

DIMENSIONS OF ECONOMIC DEPENDENCY

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**HEALTH ADMINISTRATION PERSPECTIVES NUMBER A4
1967**

FOREWORD

THIS MONOGRAPH is the result of an exploratory project to examine the concept of economic dependency in the United States and how our society bears this burden. The expenditures of society as a whole are specified because economic dependency is generally arbitrarily defined as that which comes to the attention of the public and private welfare agencies. There is also a great deal of unmeasured dependency that society absorbs in other ways or not at all.

The concept of economic dependency suggested for this exploratory project was that anyone who is not earning his own way for one reason or another—disabled, ill, crippled, mentally retarded, unemployed, in school—must be supported by the economy and society in some manner. Public and private welfare programs assist those who seek their help or come to their attention and according to certain criteria, usually the means test, are selected for assistance. This is the segment of the population that is visible to welfare agencies. Its components vary in magnitude according to funds available and the policies of the agencies. Unexplored are the numbers of the dependents who do not come to the attention of the public and private agencies because they do not apply for assistance, even though eligible, or they have other means of support. Cases in point are a mentally retarded child living at home to the point of adulthood and beyond, or a bedridden oldster taken care of by a married daughter in her own home.

The specific question then is: How does our society absorb economic dependency through public and private agencies and resources of the families? We are interested in arriving at some estimates of the relative proportions of economic dependency assumed by the public and private programs—the expressions of our public policy regarding dependency—and by the private resources of the families. Illness, disability, and the expenditures for health services will receive pri-

This project was supported by Grant
No. CH 00115, Division of Com-
munity Health Services, United
States Public Health Service.

mary attention in this exploration with particular reference to low-income families.

Mr. Richardson has explored relevant and existing data, studies, and problem posing articles, which provide a solid background for formulating a research design leading to a study of some phase of economic dependency, morbidity, and the use of health services. It should be useful to have it read and pondered by others who are interested in similar and related problems. And for those interested in research this monograph should save a considerable amount of time in literature search and bibliography.

This project was made possible by a grant from the Division of Community Health Services of the United States Public Health Service. Their support of our exploratory work in this area is highly valued. It would also seem appropriate here to acknowledge the assistance of Robert Beckman, a doctoral student in Sociology at the University, in preparing material for this report.

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INTRODUCTION

THIS PAPER has been written to provide a conceptual framework on which to base an empirical study of economic dependency in the United States. We have attempted to draw together findings in a number of research areas that bear on the problem as well as to discuss certain methodological considerations, relevant issues, and unanswered questions.

After a discussion of the measurement of poverty and dependency and their interrelationship, considerable attention is devoted to two key variables: physical health and work attitudes. They are not the only ones that might well receive detailed study, but in terms of current public policy discussion seem particularly timely.

The proposed strategy implicit in this paper is to establish, in the case of a spending unit, whether there exists an unfavorable gap between need and earned or non-dependency income, to examine the dependency alternatives available, or the various ways people may receive assistance from governmental and private sources, to attempt to explain how the unit decides which alternative to take, and to determine the impact of this solution on subsequent expenditure or use behavior. Finally, there are questions that are yet to be answered.

POVERTY AND DEPENDENCY

POVERTY AND DEPENDENCY as discussed in this paper are both concerned with need and inadequate resources, but the two are not synonymous. Poverty is concerned only with inadequacy of income; dependency is concerned with the sources of income. Both poverty and dependency, although they are more than quantitative concepts, must be assigned values in order for them to be measured in terms of the resources of the entire society. To make available to the "poor" the resources of society (dependency income), "need" must be determined and measured. Thus, as all observers would agree, need is basic to the concept of poverty.

Dependency income is generally a substitute for earnings income, but usually near the subsistence level. Because of this, dependency has become associated with poverty, but the association is not theoretically necessary. Since dependency income is received because without it there would be an "unacceptable" (to both the recipient and the donor) discrepancy between level of need and level of income, variables influencing both need and income should be included in a study of dependency.

A family is poor because what it gets is barely adequate or less for even a very low standard of living. The test of adequacy, however, must take into account factors such as cost of living, basic subsistence requirements, and related considerations. This is so not only because of regional variations in the purchasing power of money, but also because of the stage of the family's life cycle, its size, and the assets it owns. Income alone is not a satisfactory test as, even controlling for place of residence and family size, it ignores crucial information. For example, the fact that so many elderly persons are able to maintain separate residences, albeit at a very low income level, suggests that some of the traditional meaning of poverty has changed. These persons would seem to prefer living alone

at a low income level to moving in with their children; that is, they seem to prefer poverty to dependency. It would seem that the "poor" may perceive their own relation to both poverty and dependency differently from the way society perceives it.

Poverty thus must be measured before dependency can be discussed. In attempting to measure poverty, one must first answer the question "what is basic need?" This answer will depend first on the determination and measurement of the various specific needs and then on some kind of monetary valuation placed on the total of all these needs. In other words, need must be translated into income. Two approaches can be followed:

1. Take a basic need that is fairly easy to quantify, decide what percentage of total income it represents, and from this extrapolate total income requirements. If food, for example, is determined to be a certain fraction of total need, then the amount of money required for food is multiplied by the inverse of that fraction to determine the total needed.

2. Establish the quantity and cost of each need separately—food, clothing, and the rest—and add them up to achieve gross income requirements.

The problem presented by these two approaches, and the reason that there even need be two approaches, is that each has strengths and weaknesses, and the weakness of one approach is the strength of the other. The strength of the first approach is that food is fairly easy to quantify—nutritional adequacy can be determined for various specific amounts of food whose cost is well known. On the other hand, with the second approach, other needs are not tied to food requirements but rather are determined independently and in their own terms. Only a very few needs, food in particular, have received extensive analysis. Even the determination of nutritive adequacy is fairly arbitrary, and as the list of items is increased to include elements such as housing, clothing, and recreation, even the pretense of objectivity must be dropped [1]. The weakness of the first approach is the difficulty in determining a suitable multiplier. This multiplier is best determined by empirically establishing the income at which a certain percentage of the population reaches the

given level of nutritional adequacy. Thus, solution by use of the first approach, estimating the total on the basis of food requirements, about which the most is known, precludes the use of the preferred solution of the second approach, simply totalling the costs of all requirements.

Because we are interested in studying the use of dependency resources in some detail rather than simply a gross measure of the difference between earned income and net need, the food-multiple method of determining need would not seem to be suitable. As we are planning to include in dependency income the value of free housing, for example, a specific need for housing must be estimated for each adult unit [2] studied. At the same time, however, we must be careful to avoid defining need in terms of the sum of earned and dependency income, because such a definition would eliminate the possibility of a unit's having an excess of net need over earned income, but no dependency income. MacIntyre [3], for instance, defines a unit *in* need as being one "whose financial resources do not suffice to provide minimum or subsistence levels of food, shelter, clothing and health, and *who seeks public aid to secure them*" [4]. This eliminates from the analysis a key group of units that are, in fact, in need but which, for reasons to be studied, do not seek, or at least do not receive, dependency income.

The well-established principle that need is a relative term complicates tremendously the study of alternatives to a persistent discrepancy between earned income and need. Using perceived need might improve the study, but on the other hand, it might simply further obscure the processes involved. A permanent expenditures variable might be included to achieve some measure of standard of living. It is well known that even holding constant family size and resources, calculations of "basic need" vary tremendously from state to state (far more than price levels). When one starts moving away from the basics, differences become greater still. It might be possible to use more than one measure of need. Certainly one should be based on a uniform formula (flexible, however, in terms of certain unit characteristics such as family size, age, or urban-rural residence), another more closely related to perceived need, and another based on some perceived level of typical or long run expenditure

patterns or permanent expenditures. It would be interesting to analyze expenditure or use patterns using a three-category typology that divided units into: those for which need calculated by some uniform formula was above perceived need, those for which it was below perceived need, and those for which it was approximately the same.

