MAINE PUBLIC DOCUMENTS

1952 - 1954

(in four volumes)

VOLUME IV

MAINE
LEGISLATIVE RESEARCH COMMITTEE

SECOND REPORT

to

NINETY-SEVENTH LEGISLATURE

HOSPITAL AID

December, 1954

STATE OF MAINE

SUMMARY REPORT

to

NINETY-SEVENTH LEGISLATURE

LEGISLATIVE RESEARCH COMMITTEE

From the Senate:

Samuel W. Collins, Aroostook, Chairman

John H. Carter, Oxford

Miles F. Carpenter, Somerset

Edward E. Chase, Cumberland (Deceased)

Foster F. Tabb, Kennebec (Resigned)

From the House:

Seth Low, Rockland

Earle W. Albee, Portland

Riley M. Campbell, Guilford

George D. Pullen, Oakland

Henry W. Bearce, Hebron

Stanley H. Low, South Portland

Louis Jalbert, Lewiston

Lynwood E. Hand, New Limerick (Resigned)

Director:

Samuel H. Slosberg, Gardiner

December, 1954

To the Members of the 97th Legislature:

The Legislative Research Committee hereby has the pleasure of submitting to you the second section of its report on activities for the past two years. This report deals with the problem of hospital aid. Other reports on matters assigned to the Committee by action of the Legislature will be made at a later date.

The Committee acknowledges with deep appreciation the aid given it by the Maine State Library in getting together the factual information contained in this report.

It is the hope of the Committee that the information contained in this report will be of value to the Members of the 97th Legislature.

Respectfully submitted,

LEGISLATIVE RESEARCH COMMITTEE
By: Samuel W. Collins, Chairman.

TABLE OF CONTENTS

HOSPITAL AID

Table of Contents---Hospital Aid (Continued)

HOSPITAL AID

The Legislative Research Committee voted in September, 1953 to study the problem of hospital aid. To this end a public hearing was held on October 20, 1953, at which time representatives of the State Department of Health and Welfare, the Maine Hospital Association, Administrators of Public Hospitals and Members of the 96th Legislature were present.

The Committee later voted that the Sub-committee on Hospital Aid, consisting of Hon. Seth Low, Chairman, Hon. Riley M. Campbell and Hon. Stanley H. Low, continue the study of the problem. The report of the Sub-committee, presented by the Hon. Seth Low and approved by the full Legislative Research Committee, is herewith presented.

HISTORY OF THE HOSPITAL AID PROGRAM IN THE STATE OF MAINE*

> If a man comes from another state, takes up his residence in Maine, earns $500 a year, and spends it here, then... our state has made a gain of all the work which the man does; and that this benefit is estimated.... at $500 a year.
>
> The present worth, to the state, of a man capable of earning $500 a year forever, would evidently be a sum yielding at average rates of interest $500, or, at 5 per cent, $10,000.
>
> The present worth, to the community, of a man varies according to his expectation of life. If a man will earn $500 for 5 years to come, his present worth is that sum which will exhaust itself in making five annual equal payments of $500, which (if the rate of interest be five per cent) will be $2,142.....
>
> The cash value to the community, therefore, of the surgical or medical aid prolonging the life of a laboring man is readily calculated by well-known algebraic formulae.... if... labor will average $250 a year, and interest....5 per cent...the present worth.. of adding five years to a workingman's life is at least $1,071.... Then it must be remembered that this weighing of the worth of a man simply by his own wages leaves out the view of the worth to his family, and the expense of supporting him if crippled.

This curious evaluation of the worth of a man and a hospital to a community, made in all seriousness by a "highly distinguished gentleman, well acquainted with the labor question in relation to political and social science," appears in the Annual Report of the Directors of the Maine General Hospital for 1879.

*Released June, 1952 by the
Department of Health & Welfare, State of Maine.

During 1879 this hospital accepted 74 persons for free hospital treatment, reporting that most of them were discharged either cured or much improved. The resident surgeon states in this connection that it would have been impossible to have received these patients had it not been for the "liberal grant of five thousand dollars from the state, and private contributions...." The resident surgeon further states regarding free cases:

> Some of them were unmarried men and women without dwelling places, and dependent upon daily work for daily bread. Others and by far the larger part were heads of families, to whom the conditions of health and bodily strength were necessary to enable them to meet the actual necessities of life.
>
> In view of these facts, we ask the many patrons of our institution, and especially our legislators, if the same amount of money could have been more wisely and satisfactorily bestowed, whether regarded in philanthropic point of view, or as an economic investment in the interest of the state.

The five thousand dollar grant mentioned in this report was a regular subsidy by the legislature in aid of this hospital. These grants had been made regularly to this hospital since 1876, and continued until 1929. The Hospital Aid program emerged from these grants. There is apparently no exact time at which we may fix its beginning. Rather this program appears to have come about as a gradual

change in the philosophy of these legislative grants over a period of years.

Hospitals have always regarded themselves as essentially philanthropic rather than business enterprises, and have always maintained free service for those who have been unable to pay. In the beginning Maine hospitals attempted to establish free beds for charity patients. They asked clergymen to hold a "Hospital Sunday", the proceeds of which went to establish free beds, they asked employers to establish free beds for their employees, and asked private persons for donations.

In the meanwhile as new general hospitals were established within the state, the legislature resolved sums of money for them each year. While these funds were a direct subsidy, not given for any stated purpose, both the hospitals and the legislature, as years passed, presumably came to regard them as funds to help the hospitals care for persons able to meet ordinary expenses, but were unable to pay hospital bills. The legislature continued to resolve funds " in the aid", or later "for the maintenance" of specific hospitals until 1917.

By 1917 it becomes apparent that the legislature

considered these funds as a subsidy to the hospitals to help them to care for those persons who were unable to pay, and that they considered the method of direct subsidy for the maintenance of a hospital to be unsatisfactory for this purpose. In the Report of the State Board of Charities and Corrections for the biennium ending in 1917, the Board stated that hospitals were charging lower rates for paupers than for regular paying patients. They suggested that the hospitals charge the same rates for paupers as for regular patients, since their hospitalization was paid from state and local pauper funds, "thereby reserving their charity funds and the appropriations received from the state, for the purposes for which they were presumably given, i.e., the care of those patients who are not already paupers, and who it is expected may be able, by reasons of assistance through charity funds of the institution and the state, to avoid becoming so."

In 1917 the legislature made some significant changes in the method of subsidizing institutions not fully supported by the state. Instead of making a separate resolution for each one as they had formerly done, they made a package resolution of $129,500 to include all of these institutions. $89,400 of these

funds were earmarked in specific amounts for twenty-two hospitals.

A further and more important change was that the money was not given to the hospitals as a lump sum grant as before, but rather was disbursed by the State Treasurer upon the receipt of itemized bills for the treatment of specific persons. The Treasurer might honor these bills only under certain circumstances:

> (1) That the person receiving hospitalization had not received any pauper supplies during the year prior to entering the hospital.
>
> (2) That neither the person entering the hospital nor his responsible relatives as defined by Section 18, Chapter 29 of the Revised Statutes of 1916, had the financial ability to pay for the hospitalization.
>
> (3) That the rates charged for these persons were to be no greater than those charged the general public, and that the rates charged those able to pay no less than the cost of the service rendered.

Persons receiving aid under this plan were not to be deemed paupers. The hospitals were required to submit, along with the itemized bills, evidence of the qualifications of the patients to receive aid. These were examined and approved by the State Board of Charities and Corrections before being submitted to the State Treasurer for payment.

This represents a significant change in the philosophy

of Hospital Aid. The legislature's primary concern at that time as before, undoubtedly was to give aid to the hospitals rather than the individual, but now free care of individuals, within the limits of the appropriation, was the basis of the hospital subsidy.

Hospital Aid continued in this manner until 1929 although the State Board of Charities and Corrections found it unsatisfactory from the first. The Board made the following statement in its report for 1918:

> "Some of the institutions cited in the appropriation and resolve were unable to earn the entire appropriation made for their benefit. This suggests... the advisability of making an appropriation for each class of persons to be cared for, leaving its apportionment to the several institutions to be determined by the State Board of Charities and Corrections according to the amount of work which needs to be done by a given institution.... It may be well also to make the appropriation available to any duly incorporated institution or organization which maintains the standards of care and investigation prescribed by the State Board."

There is also evidence that the hospitals themselves were somewhat dissatisfied with this type of appropriation. Since specific amounts were allotted to specific hospitals, some hospitals carried on a strenuous lobbying campaign for these funds and came away from the legislature with more money than some of the other hospitals whose lobbies were less effective.

This naturally caused the less fortunate hospitals to feel that they were receiving less than they deserved while others were receiving more, since the determination of the funds had no relation to the amount of free service rendered.

In 1929 the legislature undertook to correct this undesirable feature of the old system by passing a private and special act which set up one fund from which all hospitals might draw, rather than making a specific appropriation for each hospital. This fund was administered by the Division of Hospital Aid which the Department of Welfare, formerly the State Board of Charities and Corrections, set up for this purpose. The Division of Hospital Aid authorized the reimbursement of hospitals from this fund on a per diem care basis up to a statutory maximum of $2.50 a day, plus any emergency charges which the Division might approve. The new law further stated that no other appropriation might be made to any hospital not fully supported by state funds, with the exception of Tuberculosis Sanatoriums.

In 1933 this law was made a public law since it had proved advantageous over the four-year period which it had been in effect. This law remained in force until 1943, at which time the statutory maximum per

diem rate of $2.50 a day was removed giving the Department wider powers in the administration of the fund.

The 1929 law provided for a more equitable distribution of funds and was more satisfactory to all persons involved. There remained, however, one difficulty. Due to the large number of applications for Hospital Aid, the $160,000 which the legislature provided ran out in six or seven months and the hospitals received no compensation from the state for the rest of the year. In 1933, after careful study and conference with hospital officials, the Department arranged a new method of distributing payments from the fund. The fund was divided into quarterly installments, and each hospital was reimbursed whatever amount the fund would allow on the basis of the number of free hospital days rendered during the quarter. In this method the fund was stretched out over the entire period for which it was appropriated. This system of disbursement has continued until the present day.

Mr. Ralph Farris of Augusta, the member of the legislature who introduced the public bill in 1933, stated that while the legislature was mindful of the welfare of the individual and felt that this measure would prevent pauperizing these individuals, the main

purpose of the act was to subsidize the hospitals, and to try to pay them for actual services rendered. The Department, however, makes individual consideration of the worthiness of each case to receive the aid, and the individual case is the basis upon which the hospital is paid.

