to the bishop for assistance from the fast offering funds. Medical bills would be paid from ward funds just as are rent, utilities, and other expenses.

Such an approach would also provide the bishop with opportunity to encourage the individual to work for the assistance received, whereas currently it is much too easy for both the bishop and individual to shirk that responsibility. It could be anticipated that as patients and their bishops understand the true needs of the individual, and become aware of the magnitude of medical costs, a more reasonable level of Church expenditure would result, partly because of the reduction in unneeded care, and perhaps, more because of an increase in donated care by physicians.

A final consideration for a change in the Medical Welfare system was that the then-current system was operable only where hospitals were willing and able to provide the Church Service care that had been characteristic of Church-owned or operated hospitals in the past. The system proposed would be universally applicable, and if implemented following correct principles, including the

seeking of donated service where possible, it could be carried out in every part of the world without substantially increasing the total amount of Medical Welfare expenditures by the Church. The needs of the elderly poor would be more adequately met through home and visiting teachers, through their priesthood quorums and Relief Society, through their priesthood leaders, and through the donated care that could be provided by member and non-member physicians of the Church who would be able to provide such compassionate service.

These recommendations were accepted by those responsible for medical welfare, and the proposed program was implemented on October 1, 1975.

Suggestions for Further Research

This suggests that an appropriate topic for a doctoral or other more sophisticated research study would be an indepth study of the elderly poor within the Church. Such a study, which might attempt to determine cause and effect as this relates to the current financial and medical status of elderly members of the Church, could provide much more substantial data for developing recommendations and/or a Church program to prevent financial dependence in later years. Since the number of elderly are increasing in the Church as well as the general population, and

since a reduction in poverty among the future elderly would save not only much suffering, but considerable expense to the Church, it is recommended that such a study be encouraged.

APPENDIX A

Table 61

Billing, Service and Amount of Hospital Reimbursement,
by Hospital and Type of Service

Patient Code	Total Bill	Personal	Insurance	Medicare	Church/ Welfare[#]
01011	$ 3,672			$ 3,496	$ 176
01021	3,311			3,036	275
01031	708			552	156
01041	1,114			1,028	86
01051	267			183	84
01061	411			327	84
01071	121			17	104
01081	607		$ 84	458	65
01091	1,752			1,662	90
01102	1,405	$126	114	1,165	
01112	1,386			1,364	22[#]
01122	387		61	326	
01132	364		84	280	
01142	5,088	153	240	4,695	
01152	1,208	31	92	1,085	
01162	308	51		247	
01172	840	8		832	
01182	79	52		27	
01192	18	4		14	
01202	11				11[#]
01212	101	84		17	

[*] First two digits indicate hospital (01=Utah Valley; 02=McKay-Dee; 03=L.D.S.). Second two digits identify patient. Final digit indicates type of service (1=Church Service; 2=Non-Church Service).

Table 61 "Continued"

Patient Code	Total Bill	Personal	Insurance	Medicare	Church/ Welfare#
02011	$ 1,100			1,011	$ 89
02021	4,642			4,484	158
02031	91				91
02041	273				273
02051	502			405	97
02061	433				433
02071	3,914			934	2,980
02081	3,059			2,940	119
02091	310			233	77
02101	6,027			4,160	1,867
02111	121			66	55
02121	469			380	89
02131	35				35
02141	21				21
02151	400				400
02161	871	$ 90		781	
02172	430	90		340	
02182	1,728	43	$ 84	1,601	
02192	414	18	84	312	
02202	1,053	6	84	963	
02212	497	93		404	
02222	605	11		594	
02232	1,224		156	1,068	
02242	1,206	3		1,119	84#
02252	59	45		14	
02262	154	32		122	
02272	180	84		96	
02282	41			41	
02292	58		19	39	
02302	799	94		705	
03011	1,002			32	970
03021	2,465			1,983	482
03031	348			5	343
03041	3			2	1
03051	1,326			791	535
03061	313			221	92

Table 61 "Continued"

Patient Code	Total Bill	Personal	Insurance	Medicare	Church/ Welfare#
03071	$ -			$ -	$ -
03081	628			285	343
03091	165			6	159
03101	305			89	216
03111	3,908			2,631	1,277
03121	530			200	330
03131	530				530
03141	396			196	200
03151	1,441			1,344	107
03161	2,503		$ 100	2,310	93
03171	227			91	136
03181	2,846			2,751	95
03191	853		97	709	47
03201	490			398	92
03212	429		92	337	
03222	637		92	545	
03232	2,653	$ 97		2,566	
03242	1,381		92	1,289	
03252	528		92	436	
03262	644		92	552	
03272	1,218		97	1,121	
03282	753			635	118#
03292	1,659		123	1,536	
03302	525		92	433	
03312	2,814		142	2,672	
03322	610		92	518	
03332	2,817	70		2,747	
03342	520		92	428	
03352	220	60	92	68	

Church Service	44
Non-Church Service	42
TOTAL	86

APPENDIX B

1-2 _____ Ward Code
3-4 _____ Name Code
5 _____ Classification

MEDICAL AND SOCIAL NEEDS OF THE AGED LDS CHURCH MEMBER

QUESTIONNAIRE

Explain to respondent.