The unit of analysis—i.e., individuals, adult units, spending units, or households—determines to some extent the severity of poverty that is found. Morgan's [5] analysis of the inequality of income distribution showed that equality increased with the size of the unit of analysis—from adult units to spending units to households [6]. Morgan found that the Lorenz coefficients of inequality for the welfare ratio (gross disposable income divided by budget standard) varied from .346 for adult units to .309 for families, indicating the relevance of the family in compensating for income inequality. The size of the poverty segment is largely a consequence of the composition of the social units in which people live—a child is poor because his parents are—and it is meaningless to talk about poverty as if it were an individual phenomenon. Adult units and spending units are also inadequate, because they do not account for the value of non-cash transfers or partially reimbursed expenses such as shared housing. If it were possible to estimate the value of these benefits and apportion them "correctly," adult units and spending units could be used.

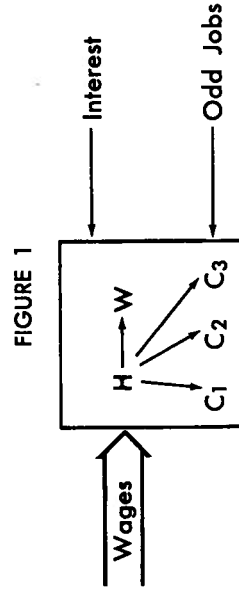
The use of households would permit us to discern situations that should realistically be classified only as involving dependency, yet which would show up as poverty if spending units were used. For example, a young married couple who keep separate finances and who, because of insufficient resources, must live with one set of parents, would show up as living in poverty if a spending unit approach were used. But by virtue of being virtually dependent on their parents they in fact are able to avoid poverty. This does not preclude a dependent's being classified as poor, of course; it does prevent dependency and poverty—which can exist as alternatives—from being confused.

Taking the extremes of dependency, any individual whose sources of income are exclusively wages and returns from investment (including contributory transfers such as Social Security payments)

may be said to be independent, while a person who receives no income from these sources is totally dependent. Between these extremes are persons who are economically dependent to a degree.

In approaching the question of how our society meets the "problem" of dependency, a necessary refinement of the definition previously given would exclude those persons who are generally expected to be dependent. This group might be considered "standard" dependents and would include housewives, children in school age 18 or below, and pre-school children, all of whom are members of households having a male head as the principal source of income. Another way of viewing this distinction might be to say that with non-standard dependents there is an element of option. There are socially acceptable alternatives to supporting abnormally functioning or adult children, or parents, while this is not the case with wife and children in school or pre-school. Of course, to the degree that alternatives in the first case are not available, this way of viewing the two types breaks down. A useful means of visualizing the problem might be to start with the simplified model of the household (Figure 1) as a norm and then examine deviations from it.

The household is made up of a head (H), his wife (W), and children who are under 18 and either go to school or are pre-school (C). The principal source of income is the head's earnings (or returns) and there is no income other than from earnings or returns.

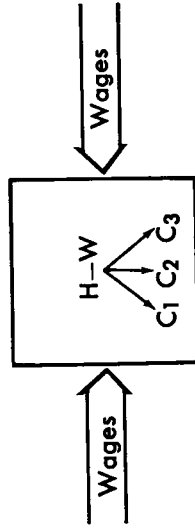


The head is the only individual who is totally independent, and for purposes of analysis it may be said that the other members of the household are dependent on him (despite small incomes from other sources).

If the wife works and receives an income to support at least her-

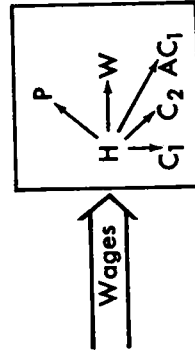
self, the scheme is altered somewhat (Figure 2). Only the children remain dependent and their source becomes both parents.

FIGURE 2



At this point the model must be extended to introduce additional forms of economic dependency (Figure 3). For simplicity it will be assumed that the head is the only wage earner. If one of the children is unable to function normally, his dependency takes on new meaning because it might be argued that the community should assume responsibility for his maintenance. Similarly an adult child (AC) not in school, over 16 and yet not earning a living, is no longer clearly the responsibility of the parents. Finally, a parent (P) or other relative may live within the household with no outside source of income. Again this is not a clearcut responsibility of the head, in contrast to the first situation.

FIGURE 3

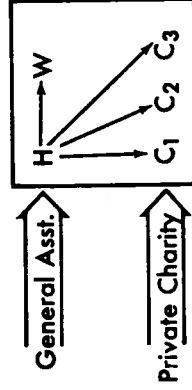


As this brief discussion indicates, the unit of analysis most appropriate for studying dependency relationships is the adult unit. Because "standard" dependency is contained within the adult unit [7], analysis across adult units will involve only "non-standard" dependency.

Up to this point, only dependency within the household has

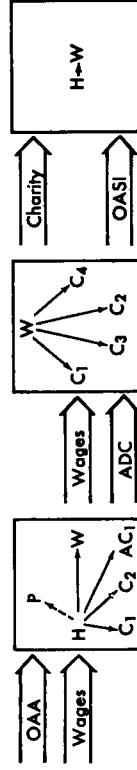
been discussed, with the original source of income being wages or returns. However, any member of the unit may be dependent on "other" sources outside and may in turn have persons dependent on him. Again starting with the basic unit structure, the "other" source may be public (i.e., welfare) or private (charity or intra-family transfers) (Figure 4). A more common composite of sources would probably involve a mixture of earnings and "other" income.

FIGURE 4



Any adult unit could be responsible for a segment of the total household income (Figure 5).

FIGURE 5



In examining either the use or influence of sources of dependency income, a distinction should be drawn between formal and informal sources. It is noted in *The Concept of Poverty* [8] that "despite all the interest and concern about the problem in recent years, no adequate detailed data exist on current private and public programs contributing directly or indirectly to the alleviation of poverty." If one thinks of formal dependency resources as issuing from private or public programs it is difficult to estimate either amounts or numbers of recipients without considerable duplication. And if detailed data are less than adequate in terms of formal dependency, they are virtually nonexistent in terms of informal dependency re-

sources, which are defined as those coming from sources such as family and friends. Including all goods and services, informal sources are probably several times as important as formal sources in the composition of dependency income for the nonstandard dependents.

An examination of economic dependency in terms of extent, forms, influencing conditions, and impact will take an approach significantly different than a study of poverty. Poverty, in effect, can be eliminated by making available a theoretically specifiable amount of money, which is not to say that it can be measured by an income yardstick, while dependency is increased by this approach. Within the context of the household, in fact, dependency may be thought of as an alternative to poverty. It is also worth noting that while one individual within a household may be dependent, if one member is poor it is because all members are poor.

Because poverty and dependency are associated, and because dependency income takes up the gap between earnings and what society determines to be an acceptable minimum income, the next several sections of the paper will discuss certain variables that influence income and need.

LOW INCOME, HEALTH, AND DEPENDENCY

THE INVERSE RELATIONSHIP between low income and incidence of disease has been given a considerable amount of attention over the past half century. Studies have measured morbidity as well as social class, but there has been limited success in determining the nature or direction of a causal relationship between them. It has been demonstrated that an inverse relationship is not confined to the infectious diseases that one would expect with crowded living conditions nor to nutritional inadequacies. Other evidence shows that the costs of medical care cannot fully explain income related differences in incidence of disease. Drawing on the reports of Ornati [9], Irelan [10], and Muller [11], as well as on studies discussed in detail below, the following picture emerges.

A number of general measurements that attempt to reflect levels of morbidity have been used by the National Center for Health Statistics. Three such measures, for each of which there is an inverse relationship with income, are:

Restricted activity day—a day on which a person substantially reduces the amount of activity normal for that day because of a specific illness or injury.

Bed disability day—in which a person stays in bed for more than half of the daylight hours for a specific illness or injury.

Work loss day—one which a person over seventeen years of age who is currently employed did not work because of a specific illness or injury. For persons aged six to sixteen the equivalent measure is school loss day.

