An Examination of the Concept of Medical Indigence

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FOREWORD

SINCE its establishment Health Information Foundation has been placing the bulk of its research resources and efforts into projects concerned with how families in this country pay for their personal health services. This research has shown the costs and utilization of services by various income groups, the extent to which families and individuals have health insurance, and the degree to which such insurance helps to pay for services.*

In the overall pattern of how families pay for personal health services there is an undetermined segment of the population called the "medically indigent" who are regarded as able to provide for themselves the basic necessities of food, clothing and shelter, but have great difficulty in meeting the costs of personal health services they need. Presumably if these families had adequate voluntary health insurance coverage, they would have less need to resort to public medical care programs. In fact, it was shown in the Foundation's nationwide study that as family income decreases there is less likelihood that families are covered by some type of health insurance.

The pilot study described in this research report was conducted to examine the concept of medical indigence in the framework of a medical program financed by public funds — a program designed specifically for people regarded as financially self-sustaining but unable to meet relatively large bills for personal health services. It is hoped that this study may help to clarify the concept of medical indigence and that its implications will be of interest to medical programs financed both by public

*Anderson, Odin W., with Feldman, Jacob J., *Family Medical Costs and Voluntary Health Insurance: A National Survey.* McGraw-Hill, N. Y., 1956; Anderson, Odin W., and the National Opinion Research Center, *Voluntary Health Insurance in Two Cities: A Survey of Subscriber-Households.* Harvard University Press, Cambridge, Mass., 1957.

funds and by private sources through voluntary health insurance. One of the enrollment problems facing voluntary health insurance is the coverage of low-income groups who are above the level of the statutory indigent.

Many persons were of assistance to the authors during the course of the study. Special mention is made of Mr. Stewart Schweizer, who assisted in the designing and execution of the field phase of the project. The generous cooperation of the following persons in the medical program is also acknowledged: Dr. J. Howard Beard, health officer, Anne Arundel County Health Department; Dr. Mark V. Ziegler, former chief, Bureau of Medical Services and Hospitals, Maryland State Department of Health; Dr. Herbert Notkin, former assistant chief; Dr. V. L. Ellicott, present chief, and Dr. Bettie Rogerson, statistician.

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I. The Concept of Medical Indigence

DURING the past generation a new welfare category has emerged called "medical indigence." This discussion will attempt to bring greater clarity to this new area of community responsibility by examining an operating program designed for persons presumed to be medically indigent.

Specifically, case material has been drawn from the records of recipients of medical care in a county administering the Maryland Public Medical Care Program. In addition, a small number of families has been selected from the case records and intensive personal interviews with these families have revealed data and insights normally not available in the records. At best, however, this is a pilot study, and tentative generalizations are based on inconclusive although very suggestive data. The field work was done in the summer of 1954.

A. *Conditions Underlying the Emergence of Medical Indigence*

The concept of medical indigence is an offshoot of the time-honored concept of indigence. Indigence, as such, is defined by law, varying in different localities, and persons classified as indigent are presumably unable to provide for themselves the minimum essentials of food, clothing, shelter and medical care. They represent a very low-income and no-income group. In the United States the general term used since the Social Security Act of 1935 is that of "recipients of public assistance." In the federal terminology, these recipients are in turn subdivided into the categories of dependent children, the blind, the aged and persons with permanent total disability, plus a catch-all group

called recipients of general assistance. Public responsibility for the provision of medical care for these groups has long been recognized, but not necessarily adequately implemented.

As personal health services have improved in character, quality and effectiveness during the past 50 years, they have become more expensive. The costs of needed services have also become more unpredictable, so that most families today are unable to save for costs of personal health services of a major nature without some sort of insurance mechanism.

