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EDITORIAL POLICY STATEMENT

Advancing the Consumer Interest is designed to appeal to professionals working in the consumer field. This includes teachers in higher and secondary education, researchers, extension specialists, consumer affairs professionals in business and government, lawyers, students in consumer science, and other practitioners in consumer affairs.

Manuscripts may address significant trends in consumer affairs, education, and law, innovative consumer education programs in the private and public sector, reasoned essays on consumer policy, and application of consumer research, theories, models, and concepts.

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3. Research reported at a level of technical sophistication applicable to practitioners as well as researchers. The emphasis of this research should be on its implications and applications for consumer education, policy, law, etc. The primary question of the reported research should be, "What does this research mean for practitioners?"
4. Application of theories, models, concepts, and/or research findings to problem solutions for target audiences.
5. Articles summarizing research in a given area and expanding on its implications for the target audience.

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International Confederation of Free Trade Unions, 1949, London.



REPRODUCED BY PERMISSION OF THE NATIONAL ASSOCIATION FOR HOME CARE FROM RESTLESS: THE MEMOIRS OF LABOR AND CONSUMER ACTIVIST ESTHER PETERSON. NOT FOR FURTHER REPRODUCTION.

Esther Peterson, 91, known as the “grand dame of the consumer movement,” died at her home on Dec. 20, 1997 following a stroke.

Esther Peterson was born in Provo, Utah in 1906. She was raised on a farm with her five siblings by her Mormon, Republican parents, Lars and Annie Eggertsen. She graduated from Brigham Young University in 1927 and later earned her master’s degree in education from Teachers College at Columbia University in New York. It was there she met Oliver A. Peterson, a socialist, whom she married in 1932.

With her husband, Esther Peterson attended political and social reform meetings and visited factories and slums. These activities enlightened her about social issues and motivated her to take action. When Oliver Peterson joined the Roosevelt Administration, Esther Peterson began her work with the International Ladies Garment Workers; she later became assistant director of education for the Amalgamated Clothing Workers Union of America. This was only the beginning of her long career as a labor activist and then a consumer advocate.

Peterson served in the administrations of Presidents Johnson, Kennedy, and Carter. In 1981, her many achievements were acknowledged when President Carter awarded her the Presidential Medal of Freedom. The words on this award sum up Esther Peterson, her mission, and her career:

Once government’s highest ranking woman, Esther Peterson still ranks highest among consumer advocates. She has advised presidents and the public, and has worked for labor and business alike, always keeping the rights of all Americans to know and to be treated fairly as her highest priority. Even her staunchest foes respected her integrity and are warmed by her grace and sincere concern.

Most recently, in 1993, Peterson was named by President Clinton as a Delegate to the United Nations General Assembly.

The editors of *ACI* would like to acknowledge Esther Peterson for her service both to *ACCI* and *ACI*. She joined *ACCI* in 1981 and was awarded an honorary membership in 1994. Peterson has graciously served on the Advisory Board of *ACI* since 1994.

Managed Care's Future Hinges on Consumer Perceptions of its Mortality

Roger Battistella and
David C. Burchfield
Cornell University

This article is about morality and managed care. That is to say it is about the issues of: right and wrong, good and bad, altruism and materialism, community welfare and self interest, and consumer interest and private gain.

How does morality relate to managed care? It is fundamental to the subject, given the aim of this article, i.e., to identify and assess what's good and what's bad about managed care in light of consumer attitudes and expectations which ultimately will determine its acceptance or rejection.

Notwithstanding the numerous complicated technical dimensions, the ultimate determination of whether managed care is worthy of public support centers on the motives of the principal actors and the structural incentives dispensing rewards and sanctions.

In this connection, managed care is alleged by its critics to be a perverse influence—an abomination or worse—that robs health care providers of their intrinsic decency and corrupts the doctor-patient relationship in ways that are detrimental to individual and social well-being. The criticism is multifaceted and stems from numerous sources, but at the very core it conveys a strong, if not strident, belief that managed care either has or soon will create far more problems than it will ever solve (Relman, 1992).

Whether this belief is true or not is for each individual to decide from the vantage point of personal experiences and future concerns.

While it is always difficult to extricate oneself entirely from the passions stirred by contemporary controversies, a review of relevant history may provide a useful perspective and open the mind to understanding the sources of some of the more substantive issues.

Perhaps the most reputable and persistent criticism of managed care comes from persons and groups familiar with its evolution over the past half century—persons such as Arnold Relman and John Iglehart. These and other critics claim that managed care has moved from its original progressive ideal (commitment to the furtherance of social equity and the elevation of medical practice to a purer plane, where clinical decision making is freed from the compromising influences of money) to a highly regressive state characterized by a preoccupation with narrow standards of efficiency and a pursuit of profits that is both dehumanizing to patients and harmful to the continued technical and scientific development of medicine (Iglehart, 1993; Relman, 1990).

In order to put this controversy into perspective, a brief historical review is illuminating. Managed care has its roots in the prepaid group practice movement of the 1930s. This movement attracted the attention of social reformers concerned about the dislocative effects of the Great Depression which had devastated the purchasing power of consumers and eroded the financial solvency of health providers. Prepaid group practice consisted of

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Prepaid group practice grew only modestly for several decades, principally because it encountered resistance within the medical profession which opposed both any dilution of solo fee-for-service principles and any encroachment into the arena of clinical decision making.

physicians from several specialties, including family practice, agreeing to provide all necessary health care to a defined population of enrollees for a prepaid monthly capitation (premium) per member.

A major impetus for prepaid group practice came from the Committee on the Cost of Medical Care (CCMC), a collection of some of the brightest health reformers and planners of that time. Many of these individuals went on to play major roles in developing the theoretical and methodological underpinnings of applied health services research and education for health services management as we know these activities today. The CCMC began meeting in 1928 and published its final report five years later (Committee on the Costs of Medical Care, 1932/1972).

Politics was an important factor in guiding the CCMC's deliberations, which focused on finding a way to bring more and better health care to the American public hard hit by the Depression. It was seeking an alternative to the socialized medicine approaches then favored in Europe, which were ideologically incompatible with American political and economic values. The Committee promulgated the advantages of prepaid group practice as a vehicle of choice for delivering health care for the reasons listed below:

- First, for making health care more widely accessible and affordable by providing consumers a way to budget in advance for health care . . . otherwise unaffordable because of the many uncertainties involved, notably the impossibility of foreseeing the occurrence and severity of illness, and the cost and outcome of medical treatment.
- Second, for creating a culture of clinical excellence in day-to-day medical practice through the power of group dynamics and the professional stimulation of peers working cooperatively to assist one another, and to provide the highest feasible quality of care to patients. The creation of frequent opportunities for continuing education was yet another feature for promoting clinical excellence.

- Third, for improving supportive services and productivity by pooling resources and providing clinical and secretarial assistants.

- Fourth, for facilitating patient referrals and the coordination of medical and surgical specialties by forming multi-specialty groups and centralizing patient records.

- Fifth, for improving the working conditions of physicians and their families through provisions for a shorter work week and more leisure time.

And, finally, for stabilizing the financial base of medical practice by eliminating the burdens of uncompensated and charity care and thus making guaranteed income a reality.

Additional support for prepaid group practices came from a heterogenous collection of sponsors consisting of social utopians, organized labor representatives, and practically-minded industrialists and manufacturers. While many of these sponsors no longer exist, others have survived to become familiar household names and, in some instances, paragons for emulation. By way of illustration, they include The Kaiser Health Foundation, The Health Insurance Plan of New York, and The Group Health Cooperative of Puget Sound. Others, such as the Community Health Association of Detroit, were acquired and assimilated into more recent organizations, as in the Henry Ford Health System, in this particular example (Somers and Somers, 1961).

Regardless of differences in sponsorship, these plans shared common characteristics. All were not-for-profit organizations with physicians organized along staff or group model lines, with prepaid group practices involving physicians who agreed to treat a fixed panel of enrollees. The principal distinction between the two involved the method of physician reimbursement. Staff model physicians were employees, while group model physicians practiced within organizations owned and managed by physicians.

Within a small and elite community of health reformers and planners, these characteristics were disseminated as the ultimate

manifestation of rationality and scientific management practice for achieving objectives similar to those promulgated by the CCMC. Included among them were the following: to bring voluntary health insurance within the economic reach of the American public; to raise standards of practice through peer review and organized provisions for life-long study and continuing education; to integrate preventive and acute medical services; to provide consumers a single entry point into a system of seamless care; and to install the primary care physician at the forefront of health services delivery and as the chief coordinator of all specialty referrals (Saward, 1969; Cohen, 1968; Falk, 1964; Silver, 1963; Clark and Hapney, 1951).

Despite its considerable appeal among proponents of health reform, prepaid group practice grew only modestly for several decades, principally because it encountered resistance within the medical profession which opposed both any dilution of solo fee-for-service principles and any encroachment into the arena of clinical decision making. Among proponents of medical freedom for self-regulation and professional autonomy, opposition further centered on the conviction that managerial control and bureaucracy are enemies of good patient care. Another major deterrent to the growth of prepaid group practice was its unpopularity among consumers who disliked having their freedom of choice curtailed.

Growth picked up somewhat following the early 1970s enactment of the HMO Act, which provided prepaid group practice with a name change, a new image, and an influx of badly needed capital. So too did the Act provide critical marketing assistance in the form of a protected industry status that compelled employers to offer employees a choice when a federally qualified HMO was nearby. However, it was not until approximately a decade later, that prepaid group practice really took off, primarily because a broader and more flexible managed care umbrella permitted the opening of participation to for-profit corporations and physicians in solo fee-for-service practice. These physicians, often formed Individual Practice Associations

(IPAs), HMOs which typically contract with a large number of solo practitioners as well as single- or multispecialty group practices. Most IPA model HMOs reimburse their physicians based on agreed-upon fee schedules or payment limits drawn from a collective. Under such an arrangement physicians often contract with multiple managed care firms and continue to see patients covered under a traditional fee-for-service insurance account (Davis, Anderson, Rowland and Steinberg, 1990).

Growth accelerated thereafter and continues to do so as the result of these and other amendments which disturb and displease supporters of a purer form of managed care, namely staff and group models organized along nonprofit lines. As of July 1, 1996, staff and group model HMOs accounted for only 16.4 percent of all persons enrolled in HMOs, while IPAs alone accounted for 39.4 percent. At the same time, for-profit HMOs controlled 61.4 percent of the market, and, from July 1995 to July 1996 alone, IPAs increased their membership by 18.4 percent, while staff and group models declined by four percent (InterStudy, 1997).

The rapid growth in for-profit managed care enrollment has not gone unnoticed by today's consumers. Widespread dependence on market incentives and commercial values has aroused anxiety about the moral foundation of managed care, that is to say, whether competitive market features have the effect of putting profits ahead of patients and materialistic values ahead of community service objectives. Although initially hesitant, whether due to inexperience or confusion, public opinion has become so receptive to such allegations that a backlash against managed care practices has led to the introduction of regulations designed to curb practices deemed inimical to patient welfare and the public interest (Church, 1997). Among the questionable practices commanding the attention of state and federal legislators are managed care restrictions in use of emergency room services, access to specialists, "gag clauses" that prohibit physicians from disclosing their method of reimbursement, and other management practices which contain incentives to underprovide

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or withhold normally appropriate care.

Especially visible and controversial practices such as 24-hour inpatient maternity stays and ambulatory mastectomies already have prompted the enactment of state and federal safeguards. Whether such regulatory initiative is advisable is open to dispute. One important danger is that politicians may be pandering to misplaced popular fears rather than allowing managed care companies to allocate resources in accordance with cost effective criteria. Such criteria is, after all, a principal justification for substituting managed care for unmanaged, fee-for-service medicine. It is estimated that over 20 percent of all health expenditures are for medically valueless or questionable procedures (Mitchell and Vartz, 1986; Wolfe, 1988; Consumer Reports, 1992; Berwick, 1994). At the same time, there is no demonstrable evidence that quality of care is impeded by early discharge from hospitals (Malkin, 1995). There is, however, cause for concern that hospitalization itself poses some risk to infection and medical misadventures. Provided that appropriate follow-up occurs after early discharge, these practices not only save money, but lead to improved health outcomes (Business and Health, 1995).

The popular backlash against managed care begs the question of whether market incentives can and will succeed in getting managed care to do a better job than was the case when care was unmanaged, so that the companies who offer consumers the best doctors, the quickest referrals, and the most courteous service will prevail over those who do not. Another troubling aspect of the sanctioning of competitive market principles is the consequence for the large and expanding number of uninsured persons. Clearly, the internal logic and incentives of managed care discriminate against the people who require coverage most and can afford it least—low socioeconomic groups and those in ill health.