The rates per person for the period July, 1962, through June, 1963, for those with family incomes below \$2,000 compared to those with family incomes above \$7,000 adjusted for age are 22.8

versus 13.7 restricted activity days; 9.7 versus 5.6 bed disability days; and 8.6 versus 5.5 work loss days. School loss day rates were 6.5 compared to 5.8 without any adjustment for age. As would be expected in light of the disproportionate number of older persons in the low income group, the rates that are unadjusted for age for this category are considerably higher than those presented above.

Another approach to morbidity levels is measurement of the prevalence of chronic and acute disease in the population for a given period of time. Data from the National Center for Health Statistics suggest that in terms of chronic illness there is very little difference between persons with low and with high family income for age groups below 45. However, the percentage of the population with one or more chronic conditions in the categories 45 to 64 and 65 and older does vary with income. Percentages for low and high income persons 45 to 64 years old are 76.8 and 61.1, while those for persons 65 or older are 86.4 and 76.2. The report suggests that this may be because, "the illness reaches a stage where it interferes with usual activities and thus becomes a limiting factor in the amount of family income." On the other hand, it is possible that "poorer diet, poorer environment, or poorer health habits associated with lower income were responsible for a higher prevalence of chronic morbidity" [12]. The former interpretation is given support when chronic conditions with and without activity limitation are compared. The proportion of the population for each age group having chronic conditions with no activity limitation increases slightly with income, while there is a fairly pronounced inverse relationship for conditions involving activity limitations. However, this may be partially a function of the tendency for low income persons to acknowledge illness only when it causes some limitation on normal activity as discussed elsewhere in this paper.

Of those persons in all age groups whose activities were limited, 38.6% had more than one condition causing limitation. This percentage varied from 59.8 for persons in families with incomes below \$2,000 to 24.1% for incomes of \$7,000 or more. This relationship holds even when the large proportion of older persons with low incomes is taken into account.

Prevalence rates were computed for specific condition cate-

gories causing limitation of activity: heart conditions, arthritis and rheumatism, mental and nervous conditions, high blood pressure, visual impairments, and orthopedic impairments except paralysis and absence of one or more limbs (see Table I). With the population divided into four age groups—under 15 years, 15 to 44, 45 to 64, and 65 or older—the difference between low- and high-income persons reflected an inverse relationship between prevalence and income for every disease category in every age category. Typically, differences seem to become less pronounced with the 65 and over category while the magnitude of the rate increases with age. In most cases this increase is rather dramatic. The rate for mental and nervous conditions for those with low incomes peaks at the age 45 to 64 level as does the orthopedic impairments rate.

Finally, it is worth noting that with the exception of high blood pressure among those aged 65 and over, where there is a slight tendency for the income category \$2,000 to \$3,999 to have the lowest rate, there is a consistent decline in the rate for every category in every age group by income using four income groups (under \$2,000; \$2,000 to \$3,999; \$4,000 to \$6,999; and \$7,000 or over).

The classic study of the relationship between chronic illness and socio-economic status by Lawrence [13], reported in 1948, found a consistent relationship similar to the findings presented above. Lawrence, however, was able to go further and explore a possible causal relationship. Lawrence resurveyed twenty years later families in Hagerstown, Maryland, that had been included in a study in 1921–24. Of 1,822 families participating in the original survey, Lawrence was able to contact 1,628 in 1943. After eliminating families for various reasons such as unknown ages, broken families, families with less than twelve months original observation, death due to nonchronic causes, and unknown socio-economic status there were 1,010 families resurveyed.

Socio-economic status was assigned according to a five group scheme in 1923: Well-to-do, Comfortable, Moderate, Poor, and Very poor. Location, condition, and taxable value of the dwelling, and place and type of employment were used as criteria; income was not used. In 1943, observers using the 1923 description for each

family recorded conditions as "improved," "same," or "reduced." The first and third categories were employed only in the event of "gross change."

TABLE I
SELECTED CHRONIC CONDITION CATEGORIES
RATES PER 1,000 BY
AGE AND FAMILY INCOME
U.S., JULY, 1962—JUNE, 1963

	FAMILY INCOME	
	Under \$2,000	\$7,000 or More
<i>Heart Conditions</i>		
Under 15 years.....	*	*
15-44 years.....	10.3	4.1
45-64 years.....	77.9	28.7
65 or over.....	127.5	84.8
<i>Arthritis and Rheumatism</i>		
Under 15 years.....	*	*
15-44 years.....	6.2	4.0
45-64 years.....	98.3	19.6
65 or over.....	138.6	63.3
<i>Mental and Nervous Condi- tions</i>		
Under 15 years.....	*	*
15-44 years.....	16.1	4.2
45-64 years.....	51.3	8.2
65 or over.....	40.2	10.3
<i>High Blood Pressure</i>		
Under 15 years.....	*	*
15-44 years.....	6.3	1.4
45-64 years.....	32.0	8.3
65 or over.....	57.0	35.3
<i>Visual Impairments</i>		
Under 15 years.....	*	*
15-44 years.....	6.0	.8
45-64 years.....	22.1	3.6
65 or over.....	62.4	32.3
<i>Orthopedic Impairments</i>		
Under 15 years.....	*	*
15-44 years.....	35.3	17.0
45-64 years.....	94.1	25.6
65 or over.....	89.1	40.0

To discover the effect of socio-economic status on chronic illness, Lawrence analyzed the data for families that in the original survey had been free of chronic illness and that had retained their original socio-economic status. Although there may have been in-

terim changes in either status or disease that were cancelled out, the findings are revealing. The incidence rates for chronic illness, adjusted for age and family size, showed a slight inverse relationship with socio-economic status, the rates being 56.4% for the Well-to-do and 68.6% for the Poor. This was not a significant difference ($p = .55$) suggesting that "socio-economic status itself does not seem to play an important part in the chance of developing chronic disease" [14].

On the other hand, chronic illness did appear to have some role as a factor in changing socio-economic status. None of those families that remained free of chronic disease in both studies had a lower status in 1943. Adjusting for age and family size, 21.6% of this group ($n = 215$) had improved status. Of those families that had no disease in 1923 but did have by 1943, 11.5% had improved status while 9.2% showed a reduction in status. For some of this group reduction in status may have occurred before illness. This would not be the case for a third group, however, which had chronic illness in both years; in this group 9.5% had improved status while 5.5% had reduced status. The differences between the last two groups and the disease free group were found to be significant. It would seem then that chronic illness has an observable effect on socio-economic status whereas status has little effect on the incidence of disease, which is consistent with the findings on activity limitation discussed earlier.

In terms of its effect on income, Morgan *et al.* found, in studying disabilities of adult unit members, not only a sharp fall in the proportion of heads who receive wages and salaries as work limitation increases, but also a decline in the proportion of wage-earning wives of disabled persons. This would suggest that wives must remain home to provide care. More than a third of those heads who are disabled and under 65 had no earned income (including returns on investments). Of adult units having the head under 65, 2% were completely limited, another 2% severely limited, and an additional 8% somewhat limited; their average annual loss of gross disposable income is estimated at \$2,571, \$1,515, and \$197 respectively [15].

In any discussion such as this, it must be remembered that the complexity of the relationships among income, morbidity and use of health services parallels the complexity of the relationship be-

tween socio-economic status and mortality. As Stockwell [16] has demonstrated, there is limited usefulness in the agreement on a gross inverse relationship. Studying the relationship by using different indices of socio-economic status and two populations, Stockwell found that the association varied by the particular component of socio-economic status used, and further that the various aspects of mortality data varied differentially with respect to the same socioeconomic component.

It might be suspected that some chronic diseases tend to result from low income while the overall direction of causality tends to be the reverse. For example, in New York City in 1961 the incidence of tuberculosis (rate of new cases per 100,000 persons) for Negroes, Puerto Ricans, and whites was 158, 99, and 33 respectively. For other diseases whose etiology is not well understood—cancer, for instance—it is possible to do little more than note the association of incidence with low income.

