Physical Condition and Medical Supervision of Nearly Two Million Aged Persons

ANNE E. GEDDES*

A PROBLEM of particular concern to administrators of programs of old-age assistance as of other assistance programs is that of providing within the framework of the Social Security Act for medical services to recipients of assistance. The Federal Government meets one-half the cost of unrestricted money payments to recipients of old-age assistance up to a maximum of $40 a month, but it cannot provide matching funds for payments which are made by the agency directly to physicians, nurses, dentists, hospitals, or clinics for services to persons on the assistance rolls. Sometimes public assistance agencies include an amount for medical needs in the monthly payment to the recipient. Frequently, however, medical costs are too large to be included in the maximum monthly amount payable in the State under its prevailing legal or administrative limitations.

In considering the problem of supplying medical services to recipients of old-age assistance two questions must be raised: (1) what is the extent of the medical needs of these old people, and (2) how adequately are these needs met? These questions cannot be answered directly, but some light is shed on them by data on the physical condition, at the time of application, of the 1.8 million aged persons accepted for old-age assistance during the 4-year period, July 1936–June 1940, and on the medical care or supervision which they were receiving at that time.

The data for the year 1936–37 are somewhat less adequate than those for subsequent years. The first grants-in-aid for old-age assistance were made by the Social Security Board early in 1936, and during the fiscal year 1936–37 the programs of old-age assistance were in a comparatively early stage of development in all States. The reports for this year relate to periods which differ from State to State. In 1936–37, reports were submitted by 41 State public assistance agencies administering or supervising programs of old-age assistance under plans approved by the Social Security Board. The data for 1937–38 cover 50 State jurisdictions, and those for the next 2 fiscal years, all 51 jurisdictions.

Physical Condition of Accepted Applicants

The workers in the public assistance agencies who determined the old people's eligibility for old-age assistance classified them as (1) bedridden, (2) not bedridden but requiring considerable care from others, and (3) able to care for themselves. A person was said to be bedridden if he was confined to bed because of chronic illness or infirmity, but not because of temporary illness. A person not bedfast but so feeble or incapacitated as to require help in dressing, eating, and getting about the house was classified as not bedridden but requiring considerable care from others. A person was considered able to care for himself when he could get about the home without assistance. There is no way of determining the degree of uniformity with which the definitions have been applied by the workers responsible for recording the physical condition of the applicants; in some measure each condition shades off into another.

The data relating to physical condition reflect the extent to which the applicants were depending on others for physical care; they do not, of course, indicate the nature or the seriousness, in terms of prognosis, of the impairments. Such information could be supplied only through examinations by physicians. It is obvious that many aged persons who are not receiving and do not need physical care from others may have serious chronic diseases or impairments. Furthermore, many persons not actually in bed or receiving help in the home may be in need of such care.

Of 1.8 million persons who were accepted for old-age assistance in the period 1936–40 and for whom information was reported, 85 percent were considered able to care for themselves, 13 percent were said to require help within the home although they were not confined to bed, and 2 percent were

*Bureau of Public Assistance.

Table 1.—*Old-age assistance: Physical condition and sex of recipients accepted during the fiscal years 1936–37 to 1939–40 in States [1] with plans approved by the Social Security Board*

Physical condition and sex	Total	1936–37	1937–38	1938–39	1939–40
All recipients accepted	1,787,571	470,527	585,877	377,233	353,934
Percent:					
Able to care for self	84.6	84.1	83.2	85.4	86.5
Not bedridden but requiring considerable care	13.0	13.5	14.2	12.2	11.3
Bedridden	2.4	2.4	2.6	2.4	2.2
Male recipients accepted	935,123	245,889	306,214	198,251	184,769
Percent:					
Able to care for self	86.6	86.1	85.2	87.6	88.4
Not bedridden but requiring considerable care	11.5	12.1	12.7	10.5	9.8
Bedridden	1.9	1.8	2.1	1.9	1.8
Female recipients accepted	852,448	224,638	279,663	178,982	169,165
Percent:					
Able to care for self	82.4	82.0	81.0	83.1	84.4
Not bedridden but requiring considerable care	14.6	15.1	15.7	13.0	12.9
Bedridden	3.0	2.9	3.3	3.0	2.7

[1] In 1936–37, 43 States were administering old-age assistance programs under plans approved by the Social Security Board, but only 41 States reported information on this subject. In 1937–38, 50 States, and in 1938–39 and 1939–40, 51 States were administering programs.

bedridden (table 1). In the general aged population, the proportions of bedridden persons and of persons not bedridden but requiring considerable care from others may be somewhat larger. Many needy aged persons who are seriously incapacitated are not on the old-age assistance rolls, because they are inmates of public institutions.

