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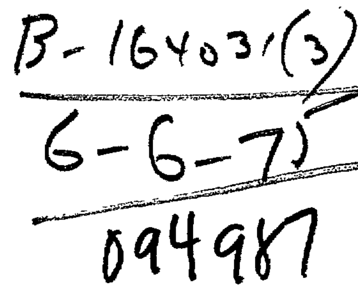

REPORT TO THE CONGRESS

Outpatient Health Care In Inner Cities: Its Users, Services, And Problems

Department of Health, Education, and Welfare

SRS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

MWD-75-81

JUNE 6, 1975

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the people who use the outpatient health care system in large cities, the services they receive, and the problems of the system. The Department of Health, Education, and Welfare is responsible for the programs discussed in this report.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

Contents

		Page
DIGEST		i
CHAPTER		
1	INTRODUCTION	1
	Administration of programs discussed in report	2
	Scope of review	2
2	USE OF OUTPATIENT CARE FACILITIES BY THE POOR	4
	Users of the outpatient care system	4
	Medicare recipients	5
	Medicaid recipients	5
	Medically indigent	7
	Concentration of the medically indigent in the inner cities	7
	Health needs of the medically indigent	9
	Reason for high use of outpatient care by low income people	12
	Conclusions	13
3	THE PROBLEMS FACING OUTPATIENT FACILITIES	14
	Funding outpatient facilities	14
	Payments to hospitals for outpatient services	15
	Payments to health centers	16
	Type of outpatient care provided	17
	Hospitals	17
	Health centers	18
	Conclusions	18
4	THE FUTURE OF OUTPATIENT CARE	19
	Lack of physicians in the inner city	19
	Increased demand because of new programs	19
	Health maintenance organizations	20
	Outpatient facility administrator's views on needed changes	21
APPENDIX		
I	Principal HEW officials responsible for administering activities discussed in this report	23

ABBREVIATIONS

CHN	Community Health Network
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HMO	health maintenance organization

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

OUTPATIENT HEALTH CARE
IN INNER CITIES:
ITS USERS, SERVICES,
AND PROBLEMS
Department of Health,
Education, and Welfare 22

D I G E S T

WHY THE REVIEW WAS MADE

GAO wanted to know what impact Medicaid and Medicare have had on cities' outpatient care systems--hospital outpatient departments and publicly financed health centers--in view of congressional emphasis on using noninstitutional health services to control costs.

Medicaid and Medicare are the two national health financing systems providing aid to millions of poor, elderly, and disabled Americans. GAO reviewed outpatient care systems in Buffalo, New York, and Cleveland, Ohio--two cities demographically representative of the Nation's large cities.

FINDINGS AND CONCLUSIONS

Outpatient care is the fastest growing service in the Nation's health care system. Between 1962 and 1973 outpatient visits increased from 71 million to 164 million.

Increasing numbers of people--particularly in the low income bracket--are seeking health services from the outpatient care system. The Federal Government has encouraged use of outpatient care as an alternative to the more expensive inpatient care and as a means of providing comprehensive care.

Many low income people who cannot afford to pay for all or part of their health care are not covered by Medicaid or Medicare. In this report these people are referred to as the medically indigent. These people and many Medicaid and Medicare eligibles seek outpatient care because of a shortage of physicians in the inner cities.

MWD-75-81

Who uses oupatient care facilities?

During 1973, 1.2 million outpatient visits (as defined on p.4.) were made to the 22 outpatient facilities--17 hospitals and 5 health centers--in Cleveland and Buffalo. People eligible for Medicaid or Medicare made about 480,000 or 40 percent of the visits. The medically indigent made about 590,000 or 48 percent of the visits.

Most outpatient visits were made because patients were unable to obtain services from private physicians. This resulted from the shortage of physicians practicing in inner city poverty areas. Using a Department of Health, Education, and Welfare (HEW) measurement technique, GAO found that poverty areas in both cities were medically underserved. (See ch. 2.)

How is the outpatient care system funded?

Outpatient facilities in Cleveland and Buffalo incurred costs of about $33.8 million during 1973. Medicaid and Medicare payments to outpatient facilities accounted for about 65 percent of direct patient reimbursements and about 28 percent of total funding.

Even though the medically indigent were primary users of outpatient care, they contributed only about 9 percent of total funds. About 43 percent of total funding came from Federal, State, and local sources, and about 15 percent came from general hospital revenues, charitable contributions, and endowments. The remaining 5 percent came from private insurance and other sources.

In 1973 the 17 Cleveland and Buffalo public and private (community nonprofit and proprietary) hospitals provided outpatient services costing $25.8 million. About $9.7 million was for services provided to the medically indigent, who paid about $3.2 million for those services.

Public hospitals relied on county revenues and Federal and State grants to cover unpaid costs; private hospitals used general hospital revenues, endowments, and charitable contributions.

The five health centers in these cities provided outpatient health care services--primarily to the

CHAPTER 1

INTRODUCTION

The outpatient delivery system--hospital outpatient departments and public health centers--provide health services to millions of Americans every year. Care provided in these facilities is the fastest growing health service in the country. Outpatient visits have increased from 71 million outpatient visits in 1962 to 164 million in 1973. Some of this increase resulted from greater use of outpatient facilities for emergencies and referrals from physicians. However, the greatest impact has come from the poor who look to outpatient facilities to obtain primary health care.

The federally supported Medicaid and Medicare programs, in operation since 1966, have been partially responsible for the rising expenditures for health care. For example:

--Federal Medicaid expenditures have increased from $1.2 billion in fiscal year 1967 to $5.8 billion in fiscal year 1974. This increase was caused in part by a rapid rise in the Medicaid rolls--from 8.6 million in 1968 to 24 million in 1974.

