Medical Care for Persons in Need

By A. J. Altmeyer*

Sickness, although no respecter of persons, strikes hardest and most often among low-income families—especially among people receiving public assistance. Failure to get medical care creates or perpetuates poverty and causes needless suffering and dependency. The Social Security Board has recommended that the use of Federal funds be authorized under the public assistance programs to share costs of medical care for persons in need.

"THE SUCCESS or failure of any government in the final analysis must be measured by the well-being of its citizens," said Franklin D. Roosevelt in 1931, when he was Governor of New York State. The State's "paramount concern," he added, "should be the health of its people."

In the intervening years the average level of health and length of life in the United States has risen greatly. Not all in our country, however, have shared equitably in that progress. We have not yet broken the vicious circle of sickness and poverty, either the poverty of individuals or that of whole communities.

It does little good to argue whether sickness begets poverty or vice versa; the two are bound together inextricably. By social measures to steady family income and by preventing and curing sickness to the best of our scientific ability we can attack that evil association. Yet we still are far from assuring a chance for health to those whose health needs are greatest and whose ability to pay for medical care is least—the people who are now in need. For them in particular there is bitter truth in the remark which Mr. Roosevelt made in 1939 in transmitting the report of an interdepartmental committee to Congress. "The average level of health or the average cost of sickness," he said, "has little meaning for those who now must meet personal catastrophes. To know that a stream is 4 feet deep on the average is of little help to those who drown in the places where it is 10 feet deep."

Sickness and Dependency

Sickness causes suffering and economic loss among all people, but it affects certain groups of people more than others. Among low-income families and people on the assistance rolls, illness comes oftener and lasts longer, on the average, than among others. The National Health Survey showed, for example, that illness which lasted a week or longer caused twice as much disability per person among families on relief as among families with $3,000 a year or more. Ill health and premature death constitute a chief cause—in most years the leading cause—of poverty and dependency. Medical care is important not only to prevent or cure sickness but also to reduce dependency.

The three groups of needy persons covered by assistance programs under the Social Security Act are likely to have especially heavy medical needs since, by definition, they are old or blind or are children in families which, in large part, have become dependent because of the death or disability of one or both parents.

Most old people, even when they enjoy a measure of health and independence, need some medical attention. Chronic diseases are very prevalent among the aged and often involve long periods of disability, prolonged care, and expensive diagnosis and treatment. Need for medical supervision and care is common among old people on the assistance rolls. In the State of Washington, for example, which has a special program for medical care of recipients of old-age assistance, from a fourth to a third of the old people receiving assistance have some medical service each month. During a year most of the aged recipients in that State receive some type of medical care or supervision.

For children, the death or incapacitating illness of a parent often not only is the cause of economic breakdown of a family but also entails the need for special protection of the health and welfare of the other members. Of the 640,000 children receiving aid to dependent children at the beginning of 1945, more than two-thirds were in need because of the death or disability of one or both parents. How much of this dependency would have been prevented by medical care cannot be estimated. But it is clear that the surviving parents and the children have unusually great health needs. Many of the parents require medical services if their health and economic capacity are to be restored. Furthermore, many diseases like tuberculosis and mental illnesses which incapacitate the parents may have serious consequences for the children. Care of illness has special significance in low-income families. Their homes are crowded, their resources meager, and their living standards low. Precautions necessary to protect the patient, the family, and others in the community are difficult.

The vision of many of the persons receiving aid to the blind might have been conserved or restored by early attention to their condition. For some, proper medical care can still arrest further loss of impaired sight or even restore some capacity to see. In this group, sickness increases the insecurities and hardships of people who are already handicapped.

Aid for persons not eligible for old-age assistance, aid to dependent children, or aid to the blind is financed wholly by the State or locality or both; no Federal funds are provided for general assistance. In about 2 out of every 5 cases accepted for general assistance in 19 large cities in 1944, the reason for aid was that a wage earner had lost employment because of illness or disability. The proportion of persons in rural communities who become dependent because they lack needed medical care may be even higher. Studies of farm borrowers made by the Farm Security Administration in 1940 found that in 21 typical rural counties in 17 States, 96 out of every 100 persons examined had one or more physical defects, and only 4 in 100 were found to be in prime physical condition.