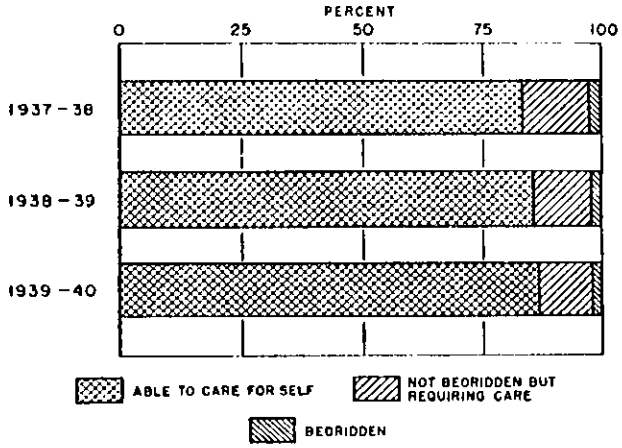
From year to year there is considerable consistency in the proportions of accepted applicants classified in the three groups. Data for the last 3 years seem to indicate a slight but progressive decline in the percentage of accepted applicants who were unable to care for themselves (chart 1).[1] This decline seems reasonable in view of the fact that the average age of new recipients has declined steadily with the normal growth of the State programs and with the lowering of the minimum age limit from 70 to 65 in a number of States.[2] The variation in average age for the 4 years was as follows:

Fiscal year	*Age*
1936–37	72.9 years
1937–38	72.7 years
1938–39	71.1 years
1939–40	70.5 years

It is obvious that serious diseases or the impairments and infirmities of old age will be more prevalent among older than among younger persons on the assistance rolls.[3]

The physical condition of the women accepted for old-age assistance in the 4-year period was consistently less favorable than that of the men. A number of studies seem to indicate that on the average in the general population, as well as in the assistance group, the rates of disabling illness [4] and of physical impairments [5] are higher among women than among men, both in the ages 65 and over and at younger ages. Three percent of the women accepted and 1.9 percent of the men were classified as bedridden, and 14.6 percent of the women and 11.5 percent of the men were reported as requiring considerable care from others in dressing, eating, and getting about the home (table 1). Actually, the differentials between the men and the women may have been somewhat greater than is indicated by the data, because some women 65 and over who share in payments to their husbands are not reported as recipients. Data are unavailable for this group of women. The practice of making shared payments is most common in the Southeast, where health status is poorest.

Chart 1.—*Old-age assistance: Physical condition of recipients accepted during the fiscal years 1937–40 in States with plans approved by the Social Security Board*



[1] For purpose of examining trends, the data for 1936–37, which are incomplete, have been disregarded.

[2] Florida, Indiana, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, Oregon, and Pennsylvania.

[3] *National Health Survey, 1935–36: The Magnitude of the Chronic Disease Problem in the United States*, National Institute of Health (Preliminary, rev. 1939), Sickness and Medical Care Series, Bulletin 6, pp. 10, 14.

[4] Collins, Selwyn D., "Cases and Days of Illness Among Males and Females, With Special Reference to Confinement in Bed," *Public Health Reports* (Reprint No. 2129), pp. 7–8, 36.

[5] Britten, Rollo H., "Sex Differences in the Physical Impairments of Adult Life," *American Journal of Hygiene*, Vol. 13, No. 3 (May 1931), pp. 741–770.

In the different sections of the United States there are marked variations in the physical condition of recipients accepted for old-age assistance. These variations are shown for the year 1939–40 (table 2), classified according to the socio-economic regions of the National Resources Planning Board.[6]

In the Southeast, 19 percent of the aged persons accepted for aid required considerable care from others although they were not bedridden, and 4 percent were confined to bed. These proportions are substantially higher than in any other region in the country and roughly twice those in the Northeast and Far West.[7] Many factors may contribute to these regional differences. The principal one is probably economic status, which has been found to be closely related to health status. In the National Health Survey, substantially higher rates of acute and disabling illness were found among relief families and families with incomes of less than $1,000 than among nonrelief families with incomes in excess of that amount.[8] Per capita income, commonly used as an index of economic status, is lower in the Southeast than in any other region and somewhat less than half as large as in the Northeast and Far West. For the period 1938–40, the estimated average annual per capita income in the several regions was as follows:

Socio-economic region	*Amount* [1]
All regions	$542
Northeast	698
Southeast	306
Southwest	391
Middle States	563
Northwest	443
Far West	718

[1] Source: U. S. Department of Commerce, Bureau of Foreign and Domestic Commerce.