The litany of consumer complaints is lengthy—the cumulative effects of which are propelling the current managed care backlash. Briefly stated, complaints about managed care center on:

- Administrative hassle;
- Delays in scheduling appointments for non-emergency conditions;
- Inadequate care due to preoccupation with cost containment;
- Inadequate specialist care;
- Cream-skimming (enrolling only the healthiest population members);
- The substitution of statistics for personal relationships;
- That managed care is more population than individual focused; and
- That cost savings are not passed on to consumers and the community but are retained instead by management and investors.

Perhaps the most effective rallying cry against managed care is that physicians are rewarded for withholding medically appropriate care and that the injection of commercial values into health care denigrates the service ethic and corrodes the basic goodness of health professionals.

The remedies suggested are many. One of the most alluring is the restoration of the service ethic—the favoring of physician and other health provider ownership and management of managed care firms as the quickest and best way to put patients ahead of profits. But, this may be somewhat unrealistic—a romantic quest that ascribes far more to physician ownership and control than can ever be delivered—as long as health care policy is driven by economic principles and commercial values.

Independent of orientation and good intentions, in a zero sum environment health professionals, whether organized on a not-for-profit or for-profit basis, ultimately must respond to market forces or suffer financial failure. When squeezed by employer cutbacks in health spending and reductions in government appropriations, the flexibility of manage-

ment is limited, regardless of ownership differences. Any appreciable curtailment of aggregate health spending necessitated by the low savings rate, combined with employer and government worries about the cost of health and retirement entitlement programs for the aging population, will surely multiply the tensions and conflicts intrinsic to managed care.

Among other possible scenarios, dissatisfaction over compensation may trigger sharp declines in physician productivity and morale. Such declines may then exacerbate relations with management and generate harmful consumer spillovers that result in a cycle of unpopular, ever-tightening restrictions and controls. In such a circumstance, any distinctions between differences in ownership and management will become blurred and inconsequential.

On the other hand, ideological conflict among proponents and detractors of the role of competitive market incentives obfuscates and distorts much of the progress managed care has made. Indeed, addressing deficiencies in health services organization, financing, and delivery constitute the general agenda for managed care, which in specific aims to:

- establish standards for reducing the unacceptably high volume of medically questionable and inappropriate services;
- eliminate surplus capacity in health facilities and personnel;
- redirect medical practice from a predisposition with high cost practice styles to a predilection for low cost practice styles;
- shift the focus of health care delivery from a preoccupation with the diagnosis and treatment of illness within individuals to illness prevention through means of population-centered health promotion and health maintenance methods;
- ration health care on the basis of medical need rather than on demand and in accord with scientifically accepted principles of efficacy and cost effectiveness; and finally

- to slow the unacceptably high rate of annual increase in health spending, preferably to parallel changes in the Consumer Price Index.

When examined dispassionately, managed care's overall accomplishments to date are quite impressive. Managed care *does* improve efficiencies in hospital resource utilization (Hill and Wolfe, 1997). The rate of increase in medical costs and health premiums *has* been retarded, without any apparent negative effect on the quality of care received (Saftlas, 1995). And, surplus capacity, as measured by the number of hospital occupancy rates, has plummeted from 77.7 percent occupancy rates as recently as 1980 to only 65.4 percent in 1994 (U.S. Bureau of the Census, 1996, Tables 187 and 189). Upon having attained a critical mass, i.e., market share exceeding 20 percent, managed care's ability to favorably affect productivity and quality control has improved materially.

Much of the controversy surrounding managed care today is inevitable considering that it is enmeshed in a gigantic struggle to rationalize and modernize a sector of the American economy noted not only for its size and complexity but for its backwardness as well. Notwithstanding the impressive parade of technological innovation in diagnosis and treatment resulting in dramatic improvements in the length and quality of life, it remains inescapably true that in matters of productivity and quality control the health care industry lags far behind performance standards common to other economic sectors.

The interest groups allied in defense of the status quo are numerous and politically influential. Consumers, providers, and suppliers understandably are reluctant to change. For the most part, all have enjoyed a pampered existence in which they were allowed to spend freely at someone else's expense. The reality that someone else, notably government and employers, can no longer afford to finance health care on an unrestricted, open-ended basis is, of course, the major stimulus for the ascent of managed care.

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The acrimony and strife accompanying health services restructuring conceals many of the accomplishments of managed care to date—and the associated recent political backlash against managed care philosophy and practices imperil the fulfillment of its public policy mission—to subject the health sector to financial and quality control disciplines contained in modern management methods.

Much of what happens next depends on consumer perceptions of whether managed care is good or bad for patients, whether it is right or wrong for the future development of the health sector, and whether it does more to enhance public interest or private gain. In summary, managed care's final chapter has yet to be written. As a dynamic and rapidly-evolving movement, it remains to be determined whether it will be judged as a force for or against the public good.

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Public Policy Issues and Financing for Rural Housing

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INTRODUCTION

Housing is a very basic human need. Since 1949, it has been a national goal to provide every American family with a decent affordable home in a suitable environment (National Housing Act of 1949). Reaffirmed and expanded over time, this goal remains the key to federal housing policies today (Cranston-Gonzalez National Affordable Housing Act of 1990). While federal housing policies have addressed topics ranging from homelessness to historic preservation, most have focused on supporting increased opportunities for homeownership.

The current National Homeownership Strategy addresses five priorities: (1) cutting housing production costs, (2) making home financing more available, affordable, and flexible, (3) targeting assistance to underserved communities, (4) opening the home buying market to underserved populations, and (5) expanding homeownership education and counseling (U.S. Department of Housing and Urban Development, 1995). Housing policy's focus on homeownership is founded on a set of underlying common popular perceptions: that homeownership promotes the economic and psychological well-being of people; that homeownership promotes neighborhood and community stability; and, that homeownership is a key component for the nation's economic growth (U. S. Department of Housing and Urban Development, 1995).



A country house next to an old shack.

While the emphasis on homeownership has remained a keystone to federal housing policy, in a major shift during the mid-1980s, policy turned away from federal funding and control of housing programs, and toward increased responsibility at both state and local levels. In addition, recent movement toward greater reliance on public/private partnerships aims to ameliorate the gap created by reduced funding for housing programs (McFadden and Brandt, 1992). For example, as “lenders of last resort,” United States Department of Agriculture programs once provided direct mortgages in rural areas, where their current emphasis is shifting toward guaranteeing loans originated by private lenders (U.S.

People's access to homeownership in the United States depends on availability and cost of capital.

General Accounting Office, 1994).

This article: (1) considers the impact of federal housing policies and financing availability for rural residents, (2) highlights factors differentiating rural from urban housing, and (3) discusses policy implications and recommendations of specific housing policies impacting rural areas.

IMPACT OF FEDERAL POLICIES PROMOTING RURAL HOMEOWNERSHIP

For most households and families in the United States, housing ownership signifies more than securing shelter, it also represents their largest financial asset (United States Bureau of the Census, 1993).¹ People's access to homeownership in the United States depends on availability and cost of capital. Residential finance had been protected by federal banking policies from the 1930s up to 1982, when legislation deregulated the banking and thrift industries. While resulting mergers have decreased the number of lending institutions, these emerging business partnerships are larger than ever. Statewide branching and interstate banking have redefined the competitive environment, particularly for isolated community bankers (Markley and Shaffer, 1993). Banks are expanding into new areas of capital use, leaving housing without a pool of money for mortgages (Meyerson, 1986).

Federal housing policies and the residential mortgage context in rural areas are changing. Meanwhile, few researchers have empirically analyzed the impact of these changes on consumers. Larger financial institutions with their advantageous economies of scale could bring a broader range of lower-cost services. On the other hand, the lower demand in rural areas may be such that services are more costly to provide there than in higher population areas. Rural areas may simply receive less attention and service, as a result.

The restructuring of lending institutions can obfuscate previous lending patterns, and it is ever more difficult to evaluate deregulation's impact within rural areas than in urban areas. This dichotomy occurs because mortgage credit conditions in rural areas are difficult to describe and understand, in part

because of a dearth of data. Many financial institutions do not maintain the detailed records necessary for studying credit availability in rural areas. For example, research conducted at the University of Wisconsin-Madison (Sullivan and Ziebarth, 1994) found lending institution consolidations meant branch-level information became inaccessible and local mortgage credit availability became impossible to analyze. In contrast, data regarding urban lending patterns is readily available. While the Community Reinvestment Act requires that lenders invest in the local area, the enforcement regulations allow for self-testing reports with non-public documents (Vartanian, et al. 1997). Green and Cowell's 1994 study of rural banks located in two Georgia counties looked at factors influencing the probability that a loan applicant successfully obtained a mortgage. They found that race was a significant factor, with White applicants more likely to be approved for mortgages than non-White applicants. Discriminatory practices can hinder rural consumers more than their urban counterparts simply because there are fewer alternative lenders within the rural community and finding financing elsewhere can be more difficult.

There is a long history of special concern about the financial markets for production of rural housing and access to homeownership opportunities among rural residents.² Public policies have been directed at facilitating the provision of rural housing partly in response to the limited access that rural residents have to financial institutions. Federal housing legislation in the 1930s provided insurance to lenders so they in turn could increase the availability of mortgage capital across the nation (National Housing Act, 1934). By the end of the 1940s, legislation was passed authorizing the Secretary of Agriculture to extend rural home mortgage assistance through the Farmers Home Administration (National Housing Act of 1949). In 1992, FmHA had 693,311 loans for single family home mortgages in open country and places with a population of 10,000 or less through their direct Home Ownership Loan Program (USDA, 1992). But recent changes within the

USDA have restructured FmHA and consolidated programs into the Rural Housing Service. This change has been made to promote efficiency, provide standardized procedures, and shift the primary lending activity from direct to guaranteed loans. Impacts on rural consumers of this and other changes in federal policies as yet are unknown.

RURAL/URBAN HOUSING DIFFERENCES

Housing availability, quality, and financing advantages in rural United States have persistently lagged behind that in the nation's urban areas. The differences are substantial and consequential. In 1993, approximately 27.3 percent of the nation's housing units were located in rural areas. Of these, about 7 percent were farm housing units (United States Department of Commerce, Bureau of Census and United States Department of Agriculture, Economic Research Service, 1993). While the rural population has been declining as a percentage of the U.S. population since the first census was taken in 1790, there remain approximately 68 million people living in rural America. In selected places throughout the country, rural areas are experiencing high rates of population growth and a high demand for mortgage credit.

Rural is not necessarily synonymous with isolation. Communities close to metropolitan areas often face housing growth management issues, and their proximity to metropolitan areas can make for improved availability of housing related organizations, related housing information, and opportunities to access competitive mortgage credit. Isolated areas are more likely than metro areas or adjacent-metro areas to be dominated by economic specialization such as farming or mining. This specialization can dictate characteristics of the local community (Fugitt and Beale, 1995). Where economic specialization occurs, the local housing market may be at risk of boom/bust cycles and the long-term commitment to mortgage financing may be less attractive to lenders.

In some rural areas, the predominance of the kind of employment which requires relatively little education and/or specialized skill

can contribute to a concentration of poverty. Poverty dampens housing development and influences the maintenance of housing as well. In the U.S., rural communities may attract poor people simply because lower cost housing is more available there; this housing scenario also discourages rural poor from moving to areas with better employment opportunities (Luloff and Nord, 1993).

Rural households are more likely to own their own homes than are urban households (81 percent versus 58 percent). Between 1973 and 1993 the median value of owner occupied homes (in constant 1993 dollars) increased 10 percent (United States Bureau of the Census, 1995). However, the 1990 median value of homes in rural areas was about 75 percent of that in urban areas. This higher value for urban area homes reflects the higher land values placed on locations near a metropolitan area.

The recent rapid growth in some rural areas has led to the demolition of severely inadequate housing units and the substantial addition of new adequate housing (Apgar, 1989). Meanwhile, housing stock in rural areas is typically older than that in urban areas, and as such often requires more maintenance and upkeep. According to the American Housing Survey (1995), in 1993 rural home owners were more likely than urban home owners to have severe plumbing problems as well as moderate heating and upkeep problems. The same survey also reported these urban home owners more likely than rural home owners to make improvements and alterations to their units. The availability and cost of home improvement loans, along with income differentials, may contribute to this difference.

Rural households are more likely to live in manufactured homes than are urban households (16 percent versus 3 percent). Manufactured housing provides several advantages. Typically financing is available from the seller and the housing unit is built to federal quality standards. In addition, in many rural areas, demand for new construction is too low to support builders of traditional housing, so manufactured housing pro-

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Housing affordability, limited alternative housing, and fewer opportunities for families in need to receive housing assistance, all lead to a risk of homelessness.

vides a means to obtain suitable rural housing that is also affordable. One builder of modular units in rural areas reported that the lack of available subcontractors was a factor in rural construction (Bevier, 1995)

The generally lower priced housing in rural areas reflects numerous factors. In many rural areas, building codes are nonexistent, not enforced, or not applicable to existing houses, resulting in overall lower-quality housing. Rural land values are lower than in metro areas, and rural housing developments cost less than urban ones. Finally, rural households may legally share accommodations to lower their housing cost and as such violate no occupancy codes, as there are few such codes in rural areas (Luloff and Nord, 1993).