"I have been asked to visit you so that we might learn more about the needs and concerns of retired people. Do you mind if we spend a few minutes together and I ask you some questions?"

6.	Type of housing is:	House		1
		Apartment		2
		Room	6-	3
		Boarding House		4
		Other		5

7. After entering the home and seating yourself, remark:

"You have a very (lovely, comfortable, compact, interesting) home.

	Do you:	Own it?		1
		Rent it?	7-	2
		Buying it?		3
		Nursing home, other."		4

8-10. "May I ask how much you are paying monthly on rent or mortgage?" (Write in amount; use 999 if no expense.) 8-10- $___

11.	"Are you:	Single?		1
		Married?	11-	2
		Widowed?		3
		Divorced?"		4
12.	Mark:	Male	12-	1
		Female		2

13-14. "You seem to be carrying your age very well. Do you mind if I ask your approximate age?" 13-14- ___ Age

15. "Are you from here originally?" (If "Yes" circle #1; if "No" ask the following.) "Where were you born?"

Same city.		1
Same county.		2
Same state.	15-	3
Same country.		4
Other country.		5

APPENDIX B "Continued"

16-17. "How many years ago did you move to this particular neighborhood?"
(Write the number of years.) 16-17- ___ Years

18. "Do you have any living children or married grandchildren?"
(If the answer is "None" skip to question #24.)

None.	18-	1
Yes.		2

19-22. "How many of your children still living reside: (Write in the number.)

Within about 50 miles?	19-	___
Within about 100 miles?	20-	___
Within about 200 miles?	21-	___
Over 200 miles?	22-	___

23. "How often do you see any of your children or married grandchildren?"

Daily or almost daily.		1
Weekly.		2
Once or twice a month.	23-	3
Infrequently.		4
Never or almost never.		5

24-25. "How many years of schooling have you completed?"
(Write in number.) 24-25- ___ Years

26. "You seem to be getting along fairly well at home. Do you live:

Alone.		1
With spouse.		2
With spouse and child or children.	26-	3
With child or children.		4
With others.		5
Nursing home."		6

27. "Do you have a car?"

Yes.	27-	1
No.		2

28. "As far as income is concerned, do you:

Find it impossible to make ends meet?		1
Have just enough to get along?	28-	2
Have more than enough to meet daily needs?"		3

APPENDIX B "Continued"

-3-

29. "Are you presently. . .

Employed part-time?		1
Employed full-time?		2
Unemployed, but seeking work?	29-	3
Retired?		4
Don't know or no response.		5

30-33. "Would you identify your present monthly income from all sources?" 30-33- $\_\_\_\_$

34. "What employment did you engage in most of your life?" (Write in.) _____ 34- $\_\_$ Code

"Do you presently receive income from any of the following?

35. Social Security, Railroad, Veteran's or other pension?	Yes		1
	No.	35-	2
	DK-NR		3
36. Income from trusts, annuities, insurance or savings?	Yes		1
	No	36-	2
	DK-NR		3
37. Income from real estate, stocks or other investments?	Yes		1
	No	37-	2
	DK-NR		3
38. Contributions from family?	Yes		1
	No	38-	2
	DK-NR		3
39. Public assistance? (Old Age, Aid to the Blind, Disability, Food Stamps, Other)	Yes		1
	No	39-	2
	DK-NR		3

40. "About how many days have you been sick during the last year?"

No sickness.		1
Less than 10 days.	40-	2
Between 10 and 20 days.		3
More than 20 days.		4

41. "Do you have a private doctor or one that you visit regularly other than at the hospital?"

Yes	41-	1
No		2

42-43. "About how many times have you seen a doctor during the last year?" (Write in the number.) 42-43- $\_\_$

APPENDIX B "Continued"

-4-

44. "Your reason for seeing the doctor was:

Routine visit or examination.		1
Illness or pain.		2
Accident or injury.	44-	3
More than one of above.		4
Don't know, can't remember.		5

45. "Did you go to the hospital this last year as either an outpatient or an inpatient? Which?"

Went as an outpatient only.		1
Went as an inpatient only.		2
Went as both in and outpatient.	45-	3
Didn't go.		4
Can't remember.		5

46. "What did you go to the hospital for?"

