Medical Care for Needy Persons in Maryland

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Maryland is one of two States that have provided medical care to needy persons, both public assistance recipients and others, through the State Department of Health. The Maryland experiment is of special interest at this time, when increasing attention is being given to the problem of providing more nearly adequate medical care to public assistance recipients.

IT IS now 10 years since Maryland inaugurated a program of medical care for needy persons, administered through the State and county health departments. One other State, Washington, formerly provided medical care for the needy through its health department but recently transferred responsibility for the program to the welfare department, where it had originally been located.

Starting in July 1945, the Maryland program went rapidly into operation, extending substantial medical care services to public assistance recipients and to other needy persons in the State. In the fiscal year 1953–54, care was available under the program to an average of 45,000 persons a month. Total expenditures for services under the program in that year, exclusive of the costs of hospitalization, which is provided outside the program, were $1,225,225.

Organization of the Program

The Maryland program consists of two separately administered and somewhat differently organized plans. One, known as the Maryland Medical Care Program for the counties of Maryland, operates in all 23 counties but excludes residents of the city of Baltimore. The other, the Baltimore City Medical Care Program, operates within the boundaries of the city, which includes about 40 percent of the total State population of 2.3 million. The city of Baltimore is not in any county.

The principal stimulus for the introduction of enabling legislation and for the organization of the programs came from the Medical and Chirurgical Faculty of Maryland (the State medical society) and the State Planning Commission. In 1939 the Faculty recommended that the State Planning Commission establish a special standing committee to study the medical care problems affecting State residents. The resultant Committee on Medical Care proposed the essential elements of the present county medical care program. A special subcommittee formulated the structure of the Baltimore plan.

Under the Medical Care Act passed by the Maryland State Legislature in 1945, the State Department of Health was directed to administer a program of medical services for welfare recipients and medically indigent persons or either of such classes of persons. The act took effect July 1, 1945. The program was under way in all 23 county health departments within less than a year. The program for Baltimore City began to operate in August 1948.

Both plans are based on physicians' home and office care, but administration of the county and city programs differs considerably, a reflection of the medical personnel and facilities available in the areas. Hospitalization is available to persons who receive care but is administered and financed apart from the medical care programs.

The Maryland Medical Care Program.—The county program is administered by the Bureau of Medical Services in the State Department of Health, headed by a full-time medical officer. A State advisory council on medical care, composed of representatives of the medical and allied professions and of the health and welfare departments, contributes to the formulation of policy. In each county the major responsibility for the program rests with the local health officer, who is also the deputy for the State Department of Health. He supervises the program, evaluates services, approves bills, maintains relationships with the providers and recipients of care, and directs those who determine the eligibility of applicants other than assistance recipients. The local health officer is given considerable latitude in the operation of his program and so is able to adjust it to specific county situations.

The Baltimore City Medical Care Program.—The Baltimore program is approved by the Board of Health of Maryland and is administered by the Medical Care Section of the City Health Department. This section was established in 1947 and is headed by a full-time medical officer. The personal physician chosen by the welfare client is the keystone in furnishing medical service. Seven outpatient clinics established by teaching and voluntary hospitals augment the services provided in his office or the patient's home by the personal physician. Baltimore's Commissioner of Health negotiated contracts with the Johns Hopkins Hospital and the University of Maryland Hospital in 1948 and with Sinai, Provident, South Baltimore, and Mercy Hospitals in 1949. Special medical care clinics were shortly thereafter established at these six hospitals. In August 1953 a clinic attached to Baltimore City Hospitals was started specifically to provide medical care clinic service to children living in foster homes in Baltimore.

Each clinic is headed by a medical director, who is responsible to his parent hospital. Each has an ad-

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visory committee consisting of at least the director, two clinic physicians, and two family physicians participating in the program. The Commissioner of Health, the Director of the Medical Care Section, and the seven clinic directors meet monthly to discuss the overall program.

The clinic director supervises the clinic and has the responsibility of assisting the general practitioners who provide home and office services to patients registered at the clinic. The clinic budget includes items for an initial examination, for consultation services for general practitioners, and for laboratory and—in special cases—outpatient services provided by the parent hospital. Within contractual limitations each clinic director has considerable autonomy in carrying out his own program.