--Medicare expenditures more than tripled from $3.3 billion in fiscal year 1967 to $10.7 billion in fiscal year 1974. A portion of this growth resulted from increases in Medicare eligibles from 19.1 million to 23 million. Some of the increase represents greater use of medical care services per person. The major portion of the increase, however, is in the cost of medical care.

Because expenditures under these programs have risen rapidly, due in part to high cost inpatient care, the Congress has encouraged greater use of less costly ambulatory care, such as outpatient care.

Although Medicare and Medicaid recipients make many of the outpatient visits, the largest single group of people using the outpatient delivery system is the medically indigent.1/ We define the medically indigent as low income people who cannot afford to pay for all or part of their medical care

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1/Although the term medically indigent is often used interchangeably for the people who are eligible for Medicaid, in this report we will be using the term as it is defined here.

but who do not qualify for Medicare or Medicaid. Because they have low incomes, they normally have little or no health insurance. Often, because of their inability to pay or the scarcity of physicians where they live, the medically indigent are not able to obtain services from private physicians. Therefore, the medically indigent look to outpatient facilities to obtain health services. Because the medically indigent cannot pay for the entire cost of the care received from the outpatient facilities, these facilities must find other funding sources to cover the costs. Many of the facilities have difficulty obtaining such funding.

The remaining chapters of this report address these problems in greater detail as they pertain to Cleveland, Ohio, and Buffalo, New York. We reviewed the outpatient care systems in these two cities because they are demographically representative of the Nation's large cities and have large concentrations of low income people.

ADMINISTRATION OF PROGRAMS DISCUSSED IN REPORT

The Department of Health, Education, and Welfare (HEW) is the Federal agency responsible for the programs discussed in this report. HEW's Social and Rehabilitation Service administers Medicaid; the Social Security Administration of HEW administers Medicare; and HEW's Public Health Service is responsible for certain Federal programs directly relating to the outpatient care system.

The Ohio Department of Public Welfare is responsible for the Medicaid program in Cleveland and the city of Cleveland government coordinates health programs in the city. The Erie County Health Department administers the Medicaid program and the public health center in Buffalo.

SCOPE OF REVIEW

Much of the data collected during our review was obtained through the assistance of the Western New York Hospital Association, Inc., and the Comprehensive Health Planning Council of Western New York, Inc., in Buffalo and the Greater Cleveland Hospital Association and the Metropolitan Health Planning Corporation in Cleveland. We discussed the contents of this report with representatives of these organizations and they generally agreed with our observations and conclusions.

We also discussed our findings with officials at HEW headquarters, the HEW Region II office in New York, the HEW Region V office in Chicago and officials of the city

low income population--at a total cost of about $8.1 million. The centers obtained most of their funding from Federal, State, city, and county agencies and Medicaid and Medicare. (See p. 14.)

What type of care is provided?

Ability to provide comprehensive care was directly related to the ability to obtain funds from sources other than patients or patients' health financing programs. Generally, outpatient facilities not able to obtain funds (except Medicaid and Medicare) from Federal, State, and local government sources did not provide comprehensive care.

Private hospitals, in particular, did not provide such care because they lacked the necessary funds; however, public hospitals and health centers provided comprehensive care because they obtained funds (in addition to Medicaid and Medicare) from city, county, State, and Federal sources. (See p. 17.)

What is the future for outpatient care systems?

The demand for outpatient care will increase if the trend toward fewer physicians practicing in inner city poverty areas continues. Demand may also be expected to increase because of new health programs.

For example, health administrators expect the implementation of the Medicaid amendment requiring that eligible recipients under the age of 21 be given early and periodic screening, diagnosis, and treatment to increase the demand for outpatient service.

Health maintenance organizations are an attempt to offer an alternative mode of health care. Early indications are that health maintenance organizations will have difficulty providing care to the medically indigent, because these organizations face some of the same financial problems currently confronting hospitals and health centers.

To improve the health care delivery system and enable it to provide comprehensive care, health administrators in Cleveland and Buffalo believe coverage under existing programs should be broadened to include the medically indigent. (See ch. 4.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

GAO did not obtain written comments from HEW or the other agencies and organizations discussed in the report. However, GAO did discuss the report with officials of HEW, State and local Medicaid and health agencies, and the outpatient health care facilities reviewed. These officials generally agreed with the material in the report.

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report makes no recommendations requiring legislative action. A number of national health insurance proposals have been introduced in both Houses of the Congress. Most proposals include coverage of outpatient health care and, in varying degrees, provide for coverage of the medically indigent. Information provided in this report will be useful to the Congress in its deliberations on the national health insurance proposals.

of Cleveland, the Ohio Department of Public Welfare, and the Erie County Health Department.

Sources for the data collected included:

--Responses to questionnaires mailed to the 15 private hospitals, 2 public hospitals and 5 health centers which constitute the outpatient care systems in Cleveland and Buffalo.

--Followup interviews with officials at the outpatient facilities in Cleveland and Buffalo.

--Health studies and demographic data from various public and private agencies.

CHAPTER 2

USE OF OUTPATIENT CARE FACILITIES

BY THE POOR

Low income people in large cities are the principal users of outpatient health facilities. About 40 percent of outpatient visits in Cleveland and Buffalo were made by people covered by the Federal Government's two national health financing programs, Medicaid and Medicare. However, the medically indigent--who we are defining for this report as low income people not qualified for Medicaid or Medicare who are unable to pay for all or part of their health care--make the most visits to the outpatient care system.

