The ADMINISTRATION OF INDIGENT MEDICAL CARE in Hawaii

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Report No. 2 - 1959

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Introduction

The administrative organization for the provision of medical care for indigents is an area of particular difficulty for American public administration because of the complexity of the problems involved and because of the fundamental differences in attitudes toward these problems. The numerous studies of and reports on indigent medical care which have been made in recent years for various state governments attest to the degree of difficulty found in dealing with the subject.*

There is at the present time a tremendous and bewildering variation in the operation of indigent medical care programs across the country in the level of services provided, in the means of financing, and in the manner of administration. These programs present an array of relationships between federal, state, and local governments, and between public, quasi-public, and private agencies and organizations. Hawaii's experience in this field is but one of many variations on a theme. While the program here has its unique characteristics, the Territory faces many of the same complexities and difficulties encountered persistently among Mainland jurisdictions.

It should be recognized, therefore, that examination and understanding of the problems of Hawaii's indigent medical care program are not easy matters. The program is not simple, and it cannot be simply explained. Difficulties which on the surface seem easy enough to comprehend and resolve are often, in actuality, only the manifestations of much more fundamental problems. Such basic problems may be inherent in the nature of the subject itself, or they may have been produced by a whole range of conditions peculiar to Hawaii. Moreover, the effects of the indigent medical care program go far beyond the specified limits of the program itself. Conversely, the program is greatly influenced by other developments in the wide fields of public health and public welfare. Hence, the medical care program for indigents cannot be viewed meaningfully except within the broad context in which it must operate.

In light of the above considerations, the following approach to the subject of administration of indigent medical care in Hawaii has been adopted. First, there is a general description of the substantive problem - or problems - involved. Second, there is a brief historical summary of developments in the assumption of responsibility for indigent medical care by various levels of government in the United States. Third, there is an examination of the administrative problem of fitting the program into the structure of government and assigning responsibility for it in accordance with organizational theory and practice. Fourth, there is a fairly detailed description of present administrative arrangements and operations of the program in Hawaii.

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*Among the states in which fairly detailed studies of this subject have been made since 1950 are: California, Kentucky, Maryland, Pennsylvania, South Carolina, Tennessee, Washington, and Wisconsin. In addition, organizations such as the American Public Health Association, the American Public Welfare Association, the U. S. Public Health Service, and the U. S. Social Security Administration have studied various aspects of the subject in recent years.

Fifth, there is noted some of the specific problem areas in the present program. Sixth, and finally, there is an indication of possible alternative courses for administering the program in the future.

I. NATURE OF THE PROBLEM OF INDIGENT MEDICAL CARE

Illness and Indigency. As the term "indigent medical care" clearly indicates, it actually encompasses two problems - the problem of indigency and the problem of need for medical treatment. The bringing together of the two problems under a single term is not without justification, however, as poverty and illness are interrelated problems. They can be distinguished from each other, but not dissociated.

While the two problems may be separable, all too frequently they are as intimately related as the proverbial chicken and egg. Thus, while there are persons who are poor, but not sick, and others who are sick, but not poor; nevertheless sickness is much more prevalent among the poor than among higher income groups. Furthermore, there is ample evidence to show that many persons are destitute because of illness or disability while many others are ill or disabled because of insufficient means to pay for medical treatment.[1]

Table 1 (p. 4), which is taken from the 1952 report of the President's Commission on the Health Needs of the Nation but is based upon the National Health Survey of 1935-36, shows graphically the relationship between economic status and disability. The incidence of disabilities is consistently higher among welfare recipients than among other economic groups, and in most cases this incidence is drastically higher among the former than among the latter.

A very large proportion of the persons on the welfare rolls are in need of medical treatment in one form or another. This fact should not come as a surprise, however, as most welfare programs are designed to meet the needs of the very young (e.g., aid to dependent children), the very old (e.g., old-age assistance), or persons who by definition are disabled (e.g., aid to the blind and aid to the permanently disabled). All of these groups are among those most susceptible to disease and illness or whose handicaps of themselves constitute disability.

Thus, the close relationship between illness and poverty should be readily apparent. It is in the medical care program for indigents that the general problems of public health and public welfare become most intimately intertwined. In this sense, then, the two may be viewed as different aspects of a broader problem. Consequently, the indigent medical care program should be approached from the points of view of both public health and public welfare.

Public Health. Most students of health and medical care administration look upon indigent medical care as being only one segment of the much broader problem of providing medical care for the entire population. A great deal of the emphasis in the general field of public health has been upon preventive measures (e.g., sanitation and inoculation programs) or in dealing with specific diseases (e.g., tuberculosis and cancer). Generally the view has been, therefore, to point out that public health is dependent upon a healthy

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[1]For a comprehensive review of evidence supporting this contention, see Margaret Greenfield, Medical Care for Welfare Recipients--Basic Problems (Berkeley, Bureau of Public Administration, 1957), pp. 7-17.

Table 1.

RATIO OF ANNUAL PER CAPITA VOLUME OF DISABILITY FOR DIFFERENT INCOME GROUPS TO THAT IN THE HIGHEST INCOME GROUP, ACCORDING TO DIAGNOSIS, NATIONAL HEALTH SURVEY, 1935-36

Diagnosis	Annual family income and relief status					
		Nonrelief				
	Relief	Under $1,000	$1,000 to $1,500	$1,500 to $2,000	$2,000 to $3,000	$3,000 and Over
Hernia	1,261	435	304	191	200	100
Tuberculosis (including non-respiratory)	886	392	253	177	139	100
Varicose veins	714	329	171	193	136	100
Blindness and deafness	562	312	171	146	150	100
Diabetes mellitus	423	231	154	141	128	100
Diseases of female genital organs and complications of pregnancy	420	230	160	150	150	100
Hemorrhoids	371	182	153	129	135	100
Orthopedic impairments	367	251	153	123	112	100
Diseases of digestive system other than appendicitis, hernia, and diseases of teeth, mouth, and gums	361	191	121	97	100	100
Rheumatism and allied diseases	351	202	132	105	110	100
Anemia	310	198	133	110	124	100
Diseases of bladder, urethra, urinary passages, and male genital organs	304	174	110	101	88	100
Nervous and mental diseases	298	212	140	120	112	100
Confinements	289	200	205	168	142	100
Diseases of skin and cellular tissue	279	176	137	101	97	100
Diseases not elsewhere classified	276	168	118	105	103	100
Cardiovascular-renal diseases	272	158	112	101	101	100
All diagnoses	266	167	121	107	106	100
Cancer and other tumors	248	148	114	114	100	100
Accidents	213	167	124	109	107	100
Pneumonia (all forms)	193	120	100	93	107	100
Diseases of respiratory system other than tuberculosis, pneumonia, and tonsillitis	192	125	92	90	95	100
Communicable diseases other than those common to childhood	183	125	83	73	78	100
Diseases of teeth, mouth, and gums	147	147	100	100	87	100
Tonsillitis (including tonsillectomies)	138	108	100	100	108	100
Diseases of ear and mastoid process	132	101	93	87	101	100
Diseases of thyroid gland	122	94	61	68	69	100
Common communicable diseases of childhood	110	86	93	95	100	100
Appendicitis (including appendectomies)	104	83	87	83	87	100

Source: Taken from Table 55, p. 49, vol. 3, Building America's Health.

population across-the-board. As a result, there has been a reluctance to focus attention on a single group within the overall population. Thus, when public health officials speak of a medical care program, they are usually thinking of medical care for everyone and not just for those who are welfare recipients.

Another important consideration from the public health point of view is the fact that medical care traditionally has been regarded as being unique in a number of ways. "Not only are health services personal in nature and highly technical, but the incentives and practices of the marketplace are not applicable to the rendition of medical services."[2] Moreover, while medical care is considered a basic need along with food, shelter, and clothing, unlike these other needs it is not considered acceptable to provide a lower quality or reduced quantity of medical care to welfare recipients:

> That the quality of health services available to indigent persons be equal to that of the services received by the general public is a basic tenet which is not subject to compromise. A double standard with respect to health care is not acceptable to the public nor consistent with the traditions of physicians, hospitals and other personnel and institutions in the health field.[3]

Because of the special position enjoyed by the field of medical care, it has generally been contended that it should be under the control and jurisdiction of those most knowledgeable as to its special requirements. This usually means medical men and those with training in the various specializations of public health. The almost inevitable result has been for public health authorities to consider medical care needs without relation to other needs.

From the public health standpoint, then, an indigent medical care program raises the following two basic problems: (1) the need to fit such a program into an overall health program, taking into consideration the special medical needs of indigents but not losing sight of the general public health goals of the society; and (2) the need to recognize and accommodate to the unique characteristics and requirements of the field of medical care as much as possible while at the same time trying to break down some of the barriers which the medical field has built around itself.

Public Welfare. Turning from the public health to the public welfare aspect of the problem of medical care for the indigent, we get a different perspective on the subject. Whereas the primary focus of attention from the health point of view is upon the value of human life and the maintenance of good health, the interest in human welfare includes this but operates from a a somewhat broader philosophical base. The concept of public welfare in the United States is rooted in fundamental precepts of American democracy relating

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[2]Kentucky, Governor's Commission on the Study of Medical Care for the Indigent, Medical Care for Indigent Persons in Kentucky (Frankfort, 1957), p. xviii.

[3]Ibid., p. xix.

to equality of opportunity, the worth of the individual, and the importance of human dignity. The growing social consciousness in recent years is based upon these fundamental precepts. The result is present broad-scaled public welfare programs under which the unfortunate, the disabled, and the underprivileged are assured sufficient assistance to make the tenets of American democracy meaningful to them and to make them as productive members of society as possible.

In this sense, then, medical care is only one of a number of needs which must be considered by social workers in dealing with welfare recipients. From the viewpoint of public welfare:

> ... the over-all problem is the aggregate of problems of individuals, who must be identified and whose health needs, environmental situations, cultural levels and personal characteristics must be recognized in formulating and carrying out program measures if these are to be most effective.[4]

Because medical care is only one among several basic needs of indigent persons and because of the fundamental differences between the provision of medical care and provision of food, shelter, and clothing, medical needs have often tended to be overshadowed by the other needs in the minds of welfare workers. This is particularly true where most social workers have had little or no medical training and are therefore not qualified to deal with this specific problem area.

Furthermore, the neglect of the medical aspects of the problem of indigency has been reinforced by the often quite limited horizons of the humanitarianism of public welfare (at least in the past). All too frequently the supporters of relief for the indigent have been satisfied merely with alleviating the most distressing needs; have been content with merely treating the symptoms of the problem and not the causes. Within this frame of reference, the ultimate goals of public welfare have been fulfilled if the minimum subsistence needs of the poor and disabled are continued to be met. The result of such an attitude is a "custodial care" program for indigents - that is, a program in which no one starves or suffers unduly but where recipients remain on the welfare rolls indefinitely and no real attempt is made to make these persons self-reliant and to return them to productivity.

Fortunately, however, a new attitude is prevailing in the field of public welfare. While only a relatively recent development, the concept of rehabilitation is fast making headway and bringing with it a very positive approach to dealing with the problems of indigency. Under this concept the push is toward finding the reasons underlying the continuance of a person on the welfare rolls and to devise measures to make such a person once again a self-sufficient and useful member of society.

The indigent medical care program has an extremely important role to play in this new approach in the field of public welfare because "the provision of medical care represents a lever by which the extent and duration of dependency

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[4] Ibid.

can be reduced." As has already been pointed out: "There is little doubt but that illness and impairments are the principal causal factor producing dependency on public aid." Thus, it would seem "in the view of this and the potentialities of modern medical science in preventing and curing disease and minimizing its toll, public interest in providing for the health care of the indigent extends beyond humanitarian considerations to the consideration of reducing to a minimum the cost of dependency in terms both of human resources and tax funds required to maintain dependent persons."[5]

To summarize the public welfare view of indigent medical care, it might be said the problem is twofold: (1) the need to recognize that medical care, while in no way the only consideration, is probably the most important means of achieving the ends of a modern welfare program, and (2) the need to utilize in the field of public welfare everything medicine and public health has to offer in the way of preventive and curative measures. To overcome this two-fold problem is going to require drastic revision of thinking among a great many in both public welfare and public health. Advances have been made, to be sure, but a great distance remains to be covered. Until a two-pronged and closely coordinated attack on the problem of indigency is mounted on both the health and welfare fronts, the problem is unlikely to be solved, or even greatly diminished.

Economics of Indigent Medical Care. Before concluding this examination of the general problem of indigent medical care, another dimension must be added - and this is the dimension of economics. The problem of indigent medical care arises in the first place out of an economic situation - namely, the financial inability of individuals to bear the costs of hospital care, physicians' services, and other medical care. When the burden of these costs is assumed by the public, answers still must be found to the questions of how the economic burden should be borne, how much financing is needed, and how the funds should be provided and applied. The resources available to meet the need are not unlimited, and, in a sense, this is the crux of the problem. No matter in what manner the public chooses to meet the problem -- whether through the instrument of government, by means of voluntary aid and philanthrophy, or through some combination of these -- it is inevitable that decisions will have to be made as to how to apportion available resources to accommodate the needs of indigent medical care.