Eligibility for Medical Services

All persons on the public welfare rolls are eligible for care under either the county or the Baltimore City medical care program. This group includes public assistance recipients under the four federally aided programs—old-age assistance, aid to dependent children, aid to the blind, and aid to the permanently and totally disabled—and recipients of general assistance and children receiving foster home care. In addition, residents of the counties who are medically indigent may qualify. In Baltimore only clients of the welfare department are currently eligible for medical care, but the medically indigent may receive outpatient care through another program.

Individuals qualify as medically indigent in the counties according to standards that vary with the economic level of the area. The financial burden and the seriousness of the individual's illness are also given consideration. In 1954 the maximum income that would permit a family of four to be classed as medically indigent ranged from $1,272 a year in the less prosperous counties to $1,452 in those that are more prosperous.

Certification procedures.—For assistance recipients the Department of Public Welfare transmits a certificate of eligibility to the Department of Health, and certification for medical care is automatic. The applicant receives an identification card, which he is expected to carry when seeking medical attention. In the counties, public assistance recipients are certified for 6 months. In Baltimore, welfare recipients are certified for quarterly periods that terminate March 31, June 30, September 30, or December 31. The identification card carries the expiration date of certification. In the counties, where the local administrator takes care of relatively few persons, 6 calendar months are calculated from the date of issue. The medically indigent applicant may be certified for any period up to 6 months but is usually certified only for the estimated duration of a single illness or medical procedure.

The county resident who is certified is free to choose his physician, dentist, or pharmacist immediately. Normally, he continues with the same physician or dentist whom he had before coming on the rolls. Just as the client may select his own doctor or dentist, the physician or dentist may accept or reject a patient. The physician completes a bill each month for each patient to whom he has rendered service, and he sends these bills to the county health officer. Laboratory services, which are provided by the central laboratory of the Maryland Department of Health and its 11 branches, are available to all patients. Several counties maintain diagnostic clinics. When a diagnostic examination seems to be desirable, arrangements for the use of the clinic are made through the patient's physician.

The person on the welfare rolls of Baltimore is told, through a letter from the Director of the Medical Care Section, that he is eligible for services under the Medical Care Program. The program is explained, and he is given an appointment at the clinic to which he is assigned. The director simultaneously notifies the clinic of this assignment.

Upon reporting to the clinic the patient registers, chooses a personal physician, and receives an identification card. Then or later he receives a physical examination that includes chest X-ray, urinalysis, blood count, and serological test for syphilis. He is given whatever immediate outpatient treatment he requires, and he may be referred from the clinic to the laboratories and outpatient department of one of the hospitals for specialized services. Like the county patient, he has free choice of physician if the physician he chooses is willing to accept him as a patient. If he does not have a family physician, he is shown a list of participating physicians from whom he may select a family doctor. Both the physician and the City Health Department are notified of the client's choice. A summary of the clinic's physical examination findings is forwarded to the physician selected. The physician is reimbursed by the Health Department on an annual per capita basis for each welfare recipient who has selected him as his personal physician; payment to him is made in advance, in quarterly installments.

Services Provided

The plans, as conceived, provided generous medical benefits, but inadequate appropriations have sometimes resulted in curtailment of the number of persons eligible, of the fees paid to physicians, and to a slight extent of the services offered.

Under the Maryland county program, the services that are provided include home and office visits; obstetrical services; consultation, X-ray, and other laboratory services rendered by physicians; limited dental care; and prescribed drugs. Certified patients are entitled to occasional sundries ordered by the physician, but they are not reimbursed for articles usually kept on the shelves of the family medicine chest. Medical supplies costing more than $5 must be authorized in advance by the county health officer.

The dental services provided vary considerably from county to county. A recent statement by the State Bureau of Medical Services reads:

> Ideally the program would provide complete dental services for all persons unable to pay for such services from their own resources. However, the facts of a limited budget, limited dental manpower, and an enormous backlog of accrued dental defects must be faced realistically and the

policies of the program adapted accordingly. With the necessity of being selective, the primary emphasis is on relatively complete services for children and young adults. Provision is made for fluoride treatment for children to reduce the further accrual of carious teeth.

In practice, the services provided and the number of eligible persons on waiting lists have varied somewhat from year to year, depending upon the amounts appropriated by the State legislature. In addition, payments to physicians, dentists, and hospitals for services rendered have sometimes been prorated to spread the available funds among all the providers of service.

In the counties, some of the major changes in the program resulting from changes in the adequacy of available funds have been as follows:

April 1, 1949: Payments to dentists for dentures discontinued.