USERS OF THE OUTPATIENT CARE SYSTEM

The outpatient care systems in Cleveland and Buffalo, for the purposes of our review, were defined as all the hospitals with outpatient departments and all the public health centers. The outpatient care systems consisted of

--15 private hospitals (community nonprofit and proprietary hospitals),

--5 public health centers, and

--2 public hospitals.

These 22 hospitals and centers can provide primary care--the type of care normally associated with the family doctor. Since we were primarily interested in people who use outpatient facilities as their primary source of health care, we excluded data relating to outpatient services (1) resulting from physicians referrals, and (2) received in emergency rooms.

It should be noted, however, that many emergency room visits are not actually for emergencies and could be handled by the outpatient department. This is especially true of visits made after normal business hours when it is difficult to obtain services from private practicing physicians and the outpatient departments are closed.

In 1973 the outpatient care systems of Cleveland and Buffalo provided services for 1.2 million visits, as shown in the following table.

Types of People Using Outpatient Care Facilities in Cleveland and Buffalo During 1973 (note a)

Type	Outpatient visits Cleveland	Buffalo	Total	Percent
Medically indigent	434,789	153,861	588,650	48
Medicaid recipients	216,593	173,946	390,539	32
Medicare recipients	61,052	33,344	94,396	8
Privately insured	23,805	36,848	60,653	5
General relief recipients (note b)	46,812	-	46,812	4
Other	2,271	30,173	32,444	3
Total	785,322	428,172	1,213,494	100

a/Data obtained from the outpatient facilities.

b/General relief recipients are people who do not qualify for Medicaid but who do receive financial assistance for medical care from a local government.

About 40 percent of the visits were made by people covered by Medicaid and Medicare; however, almost half of the visits were made by the medically indigent.

Medicare recipients

Most people aged 65 and over and persons who have been disabled for more than 2 years 1/ are eligible for Medicare. They accounted for 8 percent of the visits to the outpatient facilities during 1973. The demand for outpatient services could increase as more people become eligible for Medicare. Many Medicare beneficiaries are now receiving services from private physicians and do not have to use outpatient facilities for their primary care. However, should physicians become less available in the inner cities, Medicare recipients might turn to outpatient care facilities in increasing numbers.

Medicaid recipients

Medicaid recipients as a group are the second largest users of the outpatient care system. They made about 32 percent of the outpatient visits in Cleveland and Buffalo during 1973.

1/Medicare coverage for the disabled began on July 1, 1973.

Medicaid is a Federal-State health program which began in 1966 with the goal of providing comprehensive care to the poor. Comprehensive care includes family and individual preventive, diagnostic, therapeutic, advisory, and rehabilitation services provided by health professionals.

Initially, each State had to make available five basic services: inpatient hospital, outpatient hospital, laboratory and X-ray, skilled nursing home, and physician services. These services were to be available to the categorically needy. The categorically needy are those eligible for public assistance because they are aged, blind, permanently and totally disabled, or members of families with children deprived of parental support. These are referred to as categorical relationships.

Because of the requirement that persons must have a categorical relationship to be eligible for Medicaid, many poor people did not qualify for Medicaid. For example, single people and couples without children cannot qualify for Medicaid no matter how low their income unless they are 65 years of age or older, blind, or disabled.

People who qualify for public assistance under the Aid to Families with Dependent Children program are considered categorically needy and automatically qualify for Medicaid. The income and resource levels below which a person qualifies for the program are set by each State. The income level set by a State is called the State cash assistance standard and it varies among States. Since the State cash assistance standard also determines the allowable income level for Medicaid, the income a family can have and still qualify for Medicaid also varies among States. Ohio and New York illustrate the differences in State programs. In 1974 the federally established poverty income level for a family of four in Ohio and New York was about $4,500. However:

--In Ohio a family of four must have an income of $2,640 or less to qualify for public cash assistance and Medicaid.

--In New York that same family could earn up to $4,030 and qualify for public cash assistance and Medicaid.

Generally, aged, blind, or disabled persons who qualify for Federal cash assistance, or a mandatory State supplemental payment, under the Supplemental Security Income

program 1/ also are considered categorically needy and eligible for Medicaid.

Besides covering the categorically needy, States can elect to provide coverage to the medically needy. The medically needy are people who have a categorical relationship but have incomes higher than the State cash assistance standard. Although they are ineligible for cash assistance, they can qualify for Medicaid if their incomes are less than 133-1/3 percent of the State cash assistance standard of if their income, less their medical expenses, is lower than 133-1/3 percent of the State cash assistance standard. Ohio's Medicaid program does not cover the medically needy. However, New York is one of 32 States that provide coverage to the medically needy. Thus, a family of four with a categorical relationship could qualify for Medicaid in New York if its income is below $5,000.

Medically indigent

The group that most uses the outpatient care system is the medically indigent. They made about 48 percent of the outpatient vists in Cleveland and Buffalo during 1973.

The medically indigent

- --have health needs similar to Medicaid and Medicare recipients,
- --do not qualify for Medicaid or Medicare assistance,
- --cannot afford to pay for all or part of their health needs, and
- --often live in areas with physician shortages.

