SURVEY OF MEDICAL CARE

AND HEALTH STATUS OF RECIPIENTS OF PUBLIC ASSISTANCE

* *
*

NEW MEXICO DEPARTMENT OF PUBLIC WELFARE

DIVISION OF RESEARCH AND STATISTICS

SANTA FE, NEW MEXICO

JANUARY, 1944

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES (Cont'd.)

I. BACKGROUND OF THE STUDY

In October 1942, for the first time in its history, the Department of Public Welfare allocated funds to local offices for the specific purpose of providing medical care to public assistance recipients. This allocation was possible because of increased funds from tax sources earmarked for the Department of Public Welfare. Prior to October 1942, practically the only expenditures by the Department for medical care were small amounts of general assistance funds and allowances made in the family budgets of cases receiving cash payments from OAA, ADC or ANB funds. 1/ Under the regulations of the Department medical allowances could not be made in an amount which caused the payment to exceed the amount of individual payments subject to federal matching. Hence, the total amount of such allowances was extremely limited, especially in the ADC program where the maximum payments subject to federal matching are relatively lower than in the other programs.

The important new features of the program were that temporary policies and rules were set up governing the expenditure of medical funds, and that funds available for direct payments to doctors, hospitals, etc., were increased, although still much below a desirable minimum. In the 6 months period from April-September, 1942, inclusive, direct payments to doctors, hospitals, etc., (entirely from GA funds) were less than $5,000. In the period from October 1942-March 1943, direct payments exceeded $50,000. 2/

The Department of Public Welfare before undertaking this survey recognized that many aspects of its medical program fell below desirable standards both in quantity and quality of service rendered and in principles of administration and organization. A survey of New Mexico's medical care practices made by the Social Security Board in 1939 did much to bring the attention of the agency to its practices in this field.

Objectives

The present survey of medical care and of the health of all public assistance families was undertaken in order a) to summarize the experience of the Department with medical care and the medical care program, and b) to secure as complete a picture as possible of the amount of unmet need for medical and health care among the open cases as of March 31, 1943. An attempt was made to assemble the necessary facts in a form that would not only provide a basis for future planning but also permit comparison with similar studies in other parts of the country, and contribute to the pooled knowledge required for an attack on the problem of medical care among low income families, nationally.

Specifically, the questions to be answered included the following:

> How many families needed medical care, and how many received it? How many needed medical care, but did not receive it?
>
> What types of illness and disability were found among the persons receiving medical care, by sex and age groups?

1/ In addition, some public assistance cases received medical services from the Crippled Children's and Blind Service Programs for these special types of care.

2/ The term direct payments as used in this report, refers to direct payments to doctors, hospitals, druggists, etc., and the use of the term here should not be confused with its frequent usage, meaning cash payments directly to clients.

What agencies and organizations provided treatment?

What was the cost of providing medical care, the average expenditure per person treated, and the per capita expenditure based on the total population eligible for such care? (This figure is especially useful as a basis for estimating future needs and determining allotments for the medical care program.)

To what extent did patients receive the types of care recommended by the medical examiner? What reasons were most frequent for failure to begin treatment recommended and for interruption or suspension of treatment before it was completed?

How many cases were closed as a result of the treatment given, and how many showed other favorable changes in the family situation?

Medical Facilities in New Mexico

In the following pages a brief review is presented of medical facilities in New Mexico and of the organization and administration of the Department's medical care program. The Social Security Board Survey of 1939 showed that there were too few doctors of medicine, dentists and nurses in New Mexico. The number of dentists and registered nurses was particularly low in relation to estimated needs. The capacity of general hospitals was adequate for the State as a whole, but there were 9 counties in which there was no hospital. The ample facilities of some areas were not easily available to persons living in sections in which the number of general hospital beds was less than the suggested standard. Specialized hospital facilities were completely inadequate for care of the feeble-minded, and persons suffering with mental diseases and there were no hospitals for epileptics and no psychiatric wards in general hospitals. Absence of adequate facilities places severe restrictions on service which can be given by the Department, since medical care for public assistance cases is provided through existing facilities and agencies.

Organization and Administration

Operation of the public assistance medical care program of the Department in local offices is under the supervision of the Division of Public Assistance. A state office medical care committee coordinates the public assistance medical care program with special programs operated by the Divisions of Crippled Children Services, Services to the Blind and the State Tuberculosis Sanatorium. The purpose of this committee is to review all activities of the Department which pertain to medical care and to make recommendations directed toward a more effective and better coordinated program of medical care. The committee consists of the Supervisor of the Division of Services to the Blind, Chairman, and the Supervisors of Public Assistance and Crippled Children Services.

The Division of Services to the Blind employs a part-time state supervising ophthalmologist to supervise the medical aspects of that program and a medical social worker who serves as a consultant to local offices in the field of eye care. The Division of Crippled Children Services employs a part-time medical consultant and an orthopedic nursing consultant. Both divisions are under the general supervision of social workers. The State Tuberculosis Sanatorium operates under a part-time medical director and a business manager (non-medical). The public assistance medical care program operates without the benefit of medical supervision or consultation, except when it is sought from members of the medical staff of other divisions.

The medical care program is closely integrated with the provision of public assistance. Local workers who determine eligibility for assistance are responsible for authorizing medical treatment and for providing social services. There are no professionally trained social workers serving public assistance cases in other than supervisory positions. Considerable stress is laid in training and supervision on coordination of medical services and assistance and the case work aspects of medical care. These efforts are severely handicapped particularly for Aid to Dependent Children and General Assistance, because of funds so limited that adequate food, shelter, clothing and other essentials of life cannot be provided. Under such circumstances, new medical problems are created and efforts at rehabilitation are often futile.

The principal public sources of medical care for public assistance recipients are the Department of Public Welfare, the Department of Public Health,and the County Commissioners through county indigent funds. The Department has no official relationship with the Public Health Department relative to medical care for public assistance families, and no formal agreements have been worked out between the two agencies setting up a cooperative relationship, although an informal cooperative relationship has existed both on a State and local level. County indigent funds, under the law, are for the "relief of deserving indigent persons who are objects of charity....." In practice, the major portion of these funds are expended for medical care, since DPW funds are even less adequate for medical care than for other types of need. In many counties, the commissioners have entered into agreements with the Department of Public Welfare providing that the Department shall establish eligibility and authorize payments from indigent funds. In operating under these agreements, the Department follows its usual methods of determining eligibility and authorizing payment. These agreements, however, like the informal relationship with the Department of Public Health do not constitute a functionally coordinated public medical care program.

In planning for and administering medical service to public assistance cases, the Department has obtained little consultative service from professional groups. Representatives of the State Medical Association have conferred with the Department on problems relating to payment for services and on a fee schedule, but no continuing relationship has been developed. The Department has no formal relationship with professional groups representing dentists, nurses, pharmacists and hospitals.

Policies

All medical treatment paid for by the Department must be authorized in writing by the Department. Treatment is authorized only on the recommendation of the examining physician. All persons eligible for public assistance are automatically eligible for medical care if it has been recommended.

Under the policies of the Department as outlined above, any person whose medical needs plus regular living expenses are higher than his income is eligible for medical care. Thus, a large number of persons are potentially eligible for public medical care in addition to regular recipients of subsistence under public assistance programs. In view of limited funds, however, counties are encouraged to concentrate on public assistance recipients, so that during the 6 months covered by this survey only 25 "non-assistance" families received medical care from DPW funds. Thus it may be said that the Department makes almost no provision for the so-called "medically needy" aside from services to the blind, crippled children services and tuberculous

persons. This leaves a very wide gap in the provision of public medical services in New Mexico, since no other state-wide agency is equipped with funds or facilities to meet this need.

The policies and procedures of the Department place no restriction on the types of medical care which may be provided, so that preventive as well as curative services may be given. Limited funds, however, and limited facilities in many communities often have had the effect of restricting medical care to the more emergent situations, thus preventing a well-balanced program.

Payments for medical care are based on authorized service rendered, and the amount of the payment is determined by the physician's charge. The Department has no fee schedule, so that varying amounts may be paid for the same type of service. The State Medical Association has appointed a committee which is working with the Department in setting up a fee schedule, but no schedule has yet been agreed upon. Lack of a fee schedule causes many inequities and harms relationships with the medical profession. County directors, with only limited funds available, are often placed in the position of bargaining for cheaper rates and physicians, already overworked, have little incentive to serve on a reduced basis.

II. SUMMARY OF FINDINGS

Some of the facts revealed by this study stand out above all others, and help us to answer the more basic questions in regard to health and medical care of public assistance recipients. These questions and the facts bearing on the questions are briefly reviewed here. To see these facts in their context is not possible in so brief a presentation. (For a detailed analysis of findings see Sections IV-VIII.)

How Many Families Needed Medical Care?

More than 7 out of 10 families receiving public assistance were considered in need of medical care. (Approximately 9,000 families received public assistance.)

How Many Families Were Cared For?

Only 4 out of 10 families receiving public assistance were examined or treated by a physician; in the general population more than 8 out of 10 families receive the care of a physician in any one year.

Did All Families in Need of Care Receive It?

3 out of 10 families receiving public assistance needed medical care, but did not receive it.

What Diseases Were Most Frequent?

For persons under 18 - diseases of the respiratory system.
For persons 18-64 - diseases of the digestive system.
For persons 65 and over - diseases of the circulatory system.

Who Provided Treatment?

More than 50 different agencies and organizations provided medical care for public assistance recipients; in addition there were numerous individual contributions.

More than 4 out of 10 families receiving medical care obtained it from DPW funds only. (Approximately 3,700 families received medical care.)

3 out of 10 families receiving medical care obtained it from a combination of DPW funds and other funds.

3 out of 10 families receiving medical care obtained it from other sources only.

Other agencies and organizations serving the largest number of families were the Public Health Department, County Indigent Funds and the Proctor Eye Clinic, named in the order of the number of families served.

How Much Did it Cost?

Expenditures for medical care from DPW funds were approximately $85,000 in the 6 months ending March 31, 1943. Of this amount, 40 per cent was included in the assistance payments to clients and 60 per cent was in the form of direct payments by the Department to physicians, hospitals, etc.

Was This Sum Sufficient?

Estimated average annual expenditures per person eligible for care (including medical care from sources other than DPW) is less than $13 annually. In the general population, the average annual per capita expenditure for medical care for persons with incomes of more than $2,000 annually is above $20.

What Was the Money Spent for?

All types of medical care were provided. There were no legal restrictions or regulations preventing a well-rounded program of preventive and curative services, although inadequate funds resulted in emphasis on cure rather than prevention.

Who Received Treatment?

More than 4 out of 10 persons treated from DPW funds were 65 years of age or over. (2,538 persons were treated.)

2 out of 10 were children less than 18 years of age.

Almost 5 out of 10 persons treated were members of families receiving OAA and 3 were members of families receiving ADC.

The highest recipient rate (more than 25 per cent of those eligible for care) was among males of the wage-earning years, 18-64, since in every instance men of this age receive assistance because of a physical or mental handicap.

To What Extent was Recommended Treatment Provided?

8 out of 10 persons receiving medical care from DPW funds received the care recommended by the examining physician.

The extent to which different types of recommendations were carried out varied from 97.1 per cent for medication to 28.6 per cent for psychiatric treatment.

What Were the Results of Treatment?

Although the period covered by the survey was short (6 months) and a majority of the conditions treated were chronic, many favorable results of treatment were shown.

3 out of 10 persons treated were cured or received maximum benefit. (4 out of 10 persons treated were still under treatment as of March 31, 1943.)

49 cases were closed as a result of treatment.

The family situation was improved in at least 68 other cases by increasing the capacity of a mother to care for her children, of a child to attend school, etc.

III. RECOMMENDATIONS

The outstanding finding of the Medical Survey is that the medical needs of the Public Assistance case load are not adequately met. The Department of Public Welfare should develop plans to meet medical needs because, first, the Department has a legal obligation to provide for the medical needs as well as for the other subsistence needs of Public Assistance recipients and, second, because provision of medical care in many cases serves to terminate, reduce or prevent dependency.

Following are the recommendations of the Medical Care Committee as steps necessary for the continuation and development of the Medical Care Program:

1. The Department of Public Welfare should request and support an appropriation for this purpose. Approximately $200,000 a year is needed to meet the medical needs of families receiving public assistance. 1/

2. A medical social worker, working under the administrative direction of the Supervisor of Public Assistance, should be appointed to develop a medical care plan and to serve as a Medical Social Work Consultant.

3. Closer working relationships and better understanding should be established between the Department of Public Welfare, the State and County Health Departments, and the State and County Medical Societies.

4. The Department of Public Welfare should encourage Federal legislation whereby Federal funds would be made available to match State expenditures for medical care of Public Assistance recipients.

1/ Estimate excludes portion of medical care costs now included in assistance payment.

IV. HEALTH STATUS AND MEDICAL NEEDS OF PUBLIC ASSISTANCE FAMILIES

Recency of Medical Care

Of the 8,857 cases open on March 31, 1943, 5,151 families (58.2 per cent) included no member who had been examined or treated by a medical practitioner during the year ending March 31, 1943 (See Table 1). The range among the categories was quite wide, from 18.3 per cent for the non-assistance cases to 64.5 per cent for those receiving Old Age Assistance. 1/ The term "non-assistance case" as used in this survey applies to those cases approved for general assistance, but receiving medical care only.

TABLE 1. FAMILIES APPROVED FOR PUBLIC ASSISTANCE, CLASSIFIED BY ASSISTANCE PROGRAM AND RECENCY OF MEDICAL CARE, MARCH 31, 1943

Item	Families Approved for Public Assistance					
	All Programs	OAA	ADC	ANB	GA	NA a/
All families	8,857	5,004	2,285	238	1,248	82
No person examined or treated, April 1, 1942 - March 31, 1943	5,151	3,230	1,203	120	583	15
One or more persons examined or treated, April 1, 1942-March 31, 1943	3,706	1,774	1,082	118	665	67
	Percentage Distribution					
All families	All Programs	100.0	100.0	100.0	100.0	100.0
No person examined or treated, April 1, 1942 - March 31, 1943	58.2	64.5	52.6	50.4	46.7	18.3
One or more persons examined or treated, April 1, 1942-March 31, 1943	41.8	35.5	47.4	49.6	53.3	81.7

a/ "Non-assistance" cases as used in this survey include those cases approved for general assistance, but receiving medical care only.

Nationwide studies show that more than 8 out of 10 families with incomes of $1,200 or more receive physician's services during a year. 2/ This study shows that only 4 out of 10 public assistance families received medical examination or treatment in the 12 months ending March 31, 1943.

Health Status

The fact of having received no medical care may of course indicate either exceptionally good family health or some degree of unmet need. For the families under discussion the latter interpretation would be most often

1/ However, when persons are considered rather than cases, it is found that relatively more of those in OAA cases received care. See Table 11.

2/ Hollingsworth, Helen; and Klem, Margaret C., Medical Care and Costs in Relation to Family Income; Washington; U. S., Federal Security Agency, Social Security Board, Bureau of Research and Statistics, Division of Health and Disability Studies; Bureau Memorandum No. 51, March, 1943, p. 53 (Table 16).

true. In more than half of these 5,151 families without care (or one-third of all families) the case record indicated that medical examination or treatment or both was needed; in 22.3 per cent the family health was described as good; and in 15.2 per cent health was not mentioned (See Table 2). Relatively, the greatest amount of unmet need was found among the OAA cases, 61.6 per cent needing care, and in the GA group (61.1 per cent). Among the ADC families without examination or treatment, slightly over one-third enjoyed a health status described as good - a larger proportion than was found for the other assistance categories.

