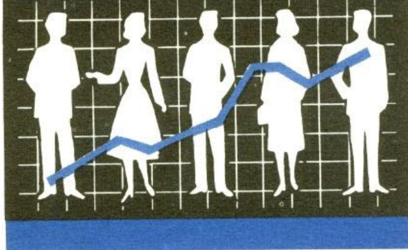

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PROGRESS IN HEALTH SERVICES

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Medical Care under Public Assistance

EXPENDITURES by all levels of government for medical care to public assistance recipients in fiscal year 1962–63 totaled about $1,241 million.* This amount is 20 per cent of all government expenditures for personal health care** and about 25 per cent of total expenditures under public assistance programs.

These expenditures were made by two methods: (1) $1 billion by vendor payments, made directly to the suppliers of medical care, and (2) about $241 million*** by inclusion of medical care allowances in money payments made to assistance recipients, who then arrange for the purchase of their own medical care. In the latter case, the cost of needed medical care is included in the computation of an individual's total requirements, on which his payment is based.

Vendor payments reached the one billion dollar mark ($5.36 per capita of entire population) in 1962–63. This amounted to about 17 per cent of total expenditures for personal health care by federal, state, and local governments.

Within the governmental sector, the federal share of vendor medical payments was $525 million, or 52 per cent of the total.

Public assistance programs

At present there are five special categorical public assistance programs in which federal grants-in-aid to all the states are available under four titles of the Social Security Act. They are Old-Age Assistance (OAA), Medical Assistance for the Aged (MAA), Aid to the Families with Dependent Children (AFDC), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD). In addition to these special Categorical assistance programs, there is the General Assistance program for which there is no federal participation. Vendor medical payments are made (though not by all states) under all these public assistance programs including General Assistance.

Looking at vendor payments only, the major portion was paid on behalf of aged public assistance recipients. Thus, the Old-Age Assistance program was responsible for 43.1 per cent of the total payments and the Medical Assistance to the Aged for 24 per cent in the fiscal year 1961–62. General Assistance (GA) and Aid to Families with Dependent Children programs accounted for about 12 per cent each of the total; the remaining portion of the vendor payments (10 per cent) was paid through the Aid to the Permanently and Totally Disabled and Aid to the Blind programs.

In 1961–62, the total number of assistance recipients under all five special categories of public assistance programs supported by the federal government averaged 3,766,276 per month, or 2 per cent of the entire population each month. The average monthly amount of vendor medical payments per recipient in each specific category varied from $2.10 for Aid to Families with Dependent Children to $14.24 for Aid to the Per-

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* Preliminary estimate, as are all data for 1962–63. Basic data are from published and unpublished material provided Health Information Foundation by the Commissioner of the U.S. Welfare Administration.

** Including all expenditures for health and medical care except those for facilities, research, operating costs of insurance, and general public health activities.

*** The amount for medical care included in money payments was estimated as 6 per cent of total money payments under four selected public assistance programs in January, 1962. When this percentage was applied to the entire fiscal year 1962–63 and to all public assistance programs, the amount $241 million was derived.

medical payments within a specific maximum.* By January, 1958, 36 out of 50 states and four jurisdictions were making direct payments to the suppliers of medical care.

Subsequently, the 1958 amendment changed the basis for federal sharing in state expenditures to include both vendor medical payments and money payments to recipients within a new general averaging formula. The use of an average in determining the amount of the federal share made it possible for states to receive federal participation in larger medical care expenses in individual cases.

By June 1959, 52 states and jurisdictions assumed some responsibility for provision of medical care to public assistance recipients. Out of the 52, 42 used vendor payment. The rest provided some items of medical care in the money grants to the recipients subject to the limitations of the state's maximum on assistance payments.

Public Law 86-778, popularly known as the Kerr-Mills Act, was passed by Congress in 1960. It provided federal grants to the states to enable them to establish a new program—Medical Assistance to the Aged—and increased federal participation in Old-Age Assistance vendor medical payments. The new program is to furnish necessary medical assistance for aged persons of low income who may not need or be receiving Old-Age Assistance payments.