In January 1947, the Division of Hospital Aid was taken from the Bureau of Social Welfare and incorporated into the Division of Hospital Services in the Bureau of Health.

APPROPRIATIONS FOR HOSPITAL AID IN MAINE, BY FISCAL YEAR

1929-1952

Fiscal Year	Appropriation
1951-1952	$ 800,000
1950-1951	1,000,000
1949-1950	578,000
1948-1949	578,000
1947-1948	578,000
1946-1947	288,000
1945-1946	288,000
1944-1945	288,000
1943-1944	288,000
1942-1943	300,000 1/
1941-1942	300,000 1/
1940-1941	300,000 1/
1939-1940	300,000 1/
1938-1939	300,000 1/
1937-1938	200,000 1/ 2/
1936-1937	200,000 1/ 2/
1935-1936	200,000 1/
1934-1935	200,000 1/
1933-1934	160,000 1/
1932-1933	160,000 1/
1931-1932	160,000 1/
1930-1931	160,000 1/
1929-1930	160,000 1/

1/ Administrative expense deducted from appropriation prior to July 9, 1943.
2/ $4,000 deducted from this appropriation and transferred to General Account of State.

RECOMMENDATIONS BY LEGISLATIVE RESEARCH COMMITTEE

The availability of hospital care for all Maine people whose health can be materially improved by treatment by a physician in a hospital is essential to the general welfare.

At the present time, however, about 15% of all patients hospitalized in the general hospitals of Maine are indigent as far as paying their hospital bills are concerned. Doctors render services without charge to these patients. The State pays approximately 55% of the hospital cost of these patients, LEAVING IT TO THE HOSPITALS TO ABSORB THE REMAINDER BY HIGH CHARGES TO PAYING PATIENTS. While Blue Cross has been beneficial to hospitals and patients alike, its growth has tended to restrict the number of "paying patients" to whom higher than cost rates could be charged. An increasingly smaller percentage of the patients in the hospitals, therefore, are being, in effect, taxed to pay for the medically indigent. The rates charged to this class of sick people have already reached the point of diminishing returns, and are a serious problem to many families which are normally self-supporting. If they rise more, many families will be forced into the position of being medically indigent. This would be a great

disadvantage to them and to the community in which they live.

We believe that it is completely and wholly unfair to put the burden of the nonpaying patient on those who do pay. To the great majority of people, sickness is a major disaster which should not be augmented by having to assume somebody else's burden.

A hospital, like any other public agency, must manage to pay its bills in some way. When income is inadequate and cannot be increased in a given period of operation, costs must be curtailed. When this occurs, the hospital is forced to adopt such policies as neglecting the maintenance of buildings and equipment, failure to employ sufficient numbers of skillful personnel, failure to provide the services the patients need, failure to institute new and beneficial services or even restriction of the supply of drugs and food available for patients. Therefore, the occurance of a financial deficit in the operation of a hospital represents not only some threat to its continued operations, but also a relatively serious impairment of its services to the sick members of the community.

In spite of considerable effort made by the hospitals, there is reason to believe that a substantial number of indigent Maine people do not get admitted to hospitals

when they need it. Therefore, they must accept suffering, disability and even death that could have been avoided by treatment that could only be carried out in a modern hospital.

The Research Committee draws the conclusion that it is the responsibility of the community in which the patient lives to provide hospital care for the indigent which they clearly need and which can be materially beneficial to them. This responsibility should be discharged by the smallest unit that can effectively do so. But in Maine even many counties are so small in population and poor in per capita taxable wealth that they cannot effectively discharge this responsibility. Therefore, the state should continue to assume part of this responsibility and should establish an equitable state-wide program. In this program, the counties and the state should share the financial load.

Such a program is outlined in this report and is strongly recommended.

1. The State of Maine should continue to assume part of the responsibility of seeing that hospitalization is equally available to all indigent sick and injured Maine people who can be helped by such treatment.

2. To discharge this responsibility, the Legislature should establish a Program for Indigent Hospitalization to be financed by state funds on the basis of matching

by counties in such percentage as the legislature shall determine.

3. The program should be based on the expectation that the medical professions will volunteer to provide the professional medical services these indigent patients need while in the hospital without cost to the program or to the patient.

4. The program should also be based on the principle of paying such costs to each participating hospital for each indigent patient under the program so as to obviate the necessity of hospitals subsidizing the program.

5. The Program for Indigent Hospitalization should be designed and administered to pay the cost of hospitalization for those citizens who are sick or injured and who can be markedly helped by definitive treatment in a hospital, and who are clearly unable to meet all or part of the full cost from their own resources or those upon whom they are legally dependent. It should not be burdened by attempting to provide purely domiciliary or nursing care for citizens with chronic, permenently disabling illness, or illness already cared for by special programs of the State.

6. The determination of financial eligibility should be made by or under the direction of a committee in the county in which the patient resides. This committee should be made up of representatives of the county government, the general public and the medical professions. Their determination shall be final, except that upon appeal of either the patient or the hospital the Commissioner of Health & Welfare shall review their findings. In this event, his decision shall be final.

7. The legislature should designate the Department of Health & Welfare as the agency to administer the Program of Indigent Hospitalization.

8. The program should include an Advisory Committee made up from citizens representing the interests of Hospital Trustees and Administrators, the Medical Professions and the General Public. It should be the duty of the Advisory Committee to make a detailed study of the operation of the program to the end that it can advise means of improving the program and can make recommendations through the Governor to the

legislature on the size of the appropriation in future biennial periods.

9. The program should be confined to hospitals licensed by the Department of Health & Welfare.

10. The Department of Health & Welfare should be given the authority and responsibility of establishing detailed rules and regulations which will govern the operation of the Program for Indigent Hospitalization, so that it conforms with the intent of the legislature. At the request of the Commissioners of any County or of the Governing Boards of the Maine Hospital Association or the Maine Medical Association or the Maine Osteopathic Association or the Maine Osteopathic Hospital Association, the Governor and Council shall hold a hearing to determine whether such rules and regulations truly express the intent of the legislature. Their decision as to this intent shall prevail.

11. The Department of Health & Welfare should establish and publish procedures and policies to guide the local county committees in the determination of financial eligibility under this program, but the actual determination should be made in and by the citizens of the county in which the patient lives.

12. To insure accurate and fair determination of full costs in the hospitals, each hospital should be required to keep comparable records of account in a manner specified by the Department of Health & Welfare, to hold these accounts open to auditing by the Department of Health & Welfare and to submit such reports as the Department shall require, or be required to accept a minimum rate fixed by the Department.

13. The program should also be administered in such a way as to provide hospitalization in whatever participating hospital can most effectively render the treatment the patient needs without regard to the county in which the hospital is located.

14. No part of the state appropriation shall be paid to hospitals in counties which do not match the state fund in the established percentage.

15. It is suggested that the State be authorized and empowered to apply for available matching Federal funds for hospital aid to the end that

State and County funds will be greatly augmented for the program of hospitalization for the indigent.

STATE AND LOCAL PROGRAMS FOR MEDICAL CARE OF THE INDIGENT AND MEDICALLY INDIGENT *

ALABAMA

Alabama does not have a state-wide indigent medical care program. By law, the governing body of any county or city in Alabama may make appropriations out of its respective treasury to aid in caring for sick and wounded persons in hospitals when they are unable to provide for themselves. However, Birmingham and Mobile have established charity hospitals, including the usual out-patient services. Montgomery maintains a staff of part-time physicians to handle the medical needs of the indigent, and the city provides hospitalization when such is indicated. Huntsville and Madison counties make monthly contributions to the Huntsville Hospital where the indigent receive care.

ARIZONA

Under present law in Arizona, "The boards of supervisors in each county of the state shall have the sole and exclusive jurisdiction to provide for the hospitalization and medical care of the indigent sick in such

*Released in 1950 and revised in August, 1953 by Council on Medical Service of the American Medical Association.

county, except in the case of the state welfare sanitarium which shall be operated solely by the state board of social security and welfare."

Each county is authorized to include an estimate of the costs of these services in its annual budget and raise the money by taxation upon real and personal property.

The largest political unit in Arizona is Maricopa County. Here, the indigent medical care program is under an appointed County Physician who is also Medical Director of the County Hospital. The entire financial responsibility is borne by Maricopa County.

Eligibility is determined by investigators appointed by the County Board of Supervisors. The program includes the indigents who have resided in Arizona for one year, the medically indigents, and private hospital patients who exhaust their financial resources. Eligible patients are entitled to unlimited medical care in the County's clinics and to surgical care, hospitalization, drugs, X-ray and laboratory work. Dental care is limited to extractions.

The patient does not have free choice of physician but is treated by one of the county physicians who determines need for medical and hospital care, prescribes drugs,

and makes referals to specialists when necessary. Most county physicians are reimbursed by salary. Specialists, when needed, are reimbursed on a fee-for-service basis, with the fees being agreed upon by the Medical Director and the specialists.

In 1949, 38,969 patients were seen in medical clinics, 4,471 in special clinics and 3,649 in the emergency room of the hospital. Total patient visits were 47,089 which do not include visits for drug refills or injections. Patient days paid for by the County amounted to 5,549 in private hospitals, 18,688 in the Tuberculosis Sanitarium, 71,069 in rest homes, and 82,617 in the County Hospital.

ARKANSAS

Each year the state appropriates a sum to be used for hospitalization of welfare recipients. Hospitalization is limited to twenty-one days, and the individual must be certified by the State Welfare Board. The indigent patients may be treated by their own physicians, provided these physicians make no charge for their services since no money is appropriated to pay for physicians' services. The Arkansas Cancer Commission has developed a special diagnostic program for the indigent. The Commission pays for transportation to one of seven free diagnostic centers and will pro-

vide twenty-one days of hospital care and treatment. The family physician certifies the necessity of examination.

CALIFORNIA

The laws of the State of California place the burden of providing medical and hospital care to indigents on the counties themselves, and each county in California makes its own arrangements for giving such care. In practically every county there is a county hospital or, if one is lacking, adequate provision is made for caring for county indigents in other institutions. The county hospitals in the more populous counties are staffed by either the medical schools or by volunteers working through a blanket arrangement between the county medical society and the county hospital. These hospitals maintain residents or interns, where they are approved, and in some cases even the unapproved hospitals have resident physicians employed on a full-time basis.