Race is another important factor contributing to the regional differences. In the Southeast, 32 percent of the recipients accepted in 1939–40 were Negroes. In other regions the percentages ranged from 2 to 13. It is well known that the economic status of Negroes is lower than that of white persons. There appears to be considerable evidence that the prevalence of disabling illness is higher among Negroes than white persons. This difference may result less from racial factors than from differences in the economic status of the two groups.[9]

Table 2.—*Old-age assistance: Physical condition of recipients accepted during the fiscal year 1939–40, by socio-economic region* [1]

Socio-economic region	Recipients accepted	Percent—		
		Able to care for self	Not bedridden but requiring considerable care	Bedridden
All regions [2]	353,934	86.5	11.3	2.2
Northeast	101,204	90.6	7.9	1.5
Southeast	70,121	77.7	18.8	3.5
Southwest	23,090	86.9	10.7	2.4
Middle States	103,614	86.6	11.2	2.2
Northwest	22,551	88.3	9.6	2.1
Far West	32,666	90.9	7.4	1.7

[1] For States comprising the several regions, see text, footnote 6.
[2] Includes 670 recipients accepted in Alaska and Hawaii.

Additional factors which may affect variations among the regions in the physical condition of recipients are (1) the availability of medical services for the general population and for specific groups in the population, such as Negroes; (2) the availability of facilities in hospitals,[10] almshouses, and other institutions where aged persons with serious diseases or impairments may be cared for instead of under the program of old-age assistance; and (3) policies concerning the care of the aged blind. In some States aged blind persons are cared for under the program of old-age assistance and in some under the program of aid to the blind. Obviously, blind persons require more care than those with sight. No data are available concerning the number of blind persons who have been accepted for old-age assistance in the several regions.

[6] These regions are: Northeast—Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia; Southeast—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia; Middle States—Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Ohio, and Wisconsin; Northwest—Colorado, Idaho, Kansas, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming; Southwest—Arizona, New Mexico, Oklahoma, and Texas; Far West—California, Nevada, Oregon, and Washington.

[7] The differential between the Southeast and other regions may be understated because of the practice of making shared payments, which is more common in the Southeast than elsewhere. Probably most of the persons included in shared payments for whom data are not available are women, who have higher disability rates than men.

[8] Britten, Rollo H.; Collins, Selwyn D.; and Fitzgerald, James S., "Some General Findings as to Disease, Accidents, and Impairments in Urban Areas," *The National Health Survey*, Public Health Reports (Reprint No. 2143), p. 10.

[9] Holland, Dorothy F., and Perrot, George St. J., "Health of the Negro," *Milbank Memorial Fund Quarterly*, Vol. 16, No. 1 (January 1938), pp. 31–34.

[10] For information on the distribution of hospitals, sanatoriums, and related institutions registered by the American Medical Association, see *Hospital Service in the United States, 1941*, reprinted from the Hospital Number of the *Journal of the American Medical Association*, Vol. 116, No. 11 (Mar. 15, 1941), pp. 1035–1147.

Medical Care or Supervision of Accepted Applicants

When workers in the public assistance agencies established the eligibility of the applicants for old-age assistance, they questioned the old people concerning the medical care which they were receiving. According to the definitions, a person was to be recorded as under medical care or supervision if he actually received any care during the period of the investigation or if he considered himself to be under such care even though no medical contact was actually being kept at the time. The definitions did not impose a limitation on the length of time that might elapse after the last contact before an individual would cease to be considered under care. Consequently, there must be some lack of uniformity in the data. Nevertheless, the information is believed to be essentially realistic. The visitors who record the information presumably have knowledge of the communities' medical facilities and are trained to obtain specific information in response to their questions. The reports relating to medical care or supervision are remarkably consistent for the 4 years.

In the period 1936–40, only 388,000 persons, or a little more than one-fifth of the 1.8 million persons accepted for aid, considered that they were receiving some type of medical care or supervision (table 3). It may be assumed that a substantial majority of persons aged 65 and over are in need of at least periodic medical attention. According to the National Health Survey, in which data were obtained on the basis of a house-to-house canvass in sample areas, the number of persons per 1,000 population reported to have a chronic disease or permanent impairment was 467 in the ages 65–74, 514 in the ages 75–84, and 602 in the ages 85 and over.[11] In the urban relief population in May 1934, 70 percent of all persons 65 years of age and over were reported as having serious physical or mental disabilities according to data obtained in a house-to-house canvass of a sample of relief families.[12] Among a sample group of 948 recipients of old-age assistance in New York City who were 70 years of age and over, only 33 were found on the basis of medical examinations to be without active symptoms of disease.[13]

As would be expected, during the period 1936–40 relatively more medical service was reported for applicants who were bedridden or up and about but receiving considerable help in the home than for those who were described as able to care for themselves. Four-fifths of the aged persons who were bedridden considered that they were receiving some kind of medical service, as contrasted with half of those who were not bedridden but had serious incapacities and only one-sixth of those who could look out for themselves. There must have been much acute need for medical services