TABLE 2. FAMILIES WITHOUT MEDICAL CARE, CLASSIFIED BY ASSISTANCE PROGRAM AND HEALTH STATUS, MARCH 31, 1943

Health Status	Families Without Medical Care a/					
	Total	OAA	ADC	ANB	GA	NA b/
No person examined or treated, April 1, 1942-March 31, 1943	5,151	3,230	1,203	120	583	15
Record indicates examination needed	2,969	1,991	561	55	356	6
Health described as good	1,146	600	410	36	98	2
Health status not recorded	785	455	213	15	97	5
Other c/	251	184	19	14	32	2
	Percentage Distribution					
No person examined or treated, April 1, 1942-March 31, 1943	100.0	100.0	100.0	100.0	100.0	100.0
Record indicates examination needed	57.6	61.6	46.6	45.8	61.1	40.0
Health described as good	22.3	18.6	34.1	30.0	16.8	13.3
Health status not recorded	15.2	14.1	17.7	12.5	16.6	33.4
Other c/	4.9	5.7	1.6	11.7	5.5	13.3

a/ Approved for assistance as of March 31, 1943.
b/ "Non-assistance" cases as used in this survey include those cases approved for general assistance, but receiving medical care only.
c/ Medical care refused; health fair for age; permanent handicap, health otherwise good; condition hopeless; and miscellaneous.

A small part (4.9 per cent) of the families without care could not be classified under the groups just described. Though health was mentioned in the record, it was not specified as good, nor was medical examination recommended. Of the 251 such families, 91 refused treatment, 67 did not receive treatment, though suffering from a permanent disability, because it was believed that medical treatment was not needed, and 54 of advanced age did not receive care because "health fair, despite advanced age."

The families in which one or more members received some form of medical care during the year totalled 3,706, or 41.8 per cent of the total open case load. Of these, slightly more than three-fourths received examination or treatment during the 6 months of the survey period.

This survey was made as of the end of the first 6 months of the medical care project, during which time health needs were more adequately met than in the past, due to availability of increased funds. In spite of this expanded program, however, an unmet need remained in at least 2,969 cases or one-third of the total, as has been shown. This is an understatement of the actual situation existing, since the survey schedules did not provide for reporting the care which may have been needed in the families whose health condition was not recorded, or additional needs among other members of families where one or more persons were examined or treated. The main reason for this lack of needed care has been insufficient funds. Other contributing factors are lack of facilities and shortage of medical personnel, especially in some areas of the State.

The significance of long-standing unmet need for medical care is illustrated in the following excerpt of a report by a county director:

> "The recording indicates at the beginning of the case history that Mrs. B. stated she was in poor health, suffered with rheumatism and gynecological trouble. In 1940, it was recorded that both were in good health. In 1941, Mr. B. stated he had been suffering with kidney trouble for the past 10 years and it is aggravated when he labors hard.... He stated that his physical condition has never been diagnosed properly as he has been financially unable to pay for the examination. He gets severe pains in his back and is unable to keep up his farm properly. Mrs. B. suffers from arthritis and teeth are irregular. She depends mostly on liquids for a diet, being unable to masticate properly. She requested an increase in the grant to get treatment, but at that time funds were limited."

Combining from Tables 1 and 2 those families which needed medical care but did not receive it (33.5 per cent) with those receiving such care (41.8 per cent), it is evident that 75.3 per cent or three out of every four families either had medical assistance or were considered in need but did not receive it during the year ending March 31, 1943.

V. INCIDENCE OF ILLNESS AND DISABILITY AMONG PERSONS RECEIVING MEDICAL CARE FROM DPW FUNDS

The medical diagnoses of persons receiving medical care from DPW funds were classified according to the Code for Tabulating Impairments Found on Medical Examinations prepared by the U. S. Public Health Service. 1/ Since reports on medical examinations were not available for persons receiving medical care from sources other than DPW funds, or on persons who may have needed but did not receive medical care, these data cannot be considered a picture of the incidence of disabilities appearing in the case load, but rather a picture of the incidence of disabilities among persons treated from DPW funds.

During the six survey months 2,538 persons received examination or treatment from the three DPW sources under study (Medical care program, general assistance, and "assistance payment"). One hundred of these persons were excluded from the tabulations - 18 with diagnosis of "no pathology" and 82 with "diagnosis unknown."

Diseases of the digestive system (including dental defects) had the highest frequency for all sex and age groups combined (See Table 3). Diseases of the circulatory system and of the respiratory system ranked next in importance in the order named. The patterns of illness at different ages vary decidedly; thus for children under 18 diseases of the respiratory system had the highest frequency; among adults, 18-64, diseases of the digestive system ranked highest; and among persons 65 years of age and over, diseases of the circulatory system occurred most frequently.

Sex variations in distribution of disabilities among the various diagnosis groups were relatively minor for all age groups combined, although musculo-skeletal impairments occurred relatively more frequently for males and diseases of the genito-urinary system more frequently for females (See Table 4). The classification "genito-urinary diseases" includes 51 normal pregnancies which although not technically a disease were included in this group since medical care is required. This accounts for the relatively high frequency of this classification among females, 18-49.

Table 3 shows the number of persons having diseases falling within the 10 main diagnosis groups and 34 sub-groups. Frequencies for the 350 individual diagnoses are not shown because of the complexity of the tabulation and the relative infrequency of many of the classifications. These were tabulated, however, and will be made available to anyone interested in further analysis.

1/ Code not in its final form at the time of this survey. Some adjustments were made in the code to allow for classification of illnesses not considered as "impairments."

Within each diagnosis group the frequencies tend to cluster about certain diagnoses. The few in each group which account for the largest numbers are listed below in order of importance.

Diagnosis	Frequency
Infectious and parasitic diseases, neoplasms and other general systemic diseases:	
Anemia (not specified as pernicious)	44
Diabetes mellitus	34
Tuberculosis, site unspecified	25
Syphilis, form unspecified	24
Infectious and parasitic diseases	21
Malignant neoplasm (cancer) of skin	20
Diseases of the nervous system:	
Epilepsy	42
Neuritis	38
"Other" mental and nervous diseases	12
Diseases and impairments of the eye and ear:	
Defective vision - cause unspecified	229
Cataract (all forms)	57
Otitis media	10
Diseases of the circulatory system:	
High blood pressure, etc.	180
"Other" diseases of the heart (non-specific diagnoses)	82
"Other" diseases of the myocardium	73
Arteriosclerosis	69
Diseases of the respiratory system:	
Infected tonsils	188
Asthma	54
Bronchitis (not specified as chronic)	36
Pneumonia	35
Bronchitis, chronic	30
Enlarged tonsils	22
Diseases of the digestive system, including dental defects:	
Decayed teeth, number unspecified	163
"Other" diseases of stomach and intestines (Miscellaneous)	75
Ulcer of stomach and intestine	50
Hernia, site unspecified	39
Appendicitis	37
Defective or deficient teeth, not otherwise specified	35
Diseases of the genito-urinary system:	
Nephritis	53
Normal pregnancy	51
"Other" diseases of female genital organs	39
Cystitis	34
"Other" diseases of the prostate (not hypertrophy)	30
Diseases of the skin:	
"Other" diseases of the skin	25
"Other" local infections	19
Other and ill-defined diseases and defects:	
Ill-defined diseases, senility, etc.	159
General debility	20
Diseases and impairments of the musculo-skeletal system:	
Arthritis and rheumatism	215
"Other" diseases or injuries of the organs of movement - (Miscellaneous)	74

TABLE 3. PERSONS RECEIVING MEDICAL CARE CLASSIFIED ACCORDING TO DIAGNOSIS GROUP, BY SEX AND AGE A/

DIAGNOSIS GROUP	BOTH SEXES							MALE							FEMALE						
	ALL	UNDER 6	6-17	18-49	50-64	65 & OVER	AGE UNK.	ALL	UNDER 6	6-17	18-49	50-64	65 & OVER	AGE UNK.	ALL	UNDER 6	6-17	18-49	50-64	65 & OVER	AGE UNK.
ALL PERSONS B/	2,438	52	424	621	306	1,020	15	1,183	30	193	243	156	559	2	1,255	22	231	378	150	461	13
INFECTIOUS AND PARASITIC DISEASES, NEOPLASMS, AND OTHER GENERAL SYSTEMIC DISEASES	372	17	31	143	48	127	6	168	11	12	62	21	60	2	204	6	19	81	27	67	4
TUBERCULOSIS	66	2	10	44	3	7	0	32	2	4	25	0	1	0	34	0	6	19	3	6	0
SYPHILIS	29	1	1	18	4	5	0	16	0	0	12	2	2	0	13	1	1	6	2	3	0
OTHER VENEREAL DISEASES	6	0	1	5	0	0	0	2	0	1	1	0	0	0	4	0	0	4	0	0	0
OTHER INFECTIOUS AND PARASITIC DISEASES	31	12	6	4	4	4	1	18	8	3	4	1	2	0	13	4	3	0	3	2	1
MALIGNANT NEOPLASMS	60	0	0	4	8	48	0	35	0	0	2	3	30	0	25	0	0	2	5	18	0
NONMALIGNANT NEOPLASMS	25	0	0	9	6	10	0	11	0	0	3	4	4	0	14	0	0	6	2	6	0
DISEASES OF THE ENDOCRINE GLANDS	36	0	4	25	1	6	0	2	0	0	1	0	1	0	34	0	4	24	1	5	0
DISEASES OF THE BLOOD & BLOOD-FORMING ORGANS	46	0	4	16	8	17	1	16	0	1	5	4	6	0	30	0	3	11	4	11	1
NUTRITIONAL DISEASES & CHRONIC POISONING	80	3	7	22	14	32	2	39	1	3	13	7	15	0	41	2	4	9	7	17	2
DISEASES OF THE NERVOUS SYSTEM	148	4	15	63	21	45	0	83	1	6	38	11	27	0	65	3	9	25	10	18	0
DISEASES OF THE CENTRAL NERVOUS SYSTEM	14	0	0	5	3	6	0	12	0	0	4	3	5	0	2	0	0	1	0	1	0
DISEASES OF THE CRANIAL & PERIPHERAL NERVES	42	0	0	12	6	24	0	22	0	0	5	2	15	0	20	0	0	7	4	9	0
PSYCHOSES	11	0	0	5	3	3	0	6	0	0	3	1	2	0	5	0	0	2	2	1	0
OTHER MENTAL AND NERVOUS DISEASES	80	4	15	42	9	10	0	42	1	6	27	5	3	0	38	3	9	15	4	7	0
DISEASES AND IMPAIRMENTS OF THE EYE AND EAR	399	5	106	71	44	171	2	171	3	45	17	15	90	1	228	2	61	54	29	81	1
BLINDNESS	17	0	1	1	4	11	0	7	0	1	0	0	6	0	10	0	0	1	4	5	0
DISEASES AND IMPAIRMENTS OF THE EYE, EXCEPT BLINDNESS	363	3	103	65	37	153	2	151	2	43	13	12	80	1	212	1	60	52	25	73	1
DEAFNESS	8	0	0	0	3	5	0	4	0	0	0	2	2	0	4	0	0	0	1	3	0
DISEASES OF THE EAR, EXCEPT DEAFNESS	16	2	2	7	3	2	0	12	1	1	6	2	2	0	4	1	1	1	1	0	0
DISEASES OF THE CIRCULATORY SYSTEM	485	1	7	47	77	350	3	239	1	3	22	38	175	0	246	0	4	25	39	175	3
DISEASES OF THE HEART, VALVES, ENDOCARDIUM AND MYOCARDIUM	121	1	2	11	14	93	0	63	1	1	8	5	48	0	58	0	1	3	9	45	0
OTHER DISEASES OF THE HEART	116	0	2	12	22	79	1	65	0	1	6	14	44	0	51	0	1	6	8	35	1
DISEASES OF THE ARTERIES	247	0	0	13	24	208	2	113	0	0	5	10	98	0	134	0	0	8	14	110	2
DISEASES OF THE VEINS	48	0	0	11	19	18	0	24	0	0	4	11	9	0	24	0	0	7	8	9	0
OTHER DISEASES OF THE CIRCULATORY SYSTEM	5	0	3	0	1	1	0	3	0	1	0	1	1	0	2	0	2	0	0	0	0
DISEASES OF THE RESPIRATORY SYSTEM, EXCEPT TUBERCULOSIS	401	20	184	66	29	100	2	188	11	88	28	12	49	0	213	9	96	38	17	51	2
DISEASES OF THE NASAL FOSSAE AND ACCESSORY SINUSES	38	3	7	9	3	16	0	9	1	3	1	0	4	0	29	2	4	8	3	12	0
DISEASES OF THE THROAT	204	7	173	22	2	0	0	97	3	84	9	1	0	0	107	4	89	13	1	0	0
DISEASES OF THE LUNGS, BRONCHI & PLEURAE	170	10	8	35	24	91	2	87	7	3	18	11	48	0	83	3	5	17	13	43	2
DISEASES OF THE DIGESTIVE SYSTEM	606	6	76	185	101	237	1	293	3	35	68	51	136	0	313	3	41	117	50	101	1
DEFECTIVE TEETH	245	1	54	72	49	68	1	111	1	24	19	21	46	0	134	0	30	53	28	22	1
DISEASES OF THE BUCCAL CAVITY, ESOPHAGUS, AND ANNEXA (EXCEPT TEETH)	39	0	5	17	8	9	0	15	0	5	5	2	3	0	24	0	0	12	6	6	0
DISEASES OF THE STOMACH AND INTESTINES	266	1	22	76	42	125	0	155	1	10	43	30	71	0	111	0	12	33	12	54	0
DISEASES OF OTHER DIGESTIVE SITES	85	4	2	24	15	40	0	36	1	1	7	8	19	0	49	3	1	17	7	21	0
DISEASES OF THE GENITO-URINARY SYSTEM	319	3	13	122	29	149	3	131	1	5	14	18	92	1	188	2	8	108	11	57	2
DISEASES OF THE KIDNEY	109	1	4	19	15	69	1	52	0	2	9	11	30	0	57	1	2	10	4	39	1
OTHER NONVENEREAL DISEASES OF THE URINARY SYSTEM	52	1	3	4	7	37	0	35	0	1	2	5	27	0	17	1	2	2	2	10	0
NONVENEREAL DISEASES OF THE MALE GENITAL ORGANS	65	1	2	4	5	52	1	65	1	2	4	5	52	1	0	0	0	0	0	0	0
NONVENEREAL DISEASES OF THE FEMALE GENITAL ORGANS	118	0	4	98	6	9	1	0	0	0	0	0	0	0	118	0	4	98	6	9	1
DISEASES OF THE SKIN	71	6	19	11	11	24	0	46	5	10	6	10	15	0	25	1	9	5	1	9	0
OTHER AND ILL-DEFINED DISEASES AND DEFECTS EXCEPT MUSCULO-SKELETAL	177	0	0	10	9	156	2	102	0	0	7	6	89	0	75	0	0	3	3	67	2
DISEASES AND IMPAIRMENTS OF THE MUSCULO-SKELETAL SYSTEM	385	2	20	92	71	199	1	234	1	13	64	40	116	0	151	1	7	28	31	83	1
DISEASES & IMPAIRMENTS LIMITED TO THE FEET	11	0	0	2	7	2	0	9	0	0	1	7	1	0	2	0	0	1	0	1	0
OTHER DISEASES AND IMPAIRMENTS LIMITED TO A SPECIFIC SITE	8	0	1	3	4	0	0	6	0	0	3	3	0	0	2	0	1	0	1	0	0
LOST MEMBERS (MUSCULO-SKELETAL) BY ANATOMICAL SITE	12	0	1	5	4	2	0	12	0	1	5	4	2	0	0	0	0	0	0	0	0
OTHER MUSCULO-SKELETAL DISEASES & IMPAIRMENTS	358	2	18	83	59	195	1	211	1	12	56	29	113	0	147	1	6	27	30	82	1

A/ 100 PERSONS EXCLUDED FROM THIS TABLE - 18 WITH "NO PATHOLOGY" AND 82 WITH DIAGNOSIS UNKNOWN.