In the less populous counties, the usual system is for a physician to be named as medical director of the hospital and probably also as county health officer. He is required to provide the medical care necessary and in some instances he may be permitted also to do a private practice from his hospital office.

In Alameda County, the Board of Supervisors has established an Institutions Commission. The Commission appoints a physician as County Medical Director who has complete supervision of the program. The County Health Officer is responsible to the Medical Director. Indigent patients are cared for by interns, residents and county physicians. Members of the medical society serve gratis on the visiting staff in the county hospitals and clinic. The program is supported almost entirely by local funds although some state, federal and private aid is utilized. Eligibility is determined by the Social Service Department of the Institutions Commission with the following as a guide:

> "A person shall be considered indigent when neither he nor his responsible relatives can provide the medical care that he needs without depriving themselves or their responsible relatives of the basic necessities of life."

State law also requires three years residence in California as a condition of public medical care--this requirement is waived in cases of acute medical emergency.

Persons eligible receive unlimited medical care in the county's clinics as well as hospitalization, dental and nursing services, and drugs. Home calls are made by the salaried county physicians. Patients are assigned to members of the medical staff who are appointed and supervised by the medical director. Need

for medical and hospital care and drugs is determined by the physician, and drugs are dispensed at the county pharmacy. In 1949, 17,503 in-patients and 139,129 out-patients were cared for. In-patient care in general hospitals averaged $13.63 per patient day. The Alameda County Medical Association takes responsibility in insuring the availability of medical care in those cases which for one reason or another are ineligible for public care. Such cases are handled on an individual basis and are referred to members of the Association for care with payment according to their social and economic situation. For example, some indigents requiring medical treatment, who are ineligible because of lack of legal residence, are referred as free cases to private physicians after discussion with and full acceptance by the physician. Through cooperation of the Medical Association and the county institutions, patients ineligible for county care because of their financial margin,but unable to afford usual fees for care, are referred to private physicians on a part-day basis.

In Fresno County, indigent medical care is provided under the County Hospital Program administered by the County Board of Supervisors. The program is supervised by a Medical Director and is served by the staff

of the County Hospital. Members of the medical society compose the voluntary staff of the hospital. Financial support is derived largely from local tax funds. Of the total budget, 93 per cent is local, 4 per cent is state tuberculosis subsidy, 1 per cent is federal grant for crippled children's service and 2 per cent comes from the National Foundation for Infantile Paralysis and from private sources. Eligibility is determined by the Director of Welfare, and, except for contagion, emergency and mental cases, only the indigent are included. Medical and hospital services are unlimited, but certain qualifications are placed on nursing and dental services and drugs. Patients have free choice of physician in home care, but not for clinic or hospital care. Need for medical care is determined by private physicians, staff doctors and public health nurses. The approximate number of patients cared for per year is 12,000 in-patients and 80,000 clinic visits including repeats.

Kern County cares for its indigent and medically indigent through the county hospital. The screening of indigents is carried on through the county welfare department. Members of the county medical society provide medical care on a visiting staff basis without charge for their services.

In Los Angeles County, the indigent program is administered by the Department of Charities which serves as the official welfare department. Officers of the medical society serve on the advisory boards of the three general hospitals; 1,200 members of the attending staffs of these hospitals give their services voluntarily; and 564 panel physicians, providing home and office care, are on a fee-for-service basis. Patients do not have free choice of physician. The Visiting Nurses Association makes visits to the medically indigent on a fee-for-service basis. The program is supported by county tax funds, although some state aid is utilized in the tuberculosis and physically handicapped children programs. Eligibility is determined by the Bureau of Medical Social Service and includes the individual unable to finance his particular medical problem. The need for medical and hospital care and drugs is determined by the attending staff or panel physician. All services except dental are unlimited. The latter covers only extractions. The panel physicians are paid on a fee-for-service basis; the consulting staff on a per capita basis; the house staffs are paid a salary; and the attending staffs give their services gratis. Figures for 1948-49 show 2,900,000 hospital patient days, 460,000 out-patient clinic visits, 220,000 outside medical relief visits,

and 16,000 visiting nurse calls at a total cost of $25,467,000. Average costs per patient day in the hospital were $10.60 for adults, $5.91 for tuberculosis and $3.41 for chronic cases.

In Sacramento County the Board of Supervisors and Medical Superintendent of the County Hospital administer the program. The members of the Medical Society on the hospital and clinic staffs determine the need for medical and hospital care and drugs. Eligibility is determined by the social service division of the welfare department. Unlimited medical and hospital service is available, but nursing and dental service and drugs are restricted. There is no free choice of physicians. The resident staff is salaried, and other participating physicians serve gratuitously. The approximate cost per patient per year averages $10.00, and from 5,000 to 10,000 patients are served.

The program of San Bernardino County operates under the Board of Supervisors with the head of the welfare department and the Superintendent of the County Hospital cooperating in administration. Unlimited services are available, and the program operates much as do the others in California. The approximate average cost per year is $1,500 for care of the indigent in remote districts and $800,000 to operate the County

Hospital. This includes 4,000 bed cases at $9.00 each, totaling $360,000, and 20,000 clinic patients at $2.40 each, costing $480,000.

In San Diego County, as elsewhere, a county hospital is maintained through local taxes and is under the direction of a medical superintendent who reports to the County Board of Supervisors. Eligibility is determined by a Social Service Department at the hospital, and both indigents and those medically indigent are included. Patients at the hospital are allowed unlimited in-hospital services. Out-patient service is limited to those who can come to the hospital for their visits. Approximately 10,000 in-patients receive care each year. Their average stay is twenty-five days at a cost of $10.00 per day. Fifty thousand out-patient visits per year are made to the hospital at an average cost of $3.00 per visit. The staff physicians contribute their time without pay.

Medical assistance in San Mateo County is administered by the Director of Public Health and Welfare. The County Board of Supervisors provides hospital and clinic facilities for medical care of persons who are not financially able to provide same for themselves or dependents. Policies concerning eligibility for

medical care are formulated by the Superintendent of Social Service and put into effect by the Director of the Department of Public Health and Welfare with the approval of the Board of Supervisors. Generally speaking, all applicants who are unable to meet the cost of necessary private care are eligible. The Medical Welfare Section of the Social Service Division has full responsibility for making investigations and determining eligibility.

Eligible patients are admitted to the Community Hospital or treated in the out-patient department. Medical care is provided entirely by the good will of the physicians who volunteer their time. Patients are attended by the physician on duty at the time. The dental profession provides one afternoon clinic for dental surgery only. Visiting nurse service is available when authorized. Drugs are dispensed by the hospital or by a local pharmacist who is reimbursed by the county. Principal financial support of the program comes from local funds. State and federal aid supplement local funds for special categories.

COLORADO

Colorado has no definite state-wide indigent medical program, either governmental or under the medical society or other voluntary organization. The nearest

approach to a state-wide program is that of the Colorado General Hospital, which is the major teaching hospital of the medical school and which is authorized by law to act as a county hospital for any counties which do not maintain their own hospitals. Such counties can, with appropriate medical authorization, send patients to Colorado General Hospital, paying a nominal per diem for the care of the patients while hospitalized.

CONNECTICUT

The Welfare Department of Connecticut furnishes complete medical care for some 31,500 State supported beneficiaries, and reimburses the towns on a percentage basis for their medical care of resident paupers. Private and town welfare agencies supply the needs of the medically indigent. The Department's policy is to provide the best possible medical care, administered on an individual rather than a group basis, at a cost which is fair to the practitioner, the institution, the vendor and the taxpayer.

The Commission for the Chronically Ill, Aged and Infirm was established by statute to provide long-term definitive medical care, over and above that furnished by general and convalescent hospitals. It stresses rehabilitation in the broadest sense through more compre-

hensive facilities for physical medicine and retraining than exist elsewhere in the State, and includes among its objectives "preventive welfare", especially for the older age group with its high incidence of disease and disability. It operates one hospital as a complete restorative center, maintains chronically ill and rehabilitation services in the State Veterans Hospital and a State-aided voluntary hospital, and makes grants to certain other institutions in aid of rehabilitation programs. It serves the State's indigent primarily, but is available to the beneficiaries of towns and counties when its special facilities are needed. Its activities are supported entirely by State funds.

The State Education Department's Bureau of Rehabilitation is designed to restore working usefulness to the physically and mentally handicapped who can reasonably be expected to profit by its aid. The program provides necessary medical, hospital, counselling and guidance services, prostheses, vocational training, maintenance during rehabilitation, necessary tools, equipment and licenses for employment, placement in suitable occupation, and follow-up to determine adequacy of the service rendered. The Bureau works closely with the Welfare Department in care of the indigent, and it

integrates counselling, guidance, special training and job placement with the rehabilitation services of the Commission for the Chronically Ill.

The State Veterans Commission operates in connection with its home for indigent veterans a 500-bed general hospital, 70 beds being allocated to the rehabilitation program of the Commission for the Chronically Ill. In addition to a full-time resident staff it employs visiting physicians and specialists on a part-time basis, and medical, surgical and rehabilitation services are available to all patients. This hospital serves the Welfare Department and other State agencies when its special facilities are required.

Partial costs of care in State mental hospitals, schools for the mentally defective, tuberculosis sanatoria and other institutions are defrayed by patients and families financially able to do so, and certain State services are subsidized by Federal reimbursement through usual statutory channels, but of the total cost of medical care for its indigent, the major part is borne by the State of Connecticut.

DELAWARE

Delaware does not have a state-wide program, nor do any of its three counties have an indigent medical care program. The city of Wilmington, however, does operate

a home care program under the supervision of the Board of Health. Care is provided by two physicians employed by the city and includes necessary drugs and appliances. Hospital care is provided throughout the state by both county and state funds.

Chronic illness patients are cared for by state funds in the State Welfare home and at the Governor Bacon Health Center. The program at the Welfare Home is supervised by a special commission; the Governor Bacon Health Center program is under the Trustees of the Delaware State Hospital.

Tuberculosis and venereal disease programs are administered by the State Board of Health which maintains Brandywine Tuberculosis Sanatorium and venereal disease clinics at several of the hospitals.

The Crippled Children's Service is carried on in conjunction with the Alfred I duPont Institute.

FLORIDA

There is no state-wide medical care program in Florida. Indigents are cared for by the cities and counties in various ways.