Public responsibility for the provision of medical care to those immediately above the line of destitution, however defined, is relatively new (even though some reference was made to it in welfare statutes a hundred years ago); this concept recognizes medical care as a *separate* need apart from food, clothing and shelter. Some low-income families may have enough income and resources to make them ineligible for public assistance, but not enough to pay for needed personal health services. This rather nebulous group is now called the "medically indigent"—not indigent because of inability to provide for themselves a minimum of food, clothing and shelter, but indigent because of inability to pay for sizeable personal health services.

In its present form this popular definition is stark and oversimplified. To a great extent the problem is not basically economic, although ostensibly so, but stems from the varying ability of families to cope with life's daily problems. On examining the literature on medical indigence, one has the impression that the medically indigent are those who are not receiving public assistance, and are recognized by hospitals and physicians as being unable to pay for recommended medical care. To hospitals and physicians, the need for care and the lack of sufficient resources are clear. Consequently it is assumed that the community should shoulder the financial responsibility.

B. Suggested Framework for Considering the Concept of Medical Indigence

The concept of medical indigence can be discussed on at least three levels:

(1) The first level provides a concept and a definition of medical indigence in the abstract. It ignores welfare traditions,

limitation of funds and other factors that must constantly be taken into account when social problems are considered.

This concept in the abstract would seem to imply that families on almost any income level are potentially medically indigent. It can be demonstrated that in a cross-section of families in the country during a given year, a few experience costs of personal health services equal to half or all of their annual incomes.[1] Others experience no costs, and still others incur costs of moderate amounts in relation to their incomes. Thus, in the abstract the concept of medical indigence is quite relative, but in application it is arbitrary, although its relative nature is recognized. Occasionally one hears of self-sustaining and financially independent families assisted by the National Foundation for Infantile Paralysis, the American Cancer Society and similar organizations concerned with long-term and extremely costly diseases. Many public programs for tuberculosis and mental disease also recognize this problem, as do crippled children's services and services for vocational rehabilitation.

(2) The second level can be called the social definition according to how the general public, the professional personnel in the health field, public officials and legislators perceive the problem. Although no opinion poll has ever been taken as to how these groups define the problem, it should not take intensive research to demonstrate that they regard the problem of medical indigence as one peculiar to low income.

(3) The third level might be called the administrative definition—the concept that emerges from a law establishing the program and the rules and regulations applying to that law. The budget is the most concrete expression of the administrative definition of the problem; it very likely represents a compromise between the social definition and the realities of implementing a given program. Both the program administrators who make budget recommendations and the legislators who appropriate money act in terms of what they conceive the magnitude of the problem to be in relation to availability of funds.

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1 It was shown that two per cent of the families in the United States incurred costs exceeding 50 per cent of their incomes. Two per cent represents one million families. Odin W. Anderson, with Jacob J. Feldman, *Family Medical Costs and Voluntary Health Insurance; a Nationwide Survey*, McGraw-Hill, New York, 1956.

It is the *administrative* definition with which this paper is concerned.

II. Chief Characteristics of the Medical Care Program for Medically Indigent

In order to gain a few insights into how the concept of medical indigence can be applied in an operating program, the case records in Anne Arundel County, Maryland, were analyzed. This county is one of the local administrative units for the Maryland Medical Care Program, which has been in operation since 1945.

Maryland has a statewide public medical care program for the recipients of public assistance (the indigent) and also for the medically indigent. There are two separately administered and differently organized programs, one for the 23 counties of Maryland and another for the city of Baltimore. This study is limited to the program for the 23 counties, and more specifically, Anne Arundel County. (This is a predominantly rural county of about 120,000 population, in which the 1949 median family income was $3,322.) There will be no attempt to present an exhaustive description of the Maryland Medical Care Program; detailed descriptions can be found in other sources.[2] However, an attempt will be made here to describe the segment of the population receiving personal health services within the framework of the Maryland program. In short, how does the particular framework in which a program operates determine what kind of people receive the services the program provides; and what are the nature and costs of the services?