Federal participation in vendor payments for medical care under the Medical Assistance to the Aged program and under the special vendor provision of Old-Age Assistance is based on the relation of a state's average per capita income to the national average per capita income.** This relation varies among states within the limited range of 50 per cent and 80 per cent, the states with lower per capita income receiving the higher percentage.

Types of medical care offered under states' plans

Under the Social Security Act, the state has the sole responsibility for provision of medical care to public assistance recipients in each category. Federal participation is based on public assistance titles of the Federal Act which is enabling legislation; the decision to operate a program rests with the state. Thus, the states designate the types of medical care that will be made available to assistance recipients, and may also set limits on the quantity of such care. Except for a few basic rules, the states determine the conditions of eligibility for receiving care. In addition, the states also specify the methods of paying for such care.

By far the most common method of providing medical care to assistance recipients is vendor payments. Thus, 49* states and 4 jurisdictions made vendor payments under one or more special categories of assistance or general assistance programs totaling $813 million in 1961–62.

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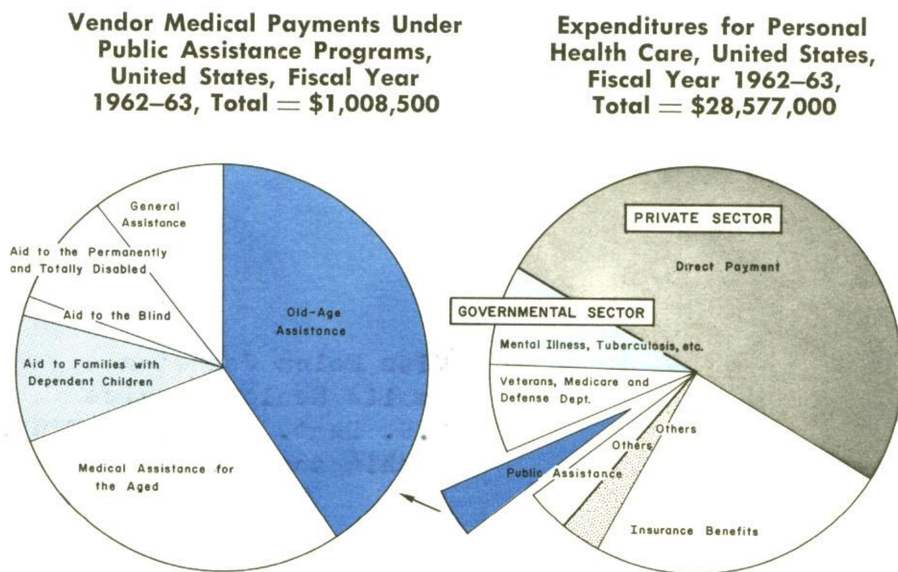
* The state which did not make such payment was Arizona.

Chart II



Sources: 1. U.S. Social Security Administration, *Social Security Bulletin, November 1963.*
2. U.S. Welfare Administration, Bureau of Family Services, *Advance Release of Statistics on Public Assistance, July 1963.*

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* Up to one-half of the sum of $6.00 multiplied by the number of adult recipients, and $3.00 multiplied by the number of child recipients per month, by program.

** As established by Department of Commerce data for the three most recent years for which such data are available.

Hospital Care: Hospitalization was the service most readily available to assistance recipients. On behalf of all assistance recipients, 49 states and jurisdictions paid $343.5 million for hospital care in vendor medical payments during the fiscal year 1961–62. Of the total $790 million vendor payments, excluding $23 million for types of services not reported, those for hospital services amounted to 43.5 per cent.

Under every one of the six public assistance programs including the General Assistance program, the biggest share of vendor payments was expended for hospital services. Seventy-five per cent of the total vendor medical payments for General Assistance recipients was expended to pay hospital bills. For the rest of the programs, hospital bills claimed from 32 to 48 per cent of total vendor medical payments. (See Table I.)

As Table I shows, the average monthly amount of vendor payment per recipient of money and/or vendor payments for hospital care was $102.04 for Medical Assistance to the Aged program. Under other special types of programs it was $6.01 or under.