Routine visit or examination.		1
Surgery.		2
Treatment for accident or injury.		3
Treatment for illness.	46-	4
More than one of the above.		5
Don't know, can't remember.		6

47. "Are you enrolled to receive MEDICARE hospital benefits?"

Yes.		1
No.	47-	2
Don't know.		3

48. "Are you enrolled for Part B of Medicare - the part for which you pay a monthly premium and which pays for some of the costs of medical care outside the hospital or for outpatient services?"

Yes.		1
No.	48-	2
Don't know.		3

49. "If you are not enrolled for Part B of Medicare, why is that?

Didn't know about it.		1
Just haven't enrolled.		2
Don't know how to enroll.		3
Can't afford premium.	49-	4
Don't believe in it or counseled against it.		5
Other.		6

APPENDIX B "Continued"

50. "What if you got sick now; could you afford to pay the Medicare deductible of $84, or would you need some help?"
(Skip if not enrolled, question #49.)

Yes, could pay all.		1
Yes, could pay some, but would need help with balance.	50-	2
No, could not pay without help.		3
Don't know, no response.		4

51. "If you need help with medical expenses, can you ask for and receive help from your children or family?"

Yes.		1
No.		2
Could not ask for help.	51-	3
Don't know, no response.		4

"Do you have any cash or assets you could use for medical assistance such as:

52. Bank or other savings account?"

Yes, could use.		1
Own, couldn't use.	52-	2
Don't have.		3

53. Automobile or other vehicles?"

Yes, could use.		1
Own, couldn't use.	53-	2
Don't have.		3

54. House or other property?"

Yes, could use.		1
Own, couldn't use.	54-	2
Don't have.		3

55. Stocks, bonds or other investments?"

Yes, could use.		1
Own, couldn't use.	55-	2
Don't have.		3

56. Business or shares in a business?"

Yes, could use.		1
Own, couldn't use.	56-	2
Don't have.		3

57. Other assets?"

Yes, could use.		1
Own, couldn't use.	57-	2
Don't have.		3

APPENDIX B "Continued"

"If an elderly member of the Church faced medical expenses and could not pay the hospital bill, do you think that member should: (Circle all that apply - one per number.)

58. Borrow money to pay the bill?"

Yes.		1
No.	58-	2
Don't know.		3

59. Ask the children to help?"

Yes.		1
No.	59-	2
Don't know.		3

60. Apply for Welfare assistance?"

Yes.		1
No.	60-	2
Don't know.		3

61. Ask the bishop for help?"

Yes.		1
No.	61-	2
Don't know.		3

62. "When you need routine medical care, what do you normally do?" (Excluding emergencies and serious illness.)

_____ 62- ___ Code

63. "When a medical emergency or a serious illness arises, tell me how you would normally obtain medical care?"

_____ 63- ___ Code

64. "Are you presently taking any medications, and if so, what for?"

Treatment for illness.		1
Prophylaxis (to control or prevent a condition such as hypertension, heart disorder.)	64-	2
Insomnia or other nervous problem.		3
One or more of the above.		4
Not taking medications.		5
Other reason.		6

APPENDIX B "Continued"

65. "Have you sought medical care from anyone other than a medical doctor or chiropractor during the past year, such as a naturopath, practitioner of radiesthesia, or other such person?"

Yes.		1
No.	65-	2
Can't remember.		3

66. If the answer to question #65 is No, go on to question #67.
If the answer is Yes, ask: "Did that person or persons resolve your medical problem satisfactorily?"

Yes.		1
No.	66-	2
Not sure or don't know.		3

67-70. Say: "I know that medical care is getting expensive these days, and a lot of older people are having trouble with medical bills. About how much money do you think you have spent on medical treatment or medications during the past year out of your own pocket?"
(Write amount.) 67-70- $____

71. "Has Medicare paid on any medical bills for you?"

Yes.		1
No.	71-	2
Don't know.		3

72. "Has any private or group health insurance, such as Blue Cross, Blue Shield, Traveller's, or other paid on any medical bills for you?"

Yes.		1
No.	72-	2
Don't know.		3

73. "Have your children or other members of your family paid on any medical bills for you?"

Yes.		1
No.	73-	2
Don't know.		3

74. "Has the state or county Welfare Office (Medicaid) paid on any medical bills for you?"

Yes.		1
No.	74-	2
Don't know.		3

75. "Has the Church paid any medical bills for you?"

Yes.		1
No.	75-	2
Don't know.		3

APPENDIX B "Continued"

-8-

76. "Are you able to get out to any Church meetings? How often?"