A. Basic Framework of the Program

The nature of the recipients of a medical care program for the indigent and the medically indigent is largely the result of the program's dominant characteristics as to eligibility requirements, types of services offered, freedom of choice of physicians and generosity of the budget.

Given this self-evident assumption, what are the main characteristics of the Maryland Medical Care Program that act to select the type of people who seek its services? How are the

[2] Howard M. Kline and others, *The Maryland Medical Care Program*, American Public Health Association, 1948, and Ida C. Merriam and Laura F. Rosen, "Medical Care for Needy Persons in Maryland," *Social Security Bulletin* 18:10-16, Nov. 1955.

services utilized in terms of cost and scope after the eligibility requirements are met and the applicants are (in administrative terminology) certified?

1. *Services*

The Maryland Medical Care Program is essentially one of utilizing the existing structure of health services, the general hospital and private practitioners, without the state's setting up a parallel or competing health service system. The state becomes, in effect, a contractor with the general hospitals, private practitioners and others. One important exception are physicians' services in the hospital, particularly surgery. As has been a long-time tradition, in-hospital physicians' services are provided at no charge by the physicians on the hospital staff.

There are two distinct programs, each with its own type of services, budgets and financial eligibility requirements. One program provides physicians' home and office calls, drugs, medicines and dental services, plus services of the hospital outpatient departments on referral by the attending physician. The other provides hospital care and in-hospital physicians' services. The local health department, through the authority of the state health department, directly administers the first program, the county health officer certifies the "medical indigent" for physisicians' home and office calls, drugs, medicines and dental services, and the indigent and medically indigent for hospital outpatient departments. The local welfare department certifies the patients for the hospital in-patient program.

2. *Eligibility Requirements*

Understandably, the eligibility requirements for those seeking medical care only are less stringent than for those seeking total financial support. Patients are certified for medically indigent care on the basis of family size and income. The top financial limits range from $15 a week for a single person to $40 a week for a family of eight (or $780 and $2,080 a year, respectively).

If the budget permits, the county health officer may certify families who exceed the above scale, and "emergency" cases, for one visit pending the verification of means. Some reasons for the exceptions are:

a. Undue length of illness.

b. Effect on the family of loss of income if the wage earner is disabled.

c. Heavy debts which the family may have incurred for past illness, burial, losses because of flood, fire or similar calamity, if there is evidence that regular payments are being made.

d. Psychological or social problems that prevent the wage earner from assuming full responsibility for his dependents.

It is thus apparent that imposition of rigid financial standards alone will not deal adequately with the problem of medical indigence. Many other factors need to be considered, even if the income of a family exceeds top limits of financial requirements.

The eligibility requirements for hospital care and in-hospital physicians' services are less severe than for the home and office care program; a single person earning up to $35 a week may be certified for hospital-centered services. The assumption behind the difference in financial eligibility requirements is that hospital-centered services are a much greater drain on family financial resources than physicians' home and office calls, drugs, medicines and other medical expenses. It can be seen, then, that concepts of medical indigence may vary with the assumed financial severity of different types of services and the financial resources of families seeking services.

B. Administrative Controls

The recipients of public assistance (indigent) and the medically indigent have free choice of physician within the county among practitioners who have agreed to participate in the program. There is also free choice of hospital to the degree the attending physicians have hospital privileges. Presumably there is no free choice of surgeon, since surgical care is provided by physicians on the hospital medical staffs.

The bulk of the referrals to the program come from physicians (21 per cent) and public health nurses (34 per cent). Hospitals account for 15 per cent of the referrals, friends and relatives for 16 per cent and other sources for the remainder

The main control is the budget, since neither the health officer nor the public welfare director is likely to certify more people than his budget permits. It is not known, of course, to what extent persons are denied needed care or to what extent persons who need care fail to seek it. Originally the health officer was allowed to set his own financial eligibility of standards, but the need soon became apparent for some type of fairly arbitrary financial requirements. Another form of control, one that is very basic if applied, is to prorate the fees claimed by physicians if there are insufficient funds to pay them in full. This method has been used in the past, but is now considered undesirable. It is now more likely that the health officer, to keep within his budget, will tighten up on certification and create a waiting list, although taking care of medical "emergencies."