May 1, 1949: Payments to physicians for services rendered in hospitals (except for obstetrical care) discontinued. Such payments had been in effect only a short time and were never large.

November 1, 1949: Payments to dentists for dentures authorized on a restricted basis. Payments to dentists for fluoride treatments for children authorized.

September 22, 1950: County health departments requested to reduce medically indigent certifications by 25 percent; dentures for persons over age 45 discontinued.

September 1950–December 1950: Payments to physicians, dentists, and hospitals prorated at 70 percent.

July 1, 1951: Payments to dentists for dentures again authorized for persons over age 45.

June 1953: Payments to physicians and dentists prorated at 52 percent for 1 month.

July 1, 1953: Adoption of increased fee schedule covering markup for pharmacists' services.

July 1, 1953: Adoption of system of limited enrollment with names of eligible persons not yet accepted kept on a waiting list.

April 1, 1955: Limited enrollment discontinued, and the waiting lists abolished.

Under the Baltimore City Medical Care Program the following services are available to persons registered at the clinics: (1) Physician's services in his office or the patient's home; (2) an adequate initial examination to appraise the need for medical care; (3) consultation with specialists and treatment services for ambulatory patients by specialists at hospitals; (4) X-ray and other laboratory services; (5) medicines and some medical supplies; (6) limited dental care; and (7) eyeglasses.

Dental care is minimal under the Baltimore plan. Most dental services are provided by the dental clinics at the hospitals operating medical care clinics. Because some of these clinics are practically limited to the extraction of teeth and are in other ways inadequate to meet the dental needs of persons under the program, a special dental clinic will soon be established in the Eastern Health District for persons unable to obtain required and authorized dental care at hospitals.

In Baltimore the program was cut drastically during the fiscal years 1950–51 and 1951–52, but a drop in relief rolls made it possible to maintain full coverage of welfare patients under the medical care plan in 1952–53. The program was again curtailed in 1953–54, but in February 1955 additional funds were made available to take care of the waiting list. The annual report of the City Health Department for 1953 describes the modifications in medical care necessitated by the cut in appropriations in the last half of 1953:

> As a consequence of the inadequate appropriation various steps were taken which reduced the quantity and quality of medical care for persons on welfare rolls. These included: (a) The establishment of a formidable waiting list, (b) the reduction of the short period during which persons were given medical care after ceasing to be on the welfare rolls and (c) stopping much needed special services such as the provision of dentures for exceptional cases. Fortunately, in order to avoid unnecessary tragedies, the hospitals conducting medical care clinics provided, from July 1 to September 30 free of charge, medical care clinic services of an emergency nature to persons on the waiting list. This generous act of the hospitals served to alleviate the immediate impact of the state budget cut.

Methods of Payment

Physicians participating in the program must be licensed to practice medicine under the law of Maryland or of a neighboring State. Private practitioners in the counties become a part of the Maryland program by submitting the customary bill form to the county health department. Private physicians in Baltimore City agree to accept clinic-referred patients, either by earlier notification to the clinic or by acceptance of patients who select them.

As indicated, under the county program the physicians and dentists are paid on a fee-for-service basis. Fees are uniform in all counties. The statewide schedule currently in effect provides $2 for an office visit, $3 for a home day call, and $4 for a home night call. No reimbursement is made for hospital services except obstetric services, for which $35 is paid in hospitals with no resident medical staff. Qualified physicians are allowed $5 and specialists $10 for consultations. In addition, consultants receive a travel allowance of 30 cents a mile one way. Other physicians receive $1 for travel of 10–15 miles one way or $2 for travel further than 15 miles. Dentists receive $2 for extractions and varying amounts for other services up to a maximum of $85 for a full set of dentures. From time to time it has been necessary to prorate reductions in these fees when total funds were inadequate.

In Baltimore City the family physician receives $7 annually for each person, sick or well, who chooses him. These payments are, in effect, about equivalent to the fees paid under the county program. Dental care is on a fee-for-service basis. With the exception of one clinic, the staff members of the hospital serve in the medical care clinics. The medical care clinic receives $10 a year, paid quarterly, in advance, for each person assigned, irrespective of whether the person is ill or well. Thus the Baltimore program is a capitation program.