B/ AN UNDUPLICATED COUNT OF PERSONS RECEIVING MEDICAL CARE. TOTALS LESS THAN SUB-HEADINGS SINCE ONE PERSON OFTEN HAD TWO OR MORE DISABILITIES.

TABLE 4. PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING MEDICAL CARE CLASSIFIED ACCORDING TO DIAGNOSIS GROUP, BY SEX AND AGE

Diagnosis group [A]	Both sexes							Male							Female						
	All	Under 6	6-17	18-49	50-64	65 & over	Age unk.	All	Under 6	6-17	18-49	50-64	65 & over	Age unk.	All	Under 6	6-17	18-49	50-64	65 & over	Age unk.
All persons	2,438	52	424	621	306	1,020	15	1,183	30	193	243	156	559	2	1,255	22	231	378	150	461	13
Infectious and parasitic diseases, neoplasms, and other general systemic diseases	15.2	32.7	7.3	23.0	15.6	12.4	39.9	14.2	36.7	6.2	25.5	13.4	10.7	100.0	16.2	27.2	8.2	21.4	18.0	14.6	30.7
Tuberculosis	2.7	3.8	2.3	7.0	0.9	0.6	0	2.7	6.7	2.0	10.2	0	0.1	0	2.8	0	2.5	5.0	2.0	1.3	0
Syphilis	1.2	1.9	0.2	2.8	1.3	0.4	0	1.3	0	0	5.0	1.2	0.3	0	1.0	4.5	0.4	1.5	1.3	0.6	0
Other venereal diseases	0.2	0	0.2	0.8	0	0	0	0.1	0	0.5	0.4	0	0	0	0.3	0	0	1.0	0	0	0
Other infectious & parasitic diseases	1.3	23.0	1.4	0.6	1.3	0.3	6.6	1.6	26.7	1.5	1.6	0.6	0.3	0	1.0	18.1	1.2	0	2.0	0.4	7.6
Malignant neoplasms	2.5	0	0	0.6	2.6	4.7	0	2.9	0	0	0.8	1.9	5.3	0	2.0	0	0	0.5	3.3	3.9	0
Nonmalignant neoplasms	0.1	0	0	1.4	1.9	0.9	0	0.9	0	0	1.2	2.5	0.7	0	1.1	0	0	1.5	1.3	1.3	0
Diseases of the endocrine glands	1.4	0	0.9	4.0	0.3	0.5	0	0.1	0	0	0.4	0	0.1	0	2.7	0	1.7	6.3	0.6	1.0	0
Diseases of the blood & blood-forming organs	1.8	0	0.9	2.5	2.6	1.6	6.6	1.3	0	0.5	2.0	2.5	1.0	0	2.4	0	1.2	3.0	2.7	2.3	7.6
Nutritional diseases & chronic poisoning	3.2	5.7	1.6	3.5	4.5	3.1	13.3	3.2	3.3	1.5	5.3	4.4	2.6	0	3.3	9.0	1.7	2.3	4.7	3.7	15.3
Diseases of the nervous system	6.1	7.6	3.5	10.1	6.8	4.4	0	7.0	3.3	3.1	15.6	7.0	4.8	0	5.1	13.7	3.9	6.6	6.7	4.0	0
Diseases of the central nervous system	0.6	0	0	0.8	0.9	0.5	0	1.0	0	0	1.6	1.9	0.8	0	0.1	0	0	0.2	0	0.2	0
Diseases of the cranial & peripheral nerves	1.8	0	0	1.9	1.9	2.3	0	1.8	0	0	2.0	1.2	2.6	0	1.6	0	0	1.9	2.7	2.0	0
Psychoses	0.5	0	0	0.8	0.9	0.2	0	0.5	0	0	1.2	0.6	0.3	0	0.3	0	0	0.5	1.3	0.2	0
Other mental and nervous diseases	3.2	7.6	3.5	6.7	2.9	0.9	0	3.5	3.3	3.1	11.1	3.2	0.5	0	3.0	13.7	3.9	3.9	2.7	1.6	0
Diseases and impairments of the eye and ear	16.3	9.6	24.9	11.4	14.3	16.7	13.3	14.4	10.0	23.3	6.9	9.6	16.1	50.0	18.1	9.0	26.4	14.2	19.4	17.5	7.6
Blindness	0.7	0	0.2	0.1	1.3	1.0	0	0.5	0	0.5	0	0	1.0	0	0.7	0	0	0.2	2.7	1.0	0
Diseases and impairments of the eye, except blindness	14.9	5.7	24.2	10.4	12.0	14.9	13.3	12.7	6.7	22.2	5.3	7.6	14.3	50.0	16.9	4.5	25.9	13.7	16.7	15.9	7.6
Deafness	0.3	0	0	0	0.9	0.4	0	0.3	0	0	0	1.2	0.3	0	0.3	0	0	0	0.6	0.6	0
Diseases of the ear, except deafness	0.6	3.8	0.4	1.1	0.9	0.1	0	1.0	3.3	0.5	2.4	1.2	0.3	0	0.3	4.5	0.4	0.2	0.6	0	0
Diseases of the circulatory system	19.9	1.9	1.6	7.5	25.1	34.3	19.9	20.2	3.3	1.5	9.0	24.3	31.3	0	19.7	0	1.7	6.6	26.0	38.0	23.0
Diseases of the heart, valves, endocardium and myocardium	4.9	1.9	0.4	1.7	4.5	9.1	0	5.3	3.3	0.5	3.2	3.2	8.5	0	4.7	0	0.4	0.7	6.0	9.7	0
Other diseases of the heart	4.8	0	0.4	1.9	7.1	7.7	6.6	5.4	0	0.5	2.4	8.9	7.8	0	4.0	0	0.4	1.6	5.3	7.5	7.6
Diseases of the arteries	10.1	0	0	2.0	7.8	20.3	13.3	9.6	0	0	2.0	6.4	17.5	0	10.7	0	0	2.1	9.3	23.8	15.3
Diseases of the veins	1.9	0	0	1.7	6.2	1.7	0	2.0	0	0	1.6	7.0	1.6	0	1.9	0	0	1.9	5.3	1.9	0
Other diseases of the circulatory system	0.2	0	0.7	0	0.3	0.9	0	0.2	0	0.5	0	0.6	0.1	0	0.1	0	0.8	0	0	0	0
Diseases of the respiratory system, except tuberculosis	16.5	38.0	43.3	10.6	9.4	9.8	13.3	15.8	36.7	45.6	11.5	7.6	8.7	0	17.0	41.0	41.5	10.0	11.3	11.0	15.3
Diseases of the nasal fossae and accessory sinuses	1.6	5.7	1.6	1.4	0.9	1.5	0	0.7	3.4	1.5	0.4	0	0.7	0	2.3	9.0	1.7	2.1	2.0	2.6	0
Diseases of the throat	8.4	13.4	40.8	3.5	0.6	0	0	8.1	10.0	43.5	3.7	0.6	0	0	8.6	18.1	38.5	3.4	0.6	0	0
Diseases of the lungs, bronchi and pleurae	6.9	19.2	1.8	5.6	7.8	8.9	13.3	7.3	23.3	1.5	7.4	7.0	8.5	0	6.6	13.6	2.1	4.5	8.7	9.3	15.3
Diseases of the digestive system	24.8	11.5	17.5	29.7	33.0	23.2	6.6	24.7	10.0	18.1	27.9	32.6	24.3	0	24.9	13.6	17.7	31.0	33.3	22.0	7.6
Defective teeth	10.0	1.9	12.7	11.5	16.0	6.6	6.6	9.3	3.3	12.4	7.8	13.4	8.2	0	10.6	0	12.9	14.0	18.6	4.7	7.6
Diseases of the buccal cavity, esophagus, and annexa (except teeth)	1.6	0	1.1	2.7	2.6	0.8	0	1.2	0	2.5	2.0	1.2	0.5	0	1.9	0	0	3.1	4.0	1.3	0
Diseases of the stomach and intestines	10.9	1.9	5.1	12.2	13.7	12.2	0	13.1	3.3	5.1	17.6	19.2	12.7	0	8.9	0	5.1	8.8	8.0	11.7	0
Diseases of other digestive sites	3.9	7.6	0.4	3.8	4.9	3.9	0	3.0	3.3	0.5	2.8	5.1	3.3	0	3.9	13.6	0.4	4.5	4.6	4.5	0
Diseases of the genito-urinary system	13.0	5.7	3.0	19.6	9.4	14.6	19.9	11.0	3.3	2.6	5.7	11.5	16.4	50.0	15.0	9.0	3.4	29.0	7.3	12.3	15.3
Diseases of the kidney	4.5	1.9	0.9	3.0	4.9	6.7	6.6	4.3	0	1.0	3.7	7.0	5.3	0	4.5	4.5	0.8	2.7	2.7	8.4	7.6
Other nonvenereal diseases of the urinary system	2.1	1.9	0.7	0.6	2.2	3.6	0	2.9	0	0.5	0.8	3.2	4.8	50.0	1.3	4.5	0.8	0.5	1.3	2.1	0
Nonvenereal diseases of the male genital organs	2.6	1.9	0.4	0.6	1.6	5.0	6.6	5.4	3.3	1.0	1.6	3.2	9.3	0	0	0	0	0	0	0	0
Nonvenereal diseases of the female genital organs	4.9	0	0.9	15.7	1.9	0.8	6.6	0	0	0	0	0	0	0	9.4	0	1.7	26.0	3.9	1.9	7.6
Diseases of the skin	2.9	11.5	4.6	1.7	3.5	2.4	0	3.8	16.7	5.1	2.4	6.4	2.6	0	1.9	4.5	3.8	1.3	0.6	1.9	0
Other and ill-defined diseases and defects except musculo-skeletal	7.3	0	0	1.6	2.9	15.2	13.3	8.6	0	0	2.8	3.8	15.9	0	5.9	0	0	0.7	2.0	14.5	15.3
Diseases and impairments of the musculo-skeletal system	15.7	3.8	4.7	14.8	23.2	19.6	6.6	19.7	3.3	6.7	26.3	25.6	20.7	0	12.0	4.5	3.0	7.4	20.6	18.0	7.6
Diseases and impairments limited to the feet	0.4	0	0	0.3	2.2	0.1	0	0.7	0	0	0.4	4.4	0.1	0	0.1	0	0	0.2	0	0.2	0
Other diseases and impairments limited to a specific site	0.3	0	0.2	0.4	1.3	0	0	0.5	0	0	1.2	1.9	0	0	0.1	0	0.4	0	0.6	0	0
Lost members (musculo-skeletal) by anatomical site	0.4	0	0.2	0.8	1.3	0.1	0	1.0	0	0.5	2.0	2.5	0.3	0	0	0	0	0	0	0	0
Other musculo-skeletal diseases and impairments	14.6	3.8	4.2	13.3	19.2	19.1	6.6	17.8	3.3	6.2	23.0	18.5	20.2	0	11.7	4.5	2.6	7.1	20.0	17.7	7.6

[A] Percentages total to more than 100, since one person often had two or more disabilities.

The seriousness of the many forms of rheumatism and arthritis is often underestimated, and often the client, case worker and physician assume that treatment is not needed. Thus on one of the survey schedules the home visitor's notation read, "only rheumatism, no medical care needed." In 1941, a former miner was examined by the company physician in a New Mexico mining community. The diagnosis read, "Mr. M. suffers from rheumatoid arthritis, for which there is no cure." The case record continued, "Dr. H. explained to the visitor that although Mr. M.'s condition is crippling and most painful, there is nothing to be done. Special diet or care is not needed." In 1942 a new company doctor replaced the former one in this community. After examining Mr. M. he stated that although the progress of the disease could not be reversed, it could be arrested, and recommended sulfanilimide, vitamins B and C, and heat. He added, "If you want to furnish these drugs I shall be glad to administer them and supervise the treatment for a nominal fee."

Such differences of opinion among physicians are not infrequent. However, in reporting a 1930 study of chronic illness in New York City, Mary C. Jarrett says:

> Progress in medicine in the last half century has put the whole subject of chronic illness in a new light. As medicine progresses the concept of incurability is constantly changing. ... To pronounce a patient incurable in the present state of medical knowledge places a serious responsibility on the physician and implies, at times, a greater knowledge than he possesses. ...Much of the illness that exists today may be charged to the attitude on the part of physicians and the public that chronic disease is incurable. ...
>
> The indifference of the medical profession as well as the general public that lies back of this neglect of the chronic sick is the result of a number of causes....the misconceptions. ...that chronic diseases are peculiar to the aged and that they are incurable, have hampered medical investigation of these conditions. ...Another deterrent. ... is the greater necessity for dealing with social factors in the treatment of chronic diseases than in acute diseases. ... (Also) the mental component in chronic diseases....is just beginning to receive definite consideration from physicians. 1/

In regard to rheumatism the report just quoted states:

> Rheumatism. ... is a more serious cause of suffering and economic loss than any other chronic disease. ...Nearly two-thirds of the persons suffering from rheumatism in Massachusetts were not receiving medical care. ... Over a third of the persons with rheumatism in the (New York City) census of the chronic sick were not receiving care suited to their condition. ... Physicians who have studied arthritis believe that favorable treatment in early stages might arrest the disease in many cases. ... The plans of the Massachusetts Department of Public Health include State-aided diagnostic clinics. This will be the first attempt of official health authorities in this country to control the disease. 2/

1/ Jarrett, Mary Cromwell; Chronic Illness in New York City; 2v; New York; Columbia University Press, 1933; Vol. I, pp. 2-6.

2/ Ibid., Vol. I, pp. 168-173.

The report also quotes a statement issued in 1929 by the American Branch of the International Committee for the control of rheumatism, recognizing chronic arthritis as "one of the most important, if not the most important of existing social and industrial handicaps," and urging more general use of "methods of treatment of proved value." 3/

Outstanding among the illnesses and disabilities treated were defective vision, cause unspecified (229 persons), and rheumatism and arthritis (215 persons). Next highest are infected tonsils, high blood pressure, decayed teeth and senility, all with frequencies above 150.