III. The People Receiving Care

A. Classification of Families

In the county selected for study, case records for 1,249 families and 4,191 individuals, the total for the twelve-month period covered by the study, were analyzed to determine family composition, utilization of services and cost of services. The medically indigent group receiving service at public expense comprised 0.9 per cent of the county population, and the recipients of public assistance, or indigent, 0.4 per cent, a total of 1.3 per cent.

The families were classified as follows:

1. Families certified as medically indigent for physicians' and other services outside the hospital. (Presumably, these families are also eligible for hospital-centered services.)
2. Families rejected for medically indigent physicians' certification during the fiscal year.
3. Families certified as medically indigent for hospital-centered services during the fiscal year.
4. Families certified as indigent.

It is felt that these classifications are useful for meaningful comparisons of different types of welfare categories as to family type and composition. Each program appears to select different types of families.

These classifications also reveal the relative importance given to type of service. It is shown that 675 families were certified as medically indigent for physicians' services outside the hospital and for hospital-centered services. Roughly one-half of the families were certified for physicians' services outside the hospital and one-half for services in the hospital. Of all families seeking physicians' services, 51 families, or approximately 8 per cent of the total, were denied certification.

1. *Family Type*

It was found that approximately 65 per cent of the families certified as medically indigent had both husband and wife present. Among families receiving public assistance (indigent), only 27 per cent had both husband and wife present. This probably indicates that there were more self-sustaining families among those certified as medically indigent than among those on public assistance. This is not surprising, since families certified as medically indigent had higher incomes than those certified for public assistance.

2. *Age Composition*

It was assumed that the segments of the population under 18 and over 64 were nonproductive, and were dependent on the age group from 18 to 64. Housewives were not regarded as dependents, unless they were over 64 years of age.

Given these assumptions, it was possible to show the size of the young, middle and older age groups associated with different programs.

The group with the highest proportion of dependents, as defined, was the indigent; 72.5 per cent of the persons in this group were under 18 or over 64. The group with the lowest proportion of dependents (58 per cent) was the one denied certification for medically indigent services. The first group represents a relatively low level of economic independence, the second a relatively high level of economic independence. Furthermore, families on the medically indigent active roles showed a higher proportion of persons 65 and over (12.1 per cent) than did the medically indigent inactives (5.2 per cent). Families going off the program had fewer dependents as a rule. The general population of Anne Arundel County had roughly only

half the proportion of persons in the dependent age groups as did the indigent and medically indigent groups.

3. *Families by Income*

The distribution of family income by program status showed expected differences. The medically indigent, active and inactive, had lower average incomes than the families denied certification, $1,108 as against $2,418, and one would expect the families certified as medically indigent for hospital-centered services only to show a higher average income than the others. It will be recalled that the income ceilings for this group are higher, because of the relatively great impact that hospital-centered services are assumed to have on family medical care expenses. Depending on the subgroups in the study, between 20 to 30 per cent of the medically indigent reported no cash income, but over 70 per cent of the families reported steady full-time jobs. The families denied certification contained a much larger proportion with incomes of $3,000 and over than the other groups, an understandable fact.

A very unexpected finding, however, was that families certified as medically indigent reported a *lower* average cash income than families on public assistance. Before families receiving public assistance were certified as indigent, their resources were lower than families certified as medically indigent, since eligibility requrements for public assistance are stricter than those for medical indigence. After families began to receive cash income from public assistance, however, their incomes were higher than those of families certified as medically indigent. Person for person the reported cash income for the medically indigent was $21 per month; for those on public assistance the figure was $29 per month.