CONCENTRATION OF THE MEDICALLY INDIGENT IN THE INNER CITIES

The poverty income level is a convenient measurement to define the poor. Many poor people with incomes below this level--estimated at 9 million--are not eligible for Medicaid. In 1967 the Bureau of Labor Statistics defined three living standards--low, intermediate, and high. The Bureau

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1/ The Federal Supplemental Security Income program replaced Federal/State Old Age Assitance, Aid to the Blind, and Aid to the Permanently and Totally Disabled programs on January 1, 1974.

developed annual family budgets to coincide with each level. For instance, a family of four needs an income of almost twice the poverty level to be considered in the low standard of living group.

Families with incomes between the poverty level and twice the poverty level are apt to become medically indigent. As family income drops toward the poverty level, it becomes increasingly difficult for a family to meet all of its needs. For example, the lower level budget for a Cleveland family of four is $8,105, and provides $655, or 8 percent, of the budget for medical care.

If a family of four with an income 10 percent above the poverty level (about $4,700) spent the low standard medical budget, medical costs would represent 14 percent of their income. This would require cutting back on other basic necessities such as food, shelter, and clothing. An HEW study has shown, however, that as income goes down fewer medical services are sought. As family income drops toward the poverty level, the family is less able to afford health care and seeks less care.

We used twice the poverty income level to determine the number of low income families in Cleveland and Buffalo since it is approximately equal to the Bureau of Labor Statistics lower level budget. Using data from the 1970 census, we found that about a third of the families in each city were in the low income bracket, as shown in the following table.

	Percent	
	Cleveland	Buffalo
Families below poverty level	14	11
Families below one and one-half times the poverty level	22	22
Families below twice the poverty level	33	34

We also used the 1970 census data to determine the low income areas within each city. Most of the low income families were concentrated in 8 of Cleveland's 28 social planning areas and in Buffalo's model cities area. The following table presents the data for these low income areas.

	Percent	
	Eight Cleveland planning areas	Buffalo model cities area
Families below poverty level	26	28
Families below one and one-half times the poverty level	39	46
Families below twice the poverty level	52	60

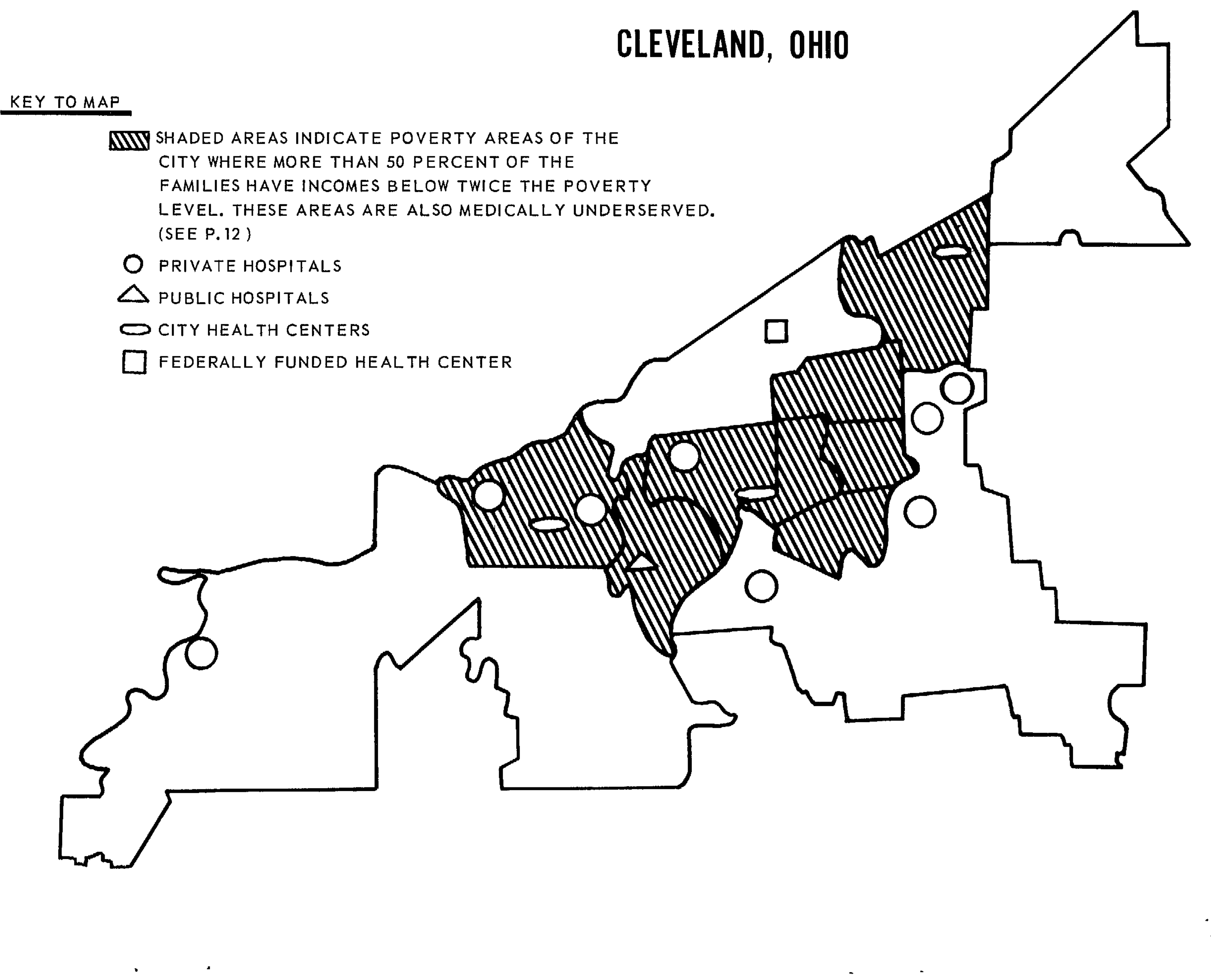
The maps on the next two pages show where these poverty areas are located in relation to outpatient facilities.