Table 3.—*Old-age assistance: Medical care or supervision and physical condition of recipients accepted during the fiscal years 1936–37 to 1939–40* [1]

Physical condition and medical care or supervision	Total	1936–37	1937–38	1938–39	1939–40
All recipients accepted	1,787,571	470,527	585,877	377,233	353,934
Percent with—					
No medical care or supervision	77.9	78.8	78.5	77.3	76.2
Some medical care or supervision	22.1	21.2	21.5	22.7	23.8
Recipients able to care for self	1,511,384	395,630	487,336	322,311	306,107
Percent with—					
No medical care or supervision	84.0	85.3	84.9	83.2	81.9
Some medical care or supervision	16.0	14.7	15.1	16.8	18.1
Recipients not bedridden but requiring considerable care	232,068	63,447	82,918	45,878	39,825
Percent with—					
No medical care or supervision	48.7	48.8	51.8	47.0	44.0
Some medical care or supervision	51.3	51.2	48.2	53.0	56.0
Recipients bedridden	43,613	11,137	15,663	9,012	7,001
Percent with—					
No medical care or supervision	20.6	20.7	22.2	19.6	18.6
Some medical care or supervision	79.4	79.3	77.8	80.4	81.4

[1] See table 1, footnote 1.

Table 4.—*Old-age assistance: Medical care or supervision of recipients accepted during the fiscal year 1939–40, by socio-economic region* [1]

Socio-economic region	Recipients accepted	Percent with—	
		No medical care or supervision	Some medical care or supervision
All regions [2]	353,934	76.2	23.8
Northeast	101,204	75.9	24.1
Southeast	70,121	78.7	21.3
Southwest	23,009	83.6	16.4
Middle States	103,614	71.6	28.4
Northwest	22,551	80.2	19.8
Far West	32,666	78.7	21.3

[1] For States comprising the several regions, see text, footnote 6.
[2] Includes 679 recipients accepted in Alaska and Hawaii.

[11] *National Health Survey, 1935–36: The Magnitude of the Chronic Disease Problem in the United States*, op. cit., p. 14.

[12] Federal Emergency Relief Administration, *Disabilities in the Urban Relief Population, May 1934* (Preliminary), Series 1, No. 6, May 22, 1935, appendix A, table 1.

[13] New York Department of Social Welfare, *A Study of the Medical Needs of Recipients of Old-Age Assistance in New York City in 1934*, 1937, p. 22.

among the remaining one-fifth of the persons who were bedridden, the remaining half of those in need of considerable care from others, and the remaining five-sixths of those able to care for themselves.

Marked regional differences were reported in the proportions of applicants who considered that they were under some medical care or supervision, as in the proportions who were incapacitated. In the Middle States, 28 of every 100 applicants accepted for aid considered themselves to be under some supervision, and in the Southwest 16 per 100 (table 4). The prevalence of conditions requiring medical treatment may also be presumed to vary from region to region and may be most acute where facilities for services are most meager.

What types of medical care or supervision were the applicants receiving at the time of investigation? In the 4-year period, almost seven-eighths of those who considered that they were receiving some medical services stated that they were under the care of private physicians who attended them either in the office or at home (table 5). One-ninth were said to be attending clinics. As would be expected, in view of the fact that the old-age assistance program is not intended to care continuously for persons in public hospitals and that the definitions excluded temporary hospital care for persons with acute illness, very few applicants were recorded as receiving care in hospitals or nursing homes. Few persons also were receiving care from other types of practitioners, such as osteopaths or chiropractors.

Care by an individual physician was the predominant form of medical service for all groups of applicants receiving some medical supervision. The physical condition of the applicants, however, governed to some extent the types of care they were receiving. In the 4-year period, 15 per 100 of the applicants classified as able to care for themselves were attending clinics. Among the bedridden group, on the other hand, only 2 per 100 were reported as attending clinics. The report that any of the bedridden were receiving clinic care raises a number of questions. Were these old people temporarily disabled at the time of investigation and incorrectly classified as bedridden? Had some of them received clinic care before becoming bedridden and would they be unable to attend clinics in the future? Did some of them leave their beds to go to clinics because

Table 5.—*Old-age assistance: Type of medical care or supervision and physical condition of recipients accepted during the fiscal years 1936–37 to 1939–40* [1]