The Health and Welfare Program of Miami and Dade County operates with the cooperation and approval of the County and State Medical Associations. The Home

and Hospital Committee of the Dade County Board of Commissioners supervises health and welfare activities and the county hospitals.

The county maintains two hospitals, one of 175 beds known as the Dade County Hospital, and a large general hospital in Miami, the Jackson Memorial Hospital. Clinics for indigent patients are operated at both of these hospitals and at a few other points in the county.

Services for crippled children, those with defective vision, with or suspected of having cancer, and those under the State Vocational Rehabilitation Program, are arranged directly between the state agency or its county or district unit and the hospital. These programs depend largely on Jackson Memorial Hospital to provide service. The recently opened Variety Children's Hospital is taking part of the local work under the Crippled Children's Commission.

All of these programs have separate medical directors, medical advisory committees, boards of directors including licensed physicians, or, as in the case of those coming under the health department, the organized supervision of that department.

Local financial support is derived through a levy on

real estate and personal property. This levy pays in full for indigent and welfare activities of the county. Hospitals are compensated in large part by state appropriations in support of Crippled Children's Commission, Council for the Blind, and Cancer Control Programs. The state takes advantage of all moneys available through federal appropriations for the support of health, hospital, and welfare activities.

Persons eligible for medical care are all individuals, residents of the County for at least one year, who are financially unable to provide their own medical care. Eligibility rules are applied with considerable leniency. Patients are certified for out-patient care and admission to County Hospital by the County Social Service Department. At Jackson Memorial, ability to pay is determined by the admitting office.

Medical and hospital services are unlimited. Dental care is restricted to surgery and replacement of dentures for adults. A preventive dentistry program is operated in connection with the public schools. Public health nursing is provided by the county health department, and limited visiting nurse service for indigents is provided by the local Community Chest. Drugs are unlimited for indigent patients and are provided by county funds.

Need for medical and hospital care and drugs is determined by resident and attending physicians in out-patient clinics and by resident and attending staffs in the hospitals. Choice of physician is restricted to those on duty in these capacities. Most of the service to in-patients and out-patients is done on a voluntary basis by members of the attending staff. Other participating physicians are on a salary basis.

The approximate average cost for indigent patients is $16.54 per diem based on 92,488 hospital days. The program includes approximately 140,000 out-patient visits and 15,000 in-patient admissions per year.

GEORGIA

(No reply)

IDAHO

In June, 1949, the House of Delegates of the Idaho State Medical Association assigned the problem of studying public assistance to its Legislative Committee. This Committee prepared a questionaire which was sent to all of the county physicians in the state and which requested specific information as to how county programs of providing medical and hospital care to indigents and the aged were determined. The Legislative Committee request that this program be

assigned to a special committee which is known as the Advisory Committee for the Care of the Indigent.

ILLINOIS

Illinois has a state-wide public assistance program which includes: recipients of old age assistance; aid to dependent children; aid to the blind; as well as public assistance cases and the medically indigent. A medically indigent person is defined as:

> "Any person not otherwise eligible for or receiving general assistance".... who "shall fall sick or die not having sufficient money, property, or other resources, including income and earnings available to him over a twelve-month period, to meet the cost of necessary medical, dental, hospital, boarding or nursing care, or burial...."

The program is authorized by state law and was developed about 1940 through the cooperative efforts of the Illinois State Medical Society and the Illinois Public Aid Commission.

State and county medical advisory committees are appointed by the medical societies. The State Advisory Committee assists and guides the Illinois Public Aid Commission in establishing policies, rules and regulations and fee schedules. At the county level, the program operates through county branches of the Public Aid Commission and county advisory committees.

Eligibility is determined by the Public Aid Commission's local branches and the medical advisory committees.

Medical, hospital, dental, and in-hospital nursing services and drugs are unlimited except where lack of funds may curtail hospital services. The patient has free choice of physician, and the attending doctor determines need for medical and hospital care and drugs, subject to review and correction by the County Medical Advisory Committee. In most cases, physicians are paid by the patients on a fee-for-service basis approved by the state medical society.

The total program is supported about 50 per cent by federal funds with the remainder, including all hospital care, coming from state funds.

INDIANA

In Indiana the township trustee is the overseer of the poor. Money to provide for the poor is raised through a special tax levy for "poor relief". The township trustee, often aided by an advisory board, doles out this relief in the form of purchase orders. For the most part, the trustee selects the physicians to care for indigents and pays them direct. The trustees have sole authority to determine who and how much, except in cases needing hospital care.

The county welfare departments are given the responsibility for hospitalization of the indigent. These departments determine by a means test which individuals

are entitled to hospitalization at the taxpayer's expense and pay for all care authorized. This care is provided through local hospitals and the Indiana University Medical Center. In cases where the county welfare departments provide medical care to recipients of public assistance, the participating doctors are paid direct by the welfare department. These funds, in most cases, come jointly from the county, state and federal governments. Each county develops its medical care plan subject to the approval of the state welfare department.

The medical care program in Lake County is administered by the county medical society's Reviewing Committee in cooperation with the medical division of the welfare department. The welfare department reviews all claims from the administrative standpoint, does the paper work and pays the bills. Eligibility is determined in the case of public assistance recipients by the welfare department. Other indigents are certified by the township trustee. The medical society's Reviewing Committee determines fees and reviews all claims in accordance with the fee schedule. It also reviews cases of prolonged hospitalization. Participating physicians sign an agreement to accept any patient under the program and to abide by the fee schedule. About 98 per cent of the medical society

members participate.

This program is supported by county funds except in the case of specific categories for which state grants are available. Eligible patients have access to unlimited medical, hospital, dental, and nursing care. The new and more expensive drugs are not included. The patient has free choice of physician, and the attending doctor determines need for care and drugs. Physicians and pharmacists are paid direct from welfare funds. The average cost per patient per month is $16.50, and approximately 13,000 patients are cared for per year.

The medical care program in St. Joseph County is under the township trustees and Director and Board of the County Department of Welfare, with eligibility being determined by either group. The county medical society determines the fee schedule, and its members provide necessary services. The city and county health departments provide visiting nurse service. The Children's Dispensary, Polio Foundation, Tuberculosis League, Crippled Children and Crippled Adult Societies also participate in the program.

Fifty per cent of the financial support comes from local funds, 40 per cent from the state and federal government, and 10 per cent from the Community Chest.

Unlimited medical, hospital, dental and nursing services and drugs are available to eligible patients. The patient has free choice of physician and the doctor in attendance determines need for medical and hospital care and drugs. Fees and drugs are paid direct to physicians and pharmacists out of the welfare funds. There are 500 to 525 eligible persons in St. Joseph County. The average cost per eligible person is $45 per year, and the cost per patient is $350.

IOWA

In Iowa the program of medical care for the indigent is carried out on a county basis and has been in operation for twenty years. The county medical societies make contracts with the county boards of supervisors for care of the indigent and medically indigent. Ordinarily, the supervisors place a given amount per month per person on relief in a fund, and this is paid in each month to the medical society. Calls to the doctor are authorized by the director of relief or a relief office. The patient is cared for by his own doctor, and physicians submit their bills to an auditing committee of the county medical society. Payment is then made by the medical society from the fund on a pro-rata basis when necessary.

The indigent program in Polk County is operated through working agreements between the Board of Supervisors and the Polk County Medical Society, acting as the agent for its members. Any medical society member may participate in the program by designating the society as his agent. Medical care (non-hospitalized) is authorized by the Director of the Welfare Division. The attending physician submits a complete report on the authorization form which then serves as a claim for the doctor's fee. The county pays the medical society for all allowed claims and the society pays the physicians. County patients eligible for medical care under this agreement include all persons having legal settlement in Polk County and who are supported in whole or part by the county, and non-residents who become charges of the county, except those actually confined in Broadlawns Hospital, beneficiaries of the Polk County Soldiers Relief Commission, and inmates of the Polk County Home. Doctors are assigned to care for patients at the County Jail and inmates of the Juvenile Home on a rotating basis, and a doctor is employed to care for the inmates of the County Home.

The general department of Broadlawns Polk County Hospital cares primarily for indigents who have legal settlement. The Medical Society has an agreement with

the Board of Trustees to staff the hospital and care for indigent patients on a voluntary basis.

KANSAS

There is no state-wide program in Kansas for medical care of the indigent and medically indigent. In Butler and Cowley Counties identical programs have been operated by the County Medical Societies for about eight years. The two County Societies have the same executive secretary who supervises both programs. The public health departments participate by furnishing immunizations and home nursing care. The county welfare departments supply the funds to pay for care and determine eligibility. The program is supported entirely by county funds. Persons receiving public assistance and the medically indigent are eligible for care. The program is operated on the order of a prepayment insurance plan, and provides complete hospital and medical service and drugs. Patients have free choice of physician, and the individual physician determines need for hospital and medical care and drugs. The medical societies receive $5.25 per case per month, and a case may be one or more depending on the family unit. The society pays for hospital care and drugs out of this fund as well as the physicians' fees which are set by the medical society. Any balance in the fund at the end of each month is divided among the physicians on the basis of

number of cases seen. Butler County cares for about 6,300 patients per year and Cowley County for about 8,400.

The present plan for care of the indigent in Sedgwick County (Wichita) has been in effect since 1932. Patients are cared for in several out-patient departments and are hospitalized in the county hospital. Services are provided by a rotating staff composed of members of the Sedgwick County Medical Society. This staff is appointed by the executive council of the Medical Society and represents the specialties as well as general practice and serves without pay. Each doctor serves for a period of two to six months without personal remuneration. The welfare board pays $500 per month to the Medical Society, and this is used partially to finance the Society's activities.

The Medical Society and the Community Chest of Wichita also operate a Medical Service Bureau which screens borderline indigents with the idea of establishing the opportunity for and incentive in these people to pay something for services they receive and possibly to assist in keeping them off the welfare rolls.

The Indigent Medical Care Program of Shawnee County also operates on the order of a prepayment plan,

furnishing medical care, hospitalization, surgery, drugs, medical appliances and dental care. It is administered by a Medical Service Board elected by the Medical Society, with the executive secretary serving as administrator. The public health department participates by providing clinic space and personnel and some dental and nursing services. The welfare department determines eligibility and reimburses the medical society a specified sum ($3.30) per eligible person per month. The program is supported by the welfare and public health funds made available through local taxation and state and federal grants. Patients have free choice of physician except in clinics. The attending physician determines need for services and drugs, and all drugs are paid for out of the fund. Physicians are also compensated from the fund according to a fee schedule set by the Medical Service Board. Under the program approximately 550 patients are cared for per month out of 3,000 eligible persons. The average cost per patient per month is about $18.