Weekly or more often.		1
Once or twice monthly.	76-	2
Infrequently.		3
Never or inactive.		4

77. The dominant respondent in this household was:

The husband.		1
The wife.		2
Single man, no spouse.	77-	3
Single woman, no spouse.		4
Other person present.		5

78-80. Say: "I have appreciated so much the opportunity to talk with you. As you can see, I am especially interested about your health, and about how you pay for any medical care you may need from time to time. Is there anything else you want to tell me about this?" (Write response verbatim.)

Response_____

_____

_____

_____

_____

_____

Say: "Thank you so much for your time. I am sure this information will be most helpful as we attempt to help older people get along well. Goodbye."

BIBLIOGRAPHY

1. Anderson, N. N. "Evaluation Overview," Evaluation: A forum for human service decision-makers, 1:47-9, 1973.

2. Blankener, M. "Environmental Change in the Aging Individual," Gerontologist, 7:101-5, 1967.

3. Brian, E.W. and S.F. Gibbens. "California's Medi-Cal Co-Payment Experiment," in Medical Care (Supplement), 12:27-56, 1974.

4. Cannon, R. Personal Interview. Salt Lake City, Utah, June 24, 1975.

5. Cutler, S. J. "Voluntary Association Participation and Life Satisfaction: A cautionary research note," Journal of Gerontology, 28:96-100, 1973.

6. Eckstein, D. "Common Symptoms and Complaints of the Elderly," Journal of American Geriatric Society, 21:440-3, 1973.

7. Garfield, S. "Prevention of Dissipation of Health Services Resources," American Journal of Public Health, 61:1495-99, 1971.

8. Gillet, J. A. "Health Education of the Elderly," Community Health, 4:254-60, 1973.

9. John 6:26.

10. Letters of Marcus Tulius Cicero, ed. C. W. Eliot. New York: P. F. Collier & Son, 1909.

11. Markson, E., et al. "The Elderly in the Community: Reidentifying Unmet Needs," Journal of Gerontology, 28:503-9, 1973.

12. Nelson, Lee. Personal Interview. Salt Lake City. Utah, April 10, 1975.

13. Poulter, Don R. "Liberty Stake Profile." Salt Lake City, Utah: Latter-day Saints Hospital, May 5, 1972. (Mimeographed)

14. Pyper, G. M. and E. M. Smith. "Geriatric Nutrition," in Working with Older People: The aging process - needs and services. U. S. Public Health Service. Bethesda, Md.: National Institutes of Health, 1970.

15. Rosen, H. J. "Modern Health Care Delivery for the Aged: A program in total health maintenance," Journal of American Geriatric Society, 20:505-9, 1972.

16. Utah Department of Social Services, Assistance in Medical Payments, Fiscal Year 1972-73. Salt Lake City: Department of Social Services, January, 1974.

17. Utah, University of Utah, Bureau of Economic Business Research. Statistical Abstract of Utah, 1973. Salt Lake City, Utah: University of Utah, 1973.

18. U. S. Bureau of the Census. "General Social and Economic Statistics Final Report." CP (1)-C Utah. Census of Population: 1970. Washington: Government Printing Office, 1970.

19. U. S. Department of Health, Education and Welfare, Age Patterns in Medical Care, Illness and Disability, United States, 1968-69. Vital and Health Statistics series 10, No. 70, DHEW No. 72-1026, Rockville, Md., 1970.

20. _____, The Size and Shape of the Medical Care Dollar - Chart Book, 1970. Washington: Government Printing Office, 1971.

21. _____, Social Security Bulletin, May, 1972. Washington: Government Printing Office, 1972.

22. _____, Social Security Bulletin, May 1974. Washington: Government Printing Office, 1974.

23. _____, Social Security Programs in the United States. Washington: Government Printing Office, 1973.

24. Williams, H. A., Jr. "Problems of Older People," Bulletin of the New York Academy of Medicine, 99:1028-31, 1973.

SOCIOECONOMIC AND MEDICARE STATUS DIFFERENCES BETWEEN ELDERLY CHURCH SERVICE AND LDS PRIVATE PAY HOSPITAL PATIENTS

Edward L. Soper

Department of Health Science

M. S. Degree, April 1976

ABSTRACT

The purpose of this study was to determine the kind and degree of differences that existed in the socioeconomic status and access to financial resources of elderly members of the Church of Jesus Christ of Latter-day Saints, and to determine if differences existed between Church Service and private pay elderly hospital patients in economic status, type of housing, housing costs, marital status, sex, number and degree of access to children, savings and other assets.

Certain elderly members of the LDS Church were found to be significantly deficient economically because of inadequate income, low lifetime earnings and high medical expenses. Findings suggest the present system of medical welfare is somewhat inadequate, especially where hospitals provide direct service. Church Service individuals should be helped to more adequately plan their retirement finances.

COMMITTEE APPROVAL:

Don D. Shaw, Chairman

Brent Hafen, Committee Member

Ray Watters, Department Chairman