Of the entire list of over 350 code numbers, 93 were not used in the present study, indicating that these disabilities were either not present or not diagnosed in the 2,538 persons receiving medical care. The reasons for the non-appearance of a certain condition may vary considerably, of course. Many of the numbers not used refer to congenital abnormalities of various parts of the body or to unusual diseases which it is no doubt safe to assume occur only rarely in any population. Others, such as alcoholism and drug addiction, may not be commonly considered as illnesses requiring treatment. The fact that no case of rickets was reported is less easily explained. Does it mean that this condition to is frequently overlooked or its seriousness not recognized? It may also be that most or all cases of rickets in the families studied have been referred to Crippled Children's Services and have not therefore received care financed by the three DPW funds covered in the survey. This explanation also applies in large measure to other bone and joint conditions among children in public assistance families. Lastly, there is a group of conditions, illustrated by the diagnosis "gonococcus infection of the joints" which probably do occur in the population studied but have not been described due to non-specific or inadequate diagnosis by the examining physician.

Among the 2,438 persons receiving medical care for whom diagnoses were available, a total of 3,838 disabilities were present. The average number of disabilities present per person was 1.57. The variation among the age and sex groups is as follows:

Sex and Age	Average Number of Diagnoses Per Person
Both Sexes	1.57
Under 6	1.29
6 - 17	1.19
18 - 49	1.49
50 - 64	1.71
65 and over	1.76
Male	1.62
Under 6	1.30
6 - 17	1.23
18 - 49	1.58
50 - 64	1.77
65 and over	1.75
Female	1.53
Under 6	1.27
6 - 17	1.16
18 - 49	1.44
50 - 64	1.65
65 and over	1.77

3/ Jarrett, Mary Cromwell, Op. Cit., Vol. I, pp. 170-171.

This would indicate that multiple diagnoses tend to be present more often in the higher age groups than in the lower, and that the number is slightly higher for males than for females. Among children less than 6 the number is higher than among children 6-17.

Table 5 shows that 60.4 per cent of persons treated had one diagnosis; 26.2 per cent had two diagnoses; and 13.4 per cent had three. Although not presented in this report, data on diagnoses were tabulated according to number of diagnoses present, by sex and age. These data may serve for further analysis of the association of various diagnoses.

TABLE 5. PERSONS RECEIVING MEDICAL CARE (3 DPW FUNDS), BY SEX, AGE AND NUMBER OF DISABILITIES PRESENT

Sex and Age	All Persons a/		Persons With One Disability		Persons With Two Disabilities		Persons With Three or More Disabilities	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All	2,438	100.0	1,472	60.4	639	26.2	327	13.4
Under 6	52	100.0	40	76.9	9	17.3	3	5.8
6 - 17	424	100.0	354	83.4	59	14.0	11	2.6
18 - 49	621	100.0	398	64.0	162	26.0	61	10.0
50 - 64	306	100.0	162	53.0	92	30.0	52	17.0
65 and over	1,020	100.0	505	49.5	316	31.0	199	19.5
Age unknown	15	100.0	13	86.7	1	6.6	1	6.7
Male	1,183	100.0	689	58.2	319	27.0	175	14.8
Under 6	30	100.0	23	76.6	5	16.7	2	6.7
6 - 17	193	100.0	156	80.9	30	15.5	7	3.6
18 - 49	243	100.0	146	60.0	70	28.9	27	11.1
50 - 64	156	100.0	77	49.3	51	32.7	28	18.0
65 and over	559	100.0	285	51.0	163	29.1	111	19.9
Age unknown	2	100.0	2	100.0	0	0	0	0
Female	1,255	100.0	783	62.4	320	25.5	152	12.1
Under 6	22	100.0	17	77.3	4	18.2	1	4.5
6 - 17	231	100.0	198	85.7	29	12.6	4	1.7
18 - 49	378	100.0	252	66.7	92	24.3	34	9.0
50 - 64	150	100.0	85	56.7	41	27.3	24	16.0
65 and over	461	100.0	220	47.8	153	33.2	88	19.0
Age unknown	13	100.0	11	84.6	1	7.7	1	7.7

a/ Not including 18 persons with "no pathology" and 82 with "diagnosis unknown."

VI. RECIPIENTS OF AND EXPENDITURES FOR MEDICAL CARE

Source of Funds

Table 6 presents the sources of funds through which medical care was provided for the 2,849 families who received it from all sources during the six months from October 1, 1942 to March 31, 1943.

TABLE 6. FAMILIES RECEIVING MEDICAL CARE, BY CATEGORY AND SOURCE OF FUNDS, OCTOBER 1, 1942 - MARCH 31, 1943.

Source of Funds	Families Receiving Medical Care					
	Total	OAA	ADC	ANB	GA	NA
All Funds	2,849	1,338	847	81	519	64
Three DPW funds only a/	1,244	664	370	23	175	12
Three DPW funds and other sources b/	713	342	218	20	120	13
Other sources only b/	865	317	253	38	218	39
Source unknown	27	15	6	0	6	0
	Percentage Distribution					
All Funds	100.0	100.0	100.0	100.0	100.0	100.0
Three DPW funds only a/	43.7	49.6	43.7	28.3	33.7	18.8
Three DPW funds and other sources b/	25.0	25.6	25.7	24.7	23.1	20.3
Other sources only b/	30.4	23.7	29.9	47.0	42.0	60.9
Source unknown	0.9	1.1	0.7	0	1.2	0

a/ Includes assistance payment (OAA, ADC, ANB), Medical Care Project, and General Assistance funds.

b/ "Other sources" includes the following DPW funds: Services to the Blind, Crippled Children's Services, Child Welfare Services, State Tuberculosis Sanatorium and administrative funds used for medical examinations to determine eligibility for assistance.

Of the total families receiving care, 30.4 per cent received care only from sources other than the three DPW funds under study, 43.7 per cent from DPW funds only (assistance payment, general assistance, and medical care project), and 25.0 per cent from a combination of DPW funds and other funds. These figures roughly indicate the importance of other sources in providing medical care. An exact indicator of relative importance is not available since there is no data on expenditures or services received from other sources.

Other sources of medical care included 5 funds financed by the Department of Public Welfare. The number of public assistance families receiving funds from these sources is indicated in Table 7 below:

TABLE 7. FAMILIES RECEIVING MEDICAL CARE FROM DPW FUNDS OTHER THAN ASSISTANCE PAYMENT, GA FUNDS AND MEDICAL CARE PROJECT FUNDS, OCTOBER 1, 1942 - MARCH 31, 1943

Source of Funds	Families Receiving Medical Care					
	Total	OAA	ADC	ANB	GA	NA
Services to the Blind	179	83	50	19	27	0
Crippled Children's Services..	33	3	20	1	8	1
Child Welfare Services	4	0	1	0	3	0
Administrative Funds a/	25	3	14	3	5	0
State Tuberculosis Sanatorium.	21	4	11	0	6	0

a/ To determine eligibility for ADC or ANB.

Table 8 shows that more clients received free medical care from physicians than from any other single source. Next in importance to physician's services were funds paid by the client himself. In these cases, 256, the money for medical care came from the assistance payment or the family's own resources, when medical care was not included in the family budget. This means that funds intended for food, shelter, clothing, etc., were used for medical care, in spite of the increased hardship which this involved.

The most important public source of medical care (other than the DPW), was the Department of Public Health. Among 207 families receiving medical care from this source, 72 received care from venereal disease clinics and 3 from care for servicemen's dependents. The number receiving care from maternal and child health clinics of the Public Health Department was not specified, but it is undoubtedly a relatively high proportion of the 207 families.

County indigent funds were also an important source of public funds, 186 families having received medical care from this source. Total expenditures from county funds for medical care during the 12 months ending March 31, 1943 were approximately $27,000. The portion of this sum expended for public assistance recipients is not known, but it seems likely that public assistance recipients received a substantial part.

More than 50 different agencies and organizations provided medical care for public assistance recipients. The multiplicity of organizations from which medical care is available suggests the need of coordination for effective use of available sources.

TABLE 8. FAMILIES RECEIVING MEDICAL CARE FINANCED WHOLLY OR IN PART FROM SOURCES OTHER THAN DPW FUNDS, A/ - OCTOBER 1, 1942 - MARCH 31, 1943

Source of Funds	Families Receiving Medical Care					
	Total	OAA	ADC	ANB	GA	NA
Public Sources:						
Department of Public Health	207	33	103	9	58	4
County Indigent Funds	186	59	45	3	74	5
Veterans' Facility	14	0	11	0	3	0
State Hospital for the Insane	7	2	2	3	0	0
U. S. Army	3	2	0	0	0	1
Vocational Rehabilitation	3	1	2	0	0	0
Miscellaneous	10	2	5	0	3	0
Private Organizations:						
Proctor Eye Clinic	71	30	24	6	11	0
Catholic Clinic (Santa Fe)	37	2	19	4	10	2
Community League (Quay)	16	9	4	0	3	0
Tuberculosis Seal Fund	12	1	10	0	1	0
Maternal Health Center (Santa Fe)	10	1	5	0	4	0
Missionary Catechists	6	1	2	0	2	1
Red Cross	5	0	2	0	1	2
Miscellaneous	20	2	13	0	4	1
Individuals:						
Physicians	355	189	83	13	69	1
Clients B/	256	116	75	7	53	5
Relatives of Client	187	119	34	5	28	1
Other: Friend, Employer, etc.	54	29	9	0	14	2
Dentists	7	3	4	0	0	0
Taos County Cooperative (FSA)	67	36	23	0	8	0
Miscellaneous Funds	3	1	1	0	1	0
Source Unknown	27	15	6	0	6	0

A/ This is a multiple count, as one family may have been assisted from two or more of the sources listed here, or in addition may have been assisted from one or more of the DPW sources listed in Tables 6 and 7.

B/ Medical care paid by client from his assistance payment (medicals not budgeted), or from his own resources.

The families receiving medical care paid for by the three DPW funds studied, whether alone or in combination with other community sources, totaled 1,957. Table 9 gives the number and percentage distribution of these cases, by assistance program and fund. Since one family may have received care financed from two or more funds, the percentages do not total to 100.

TABLE 9. NUMBER AND PERCENTAGE DISTRIBUTION OF FAMILIES RECEIVING MEDICAL CARE PAID FOR WHOLLY OR IN PART FROM THREE DPW FUNDS, BY ASSISTANCE PROGRAM AND FUND, OCT. 1, 1942-MARCH 31,1943

Source of Funds	Families Receiving Medical Care					
	Total	OAA	ADC	ANB	GA	NA
All Sources a/	1,957	1,006	588	43	295	25
Assistance Payment	996	762	202	32	-	-
General Assistance	191	21	35	1	129	5
Medical Care Project	1,011	334	431	16	209	21
	Percentage Distribution b/					
Assistance Payment	50.9	75.7	34.4	74.4	-	-
General Assistance	9.7	2.1	6.0	2.3	43.7	20.0
Medical Care Project	51.7	33.2	73.3	37.2	70.8	84.0

a/ An unduplicated count of persons receiving medical care from the 3 DPW funds.

b/ Percentages do not total to 100.0 as a given family may have been assisted from two or more resources.

Here the variation in agency policy, as to financing medical care within the several assistance categories, is clearly evident. There is a marked tendency to use the assistance grant for OAA and ANB cases, three out of every four aided being from this source. On the other hand, over 70 per cent of the ADC, GA and NA cases receiving medical care were helped through medical care project funds. General assistance funds were used much less often throughout. Many factors, of course, affect these existing policies - limitations as to maximum grants, availability of other funds, type of illness, age of persons needing care, possibility of rehabilitation, etc.

Recipients of Medical Care

Among 1,957 families for whom expenditures were made from DPW funds, there were 2,538 persons who received medical treatment (see Table 10). Fewer than 20 per cent of persons treated were less than 18 years of age. More than 40 per cent were persons 65 years of age or over.

The proportion examined or treated of the total eligible population (persons in public assistance families) at different age levels is significant for estimating future needs. These percentages are given in Table 11.

TABLE 10. NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING MEDICAL CARE (3 DPW FUNDS), BY ASSISTANCE PROGRAM, SEX AND AGE
OCTOBER 1, 1942 – MARCH 31, 1943

SEX AND AGE	PERSONS RECEIVING MEDICAL CARE					
	ALL PROGRAMS	OAA	ADC	ANB	GA	NA
BOTH SEXES	2,538	1,167	833	51	402	85
UNDER 6	61	4	36	0	17	4
6 – 17	440	36	310	4	47	43
18 – 49	644	67	373	19	156	29
50 – 64	322	64	99	12	140	7
65 AND OVER	1,056	990	12	16	36	2
AGE UNKNOWN	15	6	3	0	6	0
MALE	1,226	582	371	24	210	39
UNDER 6	35	3	20	0	9	3
6 – 17	199	16	148	2	16	17
18 – 49	249	24	130	5	76	14
50 – 64	162	8	61	8	81	4
65 AND OVER	579	531	11	9	27	1
AGE UNKNOWN	2	0	1	0	1	0
FEMALE	1,312	585	462	27	192	46
UNDER 6	26	1	16	0	8	1
6 – 17	241	20	162	2	31	26
18 – 49	395	43	243	14	80	15
50 – 64	160	56	38	4	59	3
65 AND OVER	477	459	1	7	9	1
AGE UNKNOWN	13	6	2	0	5	0
	PERCENTAGE DISTRIBUTION					
BOTH SEXES	100.0	100.0	100.0	100.0	100.0	100.0
UNDER 6	2.4	0.3	4.3	0	4.2	4.7
6 – 17	17.3	3.1	37.2	7.8	11.7	50.6
18 – 49	25.4	5.7	44.8	37.3	38.8	34.1
50 – 64	12.7	5.5	11.9	23.5	34.8	8.2
65 AND OVER	41.6	84.9	1.4	31.4	9.0	2.4
AGE UNKNOWN	0.6	0.5	0.4	0	1.5	0
MALE	48.3	49.9	44.5	47.1	52.2	45.9
UNDER 6	1.4	0.3	2.4	0	2.2	3.5
6 – 17	7.8	1.4	17.8	3.8	4.0	20.0
18 – 49	9.8	2.1	15.6	9.8	18.9	16.5
50 – 64	6.4	0.7	7.3	15.7	20.2	4.7
65 AND OVER	22.8	45.4	1.3	17.8	6.7	1.2
AGE UNKNOWN	0.1	0	0.1	0	0.2	0
FEMALE	51.7	50.1	55.5	52.9	47.8	54.1
UNDER 6	1.0	0.1	1.9	0	2.0	1.2
6 – 17	9.5	1.7	19.4	3.9	7.7	30.6
18 – 49	15.6	3.7	29.3	27.5	19.9	17.6
50 – 64	6.3	4.8	4.6	7.8	14.7	3.5
65 AND OVER	18.8	39.3	0.1	13.7	2.2	1.2
AGE UNKNOWN	0.5	0.5	0.2	0	1.3	0

TABLE 11. ESTIMATED PERCENTAGE OF PERSONS IN PUBLIC ASSISTANCE FAMILIES WHO RECEIVED MEDICAL CARE (3 DPW FUNDS) OCTOBER 1, 1942 - MARCH 31, 1943, BY ASSISTANCE PROGRAM, AGE, AND SEX