KENTUCKY

Kentucky does not have a state-wide program for indigent medical care. With the exceptions of tuberculosis, mental health, and similar accepted state services, indigent care is handled on an individual

basis by each county.

LOUISIANA

Louisiana has no state-wide indigent medical care program. However, in various centralized areas of the state, hospitals have been erected for the purpose of providing medical and surgical care to the indigent. State laws have been passed defining indigency and giving certain limits of income to be used as guides by the officials of the hospital in accepting or rejecting applicants for service. People who are ill are picked up by state ambulances and carried to the state hospitals in their respective districts. This form of state responsibility for the care of indigent and medically indigent started around the year 1780 when the first unit of the State Charity Hospital was constructed in New Orleans. The State Committee on Hospitals, employed by the Governor of Louisiana and composed by both lay and professional members, supervises the program. The State Medical Society has a committee which acts in an advisory capacity to the State Committee on Hospitals on matters of procedure and proper care for indigent patients.

Local doctors determine the care and type of drugs to be administered only until the patient is admitted

to a hospital as an indigent. If the patient is dissatisfied with the physician assigned to him in the hospital, he may make proper application to the superintendent, and a change will be made. Hospital physicians are paid on both a salary and fee-for-service basis. The pay basis is predicated on the action of the Committee on Hospitals and is determined by prevailing prices for sick services in the community where the hospital is located. Physicians receive their fees from the hospital funds.

Institutions are erected when the need for such is shown in some locality and when State finances permit. Under certain circumstances private hospitals in the state may accept indigent patients and be reimbursed for such services by the State Hospital Committee.

MAINE

Maine has no organized state-wide program for medical care of the indigent and medically indigent. These people receive the usual free medical care provided for indigents by individual doctors, and free clinics are available in some of the hospitals. For the most part, medical care for the indigent is furnished by the municipalities as pauper aid. Under the law, if it is a state pauper case, the municipality of the patient's residence provides him with medical care and

is reimbursed by the state. Many of the cities furnish medical care through a part-time salaried physician. Smaller towns use a fee-for-service system. In most cases choice of physician is restricted.

A state-aid system for providing hospitalization does exist, but because of limited appropriations from the State, this program has been curtailed. The result has been that hospitalization is also furnished largely as pauper aid under a program similar to that for medical care.

MARYLAND

The Maryland Medical Care Program was authorized by the enactment in 1945 of a state law providing for a program of medical, hospital, nursing, and dental care to indigents and medical indigents. The program was planned and recommended by a Committee on Medical Care within the State Planning Commission which represented the professional and lay health and welfare groups. This Committee was instigated by the Medical and Chirurgical Faculty of Maryland.

The overall program is administered by the State Department of Health with the State Council on Medical Care acting in an advisory capacity. It is composed of fourteen members representing the organized medical,

hospital, pharmaceutical, dental, and nursing professions, the two medical schools, and other groups. In each county there is a full-time medical health officer responsible for administration at the county level. Each county has a lay-professional advisory council similar to the State Council on Medical Care. The welfare department is represented on the advisory councils and certifies public assistance recipients for medical care. The medically indigent make application to the county health departments and are certified by the health officers. Identification cards are issued every six months to all eligible persons.

Services available include unlimited medical and in-hospital service and drugs, out-patient diagnostic service, dental fillings and extractions, and dentures in some cases. Nursing service is limited by the number of public health nurses.

Patients are cared for by their private physicians and dentists, and are hospitalized in chronic disease and general hospitals. Over 1,000 physicians have participated in the program. They receive payment from the fund on a fee-for-service basis. The fee schedule is approved and recommended by the State Council on Medical Care. Drugs prescribed by attending physicians are also paid out of the fund. The

program is supported entirely by an annual state appropriation, amounting to $540,000 in 1948.

Supplementing the medical care program in the 23 counties of Maryland, the Baltimore City Medical Care Program, inaugurated in 1948, provides ambulatory clinic and private physician home and office care for the 28,000 persons receiving public assistance in the city. This work is financed by state appropriations made available through the State Department of Health to the city and administered by the Baltimore City Health Department. Traditional hospital and out-patient services continue as in past decades, supported by local tax moneys, private funds, or state subsidies.

The new medical care program in Baltimore differs from its counterpart in the counties chiefly in three ways. In the city,

(1) specially organized medical care out-patient clinics in six hospitals are paid by the City Health Department, under contract, on a per capita basis, $10 per year, for each of the 28,000 odd persons receiving public assistance from the City Welfare Department.

(2) Private physicians, often those who have no hospital privileges, and who may work and consult with these new medical care clinics, are paid $7 per capita per year by the City Health Department to give home and office care to these same persons, whether they are sick or well. In contrast, in the counties of Maryland payment to physicians for the care of the sick is on a fee-

for-service basis.

(3) so far, in Baltimore, the program is limited to persons receiving public assistance, whereas in the counties, in addition to serving such persons, about one-third of the funds now being spent go for the medical care of medically indigent persons, not poor enough to receive public assistance.

In Baltimore, following the county pattern, approved drug bills for persons within the program are paid directly by the Health Department to the neighborhood druggist.

MASSACHUSETTS

The program in Massachusetts for providing medical care to the indigent and medically indigent is part of the general public assistance program which has been in operation in one form or another since 1864. It was originally under the State Board of Charities, but in 1919 this responsibility was delegated to the Department of Public Welfare. The program is authorized by the Acts and Resolves of the General Court of Massachusetts. The local boards of public welfare of the 351 cities and towns administer the program. The State Department of Public Welfare is an administrative and supervisory body which functions mainly through its seven district offices. The Medical Society serves in an advisory capacity, and its component district societies are on a consultative basis to the local boards of public welfare.

Eligibility is determined by the local boards of Public Welfare and both the indigent and medically indigent are included. Five years local settlement is required by the cities and towns for general relief. Those without required residence are classified as unsettled and are the responsibility of the State. The eligible patients are provided medical, dental, out-patient, and nursing services and drugs. In-hospital service, including professional costs, is limited by statute to $10 per day. Patients under Old Age Assistance have free choice of physician by state law, and fees are paid direct to the recipient of care. Whether there is free choice for other classes of patients is indicated by local programs. For the most part, these are cared for by city physicians who are on a salary basis. Old Age Assistance and Aid to Dependent Children recipients receive extra grants for necessary drugs, and general relief patients are usually required to get theirs from a city dispensary.

The program in Essex North District is administered by the Committee to Cooperate with Public Welfare Departments. It operates as part of the state-wide program. All classes of patients have free choice of physician. The physician receives $2.00 for office calls and $3.00 for house calls and is paid by the patient who in turn receives the amount from the local government. Fees

are determined in general by the State Medical Society after conference with the District Committee.

The program in Hampden District is administered by the Hampden District Director of the Massachusetts Department of Public Welfare and operates after the same general pattern. Recipients of general relief and dependent children are limited in free choice of physician. Fees are based on prevailing local rates, and for general assistance cases, physicians are paid direct by the fund. Approximately 8,864 patients are cared for per year at an average cost of $5.00 plus.

In Worcester District, the local city or town welfare boards administer the program. A city physician is appointed for Worcester to serve as advisor to the medical activities of the local board. Free choice of physician is limited. Physicians are compensated on a fee basis established by the local Board of Public Welfare. They receive their fees directly from the fund. Approximately 1,600 patients are cared for per year at an average cost of $75 per patient and $16 per eligible person.

MICHIGAN

There are seven medical relief categories in Michigan: Afflicted Child; Crippled Child; Afflicted Adult; Direct Relief; Old Age Assistance; Aid to Blind and Aid to

Dependent Children. The Afflicted Child and Crippled Child programs are under the Michigan Crippled Children Commission.

The County Board of Social Welfare administers the direct relief program, determines eligibility, and pays the bills. The Board makes investigation of the financial condition of the recipient and certifies him for medical aid (home and office calls) on the basis of the referring physician's statement. The physician submits his itemized statement to the County Board and is paid direct by the Board on a fee-for-service basis. Both county and state funds are involved.

In Genesee County (Flint) the indigent medical care program is supervised by the County Welfare Commission. The medical society participates in the program, and the Mott Foundation and Elizabeth Funds both participate and provide financial aid.

In Muskegon County the indigent program is handled by the medical society and county board of welfare. A plan for caring for chronic cases was instigated in 1929. All physicians in the county organized The Muskegon County Participating Association which was authorized to contract with the welfare department for the medical care of chronic indigent cases requiring hospitalization at a flat fee of $50 per case. The

welfare department pays the hospital bill under a contract with the county. The $50 medical fee is retained by the participating association for specific uses, and the members provide their services gratis. The welfare board pays physicians on a fee-for-service basis for taking care of the non-hospitalized acute cases.

MINNESOTA

Medical Service for Recipients of Relief and Public Assistance is the title of the Minnesota program. It is authorized by the Session Laws of Minnesota and has been in operation since 1933 with revisions in 1937 and 1941 . The program is administered by the Division of Social Welfare and operates at the community level under the county and township welfare boards. The Committee on Medical Service of the State Medical Association and the Special Advisory Committee to the Division of Social Welfare assist in establishing policies for the program.

Eligibility is determined by the local welfare boards. The indigent receive unlimited medical and hospital services, drugs as prescribed, and limited dental and nursing service. In most cases the patient has free choice of physician. Participating physicians receive their fees from the county or township in

accord with a schedule established by the Medical Advisory Committee, the Welfare Agency, and the State Medical Association. The program is supported by federal, state and local funds.

Hennepin County has recently initiated a program for the medically indigent, those unable to qualify as beneficiaries of the welfare agencies. The Medical Society is working in close cooperation with the case workers of the County Welfare Department and the City Health Department in providing care for this group. For the present the doctors are giving their services gratuitously. Drugs and medications are being provided by outside sources. This program is an experiment being conducted by the Bureau of Medical Economics of the Medical Society.

