FREE CHOICE OF PHYSICIAN IN HAWAII'S MEDICAL CARE PROGRAM

AN APPRAISAL

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PREFACE

Attached is a report on a study of the implications of affording indigents free choice of physician. This matter has been discussed in recent sessions of the legislature, and renewed interest was evidenced by a request from the House Committee on Public Health that the Legislative Reference Bureau "review the desirability" of free choice.

There appears to be little question that the principle of free choice is acceptable to, even desired by, all concerned with medical care. The problem is its cost, which might be twice as high as the present medical program for indigents. Further, absolute free choice is not practical, and in the necessarily highly organized medical system of today, many paying patients have their choice considerably limited. The choice lies between the present low-cost no-choice system and one which is freer and more costly; a decision can be made only on the basis of whether the freedom available as a practical matter is worth the higher cost.

The study was conducted and the report prepared by Takaaki Izumi, Research Assistant, Legislative Reference Bureau, State of Hawaii.

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I. THE QUESTION OF FREE CHOICE

Medical care is available to indigent persons in Hawaii at public expense, as it is in all states, and the medical aspects of the state's welfare program have grown in importance in recent years. The program has therefore received considerable attention, both in the legislature and in the administrative branch, which attention has included interest in the possibilities of permitting indigents to exercise free choice in the selection of physicians. At present, the indigent and medically indigent in Hawaii do not have such a choice, in contrast to the situation in most state medical care programs where it is practiced in one form or another.

This study covers the prevailing views on free choice of physician; briefly reviews practices in other states; discusses systems of providing physicians' services in welfare medical care programs; touches upon new developments in medical practices and how they affect free choice; reviews the present system of providing physicians' services in Hawaii's medical care program; and evaluates costs attendant upon the present system and a typical possible free choice program. Discussion is limited to the outpatient aspect of the medical care program except where references to inpatient care are clearly pertinent.[1]

Philosophical Aspects of Free Choice

In the matter of free choice of physician for recipients of welfare medical services, there are three basic points of view. These views are those of: the medical profession, the public welfare profession, and the public health profession. For this particular study, the last is omitted since in Hawaii the medical care program has recently been transferred to the Department of Social Services and the Department of Health no longer participates directly in the program.

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[1] For hospitalization of indigents, see Legislative Reference Bureau, The Costs of Hospitalization for Indigents in Hawaii, Report No. 3 (1960).

The Medical Profession

The medical profession through the American Medical Association has consistently endorsed free choice of physician by purchasers of medical care. According to the American Medical Association News of December 14, 1959, the Association adopted a resolution reaffirming its previous stand for free choice:

> The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses.
>
> Each individual should be accorded the privilege to select and change his physician at will or to select the preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives.

In addition the AMA took the position that free competition as well as free choice are prerequisites to optimal medical care. Thus, the official AMA view is that free choice is a vital contributing factor to optimal medical care.

The Public Welfare Profession

The stand taken by the Hawaii Department of Social Services on free choice of physician is similar to that taken by the medical profession. As guiding principles, the department outlines eleven points, among which is the statement that "traditional physician-patient relationship should not be disturbed". In other words, recipients should be able to receive medical care from a physician, dentist, clinic, or hospital of their own choice. The full text of these principles is reproduced in the appendix of this report. The department also recognizes that if the principle of free choice is to be made a reality in Hawaii, it would require the abolition of the government physician system in Rural Oahu and the neighboring counties, and an alteration in the present system in metropolitan Honolulu in which outpatient clinics of five private hospitals and Maluhia Hospital provide care on a fee-per-visit basis but with free physician services. The department is for free choice as a humani-

tarian principle, although it realizes that in administering a medical care program without unlimited financial resources, this principle must be tempered by practical considerations. The department wants to make it clear that it is not engaged in any activity to effectuate free choice.