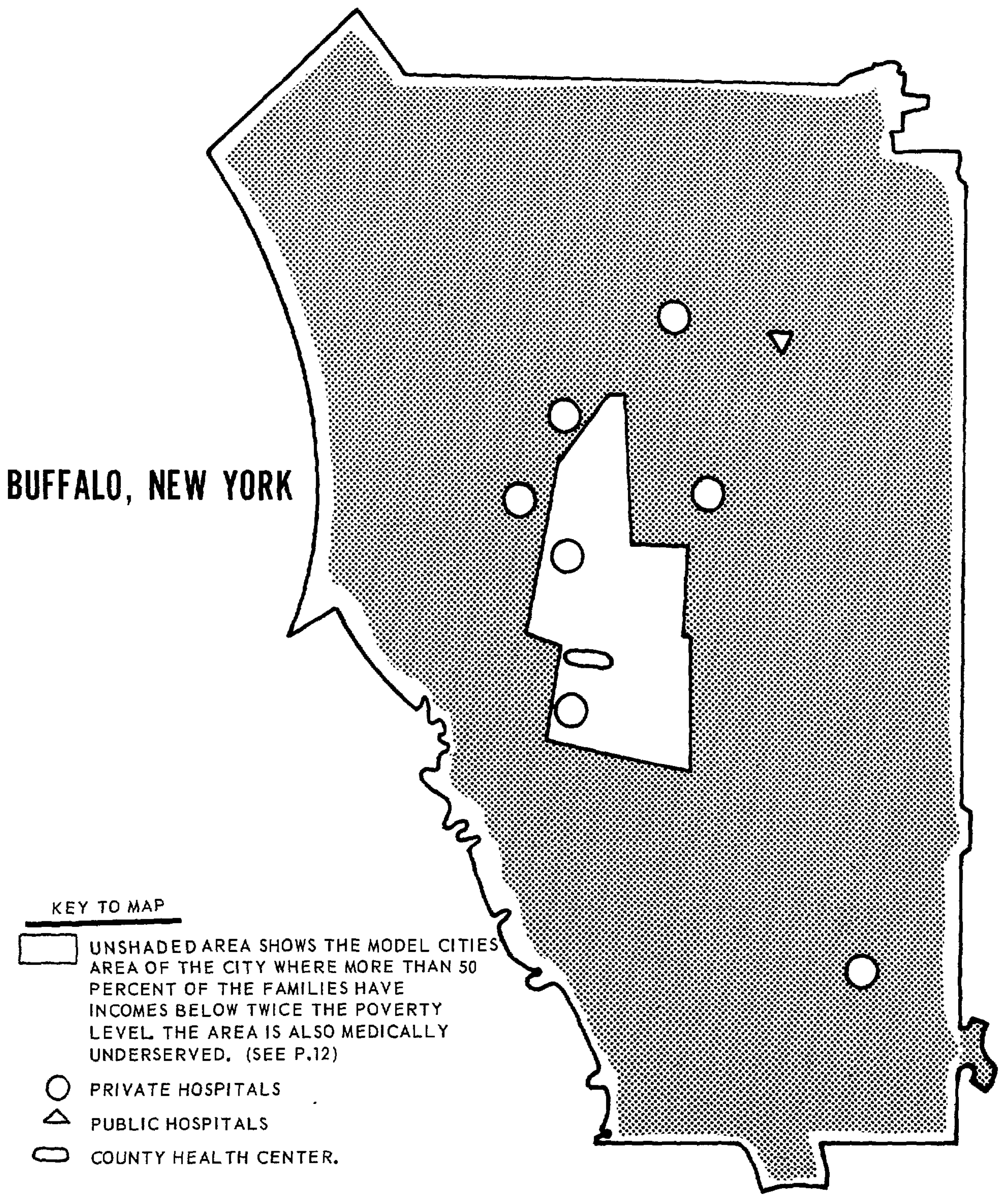
HEALTH NEEDS OF THE MEDICALLY INDIGENT

Many studies have shown an association between poverty and poor health. For example, HEW studies show that:

--Morbidity from many diseases, including tuberculosis, rheumatic fever, infectious hepatitis, poliomyelitis, diptheria, and measles, are all found to be significantly related to poverty or poverty areas.

--The poor suffer chronic, disabling illnesses in much greater proportions than the nonpoor.


CLEVELAND, OHIO
KEY TO MAP
SHADED AREAS INDICATE POVERTY AREAS OF THE CITY WHERE MORE THAN 50 PERCENT OF THE FAMILIES HAVE INCOMES BELOW TWICE THE POVERTY LEVEL. THESE AREAS ARE ALSO MEDICALLY UNDERSERVED. (SEE P. 12)
PRIVATE HOSPITALS
PUBLIC HOSPITALS
CITY HEALTH CENTERS
FEDERALLY FUNDED HEALTH CENTER


BUFFALO, NEW YORK
KEY TO MAP
UNSHADED AREA SHOWS THE MODEL CITIES AREA OF THE CITY WHERE MORE THAN 50 PERCENT OF THE FAMILIES HAVE INCOMES BELOW TWICE THE POVERTY LEVEL. THE AREA IS ALSO MEDICALLY UNDERSERVED. (SEE P.12)
PRIVATE HOSPITALS
PUBLIC HOSPITALS
COUNTY HEALTH CENTER.