Irelan [17] in an article on the health practices of the poor, links research findings on low income or lower class groups to present a composite sketch of the attitudes and health behavior of the poor. The greatest problem with this approach is its implicit assumption of a homogeneous segment of the population that can be labeled as poor. Some of the studies refer to income, some to various composite measures of status. In a few instances findings are based on broad representative samples, in others the universe is fairly restricted. Summarizing these findings on the health behavior of the poor Irelan observes, "ways in which the low-income stratum copes with its health problems are traceable either to the material situation of poverty itself, to the social structure of poverty, or to aspects of the life outlook of poverty—the ideals, values, and beliefs to which the poor man adheres." However, the crucial question, it would seem, is how does the health behavior of various segments of the poor differ along each of these dimensions.

Examining the last dimension first, an example of the type of research that attempts to discover this dimension is that of Freidson [18]. Discussing the lay referral system, Freidson describes the network of consultations starting with immediate family and eventually ending with the professional. He notes that the lower classes were not well informed about medical services and possi-

bilities available, while upper class patients tended to have a much less elaborate lay consultation and referral network.

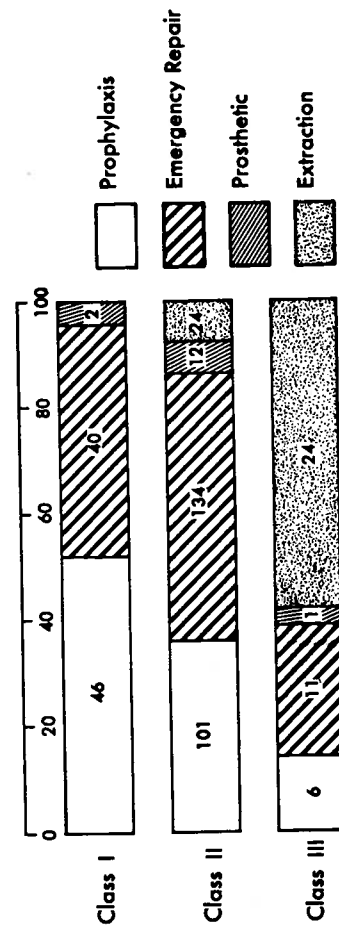
It appears that despite the fact that they are less well informed and could benefit relatively more from the professional referral structure (and particularly the formal structure of group practice medicine) the poor may be inclined to shun organization. It may be viewed as conflicting with the lay referral system to which they are accustomed, or care as organized may not be accessible in terms of either time or geography. The "cultural gap" between low income persons and the providers of medical care can have a significant impact on patterns of use of modern health services as shown by Saunders [19] for one fairly specific cultural group, Spanish speaking people of the Southwest. The effect of the relationship between low income groups and knowledge and attitudes is analyzed by Suchman [20] for a more comprehensive sample of the U.S. population (the Washington Heights District of New York City, which contains many ethnic and socio-economic groups).

Suchman's study examines this relationship in terms of "the effect of the more ethnocentric and restricted social relationships of the lower income minority groups upon their knowledge of disease, their attitudes toward professional medical care, and their responses to illness" [21] Suchman found a significant and consistent inverse relationship between ethnocentrism and socio-economic status in the group he studied. A "Medical Orientation" scale was developed that combined responses to three groups of questions related to: knowledge of the etiology, symptoms, and prognosis of various diseases; attitudes toward medical care; and response to illness in terms of degree of dependency. An inverse relationship was found between medical orientation and ethnocentrism and a direct relationship was found with respect to socio-economic status as would be expected. Looking further at the relationship within different minority groups the relationship with status holds in all cases studied. Within socio-economic status and ethnic groups there is a significant inverse relationship between ethnocentrism and medical orientation. This might suggest that the approach of low income persons to health care is simply one example of a generally restricted "life outlook."

Koos' finding on the knowledge, attitudes and behavior of the lowest socio-economic class are consistent with the Suchman results, although not focused on ethnocentrism. When asked whether they would consult a doctor to receive medical attention with respect to seventeen specific symptoms, Class III, that is the lowest class, respondents showed "marked indifference to most symptoms, ten being checked by 25% or less. Only three symptoms were checked by 50% or more, and these were all associated with unexplained bleeding [22]. Fifteen of the seventeen symptoms were checked by 75% or more of Class I respondents. Koos' study also indicates, as does Feldman's report [23], that there is a substantial discrepancy between what a person says with respect to the importance of a symptom and his subsequent behavior. Factors such as fear, urgency, past experience, and group norms were found to be influential.

An element of fatalism has been characterized as typical of low income persons. Diseases that are curable may often be defined as unavoidable and incurable [24]. Koos' findings on dental treatment suggests this. The percentage of respondents in Class I having a family dentist was 94 whereas 47% of Class II families had family dentists, but only 12% of Class III families did. The proportion of each class treated by a dentist in the preceding twelve months was .84, .38, and .15 respectively. Probably of greatest interest, however, is the relationship of social class membership to type of treatment for those individuals who did visit the dentist (Figure 6). Fifty-

FIGURE 6



two percent of those individuals who were in Class I visited the dentist for prophylaxis, while none went for extractions. On the other hand, for Class III individuals, only 14% had visits for prophylaxis, but 57% went for extractions.

Finally, it would hardly be appropriate to close a discussion of the health behavior of the low income population without brief coverage of use and expenditure patterns for medical and hospital services. The relationship between use and expenditures is not entirely clear and undoubtedly changes with income. Among low income persons one would expect a fairly tenuous relationship due to free care, while at higher income levels the relationship would be stronger although still complicated by school and industrial health programs and professional courtesy.

Looking first at family expenditures and controlling on family size, there is a quite regular increase in absolute expenditure as income increases (up to \$10,000). The pattern of expenditures for medical care as a percentage of total income however is quite different. Examination of Table II suggests that as income increases the percentage spent on medical care declines, but more gradually as family size increases, until with very large families the percentage increases. There appears to be a convergence in the highest income category at somewhere between 6 and 6.5% of income regardless of family size. Returning to absolute expenditures, it is interesting to note that generally the larger the family, controlling on income, the smaller the total family expenditure, until at the highest income level the expenditure is about the same, no matter what the size of the family.

The consistent jump in expenditures between single individuals and two person families is what might be predicted. However, the intriguing question is why expenditures fall off with increased family size. Additionally it must be asked to what degree does this reflect use patterns. At the lower income levels, large amounts of free care may explain this phenomenon. More generally, these figures may indicate that medical care is not as essential a commodity as, for example, food and housing, and expenditures for health will tend to be relatively low until other needs are met. If this is the

TABLE II
CONSUMER EXPENDITURES OF MEDICAL CARE BY FAMILY INCOME AND
NUMBER OF PERSONS IN FAMILY, U.S., 1960-61

Family Income	Number of Persons in Family									
	1	2	3	4	5	6 or more	Percent of Total Income	1	2	3 or more
\$1,000 or Less	103	173	173	201	120	98		4.9	6.9	14.3
\$1,000 to \$1,999	176	270	306	329	316	259		5.0	5.7	5.5
\$2,000 to \$2,999	135	197	241	264	259	197		5.4	6.2	5.5
\$3,000 to \$3,999	195	306	329	343	349	256		5.7	6.6	5.9
\$4,000 to \$4,999	199	329	343	437	460	262		6.1	6.6	6.1
\$5,000 to \$5,999	256	343	437	460	466	485		6.1	6.6	6.1
\$6,000 to \$7,499	187	437	460	466	485	484		6.1	6.6	6.1
\$7,500 to \$9,999	262	460	466	485	484	484		6.1	6.6	6.1

Source: Supplement 2 to BLS Report 237-93 (June, 1966).

case, one would expect to see higher expenditures with increased family size at income levels above those shown here.

Turning to a brief consideration of the use of health services (Table III), number of physician visits per year increases monotonically from 4.3 for persons with family incomes under \$2,000 to 5.1 for those with family incomes of \$10,000 and over. Age-sex adjusted hospital discharges show a substantial increase moving from the lowest to the \$2,000 to \$4,000 level and then decline steadily with the lowest rate (in a year's time 120.1 discharges per 1,000 population) at the highest income level. Average length of stay declines substantially as income increases, excepting a slight rise for the highest group.