Payments for drugs and medical supplies are made on the same basis under both plans. Pharmacists are paid the wholesale cost of ingredients, plus the cost of the container, plus a set markup fee that amounts to about 30 percent. This method of payment was developed by State and city health departments in collaboration with the State Pharmaceutical Association and the Baltimore Retail Druggists Association. No payment is allowed for certain expensive or experimental drugs.

Related Health Services

Additional medical care and health services are available to assistance recipients and other needy persons through other programs. Such resources are utilized wherever possible.

Health department clinics and other services.—Several of the counties have a master index file that includes medical care patients as well as patients receiving any other health department services. Such a file serves to coordinate preventive and curative services. Whenever time permits, public health nurses visit the homes of medical care patients. Arrangements for services needed are made through the personal physician if possible.

The medical care clinics in Baltimore regularly refer patients to the clinics maintained by the City Health Department under other auspices. Children under age 5 and maternity patients without complications are directed to the well-baby clinics and conferences or to prenatal clinics. They are also directed to Baltimore City Health Department dental clinics, where the load will soon be relieved by the special dental clinic to be established under the program at the Eastern Health District Building. Such programs are apart from the medical care plan but treat welfare recipients who apply.

Hospitalization. — Inpatient hospital care is the major item of expenditure for medical needs of welfare recipients not included in the services under the two medical care programs. The Department of Public Welfare is responsible for certification of persons eligible for State aid towards the cost of inpatient care. Because inpatient care places a greater financial burden on the patient, the means test used to determine medical indigency is more liberal than that used in the medical care program. The medical and surgical services required by the assistance recipient in the hospital are usually provided by staff doctors.

General hospitals in 12 counties and the 13 hospitals in Baltimore City provide inpatient care to certificants. Appropriations for this care are made directly to the State Health Department, which reimburses the hospital within the limits of the State appropriation at the lowest of three rates—(a) $12 per patient day, (b) hospital costs per patient day, and (c) billings per patient day for like services to other patients.

In addition, many hospitals receive supplemental local public funds in varying amounts. All hospitals are faced with the problem of financing the difference between the actual cost of care and the payments from public funds. Hospitals are allowed to make collections from or on behalf of medically indigent State-aided patients. State funds payable to the hospital are reduced by an amount equal to 50 percent of such collections; the remaining 50 percent is available to the hospital as an offset towards the differential between cost and reimbursement from public funds.

Program regulations require medical review and recommendations of the hospital staff, in addition to review and authorization by the State Health Department, for patients requiring more than 30 days of hospitalization. The State Health Department also has an active program to assist hospitals in the relocation of patients no longer requiring care in a general hospital.

In the fiscal year 1953–54, the State appropriation for the 36 general hospitals under the Maryland Hospital Inpatient Program totaled $2,217,965. About one-fourth of the expenditures for inpatient care were for welfare recipients. Of 16,447 discharges, accounting for a total of 229,269 approved State-aided days of care under this program, 22 percent were classified as assistance or welfare recipients.

Two large public hospitals—the Baltimore City Hospitals and the University (State) Hospital—operate under separate arrangements. There is no basis for estimating the cost of the services they provide to assistance recipients.

In addition to this program of care in general hospitals, State funds are appropriated for the care of welfare recipients and medically indigent persons in nine special hospitals offering care for convalescent children and the chronically ill.

The State also operates directly two hospitals for the chronically ill for its low-income citizens and is planning to build a third.

Table 1.—*Average number and percent of persons enrolled for medical care in Maryland, by assistance category and by medical care program, fiscal year 1953–54* [1]

Assistance category	Persons certified					
	Total [2]		Under Baltimore City program [3]		Under Maryland county program [4]	
	Number	Percent	Number	Percent	Number	Percent
Total	45,321	100.0	22,878	100.0	22,443	100.0
Old-age assistance	10,683	23.6	5,056	22.1	5,627	25.1
Aid to dependent children	19,899	43.9	12,894	56.4	7,005	31.2
Aid to the blind	486	1.1	287	1.2	199	.9
Aid to the permanently and totally disabled	3,829	8.4	2,451	10.7	1,378	6.1
General assistance	1,922	4.2	1,391	6.1	531	2.4
Foster home care for children	2,658	5.9	799	3.5	1,859	8.3
Services for medically indigent	5,844	12.9	----------	----------	5,844	26.0

[1] For Baltimore, the distribution of the average number of persons other than children receiving foster home care is assumed to be the same for the fiscal year as for Aug. 15, 1953. For the counties, the distribution of the persons other than the medically indigent who received medical care is assumed to be the same as for the estimated population receiving public assistance or foster home care during that period.