A widely used indicator of health conditions within a community is its infant mortality rate. This rate has traditionally been used to classify communities or populations in terms of their overall level of health. The national infant mortality rate in 1973 was 17.6 per 1000 births, whereas it was 23.6 in Cleveland and 20.1 in Buffalo. In the eight social planning areas of Cleveland and the model cities area of Buffalo where the poor are concentrated, the rate was much higher--28.8 and 35.5, respectively.

REASON FOR HIGH USE OF OUTPATIENT CARE BY LOW INCOME PEOPLE

Most low income people, both Medicaid recipients and the medically indigent, are concentrated in inner cities where physicians are scarce. Therefore, those with low incomes turn to the outpatient facilities to obtain physician services.

Several studies in Cleveland and Buffalo show a significantly lower ratio of physicians to residents in low income versus other areas. For example, a 1967 study conducted in Cleveland to determine the availability of physicians to the poverty populations showed that there was only 1 physician per 2,222 persons in the poverty areas as compared to 1 physician per 885 persons in nonpoverty areas. Since 1967 the number of physicians providing health care to the poor of the city has decreased further. A 1972 study by the Cleveland Health Department showed that in 3 social planning areas in the poverty section of the city there was only 1 physician per 3,548 residents. The same situation also exists in Buffalo where a study showed that there was 1 physician per 3,448 residents in a poverty area. Because of the shortage of physicians in the inner city, Cleveland Medicaid recipients, whose physician bills are paid by Medicaid, made two outpatient visits for every physician visit.

HEW has developed an indicator to identify medically underserved areas. This indicator is composed of: percentage of population with income below the poverty level, percentage of population 65 and over, infant mortality rate, and physicians per 1,000 population.

Using this indicator, we determined that the eight social planning areas in Cleveland were significantly medically underserved. Using the same indicator, the Erie County Health Department determined that an area in Buffalo having a large concentration of the poor also was significantly medically underserved. This area included most of the model cities area. In both cities these medically underserved areas contain the greatest concentrations of low income people.

CONCLUSIONS

Low income people--Medicaid recipients and the medically indigent--are the primary users of the outpatient care system in Cleveland and Buffalo. This results to a large extent from the fact that there are insufficient numbers of physicians in the inner cities to serve these people and thus many of the poverty areas are medically underserved. If the trend toward fewer physicians practicing in the large cities, especially inner city poverty areas, continues, the demand for outpatient care will probably continue to rise.

CHAPTER 3

THE PROBLEMS FACING OUTPATIENT FACILITIES

Because of the large number of people going to outpatient facilities for primary care, the outpatient care systems in Cleveland and Buffalo are in a financial bind and they are hard pressed to provide comprehensive outpatient care.

FUNDING OUTPATIENT FACILITIES

Services provided during the 1.2 million visits made to Cleveland's and Buffalo's outpatient systems in 1973 cost $33.8 million.1/ These costs were reimbursed from several sources as shown in the following table.

Sources of Funds for the 22 Outpatient Facilities in Cleveland and Buffalo--for 1973 Services

Source of funds	Cleveland	Buffalo	Total	Percent
		(millions)		
Federal, State, and local funds other than Medicaid and Medicare (note a)	$11.2	$ 2.6	$13.8	41
Medicaid	4.0	3.9	7.9	23
Hospital revenues, charitable contributions and endowments	3.1	2.0	5.1	15
Medically indigent	2.1	1.1	3.2	9
Medicare (note b)	1.1	.7	1.8	5
Private insurance (note b)	.3	.7	1.0	3
General relief	.5	-	.5	2
Others	-	.5	.5	2
Total	$22.3	$11.5	$33.8	100

a/Examples are Federal Comprehensive Health Grants, Federal revenue sharing moneys, State grants, and county general revenues.

b/Coinsurance and deductibles paid by the beneficiaries are included here.

1/Cost data was obtained from the outpatient facilities accounting records and was not audited by us.

The medically indigent, who made 48 percent of the visits and are the chief beneficiaries of outpatient care, paid only a small portion--9 percent--of total outpatient costs. Grants from the Federal, State, and local governments were the primary funding source--paying for 41 percent of total outpatient costs. Medicaid and Medicare were important funding sources which paid about 28 percent of total costs and about 65 percent of the direct payments for patients treated by the outpatient facilities.

PAYMENTS TO HOSPITALS FOR OUTPATIENT SERVICES

The 17 hospitals surveyed in Cleveland and Buffalo provided outpatient services costing $25.8 million for 985,000 patient visits in 1973. As the following table shows, three-fourths of these services were given to Medicaid recipients and the medically indigent.

Cost of Outpatient Services Provided by Cleveland and Buffalo Hospitals During 1973

Recipient	Cost of outpatient services			
	Cleveland	Buffalo	Total	Percent
Medicaid	$ 4,895,000	$ 4,976,000	$ 9,871,000	38
Medically indigent	6,167,000	3,517,000	9,684,000	38
Medicare	1,608,000	790,000	2,398,000	9
Privately insured	683,000	976,000	1,659,000	6
General relief	1,224,000	0	1,224,000	5
Other	57,000	907,000	964,000	4
Total	$14,634,000	$11,166,000	$25,800,000	100

Hospitals in both cities were not totally reimbursed for services provided, according to their records. Only 56 percent of these costs were paid by the people served or by the financing programs covering them, which left about $11 million to be covered by other funds. Most of the unpaid costs were for services provided to the medically indigent and to Medicaid recipients--58 percent and 21 percent, respectively.