The Ramsey County program is directed by the County Welfare Board which is also the governing body for the county hospital. For the most part local funds are utilized. The Board of Welfare sets standards of eligibility and certifies patients. Eligibles are cared for by the hospital staff and in conjunction with the intern and resident training program. Physicians receive no pay. Drugs are provided through the hospital. Dental services are limited to public assistance recipients, and limited nursing service is

provided. Approximately 8,600 in-patients and 13,900 out-patients are cared for per year at an average cost of $98 per patient.

MISSISSIPPI

Mississippi reported no special program for indigent medical care.

MISSOURI

Missouri does not have a state-wide program for the care of the indigent. A special committee has been appointed to study the matter.

Greene County (Springfield) provides medical care to approximately 600 indigents per year. The program is administered by the County Commissioners and is operated by the County Health Department in conjunction with the Welfare Department. The Medical Society serves in an advisory capacity, and the Health Council assists in the development of health education material. Support comes entirely from local funds. Eligible patients are certified by the Welfare Department on the basis of a means test. Medical care is provided through a clinic by salaried county physicians. Drugs are dispensed at the clinic. Hospitalization is provided when necessary, and children may receive dental services. No house calls are made, and only preventive nursing service is provided.

MONTANA

Montana has no state-wide indigent care program. Many counties, however, have a modified county-physician plan. A few counties have other types of programs developed cooperatively by the county medical societies and county commissioners.

Under the Cascade County Welfare Medical Care Program, the Medical Society bids for the contract for caring for the indigent. The county pays $2.00 per capita per month for all indigents on the relief rolls. A report covering a period of ten months from July 1, 1949 to April 30, 1950, shows the following figures:

> During the period reported on, $2.00 per month per capita was paid by the county for medical services and $200 per month for statistical and/or administrative expenses. The administrative expense amounted to 22¢ per month per capita, and payments to physicians were pro-rated on an average of 54.12 per cent of the fee schedule. The average number on relief rolls per month was 1,768, and the average amount paid out monthly by the county was $3,535. An average of 280 claims were made per month at an average cost of $2,389 or $8.54 per claim.

NEBRASKA

Nebraska established an indigent medical care program in 1946 by legislative action. This Medical and Hospital Care Assistance program is administered by the Department of Assistance and Child Welfare under the supervision of the State Board of Control. The Medical Society has a liaison committee which

furnishes medical supervision. The program operates at the community level through the county assistance staffs supervised by county boards.

Eligible patients include recipients of Old Age Assistance, Dependent Children, the Blind and Indigent. Eligibility is determined by the County Board on investigation of the applicant's resources, relatives' resources, age, and need. Services available to eligibles are unlimited, with the exception of dental service. Free choice of physician depends on local situations, facilities and resources. The Nebraska State Medical Association has established a fee schedule which local costs cannot exceed. The program receives federal, state and local financial aid.

NEVADA

Nevada does not have a state-wide program for indigent medical care. The individual counties provide for their own indigent patients out of local funds. Physicians supply their services without compensation in a manner approved by the State Medical Association.

NEW HAMPSHIRE

Medical care of the indigent is divided between the local, county and state governments. The state cares for the aged, blind, families with dependent children, and totally and permanently disabled, on

a fee-for-service basis. The other indigent are cared for by the cities, towns and counties on either a salary or fee-for-service basis. County indigent are admitted to county hospitals; others are cared for in the non-profit hospitals of the state on a fee basis, except in a few instances where a city makes a lump sum payment to a hospital caring for its indigents.

NEW JERSEY

The administration of medical care for the indigent and medically indigent varies considerably among the 566 municipalities in New Jersey. However, the State Medical Society has been encouraging greater uniformity in these plans. About ten years ago the Medical Society organized a separate corporation known as "Medical Service Administration of New Jersey". This corporation developed the "City of Newark Medical Plan" as an experiment and later as the type program all of the State's larger cities might adopt.

The City of Newark Plan is on a reimbursement basis. Physicians bill the plan for services rendered. Medical Service Administration pays for all approved services rendered and is reimbursed at monthly intervals by the City for the amounts expended plus 10 per cent for administrative expenses. The Plan includes the indigent whose names appear on the welfare

rolls of the City, and also the medically indigent--those otherwise self-supporting persons who, in the opinion of the Social Service Bureau of the Board of Health, are unable, because of lack of funds, to provide themselves with adequate medical care. The Plan covers only medical care rendered eligible persons confined to their homes with illness.

Administration is in accordance with an informal "memorandum of understanding" between the Medical Service Administration, Newark Department of Welfare, and Newark Board of Health. The Essex County Medical Society appoints an Advisory Committee. The Plan provides for free choice of physician and payment for physicians' services on a fee-for-service basis.

The Medical Society of New Jersey has agreed on the following general policy concerning medical care of needy persons:

> (1) that the term "needy persons" be interpreted to mean all persons who, because of low income, are unable to provide themselves with adequate medical care;
>
> (2) that the determination of need be made at the local level by representatives of local government; and
>
> (3) that all needy persons be allowed free choice of physician except those cared for in public clinics and in hospitals.

NEW MEXICO

The Advisory Committee for Indigent Medical Care acts chiefly as an advisory group to the Department of Public Welfare. The physicians medical report has been revised, thus reducing the amount of time consumed in reporting welfare examinations. Medical fees are handled by direct payment alone. The fee schedule has been completely revised due to a considerable reduction in the State Welfare Budget. The Department of Public Welfare and the committee have suggested that in cases where fees were already small, only small cuts should be made, while in the larger fees, larger cuts should be taken. Since the fees are paid by direct payment, the physician is sure of getting his payment.

NEW YORK

The New York State Department of Welfare establishes the rules and regulations regarding indigent medical care. The Commissioner of Social Welfare administers the program through local welfare commissioners. The State Medical Society appoints an Advisory Committee and local county medical societies participate in the program with the approval of the State. The indigent, medically indigent and recipients of Old Age Assistance are eligible. Need for medical and hospital services and drugs is determined by the local

department of social welfare on the advice of staff or individual physicians. Services are provided by individual authorization or subsequent authorization when necessary. Physicians receive their fees from the patients, with the fees based on a schedule agreed upon by the Department of Social Welfare and the Medical Society. Local governments are required to pay at least 20 per cent for the support of the program. The federal government makes grants for Old Age Assistance, and the State provides financial aid according to a formula established by the Department of Social Welfare.

In Erie County (Buffalo) medical care of the indigent is administered and controlled by the Erie County Department of Social Welfare. The County Board of Supervisors maintains the Department and appoints a five-man Board of Social Welfare. This Board in turn appoints a Commissioner who administers the Department. Within the Department are a Medical Division, Hospital Division, and Dental Division. Medical policies and administration are concentrated in the Medical Division. The Erie County Medical Society helps formulate all medical policies dealing with the indigent.

Applicants for aid are investigated according to state

and county policies and may be deemed eligible for full or supplementary aid. Patients are allowed free choice of physician, clinic, hospital, and dentist. Most hospitals maintain out-patient departments which contain dental units. Nursing care must be authorized as a special item. Most services are unlimited, except that the Medical Division exercises certain controls to prevent abuse. All medical services by physicians in hospitals are rendered without charge. Private physicians bill the Welfare Department on a fee-for-service basis for home and office care at the end of each month. The Department sends a check to the patient to be endorsed and turned over to the physician. Approximately 600 physicians participated in the program in 1949, and the total case load of the Welfare Department was 149,154.

The total cost for welfare care in Erie County for 1949 was $15,653,000. In some categories of relief, the State reimburses the county up to 80 per cent of the total cost. The rest is raised by direct local taxes.

New York City's medical care program for recipients of Old Age Assistance is administered by the City Department of Welfare. The major policies of this Department are based upon the recommendations of the Medical Advisory Board which is composed of physicians represent-

ing the five County Medical Societies, the Coordinating Council of the five County Medical Societies, the Departments of Health and Hospitals, the Tuberculosis and Health Association, the Central Manhattan Medical Society, and specialists in various branches of medicine whenever required.

Individuals over the age of 65 for whom eligibility for Old Age Assistance has been established are afforded the same medical care as that rendered to clients under the age of 65 years. The physicians are members of a Department of Welfare medical panel and are free to join this panel providing they are of good standing and registered within the State of New York. These panel physicians offer medical care in the home for acute illnesses where hospitalization is not indicated or not desired by the client. Persons who are chronically ill and unable to attend clinics and are not suitable for hospitalization are taken care of through a special service division.

Prescriptions written by panel physicians are honored by panel pharmacies throughout the city. Prescriptions written by some of the voluntary hospital clinics, exclusive of the municipal hospitals, are paid for by the Department of Welfare through contractual agreement with the hospital concerned.

Nursing services are rendered through the Visiting Nurse Associations upon order by the attending panel physician. Nursing home care is offered for convalescence from recent illnesses. Up to six months is permitted to convalesce from the ordinary illness. Where an individual falls into the chronically ill category after this period of time, he is transferred to a hospital for the chronically ill.

The Department of Welfare also cooperates with the home care programs administered through the municipal hospitals of the City of New York and Montefiore Hospital. The Dental Care Program of the Department fills the needs of these individuals for operative and prosthetic dentistry. Eye refractions, eye glasses, eye pathology, hearing aids, appliances, and rehabilitation care are provided by special arrangements.

NORTH CAROLINA

The General Welfare Laws of North Carolina place responsibility for the medical care of the indigent medical with the county welfare departments. For the most part the extent of such care is determined by the sizes of local budgets; physicians give their services gratis or for a reduced fee; and free choice is seldom offered to patients.

NORTH DAKOTA

The care of the indigent in North Dakota is a three-way responsibility. Funds are received through the State Welfare Department from the federal government; funds are appropriated by the state legislature; and funds are appropriated by the various Boards of County Commissioners. The State Welfare Department has the overall supervision, while the local administration is carried on through the various County Welfare Boards. At the present time North Dakota has no fee schedule with the State Welfare Department. A schedule which existed since 1943 was revoked by the State Medical Association due to the fact that the State Welfare Board would not realistically negotiate a new schedule. Care on the county basis is operated on a free choice, fee-for-service basis. Authorizations are issued by the County Welfare Boards. Relations with the various County Welfare Boards and the State Welfare Board with the physicians have been good with the exception of the current dispute over the fee schedule. It is believed that this will be satisfactorily adjusted before too long.