Free Choice in Other States

As reported by a survey of states conducted in 1957, the administration of medical care for indigents was primarily a local government function in 22 of the 48 states covered (Hawaii and Alaska were excluded). The remaining 26 states had broad medical care plans which were either state-administered or state-supervised. Free choice of physician was permitted to patients in all 26 states with state programs, except for some areas in seven states where a city or county physician or one of a panel of physicians must be used. The exercise of choice by recipients, then as now, is limited in general to physicians willing to accept the established fee schedule (usually negotiated between the state welfare agency and medical professional associations) and to physicians living within a reasonable distance of the patient's residence. In 1957, freedom of choice was permitted in the states of Connecticut, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Pennyslvania, Rhode Island, Texas, West Virginia, and Wisconsin. Alabama allowed free choice only when public facilities were not available. In New York, free choice was permitted except for a few local government agencies which used the panel and government physician systems. In Ohio, all three systems -- government physicians, panel, and free choice -- were in operation. In Oregon, free choice prevailed except in Multnomah County where first consideration was given to obtaining care at the University of Oregon Medical School clinics. A few cities in Virginia employed their

own physicians to treat indigents. In Washington, indigent patients exercised free choice except in King County where patients had to use the staff of hospitals.[2]

Since 1957, California instituted a state-wide outpatient medical care program for welfare recipients in the federal-matching categories (Old Age Assistance, Aid to Dependent Children, Aid to the Permanently and Totally Disabled, and Aid to the Blind) in which the free choice of physician is available.[3] In California the freedom of choice is reported to be virtually unrestricted.

Systems of Providing Physicians' Services

In welfare medical care programs, physicians' services provided through publicly operated health institutions (hospitals, clinics, etc.) are more prevalent in urban areas, particularly when responsibility for care is chiefly a local government function. When state and federal financing is available, service is more frequently purchased from private suppliers and usually paid for after it is rendered.

Provisions for such services may be by any or all of three basic methods: (1) appointment of full-time or part-time county or district physicians (government physicians) paid on a salary basis; (2) designation of a number of physicians who comprise a county or district panel from which the patient may choose and payment is made either on a fee-for-service or a per capita basis; and (3) free selection of a physician in private practice by the recipient with payment by the welfare department as a vendor payment, or by the recipient out of his cash assistance allowance.

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[2] Margaret Greenfield, Medical Care for Welfare Recipients--State Programs (Bureau of Public Administration: University of California at Berkeley, May, 1957), pp. 5, 7-9.

[3] Jacobus tenBroek, "California's New Medical Care Law and Program," California Law Review, 46 (October, 1958), p. 571.

The Government Physician System

The chief advantage of using a system of salaried physicians reportedly is in comparative economy and ease of administration. More services can be bought for money spent, and administrative and cost controls can be more easily exercised by the government -- including the setting of standards.

Among the reported disadvantages of the system, it is claimed that foremost is the complete lack of choice in the selection of a physician by the patient. In addition, other disadvantages, as seen by both the medical and social welfare professions, lie in the general area of the greater likelihood that medical services provided under this system may be comparatively inferior. This effect may be a result of an insufficient number of physicians being hired and the presence of greater opportunity for "politics" to be injected into the program.[4] The disadvantages just listed were not, however, mentioned by anyone as being characteristic of the Hawaii program.

The Panel System

Under this system, a number of physicians who have agreed to work with the welfare department are officially designated as practitioners from whom welfare recipients may receive services. Payment is usually made on the basis of a fee schedule for specific services. The element of free choice, although limited to participating physicians, is looked upon as a distinct advantage by physicians and patients.

The panel system, however, has drawbacks of which the most severe seems to be that many physicians who are doing well in private practice choose not to join the program. In addition, the welfare agency must usually construct detailed rules and

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[4] Greenfield, Medical Care for Welfare Recipients--Basic Problems (Bureau of Public Administration: University of California at Berkeley, March, 1957), pp. 40-41.

regulations to control expenditures and prevent excessive use. It is likely that this system would require a larger administrative staff than the government physician system to approve services and review, audit, and certify bills.

Free Choice

It is constantly stressed by the medical profession that it is the right of a patient, regardless of his social or financial position, to choose his own doctor. It is claimed that freedom of choice is an important aspect of patient recovery since it fosters the confidence of the patient in his physician; that it provides physicians equal opportunity to work; and that it acts to safeguard the quality of medical care provided.

The disadvantages of a free choice system, more than the panel system, are its relatively high cost in administration and its inability to ensure that otherwise eligible physicians will agree to take part in the program.

There is, of course, no such thing as complete free choice as there are some common sense limitations, such as the requirement that a physician should be chosen within the geographical proximity of the patient's residence and that choice would be limited to only those physicians willing to accept the fee schedule. In addition, free choice raises a number of delicate questions, such as: Should choice be restricted to general practitioners or should it also include specialists? Should it include hospitals and clinics as well as home and office visits? How would screening of applicants be done so as to avoid interference with medical practice? What system of policing can be used so that physicians are exempted from a great deal of "paperwork"? There may be other equally delicate problems which would require solution or agreement between the social welfare agency and participating physicians.[5]

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[5] Ibid., pp. 42-43; Franz Goldmann, Public Medical Care, Principles and Problems (New York: Columbia University Press, 1945), p. 97.