[2] 1.8 percent of the State population.

[3] 2.5 percent of the city population.

[4] 1.5 percent of the counties' population.

Nursing home care.—Grants for nursing home care may be authorized by the Department of Public Welfare. For persons eligible for any one of the categories of public assistance, the Department of Public Welfare standards provide an amount for "nursing care." Just as an individual may receive and use a public assistance grant based on allowable amounts to maintain his own home or to maintain himself in the home of a relative or in a boarding home, a person may use his public assistance grant to purchase nursing home care or nursing care in his own home to the extent that the standards permit him to do so.

The maximum amounts allowable to an individual monthly under the standards are $90.00 for "total care" and $68.50 for "partial care." These amounts are considered to include $3.50 for clothing. "Total care" is defined as care needed when "because of physical or mental incapacitation the recipient is bedridden or is unable alone to take care of most of his personal needs." "Partial care" is defined as needed when "because of physical or mental incapacitation the recipient needs care and supervision for part of his needs, even though he may be able to be out of bed and to partially take care of himself." The person whose grant covers an allowance for nursing care is certified for the State Medical Care Program just as is any recipient of assistance. The individual and not the welfare department pays the nursing home for his care.

Although an attempt is made to maintain standards through the administration of the licensing law, in general a poor caliber of nursing home is accepting welfare patients at these low rates. Health Department officials feel that they have made some headway in enforcing better standards in the homes that care for welfare patients but will find it difficult to enforce high standards until the allowance for nursing home care is raised.

Outpatient care.—Outpatient services for Baltimore City residents who are medically indigent are provided under a separate program financed from State and city funds on an equal matching basis. (The welfare recipient in the city has available to him, under the Medical Care Program, the resources of the medical care clinic and the outpatient department of the parent hospital, as well as the private physician he has selected.) For county residents, the outpatient program provides diagnostic and treatment services on a referral basis for both welfare recipients and medically indigent persons. The program is financed by State and county funds on an equal matching basis. For the fiscal year 1953–54, State funds appropriated for this purpose amounted to $180,000 for city residents and $20,000 for county residents.

Selected Program Operations

Two measures of the Medical Care Program in Maryland are the number of persons eligible for services and the number of doctors who give these services. The dispensing of drugs is also of interest.

The latest period for which data are complete is the fiscal year ended June 30, 1954. The analysis that follows relates to that period.

Persons certified.— Approximately 45,000 persons were certified for medical care under the two plans (table 1). In an average month these persons represent less than 2 percent of the population of the State. The proportion of the population receiving care under the program was considerably larger in Baltimore City than in the counties

Table 2.—*Number and percent of home and office calls, by medical care program, fiscal year 1953–54*

Location of call	Number of calls	Percent of calls
Total	211,682	100.0
Patient's home	53,673	25.4
Physician's office	158,009	74.6
Baltimore City program [1]	65,500	100.0
Patient's home	12,000	18.3
Physician's office	53,500	81.7
Maryland county program [2]	146,182	100.0
Patient's home	41,673	28.5
Physician's office	104,509	71.5

[1] In addition, clients of the Baltimore program were given 2,279 general examinations, 43,396 other examinations and outpatient services, and 11,987 laboratory services.

[2] Participating physicians also rendered consultant, laboratory, X-ray, and obstetrical services totaling approximately $20,000.

in spite of the fact that only persons on the welfare rolls were eligible for care in Baltimore.

Assistance recipients under the four federally aided categories constituted 77 percent of all persons certified—90 percent in Baltimore City and 63 percent in the counties.

On June 30, 1954, more than 3,000 persons were waiting to be certified for medical care in Baltimore City. This number grew to more than 5,000 in subsequent months, but in February 1955 additional funds were appropriated to take care of the waiting list. Enrollment in the counties was likewise limited during the fiscal year 1953–54, when the average number of persons waiting to be certified for care was 1,080.

In the Baltimore program about one-fourth of the medical care recipients were white; in the county program, three-fourths of the patients to whom a service was rendered were white. More than one-third of the patients in the Maryland county program and more than one-third of the persons enrolled in the Baltimore City program were under age 15. About one-fourth of the persons enrolled in Baltimore and of the patients attended in the counties were aged 65 or over. In the counties, however, approximately 40 percent of the expenditures under the program were for persons aged 65 and over and only 14 percent were for persons under age 15.