B. Costs of Services

Some of the families experienced high costs for which the state assumed responsibility. Total expenditures as high as $2,300 per family were reported. For hospital care, approximately 10 per cent of the families had costs in excess of $340, and 4 per cent in excess of $600. For physicians' services outside the hospital, approximately 15 per cent of the families reported costs of over $40, ranging up to a high of $135. Approximately

10 per cent of the families experienced costs for drugs and medicines of from $40 up to the high of $175.

On the whole, considering hospital and all medical care, the costs assumed by the state amounted to approximately 12 per cent of the family incomes—an appreciable percentage in view of the fact that the nationwide average among families is 4 to 5 per cent. Twelve per cent, however, is the approximate national average for families under $2,000. All of the medical costs actually incurred do not appear on the records of the programs; thus, these costs represent approximate state expenditures, but not necessarily total costs per family.

C. Duration of Certification and Utilization of Services

The medically indigent active families who were on the medical care rolls at the end of the survey had been on the program for over seven months. Those who had gone off the rolls had been actively certified for over five months. Forty per cent of those still on the rolls had been certified for a year. Turnover among the medically indigent is less than one might anticipate considering the temporary nature of the concept of medical indigence. In contrast, among recipients of public assistance 12 per cent had been certified for five months and over eighty per cent for 12 months. Among those classified as medically indigent during the study, 13 per cent had once been recipients of public assistance.

Among the families denied certification for physicians' services outside the hospital, 20 per cent were certified during the year for in-hospital services. Also, 37 per cent of the families rejected had received some form of medical assistance under the Maryland Medical Care Program since its establishment in 1945.

D. Insights from 83 Families Interviewed

In order to gain some first-hand knowledge of the families certified as medically indigent and to acquire some feeling for their problems, 118 families were randomly selected for household interviews through a questionnaire. The local public health nurses were recruited to conduct the bulk of the interviewing. Eventually 83 families were interviewed, 35 families not being reached because they had moved or for other reasons.

1. *Dependency History of Families*

By and large the families interviewed had always been living on the borderline of poverty. Thus they constituted a chronic near-poverty class. Only 13 per cent of the families experienced a decrease in incomes because of medical problems. In general it appears that the great majority of the families had social, psychological and economic problems which increased their medical problem and encouraged their dependency. In other words, medical care was not a cause but a part of the total problem.

2. *Source of Knowledge of Medical Program*

Families with relatively major illnesses generally learned of the medical program through physicians. Families with minor conditions usually learned of the program through the public health nurse. This may indicate that the public health nurses encouraged families to seek care before conditions became major, or that families sought the advice of the nurses before consulting physicians.

3. *Perceptions of the Medical Program*

Families interviewed were asked to check on a list of symptoms or any symptom that members of the family had reported during the year prior to the interview. The report of a given symptom in the list was supposed to indicate the need for a physician's attention.[3] The over-all impression was that symptoms reported by families were brought to the attention of a physician. It is important to note, however, that the symptoms mentioned are symptoms *perceived by the family* respondent that, according to medical opinion, require medical attention. There may have been symptoms requiring a physician's attention that were not perceived as being of sufficient gravity.

IV. Generalizations and Implications

This exploratory study has attempted to collect information about medical indigence that is usually not analyzed routinely. The emphasis has been on the recipient of services rather than on the program itself. Eligibility requirements had to be con-

[3] The list was developed and applied at Michigan State University. Charles R. Hoffer and others, *Health Needs and Health Care in Michigan: a Report of a Statewide Survey*. East Lansing, Michigan State College, 1950. 94 pp. (Agricultural Experiment Station Special Bulletin 365, June 1950.)

sidered, however, to show the nature of the population covered by the program.

If this type of program were transplanted to another area with approximately the same type of general population, it is probably not too rash to predict that the new program would have approximately the same kind of people on its medical care rolls as the county under study in Maryland.