Nursing Home Care: On behalf of all public assistance recipients, 45 states and jurisdictions paid $232 million in vendor payments for provision of nursing home care in 1961–62.* This constituted 29 per cent of total vendor medical payments by states reporting the type of service provided. Thus, after hospital care, the payment for nursing home care accounted for the greatest share of total vendor payments.

About 90 per cent of vendor payments for nursing home care was on behalf of aged assistance recipients: 49 per cent for Old-Age Assistance and 40 per cent for Medical Assistance to the Aged recipients.

Physicians' Services, Prescribed Drugs, and Others: Through vendor payments, 42 states and jurisdictions paid $84.5 million for the provision of physicians' services in 1961–62. This amounted to about 11 per cent of total vendor medical payments from the states reporting types of service provided. For prescribed drugs, $74 million were paid out in vendor payments by 39 states and jurisdictions. The amount for dental care was $19 million, and the remaining $37 million went for other medical services.

Limitations on Provision of Care: Among the states which offered a specific type of medical services to assistance recipients, many imposed limitations of one sort or another in 1961–62. In providing hospital care, for instance, several states did so only for emergencies or acute conditions and paid only for a certain number of days of care per admission per year, or per quarter. As for physicians' services, some states paid for such services in the office or home but not for surgical or other physicians' services in a hospital. Several states imposed definite limitations on the number of calls or visits which would be paid for in a given period of time or per case of illness. Similar limitations existed on provision of nursing home care, prescribed drugs, dental care and others.

Table I

State and federal payments for vendor medical bills: Total amounts for specified type of service and average amount per recipient of money and/or vendor payments for specified type of service, fiscal year 1961–62

	In-patient hospital care		Nursing home care		Physicians' services	
	Total amount (in millions)	Average monthly amount per recipient	Total amount (in millions)	Average monthly amount per recipient	Total amount (in millions)	Average monthly amount per recipient
Old-Age Assistance	$119.6	$4.40	$114.2	$4.20	$44.3	$1.63
Medical Assistance for the Aged	92.9	102.04	92.6	101.66	4.4	4.80
Aid to Families with Dependent Children	37.7	0.87	0.2	(a)	22.3	0.52
Aid to Blind	2.9	2.36	2.0	1.62	1.4	1.13
Aid to Permanently and Totally Disabled	28.8	6.01	20.0	4.17	5.2	1.09
General Assistance	61.6		3.0		6.9	
Total:	$343.5		$232.0		$84.5	

(a) less than 1 cent.

Source: U.S. Bureau of Family Services, Division of Program Statistics and Analysis, January 31, 1963.

* $232 million was an 84 per cent increase over 1960–61, and part of this increase was caused by the shifting in methods of payment from money payment to vendor payment.

Indigency and Medical Requirements

The status of indigency for all recipients of the five special categories of assistance programs except those receiving assistance under Aid to Families with Dependent Children has a close relation to, or is caused by their health conditions. Such relation is obvious for assistance recipients under Aid to the Permanently and Totally Disabled, Aid to the Blind, and Medical Assistance to the Aged programs: either their physical condition has reduced their ability to earn an adequate living, or the aid is in the form of payments for medical costs only. For Old-Age Assistance recipients, a National Opinion Research Center survey in 1957 shows that among those who are aged 65 and over and "very sick," 37.1 per cent reported Old-Age Assistance as their main source of income, as against 10.7 per cent of all others aged 65 and over.*

Of seven states which compiled the data between 1957 and 1960, four states reported between 220 and 427 hospital admissions annually per 1,000 Old-Age Assistance recipients. In the remaining three states, the rates ranged from 121 to 156. This is to be compared with about 146 hospital admissions per year per 1,000 persons among the general population 65 and over.** Significantly higher hospital days per 1,000 were also reported among Old-Age Assistance recipients. Whereas among the general population of 65 and over there will be about 2,200 days of hospital care annually per 1,000 persons,*** recipients of Old-Age Assistance in two states, Michigan and Massachusetts, received 12,000 to 13,000 days of hospital care per 1,000. In three states, Colorado, Connecticut, and North Dakota, the figure was from 5,000 to 9,000 days.