The characteristics of white and nonwhite medical care clients in Baltimore differ. Among the white persons, women outnumbered men, but the difference is not great. Among the nonwhite clients, there were almost twice as many women as men. About 18 percent of the nonwhite but 46 percent of the white enrollees in Baltimore were aged 65 years or over, while 45 percent of the nonwhite but only 24 percent of the white clients were under age 15. These differences were not apparent in the counties, where Negro clients did not predominate as they did in Baltimore.

Physicians' services.—During the fiscal year ended June 30, 1954, 879 physicians were participating in the county program: 651 in counties excluding the city of Baltimore, 112

in Baltimore, 55 in the District of Columbia, and 61 from other States. Three hundred and three physicians were participating in the Baltimore program. Many more physicians have indicated willingness to accept patients, although the location of their offices makes it impractical. The total number of physicians who have participated since the initiation of the program is far greater than 879. Both county and Baltimore administrators feel they have the wholehearted cooperation of the medical societies.

Table 2 shows the number of physician calls, both home and office, for each program during 1 year. The average number of calls per year of coverage in the city of Baltimore was close to 3 per patient. In the counties, it was 5½ per indigent patient and 9 per medically indigent patient.

Drugs. — Expenditures for prescribed drugs have increased rather markedly over the years. It is the opinion of the State Health Department that the increase represents principally a change in the prescribing habits of physicians—a change that probably has had equal effect upon private patients. The annual costs for drugs under the Baltimore program have risen from $6.79 per capita in 1949–50 to $7.70 in the fiscal year 1953–54.

Information on pharmacy services under each plan in 1953–54 follows:

Item	Baltimore program	Maryland county program
Number of prescriptions filled	108,312	129,196
Mean number of prescriptions per assigned person	4.6	5.8
Average payment per prescription	$1.68	$1.76
Annual cost of coverage per enrollee	$7.70	$10.10
Number of participating pharmacies	402	[1] 415

[1] 320 are located in the counties and 95 in Baltimore City. These 95 may also be included in the 402 pharmacies in Baltimore's program.

In the counties, where these data include services to the medically indigent, it is noteworthy that the annual cost of coverage for pharmacy service was $15.64 for the medically indigent in contrast to $8.15 for the indigent and that the mean number of prescriptions per year of coverage was 8.4 for the former and 4.9 for the latter.

Costs

Total expenditures for services under the medical care programs in 1953–54 amounted to $1,225,225, with slightly less than half this amount spent in Baltimore City (table 3).

A substantially larger amount of public funds ($2.2 million) was spent under the Maryland State program of general hospital care for needy persons during the same period. While about four-fifths of the expenditures under the medical care programs were for assistance recipients and only one-fifth for the medically indigent, under the hospitalization program about one-fourth of the total expenditures were for welfare clients and about three-fourths for medically indigent persons.

Per capita cost of services.—Exclusive of hospital care, annual per capita costs of services for the indigent under both programs are quite similar—$24.66 under the Baltimore City capitation program and $23.73 under the fee-for-service program in the counties. The per capita costs of the medically indigent in the counties are considerably higher, $41.94. The medically indigent are usually certified under the county program in the face of actual medical need.

These figures include only part of the medical care costs for children in foster homes in Baltimore City. The average annual cost for such a child to the program is $14.47. In addition, Baltimore provides medical care clinic services for them at a per capita cost of $10.00.

The costs cited above do not include administrative expenditures under either program, nor do they include the cost of many other services furnished under other health department programs or activities—for example, hospital care, nursing home care, and health department clinic and laboratory services.

Federally aided categories of assistance.—Of the 45,321 persons who received medical service under the Maryland programs, 34,897 were recipients under the four federally aided categories of assistance. Only a very rough estimate of the amount spent for medical care services for these recipients can be made at this time. Per capita expenditures for 1954 under both medical care programs combined for all welfare cases were $24.83, but they were known to be less than that amount for children receiving foster care. The per capita costs for general assistance recipients are thought by the administrators of the programs probably to have been higher than the average. The Maryland State Department of Health is developing plans for a detailed distribution of expenditures by category. Until such figures become available, it is probably expedient to assume that per capita expenditures for recipients of the special types of assistance are the same as those for the entire welfare group. Total expenditures under the medical care program for recipients of the four types of aid may thus be estimated at approximately $850,000 in the fiscal year 1953–54.