In discussing health insurance coverage of the aged and their hospital utilization, Rice observes that the lower discharge rate and higher average length of stay for uninsured persons "suggests that persons without insurance may tend to postpone entering a hospital until the need is critical and that they then require longer periods for recovery" [25]. This reasoning might be extended to income differences; however, it appears that both discharges and length of stay decline as income increases. As income increases, too, a rise in number of physician visits is observed. One might suspect either a substitution effect or more effective preventive care at high income levels. However, when age is controlled for, there are problems with the substitution argument because the rates show no consistent relationship. Also, there are the same number of physician visits in the lowest two income categories while there is an increase in discharges further weakening the substitution argument.

As was noted earlier, the behavior that seems to merit the greatest attention is the difference in use of various types of health services between the low income and dependent segment and the rest of the population. It is fairly evident from Table III that patterns do vary by both age and income.

Table IV shows the proportion of the population by income seeing certain specialists in one year and the average numbers of visits to specialists. In general a considerably greater proportion of high income than low income persons see specialists; however, the differences in average number of visits of those actually having

TABLE III
PHYSICIAN VISITS PER YEAR, HOSPITAL DISCHARGES AND AVERAGE
LENGTH OF STAY BY AGE AND INCOME, U.S. 1963-1964

PHYSICIAN VISITS PER YEAR, HOSPITAL DISCHARGES AND AVERAGE LENGTH OF STAY BY AGE AND INCOME, U.S. 1963-1964				
	PHYSICIAN VISITS PER YEAR ¹	DISCHARGES PER 1000 PER YEAR ²		AVERAGE LENGTH OF STAY ³
		Age-Sex Adjusted		
All ages				
All incomes.....	4.5	128.1	122.2	8.1
Under \$2,000.....	4.3	136.4	140.4	10.2
\$2,000-\$3,999.....	4.3	145.6	133.0	9.4
\$4,000-\$6,999.....	4.5	128.0	125.5	7.2
\$7,000-\$9,999.....	4.7	121.7	120.1	7.2
\$10,000 and over...	5.1	116.5		7.4
Under 15 years				
All incomes.....	3.7*	67.6		6.0
Under \$2,000.....	1.9	55.3		10.0
\$2,000-\$3,999.....	3.0	63.8		8.2
\$4,000-\$6,000.....	3.8	72.0		5.8
15-24 years				
All incomes.....	4.3	150.9		5.6
Under \$2,000.....	4.2	163.4		5.3
\$2,000-\$3,999.....	4.6	204.1		5.0
\$4,000-\$6,999.....	4.2	167.6		4.8
\$7,000-\$9,999.....	4.3	119.0		7.2
\$10,000 and over...	4.7	91.4		7.3
25-34 years				
All incomes.....	4.7	179.5		5.9
Under \$2,000.....	3.2	163.2		5.5
\$2,000-\$3,999.....	3.7	196.2		7.8
\$4,000-\$6,999.....	4.9	175.7		5.9
\$7,000-\$9,999.....	5.2	187.4		5.3
\$10,000 and over...	5.2	174.9		5.0
35-44 years				
All incomes.....	4.4	132.6		8.0
Under \$2,000.....	4.2	148.4		8.1
\$2,000-\$3,999.....	3.9	132.4		11.7
\$4,000-\$6,999.....	4.4	134.5		8.2
\$7,000-\$9,999.....	4.5	134.0		7.0
\$10,000 and over...	4.8	136.2		7.2
45-64 years				
All incomes.....	5.0**	146.4		10.7
Under \$2,000.....	5.2	138.3		13.3
\$2,000-\$3,999.....	5.1	167.9		12.4
\$4,000-\$6,999.....	5.1	151.3		9.8
\$7,000-\$9,999.....	5.3	149.3		10.0
\$10,000 and over...	5.1	131.4		9.3
65 years and over				
All incomes.....	6.7**	190.0		12.1
Under \$2,000.....	6.0	178.1		12.5
\$2,000-\$3,999.....	6.7	198.7		11.8
\$4,000-\$6,999.....	7.0	189.1		12.0
\$7,000-\$9,999.....	7.0	179.9		10.0
\$10,000 and over...	7.7	226.3		13.7

¹ Volume of Physician Visits—July, 1963–June, 1964, National Center for Health Statistics, Series 10, Number 2.

² Hospital Discharges and Length of Stay: Short Stay Hospitals, United States—July, 1963–June, 1964, National Center for Health Statistics, Series 10, Number 30.

* Combination of "Under 5" and "5-14" weighted by Bureau of the Census Population estimates used in National Center for Health Statistics report, Series 10, Number 18.

** Because "income unknown" classifications were eliminated, the summary statistics may not always be consistent with the sub-categories. See for example, Physician Visits for ages 45-64 years.

TABLE III—Continued

	PHYSICIAN VISITS PER YEAR ¹	DISCHARGES PER 1000 PER YEAR ²	AVERAGE LENGTH OF STAY ³	
			Age-Sex Adjusted	
45-64 years				
All incomes.....	5.0**	146.4		10.7
Under \$2,000.....	5.2	138.3		13.3
\$2,000-\$3,999.....	5.1	167.9		12.4
\$4,000-\$6,999.....	5.1	151.3		9.8
\$7,000-\$9,999.....	5.3	149.3		10.0
\$10,000 and over..	5.1	131.4		9.3
65 years and over				
All incomes.....	6.7**	190.0		12.1
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\$2,000-\$3,999.....	6.7	198.7		11.8
\$4,000-\$6,999.....	7.0	189.1		12.0
\$7,000-\$9,999.....	7.0	179.9		10.0
\$10,000 and over..	7.7	226.3		13.7

visits is relatively small. This might suggest that once contact is made with the medical profession, the course of treatment does not vary greatly by income, while factors mentioned above result in considerable differences in the degree of contact. This interpretation may be further supported by the findings that emerged from data of the National Center for Health Statistics [26] showing the influence of non-whites on the aggregate relationship between physician visits per year and income. The white rate remained almost constant throughout the range while the non-white rate increased from 1.9 to 4.3. This further suggests that any analysis of use patterns based on dependency income sources must control for race.

Turning to the relationship between dependency, and health and use of health services, estimates of the importance of illness in precipitating use of public assistance vary. Notkin [27] found that 35% of recipients of Old Age Assistance (OAA), General Assistance (GA), and Aid to Families with Dependent Children (AFDC) had illness as the precipitating factor. For AFDC alone, the figure was 40%. On the other hand, Burgess and Price [28] estimate incapacity, a somewhat more limited category, as precipitating for approximately 20% of AFDC cases. Notkin found illness as a contributing or

precipitating factor in over half (55%) of the cases studied. The relationship of this estimate to Burgess and Price's major crisis category is about the same (2:1) as above.

Notkin concludes that "a very large amount of formal economic dependency is due in one way or another to medical conditions." This conclusion may be valid if strictly interpreted; however, the implications that are presented in the writings of some are hardly justified. In some cases the medical condition may not be reversible, while in others the person would be dependent even if well. Thus even if we attain the best possible solution to the health problem, we do not thereby reduce formal dependency by the percentages quoted above. The emerging implication of a number of recent studies would seem to be the coalescence of several factors, rather than single factors, resulting in dependency [29]. It may be that the nature of medical care makes it appear important by itself. Since it is irregular in occurrence of need and increasingly expensive, it is a more visible factor than, for example, food, which is regular in occurrence of need and increasingly expensive. If it weren't taken for granted, need for food might equally well be considered a "contributing factor."

Nevertheless, medical care does have its unique characteristics and vendor payments, that is, payments made by the government directly to the providers of care, in 1963 did amount to over \$1 billion or better than one-fifth of all public assistance payments. Three-quarters of this amount went for payments to hospitals and nursing homes [30], while only 12.4% went for physicians, dentists, and other practitioners, suggesting the traditional emphasis on meeting the crisis rather than preventing it. A significant question to be answered in future research is, to what degree do formal transfers, such as government financed medical care, simply relieve the burden of informal dependency and to what degree do they actually increase utilization where it is appropriate.