Housing affordability does not depend upon the cost of housing alone, but also upon the match between household income and housing costs. Differences between urban and rural housing affordability have been found to be determined primarily by income differentials rather than by housing cost differences (Ziebarth, et al., 1997). Between 1973 and 1993 housing affordability declined for all households. Rural households have, on average, incomes about 19 percent lower than their urban counterparts (Tin, 1993). In constant 1993 dollars, incomes for all homeowners declined 2 percent, while renters' incomes declined 19 percent between 1973 and 1993. This income decline directly impacts housing affordability. Not only did incomes decline, but rent costs for tenants increased 12 percent (American Housing Survey, 1995). As a result, 18 percent of all rural homeowners and 37 percent of all rural renters were cost burdened, paying more than 30 percent of their income for housing in 1993 (United States Bureau of the Census, 1995).³

Like rural households overall, the average income of rural renters is less than their urban counterparts, yet rural renters are less likely than urban renters to live in public or subsidized housing, with 10 percent of rural renters receiving housing assistance compared to 15 percent of urban renters (Tin, 1993). Housing affordability, limited alternative housing, and fewer opportunities for families

in need to receive housing assistance, all lead to a risk of homelessness. Rural homelessness has become a widespread national problem (Burt, 1996).

Research by Nord (1994) found that poor rural residents tend to move more than better-off rural residents and to have settled in communities that are even poorer than the places they left. Work by Fitchen (1992) in rural New York state found that low income tenants there have precarious housing situations and are at extreme risk of homelessness. They are often forced to relocate, as when rents increase or dwellings are sold, and expensive relocation costs include security deposits, first month's rent, and utility hook-up fees.

Economic development and job creation in rural areas may impact housing affordability. Drabenscott and Smith (1996) reported that those rural heartland counties experiencing economic growth greater than the respective state average had a relative wage rate at 69.4 percent of U.S. wage rates, compared with 74.3 percent for those counties experiencing lower than average economic growth. In contrast, the median value of owner-occupied housing units in counties experiencing economic growth was higher than in those counties experiencing a declining or stagnant economy. This suggests that matching incomes to housing costs would result in greater housing cost burdens for households in economically improving rural counties.

Economic development often increases the pressure for additional housing construction. New construction in isolated rural areas is often be more expensive than in more urban areas, where contractors are more plentiful. The decreased competition frequently results in higher specialized labor costs, a major component of new construction prices. Another cause of higher new construction costs is that in rural areas adjacent to metropolitan growth areas, zoning restrictions often require large lots increasing land costs per unit. In addition, construction financing is often difficult to obtain in rural areas where lenders have tightened capital reserve requirements and are reluctant to add real estate loans into their portfolios (Shreve and Belsky, 1991).

RURAL HOUSING FINANCE

As mentioned earlier, research indicates that residential financing continues to be less available and more costly in rural areas than in urban areas (United States Bureau of the Census, 1995). At the 1995 Research Roundtable Series sponsored by the Fannie Mae Office of Housing Research, Leslie Strauss reported a 9.4 percent median interest rate for nonmetropolitan borrowers, 9.1 percent for central city borrowers, and 9.0 percent for suburban borrowers (Strauss, 1995). Furthermore, rural home owners with moderate incomes are about twice as likely as their urban counterparts to have a non-bank financed mortgage. When compared to metro areas, interest rates on home mortgages are 40 to 80 basis points higher in rural areas, where loan terms are 5.4 to 7.7 years shorter and loan ratios are 2.1 to 5.8 percent lower on conventional fixed rate bank-financed mortgages (Shreve and Belsky, 1991).

New housing units account for approximately 10 percent of the U.S. housing stock each year. Although most new housing is built within urban Metropolitan Statistical Areas, 21 percent of all new units in 1993 were built in rural areas (United States Bureau of the Census, 1994a). Financing methods for new housing varied by location, and rural housing was purchased with cash 28 percent of the time compared to 9 percent for urban purchases. Conventional financing was used for 64 percent of rural purchases and for 74 percent of urban purchases. Government sponsored financing was used for 19 percent of urban housing purchases and for 8 percent of rural purchases (United States Bureau of the Census, 1994a). According to Lynette Steinbacher, Executive Director of the local community development corporation in Scottsbluff, Nebraska, "Rural communities like ours have suffered from a relative lack of private, affordable mortgage resources." (Pilot plan to aid rural home buyers, 1996).

The feasibility of purchasing rural housing with cash may be related to the lower price of housing there, although this is offset by lower household incomes in most such areas. Land and financial assistance to rural children may

also impact feasibility of ownership, but this concept has not been examined empirically. The lack of Government Sponsored Enterprises (GSEs) is another limiting factor for rural mortgage lending, and Congress has directed that these organizations increase their activities in rural areas. As a result of this directive, one secondary market participant, Freddie Mac, reported mortgage purchases in rural areas increased from 13 percent to 15 percent between 1993 and 1994. Although 2 percent may seem small, 2 percent of Freddie Mac's \$354 billion mortgage program translates into \$7.1 billion in mortgages (Freddie Mac, 1995). Bruce (1995) reported that for all GSEs in this time period, non-metropolitan acquisitions accounted for 12 percent of total mortgage acquisitions. Thus, Congressional policy directives seemingly provide at least some limited benefit in reducing the rural urban gap in access to residential financing. The scarcity of GSEs activity in rural areas is due in part to the relatively smaller rural mortgage market, to a lack of understanding of GSEs, and to the GSEs requirements that smaller institutions may be unable to meet.

The differences in urban and rural mortgage financing significantly impact families and households. Mortgage terms in urban areas are more attractive than those offered in rural areas (Urban Institute, 1990), where loan terms are typically shorter and loan-to-value ratios are lower in comparison (U.S. Department of Commerce and U.S. Department of Housing and Urban Development, 1995). There are no differences in types of mortgages selected (fixed rate, adjustable rate, adjustable term, graduated payment, etc.) by rural and urban purchasers. According to the 1993 American Housing Survey (published in 1995), 86 percent of residents in both locales had fixed payment mortgages.

Several factors may contribute to the varying rural and urban financing alternatives, including: the lack of rural savings and loan institutions, the financial characteristics of the borrowers, the lack of comparable properties for appraisal, differences in re-sale opportunities, and property appreciation

Congressional policy directives seemingly provide at least some limited benefit in reducing the rural urban gap in access to residential financing.

expectations. While there is little empirical research identifying just which factors are dominant, the Urban Institute (1990) has suggested two rationales for differences. First, they suggest that a weak local economy creates no demand for mortgages, a situation that, obviously varies across the country. Second, they suggest that loan risk is higher in rural areas than in urban areas.

Based on the Survey of Residential Financing (United States Bureau of the Census, 1994b), commercial banks are the primary holders of mortgages in rural areas, with 26.4 percent of rural mortgage versus 11.4 percent in urban areas; savings and loan institutions are second, with 22.1 percent versus 22.2 percent in urban areas; and federally-sponsored agencies or pools are third, with 18.1 percent versus 37.5 percent in urban areas. Mortgage bankers supply only 3.5 percent of rural and 8.3 percent of urban mortgage loans. Thus, sources of financing seem to vary considerably between urban and rural locations. The larger role played outside urban areas by commercial banks was also reported earlier by Meeks (1988).

Concerns of Congress and others that rural households seeking to purchase homes are hindered by a private sector loan shortage have prompted creation of special programs to finance rural housing. One of the major program efforts influencing the quality and availability of housing in rural areas is the Rural Housing Service (RHS, formerly the Farmers Home Administration, FmHA). These loan programs were directed to very low-, low-, and moderate-income borrowers seeking financing for modest rural homes. As of June 1995, these loans were worth \$18.7 billion (Government Accounting Office, 1995). Over 2 million single-family loans have been made since the inception of RHS and its predecessor, FmHA.

Current policies are shifting these programs from direct lending to guaranteed loans that are originated and serviced by private sector lenders. The impact of this shift is unknown but is expected to disadvantage lower income households (Collins, 1995). Furthermore, if rural lenders are reluctant to actively market

products that involve government or quasi-governmental agencies, such as secondary markets or guaranteed loan programs, then rural places may by default face residential mortgage redlining.

Other sources of publicly-supported residential mortgage financing include the Farm Credit System, the Federal Housing Administration (FHA) and the Veteran's Administration (VA). Of all rural housing units, 8.7 percent received FHA assistance and 6 percent received VA assistance (United States Bureau of the Census, 1994a). This compares with urban areas, where 20.6 percent received FHA assistance and 9.8 percent received VA assistance. While sources for mortgages vary between urban and rural locations, government financing is used less in rural areas than in urban areas. Lack of program knowledge, perception of red tape, and dislike or avoidance of government assistance have all contributed to this lack of program use (Frumkin, 1995).

FINANCIAL MARKET CHANGES

The mortgage loan market functions at two levels: the primary market, or loan origination market, and the secondary market, which consists of investors who purchase the loans made in the primary market. Roth (1988) reports that the secondary market has led to a national market for residential mortgages, even though mortgage origination is still regional. Although a national market may exist for access to capital, there is an underlying assumption that all institutions are equally knowledgeable about the market and are equally able to tap into it. This still leaves untouched the issue of having a local institution that consumers may contact.

An institution's size may be a factor in availability of credit. Hiemstra (1990) noted that the benefits of banking deregulation accrue from increases in firm and market efficiencies. He examined the likelihood of efficiency gains occurring when rural banks participate in securities markets. He notes that large rather than small banks are likely to gain the most from such participation, both because smaller banks are less likely to

understand securities markets and because risks of insolvency affect rural banks more than urban banks. Sales of mortgage loans to the secondary market can reduce default risk and provide a continued source of funds. However, the secondary market is only available to lenders who can package a pool of similar loans which are purchased in a bundle. For lenders with small volumes or dissimilar loans it is difficult to use the secondary market's advantages.

Alternatively, some suggest that various problems rural banks face stem not from their size but from their location. The Federal Agricultural Mortgage Corporation (Farmer Mac) has partnered with AgFirst Farm Credit Bank and the Federal National Mortgage Association (Fannie Mae) to offer Farmer Mac stockholders greater access to affordable rural mortgage funding (Federal Agricultural Mortgage Corporation, 1995). AgFirst pooled purchased housing loans from financial institutions that serve rural areas and communities with populations of up to 2,500. The AgFirst and Fannie Mae partnership was expected to generate \$100 million in loans during the first 12 months of operation. Although it ultimately failed to generate the expected volume, the partnership is still in place and exemplifies the innovations taking place in the mortgage market.

Location determines, in part, whom the bank will serve as well as which major financial markets the bank may access. Indeed, access to secondary markets may be critical to rural lenders, where low population density and remoteness can hinder delivery of financial services. In some rural communities computer internet access is unavailable because the small telephone companies there lack digital switching telephone lines. Where the infrastructure is sufficient telephone and on-line services may expand mortgage services by linking lenders to national markets and consumers to distant financial institutions. However, it is unlikely that many households, especially those with lower incomes, will have access to this technology unless a public institution subsidizes and promotes it.

PUBLIC POLICY TRENDS AND IMPLICATIONS FOR RURAL HOUSING FINANCE

Federal housing policy shifted dramatically with the Cranston-Gonzalez National Affordable Housing Act (1990), which refocused federal housing priorities from housing construction and rehabilitation to concerns for housing affordability. The federal government backed away from being the sole housing assistance provider for low income individuals and families, and partnerships between private and public or non-profit organizations or agencies were promoted. Direct assistance was de-emphasized and new programs were initiated, such as tax incremental financing for affordable housing, loan guarantee programs, and rent assistance vouchers. On the housing finance side, recent policies have made way for deregulation of the mortgage lending system and have at the same time enforced non-discriminatory lending practices though Community Reinvestment Act requirements (Bratt, 1995).

Proposals under current consideration would further restructure federal housing policies. These include policies to combine housing programs, decrease overall support, and allocate block grant funds to states. States would then be responsible for setting program priorities and allocating resources among a set of eligible activities, including community development, housing rental assistance, first time home buyers downpayment programs, affordable housing construction incentives, assistance for homeless individuals and families, and public housing operations and management. If states maintain the patterns established under the Community Development Block Grant (CDBG) programs, housing assistance programs will remain less fiscally attractive than infrastructure projects such as water, sewer, flood, and drainage facilities. These latter projects received 55 percent of all State and Small City CDBG funds in 1991, while housing-related activities received about half that amount, or 26.8 percent (Coalition for Low-Income Community Development, 1995).