Of those who became Old-Age Assistance recipients for the first time during the first six months period in 1961, 31 per cent reported health problems as the reason for needing assistance, in the 25 states that compiled the data. Eleven per cent of total cases opened reported reduction in earnings due to illness, injury, or

* Ethel Shanas, *The Health of Older People, A Social Survey*, Harvard University Press, 1962, p. 70. The "very sick" is defined using an index of degree of illness as developed from the interviews. See p. 189.

** U.S. National Health Survey, *Health Statistics*, Series B-No. 32, p. 18. Data were collected in household interviews during July, 1958–June, 1960.

*** *Ibid.*, p. 4. U.S. National Health Survey data are for general hospitals only. If the seven states compiling the data included long-term hospital patients, these two data are not strictly comparable.

The Need for Public Action

Sick people must receive needed medical care, whether or not they are able to pay for such care. Hospitals and physicians have always subscribed to this philosophy and much philanthropic support of hospitals has been predicated on it. However, the system has always had imperfections and at best can only function with governmental support, which for many years has been inadequate.

In spite of the good intent of those who provide care, the poor often delay seeking services or find it difficult to secure access to hospitals and physicians, except in emergencies. On the other hand, hospitals find it particularly difficult to provide free care, and can only do so with philanthropic help or by assessing higher charges to self-supporting patients.

The increase in government funds reported in this issue of *Progress in Health Services* is giving the sick poor greater access to medical services, in part relieving hospitals of this financial burden. At the same time, the cost of care has been rising and there is a higher demand from our aging population, so that even the sharp increase in public funds to the present level of about a billion and a quarter dollars a year is not enough.

The enactment in 1960 of the Kerr-Mills Bill financing federal participation in state programs providing Medical Assistance for the Aged (MAA) was a major step forward. For the first time, federal funds are available for older people in need of medical care but otherwise able to provide for their own support. The fact that some states have not participated in the Kerr-Mills program, and that most others are providing but small assistance for needy older people, is indicative of the historic resistance of state and local governments to providing enough money for medical care.

Public expenditures for medical care for the needy, then, have increased substantially, but this increase is not enough. Not all needy people are receiving required care, and hospitals and nursing homes are forced to provide care either without being reimbursed or on a substandard basis. Only insistence by the public will lead government at state and local levels to assume their proper responsibilities in providing enough money to pay for care for those unable to meet the cost.

—GEORGE BUGBEE, *Director*
Health Information Foundation

impairment, and 13 per cent increased need for medical care. The remaining 7 per cent reported that their assets had been exhausted to pay for their medical costs.

Variations among States

The average monthly amount of vendor payment per Old-Age Assistance recipient (including those who receive money payment only) varies widely from state to state. Thus, whereas the nation's average was $15.37 in July, 1963, for 16 states it was less than $10.00, and more than $32.00 for nine states.

The variation among states was of greater magnitude for payments under Medical Assistance to the Aged program. Although the nation's average monthly payments per Medical Assistance to the Aged recipient was $213.93 in 1961–62 fiscal year, the average monthly payment for eight states was $73.83 or less. By the end of August 1963, 22 states did not have Medical Assistance to the Aged programs in operation. Of these 22 states, some had their own medical care program for the aged without federal grants. Colorado is an example.

About 90 per cent of all Medical Assistance to the Aged expenditures were made in four states—New York, Massachusetts, California, and Michigan in the fiscal year, 1961–62. The population aged 65 and over residing in these four states comprised about 26 per cent of the total population aged 65 and over. New York State, which had about 10 per cent of the nation's aged population, expended about 51 per cent of the total payments under the Medical Assistance to the Aged program. It should be remembered that New York receives the minimum federal percentage grant—50 per cent—according to the formula in use.

Summary

The role of government in providing medical care for the low-income and the destitute has been an accepted public policy for a long time. The extent to which that policy has been applied has had an uneven history. The development and data presented here indicate that government in this country is beginning to fulfill its long accepted responsibility in a concrete manner.

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