Limitations Under the Social Security Act

Now there is no comprehensive provision for Federal participation in the costs of general medical services. With the exception of services for a few special groups, such as the military forces, veterans, Indians on reservations, wives and babies of men in the armed forces, and merchant seamen, such public medical services as are provided for individuals are fi-

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nanced wholly from State and local funds. Except for mental illnesses, tuberculosis, and other diseases which affect the public health, for which a needs test is seldom rigorously applied, such care is usually available only to persons in need. Public medical services are commonly provided through a public assistance or a public health agency. For a large group, therefore, public assistance now provides, though inadequately, for needs which ultimately may be better met through programs designed to meet the medical needs of the Nation, but for which there now is little or no other provision.

In the broad framework of social security, public assistance complements and supplements social insurance. As social insurance is broadened in coverage and scope, the need for public assistance will be lessened. Now, however, public assistance is a chief means of filling one of the most serious gaps in social insurance—the lack of insurance against illness. Until social insurance coverage is extended and disability insurance and medical benefits are added, public assistance will continue to be an important means through which persons who cannot pay will get needed medical services.

Many provisions of public assistance legislation make it unnecessarily difficult to provide for medical care for needy persons. The maximums on the amount of Federal funds in assistance payments under the Social Security Act have limited expenditures for medical care in some States. In aid to dependent children, not more than $9 a month in Federal funds can be used toward the payment for the first child in a family receiving aid to dependent children, and not more than $6 for each other child aided. In payments of old-age assistance or aid to the blind, the matching Federal part cannot be more than $20 a month. These Federal maximums have influenced States to adopt similar or even lower amounts for their part of the payment. Some State maximums are specified by State law; others, by administrative order. The maximum limits the money which any recipient can get, however great his need, even though the State may have ample financial resources. The maximums and the unpredictable and relatively high cost of medical care often make it impossible for an agency to give a needy person enough to enable him to pay for his medical care. Many low-income States do not have enough assistance funds to make payments that will cover costs of food and shelter. Since the Federal Government matches only what the State or the State and locality provide, the less the State spends, the less help the Federal Government can give toward meeting medical costs and other essentials. Only State and local funds, if any, are available for medical care for the many people receiving general assistance.

Under the Social Security Act, the Federal Government may share in medical expenses of the needy aged, blind, and dependent children only when these costs are included in determining the amount of the money payment to the needy person or family. Federal matching is possible only when these payments are made in cash, to the recipient or his legal guardian, without control by the agency of how the money shall be used. The limitations in the amount of individual payments, and in the method of making them, hinder the State agencies in providing for medical care through public assistance.

Medical bills are usually in the form of fees for services and are large for the individuals who have long, serious, or frequent illnesses. Many agencies are reluctant to make large cash payments to individual recipients. Many cannot make large payments because of the ceilings on Federal matching and the lack of sufficient funds of their own.

It is now generally believed by welfare administrators that the cash payment is the best way of meeting the needs of dependent persons. It does not set them apart from other people by reason of their dependency. They are in a position to expend their income to the best advantage, just as other people do. But a person cannot foresee when he will be ill, for how long, or how much the cost will be. He cannot plan for medical care as he can for other necessities. Even if assistance payments were much larger, the recipient could not be sure of having enough to meet medical costs, just as wage-earning families and even well-to-do families cannot always be sure.

Problems also arise because of the requirement that payments be made to the recipient or his guardian, without control by the agency of how the money shall be spent. The assumption underlying the money payment is that persons are able to plan and manage their own affairs. Although this is generally true, with sick people it often is not the case. Many people do not know how to go about getting the care they need. Even when they do know, they may have difficulty in actually getting a doctor, particularly if the doctor is going to have to give them credit.

Some assistance agencies and many practitioners and medical institutions have not fully understood that the money payment requirement in the Social Security Act is intended to assure the recipient the right to manage his money as he thinks best. They have difficulty in recognizing that the recipient, as the buyer of medical services, has the same relationship to the doctor and hospital as other persons in the community. Agencies then may become involved in practices which have the effect of telling the recipient what he is to buy or whom he is to pay, or guarantee payment to a doctor or hospital by helping to collect payment. Any such activities restrict the recipient's use of his assistance payment, and there can be no Federal matching.

Another difficulty arises because the payment must be made to the recipient and the costs of his last illness may not be known until after his death. This may be a sizable problem since during a year 1 old-age assistance recipient in 10 dies. If an assistance recipient dies before the bill is presented and has no insurance or other assets, costs of the care he received in his last illness must be met from State or local funds without Federal matching.

Several States, most of them rich States, have worked out ways of providing medical care for at least some recipients of public assistance in spite of the limitations in the Social Security Act.[1] All these plans involve expenditures for which matching Federal funds are not at present available. States with limited financial resources are unable, without Federal aid, to make adequate medical care available to the needy people on their assistance rolls. It is important that changes be made in the Social Security Act to enable State public assistance agencies to develop better

[1] For a brief summary of some such programs, see pp. 29–30 of this issue of the *Bulletin*.

and more nearly adequate ways of providing for medical care to persons in need.

