Medical Care for the Indigent

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THE CITY of New York traditionally has assumed responsibility for the provision of medical care services to its indigent and near-indigent population. These services run the gamut from ambulatory emergency room care to highly specialized outpatient clinic care, inpatient hospital care, and hospital-supervised home care.

Through the vast system of municipal hospitals operated by its department of hospitals and the many voluntary hospitals established by religious and other nonprofit organizations, New York City offers what probably is the widest range of diagnostic and curative services of any city in the nation. In addition, the city's department of health provides an array of preventive services and a limited amount of treatment services in selected specialties through its network of child health stations, adult hygiene and diagnostic and screening clinics, tuberculosis clinics, school health and dental programs, and its program for handicapped children. Further, the department of welfare includes a panel composed of 2,000 private medical practitioners, who provide emergency care and consultation at home and in nursing homes to the acutely and chronically ill. This department also has dental and eye clinics for adults (*1*).

Background

Illness and disability are generally considered to constitute major causes of public dependency. In 1957 in New York City, 43.8 percent of all adult recipients of public assistance were reported to have some kind of chronic illness or disability. Thirteen percent of the adults receiving assistance from Aid to Dependent Children—the adults on whom the children depended for support and supervision—were reported to have chronic illness or disability. In 1957 almost 10 percent (28,000 persons) of all relief recipients in the city receiving support under the Aid to Disabled category (a group with chronic illness or disability) and 54 percent of the persons receiving Old Age Assistance (recipients over 65 years of age) were reported to have chronic illness or disability.

Of the 329,000 persons in New York City families receiving public assistance in 1960, more than 142,000 were children under 18 years of age. These children depended entirely on publicly supported medical services for pediatric care, immunization, dental service, and care of all acute and chronic conditions. If private or public agencies did not provide this care, the children simply would go without (*2*).

Of the 78,500 adult persons in the Old Age Assistance, Aid to the Disabled, and Aid to the Blind relief categories alone, 19,000 required hospitalization in 1957. Thirty-six percent of the hospital days of care required by these adults was in public chronic-care hospitals. The average length of stay for the patients was a little more than 1 year.

In December 1958, at the request of the city's commissioner of welfare and after consideration by the interdepartmental health council (a coordinating group set up by the mayor of New

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York City in 1952 as a mechanism for coordinating the city's health and medical care services and comprised of the commissioners of health, hospitals, mental health services, and welfare), the departments of health, hospitals, and welfare began a joint undertaking to review and improve health services and medical care for recipients of public welfare.

As stated in a report by Yerby to the commissioner of health in 1960, further impetus was given to this effort by the ruling of the State board of social welfare that reimbursement for outpatient clinic care would be granted provisionally until such time as significant progress had been made in reorganizing the administrative structure of the welfare medical care program.

Those who decided on the joint venture did so thinking that it would be possible to apply the professional competence and skill demonstrated by the public health profession in this city when organizing other health services to the welfare medical care program. The commissioner of health agreed to provide leadership and to make available from that department the personnel and resources for this undertaking.

To implement this agreement, a task force on welfare medical care was appointed in January 1959 to look at the problem and to chart lines of action. Dr. George James, then first deputy commissioner of the department of health in New York City, was designated chairman of the task force. At the same time, James was "loaned" to the department of welfare to serve part time as its director of medical care during the initial review of the program.

The task force reviewed the stipulations of the State department of social welfare and conferred with many individuals and groups within the city departments and with representatives of professional organizations in the city who are experienced and expert in the many facets of medical care and are deeply concerned with its quality. As a result of the review and recommendations of the task force and with James' guidance, the following steps were taken.

1. The division of medical care in the department of welfare was removed from the bureau of public assistance, and its acting head was made responsible to the commissioner of welfare.

2. The health department's district health officers were assigned to serve on a part-time basis as medical consultants to the welfare centers in the city.

3. The medical audit team was formed to assure strict adherence by hospitals to the established procedures of the State department of social welfare for outpatient department reimbursement and to assist the hospitals in improving their capability to comply with these procedures and to meet the specific needs of the welfare population.

4. Liaison was established to improve the coordination of services of the departments of health, hospitals, and welfare.

5. The interdepartmental working committee on medical reporting was created to improve interagency reporting of medical information on welfare patients.

6. As a result of steps 2, 3, and 4, efforts were made to improve medical supervision for relief clients in nursing homes and for children in families on Aid to Dependent Children, to expedite the processing of Aid to Disabled cases, and to obtain more prompt and thorough medical evaluation of the potential for rehabilitation.

