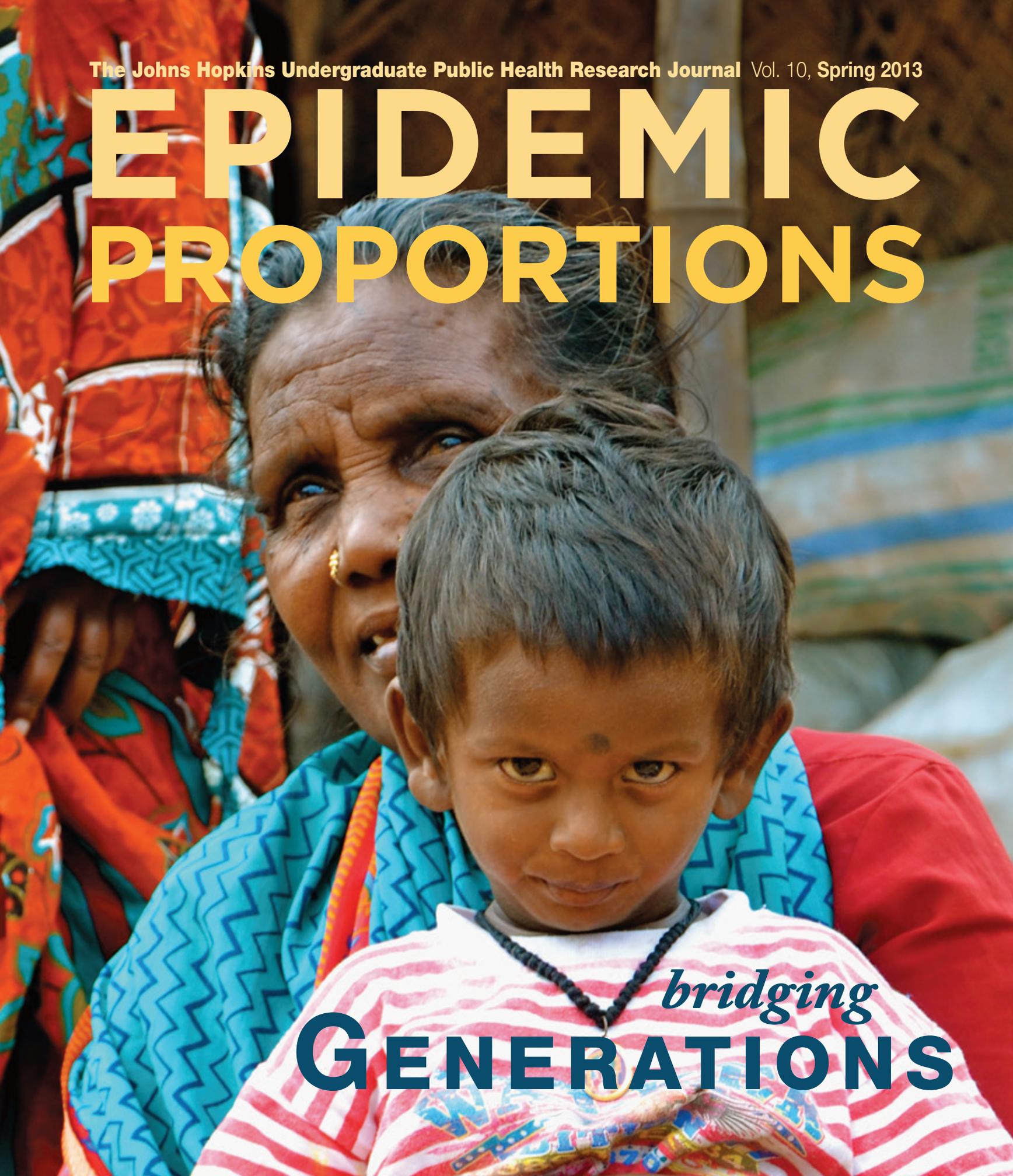


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EPIDEMIC PROPORTIONS



bridging
GENERATIONS

Public Health and Primary Care: Maryland's Track Record of Innovation

Former Baltimore City Health Commissioner Dr. Peter Beilenson recently stepped down from his post as Howard County health officer to lead a new non-profit health insurance co-op, Evergreen Health Cooperative. Evergreen—which has received a federal loan of \$65 million to help it get established—will employ a range of salaried health care professionals to provide seamless preventive and primary care under the Patient Protection and Affordable Care Act (PPACA, popularly known as Obamacare).¹