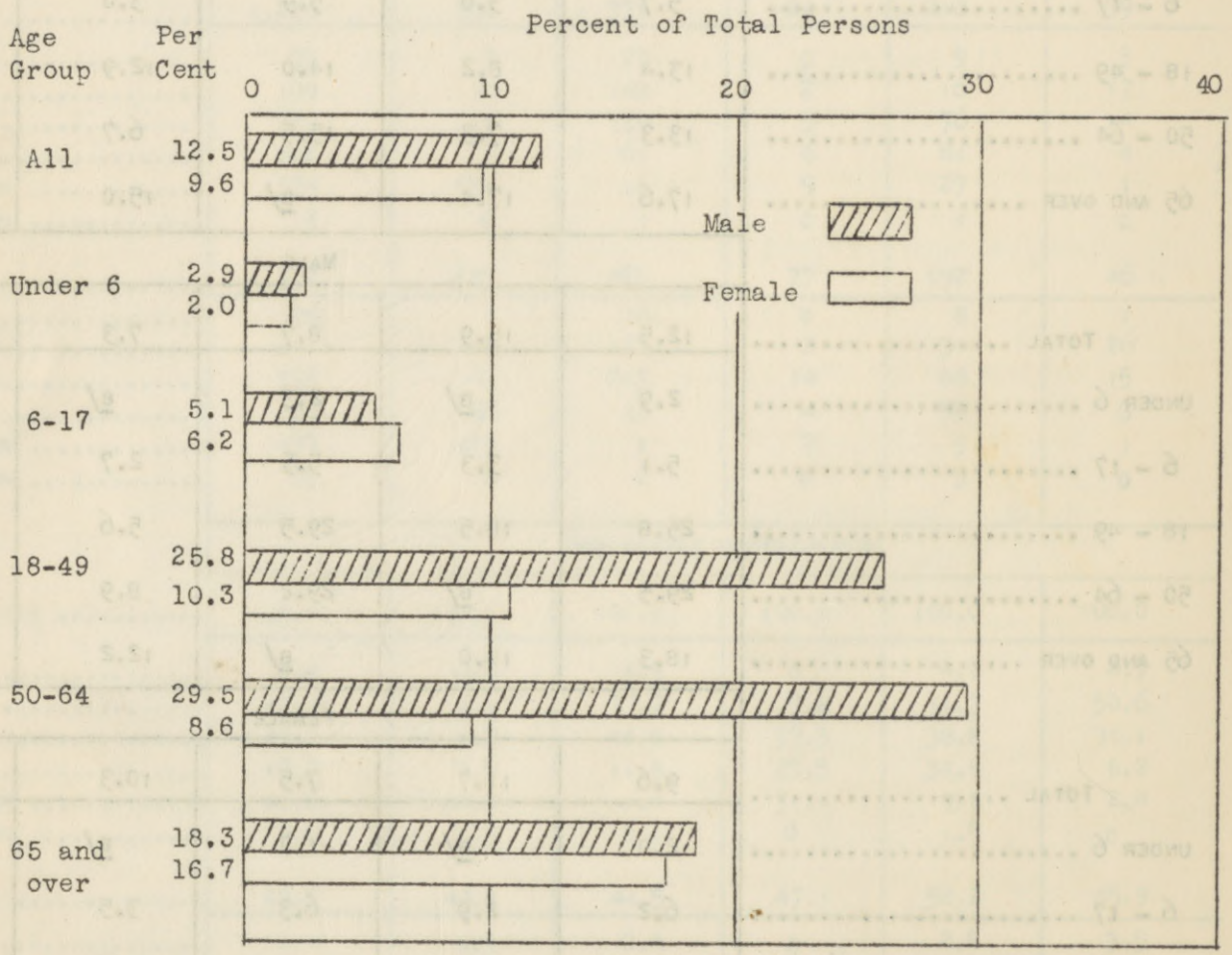
SEX AND AGE	ALL PROGRAMS	OAA	ADC	ANB	GA A/
	BOTH SEXES				
TOTAL	10.8	13.5	8.0	8.6	12.7
UNDER 6	2.4	7.7	2.0	B/	3.7
6 - 17	5.7	3.0	5.9	3.0	7.7
18 - 49	13.4	8.2	14.0	12.9	15.8
50 - 64	13.3	7.3	15.5	6.7	20.5
65 AND OVER	17.6	17.4	B/	15.0	19.8
	MALE				
TOTAL	12.5	15.9	8.7	7.3	15.9
UNDER 6	2.9	B/	2.3	B/	4.1
6 - 17	5.1	3.3	5.5	2.7	5.1
18 - 49	25.8	18.5	29.5	5.6	29.7
50 - 64	29.5	B/	29.2	8.9	41.1
65 AND OVER	18.3	18.0	B/	12.2	29.2
	FEMALE				
TOTAL	9.6	11.7	7.5	10.3	10.5
UNDER 6	2.0	B/	1.7	B/	3.3
6 - 17	6.2	2.9	6.3	3.5	11.0
18 - 49	10.3	6.2	11.0	24.6	11.1
50 - 64	8.6	6.7	8.9	4.4	12.2
65 AND OVER	16.7	16.9	B/	B/	10.4

A/ NON-ASSISTANCE INCLUDED WITH GA, SINCE DATA ON AGE AND SEX DISTRIBUTION ARE NOT SEPARATELY AVAILABLE FOR GA AND NA PROGRAMS.

B/ LESS THAN 0.05 PER CENT.

Among the females, considering all assistance categories together, the proportion of the eligible population receiving medical care increases for successive age groups up to age 50, then drops in the group 50-64 years of age, and rises again for those 65 and over. Among the males the increase continues through the 50-64 age group. These patterns are shown graphically in Chart 1.

CHART 1. ESTIMATED PERCENTAGE OF PERSONS IN PUBLIC ASSISTANCE FAMILIES WHO RECEIVED MEDICAL CARE, OCTOBER 1, 1942 TO MARCH 31, 1943, BY SEX AND AGE GROUPS, ALL ASSISTANCE CATEGORIES
(Based on data of Table 11)



Differences between males and females in percentage of persons treated are relatively slight for persons under 18 and for persons 65 and over. In the employable years 18-64, however, the percentage of males treated is roughly 3 times as great as for females. This undoubtedly results from the fact that males of this age do not ordinarily appear in the case load, unless there is some physical or mental handicap. This would also indicate that some emphasis is being placed on economic rehabilitation of families receiving assistance.

Expenditures for Medical Care

A state total of $84,749.18 was expended through the three DPW funds studied to provide care for 1,957 public assistance families during the six months of the survey period. Table 12 presents a distribution of medical care payments according to category and method of payment.

TABLE 12. EXPENDITURES FOR MEDICAL CARE FROM THREE DPW FUNDS, BY ASSISTANCE PROGRAM AND SOURCE OF FUNDS
October 1, 1942 - March 31, 1943

Source of Funds	Expenditures for Medical Care					
	Total	OAA	ADC	ANB	GA	NA
	$	$	$	$	$	$
All Sources	84,749.18	38,767.80	23,628.80	3,347.22	16,296.46	2,708.90
Assistance Payment...	33,698.32	26,841.92	5,362.90	1,493.50	0	0
General Assistance...	7,853.25	324.11	1,280.13	10.00	6,001.76	237.25
Medical Care Program	43,197.61	11,601.77	16,985.77	1,843.72	10,294.70	2,471.65
	Percentage Distribution					
All Sources	100.0	100.0	100.0	100.0	100.0	100.0
Assistance Payment...	39.8	69.3	22.7	44.6	0	0
General Assistance ..	9.2	0.8	5.4	0.3	36.8	8.8
Medical Care Program	51.0	29.9	71.9	55.1	63.2	91.2

Here again the proportion of funds included in assistance payment for OAA cases (69.3 per cent) is in contrast to that for the ADC group, where medical care project funds again predominated.

Expenditures for males were slightly higher than for females (see Table 13). Males in the age group 65 and over received more than $21,000 in medical care, or approximately one-fourth of the total expenditure.

The per person expenditures for persons receiving medical care are shown in Table 14. The figure of $33.39 per person receiving medical care represents average expenditure for care given during a six-months' period for all programs, all ages and both sexes. For the separate programs the range is from $28.37 for persons in ADC families to $65.63 for the ANB group - an exceptionally high figure, due largely to the five males between 18 and 49 years of age who received average expenditures above $200 each. The persons treated in GA families apparently required large or complicated forms of care, the average expenditure being $40.54, about 25 per cent above the general mean.

The largest average expenditure for both sexes occurs in the age group 18-49. Average expenditures tend to increase rapidly in each age group up to 18-49, and to decrease slightly after this age group. There are some variations from these patterns in individual categories, but this may result from the small number of cases involved in some of the sex and age groups. In general, there tends to be below average expenditures for persons under 18 and above average expenditures for persons 18 and over.

TABLE 13. AMOUNT AND PERCENTAGE DISTRIBUTION OF MEDICAL CARE EXPENDITURES (3 DPW FUNDS), BY ASSISTANCE PROGRAM, SEX AND AGE
OCTOBER 1, 1942 – MARCH 31, 1943

SEX AND AGE	EXPENDITURES FOR MEDICAL CARE					
	ALL PROGRAMS	OAA	ADC	ANB	GA	NA
BOTH SEXES	$ 84,749.18	$ 38,767.80	$ 23,628.80	$ 3,347.22	$ 16,296.46	$ 2,708.90
UNDER 6	701.27	51.50	482.50	0	149.87	17.40
6 – 17	9,291.17	699.17	6,111.01	80.00	1,521.54	879.45
18 – 49	26,633.96	2,531.43	13,055.88	1,823.47	7,887.33	1,335.85
50 – 64	11,894.17	2,334.99	3,781.66	777.99	4,540.33	459.20
65 AND OVER	35,794.39	32,853.36	175.75	665.76	2,082.52	17.00
AGE UNKNOWN	434.22	297.35	22.00	0	114.87	0
MALE	44,183.01	20,766.46	10,549.88	2,103.92	9,293.10	1,469.65
UNDER 6	421.28	21.50	271.64	0	120.74	7.40
6 – 17	4,429.27	407.79	2,682.61	30.00	829.07	479.80
18 – 49	11,789.25	1,055.18	4,772.14	1,118.93	4,122.05	720.95
50 – 64	6,509.95	361.00	2,676.74	639.99	2,575.72	256.50
65 AND OVER	21,029.76	18,920.99	145.75	315.00	1,643.02	5.00
AGE UNKNOWN	3.50	0	1.00	0	2.50	0
FEMALE	40,566.17	18,001.34	13,078.92	1,243.30	7,003.36	1,239.25
UNDER 6	279.99	30.00	210.86	0	29.13	10.00
6 – 17	4,861.90	291.38	3,428.40	50.00	692.47	399.65
18 – 49	14,844.71	1,476.25	8,283.74	704.54	3,765.28	614.90
50 – 64	5,384.22	1,973.99	1,104.92	138.00	1,964.61	202.70
65 AND OVER	14,764.63	13,932.37	30.00	350.76	439.50	12.00
AGE UNKNOWN	430.72	297.35	21.00	0	112.37	0
	PERCENTAGE DISTRIBUTION					
BOTH SEXES	100.0	100.0	100.0	100.0	100.0	100.0
UNDER 6	0.8	0.1	2.0	0	0.9	0.6
6 – 17	11.0	1.8	25.9	2.4	9.3	32.5
18 – 49	31.4	6.5	55.3	54.5	48.4	49.3
50 – 64	14.0	6.0	16.0	23.2	27.9	17.0
65 AND OVER	42.3	84.8	0.7	19.9	12.8	0.6
AGE UNKNOWN	0.5	0.8	0.1	0	0.7	0
MALE	52.1	53.6	44.6	62.9	57.0	54.3
UNDER 6	0.5	0.1	1.1	0	0.7	0.3
6 – 17	5.2	1.1	11.4	0.9	5.1	17.7
18 – 49	13.9	2.7	20.2	33.5	25.3	26.6
50 – 64	7.7	0.9	11.3	19.1	15.8	9.5
65 AND OVER	24.8	48.8	0.6	9.4	10.1	0.2
AGE UNKNOWN	0.0	0	0.0	0	0.0	0
FEMALE	47.9	46.4	55.4	37.1	43.0	45.7
UNDER 6	0.4	0.1	0.9	0	0.2	0.4
6 – 17	5.7	0.8	14.5	1.5	4.2	14.8
18 – 49	17.5	3.8	35.1	21.0	23.1	22.6
50 – 64	6.4	5.1	4.7	4.1	12.1	7.5
65 AND OVER	17.4	35.8	0.1	10.5	2.7	0.4
AGE UNKNOWN	0.5	0.8	0.1	0	0.7	0

Average expenditures for males are higher than for females in each age group (see Table 14). The differences are relatively smaller for younger persons than for the middle and higher ages. The explanation of the difference in average charges apparently lies in the relative severity of illnesses treated for the two sexes.

TABLE 14. AVERAGE EXPENDITURE PER PERSON RECEIVING MEDICAL CARE (3 DPW FUNDS), BY ASSISTANCE PROGRAM, SEX AND AGE a/
October 1, 1942 - March 31, 1943

Sex and Age	Average Expenditure					
	All Programs	OAA	ADC	ANB	GA	NA
Total	$ 33.39	$ 33.22	$ 28.37	$ 65.63	$ 40.54	$ 31.87
Under 6	11.50	12.88	13.40	0	8.82	4.35
6 - 17	21.12	19.42	19.71	20.00	32.37	20.45
18 - 49	41.36	37.78	35.00	95.97	50.56	46.06
50 - 64	36.94	36.48	38.20	64.83	32.43	65.60
65 and over	33.90	33.19	14.65	41.61	57.85	8.50
Age unknown	28.95	49.56	7.33	0	19.14	0
Male	36.04	35.68	28.44	87.66	44.25	37.68
Under 6	12.04	7.17	13.58	0	13.42	2.47
6 - 17	22.26	25.49	18.13	15.00	51.82	28.22
18 - 49	47.35	43.97	36.71	223.79	54.24	51.50
50 - 64	40.18	45.12	43.88	80.00	31.80	64.12
65 and over	36.32	35.63	13.25	35.00	60.85	5.00
Age unknown	1.75	0	1.00	0	2.50	0
Female	30.92	30.77	28.31	46.05	36.48	26.94
Under 6	10.77	30.00	13.18	0	3.64	10.00
6 - 17	20.17	14.57	21.16	25.00	22.34	15.37
18 - 49	37.58	34.33	34.09	50.32	47.07	40.99
50 - 64	33.65	35.25	29.08	34.50	33.30	67.57
65 and over	30.95	30.35	30.00	50.11	48.83	12.00
Age unknown	33.13	49.56	10.50	0	22.47	0

a/ Based on data of Tables 10 and 13.

The average expenditure per person treated (Table 14) is a useful figure in judging adequacy and economy of a medical care program. More important, however, as a basis for estimating future need and allocating medical funds is the amount expended per person eligible for care. In the literature of medical care this figure is commonly referred to as the amount spent per head,

or per capita, of the eligible population - i.e., all persons in public assistance families. Table 15 presents such per capita expenditures for New Mexico, covering the six months of the survey period only.