Fiscal year and type of medical care or supervision	Recipients with some medical care or supervision			
	Total	Able to care for self	Not bedridden but requiring considerable care	Bedridden
Total, 4 years	388,190	237,337	116,608	34,155
Percent:				
Under private physician	85.5	82.7	89.7	90.2
In clinic	11.0	14.6	6.4	2.3
In hospital	1.5	.9	1.6	5.0
Under care of other type of practitioner or agency	2.0	1.8	2.3	2.5
1936–37, total	95,822	55,984	31,171	8,613
Percent:				
Under private physician	86.1	82.3	91.2	91.8
In clinic	10.0	14.9	5.3	1.8
In hospital	1.6	1.3	1.5	4.2
Under care of other type of practitioner or agency	1.7	1.5	2.0	2.2
1937–38, total	124,330	72,902	39,375	11,987
Percent:				
Under private physician	85.4	82.9	88.7	89.4
In clinic	10.7	14.1	6.9	2.7
In hospital	1.6	.9	1.9	5.3
Under care of other type of practitioner or agency	2.3	2.1	2.5	2.6
1938–39, total	84,853	53,605	24,050	7,187
Percent:				
Under private physician	86.7	84.7	90.2	90.3
In clinic	10.0	12.8	6.3	2.1
In hospital	1.3	.7	1.4	5.2
Under care of other type of practitioner or agency	2.0	1.8	2.1	2.4
1939–40, total	83,185	54,780	22,012	6,368
Percent:				
Under private physician	83.8	80.9	89.1	89.5
In clinic	13.1	16.7	7.1	2.6
In hospital	1.2	.7	1.4	5.3
Under care of other type of practitioner or agency	1.9	1.7	2.4	2.6

[1] See table 1, footnote 1.

medical attention better suited to their needs was not available? A study of the medical needs of recipients of old-age assistance in New York City calls attention to the fact that it is an effort for aged persons to travel long distances to clinics and to wait for extended periods in clinic waiting rooms.[14]

Care in hospitals, according to reports, was relatively more frequent among bedridden persons under medical care or supervision than among those less seriously incapacitated. Of the 5 per 100 bedridden persons who were stated to be receiving hospital care at the time of investigation, some may have continued to remain in hospitals while on the old-age assistance rolls. The Social Security Board will match payments to recipients living continuously in private hospitals or nursing

[14] New York Department of Social Welfare, op. cit., p. 64.

Table 6.—*Old-age assistance: Type of medical care or supervision of recipients accepted during the fiscal year 1939–40, by socio-economic region* [1]

Socio-economic region	Recipients with some medical care or supervision	Percent—			
		Under private physician	In clinic	In hospital	Under care of other type of practitioner or agency
All regions [2]	83,185	83.8	13.1	1.2	1.9
Northeast	23,836	78.2	18.6	1.4	1.8
Southeast	14,766	90.1	7.0	.8	2.1
Southwest	3,774	86.9	9.8	1.0	2.3
Middle States	29,374	87.7	9.5	1.1	1.7
Northwest	4,424	90.2	5.8	1.7	2.3
Far West	6,933	66.6	28.3	2.5	2.6

[1] For States comprising the several regions, see text, footnote 6.
[2] Includes 78 recipients accepted in Alaska and Hawaii.

homes.[18] In some States, however, under State law or policy, assistance is not given to residents of private institutions.

There are particularly interesting differences in the relative importance of the various types of medical care or supervision among applicants accepted for aid in the several regions (table 6). In 1939–40, 28 of every 100 applicants in the Far West who received some medical attention were reported to be attending clinics; in the Northwest the corresponding number was 6 per 100; and in the Southeast, 7 per 100. Hospital facilities, according to the workers in the public assistance agencies, were utilized by applicants most frequently in the Far West and least frequently in the Southeast. There are equally striking variations among the regions in the availability of hospital and clinic facilities for the general population. One measure of the variations in hospital facilities is the number of general hospital beds per 1,000 population in 1940.

Socio-economic region	*General hospital beds per 1,000 population*
All regions	3.5
Northeast	4.2
Southeast	2.4
Southwest	2.7
Middle States	3.4
Northwest	4.0
Far West	5.0

Source: *Hospital Service in the United States, 1941*, op. cit., p. 1057.

No information is available concerning the quality of the medical services which the aged persons were receiving, the amount or frequency of care, or its adequacy in meeting their medical needs. Data are also lacking on the extent to which medical services were being supplied to these old people free or at reduced fees by general relief authorities, hospital departments, other public and private agencies, or by physicians in private practice. In view of the fact that all these aged persons were found to be needy when their eligibility for old-age assistance was established, it seems probable that many of those under medical attention were receiving either free care or care on a part-payment basis. It is also reasonable to assume that many who considered that they were under some medical care or supervision were then receiving and always had received irregular or inadequate care.

Physical Condition and Medical Supervision of Recipients

It may be assumed that the physical condition of persons on the assistance rolls is less favorable generally than that of the applicants at the time they were accepted for aid. The average age of persons in the case load is obviously higher than that of persons in the intake, and, as has already been pointed out, both the prevalence and severity of chronic diseases and impairments increase with age.

For purposes of planning to provide medical services to recipients of old-age assistance, more precise information is needed from physicians on the disabilities and impairments of recipients, and on the recommended treatment and care.