Thus, from the economic point of view, the problem of indigent medical care raises such issues as: (1) how much medical care can society afford to provide to the indigent? (2) to what extent can society afford not to provide indigent medical care? (3) what priority can indigent medical care claim in relation to other pressing demands upon society? (4) who should bear the cost of indigent medical care, and in what proportion? and (5) how should payments for such care be made? Such considerations may seem so obvious as not to require enumeration. However, in many instances the problem of an indigent medical care program is discussed almost as if in a vacuum, without due attention being given to the economic conditions surrounding such a program.

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[5] Ibid., p. xx.

It is important, therefore, to try to relate what is highly desirable to what is economically feasible, and, on the other hand, to make sure that what money is spent produces the best results possible within the limits of such expenditure.

Figuratively, therefore, it might be said that the indigent medical care program resembles a three-legged stool in that it should rest upon the supports of adequate financing, full appreciation of the goals of modern public welfare and modern public health, and complete utilization of the achievements of medical science and public health. The problem of administering the program is to ensure it rests firmly upon the three and does not fall somewhere in between and thereby be doomed to failure and frustration.

"Indigent" and "Medically Indigent." One further general comment is in order before proceeding to a detailed consideration of the problem of indigent medical care. This concerns a clarification of terms. Throughout the literature on the subject of indigent medical care there recur frequently references to "indigent" and "medically indigent." To simplify the two terms as much as possible, the former refers to needy persons who are receiving some sort of public assistance payments and thus appear on the welfare rolls. These are persons who have been found to be unable to make sufficient income to meet their basic needs (food, clothing, and shelter) and for whom society has assumed an obligation to support. They may also require medical care in addition to the aforementioned basic needs. However, it has only been very recent that this fourth need has been recognized as a "basic" need and one which will be taken care of through public assistance. This is one group which indigent medical program is designed to help.

"Medically indigent" refers to those persons who are able to make enough to provide for their minimum basic needs of food, clothing, and shelter, but who do not have sufficient income to pay for needed personal health services. Hence, while they are not destitute, as are the "indigent," they are very low income individuals and do not have the ability to pay sizeable medical bills. They are on the brink of poverty, so to speak, and may actually go on the welfare rolls if subjected to expensive medical treatment. Thus, they are medically indigent. This is the second group an indigent medical care program helps.

Although the lines between the two are blurred, the distinction between "indigent" and "medically indigent" is important because in most jurisdictions different means and standards for determining eligibility for medical care at public expense are used. In some states, in fact, entirely different agencies are charged with determining the financial eligibility of the two groups and the level of medical services they will receive. Furthermore, federal matching funds may be used to help defray the cost of medical care for indigents, but the medically indigent are ineligible for such funds. These differences have important bearing on the organization of an indigent medical care program and the assignment of responsibility for it.

II. DEVELOPMENT OF PUBLIC RESPONSIBILITY FOR INDIGENT MEDICAL CARE

The interrelated problems of poverty and illness have plagued mankind down through the ages, and, of course, are still prevalent in varying degrees throughout most of the world today. However, in recent times great strides have been made, in the United States and elsewhere, toward the lessening of these two problems. Much of this progress is attributable to advances in science, technology, and living standards, but due credit should also be given to marked changes which have occurred in popular attitudes toward these problems, the obligations of society in dealing with them, and the means by which society assumes such obligations.

It is these general developments which form the background for moves which have been made up to the present in the field of indigent medical care - a problem area where much remains to be done and where there is the most obvious overlapping and direct relationship between efforts in public health and those in public welfare.

To tell the whole story of the development of indigent medical care in the United States and in Hawaii would require an extensive social history, and will not be attempted here. The present purpose is merely to outline the broad framework in which Hawaii's existing program should be considered.[1]

"Poor Law" System. The origins of our present approach to public assistance can be traced back to our English heritage. Among the social and legal institutions which the colonists brought over with them and transplanted on American shores was the English poor law system, a product of the Elizabethan era. By modern and progressive standards, many of the provisions of the poor law system were quite harsh, but in spite of this fact the system still serves as the legal basis for many of the public welfare programs maintained by local and state governments in this country today.

The basic principles of the poor law system are: (1) public assistance is a local responsibility and local governments have the task of administering relief; (2) care for dependent persons is first and foremost a family responsibility and the local government is entitled to enforce this responsibility through stringent legal obligations on the family; and (3) as each community is responsible for the care of its own poor, it should not be responsible for the poor of other communities - therefore, determining legal settlement or residence is an important consideration.

Throughout most of the country's history, the governmental approach to public assistance has operated from the premises of the poor law system. Provision for the needs of the poor and disabled have been primarily the responsiblity of local government and this has resulted in such infamous local institutions as the poorhouse or workhouse.

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[1] A good historical treatment of public welfare can be found in Arthur P. Miles, An Introduction to Public Welfare (Boston, D. C. Heath & Co., 1949), from which much of the following description has been taken.

Private Charity. Alongside these limited and oftentimes harsh governmental efforts, however, there has developed other means by which the public has assumed responsibility for the needs of the poor and disabled, and which have done much to ameliorate conditions imposed by the poor law system. Americans have long met the needs of the unfortunate through the minstrations of religious, charitable, philanthropic, and voluntary organizations and groups. Moreover, free medical care has long been rendered by physicians, hospitals, and other medical institutions. Such means have been employed not only to supplement, but in many cases actually to supplant, action by government.

Through such private (i.e., non-governmental) means there has been provided public assistance on a very large-scale basis, and voluntary efforts still figure importantly in providing for the needs of the indigent and disabled in the United States. There has developed, however, a close cooperation between private and governmental agencies so that today there is a wide variation of relationships and working arrangements between privately-supported and tax-supported activities in the fields of public health and welfare.

Public Health Programs. As for medical care for indigents, public assistance programs have been supplemented for many years by public health acts of various types, although a separate medical care program for this particular segment of the population is a relatively new development. First concern in the field of public health has been directed principally at the preventive measures of environmental sanitation and control of communicable disease, although curative treatment has long been provided for such diseases as tuberculosis.

In the twentieth century, however, the scope of public health activities has expanded considerably so that they now include, among many programs, such things as immunization, pre-natal, well-child, dental and orthopedic clinics; diagnostic clinics for cancer, diabetes, and heart disease; mental hygiene services; mass chest x-ray surveys; and sometimes hospital care and comprehensive medical care for indigents. Of course many of these programs are available to everyone, but are utilized chiefly by needy and medically needy persons. For this reason, indigent medical care should not be considered apart from the general public health programs.

As in the case of public welfare, most public health programs were undertaken initially at the local level, and for most of our history responsibility for them has reposed in the local communities. Responsibility for meeting these needs are tending to gravitate to higher levels of government today, but only very gradually have the states moved into these fields, and the federal government did practically nothing in them until the 1930's.

Early State Activities. The first steps taken by the states began relatively early in our history, but in the initial stages were quite limited. The first state actions were to provide institutional facilities for particular classes of individuals who required such treatment but were not receiving it from local communities. Hence, special institutions under state control, such as those for the insane, the criminal, the deaf and dumb, the blind, the delinquent, and the feeble-minded, have long been in existence.

In the latter half of the ninteenth century several of the more progressive states inaugurated state boards of control or boards of charity to supervise and oversee various state and local institutions operating in the broad fields of health and welfare. Initially, the activities of these boards were limited to inspection of various institutions and to the dissemination of information concerning proper methods of dealing with various social problems, etc. However, as a result of reform movements and efforts to accomplish greater governmental economy and efficiency, a number of states have gradually developed centralized departments with broad powers to control and operate institutional, welfare, and health facilities maintained by such states.

Although there were these beginnings of action on the state level, by the end of the second decade of the twentieth century medical care for the needy was still overwhelmingly dependent upon the resources of local governments and charities. Far from being adequate even then, these local efforts completely foundered under the impact of the economic depression of the 1930's. Local treasuries were depleted in the face of rapidly declining revenues while at the same time relief costs were mounting astronomically. Both the state and federal governments were obliged to assume a large portion of this burden.[2]

Federal Relief Programs. The first federal relief act was passed in 1932 and provided for Reconstruction Finance Corporation loans to state governments for relief and work relief for the needy. The $300,000,000 allotted under this act was quickly exhausted. It was followed in 1933 by the creation of the Federal Emergency Relief Administration, which provided a measure of medical care to recipients and set the precedent for federal and state participation in direct medical assistance to the needy.

Social Security Act. Other relief programs sprung up after the discontinuance of FERA in 1935, but the next major step in the development of indigent medical care was the passage of the Social Security Act of 1935. In addition to other important features, this act provided grants-in-aid to the states for assistance payments to specified categories of needy persons. Federal aid was conditioned on cash payments to the recipients, however, with the recipients being given the greatest independence possible in the expenditure of the payments. The result was that medical care was frequently neglected because the payments were so low in most parts of the country that the entire amounts were diverted to food, shelter, and clothing.

1950 Amendment. In 1950 the Social Security Act was amended so as to accomplish the following three major changes:

1. A fourth specific category - permanently and totally disabled - was added to those entitled to payments from federally-matched funds.
2. The definition of assistance was broadened to include medical or remedial care in behalf of recipients in the four specific categories, in addition to cash payments. This was interpreted by the Social Security Administration to allow contributions to prepayment plans on behalf of recipients and thereby permit contract arrangements by welfare departments with

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[2]This and much of the following description is based upon: Margaret Greenfield, Medical Care for Welfare Recipients--Basic Problems (Berkeley, Bureau of Public Administration, 1957), pp. 18-27.

health departments, other public agencies, and private prepayment plans.

3. Federal aid was also made available to finance payments to persons falling under the specified categories who were patients in medical institutions, except those who were under hospital care as a result of tuberculosis or mental disease.

The amendments were designed to enable greater flexibility in administering the medical aspects of assistance. This was particularly evident in the provision allowing the option of cash payment to the recipient for medical care or direct payment to the vendor in behalf of the recipient. However, no additional federal funds were made available so that medical care still had to be met within the already existing limits set on payments to individuals. Therefore, states which already made assistance payments at or above the participating ceilings set by the federal government derived little or no advantage from the new law. Another shortcoming of the 1950 amendments was that they resulted in rather complicated fiscal procedures.

1956 Amendment. In 1956 the Social Security Act was further amended so as to permit the separate financing of medical care. Beginning July 1, 1957, the federal government was to provide half of the total state expenditures up to $6 per month for each adult and $3 for each child on the welfare rolls covered by a state plan for medical care. These expenditures were to be made exclusively for payments to suppliers of medical care or for medical care insurance payments. It was anticipated that each state would have a definite medical care plan which would be statewide in application and would give equal consideration to individuals in similar circumstances. It also seemed to presuppose that the states would extend and broaden existing indigent medical care programs. However, it should be remembered that the law was permissive and did not make such action mandatory. Also many authorities contend the amounts made available are entirely inadequate to cover soaring medical costs.

The role of the federal government in the field of indigent medical care, then, is fixed by the Social Security Act of 1935, as amended in 1950 and 1956. This law provides matching funds for four of the six categories of recipients on the welfare rolls of the states. Medical care for persons in these four categories can be provided for out of the direct cash payments to the recipients (which must cover food, shelter, and clothing also), or, under present arrangements, a separate plan for financing medical care may be set up whereby payments may be made to the vendors of medical care instead of the welfare recipients.

Other Federal Programs. It should not be overlooked, however, that in addition to this direct approach to indigent medical care the federal government is engaged in a number of other programs of indirect benefit to the poor and disabled. Through the Public Health Service, the Children's Bureau, and the Office of Vocational Rehabilitation the federal government is actively supporting research programs, hospital construction, vocational rehabilitation, maternal and child care, and preventive measures against mental illness, venereal disease, tuberculosis, cancer, heart disease, and other chronic illnesses. Furthermore, millions of persons are receiving direct medical care as a result of being military persons or their dependents, veterans, Indians, and others.

Primary Responsibility Still in Localities. Under the impetus provided by matching funds from the federal government and by continued demands from local communities for increased assistance for indigent medical care, the states have embarked upon programs to provide medical and remedial care to welfare recipients. However, such state action, with few exceptions, has been quite modest throughout the United States with the result that even today major responsibility for indigent medical care lies largely with the local communities.

A comprehensive survey[3] conducted in late 1956 indicates that in 22 states indigent medical care is still primarily a responsibility of the locality, although in 11 of these the state welfare departments do make limited contributions toward bearing some of the costs of such care. In the remaining 26 states broad medical care programs have been written into law which create the necessary legal framework for comprehensive indigent medical programs to be administered or supervised by the state government. However, in 12 of the 26 states with such laws there are restrictions (i.e., exceptions, limited appropriations, etc.) which make the programs somewhat less than comprehensive in actual practice and which allow a wide diversity in the amount and quality of medical care available among different localities within the same state. In only 14 states, therefore, are there programs which are uniform throughout the state and offer reasonably comprehensive medical services to public assistance recipients. These 14 states, then, are the only ones where there is a general recognition and acceptance of the idea that indigent medical care is a problem of statewide concern and responsibility.

Public Welfare in Hawaii. Hawaii has been at the forefront of jurisdictions assuming responsibility for indigent medical care, and, in fact, compares very favorably with the 14 states which have comprehensive programs. The territorial experience parallels in many respects the general pattern of development of public responsibility for indigent medical care, but has also had its unique features.