The two public hospitals (one in each city) covered their unpaid costs by using general county revenues. The 15 private hospitals had to rely on general hospital revenues, endowments, and charitable contributions to make up the difference between total costs and reimbursed costs. One private hospital in each city did not have sufficient funds to offset

its unpaid costs, and both showed operating losses for their outpatient clinics--$97,000 for one and $14,000 for the other.

The Medically indigent did not pay for 67 percent of the services they received. This group accounted for 58 percent of the unpaid costs the 17 hospitals had to make up from other sources.

PAYMENTS TO HEALTH CENTERS

The 5 health centers in the Cleveland and Buffalo outpatient systems spent $8.1 million in 1973 for services associated with 228,500 visits for outpatient care. With the exception of a few hundred visits by privately insured and general relief people, Medicaid recipients and the medically indigent accounted for all the visits. The medically indigent made 87 percent of the visits.

Health centers provide free care to the medically indigent by obtaining funds from a number of governmental sources. In 1973 the federally funded health center in Cleveland received $3.6 million in HEW grants. The center received an additional $352,000 from the State of Ohio for services provided to Medicaid recipients. The HEW grants and Medicaid reimbursements were used to provide services to the poor (about 90,000 visits) living in the 3 social planning areas the center served. Two-thirds of the visits were made by the medically indigent.

The three other health centers operated by the city of Cleveland provided free care to Cleveland residents. All 134,000 visits to these centers were made by the medically indigent. To pay for the services the Cleveland Health Department relied on funds from the city, State grants, and various Federal sources. The following table shows the sources and amount of funds received by the city health centers.

Funds Received by
City of Cleveland in 1973
to Support Health Centers

Source of funds	Total funds received
City	$1,507,000
Federal revenue sharing funds	1,262,000
Federal Emergency Employment Act funds	102,000
Federal grants	746,000
State grants	357,000
Total	$3,974,000

The single, county-operated health center in Buffalo began operations in April 1973 and had 4,500 visits in 1973 at a cost of $385,000. About 2,600 of these visits were made by the medically indigent. A Federal model cities grant paid for 70 percent of the center's costs. Medicaid provided 7 percent, and the remaining funds came from local government, private insurance, and self-pay moneys.

TYPE OF OUTPATIENT CARE PROVIDED

The type of care provided by outpatient facilities can be classified as comprehensive or episodic. Comprehensive outpatient care, as defined for our review, includes preventive, diagnostic, therapeutic, advisory, and rehabilitative services. Episodic outpatient care is defined as care where only the immediate health need of the patient is satisfied. These definitions were agreed upon by the hospital associations and comprehensive health planning agencies in both cities, the Medicaid agencies in both States, and us. Generally, facilities providing comprehensive care incur higher costs per person served.

Hospitals

The type of outpatient care provided by the 17 hospitals in Buffalo and Cleveland varied. The ability of individual hospitals to obtain funds to offset their unpaid outpatient costs was directly related to the type of care provided.

The two public, county funded hospitals considered the care they provided to be comprehensive. These two hospitals accounted for 335,000 outpatient visits or about a third of all hospital outpatient visits. Because of the large number of visits and because they provided comprehensive care, unpaid costs were about $4.3 million in the Cleveland hospital and $2.3 million in the Buffalo hosptial. Both hospitals used county funds to cover the unpaid costs.

Two private hospitals in Cleveland and one in Buffalo also considered their outpatient care to be comprehensive. These hospitals were able to provide comprehensive care by offsetting their deficits primarily with endowments and charitable contributions. The administrators of the other 12 hospitals (6 in each city) considered the care which they provided to be episodic. These hospitals had to rely primarily on general hospital revenues to offset their unpaid costs.

The private hospital administrators believed comprehensive care should be provided. They said, however, that additional funding sources are needed to enable their facilities to provide such care.

Health centers

All of the health centers in Buffalo and Cleveland received most of their funds from governmental sources, primarily Federal. Two of the city health centers in Cleveland are currently special purpose clinics--one pediatric and the other well child. The well-child clinic expects to expand its services in the future and become a comprehensive health center.

The two other Cleveland health centers and the center in Buffalo were designed and funded to provide comprehensive care. The three centers are funded almost exclusively with Federal, State, and local governmental moneys. This funding enables them to provide comprehensive care to the low income people in their areas.

CONCLUSIONS

Outpatient facilities in Cleveland and Buffalo providing comprehensive care were able to do so because they obtained a considerable part of their funds from sources other than the patients served or the patients' health financing programs. These additional sources were usually Federal, State, or local governments, but a few facilities received charitable contributions or endowments to cover some of the costs. Outpatient facilities which had to rely on general hospital revenues to offset unpaid costs generally provided only episodic care. Thus, many low income people were not receiving comprehensive care.

CHAPTER 4

THE FUTURE OF OUTPATIENT CARE

The demand for outpatient care will continue to rise if the trend toward fewer physicians practicing in the inner city continues. Also, new programs, such as early and periodic screening, diagnosis, and treatment of children under Medicaid, could increase the demand for outpatient care. The ability of health organizations to provide care to the medically indigent depends on their success in obtaining funds for this purpose.

LACK OF PHYSICIANS IN THE INNER CITY

As discussed in chapter 2, decreasing numbers of physicians are practicing in the large cities, especially in the inner city poverty areas. As the number of physicians declines, it becomes more difficult for people to obtain physician services from private practice doctors and they turn to outpatient facilities for primary care.

In responding to our questionnaires, 17 of the 22 outpatient facilities said that demand for outpatient care had increased because physicians had moved from the inner city to the suburbs. If physicians continue to leave the inner city, demand will continue to grow.