Changing Medical Practices Affecting Free Choice[6]

There are a great many changes in the field of medicine which profoundly affect the idea and exercise of free choice by patients, both indigent and self-paying. Of these, the most important appear to be: (1) increasing technological advances and usage; (2) increasing specialization; and (3) the "institutionalization" of medicine.

Scientific and Technological Advances

The vast and rapid advances in the fields of medical science and technology are well known. It might be said that medicine did not emerge from its low estate until the development of modern medical science. The cornerstone in the foundation of modern medical science is the growth of clinical medicine, which really began to make its contributions with the merger of previously independent branches of research -- clinical and anatomical. Only after the correlation of the two did it become possible to identify distinct diseases and how they affect the human body and to reap the great advances in medicine. Other branches of medicine which contributed greatly are the cell doctrine which laid the theoretical groundwork for anatomical, physiological, and pathological advances; medical bacteriology which had its beginnings in the latter half of the 19th century; discoveries in the field of pathogenic microorganisms which dealt largely with the external agents of infection in the early days of the discipline and today covers dietary, glandular, and other branches as well; the field of endocrine disorders and biochemistry which treats of but is not confined to the study of glandular illnesses and hormones; and, more recently, the significant developments in the field of psychiatry. Each of these has contributed no small part and collectively they have enabled the advent and growth of preventive medicine.

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[6]This portion is summarized from Herman M. Somers and Anne R. Somers, "Private Health Insurance," California Law Review, 46 (August, 1958), pp. 395-409.

Medical progress during the last hundred years has been closely related to the development of instruments that facilitate diagnosis and treatment. Milestone inventions are the microscope, thermometer, stethoscope, ophthalmoscope, stomach tube, etc., in the 19th century, and subsequently the more complicated x-ray, iron lung, artificial kidney and heart, etc., to name but just a few. Use of these instruments requires skilled medical personnel in addition to the physician.

Specialization in Medicine

Historically, specialization in medicine has to a considerable degree been dependent upon discoveries in medical science and the invention of instruments indispensable to diagnosis and treatment of diseases. Specialization is an aspect of increasing total knowledge and the resulting variety of skills in the profession. There are 32 specialized medical careers whose standards and requirements are set by 19 examining and accreditation boards. The ratio of full-time specialists to all physicians has moved quickly upward since about the middle of the 1920's. In 1955, general practitioners comprised only 42 per cent of the physicians in private practice. General practitioners have also declined in absolute numbers -- a 22 per cent decline from 1940 to 1955 -- while the number of full-time specialists nearly doubled. Although there has recently developed a professional concern about the consequences of an inadequate number of general practitioners, the trend appears to be toward a new "hybrid" of physician who combines a general orientation with aspects of specialization.

"Institutionalization" of Medical Practice

The practice of medicine is presently undergoing an accelerated evolution in new forms of medical care organization -- the growth of various types of combined practice and expanded hospital services. Advances in science and technology led to specialization and this in turn increased the interdependence of medical practice.

It made general practitioners dependent upon specialists, specialists upon each other, and all physicians upon ancillary personnel, large-scale facilities, modern laboratories, hospitals, and clinics. Complete medical care is not only beyond individual capacity for knowledge and skill but also financially unfeasible because of the huge capital investment needed to equip and operate an office which is equal to the demands of modern medicine. Thus, cooperative arrangements among doctors, either formal or informal, are now universal in the United States. Even the most individualistic practitioner tries to establish working relations with a hospital and has a list of specialists to whom he may refer patients. At least three fundamental forms of group or combined practice have emerged: (1) sharing of facilities; (2) sharing of income; and (3) sharing of responsibility for individual patients. Combined practice has undoubtedly contributed a great deal to quantitative and qualitative advances in the practice of medicine. And, regardless of the form, the increase in combined practice is an indisputable trend.