From the standpoint of public welfare, the indigent medical care program in Hawaii has developed in a manner very similar to that in many Mainland jurisdictions. In a book written in 1929 one authority on the territorial government commented: "The problem of poor relief in Hawaii is largely in the hands of the counties, but the territory does maintain a board of child welfare in each county and city-and-county. These are composed of five members each, chosen by the governor and the senate. . . . Though these boards are chosen by the governor, they must depend on local governments for the money they spend. Thus, the agencies are partly territorial, partly county." He then concluded: "It is a question whether the matter of welfare ought not to be left entirely to the counties, as all of the money comes from them."[4]

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[3]Margaret Greenfield, Medical Care for Welfare Recipients - State Programs (Berkeley, Bureau of Public Administration, 1957).

[4]Robert M. C. Littler, The Governance of Hawaii (Stanford University, Stanford University Press, 1929), pp. 130-131.

Hawaii did not escape the impact of the Depression of the 1930's, however, and the local governments of the territory proved as inadequate in dealing with the immense problems of relief as did those on the Mainland. As did the state governments, the territorial government began to play a larger role in this field of activity and to take advantage of the relief programs being promoted by the federal government.

Hawaii Unemployment Relief Act. In 1933 the Hawaii Unemployment Relief Act[5] was passed which created a ten-member Unemployment Work Relief Commission and imposed a tax of .5% on compensation (i.e., regular salaries and wages) and on dividends to help cover the costs of relief. The revenues from the tax were paid into a special fund, the Unemployment Work Relief Fund. The commission was charged with administering relief directly in Honolulu and overseeing the work of five-member subcommittees appointed in each of the three counties.

Hawaii Public Welfare Law. The Unemployment Work Relief Commission was abolished in 1937 and replaced by a territorial Board of Public Welfare and county welfare commissions. Under this Public Welfare Law[6] the seven-member Board of Public Welfare was made responsible for supervising the territorial public welfare program and had the power to appoint a director and other personnel. The county welfare commissions were left to administer public assistance under such supervision. The earmarked funds for public welfare were continued.

Hawaii Social Security Act. In 1939 the organization of the welfare agency was revamped, and its title was changed to Department of Social Security. This Social Security Act[7] placed the director at the head of the department and made the five-member board advisory to him. Welfare activities were greatly centralized under the director, as evidenced by the fact that he was empowered and directed to appoint an agent in each county to administer the welfare program. Revenues from the compensation and dividends tax and federal matching funds constituted the financial support for the department.

The agency's name was changed back to Department of Public Welfare in 1941, but the organization remained essentially the same, with a strong executive type director at the head and a five-member advisory board. The system of county agents was retained under this law[8] and the director was charged with administering and supervising a broad public welfare program throughout the Territory. The Public Welfare Tax Law[9] was also passed in 1941 and this act amended the previous tax on compensation and dividends.

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[5]Act 209, Session Laws of Hawaii 1933.

[6]Act 242, Session Laws of Hawaii 1937.

[7]Act 238, Session Laws of Hawaii 1939.

[8]Act 296, Session Laws of Hawaii 1941.

[9]Act 213, Session Laws of Hawaii 1941.

It permitted raising the tax rate to .6% if necessary to cover welfare costs, provided the receipts did not exceed $500,000 in a six-month period. The tax revenues continued to be earmarked for public welfare purposes.

An act[10] of 1943 amended the Public Welfare Tax Law to change the name of the tax to a "compensation and dividends tax" and increased the rate to 2%. The "public welfare fund" as a special fund was retained and was entitled to receive an amount equalling .5% (or .6% if the maximum limit was utilized) of the total tax base. The rest of the revenues from the tax were to be deposited in the general fund.[11]

Beginning of Indigent Medical Care by the Department of Public Welfare. Also in 1943 the Department of Public Welfare was authorized to furnish or pay the cost of medical care, hospitalization, dental care, and burial of the dead for needy persons. Previous to this act,[12] all such costs were borne by the counties. Under wartime conditions the welfare rolls were at the lowest possible minimum as practically everyone found employment in activities supporting the war effort. At the same time, this full employment meant a tremendous increase in revenues pouring into the special public welfare fund. Under such a combination of factors it was almost inevitable that a surplus of funds available for public welfare would be produced. However, the counties were not enjoying a similar financial bonanza, but, rather, found an even greater squeeze placed on their somewhat meager resources. Therefore, the 1943 enabling legislation was passed so as to permit the use of public welfare surpluses to relieve the burden on the counties.[13]

Return of Responsibility to Counties. The 1943 law did not fix specific responsibility for indigent medical care on the Department of Public Welfare, but during the period when sufficient funds were available the department did cover medical costs of the needy on a broad scale. During the postwar period, however, medical costs mounted rapidly while at the same time other demands upon the department's resources were increasing. Medical care costs rose from $607,000 in the calendar year 1945 to $729,000 in 1946 and to $504,000 in the first six months of 1947.[14]

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[10]Act 100, Session Laws of Hawaii 1943.

[11]For a fuller explanation of this tax, see Robert M. Kamins, The Tax System of Hawaii (Honolulu, University of Hawaii Press, 1952), pp. 55-57, 170-171.

[12]Act 36, Session Laws of Hawaii 1943.

[13]This is the explanation given by officials in the Department of Public Welfare in a personal interview, and a similar view is contained in the report of the Honolulu Chamber of Commerce, Public Health Committee, entitled: Public Medical Care in Hawaii (Honolulu, 1947), p. 1.

[14]Department of Public Welfare, Annual Report, 1947, p. 24.

In the face of such conditions, the department in 1948 reported:

> Because there have been insufficient funds for welfare purposes, particularly for those functions mandated by law, the department found it necessary to reduce the scope of its hospital and medical care program. It turned back to the county governments responsibility for dental care, for hospitalization of the "medically needy," for all hospital care in county institutions, and for burial.[15]

Actually, the department's return of financial responsibility for indigent medical care to the counties was quite gradual and took place during the period from 1946 to 1951. It was not until the middle of 1951 that the department had divested itself of practically all direct participation in providing medical care to the indigent. Table 2, which was prepared by the department, sets forth the timetable of this process of shifting financial responsibility back to the counties.

Table 2.

CUTBACKS IN THE DEPARTMENT OF PUBLIC WELFARE'S
MEDICAL CARE PROGRAM
July 1, 1943 - June 30, 1951

Medical care services returned to the counties:

1. TB Cases in Public Institutions - 1946. (?)
2. Care in County Institutions - July 15, 1947.
3. Burials - July 31, 1947.
4. Dental Care - August 31, 1947 (except emergencies).
5. Private Hospital Care - TB Cases - Oahu - October 20, 1947.
6. Private Hospital Care - TB Cases - Other Islands - November 10, 1947.
7. Eye Care - Medical Indigents - November 15, 1947.
8. Collapse Therapy Treatment for TB Cases at Private Clinics - November 30, 1947.
9. Hospital Care to non-DPW recipients - March 31, 1948.
10. All remaining medical care to non-DPW recipients - June 30, 1949.
11. Emergency Dental Care - December 21, 1950.
12. All medical care except for a few patients in private convalescent nursing homes - June 30, 1951.

Source: Hawaii, Department of Public Welfare memorandum of May 21, 1952, revised December 1957.

[15] Annual Report, 1948, p. 19 (unnumbered).

To summarize the decade of the 1940's, then, it might be said that the Department of Public Welfare took on quite suddenly in 1943 a broad program of providing medical care to the indigent and then during the ensuing years gradually turned this responsibility back to the county governments, which had originally provided such care.

Separate Agency for Blind. Two other important changes affecting the department also took place during the same period. One of these was the creation of an independent Bureau of Sight Conservation and Work with the Blind. This new and separate agency was charged with the duties of providing vocational guidance, training and placement to the visually handicapped and was authorized to embark upon a program of rehabilitation for the blind. Thus, the Department of Public Welfare was relieved of the job of remedial work with the blind, but the department did retain responsibility for administering public assistance payments to the blind.[16]

Abolition of "Public Welfare Fund". Another important development affecting the department came in 1949 when the special "public welfare fund" was abolished and the earmarking of a portion of the revenues from the compensation and dividends tax for public welfare was eliminated. From that time on, the department has been dependent upon appropriations from the general fund - beginning with an appropriation of $9,551,565 for the 1949-51 biennium.[17]

Public Health in Hawaii. With this review of the development of public welfare in Hawaii in mind, let us now take a look at the history of public health in the Territory.

Hawaii has a long history of activity in the field of public health on an island-wide basis. This is apparent in the following statement made in December 1949 by Dr. C. L. Wilbar, Jr., President of the Board of Health:

> This Board is one of the oldest health boards established in the United States. King Kamehameha III appointed a Board of Health in December, 1850, and it has been in continuous existence since then. Funds were first appropriated for it by the 1851 legislature. This Board of Health was established to meet all types of community health problems. The early Hawaiian government recognized the need for the care of the indigent sick and provided free medicines for distribution to the poor. The first indication of public medical care in our health reports goes back to 1853 when free medicines were provided by the government through the Board of Health. Traveling physicians were appointed to provide medical care. Later, these physicians provided not only curative services but also preventive health services. They were also concerned with sanitation, communicable disease control, vital statistics and health education.[18]

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[16]Acts 113 and 125, Session Laws of Hawaii 1945.

[17]Acts 350, Session Laws of Hawaii 1949.

[18]"Statement on Medical and Hospital Care for the Needy," made on December 5, 1949, to the Advisory Group, Subcommittee on Hospitals, Medical Care, Health and Public Welfare of the Legislative Holdover Committee of 1949 (mimeo.), p.2.

Government Physicians. Thus, the health agency in Hawaii was established 19 years prior to the creation of the board of health in Massachusetts, the first state health board on the Mainland. The oldest medical service carried on in the territorial health department is that rendered by "government physicians." The institution of the "government physician" dates back to at least 1860, and is still an important part of the department's activities. Government physicians are doctors who are subsidized by the territorial government and are under contract with the health department. They are located throughout the Territory outside of Honolulu "proper" (i.e., in rural Oahu and on the neighbor islands). By this means, the Territory ensures that medical care is available to the entire population of Hawaii. It has long been the practice for government physicians to treat the needy sick without charge, as indicated above. Therefore, the direct rendering of medical care to the indigent by the territorial government has a long and honorable history behind it.

As a matter of fact, however, governmental activity in Hawaii has always been much more centralized than is normally true on the Mainland.[19] This is particularly apparent in the public health field where many of the health and sanitation activities were initially undertaken by the central health agency directly and still rest primarily in this agency. This idea finds expression in the law of the Territory, which states: "All county health authorities, sheriffs, and police officers and all other officers and employees of the Territory, and every county thereof, shall enforce the rules and regulations of the board [of health]. All such powers in health matters as have been or may be conferred upon any county shall be concurrent with those of the board."[20] Such conditions led one observer to say, "there is no local autonomy for public health administration as is characteristic of the majority of state health programs."[21]

One exception to the above generalization is in Honolulu "proper" where there are no government physicians and where indigent medical care has been provided primarily through the voluntary services of doctors in the city. The members of the medical association have assumed responsibility for free staffing of hospitals and outpatient clinics serving the needs of indigents, following the pattern predominate throughout most of the country.

As for the other public health activities which have long been performed by the health department, the ones most closely related to indigent medical care include: (1) the maternal and child health and crippled children medical care programs, (2) the Hansen's disease program, (3) the communicable disease control program, (4) the mental hygiene program, (5) venereal disease and cancer control program, and (6) the tuberculosis program. Some of these services

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[19]For an excellent examination of this phenomenon, see Norman Meller, "Centralization in Hawaii: Retrospect and Prospect," The American Political Science Review, Vol. 52, No. 1 (March 1958), pp. 98-107.

[20]Sec. 46-8, Revised Laws of Hawaii 1955.

[21]Jennie S. T. Ching, Public Health Administration in Hawaii (unpublished M.A. thesis, University of Chicago, 1941), p. 75.

are only diagnostic, consultative, and educational in nature while others entail the direct rendering of medical care by the departments.

Health Department Administration of Indigent Medical Care Program. At the present time the health department is also charged with administering directly the separate indigent medical care program. This program was placed under the department in 1951 as a result of several years of study and consideration of the problem of indigent medical care by both private and public groups.

The problem of indigent medical care received the attention of the public health committee of the Chamber of Commerce of Honolulu in 1947-1948.[22] In 1949 the problem was referred to the Legislative Holdover Committee, which considered the matter through its Subcommittee on Hospitals, Medical Care, Health and Public Welfare. The subcommittee in turn appointed an advisory group, composed mainly of doctors, to assist in its consideration of the question. After a number of public hearings and a great deal of study had been devoted to the problem, the subcommittee finally proposed a bill embodying the essential features of the program which was enacted under Act 129, Session Laws of Hawaii 1951.