TABLE 15. EXPENDITURES FOR MEDICAL CARE PER PERSON ELIGIBLE FOR CARE (PER CAPITA) BASED ON TOTAL MEDICAL EXPENDITURES FOR SIX MONTHS (OCTOBER 1, 1942 TO MARCH 31, 1943) AND ON ESTIMATED AGE AND SEX DISTRIBUTION OF ALL PERSONS IN PUBLIC ASSISTANCE FAMILIES

Sex and Age	All	OAA	ADC	ANB	GA a/
Both Sexes	$ 3.60	$ 4.48	$ 2.26	$ 5.67	$ 4.95
Under 6	.28	.99	.26	b/	.30
6 - 17	1.00	.59	1.16	.61	2.05
18 - 49	5.55	3.08	4.91	12.40	7.88
50 - 64	4.92	2.65	5.93	4.32	6.97
65 and over	5.95	5.78	b/	6.22	10.94
Male	4.50	5.66	2.47	6.41	8.89
Under 6	.35	b/	.31	b/	.44
6 - 17	1.13	.84	.99	.40	2.01
18 - 49	12.24	8.12	10.85	12.43	15.98
50 - 64	11.86	b/	12.81	7.11	13.68
65 and over	6.66	6.40	b/	4.26	17.17
Female	2.96	3.61	2.11	4.74	3.62
Under 6	.22	b/	.22	b/	.14
6 - 17	1.26	.42	1.33	.88	2.11
18 - 49	3.87	2.13	3.73	12.36	5.05
50 - 64	2.88	2.35	2.58	b/	4.25
65 and over	5.18	5.11	b/	b/	4.70

a/ Non-assistance included with GA, since estimates on age and sex distribution not separately available for GA and NA programs.

b/ Not computed because base less than 50.

The per capita expenditure during the six months period for both sexes and all categories was $3.60 (see Table 15). The range among categories was from $5.67 for Aid to Needy Blind to $2.26 for Aid to Dependent Children. The relatively high per capita expenditures under the GA program are explained by the nature of the case load which is so largely composed of persons with illnesses or physical disabilities. The relatively low expenditures under the ADC program are explained by the high proportion of children in the case load for whom average expenditures are low.

Per capita expenditures for males are considerably higher than for females. Among children there is no significant difference between males and

females. Among adults, however, between the ages of 18 and 64, expenditures for males are significantly higher than for females. For adults 65 and over there is a lesser difference, although per capita expenditures for males are higher. Among the general population of the U. S. there are no consistent differences in medical expenditures of males and females; in adult groups, however, expenditures for women are substantially higher than for men. 1/ The high expenditures for men in the public assistance case load are probably accounted for by the selective nature of the case load which tends to draw men with physical handicaps and by efforts at rehabilitation of families in need because of physical disability of the male breadwinner. That these are factors is evident since per capita expenditures for males are significantly higher than for females only for the wage-earning years, 18-64.

Data on average expenditure per person eligible for care (Table 15) are incomplete in the sense that they include only expenditures from the three sources under study. The additional amount from other sources is unknown and cannot be accurately estimated. A considerable portion of this additional medical care was undoubtedly received in the form of clinic visits and office or home visits by physicians, average charges for which are generally low. Furthermore, the number receiving care from other sources was fewer than those receiving care from the three DPW sources under study (see Table 6). It seems probable, therefore, that the monetary value of such services was much less than that supplied from the three DPW sources under study. Assuming, however, for purposes of comparison that the average value per case of other care received was equal to that paid for by the DPW, and adjusting the six-month expenditures for an annual period, we can estimate the average value of medical care received by public assistance recipients at less than $13 per person annually.

A study made by the committee on costs of medical care (1928-1931) produced the following estimates of average annual expenditure per person for medical care for persons in towns of less than 5,000 and rural areas: 2/

Income Group	Average Per Person
Less than $1,200	$ 9.54
$1,200 - 1,999	13.90
2,000 - 2,999	19.71
3,000 - 4,999	26.90
5,000 - 9,999	42.04

It appears that expenditures in the public assistance case load may not be materially less than for the lower income groups of the country as a whole, but that they are considerably below those for the middle and higher income groups who are able to purchase needed medical care. Since studies show that medical needs of low income families are higher than for the general population it can safely be said that average expenditures per person were below a desirable minimum.

Method of Payment

One of the problems arising in administration of a public assistance medical care program concerns method of payment for services rendered.

1/ Hollingsworth, Helen, and Klem, Margaret C., op. cit., p. 18.
2/ Hollingsworth, Helen, and Klem, Margaret C., op. cit., p. 74.

Two methods were in use at the time of the study: 1) through the assistance grant (cash payment from OAA, ADC or ANB fund), and 2) through general assistance or medical care project funds, with payment directly to the vendor. In the first of these methods the Federal Government matches State funds to cover medical and other needs, within maximum limits for individual payments, subject to the provision that the client cannot be conditioned in the expenditure of his assistance payment. Though the budget is planned to cover specific items, there is no check on the client's actual use of the money. From the viewpoint of the medical practitioner the method of payment through the assistance grant is relatively less satisfactory, since amounts budgeted or "allowed" for medical items do not always reach the doctor, dentist, druggist, etc., when services have been rendered to the client and obligations incurred. Physicians sometimes lower their scale of fees when direct payment is assured, in recognition of the lessened financial risk involved.

From the viewpoint of the agency, provision of care through the assistance payment is unsatisfactory because it produces poor relations with physicians. They often expect the Department to assume responsibility for payment if the patient is a DPW client, but the Department, under the law, is not permitted to do this. Furthermore, the Department is relatively limited in any attempt to improve standards of medical service, and the administration of the program becomes relatively more complex, since two different methods of payment are in use.

In tabulating the data of the present study this problem was considered. Both GA and MCP expenditures are "direct payment," in contrast with the method of payment through the assistance grant. Table 16 gives the relative expenditures by the two methods, and the corresponding percentage distribution of persons receiving care.

TABLE 16. PERCENTAGE DISTRIBUTION OF EXPENDITURES FOR MEDICAL CARE (3 DPW FUNDS) AND OF PERSONS RECEIVING CARE, BY CATEGORY AND METHOD OF PAYMENT

Method of Payment	Total	OAA	ADC	ANB	GA	NA
	Expenditures					
Total	100.0	100.0	100.0	100.0	100.0	100.0
In Grant	39.8	69.3	22.7	44.6	-	-
Direct Payment a/	60.2	30.7	77.3	55.4	100.0	100.0
	Persons					
Total	100.0	100.0	100.0	100.0	100.0	100.0
In Grant	37.8	64.4	21.5	60.8	-	-
Direct Payment a/	55.7	27.0	71.7	27.4	100.0	100.0
Both	6.5	8.6	6.8	11.8	-	-

a/ Direct payments by the DPW to medical practitioners, etc.

From the data of Table 16, it is evident that in Old Age Assistance cases the main dependence has been on medical payments through grant only, while among those families receiving Aid to Dependent Children over three-fourths of the total amount was spent by direct payment.

One explanation of the tendency to use direct payment more often in ADC cases than in the OAA group is the fact that maximum grants (for Federal matching) are lower for the former category (ADC), and agency policy does not permit "overgrants" for medical care. Instead, GA or MCP funds have been utilized, when available, to meet medical needs, supplementing the assistance grant. It is also true that persons in ADC families are on the whole younger and likely to have illnesses or disabling conditions which can be completely cured or greatly improved by adequate treatment, which is often not possible within the limitations of the assistance grant. In such cases this may mean the rehabilitation of the family, through improved health of the chief wage earner. Persons in OAA cases, on the other hand, are older and more often suffer from chronic conditions which can be alleviated but seldom cured.

An evaluation of the relative merits of the two methods of payments is not possible with the tabulations presented in this survey. Table 17, however, permits comparison of the outcome of treatment for the two methods of payment. Where payment was made through the assistance payment only, 12.9 per cent of persons treated were cured or received maximum benefits; where direct payments to vendors were made, 46.4 per cent were cured or received maximum benefit. This large variation, no doubt, results primarily from the fact that direct payment was the major method of payment for ADC cases and the only method for GA. In these categories the patients were younger and the prognosis better, whereas the assistance payment was the primary method of payment in the OAA category where chronic conditions connected with advanced age are more prevalent.

TABLE 17. PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING MEDICAL CARE, a/ BY STATUS OF TREATMENT AND METHOD OF PAYMENT

Status of Treatment	All Methods	Assistance Payment Only	Direct Payment Only	Both Methods
Total	100.0	100.0	100.0	100.0
Treatment not begun	5.0	3.0	7.0	1.9
Now under treatment	42.5	70.0	20.5	55.2
Treatment suspended or discontinued	3.9	4.1	3.6	5.0
Treatment completed	47.2	22.4	66.8	37.9
Patient cured or maximum benefit received	31.4	12.9	46.4	21.6
Condition improved	11.7	6.5	15.4	12.4
Other	4.1	3.0	5.0	3.9
Unknown	1.4	0.5	2.1	0

a/ Persons in cases open March 31, 1943 who had received medical examination or treatment in the preceding 6 months.

The hypothesis that patients receive better and more adequate care when direct payment is made can only be tested by controlling for age, sex, type of disability and other factors. Unfortunately the number of cases in any one group, when necessary factors were controlled, was so small as to permit statistical analysis of variations only in 3 groups - females, 6-17, with defective vision, and males and females, 6-17, with defective tonsils. As would be expected for these disabilities, there was no statistically significant difference in the outcome of treatment under the two methods of payment, since favorable outcome occurred in practically every case.

Object of Expenditure

The total medical expenditures are broken down in Table 18 according to the object of expenditure - i.e., physicians' services, hospital care, drugs, special diet, etc. Table 20 shows the corresponding number of persons receiving each type of care. This is unavoidably a multiple count, since one person may have received hospital and dental care, home nursing, housekeeping service, etc., or any similar combination of more than 20 items listed. For comparative purposes, two averages are presented: the average payment per person treated (Table 21), and the per capita expenditure per person in the eligible population (Table 22).

The major medical expenditures were for physicians' services, hospitalization, drugs and dentist fees, listed in their order of importance. This roughly corresponds with the experience of the general population.

There is considerable variation in the distribution of expenditures between payments included in the assistance grant and direct payments. Items with high unit costs such as hospital care tend to be handled by direct payment to the vendor. Items of low cost required over a long period such as drugs tend to be included in the assistance grant. In view of restrictions which prevent inclusion of large items in the assistance payment, it would be almost impossible to operate a well-balanced medical care program using this method of payment only.

Table 20 indicates that under the present system of free choice of physicians, a relatively small part of funds expended goes to non-medical practitioners. The extent to which specialists were used in providing treatment is not known.

The most costly items of expenditure in terms of average per patient are for care of patients outside of hospitals including convalescent care, board and care, nursing care and housekeeping service, the range being from $121.90 for convalescent care to $40.37 for housekeeping service. These figures represent average costs during a six-month period. The average cost of hospital care was $41.83. Dental services ran fairly high at $31.52 per patient treated. This high average probably resulted from the fact that only the more serious conditions were treated and that the cost of dentures was included. Physicians' services averaged $16.92. Average charge per patient treated for medical doctors and doctors of osteopathy was close to this figure. The average charge by doctors of chiropracty was almost twice as much ($30.20). However, since only 15 patients were treated by chiropractors, this average may not be reliable.

TABLE 18. EXPENDITURES FOR MEDICAL CARE (3 DPW FUNDS), BY OBJECT OF EXPENDITURE AND METHOD OF PAYMENT
OCTOBER 1, 1942 - MARCH 31, 1943

OBJECT OF EXPENDITURE	EXPENDITURES BY METHOD OF PAYMENT		
	TOTAL	ASSISTANCE GRANT	DIRECT PAYMENT
TOTAL	$84,749.18	$33,698.32	$51,050.86
PHYSICIANS' SERVICES	25,895.06	8,222.53	17,672.53
MEDICAL DOCTOR	22,564.49	7,073.42	15,491.07
DOCTOR OF OSTEOPATHY	2,809.57	832.61	1,976.96
DOCTOR OF CHIROPRACTY	453.00	285.00	168.00
OTHER	62.00	31.50	30.50
TYPE UNKNOWN	6.00	-	6.00
HOSPITAL CARE	14,430.33	1,901.63	12,528.70
PHYSICIANS' SERVICES AND HOSPITALIZATION A/	4,798.09	996.05	3,802.04
DRUGS	13,396.92	11,510.54	1,886.38
DENTIST SERVICES (INCLUDING DENTURES)	8,730.51	905.50	7,825.01
NURSING SERVICES	2,486.89	1,798.79	688.10
REGISTERED	129.20	95.20	34.00
PRACTICAL	2,357.69	1,703.59	654.10
MIDWIFE SERVICES	63.00	-	63.00
REFRACTION AND GLASSES (TO PHYSICIANS)	2,472.05	313.25	2,158.80
EYEGLASSES (NOT TO PHYSICIANS)	567.70	162.55	405.15
APPLIANCES (OTHER THAN DENTURES AND GLASSES)	1,314.97	98.35	1,216.62
X-RAYS	80.00	36.00	44.00
CONVALESCENT CARE	1,828.50	965.00	863.50
BOARD AND CARE	3,047.90	2,151.00	896.90
HOUSEKEEPING SERVICE	1,493.60	1,116.50	377.10
FOSTER CARE (OF CHILDREN)	237.00	151.50	85.50
SPECIAL DIET	872.64	680.81	191.83
TRANSPORTATION	705.53	382.39	323.14
MISCELLANEOUS	67.06	46.50	20.56
DIVISION OF FUNDS UNKNOWN	2,261.43	2,259.43	2.00

A/ HOSPITALS OPERATED BY PHYSICIAN - DIVISION OF FUNDS UNKNOWN.

TABLE 19. PERCENTAGE DISTRIBUTION OF EXPENDITURES FOR MEDICAL CARE (3 DPW FUNDS), BY OBJECT OF EXPENDITURE AND METHOD OF PAYMENT
OCTOBER 1, 1942 - MARCH 31, 1943

OBJECT OF EXPENDITURE	METHOD OF PAYMENT		
	TOTAL	ASSISTANCE GRANT	DIRECT PAYMENT
TOTAL	100.0	100.0	100.0
PHYSICIANS' SERVICES	30.6	24.4	34.6
MEDICAL DOCTOR	26.6	21.0	30.3
DOCTOR OF OSTEOPATHY	3.3	2.5	3.9
DOCTOR OF CHIROPRACTY	0.6	0.8	0.3
OTHER	0.1	0.1	0.1
TYPE UNKNOWN	-	-	-
HOSPITAL CARE	17.0	5.6	24.6
PHYSICIANS' SERVICES AND HOSPITALIZATION A/.	5.7	3.0	7.4
DRUGS	15.8	34.2	3.7
DENTIST SERVICES (INCLUDING DENTURES)	10.3	2.7	15.3
NURSING SERVICES	2.9	5.4	1.4
REGISTERED	0.2	0.3	0.1
PRACTICAL	2.7	5.1	1.3
MIDWIFE SERVICES	0.1	-	0.1
REFRACTION AND GLASSES (TO PHYSICIANS)	2.9	0.9	4.2
EYEGLASSES (NOT TO PHYSICIANS)	0.7	0.5	0.8
APPLIANCES (OTHER THAN GLASSES)	1.5	0.3	2.4
X-RAYS	0.1	0.1	0.1
CONVALESCENT CARE	2.1	2.9	1.7
BOARD AND CARE	3.6	6.4	1.8
HOUSEKEEPING SERVICE	1.8	3.3	0.7
FOSTER CARE (OF CHILDREN)	0.3	0.4	0.2
SPECIAL DIET	1.0	2.0	0.4
TRANSPORTATION	0.8	1.1	0.6
MISCELLANEOUS	0.1	0.1	-
DIVISION OF FUNDS UNKNOWN	2.7	6.7	-

A/ HOSPITALS OPERATED BY PHYSICIAN - DIVISION OF FUNDS UNKNOWN.