OHIO

Under the State Poor Relief Act passed by the Ohio Legislature in 1939, the state is authorized to provide the indigent with necessities, including medical

care. The State Welfare Department is charged with overall official supervision, and local relief agencies with local supervision and administration. Anyone certified by the local relief agency as eligible for poor relief is eligible for medical care. There is no limitation on services as imposed by law. However, the amount of funds appropriated or available in a particular area may necessarily impose limits on services. The local programs operate on a free choice, fee-for-service basis except in a few areas where physicians are employed by the local health or welfare department. The attending physician determines need for medical and hospital care and drugs, but final authorization rests with the relief agency. Fee schedules are determined by the relief agency, usually in cooperation with the local medical society. Physicians are paid direct from local funds. Programs are supported by state and local funds on a matching basis. Some Community Funds and unofficial local welfare agencies provide nominal aid. The State Medical Association has set up a model agreement for local medical societies and relief agencies in providing indigent medical care.

Cuyahoga County (Cleveland) has fifty-three political subdivisions and no so-called rural area. The responsi-

bility for the indigent sick is divided between the City of Cleveland, the county government, and the governments of the larger municipalities with financial aid from the state for certain types of cases. The indigent are hospitalized in the city general and tuberculosis hospitals, the county nursing home, and some eighteen private hospitals, most of which have out-patient departments for the ambulatory indigent and wards for in-patients who are able to pay little or nothing. The private physicians take care of a large load of free cases. In some instances the doctor is recompensed by agencies which supervise the care of these indigents. Home visits are made by the city district physicians in Cleveland, by private physicians under contract or agreement with the various suburbs, or by individual physicians called by the Academy of Medicine, particularly in emergencies. The Academy appoints an advisory committee for the programs outside the city. This committee exercises certain controls to prevent abuses. All of the welfare agencies and the city maintain a central registration bureau so that investigation by any agency as to eligibility of the patient or his financial needs is on record. Each agency makes the initial investigation and files its report with the central agency.

Medical care for the indigent of Franklin County (Columbus)

is administered by the Family and Children's Bureau, Child Welfare Board, Franklin County Division of Aid for the Aged, and Franklin County Department of Public Welfare. The Medical Society provides an official 24-hour Central Call Service through the Medical Bureau. The Welfare Department pays for one operator and one phone in order to include the indigent and medically indigent in the service. The Welfare Department also pays for home and office medical care, drugs and appliances for patients. Other special health agencies participate in the overall program. Most health agencies have a medical advisory committee and policies for all agencies giving medical care are recommended by the Metropolitan Health Council.

Eligibility is determined by the agency paying for services. All agencies are encouraged to use the standards set by the Department of Public Welfare in determining eligibility for medical care. Need for medical and hospital services and drugs is determined by the attending physician. There is no limitation imposed on services. Patients have free choice of physician, and physicians are paid according to fee schedules set by the Academy of Medicine and Ohio State Medical Association. Pharmacists submit their bills to the agency paying for service . Under the Welfare Department there were 3,441 cases in 1949 at an average

cost of $4.32 for medically indigent and $7.12 for indigents. In 1949, there were 425 cases under Aid for the Aged at an average cost of $44.

The Lucas County (Toledo) plan for medical care of the indigent is under the direction of the Health Commissioner. He administers and supervises the Bureau of Medical Relief and serves as liaison officer with the Welfare Department, City Council, and Academy of Medicine. The Academy contacts physicians for home calls and arranges hospitalization for these patients. The program is entirely under medical supervision.

The Bureau of Medical Relief and City Welfare Department determine eligibility. All persons on relief rolls are automatically eligible. Others must apply to the Bureau for authorization. The medically indigent are covered for hospitalization by the Central Hospital Bureau.

Unlimited medical service is provided at Public Health Clinics, or home calls may be made by a physician assigned on the basis of location and availability. Patients have no choice of physician. The indigent are hospitalized at the county hospital and may be treated in the out-patient department and clinics, one of which is dental. The Red Feather Agency also operates a dental dispensary supplying service at cost. Nursing

service is authorized by the City Council. The need for services and drugs is determined by the Health Commissioner at the clinics and by the attending physician on home calls.

Out-patient and clinic physicians are salaried. The home physicians receive fees for specified services. They provide surgical and in-hospital service gratis. Physicians and pharmacists are paid direct by the City Council.

The City Council administers city and county relief funds. Fifty per cent of general relief comes from city and county funds and 50 per cent from state funds. Some federal aid is utilized; and private charities, the Toledo Public Health Association, and the Junior Chamber of Commerce give additional support.

OKLAHOMA

Oklahoma has no organized state-wide program for medical care of the indigent. The hospitals of the University of Oklahoma School of Medicine are charitable institutions giving general medical care to any Oklahoma citizen certified to them by county court. Other agencies, such as the Oklahoma Commission for Crippled Children, can render advice and financial assistance for unmarried individuals under the age of twenty-one who are certified to it by the county court as being unable

to pay for medical assistance.

The indigent and medically indigent of Kay County are provided medical care through the welfare department with the cooperation of the medical society, public health department, and civic groups. Individual doctors treat patients at the request of the welfare department or the patient. The welfare department or county commissioner must certify a patient as eligible for services at the county's expense. Hospital, medical, and dental services and limited nursing service and drugs are furnished. The patient has free choice of physician unless treated by a city or county health department physician. Hospital and drug bills are paid by the county. Physicians are paid on a fee-for-service basis and receive about 10 per cent of their bills. About 500 patients are cared for each year.

OREGON

The Oregon State Public Welfare Commission provides medical care for the recipients of welfare under three general plans:

> (1) Emergency care which can be supplied by a doctor and hospital without authorization as long as the welfare agency at the county level is notified within forty-eight hours. This agency then determines eligibility of the individual for receipt of assistance on the financial basis only. The medical needs are not questioned if found eligible for assistance. Services are paid for at the adopted fee schedule rates.

(2) Medical care is provided with free choice of physicians for all recipients of welfare on the basis of request for authorization from the county welfare office to go to the doctor of choice. The doctor submits a report of his findings, indication for treatment, and these are approved or disapproved by the Medical Advisor of the State Public Welfare Commission. Approval is for the medical plan as outlined by the doctor and the Medical Director indicates whether this is urgent, necessary, or desirable medical care. This care is provided within the limits of funds available for general assistance in the county at that time. At present, in most counties, only urgent medical care is being provided.

(3) Cases of chronic illness, so stated to be by the physician of the patient's choice, are provided funds in the amount of $5.00 per month for medical services and $3.00 per month for drugs, payable to the recipient of welfare in their grant. They in turn pay their own drug bill and physician's services. If these individuals become acutely ill, they may be removed from the chronic illness program and returned to either Group 1 or 2 as they so fit.

Fee schedules are paid to hospitals at private rates, less 10%, and to the doctors according to the fee schedule adopted by the State Public Welfare Commission after consultation with the state Medical Society. These fees represent, roughly, 25% of an ordinary pre-payment medical plan fee schedule, and in the reduction below that schedule for services rendered by the physicians, the physicians are making a contribution close to $1,000,000 per year to the program. The state Medical Society provides a committee in charge of medical care, which acts as an advisory

committee to the Director of Medical Division and, through him, to the State Public Welfare Commission. It is important to point out the great lack in the program, at the present time, is for the care of people who are medically indigent only. This care was provided up until 1947 but at the present time limitation of funds prevent this from being done.

PENNSYLVANIA

The Indigent Medical Care Program under the Department of Public Assistance of the Commonwealth of Pennsylvania was authorized in 1938 by an amendment to the Public Assistance Law at a Special Session of the Pennsylvania Legislature. The State Medical Society is responsible for its instigation, supervises the medical care aspects, and advises in all professional activities. The State Healing Arts Advisory Committee, representing all the professions, also assists in supervising the program. The Department of Public Assistance is charged with administration, and the Governor appoints a local bi-partisan board in each county known as the Board of Public Assistance to carry out community operations.

Recipients of public assistance, old age assistance, aid to blind, aid to dependent children, and general assistance are eligible. Eligibility is determined

by the Department of Public Assistance according to established formulas. Services available to the patient include medical, dental, nursing, and clinic service, medications and medical goods and supplies within prescribed limits. The program is on a free choice, fee-for-service basis. Fees are determined by the State Healing Arts Advisory Committee. The program is supported by state funds, and the physicians and pharmacists receive their fees from the welfare agency. School children receiving public assistance may receive School Medical Services not included in the regular Medical Assistance program. Local programs duplicate the pattern of the State program and are integrated and controlled by the State Department of Public Assistance.

RHODE ISLAND

Rhode Island's program for indigent medical care operates through the State Department of Social Welfare and local community welfare programs. It was authorized by state legislation and has been in existence for about ten years. The Medical Society has a committee which serves in an advisory capacity for conduct of the programs. The public health departments supply certain laboratory facilities and medical services, and the welfare departments administer the programs and reimburse patients for part or all of

expenditures.

Indigents apply to the agencies which investigate and authorize expenditures. The welfare departments follow a very liberal policy in determining eligibility and any person in need may apply. Emergencies are handled without question. Services available to patients include all medical care, hospital ward, outpatient, dental, ward nursing, and non-experimental drugs. Patients have free choice of physician and the attending doctor determines need for medical and hospital care and drugs. Physicians receive their fees from the patient and are reimbursed on a per capita or fee-for-service basis according to schedules set by the agencies. Some local and federal aid is utilized, but the program is supported mainly by state funds. Charitable organizations lend some additional aid.

SOUTH CAROLINA

South Carolina has had no state-wide program. Each county provides medical care for the indigent in its own fashion. A special committee of the State Medical Association is studying the problem with a view to presenting a definite plan on a state-wide basis for the legislature to consider.

SOUTH DAKOTA

South Dakota has no program for indigent medical care on a state-wide basis with the exception of special programs such as services to Crippled Children. Indigent medical care programs operate at the community level under county commissioners. These programs vary from county to county.

TENNESSEE

Tennessee has a "county poor law" which provides that counties may establish "poor houses" or use jails or other county property for housing the medically indigent and may employ a county physician to treat those for whom the county court authorizes treatment. The state maintains certain hospitals and institutions for the care and treatment of special categories of indigents. Some emergency measures are permissible under this program as well as under the "county poor law". The larger and more populous cities and counties have public supported general hospitals which provide for services to the indigent.

Davidson County (Nashville) indigents are hospitalized and treated at the Nashville General and other private hospitals for which the county pays the institution $8.00 per day. Indigents in Memphis and Shelby County are cared for at the city and other hospitals.

Members of the medical society provide their services gratuitously.