Act 129 created the present framework of the Territory's indigent medical care program and placed it under the Board of Health. According to Standing Committee Report No. 313, Senate Committee on Public Health, May 2, 1951, the intent and purpose of the act were summarized as follows:

> The purpose of this bill is to assign to the health department the supervisory and policy-making authority for administration of the program of medical care for persons who are "indigent" or "medically indigent," which terms are defined in the measure. For this purpose, the bill establishes a division of hospitals and medical care within the health department, and provides for an advisory commission to the health department to be composed of eleven members. The bill likewise sets up advisory committees in each of the counties. The Board of Health has broad supervisory authority, but actual administration of the program will be handled by each of the counties.
>
> Your Committee on Public Health is convinced that the proposed legislation is highly desirable to establish a Territory-wide policy and program of administering to the medical needs of all who are unable to obtain same for themselves. In the past there has been a rather haphazard handling of the problem, partly by the Department of Public Welfare and partly by the counties. This bill was developed from careful study by the Holdover Committee of 1949, with valuable assistance from an advisory group. The Board of Health, the Department of Public Welfare, the Bureau of the Budget and the Department of the Attorney General have all been consulted and have worked out the details of this measure, and all have expressed approval of it.

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[22] See the following two publications issued by the committee: Public Medical Care in Hawaii (1947) and Planning for Health in Postwar Hawaii (1948).

> The bill makes a large appropriation for the administration of the program, and contains a proviso under which there can be a transfer of the appropriated funds from the Board of Health to the Welfare Department, in the event it should be found that such transfer would be necessary to obtain the maximum amount of available Federal matching funds.
>
> Your Committee is heartily in accord with the intent and purposes of this bill and strongly recommends its passage. . . .

This system set up in 1951 brings together in the administration of the indigent medical care program the health and welfare departments and the county governments, and also provides for federal participation. However, the Board of Health has primary responsibility for the program. A more detailed description of the present administrative organization and operation appears in following sections.

III. PLACE OF INDIGENT MEDICAL CARE PROGRAMS IN STATE ADMINISTRATIVE ORGANIZATIONS

The effectiveness and efficiency of administrative organizations depend in large part upon a rational classification and assignment of functions to be performed. In an attempt to provide the desired rational basis for governmental organization, numerous writers in the field of public administration have listed general principles or broad classifications to guide the organization of governmental functions.

Representative of the efforts to set forth a general plan for classifying public activities for purposes of organization is the list which W. Brooke Graves has included in his book on public administration.[1] Graves states that functions should be organized according to:

1. Purpose, e.g., furnishing water, conducting education;
2. Process or technical skill, such as engineering or accounting;
3. Place where performed;
4. Clientele and persons served, such as immigrants, veterans, Indians;
5. Knowledge available, that is, the store of available information gathered in the course of administrative operations.

While many governmental activities fit neatly into this type of categorization, the functions of government are so diverse in purpose and character that some of them defy such easy classification. In fact, they combine features of more than one of the abovementioned broad classifications. In many cases this overlapping is such that equally strong arguments exist for placing a particular function in at least two of the classifications. Indigent medical care seems to be one of these particular functions. Both health and welfare departments in various states have staked out claims of jurisdiction over this activity, or, conversely, have sought to disclaim responsibility for it.

If purpose is used as the guiding principle for organizing activities, then it might be contended that the indigent medical care program is a function based on the purpose of furnishing medical care and thus logically should be administered by the health department. If clientele is to be the determining factor, however, it might well be argued that this activity is only part of an overall program relating to a particular segment of the population - i.e., indigent persons. Following this line of reasoning, the indigent medical care program should be a function of the welfare department. Therefore, in this case Grave's list is not too helpful.

On theoretical grounds the controversy over the proper location of the indigent medical care program has not been resolved in favor of either the health department or the welfare department. In actual practice, however, the majority position has been to place this function under the jurisdiction of welfare departments. An important practical consideration in determining this assignment of function, however, is the fact that the federal government requires all welfare grants-in-aid funds to be administered by a single state agency. This is made abundantly clear in the following discussion.

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[1] Public Administration in a Democratic Society (Boston, D. C. Heath & Co., 1950), p. 55.

Kentucky. Practically all of the states which have considered or have actually undertaken the operation of a statewide program of medical care for indigent persons have experienced some difficulty in formulating a satisfactory administrative arrangement for such a program. The nature of the difficulty has been aptly stated in a report of the governor of Kentucky's commission on the study of indigent medical care. As this commission has pointed out:

> A medical care program for the needy is in a sense a hybrid type program in that it cuts across the normal division of responsibilities between the fields of public health and public welfare, which in Kentucky are represented, respectively, by the State Department of Health and the State Department of Economic Security. Both of these agencies have basic and well established concern with essential aspects of a medical care program for the needy and both have competency in specific functions which are involved in its operation.
>
> The Department of Health . . . has important responsibility for the availability of medical care. Because of the functions it discharges, this Department has the organization, professional staff, and relationships which make it the best qualified and equipped existing agency to deal with the health aspects of the program. It is significiant in particular that with its affiliated local health departments, which exist in all counties of the state, the Department of Health has the structure for performing many of the essential operational functions of the program and assuring professional supervision where this is needed.
>
> Likewise, the Department of Economic Security is specially qualified to handle many of the essential functions involved in program operation. It has responsibility for providing assistance payments for persons in the public assistance categories, the group which the Commission recommends should receive first priority for coverage under the program. Consequently, the Department of Economic Security has continuing contact with the persons comprising this group and is the sole source of information on their characteristics and needs. Among existing agencies, it is this Department which has the organization, experience, and special competence required for performing the essential function of determining economic eligibility in accordance with defined standards. . . .
>
> A further major consideration bearing on the formulation of the administrative structure for the program is the requirement of the Social Security Act that the use of federal grants-in-aid to the state for the purpose of providing benefits to public assistance recipients must be in accordance with an approved plan designating a single state agency to administer or supervise administrative arrangements for the provision of benefits. In Kentucky the agency . . . so designated . . . is the Department of Economic Security. Since federal grants-in-aid in substantial amount specifically earmarked for medical care have recently become available to the state and are being looked to as a major source of financial support for the proposed program, it is considered highly important that the

administrative structure for the program qualifies under the federal requirement.[2]

In light of the above considerations, the Kentucky commission's solution was to recommend that the administration of the proposed statewide indigent medical care program be centered in the Department of Economic Security. However, the commission further recommended the creation of a "State Advisory Council for Medical Care of the Indigent" (composed of the heads of the health and welfare departments, a doctor, a dentist, a representative of the state hospital association, and four laymen) which would have responsibility for formulating the overall plan for the indigent medical care program. This responsibility would include establishment of: (1) the scope and definition of services to be provided; (2) the methods to be used in providing services; (3) general policies regarding standards, regulations, and restrictions; and (4) formulas to be adopted to determine amounts of payments to vendors. The council would also make periodic evaluations of the program, and in its reports set forth its findings and recommendations. The council would be assisted by a number of "Technical Advisory Committees" consisting of experts in various specialized fields related to the overall program.

While the Department of Economic Security would have direct responsibility for administering the program, in accordance with the policies adopted by the council, the commission also recommended the department be empowered to delegate by contract certain functions to the health department. This arrangement would permit centralization of responsibility, meet the requirements of the federal government, and at the same time allow for the utilization of the resources of the health department in areas where it was especially qualified to act. To insure further qualified judgment on medical aspects of the program, the commission recommended the creation of "Local Medical Review Committees" in each county, which would determine the medical care needs of eligible applicants. The role of the Department of Economic Security, then, would be to provide overall administrative supervision of the program, to determine eligibility of persons to be covered, and to handle all fiscal and budgetary aspects of the program.

This elaborate administrative structure emphasizes the difficulty encountered in trying to achieve an acceptable organizational arrangement to administer the comprehensive indigent medical care program which the commission thought the state should undertake.

Washington. Even states which have had considerable experience in this field of activity, however, have had difficulties finding a satisfactory solution as to the problem of program administration. This is well illustrated by Washington, which was one of the first states to provide medical care for the needy on a statewide basis. In Washington the program was set up originally in the welfare department, was transferred in 1950 to the health department, and then in 1955 was re-established under the welfare agency.

Under the reorganization of 1950 in Washington the health department was charged with budgeting the medical welfare program, but the welfare department retained responsibility for determining the eligibility of recipients of public

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[2] Medical Care for Indigent Persons in Kentucky, pp. 72-73.

assistance and for certifying these to the health department. The health department determined the financial eligibility of the medically indigent. The resulting overlapping of functions meant that close cooperation and coordination between the two departments were essential to a smooth operation of the program.

These administrative arrangements were found to be unsatisfactory and it was recommended that the indigent medical care program be transferred back to the Department of Public Assistance. However, it was also recommended that the system of "screening physicians", established under the health department to certify to the medical needs of applicants, be continued under the welfare department. It was also anticipated that medical care would continue to be provided through contract with the local medical service bureaus of the Washington Physicians' Service. These recommendations were strongly supported by the head of the health department, by the Washington State Hospital Association, and by the Department of Public Assistance.[3]

The reasons given for these recommendations reemphasize some of the problems of organizing an indigent medical care program. First, it was found difficult "to settle respective areas of responsibility - which Department should be taking care of which applicants and/or patients." Second, there was often conflict and duplication of efforts on the part of the medical service workers of the health department (handling "medically indigent") and the social workers of the welfare department (dealing with "indigents"). Third, it was felt that the health department was not oriented to "the administration of medical service to individuals" and that its other activities were not directly related to a medical care program for indigents. Finally, it was pointed out that the state could qualify for an estimated additional $3,400,000 annually in federal matching funds if the state met the requirement that all welfare funds be administered by a single state agency.[4]

The above considerations were sufficiently persuasive to cause the legislature to transfer the indigent medical care program back to the welfare department. After a brief experiment of placing indigent medical care under health department jurisdiction, therefore, Washington has joined the ranks of the overwhelming majority of states and makes indigent medical care a welfare department activity. This means only two comprehensive indigent medical care programs are still administered by health departments - those in Maryland and in Hawaii.

Maryland. Doctors in Maryland initiated that state's indigent medical care program through the Medical and Chirurgical Faculty of Maryland (the state medical society). The efforts of this group date back to the early 1930's, but the first concrete steps toward action did not take place until 1939 when the State Planning Commission set up a special standing committee to study the state's medical care problems. In 1945 the legislature established a medical care program based on the plan recommended by this

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[3]Washington, State Legislative Council, Subcommittee on Public Welfare, Report (1953-1955 Biennium), pp. 47-53.

[4]Ibid.

committee. In adopting such a program, Maryland "set out to prove that a state can solve its own health problem without Federal aid or Federal intervention."[5]

The Maryland program actually consists of two programs. One applies to the 23 counties outside of Baltimore and is administered by the Bureau of Medical Services of the State Department of Health. The other exists only in the City of Baltimore and is under the jurisdiction of the Medical Care Section of the City Health Department, but subject to approval by the Board of Health of Maryland. Both programs are headed by fulltime medical officers. Under the Maryland plan, the Department of Public Welfare determines the eligibility of "indigents", and medical care is automatic for public assistance recipients upon certification by the welfare department to the health department. However, the health department is responsible for determining the eligibility of the "medically indigent." There is also a Council on Medical Care, composed of representatives of the medical and allied professions and of the health and welfare departments. This council advises on the formulation of policies and the establishment of forms of contracts, scales of fees, eligibility criteria, and administrative procedures. Administration of the program is decentralized with considerable latitude being given to each county health officer, who is also a deputy of the state health department. He supervises the program, evaluates services, approves bills, maintains contact with both providers and recipients of medical care, and directs those who determine eligibility of "medically indigents." In the counties private physicians provide the medical care on a fee-for-service basis. In Baltimore private doctors are paid on a per capita basis for each patient choosing a particular doctor, but the services of clinics are also widely utilized. As already indicated, the programs are financed entirely from state and local funds and do not receive any matching funds from the federal government.[6]

Evaluating the Maryland programs after ten years of operation, two observers have said:

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

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[5]Maryland State Planning Commission, Committee on Medical Care, Report of the Committee to Review the Medical Care Program (Annapolis, 1953), pp. 2-5.

[6]For detailed descriptions of the Maryland programs, see ibid., pp. 1-74, and Ida C. Merriam and Laura F. Rosen, "Medical Care for Needy Persons in Maryland," Social Security Bulletin, Vol. 18, No. 11 (November 1955), pp. 10-16.

> In combination with the provisions for hospitalization, the programs have gone a long way to guarantee adequate medical services to that needy portion of the population of Maryland that would otherwise go largely unattended. The poorest children receive medical care on a regular and relatively comprehensive basis; the needy aged may go directly to the physician's office just as a paying patient does, in dignity. With the program an administrative base has been established through which additional services and more comprehensive care for needy and medically needy residents of the State may become available up to the limit of public funds allotted to this purpose.[7]

General Conclusions. The Washington and Maryland experiences in the field of indigent medical care tend to substantiate the conclusions reached by Margaret Greenfield in her thoughtful study of the problem of indigent medical care. Based upon a thorough survey of activities of all the states in this field, she states:

> One principle that has evolved from two decades of re-examination is that each program should be carried out as a coordinated balanced whole. Whether the program is directed by a health or welfare agency now seems to be of less importance than whether there is close cooperation between the two in planning and operating the program.
>
> Obtaining advice and cooperation from the medical and other professions and agencies concerned with provision of medical care is also essential. Joint consideration of the problems of the program through an advisory health committee is a recommended device.
>
> Qualified direction and administration are of prime importance. Experts disagree as to whether the director must be a physician or may be a layman who has sufficient knowledge of the medical field to direct the program in the same sense in which a lay superintendent directs a hospital. It is agreed, however, that provision must be made for professional supervision of the quality and adequacy of each type of care, and that there must be no lay interference...
>
> Importance of the continuity of care is stressed. In some programs recipients have free choice of physician in the home. If they are ambulatory, however, they go to clinics, and if hospitalized, they are served by physicians on ward service. In such cases, some mechanism is necessary whereby medical information is exchanged among the various physicians.
>
> A similar problem is coordination of the emotional, social, and economic factors of a patient's life with his illness and his treatment. Modern medical practice has made clear that satisfactory care cannot be given without careful consideration of all these elements or without proper coordination between medical and social services.[8]

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[7] Merriam and Rosen, ibid., p. 16.