7. Attention was directed toward improvement of the medical evaluation of disabled parents in families on Aid to Dependent Children.

8. The position of director of medical care for the city was established; the incumbent would serve as a deputy commissioner in both the departments of health and welfare.

9. A project was started with the department of medicine of the Cornell University Medical College and the New York Hospital and the departments of health and welfare to demonstrate the feasibility of providing comprehensive, coordinated medical care in the home, clinic, hospital, or nursing home from a single source of service with the standards of quality of a major medical center.

Current Administration

In 1960 the department of health assumed full-time responsibility for the administration and direction of the medical care program for

welfare recipients. This commitment, based on an agreement between the commissioners of health and welfare, contained an understanding that major emphasis would be placed on the development of new patterns of providing medical services, with particular concern for continuity and quality of care. The department had appointed an executive director of medical care services in the department of health to serve also as the medical welfare administrator in the department of welfare. Since then, the administrator has been additionally appointed as coordinator of welfare services in the department of hospitals. Under his direction the following demonstration programs have been developed and have received national attention.

- Coordinating and service units specially organized in the outpatient departments of two major teaching hospitals. These units have provided and promoted comprehensive medical care services to patients in an integrated fashion hitherto seldom available. Treatment for individual ailments and significant medical and social needs have been coalesced into patterns related to the concept of the "whole patient," as outlined for the New York Hospital project.
- Prepaid group practice health insurance for provision of medical care to aged recipients of Old Age Assistance and Medical Assistance for the Aged in their own homes, in group practice centers, or in nursing homes. (A promoted revision of the State Insurance Law followed by amendment of the State Welfare Department Law paved the way for this enterprise.)
- Arrangement of special transportation services for disabled recipients who are unable to travel for needed medical care services.
- Rehabilitative services provided in selected nursing homes where the patients were principally supported by public assistance. This activity was an extension of earlier efforts in special categories.
- Functional affiliations between voluntary hospitals and proprietary nursing homes, including transfer arrangements and use of hospital medical staffs and laboratory and X-ray services for indigent nursing home residents.
- Use of programs and facilities conforming to standards set by experts in cardiac surgery and amputee services; payments are withheld from services not meeting such standards.
- Use of clinical audits to measure the quality of care provided by community services and, when necessary, to exclude providers of inadequate services from participating in the welfare medical care program. Such audits were extended to include nursing homes in addition to hospital clinics.
- Extensive use of health department facilities, such as X-ray surveys, and health department clinics and personnel.
- Payment of tuition for postgraduate training in rehabilitation and geriatric medicine for participating physicians.
- Review of the medical programs of participating voluntary agencies such as homes for the aged.
- Evaluation of the welfare department's dental program by an impartial authority.
- Extensive use of organized home care programs.
- Evaluation of long-term indigent residents of nursing homes, resulting in the discharge of a significant number to their own homes or foster homes in the community.
- Development of standards for home care and outpatient care and use of financial sanctions to encourage compliance.
- Assignment of additional district health officers to serve as part-time medical consultants to district welfare centers.
- Assignment of a psychiatric consultant by the New York City Community Mental Health Board to the department of welfare, and arrangements to bring psychiatric consultation to the casework staff in neighborhood welfare centers.

These measures were undertaken, in addition to the ones listed previously, following recommendations of the task force.

Some of the demonstration projects have become permanent parts of the welfare medical program and have been expanded. Others are slated for termination after the experimental phase. Among the medical care facilities included in project affiliations and demonstrations are those experimenting in delivering medical care to cohorts of welfare recipients by the departments of medicine in New York and

St. Vincent's Hospitals, using a prepayment health insurance plan (Health Insurance Plan of Greater New York) for selected areas comprising recipients at home and in nursing homes, participating in the medical care services to a housing project for the elderly (Queensbridge), and several hospital-nursing home affiliations providing medical services and responsibility for care: Beth Israel Hospital for Riverview Nursing Home, Lenox Hill Hospital for Peter Cooper Nursing Home, and St. Vincent's Hospital for Village Nursing Home. Negotiations are currently underway with four other hospitals for similar arrangements in other sections of the city. In another project young private physicians serve as medical staff for a large proprietary nursing home and a large municipal home for the aged, linking the two homes in an effective relationship.

Coordination and comprehensiveness of care have been stressed in projects and continuing services. Additionally, the social needs of the population in nursing homes and elsewhere have received renewed attention. The nonuse of services and the need of inservice education of the staff on medical objectives remain as continuing problems.