Under the hospital care program, perhaps $500,000 was spent for this group. The estimate is based upon the assumption that recipients in the four categories comprised approximately the same percentage of welfare clients receiving hospitalization as of those receiving medical care. Through the medical care and hospitalization programs, then, Maryland was spending on the average about $38.70 per year for each certified recipient of old-age assistance, aid to the blind, aid to dependent children, and aid to the permanently and totally disabled. This figure does not include the cost of nursing home care, nor does it take account

Table 3.—*Total expenditures for professional services, Maryland medical care programs, fiscal year 1953–54*

Item of expense	Total	Baltimore City program	Maryland county program
Total	$1,225,225	$586,311	$638,914
Services for indigents [1]	980,123	586,311	393,812
Medical care clinics	228,780	228,780	----
Physicians' services	391,282	154,824	236,458
Pharmacy services	320,135	184,797	135,338
Dental services	34,544	12,528	22,016
Eyeglasses	5,382	5,382	----
Services for medically indigent	245,102	----	245,102

[1] Recipients of public assistance, including general assistance, and children receiving foster home care.

of assistance recipients on waiting lists for the medical care program—1,080 on the average during 1953–54 for the counties and several thousand for Baltimore City.

In addition, members of this group received some services at the two public hospitals operated by the city and the State and also at public health clinics and ancillary outpatient departments.

Evaluation

It is impossible without further study to evaluate the respective merits of the Baltimore City and the Maryland county medical programs. Theoretically, at least, advantages pertain to the physical arrangements of the Baltimore plan, which operates in an area well provided with hospitals and which, through its clinics, augments the facilities of the solo practitioner. The degree to which county patients receive comparable diagnostic care cannot be determined.

The annual per capita cost for indigent persons is about $1 higher under the city program than under the county program for indigent persons. Presumably this difference is accounted for by wider application of diagnostic services in the Baltimore clinics. On the other hand, the indigent patient in the county receives about twice as many physicians' calls as does the indigent patient in the city. So there is little basis for comparing the costs of a capitation and of a fee-for-service program.

Persons close to the Maryland health programs praise the high level of administrative and professional efficiency demonstrated in their operation. It is generally agreed that skillful organization has minimized red tape, maximized the individual patient-physician relationship, and encouraged a high quality of medical care. Problems that remain unsolved are fairly obvious from the preceding discussion.

Some of these problems are almost identical with those of ordinary medicine. The typical maldistribution of physicians with reference to the geographic location of patients presents an obstacle to equitable application of the provisions of the medical care programs. The shortage of Negro doctors and dentists is also regrettable.

Adequate medical care coverage would require expansion of certain types of services; bedside nursing, nursing home care that meets a higher standard, dentistry, and provision for eyeglasses. Furthermore, because of variations in county resources, persons of comparable circumstances do not receive comparable services in different parts of the State unless they take the initiative to seek medical care in a neighboring county or city. Contrasts exist between Baltimore and the rural areas, partly because of differences in the facilities and personnel available and partly because of differences in available funds or the varying attitudes of attending health officers and advisory committees. Special incentives for the training of medical personnel who will agree to settle in rural areas and a provision (now lacking in the program) to pay costs of transportation, whereby persons may obtain services in neighboring counties or cities, would help meet some of these problems. It is obvious also that complexities stemming from the number of different agencies involved and the dual nature of the medical program must hinder public understanding even if they do not present a real barrier to receipt of needed services.

In spite of these limitations, the accomplishments of the programs are many. The programs reflect overall planning, the utilization of both preventive and therapeutic services, the referral of patients to clinics operated under other auspices, coordination with specialized health programs (such as that for crippled children), and vocational rehabilitation. At the same time decentralization has made possible flexibility of operation. It is encouraging that political intervention has been absent and that, according to competent observers, patients have rarely demanded over-service or shopped around from one physician to another.

In combination with the provisions for hospitalization, the programs have gone a long way to guarantee adequate medical services to that needy portion of the population of Maryland that would otherwise go largely unattended. The poorest children receive medical care on a regular and relatively comprehensive basis; the needy aged may go directly to the physician's office just as a paying patient does, in dignity. With the program an administrative base has been established through which additional services and more comprehensive care for needy and medically needy residents of the State may become available up to the limits of public funds allotted to this purpose.