[8] Medical Care . . . Basic Problems, pp. 62-63.

The problems of organizing and administering indigent medical care programs have also been recognized by the national organizations most intimately concerned with this field. A joint conference of five of these organizations (American Dental Association, American Hospital Association, American Medical Association, American Public Health Association, and American Public Welfare Association) met in 1955 and drafted a "statement of principles" to provide "a guide for the provision of tax-supported personal health services required for those individuals who are unable to obtain such services through their own resources or with the assistance of their families or voluntary agencies."[9]

This statement of principles is included here (pp. 28 and 29), and has been approved as drafted by the public health and welfare groups with minor changes (relating primarily to the question of federal aid) by the dental and hospital associations. The American Medical Association has issued a separate statement which in intent and concept parallels the statement of principles but differs with it in some important respects.

This statement of principles clearly illustrates there is no agreement as to whether indigent medical care should be provided under the health agency or the welfare agency. It does demonstrate, however, the almost universal acceptance of the idea that the technical aspects of any program of medical care for the needy should be placed under the administrative direction of trained and professionally qualified personnel. This means that a hybrid-type function such as indigent medical care places a demand upon the specialized talents and resources of both health and welfare departments. This in turn reemphasizes the point that direction of the indigent medical care program by either the health or the welfare agency seems to be less important then whether there is close cooperation between the two in planning and operating such a program.

In viewing Hawaii's indigent medical care program, therefore, it is important to bear in mind that there is no consensus among the "experts" as to the best location of such a program in the overall structure of government. Rather, there is widespread recognition of the competing claims of both health and welfare agencies and of the need to find some sort of relationship between them that will allow the indigent medical care program to benefit from what both have to offer. This suggests that other factors (e.g., local conditions, other activities of the two departments concerned, and past relationships between health and welfare agencies) should be taken into consideration when assessing the position of the indigent medical care program. For this reason, a detailed description of the present program in the Territory is set forth in the next section, beginning on page 30.

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[9] "Tax-Supported Personal Health Services for the Needy: A Statement of Principles," American Journal of Public Health, Vol. 45, No. 12 (December 1955), pp. 1593-1594.

A STATEMENT OF PRINCIPLES

1. Tax-supported personal health services for the needy should be administered by an appropriate governmental unit, local or state, as close to those being served as is consistent with effective, efficient, and economical administration.

2. This responsibility (with the possible exception of services provided in public institutions) should be assumed by a single agency which may be either the health or welfare agency at each level of government.*

3. The financing of such health services should be assumed by the appropriate unit of government, local or state, supplemented by funds from higher governmental authorities in order to assure adequate service.

4. The health service program should be directed by persons with technical knowledge of health care and should provide for professional supervision of all professional aspects. Appropriate advisory committees should be appointed and used to provide advice and guidance on various aspects of the program.

5. Care provided in tax-supported personal health service programs for the needy should meet as high standards of quality and adequacy as can reasonably be made available to others in the community. Such standards should be professionally determined by the administrative agency in cooperation with representatives of the professional group concerned.

6. Persons eligible for service should have the opportunity to receive care from a family physician, dentist, or clinic of their own choice, selected from among those accepted as qualified by the agency responsible for the program.

7. The personal health service program should encourage continuity of care, whether services are made available in the office, clinic, or hospital.

8. To conserve good health and reduce dependency resulting from ill-health, the health service program should emphasize positive health promotion, including health education, disease prevention, early diagnosis and treatment, and rehabilitation.

9. The responsible administrative agency and the individuals and institutions providing the service should protect the rights and dignity of the patient, including the confidential nature of information regarding the patient's illnesses. The information needed for sound administration and for coordination of health and social services in the best interests of the patient should be available to the administrative agency and the providers of service.

10. Services should be so organized and administered as to assure maximum economy without sacrifice of quality of care. The program should avoid unnecessary duplications by utilizing existing services and facilities that meet high standards.

11. Financial eligibility for tax-supported medical care should be determined by a public agency and not by the provider of service.

12. The process of determining financial eligibility should be prompt and should not delay receipt of necessary care. The eligible person should have access to medical care, as needed, during the period of his eligibility.

13. Objective standards of eligibility should be applied equally and without discrimination to all applicants.

14. Methods and amounts of payment for personal health services should be equitable and determined in conference between the responsible public agency and representatives of the providers. In the case of institutions, payment schedules should be based on the full certified cost of services as determined by acceptable cost accounting procedures.

Source: American Journal of Public Health, Vol. 45, No. 12, (December 1955), pp. 1593-1594.

*Note: On the basis of recent discussions with officials of the American Public Welfare Association, Miss Mary Noonan, Territorial Director of Public Welfare, reports there is an important qualification to that organization's endorsement of this statement of principles. The position of these officials is that financial and administrative responsibility for indigent medical care is properly a public welfare function, but that contractual arrangements might be made for health agencies to render actual medical care and advice.

IV. PRESENT ORGANIZATION AND OPERATION OF THE INDIGENT MEDICAL CARE PROGRAM IN HAWAII

The development of the indigent medical care program in Hawaii and the various legal changes it has undergone have already been described. The purpose here is to explain how the program operates at present and to set forth in some detail the administrative arrangements between the various agencies involved in the program.

Present Legal Framework. The legal framework for the present indigent medical care program in Hawaii was established by Act 129, Session Laws of Hawaii 1951, which appears now as Chapter 48, Revised Laws of Hawaii 1955, entitled: "Hospitals and Medical Care." This law states the purpose of the program, establishes the organization to carry it out, defines various terms, sets the limits of authority and responsibility of all affected agencies, and provides the basis for administrative arrangements which may be made to achieve the goals of the program.

There is created a "division of hospitals and medical care" which is under the territorial board of health and which "shall be administered as directed by the board." (Sec. 48-2) Among its functions and duties, the division is charged with "the supervision of government physicians in the Territory." (Sec. 48-6) The board of health is responsible for making and publishing "rules and regulations to carry into effect and administer the provisions of this chapter." (Sec. 48-10)

The law also provides for a "territorial advisory commission for hospitals and medical care" to be composed of 10 members appointed by the governor, and the director of public welfare as the eleventh member. A majority of the membership must be "doctors of medicine, hospital administrators and representatives from allied professions." The membership must include at least one representative from each of the four county advisory groups and at least four doctors licensed to practice in the Territory. The appointed members serve four-year, overlapping terms. (Sec. 48-3)

The law empowers the advisory commission to "study conditions and the program and procedure existing in the Territory for medical care of the indigent and medically indigent and . . . /study and consider problems relating to hospital construction. . . , hospital subsidies, inspections of hospitals and licensing of hospitals." The commission is to act as advisors to the board of health in matters relating to hospitals and indigent medical care. (Sec. 48-5)

There is also created a "county advisory committee" for each of the four counties. Each committee is to consist of five to seven members, including the county health officer or his agent. The mayor of Honolulu and the chairmen of the board of supervisors of the other three counties appoint the members of these advisory groups. The duty of each group is to "act as advisors to the board of supervisors in matters concerned with medical care of the indigent and the medically indigent." (Sec. 48-4)

All persons classed as indigents and receiving assistance from the Department of Public Welfare are eligible for all types of medical care under the program. The Department of Public Welfare is to "maintain current eligible lists of such persons." (Sec. 48-7)

However, determination of the elibigility of the medically indigent is "the responsibility of the respective counties." Each board of supervisors is charged with employing "qualified personnel to aid in /this/ determination" and may also call upon the welfare department and the county advisory group to assist and advise concerning such determination. (Sec. 48-8)

The law provides that the "costs of medical care for indigent and medically indigent persons in the Territory shall be paid by the Territory." It further provides that the board of health shall advance funds semi-annually to each county to cover the estimated needs for medical care for the succeeding six-month period. At the end of such period the board of supervisors shall certify to the board of health the amounts expended for medical care. The board of health may disallow any amount "paid by any county without authority or proper determination under this chapter" and deduct such amount from the next semi-annual allotment. All hospital charges under the program are to be paid by the respective boards of supervisors, "without respect to whether such hospitals are publicly or privately owned or operated," and all payments "are to be based upon a flexible cost formula to be established by the board of health." (Sec. 48-9)

The original act (Act 129, Session Laws of Hawaii 1951) carried with it an appropriation of $50,000 to the Division of Hospitals and Medical Care "for the administration of the provisions of this Act" (Sec. 13) and an appropriation of $2,625,000 "for the costs of medical care for the indigent and medically indigent as provided in . . . this Act." (Sec. 14)

The latter appropriation contained an important additional provision, which permitted the transfer of such funds to the welfare department and upon which the Territory's qualification for federal matching funds for indigent medical care has hinged. This proviso reads:

> . . . any portion of the funds appropriated by this Act may, with the approval of the governor, be transferred to the department of public welfare for expenditure by that department in accordance with the requirements of federal laws or federal rules and regulations under which federal matching funds may be claimed by the territory. (Sec. 14)

This provision was designed, of course, to meet the requirement of the federal government that all grants-in-aid for welfare purposes be administered by a single state agency. It should be noted that this particular provision of Act 129 has been omitted from Chapter 48, Revised Laws of Hawaii 1955, apparently on the grounds that it was of a temporary nature and the function of it had been fulfilled. Nevertheless, it still serves as the basis for administrative arrangements between the health and welfare departments relating to the indigent medical care program and as the justification for continued qualification by the Territory for federal matching funds. Although no questions of legality of such arrangements and continued allotments of federal funds have been raised, as a precaution against such questions it might be wise to amend the law to make explicit that this provision applies to all subsequent appropriations made to the indigent medical care program.

To summarize the important features of the law relating to the indigent medical care program, it should be recognized that the legal framework itself makes for a very complex system of relationships. Some of the relationships

are interdepartmental; some of them are intergovernmental; and some of them are between governmental and non-governmental agencies. All of them involve complicated fiscal arrangements.

Development of Additional Arrangements and Procedures. There has developed since 1951 an intricate system of procedures to put into practical operation the indigent medical care program conceived by this law. These procedures have been designed to bridge the many gaps in the abovementioned complex of relationships and to make mesh the many diverse elements essential to carrying out the indigent medical care program. Although not completely successful in eliminating all points of friction, as will be indicated later, these procedures have evolved out of experience of seven years and have enabled Hawaii to accomplish the major goals of the Territory's indigent medical care program.

General Description of Program. The indigent medical care program is under the general direction of the Division of Hospitals and Medical Care of the Department of Health. The legislature appropriates funds to the health department for the program, but to qualify for federal matching funds it is necessary for the health department to transfer a portion of the funds to the welfare department. Upon meeting federal requirements and obtaining federal matching funds, the welfare department enters into a contract with the health department to provide medical care for welfare recipients (i.e., those in the four federally-supported categories). Under this contract the welfare department transfers the funds back to the health department and the health department agrees to provide medical care to all those welfare recipients who are "insured" under the contract. The health department thus becomes the vendor of medical care to the welfare department.

The health department does not expend the funds, directly, but advances them to the counties. Then, under the general supervision of the health department, the counties administer the program and make the actual payments to vendors of medical services. For the most part, these procedures apply only to the provision of hospital care because medical care is provided directly by government physicians in the counties outside of Honolulu and in the "rural Oahu" portions of the City and County of Honolulu. In Honolulu proper, medical care is provided through the out-patient departments of the hospitals with emergency service furnished through the City and County Health Department. As for hospital care, this may be obtained by the counties from private hospitals, community hospitals, or county-supported hospitals.

One other important general consideration is that medical or hospital care is often available to indigents and medical indigents under other public and private programs. Under the health department itself these persons might qualify for treatment under such programs as those for crippled children, cancer or tuberculosis control, and mental health or cerebral palsy. Or they might be eligible for programs under other territorial agencies, such as the Department of Institutions and the Bureau of Sight Conservation and Work with the Blind. Then there are a multitude of agencies other than those maintained by the Territory, such as the Strong-Carter Dental Clinic, Shriners Hospital, the National Foundation for Infantile Paralysis and the Veterans' Administration, which provide treatment for particular groups of people. The existence of all of these other means of medical care has the effect of making the indigent medical care program a "last resort" type of program. It is designed to meet the needs of those who cannot afford personal medical care and who do not qualify

for treatment under any other public program (i.e., either tax-supported or provided by organizations such as the National Foundation for Infantile Paralysis). The territorial health department has issued a six-page list of exclusions from its indigent medical care program and where particular types of treatment might be obtained.[1] This consideration is particularly important because it means changes in other programs can greatly increase or decrease the demands upon the indigent medical care program.