TABLE 20. PERSONS RECEIVING MEDICAL CARE (3 DPW FUNDS), BY OBJECT OF EXPENDITURE AND METHOD OF PAYMENT
OCTOBER 1, 1942 - MARCH 31, 1943

OBJECT OF EXPENDITURE	METHOD OF PAYMENT		
	TOTAL	ASSISTANCE GRANT	DIRECT PAYMENT
ALL EXPENDITURES	2,538 A/	1,125 A/	1,578 A/
PHYSICIANS' SERVICES	1,530	493	1,037
MEDICAL DOCTOR	1,328	431	897
DOCTOR OF OSTEOPATHY	177	53	124
DOCTOR OF CHIROPRACTY	15	7	8
OTHER	8	2	6
TYPE UNKNOWN	2	-	2
HOSPITAL CARE	345	47	298
PHYSICIANS' SERVICES AND HOSPITALIZATION B/	57	13	44
DRUGS	930	565	365
DENTIST SERVICES (INCLUDING DENTURES)	277	43	234
NURSING SERVICES	49	34	15
REGISTERED	6	4	2
PRACTICAL	43	30	13
MIDWIFE SERVICES	5	-	5
REFRACTION AND GLASSES (TO PHYSICIANS)	173	21	152
EYEGLASSES (NOT TO PHYSICIANS)	70	22	48
APPLIANCES (OTHER THAN DENTURES AND GLASSES)	37	11	26
X-RAYS	6	1	5
CONVALESCENT CARE	15	7	8
BOARD AND CARE	31	15	16
HOUSEKEEPING SERVICE	37	25	12
FOSTER CARE (OF CHILDREN)	6	2	4
SPECIAL DIET	56	42	14
TRANSPORTATION	82	32	50
MISCELLANEOUS	10	4	6
DIVISION OF FUNDS UNKNOWN	74	73	1

A/ UNDUPLICATED COUNT OF PERSONS RECEIVING MEDICAL CARE.
B/ HOSPITAL OPERATED BY PHYSICIAN - DIVISION OF FUNDS UNKNOWN.

TABLE 21. AVERAGE EXPENDITURE PER PERSON RECEIVING SPECIFIED TYPES OF MEDICAL CARE (3 DPW FUNDS), BY OBJECT OF EXPENDITURE AND METHOD OF PAYMENT
OCTOBER 1, 1942 - MARCH 31, 1943

OBJECT OF EXPENDITURE	METHOD OF PAYMENT		
	TOTAL	ASSISTANCE GRANT	DIRECT PAYMENT
ALL EXPENDITURES	$ 33.39	$ 29.95	$ 32.35
PHYSICIANS' SERVICES	16.92	16.68	17.04
MEDICAL DOCTOR	16.99	16.41	17.27
DOCTOR OF OSTEOPATHY	15.87	15.70	15.94
DOCTOR OF CHIROPRACTY	30.20	40.71	21.00
OTHER	7.75	15.75	5.08
TYPE UNKNOWN	3.00	-	3.00
HOSPITAL CARE	41.83	40.46	42.04
PHYSICIANS' SERVICES AND HOSPITALIZATION A/	84.18	76.62	86.41
DRUGS	14.40	20.37	5.17
DENTIST SERVICES (INCLUDING DENTURES)	31.52	21.06	33.44
NURSING CARE	50.75	52.90	45.87
REGISTERED	21.53	23.80	17.00
PRACTICAL	54.83	56.79	50.32
MIDWIFE SERVICES	12.60	-	12.60
REFRACTION AND GLASSES (TO PHYSICIANS)	14.29	14.92	14.20
EYEGLASSES (NOT TO PHYSICIANS)	8.11	7.39	8.44
APPLIANCES (OTHER THAN DENTURES AND GLASSES)	35.54	8.94	46.79
X-RAYS	13.33	36.00	8.80
CONVALESCENT CARE	121.90	137.86	107.94
BOARD AND CARE	98.32	143.40	56.06
HOUSEKEEPING SERVICE	40.37	44.66	31.42
FOSTER CARE (OF CHILDREN)	39.50	75.75	21.38
SPECIAL DIET	15.58	16.21	13.70
TRANSPORTATION	8.60	11.95	6.46
MISCELLANEOUS	6.71	11.62	3.43
DIVISION OF FUNDS UNKNOWN	30.56	30.95	2.00

A/ HOSPITAL OPERATED BY PHYSICIAN - DIVISION OF FUNDS UNKNOWN.

TABLE 22. PER CAPITA EXPENDITURES FOR MEDICAL CARE (3 DPW FUNDS), BY OBJECT OF EXPENDITURE AND METHOD OF PAYMENT
OCTOBER 1, 1942 – MARCH 31, 1943

OBJECT OF EXPENDITURE	METHOD OF PAYMENT		
	TOTAL	ASSISTANCE GRANT	DIRECT PAYMENT
ALL EXPENDITURES	$3.60	$1.43	$2.17
PHYSICIANS' SERVICES	1.10	.35	.75
MEDICAL DOCTOR	.96	.30	.66
DOCTOR OF OSTEOPATHY	.12	.04	.08
DOCTOR OF CHIROPRACTY	.02	.01	.01
OTHER	B/	B/	B/
TYPE UNKNOWN	B/	B/	B/
HOSPITAL CARE	.61	.08	.53
PHYSICIANS' SERVICES AND HOSPITALIZATION A/	.20	.04	.16
DRUGS	.57	.49	.08
DENTIST SERVICES (INCLUDING DENTURES)	.37	.04	.33
NURSING SERVICES	.11	.07	.04
REGISTERED	B/	B/	B/
PRACTICAL	.11	.07	.04
MIDWIFE SERVICES	B/	B/	B/
REFRACTION AND GLASSES (TO PHYSICIANS)	.10	.01	.09
EYEGLASSES (NOT TO PHYSICIANS)	.03	.01	.02
APPLIANCES (OTHER THAN DENTURES AND GLASSES)	.05	B/	.05
X-RAYS	B/	B/	B/
CONVALESCENT CARE	.08	.04	.04
BOARD AND CARE	.13	.09	.04
HOUSEKEEPING SERVICE	.07	.05	.02
FOSTER CARE (OF CHILDREN)	.01	.01	B/
SPECIAL DIET	.04	.03	.01
TRANSPORTATION	.03	.02	.01
MISCELLANEOUS	B/	B/	B/
DIVISION OF FUNDS UNKNOWN	.10	.10	-

A/ HOSPITAL OPERATED BY PHYSICIAN – DIVISION OF FUNDS UNKNOWN.
B/ LESS THAN ONE-HALF CENT.

Data on per capita expenditures for various objects of expenditure give one basis for appraising the adequacy of remuneration given physicians, dentists, hospitals, etc. Louis Reed and Dean Clark make the following suggestion:

> .....One basis of judging the fairness of remuneration afforded, say, to physicians is to inquire what would be the gross income of all the physicians in the community if, as a group, they derived the same per capita income from the general population as they derived from those on relief. 1/

Upon application of this principle to remuneration paid medical practitioners in New Mexico, we find that the hypothetical annual average income per physician would be slightly under $4,000 annually, which may be less than the actual income of many practicing physicians but would not indicate that the average fees paid were inadequate.

Volume and Cost of Hospitalization

Data on hospital care were more adequately reported than on other types of medical services. Therefore, it is possible to present a more detailed analysis of this one type of service. Among 2,538 persons receiving medical care there were 468 persons who received hospitalization from some source, either DPW funds or other funds. 2/ The percentage distribution of these persons according to type of care is shown in Table 23 below:

TABLE 23. PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING HOSPITAL CARE, BY ASSISTANCE PROGRAM AND TYPE OF SERVICE a/

Type of Care	All Programs	OAA	ADC	GA	NA
All Types	100.0	100.0	100.0	100.0	100.0
Major surgery	27.9	31.1	24.3	35.0	21.9
Minor surgery	34.6	13.2	47.6	22.7	58.6
Non-surgical	37.5	55.7	28.1	42.3	19.5

a/ Based on data for persons receiving medical care from 3 DPW funds under study. ANB excluded because of small number of cases included in totals. However, percentages based on data excluding 9 cases for whom type of care was unknown.

Non-surgical care predominates (37.5 per cent) although persons hospitalized were fairly evenly distributed between major surgery, minor surgery and non-surgical care. These data, however, indicate that quite different types of care predominated for the assistance programs - non-surgical for OAA and GA and minor surgery for ADC and NA. The predominance of minor surgery for these two categories results from a substantial number of tonsillectomies provided for children. In fact, many of the non-assistance cases during the survey period were opened specifically to provide tonsillectomies and other minor surgery for children in families otherwise self-supporting, "the medically needy."

1/ Clark, Dean; and Reed, Louis; "Appraising Public Medical Services," in American Journal of Public Health, Vol. XXXI, No. 5 (May, 1941).

2/ Note from Table 20 that 345 persons received hospital care from DPW funds.

A study of the Medical Care Program of the Welfare Board of Freeborn County, Minnesota (made under the auspices of the U. S. Public Health Service), found that approximately 25 per cent of admissions were non-surgical. Dean A. Clark, author of the study, makes the following comment:

> This accords with most surveys on hospitals located in predominantly rural communities. Nevertheless, it probably indicates that non-surgical cases were not admitted as frequently as would be professionally desirable. 1/

The relatively higher percentage of non-surgical admissions to New Mexico hospitals (37.5 per cent) suggests that more persons in public assistance families receive needed medical care at a relatively early stage of illness, where surgical intervention is not required. However, the concentration of these persons in the OAA and GA groups, where the incidence of chronic illnesses is relatively high, may indicate that lack of nursing care facilities for chronic cases would account for the high proportion of non-surgical cases. In this connection, note that for persons in ADC cases, 28.1 per cent were given non-surgical care, which conforms closely to the Freeborn County experience for all categories combined.

The average cost per patient for major surgery was $69.23 as compared with $13.15 for minor surgery and $46.55 for non-surgical patients (see Table 24). These figures represent obligations incurred for care received during the six months under study rather than average cost for each illness treated.

The average cost per day of care was $3.20 for major surgery, $4.35 for minor surgery and $2.10 for non-surgical care. The relatively high cost for minor surgery results from medicines, laboratory fees, etc., included in the hospital bill. The effect of inclusion of these items in the hospital bill is to increase cost per day for fewer days' treatment.

TABLE 24. HOSPITAL CARE: AVERAGE COST PER PATIENT, AVERAGE COST PER DAY AND AVERAGE DAYS PER PATIENT, BY ASSISTANCE PROGRAM AND TYPE OF SURGERY a/

Assistance Program	Average Cost Per Patient			Average Cost Per Day			Average Days Per Patient		
	Major Surgery	Minor Surgery	Non-Surgical	Major Surgery	Minor Surgery	Non-Surgical	Major Surgery	Minor Surgery	Non-Surgical
All Programs	$69.23	$13.15	$46.55	$3.20	$4.35	$2.10	21.6	3.0	22.1
Old Age Assistance	66.65	21.46	44.39	2.88	3.86	1.84	23.1	5.5	24.1
Aid to Dep. Children	57.16	11.75	30.30	4.27	5.70	3.19	13.4	2.1	9.5
General Ass't.	94.85	17.98	67.00	2.66	3.03	2.17	35.5	5.9	30.9
Non-assistance	72.76	8.21	32.36	4.34	4.11	3.29	16.7	2.0	9.8

a/ ANB excluded because of small number of cases; included in totals, however; averages based on 275 patients receiving care from DPW funds for whom complete information was available as to number of days in hospital and amount paid.

1/ Clark, Dean, The Medical Care Program of the Welfare Board of Freeborn County, Minnesota, U. S. Public Health Service, p. 47.

Contrasting average cost per day from this study with the average cost per day of the Freeborn County study, we note that the average for major surgery is 38 cents more and for minor surgery $1.55 more than in New Mexico.

Average cost per day for all types of hospital care varies considerably among the assistance programs (see Table 24). For major surgery, the range is from $4.34 for NA cases to $2.66 for GA cases. The variation in average cost per day appears to result largely from variation in average days per patient. In general, it appears that the longer the stay, the less the cost per day, although this relationship is not absolute. For minor surgery the range is from $5.70 per day for ADC to $3.03 per day for GA, the average days per patient being 2.1 and 5.9, respectively. For non-surgical patients the range is from $3.29 for NA cases to $1.84 for OAA, the average days per patient being 9.8 and 24.1, respectively.

VII. EXTENT TO WHICH RECOMMENDED CARE WAS RECEIVED

For each of the cases which received medical care from the 3 DPW funds the schedule showed the original recommendations for treatment made by the examining physician. Table 25, below, summarizes the extent to which recommendations were carried out. "All recommendations carried out" signifies that among one or more recommendations made by the examining physician all the types of recommendations were carried out. For example, if medication and X-rays were recommended and the client received both he would be classified under "all recommendations carried out" even though the number of X-ray treatments or the amount of medication did not meet desirable standards. If medication and X-rays were recommended and only medication was received the case was classified under "part, but not all recommendations carried out." In short, the scope of treatment, rather than the quantity or quality was considered. Care received included that from sources other than the 3 DPW funds.

TABLE 25. PERSONS RECEIVING MEDICAL CARE (3 DPW FUNDS) BY EXTENT TO WHICH RECOMMENDED TREATMENT WAS RECEIVED AND ASSISTANCE PROGRAM

Item	Persons Receiving Medical Care					
	All Programs	OAA	ADC	ANB	GA	NA
Total	2,538	1,167	833	51	402	85
All recommendations carried out	2,080	977	675	47	311	70
Part, but not all recommendations carried out	304	131	105	3	55	10
No recommendation carried out	70	23	23	0	20	4
No treatment recommended	35	18	6	1	9	1
Unknown	49	18	24	0	7	0
	Percentage Distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
All recommendations carried out	81.9	83.8	81.0	92.2	77.4	82.4
Part, but not all recommendations carried out	12.0	11.2	12.6	5.9	13.7	11.8
No recommendation carried out	2.8	2.0	2.8	-	5.0	4.7
No treatment recommended	1.4	1.5	0.7	1.9	2.2	1.1
Unknown	1.9	1.5	2.9	-	1.7	-

In all programs taken together, over 80 per cent of the persons examined or treated received the care recommended. An additional 12 per cent received the recommendations in part. Fewer than 3 per cent received none of the care recommended. This indicates a good record in carrying through recommendations.

Table 26 gives some indication of points which need strengthening in planning for the future. Lack of facilities near at hand and transportation difficulties explain some instances, such as failure to secure X-ray examinations or the advice of specialists. Where a recommended operation is not performed, the reason in most cases is "client or parent refuses." On the other hand failure to provide a special diet on physician's recommendation may indicate either lack of funds or underestimation of the importance of diet in the treatment plan. The highest percentages of recommendations not received are in ADC and GA families.