There is a fair amount of supporting evidence for the generalization that utilization should be increased among the group of adult units that has an excess of need over earned income, or changing it to accommodate previous research, the group that had low incomes or are poor. There is little or no research, however, that shows dif-

TABLE IV
PERCENT OF THE CIVILIAN, NONINSTITUTIONAL POPULATION WITH SELECTED SPECIALIST VISITS
AND AVERAGE NUMBER OF VISITS PER YEAR FOR THOSE SEEING A SPECIALIST
BY INCOME, U.S., 1963-64

	Derm.	Psych.	Otolary.	Ortho.	Ped.*	OB-GYN**	Ophthalm.	Optom.	Chiropr.	Podiatrist
Percent with Visits	1.1	.4	2.0	1.3	7.5	2.8	5.2	7.5	2.0	1.3
1.0	1.0	.5	1.8	1.2	11.3	5.5	4.3	7.6	2.4	1.3
1.2	1.2	.5	2.3	1.6	18.3	8.7	5.0	8.3	2.2	1.4
1.8	1.8	.6	2.9	2.1	23.8	11.0	6.8	9.5	2.5	1.7
3.0	3.0	.6	3.6	2.9	33.0	12.5	11.0	11.2	2.4	2.7
Below \$2,000	4.1	2.3	2.3	3.4	3.0	4.1	2.1	1.4	4.8	3.4
\$2,000-\$3,999	3.3	2.4	2.4	3.1	3.2	4.6	2.0	1.4	4.9	3.1
\$4,000-\$6,999	3.2	2.3	2.5	3.3	3.3	4.4	1.8	1.4	4.5	3.8
\$7,000-\$9,999	3.3	2.4	2.4	3.2	3.2	3.8	1.7	1.4	4.6	3.5
\$10,000 or more	3.2	5.4	2.6	3.0	3.1	3.1	1.6	1.4	4.9	3.9
Mean Visits per Year	3.4	4.1	2.3	3.4	3.0	4.1	2.1	1.4	4.8	3.4

Source: Characteristics of Patients of Selected Types of Medical Specialists and Practitioners—U.S., July 1963-June 1964, National Center for Health Statistics Series 10, Number 28.

* Based on the noninstitutional, civilian population under seventeen years of age.
** Based on the noninstitutional, civilian female population.

ferences in units receiving different forms of dependency income. Surprisingly, one study [31] of OAA recipients found that there was a slight *inverse* relationship between supplementary outside income (not necessarily dependency income) and physicians' visits. It is suggested that this may mean outside, unreported visits were made or possibly that their health was better because of inferred previous higher income.

UNIT MEMBERS' WORK ATTITUDES AND MANAGEMENT SKILLS

IT WOULD SEEM that work attitudes are quite influential in the determination of earned income for those near or below the standard retirement age, although their impact is severely conditioned by the economic environment. If they are not influential, they are at least very popular as an issue in the debate on the merits of public assistance. Remembering that the unit of analysis here is adult units, not individuals, and that we are recognizing that this variable is not nearly as important among persons who are beyond working age, work attitudes would appear to be a useful variable to study. The argument that poor people are simply unwilling to work usually ignores the fact that a large proportion are unemployable and that there are indeed constraints that are a function of the economic environment. Nevertheless, some attempt to get at those who cannot be excluded on these grounds would be useful.

Some suggestive findings relating to the question of work attitudes are reported by Irelan and Besner [32]. The poor have practically no bargaining power in the working world, are easily replaced, and find it virtually impossible even to acquire information and training by which they could change their situation. Awareness of their "abject status and the 'failure' which it rightly or wrongly implies understandably leads to embarrassed withdrawal and isolation." Feelings of powerlessness, meaninglessness, anomie, and isolation reflect a form of alienation. Specifically, the poor were found to doubt the possibility of their being able to influence their own lives; to be oriented, due to need, to the present; to be relatively insensitive to sequences in time; and to question societal norms—all probably due to the failure of prescribed behavior to lead to expected goals.

Nevertheless, the poor were found to place high value on ad-

vancement. But "even more than getting ahead, 'they value getting by,' avoiding the worsening of an already unstable situation." Finally, the combination of the theme of fatalism, resignation as the most appropriate approach to life, and a heavy emphasis on the importance of chance "acts as a definite brake on occupational and educational aspirations [and] in various other ways minimizes efforts to cope with deprivation and its consequences."

Morgan *et al.* [33] combined two variables, attitude toward hard work and need achievement score, to measure this attitude. Its effect as a characteristic used to explain labor force participation was not found to be significant; however, there was a significant positive relationship with number of hours worked. The authors conclude that "it is impressive that the effect of a crudely motivational measure would show up in addition to the powerful influences of demographic factors, market conditions, and custom on hours worked" [34]. Several studies have reported satisfactory results with the use of verbal expression of expectancy and desire as an index of level of aspiration [35]. Generally there is the indication that success has a consistent positive effect on aspiration level, while the effects of failure are more varied.

The impact of the social environment might be given careful study primarily as a means of examining the influence of formal dependency and permanent or customary level of expenditures on labor force participation through earned income. If formal dependency erodes a unit's propensity to participate in the labor force as has been suggested by some segments of the public, the way this might occur is through a lessening of social influence. That is, there may be a withdrawal from previously relevant others which lessens pressure both to work, or even to consider work as an activity in which there is an intrinsic virtue, and to consume at previous levels (particularly among older recipients of formal dependency aid) [36].

On the other hand, security, as noted above, is a strong force, and the desire to maintain one's position, in terms of expenditure patterns, probably exerts a strong force on individuals to re-enter or continue in the labor force. It is with this thought in mind that assistance payments have traditionally been kept below payments that would be received in exchange for work. Lamale [37] points out that

"throughout the period [early Twentieth Century], as earlier, concepts of income adequacy for self-sustaining families were more generous than those associated with assistance programs, both private and public. . . . Critics of the Bureau of Labor Statistics budget, issued in 1920, objected to the consideration of decency in the budget standard."

"Management skills" refers to a broad range of decision making involving ability to plan acquisition of and efficient use of those resources necessary for the unit's operation. Ironically, as Caplovitz has shown, those units that have the least in terms of resources are also least able to put to best use those that they have. The retailing system for very low income groups abounds with unethical and illegal practices. "The poorest risks are shunted into a special class of merchants who are ready to accept great risk" [38].

It is shown that the cost of retail goods and services to the low income consumer is high in terms of quality and price. In addition, however, those skills associated with the day-to-day operation of the household are important, and the unit's ability to cope effectively with these management problems may have a significant effect on the perceived discrepancy between income and needs. It may be through this variable (rather than directly through dependency attitudes) that intergenerational effects operate on the dependency decision.

DEPENDENCY ALTERNATIVES

BY DETERMINING, at least by some crude measure, that there exists for a unit an excess of net needs over earned income, it is then possible to examine the course of action that such a unit might take. The alternatives are seen as no dependency, informal dependency, or formal dependency, or some mixture of the last two. The interaction of dependency, work attitudes, and resources available is viewed as largely responsible for the decision. It may be possible to draw a distinction between the unit's decision to become dependent and its actual behavior, once having decided. The first may be related to attitudes while the second is related to resources available.

The focus of our approach then, having established unmet need, is the resolution of the problem and ultimately the solution's impact on behavior, such as use of health services. There is some evidence that formal and informal dependency are viewed as alternatives. A study in Cincinnati, for example, found when poor relief was cut off "that in some form the community paid and is still paying the bill for most of these cases since the needs of the families and children for help have continued. The burden has shifted from public resources [to private resources—including friends and relatives]" [39].

Bresner [40] observes that

needs which are not satisfied through the conjugal family may be supplied through friends and relatives. In a comprehensive West Coast study of social class, it was reported that lower class persons interact more with their kin, absolutely as well as relatively to their interaction with others. The individual quality of these relationships may make them valued, particularly when they provide means of avoiding potentially painful encounters with institutional sources of support. Analysis of data collected by the Bureau

of Social Science Research, in connection with a project supported by the Welfare Administration, showed that the poor, in comparison with the non-poor, receive substantially more help from relatives.

Differences among the states in the extent of financial support given to parents by their children have a considerable effect on the states' rates of old age assistance [41].