Detailed Description of Fiscal Procedures. The above general description of the administration of the indigent medical care program in the Territory provides ample evidence that it involves an exceedingly complex set of relationships between departments and levels of government and between public and private agencies. This will become increasingly evident in the more detailed description which follows. This detailed description consists of a step-by-step review of the expenditure of funds for indigent medical care in Hawaii.

1. The territorial legislature appropriates funds for a two-year period to finance the indigent medical care program, which is budgeted under the Division of Hospitals and Medical Care of the Department of Health.

2. The health department allocates this biennial appropriation in accordance with the following formula:

a. by fiscal years - 50% for each year
b. for each fiscal year, by semi-annual periods - 50% for each six-month period
c. each semi-annual allocation is pro-rated among the counties on the following basis:

(1) first allotment to the City and County of Honolulu; based on $5.05 per indigent on the Island of Oahu for outpatient care in the urban area (Honolulu "proper") in lieu of government physicians provided for the other counties and for "rural Oahu"

(2) balance apportioned to the counties and the city and county; based on the ratio of total indigents in each county and city - county to the total indigents carried on the public welfare rolls of the Territory (as shown by the Department of Public Welfare), including indigents in the urban area of the city-county

d. indigent count data for computing allotments are compiled by the Department of Public Welfare and are based on the averages of the six-month period immediately preceding the six-month period for which apportioned allotments are made.

3. The health department advances funds to the counties.[2] The law requires an advance for a semi-annual period, but in actual practice one-sixth of the

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[1]Board of Health, Territory of Hawaii, Exclusions from Hospitals and Medical Care Program (mimeo., no date).

[2]Unless otherwise indicated, "county" or "counties" includes the City and County of Honolulu.

semi-annual allotment is advanced at the beginning of each month to each county. This is due to the tight cash position of the territorial general fund.

4. At the beginning of each quarter (three-month period), the Department of Health transfers a portion of the allotment to the Department of Public Welfare. These funds are for the purchase of medical care for public assistance recipients in categories eligible for federal matching funds. The funds transferred are based on estimates prepared by the Department of Public Welfare as to the number of indigents for each category during the period and as to a reasonable insurance premium rate for each category, within the limits set by federal laws.

5. The Department of Public Welfare purchases medical care from the health department for those recipients who are "insured" for such care (i.e., recipients coming under the four welfare categories for which federal matching funds are available - aid to dependent children, aid to the blind, old-age assistance, and aid to the permanently and totally disabled). Payments for such care are made to the health department during the second week of each month and are based on the applicable premium rates times the estimated number of indigents for the month in each eligible category. These payments are financed proportionately from (a) the funds originally transferred from the health department to the welfare department at the beginning of each quarter and from (b) federal matching funds for which the Territory qualifies under the provisions of federal grants-in-aid. This provision of medical care is in accordance with a contract entered into by the health and welfare departments, a copy of which appears in the appendix. (See pp. 53-55.)

6. Under the contract between the health and welfare departments, the amounts of the monthly premium payments for "insured" recipients shall be agreed upon by the two departments and shall be set "by relating the number of individuals to be covered to the anticipated cost of hospital care, outpatient care, and dental care" in accordance with the welfare department's staff manual section entitled: "Insurance Against the Cost of Medical Care - Justification of Amounts of Premium Payments." The anticipated cost of the medical care is determined on the basis of previous experience. The cost data are calculated by the health department and then reported to the welfare department.

7. The health department receives the premium payments from the welfare department and deposits them into the same account from which funds were originally transferred to the welfare department and from which funds are also advanced to the counties. The health department maintains a subsidiary account to record premium receipts and payments, by category, and these data are reported by the Division of Hospitals and Medical Care and serve as the basis for determining costs of medical care. In the past, such reporting has usually been one year late. This means that when the welfare department calculates premium payments, the calculations are based upon data for a period two years previous to the time for which payments are being made, rather than the immediately preceding year.

8. To expend the funds advanced to them by the health department (which, because of the double transfer between the health and welfare departments, also include federal matching funds), the counties are required to supply certain information to the Division of Hospitals and Medical Care. Copies of all bills paid for indigents and medical indigents are sent to the health department at

the end of each month. Bills chargeable to other health services are transferred to the appropriate account. Funds advanced to the counties are then applied by the health department to the bills received in accordance with the following order of priority: (1) medical care for "insured" indigents; (2) medical care for non-insured indigents (i.e., persons on the welfare rolls in the two categories not eligible for federal matching funds - general assistance and child welfare services); and (3) medical care for the medically indigent. Costs in excess of available funds and costs of bills disallowed by the health department must be met by the respective counties. The health department audits the bills and tabulates data on I.B.M. cards for further use in program reports and other health statistics. Summary, semi-annual reports are also made by the health department in compliance with the law. The counties must also meet other requirements. The most important of these is that they employ "qualified" medical social workers to administer the part of the program under county control - namely, determining the eligibility of medically indigent persons.

9. In further fulfillment of its obligations, the health department collects detailed data (e.g., financial and caseload figures) on the indigent medical care program and reports these to the welfare department and in its annual report. As previously indicated, these reports are usually one year late in being published. Reasons given for this delay are: (1) staff shortages in the Division of Hospitals and Medical Care and (2) the difficulties in compiling the vast array of statistics which go into the annual report covering all the activities of the department. However, as also previously noted, the welfare department needs current information to determine the reasonableness of insurance premiums, and the long delay in obtaining such data makes it impossible to revise rates on a current basis.

10. At the end of each biennium, any excess premium payments which may have accumulated in any of the matching fund categories are lapsed into the territorial general fund, along with any other funds which have not been expended. The lapsing of funds has occurred a number of times in regard to several of the categories. However, it is also true that since 1953 deficits have consistently occurred in the premium account of the aid to dependent children category.

11. That portion of the indigent medical care program involving "insured" recipients is subject to an audit by federal authorities. Thus, this part of the program comes in for additional review and consideration, and federal authorities may require adjustments in procedures affecting the whole program.

Size and Cost of Program. To complete the picture of the administration of the indigent medical care program, it is also essential to obtain some notion of the size and cost of this particular activity.

In terms of costs, governmental expenditures for indigent medical care have averaged in excess of $1,000,000 annually since 1951, and such costs seem to be increasing rather than decreasing despite a decline in the number of persons on the public welfare rolls of the Territory. These are the costs of actual medical care for indigents and medical indigents. In addition, the territorial and county governments combined spend approximately $100,000 a year to administer the program.

Table 3 (p. 37) provides a breakdown of budget estimates, legislative appropriations, and expenditures for indigent medical care in Hawaii for each biennium between 1951 and 1959. These figures are for actual medical care and do not include the costs of administration.

Table 4 (p. 38) shows the number of administrative personnel engaged in the indigent medical care program for the period from January to December 1957, at both the territorial and county levels, and also shows the administrative costs of maintaining this size staff. It should be realized, however, that not all of the 25 persons indicated in Table 4 devote their full time to the indigent medical care program. Therefore, Table 5 (p. 39) has been included to show the amount of time devoted to the program by these persons. This shows there are only 12 persons who work full time on the program. There are five more who spend as much as 85% of their time engaged in this activity. This leaves eight who spend less than one-half of their time in the administration of the indigent medical care program.

Tables 4 and 5 also show that almost the entire burden of administration of the program is borne by the counties. Of the total of 25 staff personnel, only three are territorial. Only one of these three devotes full time to indigent medical care; the other two each give only 25% of their time to it. On the other hand, 11 of the 22 county employees are full time, and five more spend up to 85% of their time engaged in the program. Five more county employees work on indigent medical care one-third of the time, and only one out of the 22 spends as little as 25% of his time thus occupied. On the basis of this staff distribution, the Territory pays less than 10% of the cost of administering the program.

It should be remembered, however, that the territorial health department only provides general supervision and direction over the program. Much of its work consists of reviewing, auditing accounts of the counties, and similar activities. The counties, on the other hand, are responsible for determining the eligibility of medical indigents as well as actually paying the vendors of medical care. Thus, most of the county employees in the program are medical social workers engaged in investigating applicants and determining their eligibility. The note to Table 4 indicates the estimated cost to the Territory if the entire administration of the program were assumed by the territorial health department. This figure for the first biennium is $232,516.

Caseload. In terms of numbers of cases under the indigent medical care program, the total caseload has been increasing steadily during the period the program has been under the health department's supervision. This is readily apparent in Table 6 (p. 40) which sets forth the gross caseload of the program for biennial periods since 1951.

However, the increase in the number of cases requiring treatment (i.e., more than just examination or minor attention) has not been as steady or as great. This is indicated in Table 7 (p. 40) which provides a breakdown, by fiscal years from 1951 to 1956, showing the number of cases treated under the indigent medical care program and the distribution of such cases between medical care, surgical, and obstetric cases. Even in Table 7, however, it is apparent that the caseload has been increasing significantly. This fact, combined with the increases in the costs of medical care, provides an explanation for the rising cost of the indigent medical care program.

Table 3

BUDGET ESTIMATES, APPROPRIATIONS, AND ACTUAL EXPENDITURES FOR INDIGENT MEDICAL CARE IN HAWAII, 1951-1959, NOT INCLUDING COSTS OF ADMINISTRATION

Biennium	Original Departmental Request	Approved by Bureau of the Budget	Appropriated by Legislature	Additional Funds Expended by Counties	Actual Territorial Expenditures	Total Expenditures
1951-1953	No preliminary figures, as program not placed under health department until 1951 session of legislature*		$2,625,000	$ ...	$2,372,700	$2,372,700
1953-1955	$2,994,119	$2,625,000	2,125,000	12,724	2,125,000	2,137,724
1955-1957	2,682,784	2,226,526	2,000,000	220,873	1,912,868**	2,133,741
1957-1959	3,258,728	2,958,728	2,192,650	...	507,892 (July-Dec. 1957)	507,892 (July-Dec. 1957)

Source: Territorial Health Department letter dated 7/2/58.

*Legislature was presented with Department of Public Welfare and county estimates aggregating $4,200,000.

**Mandated savings.

Table 4

NUMBER OF PERSONNEL AND ADMINISTRATIVE COSTS, TERRITORIAL AND COUNTY, JANUARY-DECEMBER 1957

Jurisdiction	Number of Personnel	Administrative Costs
Hawaii	5	$25,266.30
Oahu	14	50,000.00
Maui	2	11,730.23
Kauai	1	4,724.46
Territory	3	8,247.00
TOTAL	25	$99,967.99

Source: Territorial Health Department letter dated 7/2/58.

Note: The Health Department estimates it would cost the Territory $232,516 for the first biennium if the department assumed full responsibility for the program and relieved the counties of their part of the burden. This estimate is based upon current county expenditures and staff requirements, with necessary adjustments being made. It includes the cost of salaries, supplies, housing for some of the personnel, and a new supervisory position within the Health Department, but it does not include office space rentals.

Table 5

AMOUNT OF STAFF TIME DEVOTED TO THE
INDIGENT MEDICAL CARE PROGRAM, JANUARY-DECEMBER 1957,
AND ACCOMPANYING ADMINISTRATIVE COSTS

Per Cent of Time Devoted to Program	COUNTIES		TERRITORY		TOTAL	
	No. of Persons	Cost	No. of Persons	Cost	No. of Persons	Cost
100%	11	$51,454.69	1	$3,252.00	12	$54,706.69
85%	5	25,266.30	-	--	5	25,266.30
33-1/3%	5	13,500.00	-	--	5	13,500.00
25%	1	1,500.00	2	4,995.00	3	6,495.00
TOTAL	22	$91,720.99	3	$8,247.00	25	$99,967.99

Source: Territorial Health Department letter dated 7/2/58.

Table 6

GROSS CASELOAD OF INDIGENT MEDICAL CARE PROGRAM, 1951-1957

Biennium	Total Number of Cases
1951-1953	59,140
1953-1955	68,288
1955-1957	84,537
July-Dec. 1957	24,913

Source: Territorial Health Department letter dated 7/2/58.

Table 7

NUMBER OF CASES TREATED UNDER THE INDIGENT MEDICAL CARE PROGRAM, 1951-1956

Fiscal Year	Cases Treated			
	Medical Care	Surgical Cases	Obstetric Cases	Total
1951-1952	16,607	1,112	246	17,965
1952-1953	14,627	1,094	214	15,935
1953-1954	15,522	1,273	315	17,110
1954-1955	17,749	1,513	560	19,822
1955-1956	17,740	1,258	608	19,606

Source: Territory of Hawaii, Department of Health, Annual Report: Statistical Summary (1952 through 1956).

Federal Participation in Program. A final important consideration in the examination of the Territory's indigent medical care program is the matter of federal participation. This participation is primarily in terms of financial aid and is shown in Table 8, which provides a comparison of federal contributions and total costs of the program. This table indicates that the federal contribution was only 10% to 15% during the fiscal years up until 1957-1958, when the amount of the federal funds was almost doubled. Thus, the amount of federal money devoted to the program is still far overshadowed by territorial expenditures for this purpose. Nevertheless, the amount of federal funds is of sufficient proportions to affect significantly the level and quantity of medical care available to indigents in the Territory. For this reason, continued federal participation is an important factor in considering the administration of the indigent medical care program.

Table 8.