At the same time that federal housing policy changes are being considered, banking and

Where the infrastructure is sufficient telephone and on-line services may expand mortgage services by linking lenders to national markets and consumers to distant financial institutions.

finance consolidation and deregulation continues, and revisions in Community Reinvestment Act requirements are expected (Associated Press Release, 1995). Policy makers remain under the impression that regulations are overly restrictive to business, and that rural areas and/or small institutions are not engaging in mortgage redlining or discriminatory practices (Recruits need on building standard, 1996).

Consolidation of housing programs, enhancing state and local flexibility, and cutting federal expenditures are the driving forces behind nearly all current national policy debates related to housing issues. With these forces expected to directly impact community housing efforts across the nation in the near future, key questions emerge: How might these trends impact rural communities? Can the consequences of such policy trends be anticipated? What are appropriate alternative responses? What guidelines are available to assist state officials, local decision makers, and concerned citizens in policy decisions? These critical questions are yet to be considered in the current housing policy discussions.

NOTES

1. Harvard University's Joint Center for Housing Studies reported homeowner equity at \$46,669 in 1993, accounting for close to half of owner's wealth (Survey of Income and Program Participation, 1996). Meanwhile, the Department of Housing and Urban Development (1995) reported that median net wealth exceeded \$78,400 for homeowners and amounted to only \$2,300 for renters. This HUD report also indicated that for homeowners, home equity represents almost 60 percent of their wealth.
2. Rural places are typically defined by their exclusion from urban or metropolitan areas. Urban housing includes housing units in urbanized areas and in places of 2,500 or more inhabitants outside urbanized areas. An urbanized area is an incorporated place adjacent to a densely settled (1.6 or more people per acre) surrounding where the area's combined population is at least 50,000. To be considered a metropolitan area, an area must include a city of 50,000 population, or an urbanized land area of at least 50,000 population with a total metropolitan population of at least 100,000.
3. Urban households are also cost burdened. According to the American Housing Survey, 21 percent of urban homeowners and 46 percent of urban renters paid 30 percent or more of their incomes for housing in 1993.

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Expanding Consumer Information: The Origin of the Patient Package Insert

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This development of the patient package insert in 1970 represents an important moment in the changing relationship between doctors and patients—the providers and consumers of health care—within a social framework marked by the rising influence of the women’s movement and the consumer movement.

Women who take oral contraceptives today are familiar with the leaflet each package of pills contains; it describes in tiny type the indications, contraindications, and possible side effects of taking the pill. Many other prescription medications come with similar leaflets, called patient package inserts. These instructions, written for patients by the Food and Drug Administration, did not exist 30 years ago. Instead, patients received all drug information through the filters of the prescribing physician and the dispensing pharmacist. The 1970 proposal to create a package insert for patients using birth control pills was revolutionary because it challenged the long-standing status quo of doctor-patient relationships. For more than 30 years physicians had governed the largely unidirectional flow of information about prescription drugs. Patient package inserts made patients privy to at least some of this heretofore classified data. In the case of oral contraceptives, the insert warned of the possible health risks associated with this method of birth control. This development of the patient package insert in 1970 represents an important moment in the changing relationship between doctors and patients—the providers and consumers of health care—within a social framework marked by the rising influence of the women’s movement and the consumer movement.

Before this, the Federal Food, Drug, and Cosmetic Act of 1938 had changed the nature of doctor-patient relationships in the United States. First, Food and Drug Administration (FDA) regulations enacted to carry out the legislation created a new category of drugs available by prescription only (Temin, 1980). While government regulation was designed to protect consumers from unscrupulous drug manufacturers, it also removed a significant amount of decision-making about medical treatment from the patient’s, or consumer’s, domain. After 1938, patients had to rely on physicians to instruct them about which drugs to purchase and use. The doctor controlled not only the patient’s treatment, but also the degree to which the patient understood the complexities of that treatment.

Second, the Food, Drug, and Cosmetic Act obliged pharmaceutical manufacturers to make information about the safety of drugs available to physicians. In 1961, an amended version of this 1938 legislation required that such information be listed on prescription drug package labels in the interest of “full disclosure,” and within a few years most included a detailed package insert directed to *physicians*. These pamphlet inserts contained instructions for using the medications, information on indications, contraindications, efficacy, and side effects, and as such served to reinforce the physician’s authority in medical matters.



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Chicago, 1968

In January 1970, in response to growing public controversy over the pill's adverse health effects, the United States Senate Subcommittee on Monopoly of the Select Committee on Small Business held a series of hearings on oral contraceptives as part of its investigation of the drug industry. The chairman, Senator Gaylord Nelson (Democrat from Wisconsin), stated his mission on the first day of the hearings:

The aims of these hearings ... are to present for the general public's benefit the best and most objective information available about these drugs. First, whether they are dangerous for the human body, and, second, whether patients taking them have sufficient information about possible dangers in order to make an intelligent judgment whether they wish to assume the risks (Senate 1970, 5923).

To evaluate the alleged health risks of oral contraceptives, Nelson assembled a group of "expert" witnesses to testify about the biochemical, physiological, and psychological

effects of the pill. Their testimony provided little, if any, new information about the biological effects of oral contraceptives. However, as a result of the intense media coverage of the hearings, the medical controversy over the pill's safety of the pill reached a much wider audience. As Nelson commented later,

Although very little of the information presented here or perhaps none of it was new to the experts in the field, quite obviously a lot of it was not known to the practicing physician who prescribes the pill and the public which consumes it (Senate 1970, 6818).

By the end of the first round of hearings, Americans knew a great deal more about the controversy surrounding the safety of the pill, but no more about whether or not the pill was safe to take. On February 9, 1970, *Newsweek* reported the results of a Gallup poll that surveyed women between age 21 and 45. News of the hearings reached an extremely wide audience; 87 percent of American women had heard or read about them. The survey found that 18 percent of the eight and

a half million women with pill prescriptions had stopped taking the pills in recent months, and another 23 percent were considering stopping the pill. One-third of those who had quit or thought about quitting attributed their recent or imminent abandonment of oral contraceptives directly to the Nelson hearings; another one-fourth cited side effects—experienced personally or by friends—as the reason for their doubts about the pill.

Perhaps the survey's most disturbing finding addressed one of Senator Nelson's initial questions in the pill hearings: were women being adequately informed by their doctors about the adverse health effects of the pill? The answer was a resounding "no." The poll revealed that two-thirds of women on the pill were never told by their physicians about any potential health risks of oral contraception. Millions of women chose to take birth control pills without knowing the whole story; the lack of communication between doctor and patient precluded informed consent in decision-making about birth control. This discrepancy between their doctors' actions and the expectations of the Senate committee heightened women's concerns about the wisdom of taking birth control pills in particular and about the quality of their medical care in general.

By the last days of the hearings, the central issue had boiled down to informed consent. Most physicians and scientists agreed that no new biomedical evidence had been presented to the Senate committee; the debate over whether or not the pill caused cancer, for example, would have to wait for more data before it could be resolved. They disagreed, however, on how much of this information should be presented to patients. Some concurred with Nelson, who insisted that women should be given all available information about the pill so that they could make up their own minds. Others sided with Dr. Elizabeth Connell, who testified:

To present the list of possible side effects as outlined in the present package insert to the average patient would serve no useful purpose, and would have many foreseeable and disastrous effects ... A patient cannot

reasonably be expected to make a profound professional judgment—she is not a doctor (Senate 1970, 6518).

Perhaps many physicians viewed informed patients as a threat to their authority and control in medical decision-making.

The issue of informed consent in the use of oral contraceptives crystallized on the final day of the hearings, when FDA commissioner Dr. Charles Edwards announced that his agency planned to require pill manufacturers to include a patient package insert in every package of birth control pills. This insert, written by the FDA in lay language and directed to the patient, would outline the health risks associated with taking the medication.¹

In his testimony, Dr. Edwards explained that the insert was "designed to reinforce the information provided the patient by her physician" (Senate 1970, 6800). In the absence of good doctor-patient communication (which, according to the *Newsweek*-Gallup poll, characterized two out of every three women's experiences), the insert would supply facts necessary to make an informed choice.

The following day, March 5, 1970, the *New York Times* published the proposed text of the insert. Entitled "What You Should Know About Birth Control Pills," the 600-word document described in lay language the health risks, side effects, and contraindications of oral contraceptives. Although in his testimony Edwards indicated that the patient package insert was necessary because doctors did not adequately inform patients, the insert reassured women of the competence of their doctors: "Your doctor has taken your medical history and has given you a careful physical examination. He has discussed with you the risks of oral contraceptives and has decided that you can take this drug safely." Ten of the fifteen proposed paragraphs in the proposed text made reference to the doctor as the proper authority on oral contraceptives; the insert encouraged the woman to consult her physician in no fewer than six different situations.

In spite of this deference to the doctor, the medical profession strongly opposed the patient package insert, claiming that it would intrude upon the doctor-patient relationship.

The pharmaceutical industry protested because it contended that the proposed insert overstated the potential risks and overlooked the benefits of oral contraception (Watkins, 1998). Even the Department of Health, Education, and Welfare (HEW), which housed the Food and Drug Administration, argued for revisions in the writing to satisfy somewhat murky legal issues. (On March 24, 1970, the *New York Times* reported that HEW was irked at having been left out of the loop on the development of the patient package insert.)

In response to pressure from professional, industrial, and government interests, the FDA backed away from its initial proposal and substituted a much shorter, less detailed insert. The revised text, 100 words in length, mentioned only one health complication from oral contraception: blood clotting disorders. Whereas the first draft had included statistics on increased health risks and mortality rates, the edited version omitted this information. It encouraged women to see their doctors if they experienced side effects, listing just five symptoms and conditions where the earlier draft had listed more than 25 (*Federal Register* 1970, 5962).

Outraged by this turn of events, women from the radical feminist group “Washington, D. C., Women’s Liberation” staged a sit-in at the office of HEW Secretary Robert Finch to protest the watered-down package insert proposal. Secretary Finch did not see the feminists that day, but agreed to meet with them a few days later. Their petition to reinstate the stronger version of the patient package insert failed to sway HEW and FDA officials. On April 10, 1970, the FDA published the abridged draft of the oral contraceptive package insert in the *Federal Register* and invited all interested parties to respond with comments on the proposal. During the next 30 days, letters from more than 800 individuals and groups flooded the offices of Secretary Finch, Commissioner Edwards, and the Hearing Clerk at the FDA in Rockville, Maryland.²

Much of the public interest in oral contraceptives can be attributed to the publicity generated by the Nelson hearings and the

consistent news coverage of the controversy over the pill’s safety. It is less easy to explain why people moved beyond mere interest to direct action—in this case, writing letters of protest. Most likely, the climate of the times spurred many individuals to action. Within a society attuned to the issue of rights and conducive to political activism, people felt empowered to speak out against what they perceived as a denial of the right to informed consent. During this time, many Americans felt angered by the secret policies of the government in regards to the Vietnam War; by 1970, the demand for public information had extended to a broad range of government activities. In addition, Congress had recently passed the Freedom of Information Act (in 1967), which both entitled and emboldened citizens to seek information previously withheld from them. The demand in 1970 from hundreds of people for a public hearing on the content of the patient package insert fit appropriately into this larger social context.

More than half who wrote objected to shortening the insert. Of these, most were copies of form letters distributed by women’s groups; their text complained that the warning label did not provide full disclosure on the adverse effects of the pill and called for public hearings on the matter. Over a hundred women and men wrote their own letters protesting the reduced length and scope of the warning. Some objected to the unequal distribution of power in the doctor-patient relationship:

I have inadvertently received the physician’s copy of facts and cautions now included in each 3-pack of Ortho-Novum pills; the first time I told the people who had given it to me and they said, ‘You’re not supposed to see that. That’s only for doctors.’ I was outraged and insulted at this; the only reason I can see for doctors or other parties to withhold medical information from patients is the desire to maintain their psychological and monetary power over us.

Others added their concern about the integrity of the pharmaceutical industry and its control

[A few] doctors agreed with consumer advocates that the patient should be fully informed before making the decision to use birth control pills.

Edwards aimed to appease the consumers, feminists, and patients who demanded informed consent and the physicians and manufacturers who wanted control to remain in the hands of the medical profession.

over government agencies:

I read that the FDA has called for toning-down the wording of the precautionary literature on oral contraceptives which HEW has in the planning stage. It was clear from the article the HEW is bowing to pressure from the drug industry, the AMA, and many private physicians, all of whom feel that a precise report will harm the Pill's market and their own pocketbooks." Still others expressed the opinion that women had the right to full disclosure on medical matters: "*I DEMAND,—* that as a woman, having the option to take the pill or not, I have *all* facts in front of me!