Needed Changes

In its *Ninth Annual Report* the Social Security Board recommended a prepayment plan for medical care under a national insurance system. Under such a plan all insured workers and their dependents would be able to get needed medical services. The plan would permit families dependent on public funds to be covered also through payments made by assistance agencies on their behalf.

In the same report the Board also made recommendations about the assistance titles which would affect the provision of medical care to needy persons. These include: removal of maximums governing Federal matching in aid to dependent children and increase in the maximums for old-age assistance and aid to the blind; authorization of Federal matching of payments made directly by the assistance agency to doctors, hospitals, or other agencies that furnish medical care to assistance recipients; special Federal aid to low-income States; and Federal grants to States to share costs of general assistance.

Many of the public and other groups directly concerned, including State legislatures, the Council of State Governments, and the American Public Welfare Association, have long urged that the existing public assistance program be strengthened and that Federal grants-in-aid be extended to general assistance. In 1938 the House of Delegates of the American Medical Association advocated "recognition of the principle that the complete medical care of the indigent is a responsibility of the community, medical and allied professions and that such care should be organized by local governmental units and supported by tax funds."[2] This resolution of the House of Delegates also recognized that "the necessity for State aid for medical care may arise in poorer communities and the Federal Government may need to provide funds when the State is unable to meet these emergencies."

The objectives for which the United Nations have been fighting for these 5 years and more and the changes impending in our social and economic life as the war economy declines now give added reason to review and revise our provision for people in need. By helping States make more nearly adequate assistance payments to all persons in need and by equalizing the financial burden among States and localities, the Board believes that the Federal Government could take important steps toward assuring at least a minimum of economic security to any needy person. By permitting greater flexibility in the administration of the medical aspects of public assistance, the Board hopes to strengthen the efforts of States to make better provision for the health of needy persons and thereby for the economic security of the Nation.

[2] Resolution adopted by the House of Delegates of the American Medical Association, Sept. 17, 1938, reported in the *Journal of the American Medical Association*, Vol. 111, No. 13 (Sept. 24, 1938), p. 1216.

Perspectives on the Reconversion

By W. S. Woytinsky*

OUR DEMAND FOR economic projections and prognostications is due to some extent to a feeling of insecurity. As victory dawns, we are aware of three dangers: the threat of economic dislocations and unemployment during the coming reconversion; the threat of set-back, unemployment, and social conflict after demobilization; and the danger of mass unemployment and misery a few years later, after a short spell of prosperity while industry has been catching up with the demands which have accumulated during the war years.

Experience After Previous Wars

Experience after the Civil War and the First World War justifies these apprehensions.

In the summer of 1865, immediately after the end of the Civil War, the United States experienced a set-back. Then, after an inflationary boom, a new set-back came in 1869. It was followed by a short period of prosperity and then a deep depression which lasted until the end of the 1870's.

Similarly, the end of the First World War brought a minor set-back in the autumn of 1918 and a violent contraction of economic activity in 1920. The subsequent period was called "prosperity" by some people, and "fools' paradise" by others. In relation to the First World War, this period may be described as catching-up expansion, while the great depression of the 1930's appears as the secondary postwar depression, analogous to that of the 1870's.

While history will not necessarily repeat itself, past experience is disturbing. Three dangerous turning points are hidden somewhere in the future, in the phases of the postwar economy analogous to the autumn of 1918, to 1920, and to the 1930's. Persons responsible for employment security are particularly eager to figure out what will happen in the unemployment compensation system during the coming vicissitudes.

Experience in Unemployment Compensation, 1939–44

A general answer to the last question may be drawn from an examination of the average weekly number of beneficiaries under State unemployment compensation systems during the years 1939 through 1944 (chart 1). When Germany invaded Poland, the United States was recovering from the depression of the 1930's. The first manifestation of the war boom cut down the number of beneficiaries. Then, after the conquest of Poland, a lull developed in the war theater. The "phony war" in Europe caused uneasiness and a feeling of uncertainty in this country. Recovery was interrupted by a mounting tide of unemployment. The weekly number of beneficiaries was at a peak, more than 50 percent above the prewar level, when Germany opened its second offensive by invading the Low Countries. After Dunkerque and the surrender of France, when the war became a struggle for survival, this country assumed the role of the arsenal of democracy. The drop in the number of beneficiaries was due to the expansion in de-

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