No definite conclusions can be drawn concerning the medical services available to recipients of old-age assistance from information on the medical attention which they were receiving as applicants. Inasmuch as the old people who considered themselves to be under some medical supervision were found to be needy when they were accepted for aid, it seems probable that many of them have continued to get such care while receiving old-age assistance. How much of this care and how much additional care they may be getting is not known.

A number of States are now making substantial provision for medical services to recipients of old-age assistance. For these States there is need for information in answer to the following questions: (1) to what extent do money payments to recipients include allowances for medical services; (2) to

[18] The Social Security Board may match payments to recipients in public hospitals up to a maximum of 90 days.

what extent are payments made by the agencies from old-age assistance funds without Federal matching for payments directly to doctors, nurses, dentists, clinics, and hospitals for medical services to recipients; and (3) how much medical service is provided to recipients by general relief authorities and other public or private agencies?

Provision of Medical Needs Through Money Payments

Unfortunately, there is no comprehensive information on the extent to which allowances for medical needs are included in the regular monthly payment or in an extra payment to the recipient. Such a practice is possible under State policy in many States—usually within the maximum limitations on monthly assistance payments. Sometimes State policy limits the amount which may be paid monthly to the recipient for medical services and the number of months for which such payments may be made. Allowances for medical needs may sometimes be restricted to extreme needs or to a small regular allowance for medicines. In a number of States, money payments may be made for medical care but not for hospitalization. This type of restriction may result from stringency of funds or inability to meet the costs of hospital care within established maximums on payments. Sometimes, however, hospital care is provided to needy persons through public funds allocated directly to hospitals, rather than through the welfare agency.

In New York State, a plan was put into effect in April 1941 for making separate money payments to recipients to meet their special needs, including medical services, drugs and medical supplies, and other items.[16] In May 1941, more than 11,000 money payments were made to recipients of old-age assistance for their special needs in amounts ranging from $1 to more than $220. More than half these payments were for less than $5, and three-fourths were for less than $10. On the other hand, nearly 3 percent of these payments were at or above $40, the Federal matching maximum. New York State does not limit the amount which may be paid monthly to a recipient. A distribution of the monthly payments for the special needs of recipients in May 1941 is given below.

[16] Such as fractional payments for less than a full month's assistance pending the initiation of the full monthly grant on the next regular payment date.

Size of payment	Number	Percentage distribution
All payments	11,116	100.0
Less than $5	5,871	52.8
5.00–9.99	2,465	22.2
10.00–19.99	1,622	14.6
20.00–29.99	511	4.6
30.00–39.99	348	3.1
40.00 or more	299	2.7

For Middlesex and Monmouth Counties, New Jersey, data are available on amounts for medical services included in money payments to recipients of old-age assistance.[17] The data for Middlesex County relate to the year ended January 31, 1940, and for Monmouth County to the year 1939. Types of services for which provision was made in money payments included physicians' visits, medicines, appliances, dental care, and nurses' visits. Of all cases active during the year in Middlesex County, 35 percent received allowance in the money payments for medical care during the year; in Monmouth County the corresponding percentage was 47. The maximum number of physicians' visits to an aged recipient in the year was 41 in Middlesex County and 79 in Monmouth County. A percentage distribution of amounts for medical services included during the year in money payments to individual recipients is given below.

Amount	Percentage distribution	
	Middlesex County	Monmouth County
Less than $5.00	31.4	29.8
5.00–9.99	17.7	19.9
10.00–19.99	23.9	22.4
20.00–29.99	12.4	10.0
30.00–39.99	5.4	5.7
40.00–49.99	2.3	3.9
50.00 or more	6.9	8.3

In Massachusetts, it is known that in May 1941 the maximum amount provided in a money payment to a recipient for medical needs, including both medical care and hospitalization, was $239.[18] For this month an analysis of extra payments to recipients for medical care and hospitalization [19] was made for 10 cities and towns which do not have hospitals owned and operated

[17] From unpublished reports submitted to the Social Security Board by the New Jersey Department of Institutions and Agencies.

[18] This amount covered services for more than 1 month.

[19] A negligible number of these extra payments were for needs other than medical care or hospitalization.

by the municipality. The percentage of recipients in these cities and towns receiving an extra payment ranged from 3 to 17 percent.

In Iowa about one-fourth of all recipients receive allowances for medical needs up to a maximum of $5 a month.

In the absence of more comprehensive information on the extent to which public assistance agencies are providing for medical needs of recipients through money payments, it may be worth while to examine the size of the assistance payments to recipients. Assistance payments are intended to supplement the resources of recipients to meet such requirements as food, shelter, fuel, utilities, clothing, and household necessities, as well as medical and other services. The amounts paid to recipients are governed by budgetary practices and budgetary standards, legislative or administrative maximum limitations, and availability of funds.