Doctors also wrote to the FDA in response to the proposed patient package insert for oral contraceptives. With very few exceptions, they strongly opposed the warning label. Their objections fell into two main categories: the patient package insert would interfere with the doctor-patient relationship, and the government should not regulate what information the doctor must give to each patient. Having successfully appropriated birth control as a medical "procedure," doctors were unwillingly to yield their authority. Excerpts from physicians' letters reveal their indignation at regulation from outside the medical profession: "I deeply resent the Government of the United States coming between me and my patients in the matter of a single class of prescription items ..."; "The determination of appropriate use of medications must continue to rest in the hands of the physician....To remove this clinical relationship would be just another method of eroding the foundation of American medicine." A few physicians expressed their approval of the idea of a warning label for oral contraceptives. These doctors agreed with consumer advocates that the patient should be fully informed before making the decision to use birth control pills. However, their position contrasted sharply with the large majority of physicians who preferred to retain the prerogative of how much and what kind of information to give

to each individual patient.

One doctor who wrote to the FDA in support of government involvement in disseminating information about prescription drugs argued that the patient package insert would "serve as a protection for the doctor rather than as a cause for initiating lawsuits." One would think that this reasoning would appeal to the pharmaceutical industry as well; *Time* reported on May 2, 1969, that more than a hundred lawsuits had been filed against birth control pill manufacturers. However, drug companies vehemently opposed the inclusion of an FDA-mandated warning in packages of oral contraceptives. The president of the Pharmaceutical Manufacturers Association (PMA), which represented 125 drug companies, articulated the industry's objections, both general and specific, to the proposed insert.

The manufacturers pointed out that the patient label contradicted the intent of the Federal Food, Drug, and Cosmetic Act, which clearly distinguished between prescription and over-the-counter drugs. They argued that the law designated the class of prescription drugs to be issued on a physician's prescription only and thus precluded the necessity of directing detailed information to the patient. Furthermore, "the complexity of prescription drugs as well as the delicate nature of the physician-patient relationship requires individual decisions in each case as to what information should be imparted to a patient and as to how it should be conveyed." The drug industry sided with the medical profession in preserving the sanctity of the doctor-patient relationship.

In June 1970, the FDA Commissioner announced the policy decision regarding the patient package labeling for oral contraceptives. The FDA would require manufacturers to include a brief insert in every package of birth control pills, the content of which was significantly modified from the version proposed in April. *The New York Times* reported on June 10, 1970, that the change resulted from pressure from physicians; perhaps the FDA bowed also to the interests of the powerful pharmaceutical industry. Although the mandated label did describe abnormal blood

clotting as “the most serious known side effect,” it listed no symptoms and instead simply it told the reader to “notify your doctor if you notice any physical discomfort” (*Federal Register* 1970, 9003). Four of the seven sentences in the label described the availability of an information booklet, which the patient could request from the physician. This 800-word booklet was written by the American Medical Association in conjunction with the FDA and the American College of Obstetricians and Gynecologists; it resembled in scope and content the original insert proposed by the FDA back in January. The package label merely informed the patient that further information was available; the onus fell on the patient to ask her doctor to give her the booklet. Now Commissioner Edwards noted that “the prescribing physician should be the person to provide his patient with the necessary information to assure her safe use of the prescribed medication”; the label served to remind the patient (and hopefully the physician) that “careful doctor-patient discussion about the use of the drugs” should take place at regular intervals (*Federal Register* 1970, 9002). In this way, Edwards aimed to appease the consumers, feminists, and patients who demanded informed consent and the physicians and manufacturers who wanted control to remain in the hands of the medical profession.

Of course, neither group was wholly satisfied. Consumers and feminists objected to the conscious withholding of information from patients; the FDA label-booklet compromise allowed physicians to provide less than the whole story to their patients. It took eight more years for the FDA to order that the minimal warning label on oral contraceptive packages be replaced with a lengthy information leaflet. In 1977, the FDA issued patient labeling requirements for estrogens used in hormone replacement therapy. In the wake of this mandate, the FDA decided to revise the oral contraceptive labeling requirements to be consistent with those of other estrogen products (*Federal Register* 1977, 37642; 1978, 4223; 1980, 60754-6). This 1978 version of the patient package insert repeated the infor-

mation in the physician package insert in lay language, and represented what consumer and feminist groups had wanted all along.

The battle over the patient package insert demonstrated the influence and power of the medical profession and the pharmaceutical industry over the FDA. Commissioner Edwards yielded twice to the demands of these two powerful institutions: first, in cutting the insert text to one-sixth of the original proposal before publication in the *Federal Register*, and second, in further reducing the strength of the final warning. After more than two years of Senate inquiry into the drug industry, pharmaceutical manufacturers still wielded the upper hand in the uneasy relationship with their regulatory agency, the FDA.

Given its subordinate position to the industry it was supposed to regulate, why did the FDA bother to suggest the patient package insert in the first place? Three factors contributed to this action. First, Charles Edwards, who had recently replaced the rather ineffectual Herbert Ley as the FDA’s commissioner, wanted to improve the status of his agency. A patient package insert might help to rein in the powerful drug industry.³ Second, the FDA felt pressure from legislators—Senator Nelson, in particular—to address the problem of the oral contraceptives. Since the manufacturers would not voluntarily provide information to consumers, the FDA had to respond to the demand for action by the general public and elected officials. Third, the climate of skepticism toward medicine and big business by 1970 seemed favorable to regulation of the profession and its commercial cousin, the drug industry.

Although in an abbreviated form, the early patient package insert was at best a partial victory for feminists, consumers, and others who had so ardently supported its inclusion in packages of birth control pills. On the one hand, the FDA did order manufacturers to include the insert, thus validating concerns about the safety of the pill and the quality of information that patients received from physicians. On the other hand, the mildness of the warning rendered it virtually ineffectual. To learn more about the adverse health effects

Since the manufacturers would not voluntarily provide information to consumers, the FDA had to respond to the demand for action by the general public and elected officials.

of the pill, patients had to request the longer booklet from physicians, who retained the authority to withhold information if they deemed it necessary and “in the best interest of the patient.” Still, in spite of its watered-down wording, the patient package insert represented an important turning point in the doctor-patient relationship. Patients had demanded a right to know about the medications prescribed for them, and the federally-mandated package insert legitimized this claim. This system of including inserts for patients within prescription drug packages has assured some modicum of consumer information in today’s pharmaceutical world.

NOTES

1. Previously, in 1968, the FDA had ordered warning labels on containers of isoproterenol, an inhalant used by asthmatics, but relatively few people were affected by this action, and as such it attracted little attention.
2. These letters are on file at the U.S. Food and Drug Administration. I am indebted to Suzanne White Junod of the FDA Historians’ Office for facilitating my access to these records.
3. Edwards had little success in elevating the status or improving the condition of the FDA. The agency continued in disarray well after his tenure was completed in 1973. *The New York Times* reported on March 14, 1977, that the FDA was the Federal Government’s “most criticized, demoralized and fractionalized agency.”

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Henry J. Aaron, ed. (1996), *The Problem That Won't Go Away: Reforming U.S. Health Care Financing*. Washington, DC: The Brookings Institute, \$42.95.

Haynes Johnson and David S. Broder (1996), *The System: The American Way of Politics at the Breaking Point*. Boston, MA: Little, Brown & Co., \$25.95.

These two volumes add much to the debate surrounding health care reform by directing attention to what went wrong with President Clinton's 1993-94 health care reform proposal. Both books openly acknowledge that current market forces and the strong movement toward managed care arrangements have not "fixed" the fundamental problems with the U.S. health care system. *The Problem That Won't Go Away*, considers why this is so through a long series of individually crafted reactions to the problems inherent in the U.S. health care system. *The System* does so through a scathing journalistic attack on the U.S. political system.

Neither book is intended for the weak of heart, though at least the Aaron volume gives the feel of possible solutions while Johnson and Broder present a much bleaker picture of potential changes in the state of affairs for health care or other social agenda items. Both are important books to read for educators and those involved in decisions related to public policy in general, and are must-read books for those involved specifically with health policy. Consumers who have not been following the health care debate, or those unfamiliar with the terminology, will probably find these volumes difficult.

In *The System*, Haynes Johnson and David Broder chronicle events leading up to the debacle of Clinton's stalled health care reform package. It is clear

that their careers as correspondents serve them well as they interview over a hundred of the key participants including the President and First Lady, key Congressional leaders (Dole, Gingrich, Kennedy), and many others with competing interests, and, in good journalist style, put together all of the pieces from those multiple perspectives. This is not a traditional research book, but one well worth the read. It is the more consumer-oriented book of the two, gripping the reader with in-depth reporting and a fascinating narrative that some of us would prefer were fiction. The book is divided into four sections, whose titles reflect the journalists' attempt to organize a complex mess of events into the most theatrical of contrivances: The Delivery Room; The Plan; The Debate; and The Epilogue. It works though; indeed, as the story unfolds, one feels as a mother caught in a difficult labor. The Debate offers the most compelling interpretation of lost opportunities, leaving the reader to wonder what might have been.... A Machiavellian quote opens the section reminding us that those who stand to profit from the old order will be the most resistant. (The full text actually appears in the Aaron volume leading one to wonder how far we have come in four centuries!) What some may not be prepared for is just how far the old order might go to squelch reformists. The reporting of a "plot" by Gingrich forces to kill health care reform as part of the strategy to take back the Congress and begin the dismantling of the progressive programs is among the most startling of their finds. Though presumed by many to be a causative factor, to read how it all worked is stunning. As the authors acknowledge, and as is obvious throughout, the power struggles that suppressed an honest debate about the need for health care reform—specifically, reform that might have been accept-

able to a broad and diverse audience of business, providers, and patients—are present in all late 20th century public policy debates in the United States. There is therefore much to learn so that lost opportunities are not repeated in the health care or other social arenas.

The Problem That Won't Go Away is an edited volume for which each chapter is readable on its own, though they are infinitely more useful as parts of a comprehensive whole. Aaron's position as director of the economic studies program at the Brookings Institute serves him well as he has selected an outstanding mix of contributors. Contributed works represent perspectives of those in government, policy centers, private foundations, and universities. Each writing addresses Clinton's health care reform proposal and entertains a variety of reasons as to its ultimate demise. Some speculate on the future, and all of the issues likely to be needed for future debates are included. The book is divided into four main parts: Why did the Clinton plan fail?; How can information be improved?; What does the future hold?; and Incremental reform.

Although each chapter is worthy of review, I'll offer just a few reflections. While Johnson and Broder's telling of why the Clinton plan failed is viewed from the modern day political realities and relies mostly on taped interviews, Hugh Heclo's chapter dealing with the failure, takes a useful historical perspective grounded in research publications, addressing previous understandings of political struggles for social reform. The chapters reflecting on what is now possible for health care reform—incremental changes in insurance such as we got with the Insurance Portability Act, and proposals for funding changes in Medicare and Medicaid—though perhaps politically problematic, are nonetheless well-reasoned and supported.

In "Estimating the effects of reform," Linda Bilheimer and Robert Reischauer summarize the issues facing those required to furnish the health care proposal comparison data. These authors correctly acknowledge the difficulty of trying to have the data catch up with the technology of health care, asking how one can predict what costs will be if accepted treatment modalities are changing so rapidly. Contained within is useful advice for those of us who say we can evaluate the viability of different social and health programs.

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Brown, Clair (1994), *American Standards of Living: 1918-1988*. Cambridge, MA: Blackwell, \$36.95.

This book resulted from Clair Brown's desire to answer the question, "Why are Americans driven to seek an ever-higher material standard of living instead of a more leisurely life style and higher quality of life?" Brown traces the transition from the drudgery and austerity at the turn of the century to the pressures stemming from affluence in the 1980s. She then examines the impact of economic and income growth on the way people live and differences between social groups in living standards, and documents changes in family expenditure patterns and in the social valuation of money income and time.

Brown analyzes changes across time and social classes using data from the Consumer Expenditure Surveys. The specific points in time analyzed include 1918, 1935, 1950, 1973, and 1988. Class comparisons are made primarily between three classes of families based on the employment *status* of the husband. These classes, in increasing order

of *status*, include laborer families, wage earner families, and salaried families. When the data allow, poor families and families headed by elderly persons are also analyzed.

Critical to Brown's analyses are the standard of living index and measure of economic distance she developed for this research. These empirical measures provide the structure for comparisons across time and classes. The standard of living index is a relative measure that captures the ability to meet basic needs and, once basic needs are met, the allocation of consumption expenditure. Economic distance is a measure of how differences in the allocation of consumption expenditure among classes translates into differences in living conditions.