Effect Upon Free Choice

The rapid gains in medical science and technology have produced specialization and changes in the organization of medicine. More and more, the family physician type of relationship between doctor and patient is diminishing, especially in certain types of health insurance plans such as the Kaiser Health Plan which offers panels or teams of physicians. In addition, because of increasing clinic-type operations, the nature of choice in regard to physician is undergoing change. The family physician type of doctor-patient relationship is more difficult to attain in a clinic clinic-type practice, and furthermore, the patient who wants comprehensive medical care would go to a clinic.

In Hawaii, a recent survey indicates that 25 per cent of visits made by patients were to outpatient clinics of hospitals (these visits include those by the indigent and medically indigent). An estimated additional 30 to 40 per cent made office visits

to physicians engaged in clinic or closed-panel type of practice other than hospital outpatient clinics. This indicates that in Hawaii as many as 60 per cent of patient visits made are to physicians in clinic-type or similar group practice where the nature and degree of choice is different from the family physician concept. (The membership of Kaiser Health Plan alone was reportedly 40,000 as of November 1, 1960.)

In comparison, the mainland percentage of visits to hospital outpatient clinics is reported to be around nine per cent. This indicates that in Hawaii, the percentage of patients frequenting clinic-type offices is considerably higher than on the mainland. Two reasons readily suggest why this condition exists: (1) the tradition of military and plantation clinics, and (2) the proportionately younger population in Hawaii who tend to be without family physicians and prone to accept changing medical practices. In fact, in Hawaii, an increasing number of people are receiving medical care from physicians other than their family physician.

The Psychological Aspect of Free Choice

In spite of the changing structure of medical practice, the issue of free choice remains for many an emotional one. This is because the basic social-psychological link in the relationship between physician and patient largely remains the same as it has been throughout history. The patient is a person who is or imagines himself ill or in danger of illness or death. The physician is the authoritative expert upon whom he relies for relief from pain and suffering. The patient not only is an organism seeking medical care and cure, but is also a personality with moods, insights, prejudices, conceits, opinions, and attitudes which are a basic part of the medical picture. The patient wants security, health, and self-esteem but illness or fear of illness makes him anxious and dependent. Thus, the physician traditionally has been a practitioner of an art as well as a scientist. However, it

cannot be denied that the doctor-patient relationship generally is becoming less personal than it used to be a few decades ago.[7] Yet, because of the psychological nature of circumstances which makes a person seek the services of a physician, free choice as an issue is highly emotional and often defies rational discussion and analysis.

[7]Bernhard J. Stern, American Medical Practice (New York: The Commonwealth Fund, 1945), pp. 55-57.

II. A CONSIDERATION OF FREE CHOICE FOR HAWAII'S MEDICAL CARE PROGRAM

The indigent and medically indigent in Hawaii's medical care program do not exercise free choice of physician. Instead, there are two systems in operation: (1) the government physician program in Rural Oahu and the neighboring counties; and (2) a clinic panel system in which welfare patients receive care at the outpatient clinics of various hospitals in Honolulu city proper. In the former, the receipient must go to a government physician in order to receive free care; in the latter, the patient has a choice among the six clinics in the city.

The Government Physician Program

Government physicians are located in Rural Oahu and the neighboring counties of Hawaii, Maui, and Kauai. There are 40 government physicians receiving monthly stipends and quarterly drug allotments which cover routine outpatient office visits and medicines. All are part-time public employees who also engage in private practice, in many cases in connection with rural hospitals. Special cases requiring extensive diagnostic treatment (x-ray and laboratory) and expensive drugs are charged to the medical care program.[8] During the past fiscal year, government physicians received an additional fee of $1.00 per visit in Rural Oahu and $1.25 per visit in Kauai County. These extra fees have been eliminated starting July 1, 1960. Although expenditures will be discussed subsequently in this report, it might be stated here that the cost of this phase of the program is likely to rise during the current fiscal year because of salary raises for government physicians effective July 1, 1960.

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[8] The government physician stipend and drug allotment appropriation are separate from the medical care program.

Historically, the government physician program in Hawaii may be traced to the 1860's. That period in Hawaii's history of public health is a turbulent one with successive waves of epidemics sweeping a native population extremely susceptible to diseases brought to the islands by sailors and other outsiders. The government physician system undoubtedly grew out of the need for medical services to deal with these epidemics. Such services had to be available throughout the Kingdom, so physicians were hired directly by the government.