Givens [42] calls attention to the dynamic nature of economic status, pointing out that it is

economic status over a period of time, not earnings or income for a single year, which controls consumer levels and manner of living. Economic status, in turn, is affected by the changing structure and needs of the family and economic household and by the shifting patterns of incomes within consuming units over time. Close examination of the family sharing of incomes is therefore necessary in studying the dynamics of income and expenditures of both individuals and families.

The importance of including those who are employed in a study, as opposed to only those who are entirely dependent, may be seen in figures on "supplementation." In New York State [43], 25% of all cases of General Assistance and Aid to Families with Dependent Children-Unemployed Parents (AFDC-UP) cases involve supplementing regular earnings. At the same time, however, if supplementation is in the form of a contributory transfer, there is little reason to view this as partial dependency. Indeed, one of the most significant developments of the last three decades has been the subdividing of the conditions contributing to dependency into those that can be dealt with by some social insurance mechanism (i.e., unemployment, retirement, loss of wage earner, and for the elderly, medical expenses) and those that are not subject to insurance mechanisms, that is, relating particularly to those people outside the labor force such as those receiving Aid to Families with Dependent Children (AFDC), Aid to the Blind (AB), Aid to the Totally and Permanently Disabled (ATPD), and Old Age Assistance (OAA). There is

relatively little overlap of these two classifications and the bulk of what overlap there is would seem attributable to those units' receiving Social Security (OASDHI) payments that are near the minimum level. Given this dichotomy, it is necessary to distinguish between contributory and non-contributory transfers. The study must be broad enough to encompass what Burns calls "income deficiency (as opposed to income interruption, which has been the major concern of public social policy in the last 30 years)" [44].

We start then with the notion of earned income deficiency and alternative solutions. The remainder of this paper will be concerned with a discussion of formal and informal resources available, what is known about people who seem to choose the three alternatives and finally, possible implications for future research.

FORMAL AND INFORMAL RESOURCES

THE EVOLUTION of formal dependency is well documented and its current status is well reviewed in MacIntyre's paper [45]. Our current status in terms of formal and informal resources and their relationship to the economy, however, makes a few introductory remarks appropriate here.

Some have suggested that there is an intensified urgency for increasing the rate of economic growth to raise the standards of the poor, which in turn "makes it even more important that public policy focus on making individuals more productive and hence not dependent upon welfare or philanthropy" [46]. This tacitly assumes that everyone can be made more productive. The increasing productivity of the U.S. worker, encouraged by more stringent minimum wage laws, may well more than meet the demand for an "increasing rate of economic growth," leaving a persistent group of unemployed (or unemployable). As a result there may be little logic in not concentrating to a degree on providing socially and personally acceptable alternatives to joining the labor force. The notion that work is good as an end in itself, that everyone must be conditioned to "fit into" the structure of the labor force, may no longer be viable. The economic structure is developing into one in which there is no place for the person with a low level of skills. Either the structure must be guided to accommodate this segment or, alternatively, the State must shore up their position.

Although there is evidence that almost 3 of every 10 heads of poor families work full-time, the tendency seems to be in the direction of the poor being outside the labor market. Brady's findings [47] that in 1959 unemployment in the 15-25 age group (using 20-24 as representative) resulted in greater income inequality for this cohort than all others suggest such a tendency. Also the Moynihan report [48] indicates that although there is a Negro middle class

that is improving its economic lot as the economy grows, there is a large hard core segment that has not improved at all.

Public assistance, according to Rein [49], reaches only 23% of the families in poverty. Over half receive no transfer payments in any form. Perkins [50] reports that "the AFDC program in December, 1962, at best reached not quite one out of every six impoverished families and children in the nation." This is based on what was then Orshansky's lowest estimate of impoverished families.

Considerably more emphasis in previous research has been placed on those receiving public assistance than on those who might be eligible but do not receive it. Because of the nature of the family as a collectivity, problems involving dependency are dealt with in the context of the needs of all members. When the dependency needs of one or more members threaten the functioning of the unit, it may become necessary to employ an external mechanism such as the welfare department to cope with the problem. External mechanisms have traditionally and understandably been oriented toward assisting individuals, allowing for family resources, however, and this is probably essential to the continued functioning of the family unit. The ultimate form of this approach has been the categorization of the potentially dependent, which to MacIntyre seems to typify "some of the American genius for pragmatic solution of problems not readily soluble on either logical or ideological grounds" [51].

The degree to which the family unit perceives that it is threatened by outside interference may be an important factor in determining whether or not to seek help from outside sources [52]. The decision may even be seen as a symbolic, rather than legal or economic, one by the family.

The discussion must now turn to informal dependency sources. Some of the earlier discussion has indicated that excess need over earned income is only partially met by formal sources, even for those using public assistance. Kahn and Perkins [53] have shown that even with state standards of need, in 1961 almost half of all AFDC families had unmet need (Table V). Using the lowest Orshansky need calculation, unmet need is three times as much. Burgess and Price [54] found that 34% of all AFDC families were still in need

of assistance at the time payments were terminated. Ten years earlier the figure had been 25%.

TABLE V
AMOUNT OF UNMET NEED—FAMILIES
RECEIVING AFDC IN 1961

Amount of Unmet Need/Month	Pct. of Families	No. of Families
Total	100.0	884,441
None	58.3	475,530
\$ 1-\$ 9	4.8	42,493
\$10-\$19	8.4	74,063
\$20-\$29	8.4	74,298
\$30-\$49	12.0	105,844
\$50-\$74	6.9	61,431
\$75-\$99	3.1	27,155
\$100 or more	2.7	23,627

Source: *Welfare in Review*, (October, 1964), Vol. 2, No. 10, p. 9.

Sixty-eight per cent of AFDC families as opposed to 7% of all U.S. families had incomes below \$2,000. Over 17% had income from sources other than formal dependency, earnings, or contributions from absent father. This calculation does not include free housing.

Our analysis of the value of informal dependency sources should include not only cash payments, but also, despite methodological problems, the value (actual and cost of next best alternative) of food and services rendered, such as payments for medical care, housing, and maintenance. In the past emphasis has been placed on older people (for example, Shanas' study [55]). However, "a substantial amount of housing of relatives involves children eighteen or older who have not yet left the parental home" [56]. It is meaningful to include these as most are capable of providing for themselves according to Morgan's findings.

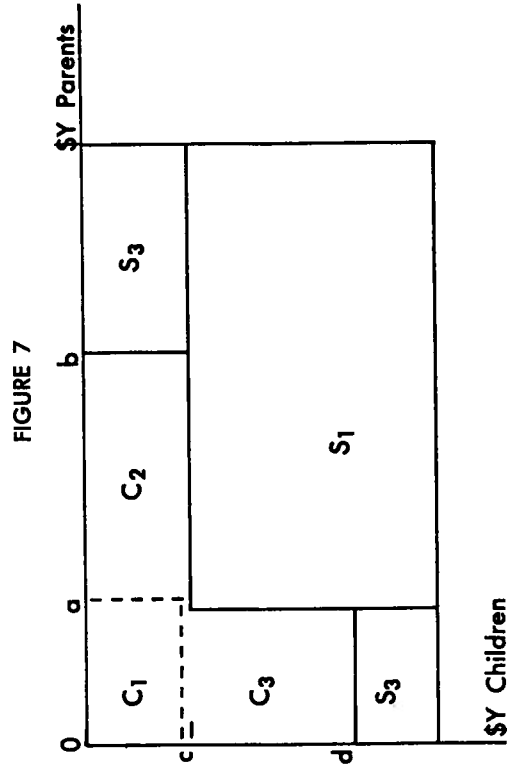
Of the 64.6 million adult units in the country, 11.2% were dependent adult units, i.e., they did not contain the major earner, and nearly one-fifth had no homes (separate dwelling units) of their own. Eight per cent of all adult units received at least \$500 in 1959

from others in the unit and an additional 5% received at least this amount from individuals outside the dwelling. This would represent a minimum informal transfer of \$4.3 billion. Even eliminating the funds transferred to those units headed by someone below the age of 25, most of whom are still receiving their education, there remains at least \$2.5 billion being given. Morgan's estimates of net intra-family transfers (between adult units within a single dwelling) indicate that the minimum figure of \$2.5 billion for these transfers understates the actual amount by something over \$1.5 billion. Total informal transfers then are at least \$5.8 billion and he suggests this is probably an understatement. Considering Shanas' [57] finding that four out of ten children of older people feel that support of aging parents is *primarily* their responsibility, this is not surprising. Morgan found that more than half felt this way.