The standard of living index included three functional components: *basics*, *variety*, and *status*. *Basics* refer to consumption expenditures made to meet fundamental material requirements necessary for a working-class family to function economically and socially. The standard for *basics* changes over time in response to the transformation of consumption norms. For example, throughout most of the first half of this century *basics* included items necessary for mere subsistence. By the later half of the century, *basics* included car ownership, telephones and communication devices, and many household amenities. The ability of families to meet the standard for the consumption of *basics* increased with income. Salaried families were able to purchase all *basics* in 1918; the ability to purchase all *basics* wasn't achieved by wage earner families and laborer families until 1935 and 1973, respectively.

Expenditures in excess of *basics* are classified as *variety* or *status*. *Variety* refers to expenditures in excess of *basics* which allow consumption of a larger quantity or *variety* of goods. *Status* refers to expenditures in excess

of *basics* for higher-priced goods associated with improved social position. The standard of living index expresses the percentage of total expenditure allocated to *basics*, *variety*, and *status*. The percentage of total expenditure allocated to *basics* is inversely related to the standard of living. Salaried families allocated a higher portion of total expenditure on *variety* and *status* than wage earner families, who allocated a higher percent than laborer families.

In addition to comparing standards of living across time and classes, Brown uses the index to analyze how real increases in income were allocated among *basics*, *variety*, and *status*. Over time, the proportion of family consumption expenditure allocated to *basics* declined, indicating improvement in living standards. The proportion spent on *variety* and *status* increased, especially after 1973. Brown coins the term, economic distance, which is defined as the difference among groups in both the level and patterns of consumption expenditure. Economic distance resulting from differences in the percent of total consumption expenditure allocated to *basics* produces real differences in the standard of living between groups. However, economic distance resulting from differences in the percentage of total consumption expenditure allocated to *variety* and *status* produce only subtle differences.

Brown carefully details the economic reality of everyday life in 1918, 1935, 1950, 1973, and 1988, devoting separate chapters to each time period. She describes living conditions, labor market conditions, social institutions, and consumption norms and behaviors prevailing in each time period. These chapters are filled with tables of extensive data. Brown discusses the transformation of consumption norms from a focus on home life and home-produced goods to a focus on money income and purchased goods and services, which

contributed to changes in the social valuation of money income and time. She chronicles how work, both in the labor market and in the home, became less physically demanding over time, thanks to technology and automation, and with respect to home work, because of decreases in family size and improvements in housing amenities. She addresses the emergence of "leisure" during the 1950s, and the expansion of social activities well beyond weekly church attendance. The period of rapid economic and income growth of the 1950s and 1960s is contrasted with the stagnation of income growth after 1973. She emphasizes the importance of education and two earners to achieving a high standard of living today.

Brown's book should be of interest to all scholars interested in economic well-being. Unique contributions include the standard of living index and measure of economic distance developed for this research. A healthy scholarly dialogue could focus on the conceptual and empirical strengths and weakness of these measures and their useful empirical applications.

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Michael Hudson (1996), *The Merchants of Misery: How Corporate America Profits from Poverty*. Monroe, ME: Common Courage Press, \$14.95.

Even a glance at the title should prepare readers of this collection for some old-fashioned muck-raking. They will not be disappointed. From the appalling catalogue of corporate misdeeds to the breathless tone of righteous indignation, the effort is worthy of *McClures' Magazine* (if not quite Upton Sinclair).

The book is a series of reprints (from sources as diverse as the *Wall Street Journal* and *Mother Jones*) which take the reader to a land where loans are quick, bad credit is never a problem, and interest rates are astronomical. Concealed behind this twilight world of pawn shops, check cashing outlets, and finance companies, are the brightly lit lobbies of some of America's largest, most respected financial institutions. It is the denizens of those lobbies, not shady underworld characters, who are preying upon the defenseless poor.

That pretty well summarizes Mr. Hudson's collection. Anyone looking for fresh insights or a systematic, analytical assessment will probably be disappointed. However, it would be unfair to criticize the work on those grounds because *The Merchants of Misery* obviously was not written as an objective analysis, but as an exposé. As such, it works fairly well. It is somewhat bothersome that the various excesses covered in the readings are treated as new discoveries, when most have been evident for over a decade. Worth remembering is that while pawn shops and rent-to-own stores dot the urban landscape, they remain invisible to most Americans.

One of the work's two main strengths is its treatment of the link between mainline financial institutions and those businesses offering financial services to the poor. This outrages the authors, but should give pause to even the most objective observer. Why are banks, even as they appear to be cutting back services to low-income consumers, involved in businesses which lend to the same people at much higher rates? Some of those businesses have evolved into large corporations, with stock traded on major stock exchanges (and touted to the more affluent as good buys by their brokers).

The second strength is Hudson's cov-

erage of the range or extent of financial services offered to the poor. Whether borrowing to buy a car, refinancing a home, cashing a check, getting a cash advance, or buying insurance, low-income consumers face a fundamentally different market from average consumers. That market features little consumer protection, as illustrated by the practices exposed by the recent collapse of an automotive lender of last resort, Mercury Finance. The readings do not make this point, but the issues they raise are particularly timely during this period of welfare reform. The oft-mentioned road from welfare to work likely passes by a check cashing outlet or finance company. The ultimate irony would be if reform merely served to expand the market for high-cost lenders.

Mr. Hudson's book should do well for those in need of a good introduction to the problems of financial markets for the poor. It should also serve as a tonic for those who are familiar with the question, but who may have lost touch with the human side of the issue. For anyone, it should underscore the need for more and better information about such issues.

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The University of Georgia

Rebecca M. Blank (1997), *It Takes a Nation: A New Agenda for Fighting Poverty*. Princeton NJ: Princeton University Press.

Perception 1: The federal government spends more than 20 percent of its budget on welfare programs. **Perception 2:** Fraud saps \$1 billion dollars from the Food Stamp Program. **Perception 3:** the U.S. antipoverity war failed.

In today's welfare debate, the above

perceptions frequently appear. Are these perceptions supported by facts? We can find specific answers in this newly published book. First, based on data provided by the U.S. Office of Management and Budget, if Medicaid is excluded, only 8 percent of federal expenditures go to antipoverty programs. If Medicaid is added in, the figure climbs to 14 percent. Second, the \$1 billion fraud accusation, widely cited in public policy discussions, first appeared in Patrick Leahy's February 2, 1994 testimony before the Senate Committee on Agriculture, Nutrition, and Forestry. No one appears to know where this number originated, which suggests that it has little empirical validity. Third, by carefully comparing the goals of various government public assistance programs and their achievements, these programs are shown to be more effective than many critics have perceived. In short, this book addresses virtually all questions raised in today's welfare debate, and provides specific answers supported by empirical evidence. Guesswork and misinformation are refreshingly absent. The author, Rebecca M. Blank, is a professor of economics and Director of the newly founded Joint Center for Poverty Research, Northwestern University and University of Chicago.

With eight chapters, the book's first three describe the demographic, economic, and policy changes of the past several decades that lie behind current discussions of welfare reform. The fourth and fifth chapters provide evidence of the effects of existing public assistance programs and discuss the key role the public sector has played in assisting low-income families. Chapters six and seven move from analysis to an explicit discussion of current policy recommendations. Chapter eight concludes the book.

According to the author, book's

main purpose is to help state program officials who must redesign their cash assistance programs because of current public policy changes. However, several of the book's features make it particularly valuable to anyone concerned with poverty issues.

This book provides a comprehensive and accurate picture of the U.S. antipoverty efforts within the last three decades, as evidenced in numerous scientific studies, and as supplemented by the author's own studies, observations, and interviews. In the author's straightforward approach she presents the materials and arguments with many chapter subtitles posed as questions for those involved in current welfare debate. Numerous tables and charts throughout present nationwide representative data, while the text's narrative portion is generally non-technical, with sources and background technical discussions offered in numerous endnotes.

Finally, besides presenting these various studies of antipoverty efforts and results, the author also provides her own views of the need for public assistance and recommends various program designs to better help the less fortunate. The author's eight philosophical arguments in favor of a public social safety net, and numerous suggestions for improving the effectiveness of various public assistance programs, are useful references for state officials, social service workers, and other concerned parties working on today's welfare reform. The message sent by this book is: "There is no single cause of poverty, and there is no easy way to abolish it. The challenge is to build a balanced system which relies on the contributions of many different groups and programs" (p. 8).

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Paul A. Jargowsky (1996), *Poverty and*

Place: Ghettos, Barrios, and the American City. New York: Russell Sage Foundation, \$39.95.

Barbara R. Bergmann (1996), *Saving Our Children From Poverty: What the United States Can Learn From France*. New York: Russell Sage Foundation, \$34.95.

Poverty in a wealthy country is an ignominy and difficult to explain. Though there have been numerous programs to alleviate poverty in the United States, especially since the 1960s, poverty continues and has increased in some localities. The authors of these two books document the extent of certain kinds of poverty, attempt to explain the problems, and propose public policy to alleviate poverty. Both authors are economists; however, their approaches and solutions to poverty are quite different. Bergmann emphasizes reducing the number of children in poverty, while Jargowsky emphasizes eradicating "neighborhood poverty."

The French spend proportionally far more than the U.S. on programs designed to help young children and parents of young children. Bergmann implies that the U.S. should spend more on children's development in much the same way that the French do. She maintains that such spending would improve the economic condition of families with small children and help these children to rise above poverty. Bergmann presents extensive data on government expenditures in both the U.S. and France for child care, income supplementation and medical care. She also presents data which support her belief that the U.S. could afford the kind of social programs adopted by France. However, in order for the U.S. to institute the extent of public support for children available in France (public-funded day care, paid leave for parents

of infants, etc.), revenue from taxes would have to increase or expenditures would have to be redirected from other programs (i.e. defense) to fund such social welfare programs.

Jargowsky justifies his focus on neighborhood poverty by noting that poverty has increased in neighborhoods even when the overall poverty rate has decreased. He defines neighborhood poverty as census tracts within metropolitan areas where over 40 percent of the residents have incomes below the poverty level. He categorizes neighborhoods into four types: *ghettos* where residents are predominantly African-American, *barrios* which are predominantly Hispanic, *white slums* which are predominantly white, and *mixed slums* where no particular ethnic group is predominant. Jargowsky admits that there are more households living in poverty *outside* these four kinds of neighborhoods, even in metropolitan areas.

Jargowsky is more objective than Bergmann. For example, he discusses various theories including the "culture of poverty theory" which he does not support. He provides an extensive review of the literature, including findings from his own research based on Census data. He criticizes studies for investigating poverty in isolation (e.g. at a neighborhood level only) rather than from a broader macroeconomic perspective (e.g. an entire metropolitan area). From the literature and his own research, he concludes that the primary determinants of neighborhood poverty are economic. He asserts that pathological and other negative behaviors are symptoms, not causes of neighborhood poverty. The most significant determinant of neighborhood is mean household income. Other significant determinants are "economic segregation" which can be caused by flight to the suburbs by both middle-class whites and African-Americans. Racial discrimination is also a determinant but not as sig-

nificant as the economic determinants.

The authors of both books outline what could be done to help the poor. Bergmann maintains that increased government spending on programs such as public-funded day care and medical and cash assistance for parents will help alleviate poverty among children. However, her arguments are one-sided and not persuasive. While it is desirable to improve the life of children, especially those living in poverty, it is unlikely that public opinion would support the kinds of public programs she suggests. The French have a different approach to economic systems; therefore, solutions for France will not necessarily work in the U.S. Bergmann fails to mention that the unemployment rate in France is much higher than in the U.S., and that perhaps extensive government spending on programs has contributed to a weakening of the French economy.

Jargowsky offers a much more objective approach and suggests various solutions, including some specific ones which would not require increased government spending, such as using a tax credit for home mortgage interest rather than the current deduction. His primary policy solution is to improve productivity within the U.S. economy which will lead to job growth.

Basically, he contends that if the economy is strong, the poor will benefit as well as other citizens. He also supports increased spending on schools and points out that the public is more likely to support spending to improve all schools, rather than those only in poor neighborhoods. While Jargowsky offers some workable solutions, his conclusions are somewhat simplistic. For example, he states that inner city residents could work in businesses in the suburbs if the government provided help to enable the poor to participate in the work force, such as improved public transportation and dissemination of information about job availability.

Such solutions do not consider the time costs of the poor. His notion that an improved economy is what we need does not consider the fact that neighborhood poverty has increased even during times of low unemployment and a strong economy. His conclusion that increasing mean income would decrease poverty is obvious given that the poverty level is defined by income, yet this is his primary solution.

In summary, Bergmann's treatment is too biased and her solutions are likely to be disregarded by most politicians. The Jargowsky book is the more interesting of the two and offers some insights and helpful solutions, even though some of his solutions are typical "trickle-down" remedies and others are simplistic and do not show an understanding of those in poverty. Jargowsky offers some intriguing insights, and researchers could glean much from the book which could aid them in future research on the topic.