A. Characteristics of Medical Indigence

Given the financial eligibility requirements established, the impression was gained that the people seeking medical care at public expense, but not eligible for public assistance, are characterized as follows:

1. They have a long history of low income.
2. Medical care is only part of the problem they face. The need for rehabilitation, more steady employment, and better general adjustment is probably more important.
3. There is a relatively small (20 per cent) but constant turnover, and also a tendency to shift from program to program.
4. There is a higher proportion of complete families among the medically indigent than among the indigent, but a lower proportion than in the general population.

In a given year probably not more than 5 per cent of the potentially eligible members of the medically indigent population seek and are certified for services. There is no way of knowing to what extent the same families reapply and are certified from year to year.

B. Observations on the Program

This study offers no way of determining the adequacy of this program for solving the medical indigence problem in Anne Arundel County; but the program is itself evidence that something is being done in a systematic way. Undoubtedly a segment of the population is receiving services it would probably not receive otherwise. Also, there would likely be agreement that more needs to be done.

The existence of two types of programs under separate administrative agencies, with different standards of means, indicates that there must be great pressure on the existing funds. Consequently some people are eligible for hospital-centered services, but ineligible for physicians' services outside the hospital. Presumably, those eligible for physicians' services outside the hospital are also eligible for hospital-centered services. These requirements presuppose that personal health services outside the hospital are less of a financial drain on families than hospital care and in-hospital physicians' services. This assumption, however, has not been corroborated by recent studies undertaken by Health Information Foundation and the National Opinion Research Center.

A seemingly anomalous situation exists where it was found that the medically indigent families were subsisting on a lower cash income than the recipients of public assistance. Presumably, the medically indigent are living on less than the state regards as minimum subsistence for its recipients of public assistance. The question that naturally comes to mind is: *Does this characterize indigent and medically indigent in other areas as well?*

Early in the program the local health officer was given free rein to determine financial eligibility, presumably because there was little knowledge as to what the volume of demand might be. In short order the certifications outran the budget, and thereafter understandably well-defined financial requirements were established. Thus, in order to establish a workable program within the available budget, medical indigence was defined as a problem peculiar to very low income groups above the public-assistance level, and not as a contingency to which a rather wide range of income groups was exposed. The relative nature of medical indigence was recognized in the exceptions made for hardship cases *above* the already established income limits.

C. Possible Extent of Medical Indigence

As has been noted, the eligibility requirements in Maryland for medically indigent medical care exclude families earning more than about $1,000 to $2,000 a year depending on size of family. Those under these incomes are regarded as medically

indigent. In the United States today approximately 14 per cent of the households (i.e., families and persons living alone) report cash incomes of less than $1,000 a year, and 26 per cent of the households earn less than $2,000.

Obviously, all the people in these income groups do not seek medical care in a given year, but it can be assumed that these income groups are the potentially indigent, given present concepts of medical indigence. There would seem to be little disagreement with the assumption that families with incomes of under $2,000 a year are unable to pay for personal health services except those of a minor character. It is possible that they can pay part of a premium for health insurance. These points need further examination of the problem of providing personal health services for low-income groups is to be clarified.

About Health Information Foundation—

The Foundation was organized in 1950 by a group of leaders in the drug, pharmaceutical, chemical and allied industries who believe that the health field can continue its great progress only if citizens assume responsibility for its freedom.

These progressive representatives of the more than 200 companies supporting the Foundation decided they could serve the public interest by:

—documenting through research the accomplishments of the present system of medical care;

—defining areas in the health field in need of improvement and investigating possible solutions to current problems;

—bringing, through all media of communication, research findings, needed facts and new knowledge related to health problems to organizations active in the health field and to the public.

Today the Foundation is studying many of the most vital problems related to health in the United States, among them the ways by which voluntary health insurance can be expanded and improved, the special problems of Americans over 65, and the opinions and attitudes of the general public toward health services.

The Foundation's President is George Bugbee; its research director is Odin W. Anderson, Ph.D., co-author of this second volume of a new series of Foundation research reports.