TEXAS

Texas does not have any state plan for medical care of the indigent and medical indigent. Each county has its own system for providing out-patient clinics, depending on its population and need. In the rural areas, medical care is supplied largely in private physicians' offices, and in about half the counties the County Commissioner's Court will assume the obligation for hospitalizing the indigent. The State Medical Association has given considerable attention to the problems of indigent care. Rather than attempt to develop a state-wide plan, they are encouraging counties to assume their community obligations in the provision of hospitalization and drugs, as well as physicians' services.

Bexar and Dallas Counties have recently conducted surveys of the number of indigent and medically indigent patients treated in out-patient clinics of the county, the number of such patients hospitalized, the number of medical society members who volunteered their services for these clinics, and the adequacy of the clinics and the medical care provided.

In Dallas County most of the free medical care is

provided by the City County Hospital System. This includes a general hospital with out-patient and clinic services. The hospital system has a social service department which passes on applications for assistance and determines eligibility on the basis of an estimated standard family budget. This budget is developed with the cooperation of all social agencies in the community which provides services to families and children. The program is supported jointly by city and county funds. Occasionally research grants are received from national voluntary organizations. Members of the Medical Society provide professional services and staff the hospitals gratuitously. The average cost per patient per day is $10.44. During the last fiscal year 9,677 patients were hospitalized. There were 54,283 clinic visits and 36,566 emergencies.

UTAH

Utah does not have a state-wide indigent medical care program. The burden is carried largely by the individual doctors with occasional slight aid from the county commissioners or private charity. The Salt Lake County Hospital, which operates in connection with the medical school, provides hospitalization for many indigents from all parts of the state.

VERMONT

Vermont's indigent medical care problem is handled on a personal or community basis. Some towns have doctors for their poor, and other towns reimburse the doctor at a reduced rate. Many patients are cared for gratuitously.

VIRGINIA

The State and Local Hospitalization program in Virginia was authorized by the State Legislature four years ago. It is under the State Welfare Department and is administered by local authority, usually the welfare department. The indigent and medically indigent are eligible when certified by the local authority.

The program provides for medical and in-hospital care and drugs. There is no free choice of physician in state hospitals, but local doctors may have patients admitted to local hospitals. Physicians are not compensated for their services. Hospitals are paid a per diem rate and the program is supported by state and local funds on a matching basis.

In Norfolk the program is administered by the Hospital Association. There is a Board representing the medical society, health and welfare departments, the hospitals, and the public at large. The program is under almost complete medical supervision. It is sup-

ported about 90 per cent by local funds with the state supplying the remainder. The Community Fund provides administrative assistance, and some public donations are received.

Eligibility is determined according to local and state standards by social workers and an executive secretary under the supervision of the Board. Medical, hospital, out-patient, limited dental and nursing services, and drugs are available. Patients are assigned to the physicians on the service at the time of admittance. Physicians receive no compensation. Drugs are paid for by city funds, the patient, or the hospital. The approximate average costs per year are $15.15 for in-patients and $2.75 for out-patients. The number of patients cared for in a year is 2,500 in-patients and 60,000 out-patient visits and emergency cases.

WASHINGTON

The Washington State Department of Social Security's present program has been in operation since January 1, 1949. It was authorized under an initiative placed on the ballots for the 1948 general election. The program is administered by the Director of the State Department of Social Security through the Supervisor of the medical program. It operates at the community level through local county welfare departments.

Under a prepaid medical contract with the Washington State Medical Bureau, the supervision and treatment of all medical cases is a responsibility of the twenty-two local county medical service bureaus. Each of these bureaus is composed of the members of the local county medical society. Determination of eligibility is made by the county welfare agency and each eligible is issued an identification card. The program includes complete medical, hospital, dental and nursing services, and drugs, and patients have free choice of physicians among those agreeing to serve. Need for medical and hospital care and drugs is determined on the recommendation of the physician, with approval from the medical advisor of the respective medical service bureau. The program has the approval of the State Medical Association.

The contract provides that the State Department of Social Security shall pay to the State Bureau a per capita of $2.50 per person on the rolls, for the medical service of the attending physician and for office X-ray and medical laboratory procedures. The State Bureau in turn reallocates this money to each bureau in the State on the same basis. The attending physician bills the bureau in accord with the bureau fee schedule, and the bureau pays him according to the funds available. Each local bureau determines its own

fee schedule covering services rendered. The State Department pays for the drugs prescribed by the physician. Although financially the federal, state, and county governments all participate, the state is obligated to carry about 90 per cent of the load.

WEST VIRGINIA

The General Medical and Hospitalization Program of West Virginia was authorized in 1936 by the Public Welfare Law. It is administered by the Division of Medical Services of the Department of Public Welfare. The Medical Association and Hospital Association serve in advisory capacities. At the community level the program is administered by county councils.

Social workers from the Department of Public Welfare determine eligibility according to a standard budget guide. Indigent persons eligible for general or categorical assistance are eligible for medical assistance. Medical, hospital and dental services and drugs are limited to cases where care is absolutely necessary. Out-patient service is available to chronic, diabetic and other patients. No nursing care is provided. Patients have free choice of physician, and doctors are paid directly from general assistance funds on a fee-for-service basis. Fees are established by joint conference between the Welfare Depart-

ment and the State Medical Association. The program is supported by state and local funds.

In Kanasha County (Charleston), the Director of the County Department of Public Assistance administers the program. Recipients of public assistance are eligible for medical assistance. Attending physicians may request aid for indigent patients. Medical, hospital, dental and nursing service, and drugs are provided within the limits of available funds. The program is on a free choice, fee-for-service basis. Doctors' fees and drugs are paid by the Public Assistance Department. When funds are exhausted, the physicians provide their services without pay. The program is supported by state and local funds. In the year ending April 30, 1950, $29,914 was spent. The number of patients cared for was 1,216 at an average cost of $24.60 per patient.

WISCONSIN

The only state-wide indigent medical care program in Wisconsin is the Supplementary Health Services program for Old Age Assistance, Aid to Dependent Children, and Aid to Blind recipients.

The Dane County (Madison) Welfare Program is administered by the County Welfare Agency and a Coordinator appointed by the County Medical Society. Members of

the Medical Society participate in the program and recommend the fee schedule. The Welfare Agency investigates and places needy patients on relief and medical care rolls. The program is supported entirely by local funds. Indigents are cared for on an individual basis in the same manner as private patients. They receive needed medical, hospital, dental and nursing service and drugs as determined by the doctor of their choice. Physicians' fees and druggists' bills are paid from the fund. There are no out-patient facilities available in the area.

Milwaukee County (Milwaukee) has an emergency medical care program administered by the County Medical Society in cooperation with the County. The program is supported by county funds, but has at times received supplementary federal aid. Persons eligible for medical assistance are those who have been declared eligible for public welfare by the social service division of the County Department of Public Assistance. Patients may be attended by their family doctor on a basis of a fee schedule set by a committee of doctors, or they may receive care in an out-patient department. Those who are chronic are admitted to the county hospital. Dental and nursing service are provided and the county pays for necessary U.S.P. and N.R. drugs.

WYOMING

Indigent medical care in Wyoming is handled on a county basis with funds raised by a state levy. The State Director of Welfare is encouraging the various counties to pattern their programs after the one in Laramie County.

The plan for medical care of welfare cases in Laramie County is based on an agreement between the County Department of Public Welfare and the County Medical Society. The Welfare Department decides the financial status of welfare applicants and requisitions medical care except in emergency cases. A judicial and adjudication committee of three is appointed, two by the County Medical Society and the other by the County Welfare Director. A county welfare nurse filters routine house calls before calling the physician, and, except in emergencies, the first office or house call must be on a referral from her. The welfare nurse must receive a release statement on every patient from the attending physician giving the number of office calls and the date discharged. Patients have free choice of physician, and physicians submit their bills to the Welfare Department. Fees are set forth in the agreement and are pro-rated from available funds. Patients in need of hospitalization are

admitted by the attending physician to service indicated. The welfare nurse must contact the patient before he is entered into the hospital, unless it is an emergency case or at night. The attending physician will continue to care for the patient, but under the direct supervision and control of the chief of the particular service involved. Individual physicians receive no fee for hospitalized welfare cases. Money set aside for such care is turned over to the County Medical Society.

HAWAII

The program for the indigent and medically indigent in Hawaii is being provided for by three public agencies. These three programs provide preventive health services, medical, surgical, hospital, and out-patient services. Dental care is limited to emergency fillings. Nursing service is limited. Drugs are usually available. None of the programs provide free choice of physician. Medical care is furnished by physicians employed by or on the staff of county agencies or county hospitals, by staff physicians in private hospitals, and by government physicians located in the rural districts to which they are assigned.

One program, Medical and Hospital Care for the Needy,

is based on an act of the Territorial Legislature (1943) authorizing the Department of Public Welfare to assist persons who are unable to procure or provide sufficient medical care, hospitalization or dental care for themselves. This program provides only for indigents who are defined by Territorial Statutes as persons without adequate and proper means of subsistence for the support of whom no other person or agency is liable or responsible. Eligibility is determined by social workers of the Welfare Department. Medical services and drugs are on a fee-for-service basis. Fees are determined by the Welfare Department and Territorial Medical Association. The program is supported by the territorial government.

Another program, Medical and Hospital Care for the Indigent and Medically Indigent, comes under the County Boards of Supervisors. The county programs have been in existence since 1909 when the county governments were granted a charter and directed to provide medical care for the needy. Both indigent and medically indigent persons are cared for by the counties. The definition of medically indigent in the Territorial Statutes is a person otherwise able to subsist but who in the emergency of sickness is not able to care for the extra expenses necessary to maintain or restore health. Eligibility is determined

by a medical social worker, or when such is available, by the county physician. Care is supplied by part-time or full-time salaried physicians, and the program is supported by the counties.

Under the third program, the Government Physicians in the rural districts of the Territory provide preventive health services and out-patient medical care for indigent and medically indigent persons in their districts. Many of these government physicians have hospitals available for their practice and provide surgical and other hospital services for indigent and medically indigent persons without additional cost to the government. By general appropriation acts, funds are provided each biennium for the salaries of part-time physicians employed in the thirty-seven rural districts. Funds for drugs are included in this budget for government physicians. Eligibility is determined either by utilizing the social workers of the Department of Public Welfare or by the physician himself. This program is supported by territorial funds.