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John P. Robinson and Geoffrey Godbey (1997), *Time for Life: The Surprising Ways Americans Use Their Time*. University Park, PA: Pennsylvania State University Press, \$24.95.

Robinson and Godbey have written what is simultaneously an interesting and frustrating book: interesting because it brings together a massive amount of information on time-use patterns not only in the United States, but in other countries as well, from 1965 to 1985 and beyond. The data are presented interestingly. The book is frustrating because their analysis is simple-minded and atheoretical.

Their premise, presented on page

four, is that certain modern critics and commentators of our times have got it all wrong: Schor (1991) wrongly believes Americans are working more than they used to; Hochschild (1989) misreads the 20th century in asserting that women still do the same amount of housework as they used to; Mattox (1990) doesn't know the data when he asserts that children receive less attention from their parents than they used to; Burns (1993) was wrong in believing Americans spend less time eating and sleeping than they once did so they may instead complete the current mandates of the day. And so on. They, therefore, take on these and other modern, popular and semi-popular critics of the way Americans live. Conversely, Robinson & Godbey ascribe to Robert Samuelson's (1995) analysis which argued that this age of discontent has been created because our expectations have outstripped our performance and not that it has lagged absolutely. And rather disingenuously, they whine that because of the popularity of Schor's, Hochschild's Mattox's and Burns' views, they had to be satisfied with Pennsylvania State University Press as a publisher (p. xix).

The heart of the book presents basic results of the 1985 Americans' Use of Time national survey conducted (in 1985) by John Robinson at the University of Maryland along with comparisons with two earlier national time-use surveys Robinson was involved with done at the University of Michigan in 1965 and 1975. (See Morgan, et. al., 1966 and Juster et. al., 1985.) Chapter after the chapter, each segment of time use is clearly albeit simplistically presented through the vehicle of one-way tables. Only here and there do the authors refer obliquely to Multiple Classification Analysis, the only multivariate technique they use, and that very infrequently. Their data do, indeed, show that in America men have reduced

and women have increased the time spent in paid employment; that men have increased and women have decreased the time spent in housework; that men do about the same and women do somewhat less child care in 1985 than in 1965, that much of the increased "free time" Americans have fallen heir to in the last 25 years has been spent watching TV. In total, they find both American men and women have reduced their time spent in "productive activity;" i.e., paid work, housework, child care and shopping. They further point out that while women spend less total time in child care overall, they spend more time per child than previously. Finally, over the 20 year period from 1965 to 1985, they note that sleep time by American men and women has remained constant. So much for Schor, Hochschild, Mattox, and Burns.

And yet it's all too simplistic. One-way tables conceal more than they reveal. While they do, here and there, present time-use cross-tabulated by age, education, income or marital status, they never present a multivariate analysis in displaying the effects of these demographic and economic variables, holding the others constant. It may well be that men and women, on average, spend less time in paid and unpaid work than they once did. But, it also may be that this has happened, not so much by everyone working fewer hours, but because some of us are now working very little while others work all the time. While they allude to the leisure of the young, the early retirement of the 55 year-olds and older, and the longer work hours of the middle years, they do very little with it. And they make little or no use of marital status or numbers and ages of children. One is left, after reading their book, wanting a great deal more analysis and less hand waving.

Positive virtues of their book are many. Diary and recall methods of collecting time-use data are compared, especially

with respect to time spent in paid work. U.S. time-use patterns are compared with time-use in Europe, Japan and Canada. Four chapters are devoted to surveys collecting subjective data on how Americans spend their time: their perceptions, which time-uses are liked and which satisfy, and the connections, if any between the results of time-use and the time-use itself. It is in this and the last more speculative sections of the book that Robinson and Godbey ascribe to Robert Samuelson's thesis of the rising gap between expectations and reality.

Time For Life is the kind of book that should be read by those interested in the state of and trends in American society. Robinson and Godbey do present important data on how we Americans use our time and how the reality does depart in important ways from popular beliefs. The book will also be a wonderful springboard for critical analysts because it contains much to criticize.

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UNFAIR DEBT COLLECTION PRACTICES

Curtis Bartlett v. John A. Heibl, et al.
128 F.3d 497 (7th Cir. 1997).

Curtis Bartlett received a debt collection letter from Attorney John A. Heibl in October, 1995. Heibl had been retained by Micard Services to collect a consumer credit-card debt of approximately \$1,700.00 incurred by Bartlett. Bartlett received, but did not read, Heibl's letter. The letter indicated that if Bartlett wished to resolve the matter before legal action was commenced, he was required do one of two things within a week of the date of the letter: (1) pay \$316.00 toward the satisfaction of the debt; or (2) get in touch with Micard to make suitable payment arrangements. The letter went on to state that if Bartlett did neither of these two things, Heibl would assume that legal action would be necessary. Finally, at the bottom of the letter, under Heibl's signature, there appeared a literal paraphrase of section §1692g(a) of the Fair Debt Collection Practices Act (FDCPA) informing Bartlett that he had thirty days within which to dispute the debt, in which event Heibl would mail him verification of the debt. The letter also indicated that Bartlett could bring a lawsuit at any time before the expiration of the thirty-day period.

Bartlett filed suit against Heibl for violations of the FDCPA. Specifically, Bartlett claimed that Heibl's letter violated the statute by stating the required information regarding a debtor's right in a confusing manner. The district court found that the letter was not confusing and ruled in favor of Heibl after a bench trial. Bartlett appealed the decision of the trial court, claiming that the judge's ruling was clearly erroneous. Heibl disagreed and also contended that even if the letter was confusing it was irrelevant since Bartlett

had not read the letter.

Chief Judge Posner, writing for the Seventh Circuit panel, first addressed Heibl's argument that because Bartlett had not in fact read the letter, it was irrelevant that the letter may have been confusing. The court noted that had Bartlett been seeking actual damages, that is, damages that he suffered as a consequence of being misled by the confusing letter, he would have had to prove that he had read the letter. However, since Bartlett sought only statutory damages, that is, damages enumerated in the statute for violations of the statute, all Bartlett was required to prove was that the statute had been violated.

The court then turned to the substance of Heibl's letter, and whether the letter was sufficiently confusing to violate the FDCPA. The court first acknowledged that the statute does not say in so many words that the required disclosures must be made in a nonconfusing manner. Rather, courts have held that:

debt collectors may not defeat the statute's purpose by making the required disclosures in a form or within a context in which they are unlikely to be understood by the unsophisticated debtors who are the particular objects of the statute's solicitude.

The court also pointed out that the "nonconfusing standard" created by the courts had not been sufficiently explained and was itself confusing. Confusion may be induced by several methods: contradictions, "overshadowing," or failure to explain an apparent though not actual contradiction are all ways in which a notice may be confusing.

The court noted that while the judges did not like to think of themselves as "your average unsophisticated consumer," they nevertheless found the letter to be confusing. On that basis, the court reversed the trial court's rul-

ing and held in Bartlett's favor.

However, the court went further, saying that "judges too often tell defendants what the defendants cannot do without indicating what they can do." In an effort to provide guidance for future debt collection, the court redacted and rewrote Heibl's letter so that it complies with the FDCPA as interpreted by the court. The court announced that its letter will be a safe haven in the 7th Circuit for debt collectors "who want to avoid suits by disgruntled debtors standing on their statutory rights." The court noted that debt collectors are not required to use the court's letter but would be well advised to stick close to it.

Ruthene Whitaker, on her own behalf and on behalf of all others similarly situated v. Ameritech Corporation
1997 WL 721554 (7th Cir. 1997).

Ruthene Whitaker had two telephone lines, each serviced by Ameritech Corporation. The first line, "0508," was Whitaker's primary household telephone line. The other line, "0499," had been installed for Whitaker's college-aged daughter. Ameritech provided local telephone services to both lines. Ameritech also contracts with other telephone service companies, such as long distance and "information providers." Information providers provide such services as adult entertainment and trivia games. Ameritech purchases the accounts receivable of these providers, bills the customer and collects payments. Therefore, an Ameritech customer receives one consolidated bill which includes the local telephone service charges as well as long distance and information provider services charges.

In December 1993, Whitaker incurred charges for three calls to information providers on the 0508

line. Following its standard operating procedure, Ameritech sent Whitaker disconnect notices with demands for payment in February and March 1994. Ameritech temporarily disconnected the 0508 line in April 1994. In May 1994, Whitaker's minor son made additional calls to information providers, incurring a bill in the hundreds of dollars. Whitaker disputed the charges, but in June 1994, Ameritech sent her a disconnect notice which included charges for the May 1994 and December 1993 information provider calls. In July 1994, Whitaker made a partial payment, but in August 1994 Ameritech permanently disconnected her telephone service.

In October 1994, Ameritech temporarily disconnected the 0499 line for nonpayment. Whitaker paid the full amount due, and Ameritech reconnect-ed service. After October 1994, several small charges to information providers appeared on the 0499 line bill. However, Ameritech had not disconnected the line nor taken legal action with regard to the 0499 line.

Ameritech sued Whitaker for the balance due on the 0508 line. Ameritech obtained a default judgment against Whitaker in Illinois state court and began garnishing her wages. Whitaker then sued Ameritech in Federal court asserting violations of the Fair Debt Collection Practices Act (FDCPA), the Racketeering Influenced and Corrupt Organizations Act (RICO), and the Illinois Consumer Fraud and Deceptive Trade Practices Act (Illinois Act). The trial court held that all of Whitaker's claims were barred by res judicata. In other words, the court held that the default judgment obtained by Ameritech barred Whitaker from making additional claims against Ameritech.

The appellate court first examined the rules of res judicata as interpreted by the Illinois courts. Two approaches

to res judicata are utilized by the Illinois courts: the "proof" or "evidence" approach and the "transactional" approach. The court found that the Illinois courts allowed application of either approach.

Whitaker first claimed that Ameritech violated RICO "by sending out telephone bills that fail to disclose that customers could refuse to pay charges to information providers without risking disconnection of their local service, by using misleading trade names and logos, and by failing to disclose the true amount required to pay to avoid disconnection." The appellate court, agreeing with the district court's analysis, held that Whitaker's RICO claim was barred by the Illinois court's default judgment. Relying on *Henry v. Farmer City State Bank*, the court stated that "a subsequent RICO suit [based on allegations of fraud] after litigation on the underlying debt" is barred, even though Whitaker had not raised the defense of fraud in the state court proceedings. The appellate court also held that Whitaker's RICO claim was barred by the transactional approach to res judicata, stating that "fraudulent and misleading telephone bills lurk in the same transaction, incident or factual situation."

Similarly, the court held that Whitaker's Illinois Act claim was barred by the default judgment. Noting that the analysis of her "RICO claims transfers neatly into her Illinois Act claims," the court held that in essence Whitaker claimed that Ameritech "engaged in fraud in order to take her money." The court held that this issue had been decided by the Illinois court in the default judgment, and that Whitaker should have raised the fraud issue in the state court action.

The court next turned to Whitaker's FDCPA claim. The court initially held that her FDCPA claim was not barred under either approach to res judicata.

Turning to the substance of her FDCPA claim, the court held that Ameritech was not a "debt collector" within the meaning of the FDCPA. The FDCPA excludes from its definition of "debt collectors" those entities who acquire a debt "not in default at the time it was obtained." 15 U.S.C. §1692a(6)(F)(iii). The court noted that while Ameritech does collect money owed to long distance companies and information providers, it does not acquire those debts after they are in default but rather as they are incurred. If a customer defaults on the debt, he does so after Ameritech acquires the debt. Therefore, the court reasoned, Ameritech is not a "debt collector" within the meaning of the FDCPA. The court affirmed the trial court's dismissal of Whitaker's FDCPA claim.

TRUTH IN LENDING ACT

Gibson v. Bob Watson Chevrolet-Geo, Inc., 112 F.3d 282 (7th Cir. 1997).

Gibson purchased, on credit, a used car from a dealer. The dealer gave her an itemized statement of the amount financed. An entry was labeled "amount paid to others on your behalf—to North American for extended warranty—\$800." As it turns out, this was a false representation because the dealer did not pay \$800 to North American; he retained a substantial (currently unknown) portion for himself.

The Truth in Lending Act (TILA) requires finance charges to be disclosed to the customer. §§15 U.S.C. 1605 (a), §1638(a)(3). TILA also requires the lender to provide, if requested, a written itemization of the amount financed, including amounts paid by the creditor to third

persons. 15 U.S.C. §§1638(a)(2)(B)(iii), 12 CFR 226.18(c)(2).