COMPARISON OF TOTAL MEDICAL CARE COSTS FOR INDIGENTS AND THE AMOUNTS OF FEDERAL MATCHING FUNDS, 1951-1958

Fiscal Year	Total Medical Care Costs	Amount of Federal Matching Funds
1951-1952	$1,126,085	$ ...
1952-1953	1,273,915	145,204
1953-1954	1,062,500	128,885
1954-1955	1,062,500	148,247
1955-1956	956,434	152,295
1956-1957	956,434	114,723
1957-1958	1,080,576	266,779

Sources: Territorial Health Department letters dated 7/2/58 and 9/30/58.

V. PROBLEM AREAS IN HAWAII'S PRESENT INDIGENT MEDICAL CARE PROGRAM

With the complexity of relationships and procedures outlined above, it is practically inevitable that differences will occur and frictions develop between the many units involved in Hawaii's indigent medical care program. To keep these many parts articulating smoothly requires constant attention and may, on occasion, necessitate readjustments in procedures, scopes of authority, interpretation of rules, etc. Indeed, a special governor's committee has been formed to review the administration of this program, and it still has the matter under consideration. The purpose here is to identify some of the problem areas which have been revealed by the work of this committee or through interviews with officials in the health and welfare departments.

Overall Coordination Between Health and Welfare Departments. One important problem area in Hawaii's indigent medical care program is that arising from the fundamental differences of view between the health and welfare departments as to whether this program should be considered a health or a welfare function. The point has been strongly made that such differences seem to be inherent in a hybrid-type activity such as indigent medical care, where two sides can put forth almost equally legitimate claims for jurisdiction. In addition, however, such differences are intensified by the very natural tendency among human institutions - governmental organizations, in particular - to compete for programs, personnel, prestige, and appropriations.

Such factors are present in Hawaii's program for medical care for the needy, and, consequently, give rise to a certain amount of friction. However, Hawaii is not unique in this regard. Moreover, any such sentiments have been kept well under control and have not interfered materially in the accomplishment of the major goals of the program. There are two reasons for making this point, however. First, it is important to remember that when two departments are involved in administering a program jointly, they will not always see eye to eye and relationships will not always be completely harmonious. The situation becomes unhealthy only when petty differences are carried to an extreme and are allowed to disrupt the program. Second, some sort of joint responsibility for this particular program is almost unavoidable. Even if primary responsibility for it were transferred to the welfare department, there would still be the necessity to relate the program to other health activities (e.g., the system of government physicians and other treatment programs for which indigents might be eligible). On the other hand, if the program is continued under the health department, it would be absurd to try to duplicate the work of the welfare department in determining eligibility.

Thus, one major problem of providing indigent medical care seems to be that of coordinating the activities of the health and welfare departments and of maintaining between the two mutual respect and a proper spirit of cooperation.

Interpretation of Contract Between Two Departments. A much more specific problem area - and actually part of the first one - centers around the significant differences of opinion between the health and welfare departments as to the interpretation of the contract between them and the federal regulations pertaining thereto.

The health department (supported by the territorial budget bureau) maintains that Hawaii's medical care plan provides for "insuring" recipients in federally supported assistance categories in accordance with Sections 5690 through 5692, (Federal) Handbook of Public Assistance Administration, entitled: "Group /Insurance/ Plans for Medical Care Other than Pooled Funds."

Under this interpretation, the health department is considered as being the insurer of public assistance recipients in the eligible categories and is obligated to provide medical care to such persons of the type and quality specified in the contract between it and the welfare department. In this sense, then, premium payments are made to the health department as they would be paid to any group insurance carrier. On this basis, all funds are co-mingled and medical care is provided all "insured" indigents regardless of the sufficiency or insufficiency of insurance premiums paid in. Subsidiary accounts are kept to show the actual premiums paid in and the actual payments made to vendors of medical care, but only for the purpose of determining and adjusting premium rates.

On the other hand, the welfare department claims the program is in effect a "hybrid" plan and as a result is subject to part of Section 5693, (Federal) Handbook of Public Assistance Administration, entitled: "Pooled Funds for Medical Care Operated by Public Assistance Agencies." This position seems to be supported by the San Francisco regional office of the Bureau of Public Assistance.

In any event, federal auditors have taken exception to the practice of co-mingling all funds in the same account of the health department, and also to the practice of lapsing - or reverting - any surpluses in the premium account back to the territorial general fund at the end of each biennium. Not only do federal authorities maintain that premium funds should be kept separate from other funds, but that premium payments for each of the four eligible categories should be segregated so that surpluses in some could not be used to make up for deficits in others.

Up to the present time, this issue is still under consideration by federal officials and has not been finally resolved. If the federal government stands by the position taken by its auditors, then some fundamental procedural changes will be required in order for the Territory to continue to qualify for federal matching funds.

Fiscal Procedures. Another problem area, and one closely related to the preceding one, arises out of the program's fiscal arrangements and procedures. The welfare department maintains that the whole complex set of transfers of funds between various agencies makes for a cumbersome administrative set-up and complicates relationships between departments and with federal welfare officials. Moreover, it necessitates the involvement of the budget bureau in the program to a much greater degree than is the case of other programs. By thus adding to the role of the budget bureau, there is introduced still another element into the bewildering array of relationships involved in administering the program.

The health department's view, however, is that while the fiscal procedures are indeed complicated, the transfers of funds are all "on paper." Therefore, the problem is primarily an accounting problem, and the job of the budget

bureau is primarily to see that the accounts are kept straight. Furthermore, the health department feels the handling of this accounting program has been quite satisfactory and the fiscal procedures have not seriously interfered with efficient and effective provision of medical care to the needy. On the other hand, the health department does not have to deal directly with federal welfare officials and does not have to answer to them for the expenditure of federal matching funds as does the welfare department.

It should be noted that the two departments are considering possible changes to be made in the contract between them, and this may alleviate some of this difficulty. However, as long as the program remains unchanged and the Territory wants to continue to receive federal matching funds, there seems to be no alternative to complicated fiscal arrangements for transferring funds.

Reporting. Still another problem area is one concerning health department reporting and communication of information to the welfare agency. The welfare department is responsible for projecting future costs of medical care for "insured" indigents in order to determine and maintain reasonable premium rates. These projections should be based upon as current information as it is possible to obtain. It is upon such projections that allotments of federal matching funds are based. However, the welfare department has to rely upon the health department for the cost data.

As has been previously noted, the health department has often been as much as a year behind in providing such cost data. The result has been to place the welfare department in the awkward position of being responsible to federal authorities for projecting costs on a current basis, but of being unable to obtain the information to do so. Federal auditors have taken exception to the data used for determining the amounts of premium payments. They say the data are too old to reflect current conditions and as a result have probably contributed to causing surpluses in some categories and deficits in others. For this reason, the federal auditors continue to urge more up-to-date information upon which to base premium payments.

The health department has conceded there has been too much delay in providing this information to the welfare department. The large amount of work involved in compiling and reporting the maze of statistics collected by the health department and staff shortages in the Division of Hospitals and Medical Care have been given as reasons for this delay. However, the health department has promised to exert serious effort to correct this situation and to institute changes in its procedures so as to be able to issue reports within 20 days after the close of each month. If these changes are put into full effect, it should be possible to eliminate the causes of this particular problem.

Rejections for Treatment. Another source of differences relating to communication between the health and welfare departments concerns the rejections for medical care of "insured" indigents by county health officers and the reporting of such rejections to the welfare department. The welfare department feels it should be provided this information promptly so as to afford it an opportunity to check whether proper care is being rendered in accordance with the contract with the health department.

Moreover, the welfare department contends that while the health department's policy of restricting hospitalization to those indigents in need of immediate, emergency treatment may enable the indigent medical care program

to stay within its budgetary limits, it is more costly to the Territory in the long run. This is because individual indigents are denied hospitalization on the grounds that their needs are not of an immediate, emergency nature, but are forced to remain on the welfare rolls because the illness is disabling enough to prevent them from obtaining a livelihood (e.g., person in need of operation for hernia). Thus, a continuing drain on the territorial treasury in one department results from a move to reduce costs in the other department.

The health department has agreed to send copies of rejection notices to the welfare department for the purpose of maintaining records. However, it does not accept the proposition that the welfare department should be able to review such rejections and possibly overrule them. Rather, the view is that these rejections are medical decisions and should be passed upon by those qualified to do so - namely, the physicians concerned and the health officials. Effective July 1, 1957, however, the Division of Hospitals and Medical Care did establish, as a matter of internal procedure, a panel of three physicians in private practice to decide whether an applicant should be given treatment when the director of the division disagreed with the rejection of the applicant by the county or city-county doctor.

The problem still remains, therefore, that the welfare department feels it is responsible for medical care of "insured" indigents, but has no control over the rejection of any such persons by county doctors nor any means for checking on the adequacy of the medical care provided. At the same time, the health department takes the position that determination of the need for medical treatment is something only doctors are qualified to do and that present procedures provide sufficient guarantee of adequate and competent diagnoses and treatment for all indigents. The achievement of satisfactory relationships between the two departments will require a resolution of these differences of views.

Possible Benefits of Transfer of Program to Welfare Department. Another problem area - if it can be called such - is the contention of the welfare department that money could be saved and additional federal matching funds obtained if the indigent medical care program were transferred to the jurisdiction of the welfare department.

The welfare department claims that much of the work presently performed by the county medical social workers could be taken care of within existing staff limits of the welfare department. This is because the caseloads of welfare workers in the Territory have been going down. By having these workers absorb the additional work of investigating the medically indigent, a number of positions could be eliminated.

In support of its contention that more federal matching funds might be obtained, the welfare department has pointed out: (1) that the federal government views indigent medical care as a welfare function and therefore would be more willing to allocate funds to a welfare department without lengthy questioning and reviewing; (2) that federal funds are available to support part of the costs of general administration of welfare activities and these would apply, of course, to the overall supervision of the medical care program; (3) that additional federal funds are available for research and training grants for public welfare personnel (Sec. 705, Title VII, Social Security Act); (4) that the present definition of "medically indigent" and

the separate administration of this part of the program by non-welfare agencies may be operating to disqualify some persons from federally supported categories who would otherwise be eligible; and (5) that there are federal matching funds available for care provided in nursing and convalescent homes, which care is presently excluded from such support.

Although there is some validity to these contentions, there are also other factors to be taken into consideration. While it is probably true that a reduction in the total number of positions could be achieved by placing all determination of eligibility under the welfare department, it is also quite likely that the welfare department would have to employ additional qualified medical social workers and would require the services of professional consultants, and medical personnel. Therefore, any savings realized would not be in direct proportion to the number of positions eliminated. Also, such a transfer of responsibility might require the welfare department to add personnel whose talents duplicate resources already available in the health department.

In regard to additional federal matching funds, this is a difficult area in which to make any definite determinations or predictions. The matter has been discussed with federal authorities by the governor's special committee and the general conclusion seems to be that the Territory is qualifying for practically all of the federal funds to which it is entitled under existing conditions. It is prossible, but by no means certain, that the Territory could obtain significant additional funds from the federal government if the indigent medical care program were administered entirely by the welfare department. However, neither the welfare department nor the federal officials have committed themselves to any estimate as to what the amount of any such additional funds might be.

Besides, it should be remembered that all federal funds require matching funds from the Territory. Thus, more federal funds allotted for "insured" recipients would require the expenditure of more territorial funds for these persons. This might serve to divert territorial funds from the non-insured and medically indigent categories.

Generally speaking, therefore, present evidence is not conclusive that significant amounts of money could be saved or additional funds secured from the federal government through the transfer of the indigent medical care program from the health department to the welfare department. However, such possibilities for improving the financial status of the program may well exist and are worthy of further investigation.

Qualification for Federal Aid. Another matter causing some concern pertains to the manner in which the Territory qualifies for federal matching funds. As has already been mentioned, the original appropriation for the program made in 1951 (Act 129) specifically provided that such funds could be transferred from the health department to the welfare department in order for the Territory to qualify for federal aid. However, subsequent appropriating acts have not been similarly worded and the proviso does not appear in Chapter 48, R.L.H. 1955. Nevertheless, the pattern initially established in 1951 continues in effect at present.

Some fear has been expressed, however, that federal aid may be disallowed sometime in the future on the grounds of this legal technicality. For this reason, it has been suggested that it might be well to guard against such an eventuality by amending the law to clarify this particular point.

The matter is emphasized by the misgiving on the part of some that federal authorities may sometime come to the conclusion that the present arrangements for Hawaii's indigent medical care program are "just a gimmick" to get federal money and may decide the program does not fall within the limits prescribed by law. It should be noted, however, that federal authorities have already subjected the program to a thorough review on several occasions.

County-Territorial Relationships. Another factor complicating the administration of the indigent medical care program in Hawaii is the division of responsibility between the territorial and county governments for administering the program. The nature of the relationship between the two levels of government established under Act 129, S.L.H. 1951, has been described by the health department as follows:

> This legislation was recommended by the Holdover Committee of the 1949 Legislature, centralizing the legal, financial and overall administrative responsibility for the medical care of the indigent and the medically indigent in the Board of Health. The purpose was to assist the counties financially, to relieve them of political pressure for free medical care, and to establish more uniform services in all counties. The Department of Public Welfare determines the indigent and the counties have the responsibility to determine the medically indigent who may receive medical care. The counties have employed social workers for this purpose.
>
> Under the law, the Board of Health sets the financial structure and determines the hospital rates for the payment of care for these individuals but the counties actually pay the bills from funds allocated to them by the Board of Health.[1]

It has also been shown (Tables 4 and 5) that approximately 90% of the administrative costs of the indigent medical care program are borne by the counties. Furthermore, it has been noted that the counties must pay the costs of cases disallowed by the Territory and must make up any deficits which may develop when territorial allotments are insufficient to cover the costs of medical care rendered. Thus, Table 3 shows that when savings had to be made by the health department in the 1955-57 biennium, the counties augmented the funds available for indigent medical care by more than $220,000.