It appears, however, that the rationale behind the establishment of the government physicians program in the 1860's is not entirely applicable today, with the possible exception that the program may encourage practice in the most rural areas. The physicians have certain duties not related to the medical care program (acting as the agent of the Health Department in the district, performing autopsies, treating and reporting various communicable diseases, and the like), but the bulk of their work is in rendering medical care to the indigent and medically indigent. The greater portion of stipends paid to government physicians is for the treatment of indigents, and it may fairly be assumed that the system exists today primarily to serve this purpose.

Clinic-System in Honolulu City

Indigents in metropolitan Honolulu go to the outpatient clinics of five private hospitals (Queen's, Kapiolani Maternity, Children's, Kuakini, and St. Francis) and the Maluhia Hospital. The clinics are compensated on a fee-per-visit basis. There is no restriction on the choice of clinic at which any indigent may receive care. The clinics are staffed by interns and house physicians who are on rotating assignments

and there is little personal doctor-patient relationship. At least in the government physician arrangement, if on welfare long enough, a patient may get to know a government physician quite well. Furthermore, in some rural areas, the government physician is also the only physician practicing in a locality.

Program Costs[9]

For the past fiscal year, July 1, 1959 to June 30, 1960, the expense to the state government in providing outpatient medical care to the indigent and medically indigent amounted to a little more than $340,000 or an average of about $2.80 per visit. It is estimated that the county governments supplemented the program by some $30,000. Even with this amount added on to program costs, the average cost per visit was only $3.04.

State funds for outpatient medical care are spent in the government physician program and the clinic-panel system. The average cost per visit for the government physician system is estimated to be $3.10, and for the clinic-panel system approximately $2.60. Costs are summarized in the following table:

Table 1.

COST AND VISIT DATA FOR OUTPATIENT CARE,
MEDICAL CARE PROGRAM,
STATE OF HAWAII
FISCAL YEAR 1959-1960

State Expenditures Only	Total Cost	No. of Visits	Cost Per Visit
Government Physician System	$158,584.23	51,575	$3.08
Clinic-Panel System (Honolulu)	182,989.44	70,845	2.58
State-Wide	$341,573.67	122,420	$2.79
State and County Expenditures (estimated)			
State-Wide	$371,573.67	122,420	$3.04

Source: Calculated from data provided by Department of Social Services, State of Hawaii.

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[9]Unless otherwise footnoted, financial data were obtained from the Medical Payments Section, Department of Social Services, and other information on Hawaii's medical care program obtained through personal interviews with Mr. Morris G. Fox, Acting Staff Officer, Plans Office and Mr. Francis Ishida, Medical Payments Officer, Department of Social Services.

Table 1 does not necessarily reflect the total cost of the outpatient medical care program since the private hospitals in Honolulu claim that the prevailing fee of $2.40 per visit is insufficient to cover the expenses of serving indigents. If this claim be true, it would mean that additional program costs are being absorbed by the hospitals. At the time of writing, the hospitals have not submitted fiscal data to support their claim, although one hospital administrator appeared favorably inclined to do so. In view of the fact that the present fee was set in 1951 and there has been a considerable rise in medical costs since, it may well be that the present fee arrangement results in a financial loss to the hospitals in their outpatient clinic operations. Also, the flat fee covers most diagnostic treatments and all but the more expensive drugs and medication as well as professional services rendered. Such items would, for the most part, constitute additional charges to a self-paying patient going to a private physician or clinic. Why have the hospitals not negotiated with the City and County of Honolulu for a raise in the fee since 1951? An answer may lie in the movement to expand Maluhia Hospital to accommodate the whole welfare medical care program in Honolulu, a development which would cripple the intern training programs of the hospitals. Any request for a higher fee would provide an occasion for Maluhia Hospital to push for its expansion.

Evaluation of Costs

Including county supplemental funds, the outpatient medical care program incurred a cost of only $3.04 per visit for all medical services, including drugs and appliances. In comparison, the California Medical Care Program (OAA; ADC; AD) incurred an average payment per visit of a little more than $4.30 for physician services alone, while also costing $4.30 per prescription for drugs, supplies, and appliances, and incurring certain other costs. A comparison of data between the medical care programs of California and Hawaii is shown in Table 2.

Table 2.

COMPARISON OF OUTPATIENT MEDICAL CARE PAYMENTS
CALIFORNIA AND HAWAII, AS OF JUNE 1960

	JURISDICTION	
	California	Hawaii
Cost per visit	$8.27[a]	$3.04[b]
Cost per visit for professional services	4.29[c]	(d)
Cost per prescription for drugs	4.30	(d)
Cost per recipient	5.11	2.01[e]

Source: Financial data provided by Department of Social Services, State of Hawaii, and California State Department of Social Welfare, Statistical Summary of Medical Care Payments for Public Assistance Recipients in California (June 1960), 4pp.