The relationship between forms of informal resources also needs to be studied. Notestein [58], summarizing a paper by Brady has made the following points. The individual family head feels primarily responsible for the maintenance in one spending unit (which Brady calls a "consumer unit") of the nuclear family consisting of the spouse and young offspring. The claims for assistance of other relatives such as adult children and parents tend to be met, if at all, by sharing income rather than living space when it is financially possible to do so. The cost of supporting a person tends to decrease with the size of the household, so that the most economical way of supporting relatives is by sharing living space. The distribution of assistance between cash and the maintenance of a separate household, and the sharing of living quarters with the nuclear family results from the need for economy on the one hand, and the desire to restrict common living to the nuclear family on the other. Dependency problems, therefore, tend to be resolved by shared living in low-income situations and by cash re-mittances in support of separate households when income is more than average.

The difference in income between sponsor and dependent might also be relevant. Brady [59] states, "the actual number of units [households] at any time will be determined by the relative incomes of persons with income, their immediate responsibilities, and

their position in the system of family relationships." The scheme in Figure 7 by Brady is helpful in viewing the question.



The proportion of adult units who live in a relative's home distributed by age is shown in Table VI.

TABLE VI
ADULT UNITS IN RELATIVE'S HOME

Age	Proportion
18-24	61%
25-34	14
35-44	6
45-54	6
55-64	8
65-74	16
75 and older	29

Source: Morgan, J. N., "Measuring the Economic Status of the Aged," Survey Research Center, University of Michigan. (Reprint: "Age with a Future," Munksgaard, Copenhagen, 1964).

That providing housing is important relatively can be seen from the figures on sources of money income for those over 65. "Other sources" (other than retirement and veteran benefits, public assist-

ance, interest, dividends, rents, and earnings) accounted for only 4% of income in 1962 [60]. In a 1953 study of persons receiving OAA, more than twice as many received family aid in the form of shelter than in cash. Family aid in all forms is, of course, less for these recipients [61].

Some reasons for the selection of one alternative, for example, formal sources, rather than another may revolve around the programs themselves. Morgan's data [62] on disability suggest that categorical assistance, for example, is more acceptable than general assistance (the dramatic decline of GA over the past 25 years also suggests this). While the percentage receiving informal transfers remains about the same as degree of disability increases, so does the percent receiving welfare income until the category "completely disabled" is reached. This group has 19% receiving formal aid compared to 4% for both the "severely" and the "somewhat" disabled categories. Whether alternatives to welfare are even available, too, may be most significant in interpreting these statistics, as is implied by Sydney Bernard [63] in the statement, "It is difficult, however, to argue that a woman who receives her late husband's social security benefits or who has moved lock, stock, and barrel into her parents' home is displaying more sterling qualities of independence and initiative than the AFDC recipient who lacks these alternatives."

One study by Stone and Schlamp [64] begins to approach the question from the point of view of differences between the units. This study seems to be the closest to our approach to the problem. Several of their more important observations and findings will be summarized here. The sample consisted of 1,200 families. Six hundred were currently receiving AFDC-UP assistance while the other 600 with equivalent income were receiving no public assistance. The fact that the assistance group was made up of unemployed parents should be kept in mind in evaluating the findings. Important also in terms of our interests was their conclusion that families should be classified according to their welfare history rather than simply their current status. This study used: NRA—never received assistance, STA—short time assistance (median duration—4 months), and LTA—long time assistance (median duration—26 months).

"... Differences revolving around dependency ran through the range of families studied whereas differences associated with ethnic group and rural-urban residence did not" [65]. Family relationships appeared to be the least associated with differences in welfare dependency status, although this may be peculiar to the Unemployed Parent segment of public assistance. On kinship relations and activities measures the NRA group ranked high on 6 of 11 indices, while the LTA's ranked low on 8 of 11. This further supports the notion of dependency alternatives. In the case of non-kin social relationships, there was a slight tendency for the NRA's to be higher and LTA's lower than average.

In terms of economic characteristics, 83% of the sample but only 72% of the LTA's were covered by social security. This group was also found to have fewer families and lower amounts of debt compared to NRA's, suggesting less economic uncertainty among the latter. Ill health limited ability to work in 8.4% of the NRA group contrasted to 28.3% of the LTA's, indicating the importance of disability in cases of long-term unemployment.

IMPLICATIONS

THE PROBLEM of analyzing economic dependency is complicated by, among other things, its inter-relationship with poverty and the wide range of possible spending unit combinations. As has been seen, there is the additional complication that dependency can be contained within the unit exclusively or might also involve dependence on outside sources. Perhaps as a consequence of the complexity of this approach to economic maintenance, there appears to have been no comprehensive study showing the extent of dependency in comparison with wages and returns; the relationship between the two sources; a breakdown of and relationships between the several sources of dependency income; the connection between spending unit structure and sources of income; or the relationships between expenditure patterns and type of income.

The extent of the "non-standard" segment of the economically dependent, without correcting for possible overlap, appears to be in the neighborhood of 15,000,000 persons. In addition it is estimated that, in 1962, 533,000 older people received contributions from other adults. In 1960 there were 3,200,000 parents living with children and an equal number of other relatives sharing housing. In addition, there were 9½ million children and grandchildren over 18 living with their parents or other adults. It is impossible to say, however, how these forms of dependency are related to income from wages and returns or to spending unit structure. There is considerable evidence that the mixed income situation is the rule. Half the families receiving AFDC, for example, had income in addition to AFDC. As Rein has pointed out, the most fruitful understanding of the impact of dependency may come from "examining degrees and conditions of inter-dependency, rather than from isolating debits and credits in a ledger which draws a dichotomy between the dependent and the independent [66].

The perceived relationship between "earned" income and de-

pendency income has been the basis of the conservative view of welfare. The argument is that it is human nature to prefer dependency income and it will always be used to substitute for earned income when possible. Since "earned" income implies a person who stands on his own feet while dependency income implies improvidence and incompetence, the latter should clearly be kept at a minimum. Just as Bogue [67] found that Skid Row men were not a homogeneous group of alcoholic derelicts, a study of dependency will no doubt reveal that the relationship between the two types of income varies. An attempt should be made to determine the conditions under which each is the preferred source.

Of equal importance is the relationship between various sources of dependency income. What factors contribute to the decisions to use private as opposed to public sources? Availability of sources, cultural norms, awareness of alternatives, and individual attitudes may all be significant to a greater or lesser degree. The decision to get along with no dependency income will also depend on these factors. Of particular interest should be the influence of spending unit structure on these decisions. For example, an older parent living with children may be less inclined to receive outside dependency income not only because there is less need, but also because the adult children feel that it would be degrading. (A sentiment they might not have if the parent lived alone.)

Sources of income may influence spending unit structure or it may be the reverse. Both factors may well influence expenditure patterns. Particularly in areas such as medical care, it is not sufficient to look solely at amount of income as a determinant of expenditure (or better, use) patterns. The older person living alone may have very different patterns than one living with children, controlling for sources and amount of income. Similarly, persons with similar levels of income and spending unit structure may vary expenditure patterns as a function of source of income (whether "earned," intrafamily transfer, or public welfare), or all three of these factors may vary as a function of some more basic variable such as cultural ties. It is hoped that building on the thoughts developed in this monograph, a study will be designed and executed to answer at least some of the questions which have been raised.

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adult unit—an individual age eighteen or over, his spouse if any, and any children under age eighteen.
spending unit—equivalent to the term "family" used by the Bureau of Labor Statistics. It is not equivalent to the Census Bureau's definition of family (related individuals living within a household).
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