Unlike the Mainland pattern where there has generally been a fairly clear division of responsibility between state and local governments, with curative medical care being a local responsibility and with the states concentrating on preventive health measures, in Hawaii both levels of government provide for the curative medical needs of the community. This is best exemplified by the century-old system of government physicians. Thus, the present set-up is more or less a continuation of this historical development.

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[1] Annual Report, 1951, pp. 17-18.

There is, then, no clear-cut demarkation of responsibility for indigent medical care between the territorial and county governments. This may cause some occasional problems, but for the most part the strongly dominant position of the territorial government in this field - as well as in most others - has prevented any differences from developing into deadlocks. It is extremely unlikely that any problems in this area will remain unresolved for long or will be allowed to stymie the program's operations. Needless to say, however, any strong home rule movement might reverse this situation and might cause serious interference in the administration of a program such as this where there are indefinite and overlapping areas of responsibility.

In summary, there are a number of problem areas in Hawaii's indigent medical care program. Some of the most important of these have been enumerated. The following, and final, section indicates possible courses of action which might be followed in regard to the indigent medical care program, and summarizes basic considerations which should be kept in mind when making any decisions affecting the future of this program.

VI. ALTERNATIVE COURSES OF ACTION FOR INDIGENT MEDICAL CARE PROGRAM

There are a number of alternatives open as far as what might be done to improve the administration of the indigent medical care program. In this final section it may be well to review some of the alternative courses of action and to summarize the basic considerations which should be kept in mind when determining the future of this program, thereby providing a basis for rational action in regard to the program.

Alternatives. Possible alternative courses of action include the following:

1. Leave the program substantially the same as it is at present, making only those changes necessary to clarify existing areas of doubt and to keep the program up-to-date with changes in other programs or federal regulations (e.g., revise contract between the health and welfare departments, amend law to clarify the legal basis for the transfer of funds between the health and welfare departments, etc.).

2. Leave the program under the health department but transfer the entire administration of it to the territorial level and thereby relieve the counties of any responsibility for it.

3. Transfer administrative responsibility for indigent medical care from the health department to the welfare department, permitting the welfare department either to enter into a contract with the health department to act as an "insurer" or to be left free to make other arrangements for the provision of medical care.

4. Leave the program much the same as it is now but provide additional formalized administrative machinery to resolve differences which might develop between agencies involved in the program, such as required regular consultations between the two departments, converting the advisory committee into a council to act as an appeals and arbitration body, or some similar device.

5. Reduce the Territory's participation in the program and return much of the responsibility for indigent medical care to the county governments. In essence, this means returning to the conditions existing prior to 1951.

6. Reorganize the overall administration of the health and welfare departments so that the two closely related fields might be included under a single agency, thereby eliminating the need for interdepartmental treatment of hybrid-type functions such as indigent medical care.

The foregoing alternatives range all the way from changes involving little or no action to changes which would entail fundamental alterations in the overall structure of the territorial and county governments. Thus, revising the administrative organization of the indigent medical care program may have wide ramifications.

Summary of Basic Considerations. Because of the potential wide-range effects of changes in the indigent medical care program--both upon the program itself and upon the territorial government in general--it is important

that they be made in the light of some of the basic considerations discussed previously in this report. For this reason these basic considerations are summarized below. There is no perfect solution, but these should provide some guides as to what decisions to make to improve indigent medical care in Hawaii.

Basic considerations affecting the indigent medical care program include the following:

1. Indigent medical care is not an easily classificable function of government because it extends into both the fields of public health and public welfare and has important financial ramifications. As a result, both health and welfare departments have almost equally valid jurisdictional claims to an indigent medical care program. Although majority practice has placed the function under welfare agencies, Maryland has proved that a health department can operate an effective program.

2. Because of its close relationship to other activities of both welfare and health agencies, the indigent medical care program cannot be divorced completely from either type agency, no matter which department may be given primary responsibility for it. Therefore, in assigning responsibility for the program the question is not which department should have exclusive jurisdiction, but, rather, what is the best means of achieving a close working relationship between the two departments in dealing with this particular function. In other words, it is practically unavoidable that the program will be interrelated with other health and welfare activities and will require some sort of administrative cooperation and coordination.

3. In Hawaii the indigent medical care program operates under a complex set of administrative arrangements. The health department has primary responsibility for the program, but the welfare department, the budget bureau, the county governments, and federal welfare authorities all have important roles to play to keep the program operating. Such complexity has required the establishment of elaborate procedures and has given rise to certain problems and points of friction. Nevertheless, the program has operated fairly effectively since the inception of present arrangements in 1951, and the major aims of the program seem to have been accomplished within the limits of legislative appropriations.

4. There are federal matching funds available to help cover the cost of medical care for certain categories of indigents. However, the Territory has no control over the requirements to qualify for such matching funds. Therefore, the Territory must decide: (1) whether it wants to rely upon this type of federal aid, and (2) whether it is willing to meet the conditions necessary to do so. Up to now, Hawaii has sought this aid and has devised a program which has satisfied the requirements of federal authorities although it is quite different from any other indigent medical care program in the country.

5. The possibility exists that additional federal funds may be obtainable for the indigent medical care program if this program were transferred to the welfare department. However, neither the welfare department nor federal officals have made any definite estimates as to the amounts of such additional funds. There is no guarantee that the transfer would mean an increase in federal matching funds. Moreover, federal matching funds may be applied only to the costs of medical care for "insured" indigents, and, as the term

"matching" indicates, must be matched by additional territorial funds. Therefore, an increase in federal funds may mean that funds will have to be diverted from non-insured categories. It is generally agreed that the Territory is qualifying for just about the maximum amount of federal aid possible under present conditions.

6. There is also the possibility that Hawaii may be able to achieve some savings in the administration of the indigent medical care program if it were transferred to the welfare department's jurisdiction. This is on the assumption, of course, that such transfer would result in the welfare department assuming the counties' responsibility for determining the eligibility of medical indigents. However, any savings realized would not be in direct proportion to the number of positions eliminated because the welfare department would have to add certain specialized and professional positions to its staff to handle the medical aspects of the program. Moreover, such a move may actually increase the Territory's burden inasmuch as approximately 90% of the administrative cost of indigent medical care is borne by the counties at present.

7. The preceding point raises another important consideration concerning the indigent medical care program. This is the matter of the respective areas of responsibility of the territorial and county governments and the relationships between the two. Unlike many jurisdictions, Hawaii has a long tradition of dual responsibility in the field of curative medical care for the needy. Moreover, the tendency to centralize activities in the territorial government has been much more pronounced than is the case with most state jurisdictions. Thus, changes in the indigent medical care program are closely related to the question of greater home rule versus greater centralization of governmental activity in Hawaii.

8. The present indigent medical care program does not provide complete medical care for the needy in the Territory in that the rules adopted by the board of health make a number of specific exclusions (e.g., burial of indigent dead, ambulance service and domiciliary and convalescent care). However, the health department points out that such exclusions are made because appropriations have not been adequate to cover all medical costs or because the attorney general has ruled that certain costs must be borne by the counties. Consequently, those costs which were considered less essential or which could be met from other sources were excluded from this program. This means, therefore, that the level of services available under the indigent medical care program is largely determined by the amount of legislative appropriations.

9. During the long period of consideration prior to the enactment of Act 129 in 1951, the whole question of the proper organization of the indigent medical care program was given careful examination. If one should read through the voluminous minutes of the public hearings and meetings devoted to this problem, one would find that practically all the points included in this report were discussed and considered. This includes assessment of the question of health department versus welfare department administration of the program.

During this period the position of the welfare department was fully presented.[1] Nevertheless, after hearing and considering all of the evidence presented, it was recommended that the program be put under the primary responsibility of the health department.

10. When viewing the costs of indigent medical care, it should be remembered that the great bulk of such costs is made up of the actual costs of medical and hospital care and only a small proportion goes into the administration of the program. In Hawaii the annual administrative costs of approximately $100,000 amount to only about 10 per cent of the approximate $1,000,000 sum spent for hospital and medical care. This means, therefore, that no matter what economies are achieved in program administration, no really substantial reductions in costs can be made so long as the costs of medical treatment and hospital care remain high.

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[1]See "Statement on Medical and Hospital Care for the Needy" by Newton R. Holcomb, Director of the Department of Public Welfare, to the Advisory Committee of the 1949 Holdover Committee's Subcommittee on Hospital and Medical Care, November 23, 1949 (mimeo. 8 pp. and appendices).

APPENDIX

C O P Y

TERRITORY OF HAWAII
Department of Public Welfare
Honolulu

AGREEMENT BETWEEN THE DEPARTMENT OF HEALTH
AND
THE DEPARTMENT OF PUBLIC WELFARE

Under and by virtue of the provisions contained in Act 129, Session Laws of Hawaii 1951 and the past practices heretofore established by the proper authorities, the Department of Health and the Department of Public Welfare hereby enter into the following revised agreement:

For and in consideration of monthly premium payments by the Department of Public Welfare in behalf of eligible recipients assisted under Aid to the Blind, Aid to Dependent Children, Aid to the Disabled, and Old Age Assistance programs, the Department of Health agrees to provide to such persons necessary hospital care, outpatient care, and dental care as defined below. The amounts of such monthly premium payments shall be agreed upon by both departments and shall be set by relating the number of individuals to be covered to the anticipated cost of hospital care, outpatient care, and dental care, as shown in the Department of Public Welfare staff manual section on "Insurance Against the Cost of Medical Care - Justification of Amounts of Premium Payments". They shall be subject to change at not less than one year intervals on the basis of experience.

In each instance of hospital admission, outpatient visit, and dental visit, the Department of Public Welfare shall certify that the individual is or is not a recipient of Aid to the Blind, Aid to Dependent Children, Aid to the Disabled, or Old Age Assistance for whom such a premium payment has been or will be made that same calendar month.

The Department of Health shall deposit the monthly premium payments to an account from which only the cost of hospital care, outpatient care, and dental care for insured individuals shall be met. The Department of Health shall furnish or purchase hospital care in general hospitals, maintaining the standards set forth in Section 3, Public Health Regulations of the Board of Health, Territory of Hawaii, Chapter 12 on Hospitals.

Content of Hospital Care

It is understood and agreed that hospital care within the terms of this agreement is provided to insured recipients of Aid to the Blind, Aid to Dependent Children, Aid to the Disabled, and Old Age Assistance on the basis that it includes:

1. Ward accommodations, including bed and meals.

2. Regular nursing care.

3. Drugs, antibiotics, dressings, diagnostic tests, and therapeutic procedures as prescribed and ordered by the attending physician.

4. Private room accommodations and special nursing care as ordered by the attending physician in exceptional cases of serious illness.

5. All other necessary hospital care except as excluded below.

Hospital care within the terms of this standard does not include.

1. Payment for physician's services.

2. Transportation to and from hospitals.

3. Treatment in an institution operated primarily for treatment of mental illness, mental deficiency, tuberculosis, or Hansen's disease.

4. Treatment of tuberculosis, mental illness, mental deficiency, or Hansen's disease.

5. Domiciliary care and other care of patients not requiring hospital facilities.

6. Observation in connection with mental conditions which comes within the provisions of Sec. 81-25 and Sec. 81-26, Revised Laws of Hawaii 1955.

7. Hospital care available to the patient from another source.

Content of Outpatient Care

The term "outpatient care" shall include, but not be restricted to, medical services, drugs, antibiotics, dressings, diagnostic tests, and therapeutic procedures as prescribed and ordered by the attending physician.

Content of Dental Care

The term "dental care" shall include, but not be restricted to, emergency and restorative dental services and any drug prescribed by the attending dentist.

The Department of Health shall submit yearly fiscal reports not later than August 31 of each year, giving the cost and number of recipients treated in each assistance and in each county for hospital, outpatient and dental care, and the number of adults and children treated in the Aid to Dependent Children assistance category.

The Department of Health shall obtain reports quarterly from all outpatient clinics in Honolulu and county medical social workers on all rejections of medical care recommended by clinics and government physicians for insured recipients.

The Department of Health shall provide for a panel of impartial physicians who shall be called upon to review all rejections of medical care for insured recipients. The panel shall make recommendations to the Department of Health with regard to the indicated medical care. Quarterly reports on action taken as the result of a panel review shall be obtained along with reports on rejections.

All quarterly reports shall be maintained in the files of the Department of Health and shall be open to the inspection of the Department of Public Welfare at all times.

This Agreement shall be effective July 1, 1957 to June 30, 1959. At any time hereafter, upon the request of either department, this Agreement shall be subject to amendment as deemed necessary and desirable by both parties.

_____
Director, Department of Public Welfare

_____
Date

_____
President, Board of Health