INCREASED DEMAND BECAUSE OF NEW PROGRAMS

Demand for outpatient care can be expected to increase because of new programs. An example of this is the early and periodic screening, diagnosis, and treatment programs for children eligible for Medicaid.

Early detection and correction of physical and mental defects are important factors in improving the health status of the poor. Recognizing this, the Congress amended the Medicaid law in 1967 to require States to provide such care. The Congress reemphasized its interest in this program by authorizing penalties on States, beginning in July 1974, which failed to (1) inform the poor about this program, (2) provide or arrange for screening services, and (3) arrange for treatment to correct conditions disclosed during the screenings.

A screening, diagnosis, and treatment program was not available to Cleveland Medicaid recipients until July 1974. The Cleveland program allows eligible recipients to take their children to any doctor, hospital, or other place where

they can be screened. Because of the shortage of physicians for the poor in Cleveland, this program might create an additional demand on outpatient facilities.

In Buffalo the Medicaid program is being redirected to meet New York State guidelines for the screening program. According to Erie County officials the revised program is expected to create additional demands on Buffalo's outpatient delivery system.

HEALTH MAINTENANCE ORGANIZATIONS

The health maintenance organization (HMO) concept--which features compensation by voluntarily enrolled subscribers for specific health services on the basis of predetermined prepaid rates--is an attempt to offer an alternative to the traditional health delivery system. HMOs provide comprehensive health services to their enrollees.

However, the ability of HMOs to provide such care to the medically indigent will depend on their success in obtaining funds from sources other than these people. Without such funds HMOs will not be able to enroll the medically indigent.

The Congress, recognizing the potential value of HMOs, passed the Health Maintenance Organization Act of 1973, to increase Federal support for HMO experiments. The act authorizes grants, loans, and loan guarantees to assist the development of existing and prospective HMOs. It also encourages HMOs to locate in medically underserved areas.

Plans are underway to establish an HMO-like organization 1/ in Cleveland and an HMO in Buffalo.

An independent nonprofit group will operate the Cleveland HMO-like organization. The project has not received financial support under the 1973 act but was initially funded in 1971 by a Community Health Network (CHN) planning grant from the Office of Economic Opportunity. In July 1973 this and other CHN grants were turned over to HEW for administration. In April 1974 the project received a $1.3 million grant from HEW to cover the period January 1974 through December 1975.

1/The Health Maintenance Organization Act of 1973 contains specific definitions of and requirements for HMOs to be assisted under the act.

The Cleveland project is organizing a prepaid health care plan to serve people from all income levels in the community. To fulfill this goal, it plans to focus its services on three groups of people. The first group will be privately insured persons. They are expected to make up 62 percent of the enrollment. The second group will be Medicaid recipients and the third, the medically indigent.

The Cleveland CHN will be able to serve Medicaid recipients only if it can negotiate a contract with the Ohio Department of Public Welfare. A pilot project has been proposed to the department that would permit up to 10,000 Medicaid recipients to enroll in the prepaid plan. The department has issued guidelines to be used in negotiating Medicaid contracts, but an agreement had not been reached as of January 1975.

The Cleveland CHN project planned to use $567,125 of its HEW grant to subsidize enrollment of the medically indigent. Initially, medically indigent enrollment is to be limited primarily to those who are employed but have low incomes. Employers of these people are expected to contribute a portion of the prepaid rates. Once the Federal grant expires (at the end of 1975), however, funds will have to be secured from other sources. State subsidies or a national health insurance program are two possibilities.

The Buffalo HMO will be operated by the Erie County Department of Health. In October 1974 the health department received a $124,000 HEW planning grant under the 1973 Health Maintenance Organization Act to develop its existing health centers into an HMO to serve people from all income levels. County officials estimate the enrollment will be 33 percent Medicaid recipients, 10 percent Medicare eligibles, 49 percent private-pay people and 8 percent medically indigent. The services to be given to the medically indigent will be paid for by the county on a fee for service basis. No agreement had been reached as of January 1975 between the State and the HMO enabling enrollment of Medicaid recipients. The State, however, has issued guidelines to allow HMOs to enroll Medicaid recipients.

OUTPATIENT FACILITY ADMINISTRATORS' VIEWS ON NEEDED CHANGES

To improve the outpatient care system and enable it to provide comprehensive care, health administrators in Cleveland and Buffalo believe a change in the funding mechanism is necessary. They also believe coverage under existing programs such as Medicaid should be broadened to include the medically indigent.

Health administrators responsible for the 22 outpatient facilities in Cleveland and Buffalo suggested the following:

--Fifteen suggested broadening the eligibility requirements for Medicaid.

--Twelve favored a national health insurance program.

--Eight suggested making the Federal Government responsible for administering the Medicaid program and making the program uniform in all States.

--Eight suggested conforming the Medicaid reimbursement procedures to the reasonable cost principles used under Medicare.

Fourteen of the administrators believe that changes should provide for reimbursement of reasonable cost and incentives to encourage comprehensive health care or improvements in the care presently provided.

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR ADMINISTERING

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION AND WELFARE:		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ASSISTANT SECRETARY FOR HEALTH:		
Dr. Theodore Cooper (acting)	Feb. 1975	Present
Dr. Charles C. Edwards	Apr. 1973	Jan. 1975
Dr. Merlin K. DuVal	July 1971	Dec. 1972
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
James S. Dwight, Jr.	June 1973	Present
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, SOCIAL SECURITY ADMINISTRATION:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973

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