What failure to provide recommended care may mean in extreme cases is seen in the following summary of a case record:

> Tomas S., age 46, the family head, was ill with jaundice and anemia. The physician recommended medication, blood count and periodic re-examination, and special diet. Only medication was provided, at a cost of $9.61 from GA funds. Mr. S. died of jaundice and anemia. This man should have started treatments a long time before he did. Lack of funds prevented this ... Mrs. S. is now ill and in need of treatment.

In another county one of the home visitors added the following comment on the medical care survey schedule:

> Patient has been examined by several doctors ..... Since payments for medical care would constitute an overgrant, no plans for treatment have been made. Two other members of this household apparently need physical examinations.

The patient referred to was diagnosed in 1936 and 1937 as "suffering from a very bad heart and kidney lesion ... and in a very critical condition." In January 1942, a third physician diagnosed his condition as "cardiac dropsy and asthma. Prognosis unfavorable. Special diet eliminating meats recommended." Later in 1942 the same doctor recommended extraction of the patient's teeth, "as they are infected badly."

A similar situation is described by a home visitor in Bernalillo County:

> This family has been on relief for ten years, and has had medical problems of all kinds - three T.B., including family head; two pellagra; and one crippled child. Limited funds have made adequate diet impossible in a case where diet is most important for the diseases present.

The extent to which different types of recommendations were carried out varied from 97.1 per cent for medication to 28.6 per cent for psychiatric treatment (see Table 26). The majority, however, were more than 80 per cent. The following types of care were reported "not received" in a relatively high percentage of cases:

Recommendations	Percentage of Times Not Received
Psychiatric treatment	71.4
X-ray for diagnosis	37.2
Special diet	36.0
X-ray for treatment	26.7
Physiotherapy	26.7

TABLE 26. NUMBER AND PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING MEDICAL CARE (3 DPW FUNDS) BY TYPE OF RECOMMENDATION, ASSISTANCE PROGRAM AND WHETHER OR NOT RECOMMENDED TREATMENT WAS RECEIVED

RECOMMENDATION	PERSONS RECEIVING MEDICAL CARE											
	ALL PROGRAMS A/			OAA			ADC			GA		
	TOTAL B/	RECOMMENDATION RECEIVED	RECOMMENDATION NOT RECEIVED	TOTAL B/	RECOMMENDATION RECEIVED	RECOMMENDATION NOT RECEIVED	TOTAL B/	RECOMMENDATION RECEIVED	RECOMMENDATION NOT RECEIVED	TOTAL B/	RECOMMENDATION RECEIVED	RECOMMENDATION NOT RECEIVED
MEDICATION	1,402	1,362	32	796	783	12	334	315	13	222	214	7
OPERATION (DEFINITE)	400	350	48	75	57	18	212	194	17	65	59	5
HOSPITALIZATION	357	336	14	102	98	3	134	122	8	90	85	3
EYEGLASSES	276	265	8	115	113	2	119	112	6	29	28	0
SPECIAL DIET	272	171	98	138	87	50	81	52	28	44	25	18
DENTAL EXTRACTIONS ..	211	184	25	64	54	10	102	91	9	38	32	6
X-RAYS (DIAGNOSIS)...	148	89	55	35	19	15	66	36	28	40	29	11
DENTURES	139	123	16	66	63	3	46	37	9	22	18	4
DENTAL TREATMENT	96	80	14	17	10	7	57	52	3	12	8	4
OTHER APPLIANCES	74	65	8	37	35	1	28	23	5	8	6	2
X-RAYS (TREATMENT)...	30	22	8	17	12	5	8	6	2	3	3	0
PHYSIOTHERAPY	15	11	4	7	7	0	4	2	2	4	2	2
PSYCHIATRIC TREATMENT	7	2	5	2	2	0	1	0	1	3	0	3
OTHER	392	316	68	159	129	28	132	105	24	76	60	16
	PERCENTAGE DISTRIBUTION											
MEDICATION	100.0	97.1	2.3	100.0	98.4	1.5	100.0	94.3	3.9	100.0	96.4	3.2
OPERATION (DEFINITE)	100.0	87.5	12.0	100.0	76.0	24.0	100.0	91.5	8.0	100.0	90.8	7.7
HOSPITALIZATION	100.0	94.1	3.9	100.0	96.1	2.9	100.0	91.0	6.0	100.0	94.4	3.3
EYEGLASSES	100.0	96.0	2.9	100.0	98.3	1.7	100.0	94.1	5.0	100.0	96.6	0
SPECIAL DIET	100.0	62.9	36.0	100.0	63.0	36.2	100.0	64.2	34.6	100.0	56.8	40.9
DENTAL EXTRACTIONS ..	100.0	87.2	11.8	100.0	84.4	15.6	100.0	89.2	8.8	100.0	84.2	15.8
X-RAYS (DIAGNOSIS)...	100.0	60.1	37.2	100.0	54.3	42.9	100.0	54.5	42.4	100.0	72.5	27.5
DENTURES	100.0	88.5	11.5	100.0	95.5	4.5	100.0	80.4	19.6	100.0	81.8	18.2
DENTAL TREATMENT	100.0	83.3	14.6	100.0	58.8	41.2	100.0	91.2	5.3	100.0	66.7	33.3
OTHER APPLIANCES	100.0	87.8	10.8	100.0	94.6	2.7	100.0	82.1	17.9	100.0	75.0	25.0
X-RAYS (TREATMENT)...	100.0	73.3	26.7	100.0	70.6	29.4	100.0	75.0	25.0	100.0	100.0	0
PHYSIOTHERAPY	100.0	73.3	26.7	100.0	100.0	0	100.0	50.0	50.0	100.0	50.0	50.0
PSYCHIATRIC TREATMENT	100.0	28.6	71.4	100.0	100.0	0	100.0	0	100.0	100.0	0	100.0
OTHER	100.0	80.6	17.3	100.0	81.1	17.6	100.0	79.5	18.2	100.0	78.9	21.1

A/ ANB AND NA, CASES INCLUDED IN TOTAL, ALTHOUGH DATA FOR THESE PROGRAMS IS NOT SHOWN SEPARATELY.

B/ TOTAL INCLUDES SOME CASES FOR WHOM IT WAS NOT KNOWN WHETHER RECOMMENDED TREATMENT WAS RECEIVED.

VIII. OUTCOME OF TREATMENT

Status of Treatment, March 31, 1943

Among 8,857 cases open on March 31, 1943, there were 1,578 which had received medical care from DPW funds at some time during the six preceding months. In these families there were 2,275 persons who received medical examination or treatment. This section deals with the status of treatment of these persons as of March 31, 1943 (see Tables 27 and 28).

There were 115 persons who were examined but not treated. The most usual reason for not beginning treatment was that treatment was not recommended by the examining physician (44 persons). Next in importance was refusal by the client to accept treatment after it was recommended; this occurred in 36 cases. Combining these cases with 45 in which the client discontinued treatment because of discouragement and with 91 cases in which the client refused original examination although apparently in need of medical care, it appears that client attitudes on medical care are an important factor in the administration of the program, and that there is a large field for family counselling on health care.

Treatment was suspended or discontinued for only 88 persons. The most usual reason for suspension was discouragement on the part of the client. The doctor shortage, transportation difficulties and lack of funds accounted for only a small number of suspensions of treatment. It seems probable, however, that these factors were more important in preventing original examinations, since they would be considered by workers before attempting to provide medical care.

A large percentage of persons (42.5 per cent) were under treatment as of March 31, 1943. The range among assistance programs was from 56.3 per cent for Old Age Assistance to 20.0 for non-assistance cases. The high percentage for Old Age Assistance is accounted for by the prevalence of chronic conditions requiring continued treatment, and the small percentage in the non-assistance group is accounted for by the fact that these persons generally receive medical care to tide them over a period of temporary need because of accident or illness. The high percentage of persons "under treatment" indicates considerable need for family services in "following through" on treatment begun.

Treatment had been completed for almost half of persons who received care during the six survey months. The large majority of these persons (713) received maximum benefit or were cured. This appears to be an excellent record for the first six months of the medical care program.

The data in Tables 27 and 28 on "patient cured or maximum benefit received" do not give a complete picture of favorable results of medical treatment, since the cases which had been closed as a result of medical treatment or for other reasons are not included.

The condition of 267 persons was improved by treatment, but the persons were not cured. Only 29 persons showed no improvement as a result of treatment.

Cases Closed as a Result of Treatment

One of the most dramatic results of medical care, is return of the family to self-supporting status. This study would indicate that such effects cannot be expected (in so short a period as six months) among a large proportion of cases. Forty-nine cases were closed as a result of

TABLE 27. PERSONS RECEIVING MEDICAL CARE a/, ACCORDING TO STATUS OF TREATMENT, BY ASSISTANCE PROGRAM, MARCH 31, 1943

STATUS OF TREATMENT	PERSONS RECEIVING MEDICAL CARE					
	ALL PROGRAMS	OAA	ADC	ANB	GA	NA
TOTAL	2,275	1,098	777	47	323	30
TREATMENT NOT BEGUN	115	40	39	3	32	1
NO TREATMENT RECOMMENDED..	44	21	10	2	11	0
LACK OF TIME; ETC.	15	3	6	1	5	0
LACK OF FUNDS; ETC.	8	3	1	0	4	0
CLIENT OR PARENT REFUSES..	36	10	16	0	9	1
OTHER	12	3	6	0	3	0
NOW UNDER TREATMENT	967	618	203	24	116	6
TREATMENT SUSPENDED OR DISC.	88	44	24	1	17	2
PENDING CHANGE IN CONDITION	17	9	6	0	1	1
LACK OF FUNDS	5	1	2	0	2	0
CLIENT DISCOURAGED; ETC. ..	45	23	9	0	12	1
DOCTOR LEFT COMMUNITY	5	3	1	1	0	0
TRANSPORTATION DIFFICULTIES	5	1	4	0	0	0
OTHER	10	7	1	0	2	0
REASON UNKNOWN	1	0	1	0	0	0
TREATMENT COMPLETED	1,074	386	498	19	151	20
PATIENT CURED OR MAXIMUM BENEFIT RECEIVED	713	223	378	11	87	14
CONDITION IMPROVED	267	119	96	7	41	4
CONDITION NOT IMPROVED	29	15	8	0	6	0
DEATH	44	20	12	0	10	2
MISCELLANEOUS	21	9	4	1	7	0
UNKNOWN	31	10	13	0	7	1

a/ PERSONS IN CASES OPEN MARCH 31, 1943 WHO HAD RECEIVED MEDICAL EXAMINATION OR TREATMENT IN THE PRECEDING 6 MONTHS.

TABLE 28. PERCENTAGE DISTRIBUTION OF PERSONS RECEIVING MEDICAL CARE [A], ACCORDING TO STATUS OF TREATMENT, BY ASSISTANCE PROGRAM, MARCH 31, 1943

STATUS OF TREATMENT	PERCENTAGE OF PERSONS RECEIVING MEDICAL CARE					
	ALL PROGRAMS	OAA	ADC	ANB	GA	NA
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
TREATMENT NOT BEGUN	5.0	3.6	5.0	6.4	9.9	3.3
NO TREATMENT RECOMMENDED	1.9	1.8	1.3	4.3	3.5	0
LACK OF TIME	0.6	0.3	0.8	2.1	1.5	0
LACK OF FUNDS	0.4	0.3	0.1	0	1.2	0
CLIENT OR PARENT REFUSES	1.6	0.9	2.0	0	2.8	3.3
OTHER	0.5	0.3	0.8	0	0.9	0
NOW UNDER TREATMENT	42.5	56.3	26.1	51.1	35.9	20.0
TREATMENT SUSPENDED OR DISCONTINUED	3.9	4.0	3.1	2.1	5.3	6.7
PENDING CHANGE IN CONDITION	0.8	0.8	0.8	0	0.3	3.4
LACK OF FUNDS	0.2	0.1	0.3	0	0.6	0
CLIENT DISCOURAGED	2.1	2.1	1.2	0	3.8	3.3
DOCTOR LEFT COMMUNITY	0.2	0.3	0.1	2.1	0	0
TRANSPORTATION DIFFICULTIES	0.2	0.1	0.5	0	0	0
OTHER	0.4	0.6	0.1	0	0.6	0
REASON UNKNOWN	[B]	0	0.1	0	0	0
TREATMENT COMPLETED	47.2	35.2	64.1	40.4	46.7	66.7
PATIENT CURED OR MAXIMUM BENEFIT RECEIVED	31.4	20.4	48.7	23.3	26.8	46.7
CONDITION IMPROVED	11.7	10.8	12.4	15.0	12.7	13.3
CONDITION NOT IMPROVED	1.3	1.4	1.0	0	1.9	0
DEATH	1.9	1.8	1.5	0	3.1	6.7
MISCELLANEOUS	0.9	0.8	0.5	2.1	2.2	0
UNKNOWN	1.4	0.9	1.7	0	2.2	3.3

[A] PERSONS IN CASES OPEN MARCH 31, 1943 WHO HAD RECEIVED MEDICAL EXAMINATION OR TREATMENT IN THE PRECEDING 6 MONTHS.

[B] LESS THAN 0.05 PER CENT.

medical treatment. These cases were distributed among the assistance programs as follows:

Old Age Assistance	0
Aid to Dependent Children	3
Aid to Needy Blind	0
General Assistance	21
Non-assistance	25

The relatively large number of closures for general assistance and non-assistance cases no doubt results from the fact that many such cases are opened only to assist the family in receiving medical care or to assist the family while medical care is received. With the disability removed in such cases there is no further need of assistance.

Considering the fact that almost half the cases were still under treatment it is not surprising that the number of closures because of treatment is low. Many of the conditions treated are of long duration and cannot be immediately cured, and a substantial proportion of persons treated are those of advanced age and the very young who are not of employable age. The child who receives a tonsillectomy does not thereby become self-supporting. The value of the treatment, however, is no less real in terms of preventing future dependency. The twenty-five closures of non-assistance cases because of medical treatment may also be considered as preventing dependency, for if medical care had not been available some of these cases would undoubtedly have become dependent upon the Department for assistance other than medical needs.

Favorable Changes in the Family Situation as a Result of Treatment

Although immediate closure of a case as a result of medical treatment cannot often be expected, many other favorable changes occur in the family situation. The workers preparing the survey schedules were asked to specify favorable changes in family situations resulting from medical care. This was done in 68 cases. Favorable changes include improved work in school, ability of a mother to care better for her family, or of any person in the home to assume increased responsibility, participate more extensively in community activities, etc. Illustrations from the survey schedules follow:

"Margarita now in good health and able to attend school regularly."

"Catarina now able to work and support herself as well as assist her mother."

"Mrs. O. now able to do her own housework."

"Patient had spent entire savings for treatment before coming to us. (Toxic tyroid, man age 32 - ADC family head). Has apparently made complete recovery and is looking forward to being self-supporting again."

(Mother 30; 2 children under 6; endocrine unbalance and arthritis) "Mother now more able to care for children."

The intangible factors of personal satisfaction and happiness derived from good health cannot be measured; they are inter-related with many of the situations described above. Their importance, however, is above question, and they perhaps are primary considerations in the accepted goal of providing adequate medical care for persons dependent upon public aid.