The court held that TILA's purpose is to protect customers from being misled about the cost of credit and that the customer is not misled about the cost of credit if the dealer retains the same amount of the warranty price on credit purchases as he does on cash purchases.

It was a disputed issue as to whether the defendant retained the same amount on both cash and credit purchases. Consequently, it is presently unresolved whether or not a finance charge occurred. If the amount retained by the dealer differed between cash and credit purchases, then with credit purchases it was truly a finance charge and must be disclosed under TILA.

The defendant relied on a commentary to the Federal Reserve Board's Regulation Z (the Federal Reserve Board is the underlying authority for TILA), stating that it "may," as opposed to must, disclose that it retained some amount. The court rejected this interpretation; though the dealer was not required to list the exact amount, he must disclose that he retained some amount.

If the dealer's retention is systematically higher on credit purchases than on cash purchases, then it is an undisclosed finance charge; the higher retention must have a relation to the extension of credit. If a person realizes that the actual cost of the extended warranty is less than \$800, because this figure includes a dealer's "commission," he will be less likely to automatically purchase the warranty from the dealer. Instead, the customer can engage in comparison shopping. Because the complaint stated valid claims which should be addressed, the 7th Circuit reversed the district court's dismissal.

Smith v. Highland Bank, 108 F.3d

1325 (11th Cir. 1997).

This class action suit was brought by mortgage borrowers (debtors) against a mortgage lender and its assignee. Smith, on behalf of herself and others in the class, alleged that Highland Bank violated the Truth in Lending Act (TILA).

Under TILA, debtors must receive notice of their right to rescind the mortgage on a separate document that clearly and conspicuously notifies debtors of their rescission rights. The consequences for noncompliance are possible civil liability and an extension of up to three years of the debtor's right to rescind.

Smith contended that the form of notice utilized by Highland Bank did not give her a meaningful opportunity to rescind. The one-page notice consisted of the following: (1) a "Certificate of Confirmation" at the top of the page which was to be signed after the three day rescission period. Signature of it indicated that the rescission had not been exercised; (2) "Acknowledgment of Receipt" followed, which the debtor must sign to confirm that Highland complied with TILA; and (3) a statement indicating that all signatories of the "Acknowledgment of Receipt" must sign the "Certificate of Confirmation."

Smith asserted that because this information is on the same page, the average consumer would be led to believe that the "Certificate of Confirmation" had to be signed upon receipt of the notice. If so, this prompts the debtor to prematurely give up the rescission right.

Smith relied on *Rodash v. AIB Mortgage Co.*, 16 F.3d 1142 (11th Cir. 1994), in which the Certificate of Confirmation not only was listed below the Acknowledgment of Receipt, but was not a separate paragraph. The *Rodash* court found a violation of

TILA, but stressed that each circumstance of a transaction must be individually analyzed.

For purposes of determining liability under TILA, the court distinguished the circumstances in this case from *Rodash*. Here, the Certificate of Confirmation was a separate paragraph and required a separate signature; it stated that the debtor was not to sign it until after the three day rescission period, and was dated several days after the Acknowledgment of Receipt. Additionally, Highland's notice provided detailed information on how to cancel the transaction. The court found that since the clear intent of the third and last section was to ensure that all signatories of the Acknowledgment of Receipt sign the Certificate of Confirmation, it was not misleading.

Arnold v. Waterfield Mortgage Company, Inc. No. 96-1701 (4th Cir. 1997).

In 1989, Arnold obtained a loan from Union Federal Savings Bank. The loan was evidenced by an adjustable rate note and secured by a mortgage against Arnold's home. In 1995, six years after signing the loan documents, Arnold brought an action in district court to rescind the loan. The Truth in Lending Act imposes a three-year statute of limitations on actions to rescind. 15 U.S.C. §1635(f) states, "An obligor's right of rescission shall expire three years after the date of consummation of the transaction or upon the sale of the property, whichever occurs first"

More than three years had elapsed since the loan transaction closed. Arnold contended on appeal that the three-year limitations period starts anew each time a rate adjustment is made to a variable rate mortgage. The court disagreed, and held that a rate adjustment is not a "transaction" with-

in the meaning of §15 U.S.C. 1635(f) and §12 C.F.R. 226.20(c) (explaining that a variable rate adjustment is an event requiring new disclosures, but not indicating that adjustment triggers a new opportunity to rescind).

Therefore, Mr. Arnold's right to rescind was barred by the statute of limitations.

CONSUMER LEASING ACT

Turner v. General Motors Acceptance Corp., 1997 U.S. Dist. LEXIS 16344 (S.D.N.Y. 1997).

David Turner sued General Motors Acceptance Corporation ("GMAC") for failing to disclose in an automobile lease that defendant earns interest and receives certain non-interest benefits based on plaintiff's security deposit, in violation of the Consumer Leasing Act ("CLA"), 15 U.S.C. 1667 et seq. (1994).

On September 25, 1995, Turner entered into an agreement with GMAC to lease a 1995 Chevrolet Geo Prism through a Chevrolet dealership in Highland, New York. The lease agreement required Turner to pay a refundable security deposit of \$750.00. The agreement disclosed that no interest would be paid on the security deposit and that GMAC would deduct from the security deposit any amounts owed under the lease. The lease did not disclose whether GMAC earned interest or receives any non-interest benefits based on the security deposit.

GMAC placed Turner's security deposit into an escrow account it maintains with Chase Manhattan Bank ("Chase") in New York. GMAC maintains 11 bank accounts with Chase nationwide, including three security deposit escrow accounts in New York. As required by New York law, GMAC

places each security deposit that it receives from an automobile lease customer in New York into one of these three escrow accounts and does not commingle these funds with funds it receives from other sources.

GMAC does not earn interest on any funds deposited in these escrow accounts. However, GMAC does receive certain non-interest benefits from Chase based in part on the funds on deposit in the New York escrow accounts. Chase awards "earnings credits" to defendant based upon the aggregate average monthly balance of its funds on deposit with Chase, including the funds in the three escrow accounts in New York. GMAC uses these credits to offset fees that Chase charges defendant for maintaining its accounts. Thus, the only issue in this case is whether defendant's failure to disclose its receipt of "earnings credits" based in part on plaintiff's security deposit violates the CLA.

Turner argued that "earnings credits" are "interest equivalent remuneration" and therefore must be disclosed to Turner under the CLA. Turner's argument rested on two assumptions: first, that "earnings credits" are "equivalent" to interest; and second, that a failure to disclose the receipt of interest on a lessee's security deposit violates the CLA. Because the court rejected Turner's suggestion that "earnings credits" of the type at issue here are the same as interest, it did not assess the validity of plaintiff's second assumption.

Turner likened "earnings credits" to interest because Chase awarded them to GMAC as a "percentage of the total dollar value" of its funds on deposit and because it does so at a rate that is "linked to a treasury bill index." However, the court found that this is the extent of the similarities between "earnings credits" and interest. "Earnings credits"—unlike interest—

are not paid in cash and can be used only to offset fees that Chase charges defendant to maintain its accounts. "Earnings credits" which remain after the fees that apply to defendant's accounts have been offset in a given year expire and may not be carried over to the following year.

Moreover, the court found that the fact that a substantial portion of defendant's "earnings credits" for 1996 expired unused is strong evidence that these credits are not so transferrable or redeemable. Turner cited no cases and the court was aware of none which stood for the proposition that "earnings credits" are equivalent to interest.

In addition, the court found that GMAC's failure to disclose its receipt of "earnings credits" neither caused unfair surprise to Turner nor failed to provide him with sufficient information to compare more readily the various lease terms available to him. As such, its decision was not inconsistent with the overall purpose of the CLA.

FAIR CREDIT REPORTING ACT

Cushman v. Trans Union Corporation, 115 F. 3d 220 (3rd Cir. 1997).

In the summer of 1993, an unknown person, possibly a member of Cushman's household in Philadelphia, applied under Cushman's name for credit cards from three credit grantors: American Express ("Amex"), Citibank Visa ("Citibank"), and Chase Manhattan Bank ("Chase"). The person provided the credit grantors with Cushman's social security number, address, and other identifying information. Credit cards were issued to that person in Cushman's name, and that person accumulated balances totaling approximately \$2400 on the cards between June of 1993 and April of

1994. All this occurred without Cushman's knowledge.

In August of 1994, an unidentified bill collector informed Cushman that Trans Union Corporation ("TUC") was publishing a consumer credit report indicating that she was delinquent on payments to these three credit grantors. Cushman notified TUC that she had not applied for or used the three credit cards in question, and suggested that a third party had fraudulently applied for and obtained the cards. In response, a TUC clerk called Amex and Chase to inquire whether the verifying information (such as Cushman's name, social security number, and address) in Amex's and Chase's records matched the information in the TUC report. The TUC clerk also asked if Cushman had opened a fraud investigation with the credit grantors. Because the information matched, and because Cushman had not opened a fraud investigation, the information remained in the TUC report. TUC was unable to contact Citibank so TUC deleted the Citibank entry from the report.

Cushman was sent a copy of the updated report still containing the Amex and Chase delinquencies. She sent a second letter to TUC reiterating her disagreement with the facts contained in the report and offering to sign affidavits for TUC to the effect that the delinquencies were not hers. TUC subsequently performed a reinvestigation identical to the first one but did nothing more. The credit report was not changed. At no time did TUC provide Cushman with a description of its reinvestigation procedures.

Cushman filed a lawsuit in federal district court alleging negligent and willful failure to reinvestigate the disputed entries in violation of sections 611(a), 616, and 617 of the Fair Credit Reporting Act ("FCRA"), and defamation. After the suit was filed, TUC veri-

fied the information with Citibank, and placed the Citibank entry back onto Cushman's report. TUC notified Cushman of the reinsertion through her attorneys.

A few months later, Cushman for the first time disputed the delinquencies with the three credit grantors. A Citibank employee, comparing a handwriting sample provided by Cushman with the credit card application, determined that the card had been fraudulently obtained. The other two credit grantors came to a similar conclusion. TUC has since deleted the entries from Cushman's report. At the close of Cushman's presentation of her case at trial, the district court granted TUC judgment as a matter of law on all claims. Cushman appealed.

The court found that there was no evidence that TUC took the necessary steps to obtain access to pertinent documents from the credit grantors that would enable TUC to perform a handwriting comparison. TUC did allow Cushman the opportunity to complete a form requesting that a special handling statement be placed on her report, and that form required her signature. However, a TUC employee testified that the form would not have been used for a handwriting comparison had Cushman completed it. TUC advises consumers in Cushman's position to communicate with the credit grantors and complete signature verifications and affidavits of fraud with the credit grantors.

TUC contended that §1681i(a) did not impose on it an obligation to do any more than perform the reinvestigation it performed in this case. That is, TUC believed that when a consumer informs a consumer reporting agency that information contained in her consumer report is inaccurate, the consumer reporting agency is obliged only to confirm the accuracy of the information with the original source of the

information. According to TUC, it is never required to go beyond the original source in ascertaining whether the information is accurate.

The court stated that this position has been rejected by the United States Courts of Appeals for the Fifth and Seventh Circuits. The court followed the Seventh Circuit opinion in *Henson*, 29 F.3d at 286-87, which stated, "A credit reporting agency that has been notified of potentially inaccurate information in a consumer's credit report is in a very different position than one who has no such notice. . . . [A] credit reporting agency may initially rely on public court documents, because to require otherwise would be burdensome and inefficient. However, such exclusive reliance may not be justified once the credit reporting agency receives notice that the consumer disputes information contained in his credit report. When a credit reporting agency receives such notice, it can target its resources in a more efficient manner and conduct a more thorough investigation." The court also agreed with the observation by the Fifth Circuit in *Stevenson*, 987 F.2d at 293, that the plain language of the statute places the burden of reinvestigation on the consumer reporting agency.

In the current case, the court held that in order to fulfill its obligation under §1681i(a) a credit reporting agency may be required, in certain circumstances, to verify the accuracy of its initial source of information. The court further held that "whether the credit reporting agency has a duty to go beyond the original source will depend on a number of factors, including (1) whether the consumer has alerted the reporting agency to the possibility that the source may be unreliable or the reporting agency itself knows or should know that the source is unreliable; and (2) the cost of verifying the accuracy of the source versus the possi-

ble harm inaccurately reported information may cause the consumer.

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1. Submissions should be accompanied by a cover letter stating that the material in the manuscript will not infringe upon any statutory copyright and that the paper will not be submitted elsewhere while under *ACI* review. (This review normally takes 6 to 12 weeks for refereed papers.) Cover letters should include author's complete address and telephone number.
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 - With the four manuscript copies, include one title page. This page should specify the author's title and affiliation and the title of the paper.
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Leet, D. R. and Driggers, J. (1990). *Economic decisions for consumers* (2nd ed.). New York: Macmillan.
 - Journal articles (notice inclusive pages):
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