As of July 31, 1941, only 13 States [20] had no statutory maximums for monthly payments. In 2 States the statutory maximum was established at $45, above the present Federal matching maximum of $40; in 17 States [21] at $40; in 14 States [22] at $30, the former maximum in the Federal act; and in 5 States at $25 or $20. Two States permit somewhat higher maximum payments to recipients requiring medical care. Another State also makes exceptions for recipients whose needs are not met under the usual maximum. Sometimes administrative maximums are imposed, either at levels below the statutory maximum or in lieu of a statutory maximum.

Amounts needed by recipients for medical services are sometimes included in several monthly assistance payments, because the maximum limits the amount which can be paid in a single month. In Tennessee, for example, when the investigation shows that large medical bills must be incurred and that the necessary service cannot be provided through clinics, an estimate is made of needs for physicians' services and medical supplies and the necessary amount may be prorated over a 12-month period. The maximum total monthly payment to a recipient, however, is $25, and only one payment is made in a family.

[20] Two of these States had minimum limitations of $30 or $40 on the grant plus income.

[21] Of these States, five had limitations of $40 on the grant and income, and two on a flat grant minus income.

[22] Of these States, two had a limitation of $30 on the grant and income.

Table 7.—*Old-age assistance: Percentage distribution of money payments to recipients, by socio-economic region,[1] May 1941*

Socio-economic region	Number of recipients	Percent receiving—					
		Less than $10.00	$10.00–19.99	$20.00–29.99	$30.00–39.99	$40.00–49.99	$50.00 or more
All regions	2,152,073	14.1	35.5	30.0	13.0	7.3	0.1
Northeast	436,446	3.1	28.9	40.0	25.1	1.8	.5
Southeast	369,744	56.2	39.3	3.8	.7	(2)	(2)
Southwest	223,377	24.3	55.1	17.7	2.8	.1	(2)
Middle States	722,468	3.0	40.8	45.1	10.3	.8	.....
Northwest	163,852	3.5	36.6	35.3	23.8	.8	(2)
Far West	233,375	.4	0.2	12.8	20.0	60.6	.....
Territories	3,411	11.9	43.9	16.9	17.4	9.9	(2)

[1] For States comprising the several regions, see text, footnote 6.
[2] Less than 0.05 percent.

In the United States, about one-half of all money payments to recipients of old-age assistance in May 1941 were for $20 or more, and about one-fifth were for $30 or more (table 7). In the Far West, where the level of payments is highest, three-fifths of all payments were for $40 or more. On the other hand, in the Southeast, where the level of payments is lowest, the physical condition of recipients is poorest, and medical care or supervision of applicants least frequent, less than one-twentieth of the payments were for as much as $20 (table 7). Even small assistance payments, if they supplement sufficiently large resources of the recipient, may suffice to meet medical needs. But, according to reports received from the States, somewhat less than one-third (28 percent) of recipients accepted for old-age assistance in 1939–40 had any regular source of income in addition to the assistance payment. It seems unlikely that the great majority of money payments are large enough to provide for the medical needs of recipients; indeed, many payments are too small to provide for even subsistence needs at the level recognized by the agency.

Provision of Medical Needs Other Than Through Money Payments

The restrictive influence of the Federal matching provisions, which do not permit Federal participation in the agency's payments to doctors, nurses, dentists, clinics, and hospitals for services to recipients of old-age assistance, is reflected in the fact that in 1940–41 only nine States reported expenditures from old-age assistance funds for such payments; in three of these States the amount

was negligible. The amounts of these payments for medical care and hospitalization in the remaining six States are given below. No data are available on the number of recipients in whose behalf the costs were incurred.

State	Total	Medical care	Hospitalization
Kansas	$225,057	$183,506	$71,551
Massachusetts	111,049	55,520	56,420
New Hampshire	42,942	24,918	18,024
New York [1]	2,436,810	1,320,452	1,116,358
Pennsylvania	397,570	397,570	.....
Wisconsin	34,765	20,624	14,141

[1] Since April 1941, when New York State inaugurated a plan for meeting medical needs through direct money payments to recipients, indirect payments have declined in amount.

In the State of Washington, a program of medical assistance to recipients of old-age assistance was established about a year ago. Under this program, recipients of old-age assistance may be provided with medical, dental, surgical, optical, hospital, and nursing care, and also with appliances. Physicians are of the recipients' own choosing. Commitments under this program in the 4 months April through July 1941 amounted to about $450,000. Payments for services to recipients are made directly to the individuals and organizations providing the services.[23]

Medical services are frequently provided to recipients of old-age assistance by general relief authorities. General relief may be administered by the local agency which administers old-age assistance or by an entirely separate agency. According to a survey of general relief which was made by the Social Security Board as of January 1940, it was possible under State law or policy for general relief authorities to provide some medical services to recipients of old-age assistance in 35 States and some hospital care in 31 States (table 8). In about half these States, medical services are financed from local funds only and consequently are subject to the widest possible variations with respect to both adequacy and availability. In the Southwest there was no State financial participation in medical care or hospitalization. In the Middle States, on the other hand, in all but one of the States providing medical care or hospitalization to recipients of old-age assistance, there was both State and local financing of such services.