[a]Excludes dental care.

[b]Includes total cost to state and counties of outpatient program.

[c]Includes physicians and other practitioners.

[d]Included in cost per visit (see footnote b).

[e]Average per month.

The welfare medical payments for California cited in Table 2 were incurred on a basic office visit fee of $4.00 per visit, which is 20 per cent less (discount for welfare medical care) than the going rate of $5.00 in that state for office visits. The California fee schedule is believed to be comparable to what might be expected in Hawaii under a free choice program. The preliminary results of a current survey indicate that the modal fee for first office visits in Hawaii is $5.00, the same as in California, so it may be assumed that a negotiated basic fee for indigents would probably approximate the $4.00 charged in California.

Thus, assuming that California's experience is roughly comparable to what might be expected in Hawaii under free choice, projections based on the number of outpatient visits recorded during the past fiscal year can be made. In the projections below, visit data for the past fiscal year are used, assuming that future visits will approximate the present number. Another crucial factor is the type and extent of services which a flat negotiated fee, per office visit would cover. No assumption can be made concerning the latter factor, so two estimated cost projections are made, as shown below:

Cost incurred during past fiscal year in which cost per visit was $3.04	$341,573.67
Projected cost assuming basic office fee of $4.00 per visit covers routine drugs and diagnostic treatments as under present system in Hawaii	$530,000.00
Projected cost assuming separate fee schedules for drugs, special treatments, surgery, etc., as in California	$810,000.00

The estimated additional annual cost over the costs of the past fiscal year is projected to be at least $200,000 if routine ancillary services and drugs are included in the basic fee and as much as $500,000 if separate fee schedules are negotiated. These costs would be attributable to the element of free choice, as they would purchase the same quantity and level of medical services as are now available. The estimates do not take into consideration other variables, such as changes in office visit fees, number of visits, or inpatient expenditures that would affect the outpatient program through the availability of funds. If fees or visits increase markedly, the estimates are obviously conservative, but they give a rough idea as to what might be expected in terms of increased program expenditures under free choice.

Hawaii's outpatient medical care program has operated at very reasonable cost, considering the range and quality of medical care available to welfare recipients. The lack of free choice of physician is a complaint voiced by welfare medical care recipients, especially in Honolulu where interns and house physicians rotate and only by coincidence is a patient treated by the same doctor on different visits. The complaint mainly comes from persons who are accustomed to their own physicians on a self-paying basis but suddenly are denied the choice of doctor upon becoming indigent. It should be noted that the welfare patient is allowed to choose any of the hospital outpatient clinics participating in the program, but it is true that, more often than not, a different physician will treat an indigent on each visit. On the other hand, there are no complaints on the quality of medical care in the welfare medical care program. In fact, some of the "oldtimers" on the welfare rolls insist on going to the Maluhia Outpatient Clinic.

In the final analysis, the question boils down to this: Free choice is fine but can we afford it, or are we willing to pay for it even if we can afford it? In an area where it is claimed that there are not enough funds to meet all of the medical needs of welfare recipients, a higher per unit cost will mean fewer services available to patients or the same services available to fewer patients, or both, unless more funds are made available. With the recent rise in inpatient hospital rates, the state is already faced with further financial need for its medical care program, even without free choice. With free choice, the increased costs might become severe.

Table 3.

TREATMENT AND COST DATA,
MEDICAL CARE PROGRAM FOR THE INDIGENT AND MEDICALLY INDIGENT
OUTPATIENT EXPENDITURES FOR THE PERIOD JULY 1, 1959 TO JUNE 30, 1960
STATE OF HAWAII
(COUNTY SUPPLEMENTAL APPROPRIATIONS EXCLUDED)