Concerted attention to the multiple problems of the aged has been given in residences, nursing homes, chronic care facilities, and housing projects. The approach has been notable in hospital-nursing home affiliations, where medical and ancillary personnel care for nursing home patients to a degree of effectiveness hitherto lacking or available minimally. The restoration and amelioration of persons virtually written off as poor risks have been dramatically demonstrated. Dr. James G. Haughton, director of medical care services and medical welfare administrator, has commented in his 1963–64 biennial report to the commissioner of welfare that "byproducts" have included improvement in morale and less turnover of nursing home staff as the quality of care was upgraded.

Existing services such as programs on hearing aids, influenza vaccinations, chest X-ray surveys, and chronic care have been improved and are being followed on a continuing basis.

Meanwhile medical audits of clinics and nursing home services have been undertaken by specially assigned persons. An added feature has been the postgraduate training of welfare-panel physicians in rehabilitative medicine at a leading medical center.

Rehabilitative services in New York City have received special concern with the appointment of a coordinator for rehabilitation. This appointment stemmed from a State-city relationship for the establishment of primary and secondary rehabilitation centers and the coordination of facilities in the metropolitan area. Administrative supervision is vested in the executive director of medical care services, who serves also as the chairman of the interdepartmental health council's committee on rehabilitation.

Auxiliary Activities

In 1961 the medical care of prisoners, as a function of the department of correction's medical division, was added to the administrative purview of the health department's executive director of medical care services. The director of medical care of the department of correction bears the same relationship to that department as the executive director bears to the department of welfare. Budgetary appropriations for these services are now incorporated in the health department's medical-care-service unit allotment. The correctional unit also maintains mental health clinics under the direction of the community mental health board.

The medical and dental program for prisoners and those held in custody in six detention institutions and one workhouse comprises three sections: the receiving inspection, clinic facilities, and hospital facilities. The extent of this service may be gauged by the following data for 1964. The number of clinic visits includes 298,037 in the house of detention for women.

Activity	*Number*
Admission physical examinations	104,015
Clinic visits	808,555
Infirmary admissions	15,249
Addiction cases	18,219

Current and future plans have intensified medical care activities while furthering programs of professional inservice training and research functions.

Medical care activities, whether in the departments of health, welfare, or correction, have been directed toward achieving organized and coordinated programs that provide comprehensive service of high quality while taking into account the many continuing activities in a number of other units of the departments of health and hospitals.

REFERENCES

(*1*) Baumgartner, L., and Dumpson, J. R.: Health in welfare: A joint or a divided responsibility. Amer J Public Health 52: 1065–1076, July 1962.

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Welfare Provisions of Medicare

Secretary of Health, Education, and Welfare John W. Gardner has urged State Governors to take maximum advantage of expanded Federal aid authorized for State health and welfare programs under the Social Security Amendments of 1965. The improvement of State programs provided for by the amendments is in addition to the basic, supplementary health insurance plans administered through the Social Security System.

In a letter to the Governors, Secretary Gardner said, "The new law lays the foundation for a medical care program for public assistance recipients and other low-income persons that, within the next 10 years, could go far to reduce one of the major causes of poverty and other social problems—the disabilities resulting from preventable or remediable health problems among persons in all age groups who cannot now afford the medical care they need."

The following are highlights of the welfare provisions of the new legislation (Public Law 89–97) which Secretary Gardner has urged Governors to help make available in their States.

Medical care for needy people. The law enables States to pay the "deductibles" for aged persons who cannot afford to pay them under the hospital insurance program, to see that all elderly persons receiving public assistance are covered by the voluntary supplemental medical insurance programs, and to start a new medical assistance program that would ultimately include most of the medically indigent of all ages in the State.

States may start this program on January 1, 1966. If they do not have a program by 1970, they can no longer receive Federal funds for medical assistance related to the public assistance program.

Improvements in public assistance. The new law attacks the problem of low public assistance payments in several ways. It increases work incentives, increases payments, and liberalizes conditions under which students may receive payments. It authorizes payments to interested third persons for individuals unable to manage money. Federal sharing is made available in payments to aged persons in mental and tuberculosis hospitals.

Special health programs for children. Additional provisions specifically designed to benefit future generations include: (*a*) increased authorization for maternal and child health, crippled children, and child welfare services; (*b*) increased funds for grants to help colleges and universities train more professional personnel to work with crippled children, particularly the mentally retarded and the multiply handicapped; and (*c*) a 5-year program of special project grants to provide comprehensive health care and services for preschool and school-age children, particularly in areas with concentrations of low-income families.