Table 8.—*Number of States in which State and local funds for general relief may be used to provide medical services to recipients of old-age assistance, by socio-economic region* [1]

Socio-economic region	Number of States in region	Medical care				Hospitalization		
		Total	State and local funds	State funds only	Local funds only	Total	State and local funds	Local funds only
All regions	49	35	17	1	17	31	15	10
Northeast	13	9	5	1	3	7	4	3
Southeast	11	5	1	0	4	6	2	4
Middle States	8	7	6	0	1	4	3	1
Northwest	9	[2] 7	3	0	4	[2] 7	3	4
Southwest	4	[3] 3	0	0	3	[3] 3	0	3
Far West	4	4	2	0	2	4	2	2

[1] As of January 1940. For States comprising the several regions, see text, footnote 6.
[2] Special provisions for these services in remaining 2 States; in 1, a special health levy, distinct from general relief levy, is used; in the other, local funds administered by county commissioners are used.
[3] In the 1 remaining State in this region, the county supervisors supply these services from special local funds.

[23] Ratay, Vlad F., unpublished report on Program of Medical Assistance to Recipients of Old-Age Assistance in the State of Washington.

Table 9.—*Number of States in which general relief funds may be used to provide medical services to recipients of old-age assistance in some or all local units, by socio-economic region* [1]

Socio-economic region	Number of States in region	Medical care			Hospitalization		
		Total	Available in—		Total	Available in—	
			All local units	Some local units		All local units	Some local units
All regions	40	35	22	13	31	21	10
Northeast	13	9	7	2	7	6	1
Southeast	11	5	2	3	6	2	4
Middle States	8	7	4	3	4	3	1
Northwest	9	7	6	1	7	7	.....
Southwest	4	3	2	1	3	2	1
Far West	4	4	1	3	4	1	3

[1] As of January 1940. For States comprising the several regions, see text, footnote 6.

The fact that general relief authorities are permitted by State law or policy to provide medical services to recipients of old-age assistance does not necessarily mean that such services are available on a State-wide basis. Although some medical care may be provided to recipients of old-age assistance by general relief agencies in 35 States (table 9), in only 22 of these States was such care said to be available in all local units. Hospitalization was reported as available in all local units in only 21 of 31 States in which general relief funds may be used for this purpose.

Because of the stringency of funds for general relief, it seems probable that in many localities where it is permissible to provide medical services to recipients of old-age assistance, general relief

authorities are reluctant or unable to do so. There are thousands of localities in the United States where general relief funds, if they exist, are inadequate for meeting the barest subsistence needs of families not eligible for one of the special types of public assistance or for work program employment. Standards for old-age assistance are generally higher than those for general relief. Furthermore, recipients of old-age assistance represent but one of many groups who look to general relief authorities for medical assistance. Medical services may be extended from general relief funds to families receiving aid to dependent children, to recipients of aid to the blind, to families with a member employed by the Work Projects Administration, Civilian Conservation Corps, or National Youth Administration, and to some extent to persons who are needy only with respect to medical services.

Although public welfare officials have the major responsibility for providing medical services to the sick poor,[24] such services are supplied in some States and localities by other public agencies, such as hospitals, or through a special medical program. Among the States which provide some medical service through hospital departments or through special health funds are Arizona, Arkansas, District of Columbia, Louisiana, Maryland, New York, Ohio, Pennsylvania, South Carolina, Utah, and Wyoming. In some localities, medical services are provided to needy persons by voluntary agencies. Where medical assistance is available outside the public welfare agency, it is doubtless being received, although not necessarily to the fullest possible extent, by recipients of old-age assistance. It may be assumed that the workers in the public assistance agencies have referred many old persons to health agencies and to physicians in private practice for medical attention.

[24] American Public Welfare Association, *Report of the Committee on Medical Care*, June 1, 1938, p. 3 (processed).

Conclusion

As a basis for intelligent planning to meet the medical needs of recipients of old-age assistance and of recipients of other types of aid, there is need for more comprehensive and precise information on the nature and degree of disabilities of recipients, on types of treatment and care needed, and on facilities and procedures for providing such treatment and care. Such information should have direct administrative use in planning medical care programs for the needy aged and other needy groups. Public assistance agencies should take leadership in the development of medical assistance programs and in stimulating the cooperation and coordination of existing health agencies and medical societies toward this important end.