TYPE OF TREATMENT	NUMBER OF TREATMENTS AND AVERAGE COST PER TREATMENT BY COUNTIES AND STATE[a]														
	HAWAII			HONOLULU			KAUAI			MAUI			STATE TOTAL		
	Total Cost	No. of Treatments	Average Cost	Total Cost	No. of Treatments	Average Cost	Total Cost	No. of Treatments	Average Cost	Total Cost	No. of Treatments	Average Cost	Total Cost	No. of Treatments	Average Cost
Outpatient Clinic	8,607.88	3,016	2.85	135,968.66[b]	49,478[b]	2.75	3,540.41	1,507[e]	2.35	10,592.57	3,689	2.87	158,709.52	57,690	2.75
Eye, Ear, Nose Throat	4,486.30	882	5.09	7,415.02	1,748	4.24	1,831.21	102	17.95	3,634.00	422	8.61	17,366.53	3,154	5.51
Dental	9,718.00	3,494	2.78	24,225.59	18,778	1.29	3,042.00	728	4.18	6,981.55	1,559	4.48	43,967.14	24,559	1.79
Miscellaneous	7,646.17	947	8.07	15,380.17	841	18.29	5.07	1	5.07	1,414.82	141	10.03	24,446.23	1,930	12.67
Goverment Physicians'Stipends& Drug Allotments	35,508.00	10,691	3.32	29,790.00[c]	12,949[c]	2.30	13,666.25[d]	6,682[d]	2.05	18,120.00	4,765	3.80	97,084.25	35,087	2.77
TOTALS	65,966.35	19,030	3.47	212,779.44	83,794	2.54	22,084.94	9,020	2.53	40,742.94	10,576	3.85	341,573.67	122,420	2.79

[a] Cost to state only and excludes county expenditures supplementary to state expenditures.
[b] Honolulu City only.
[c] Includes $12,184 paid to government physicians in Rural Oahu at $1 per visit.
[d] Includes $2,676.25 paid to government physicians in Kauai at $1.25 per visit.
[e] Estimated.

Appendix

TAX SUPPORTED MEDICAL CARE FOR NEEDY PERSONS
GUIDING PRINCIPLES

(As furnished by Department of Social Services, State of Hawaii)

In reviewing the medical care needs in the State we believe the following to be guiding principles:

1. Medical care, other than special institutional or clinical care*, should be furnished needy persons by individuals and agencies outside the government.

2. Financing persons who do not have the resources to purchase medical insurance or pay for medical care is a public assistance function of government.

3. Eligibility of the needy recipient should be determined by the public assistance agency.

4. Medical care should be provided needy persons at the same level as is generally available to others in the State.

5. Professional and technical aspects of the program should be handled by fully qualified persons. Advisory groups should assist in determining policies, content and standards of care.

6. The traditional physician-patient relationship should not be disturbed. Eligible persons should be able to receive medical care from a family physician, dentist, clinic or hospital of their own choice.

7. Standards of medical care and eligibility should be uniform throughout the State.

8. Administration of the program should assure economy without sacrificing quality of care and without interfering with the physician-patient relationship.

9. Medical care should be provided not only to relieve suffering but to rehabilitate the patient so that he can become as self-sufficient as possible.

10. Tax-supported programs of medical care to needy persons should be coordinated with the Department of Health's community-wide activities in promoting better health and reducing and preventing illness.

11. Maximum federal funds should be secured consistent with good administration and practice.

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* For example, institutional or clinical care for mental illness, tuberculosis, Hansen's disease, venereal disease and alcoholism.

ORGANIZATION AND ADMINISTRATION

The following steps should be taken into consideration by any group deciding on how the above principles might be put into action in Hawaii:

1. Relieve counties of remaining health functions by:

   a. transforming existing county medical institutions into community hospitals and "homes" under management of citizen groups.

   b. transferring county "community health" functions to the Department of Health.

   c. allowing private practitioners to provide the services needy patients are now receiving from County Physicians.

2. Permit physicians and patients freedom of choice regardless of the patient's financial status by:

   a. revising duties of the Department of Health's Government Physicians.

   b. negotiating with the medical profession to determine what fees, if any, would be charged if the "government physicians" were no longer paid by the Department of Health for their services to needy persons. (In the City of Honolulu the physicians provide services to needy persons without charge.)

3. Secure maximum federal funds by:

   a. financing medical care payments in behalf of needy persons by appropriating the needed State funds to the Department of Social Services as "public assistance."

   b. spreading the cost as widely as possible among needy persons through a pre-payment plan which will be available to both "indigents" and "medical indigents."

4. Assure adequate medical care for all needy persons by:

   a. providing that actual cost of care will be met by "medical indigents" not covered by a pre-payment plan.

5. Safeguard the Public's Interest by:

   a. legislating a competent advisory body which will include representatives from the Departments of Health and Social Services and from professional groups.