Evergreen will operate through the Maryland Health Connection, a marketplace due to begin operations in January 2014 that will allow individuals and small businesses to compare insurance benefits, rates, and health care quality.² So far, the state of Maryland has been handed \$157 million in federal dollars to set up the marketplace, putting it alongside California, Connecticut, Hawaii, Iowa, Nevada, New York, and Vermont at the forefront of this type of innovative health care service in the U.S.³

Maryland's politicians have been quick to hail the state's progress so far. Congressman Elijah Cummings remarked that Maryland was one of the first states to implement a health care exchange. He said, "[Maryland would] continue to lead the way in improving health care access for all." Senator Barbara Mikulski said, "Maryland is an innovation state, and I am committed to ensuring we are at the forefront of putting health care into

action."⁴

Amidst all the cheerleading, it is worth remembering that this is not the first time that Maryland has led from the front in an attempt to address unequal access to primary health care. Two decades before the introduction of Medicare and

or procedure was paid for according to a set schedule).⁵

Clarifying 'medically indigent' was essential in determining who got health care and who did not. Maryland adopted the American Medical Association's (AMA) definition that 'a person who is

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Medicaid, the Maryland State Department of Health became one of the first in the U.S. to provide free medical care to those who could not afford to pay.

A State Committee on Medical Care was created at the instigation of the Medical and Chirurgical Faculty of Maryland. The Committee's report showed that Maryland's rural counties were massively underserved, and in response, a medical care program was enacted in 1945. It placed responsibility for the care of indigent and 'medically indigent' persons in the counties on the state Department of Health, which paid family physicians, hospitals and dentists on a fee-for-service basis (each test, exam

unable to meet the costs of medical, dental and other specified physical care without spending money which otherwise would go toward basic living necessities' can be considered medically indigent.⁶ The county health officer had the final say in whether an individual met this criteria. In a move that resonates with the sliding scale of premium credits under the PPACA, the designation of 'medically indigent' was primarily determined through total earnings by family size.⁷

Similar to present day circumstances, Baltimore at the time had extensive tracts of impoverished individuals, predominantly concentrated in the east and west of the city. Public finances simply

could not sustain a scheme in Baltimore that applied the state's definition of medical indigence. Consequently, only welfare recipients qualified for Baltimore's

program were medical care clinics in six hospitals at Johns Hopkins, University of Maryland, South Baltimore General (now Harbor Hospital), Sinai, Provident,

office care. Physicians were paid on a per capita basis at a rate of \$7 per patient per year regardless of whether the doctor saw a patient ten times or just once. When consultation by specialists was required, general practitioners were encouraged to refer patients to the clinic. In turn, the clinic would send patients to specialized hospital outpatient services.

The fanfare that occurred in the 1940s is comparable to what is now being given to the PPACA (Patient Protection and Affordable Care Act, popularly known as Obamacare) in Maryland.

The BMCP annual budget rose year-on-year. The initial state appropriation in 1948 was just under \$0.5 million. In 1965, this had ballooned to \$3.25 million. Pharmaceutical costs outstripped all other expenses. More than half a million prescriptions were issued in 1965, costing an average \$1.30 per month per patient. The next largest expense, clinic visits, added up to just \$1.11 per month.⁹

Medical Care Program (BMCP), which was administered by the Baltimore City Health Department. Almost 27,000 people entered the program when it began in June 1948.⁸

and Mercy. The clinics were intended to provide every eligible person with a thorough initial physical examination and laboratory work-up. The results were reported to the patient's chosen family physician that then provided home and

The state and city programs survived through a series of rising costs involving millions of dollars in state appropriations until the introduction of Medicare and

The centers of the Baltimore



Dr. Edwin Crosby, Director Johns Hopkins Hospital; TJS Waxter, Director of Welfare, Baltimore City; Herbert Fallin, Baltimore City Budget Director; Mayor Thomas D'Alessandro; Huntingdon Williams, Baltimore City Health Commissioner; Dr. J. Wilfred Davis, Director Baltimore City Health Department Medical Care Section; Dr. Harry Chant, Medical Director of Johns Hopkins Hospital Medical Care Clinic; Dr. H Boyd Wylie, Dean of the University of Maryland Medical School . *Photo courtesy of Baltimore City Health Department Annual Report 1948:35.*

Medicaid in July 1966. By this point, more than 82,000 clients—about 8 percent of the city's inhabitants—were registered. Over 110,000 diagnostic tests, 35,000 clinical examinations, and almost 20,000 laboratory tests were being carried out annually.

Although, by the 1940s, many localities were already involved in the provision of health care services (for example, for tuberculosis, venereal disease, mental health, and maternal and child health), these sorts of programs were still seen as significant developments in post-war public health. On the one hand, they cemented the view that state and local

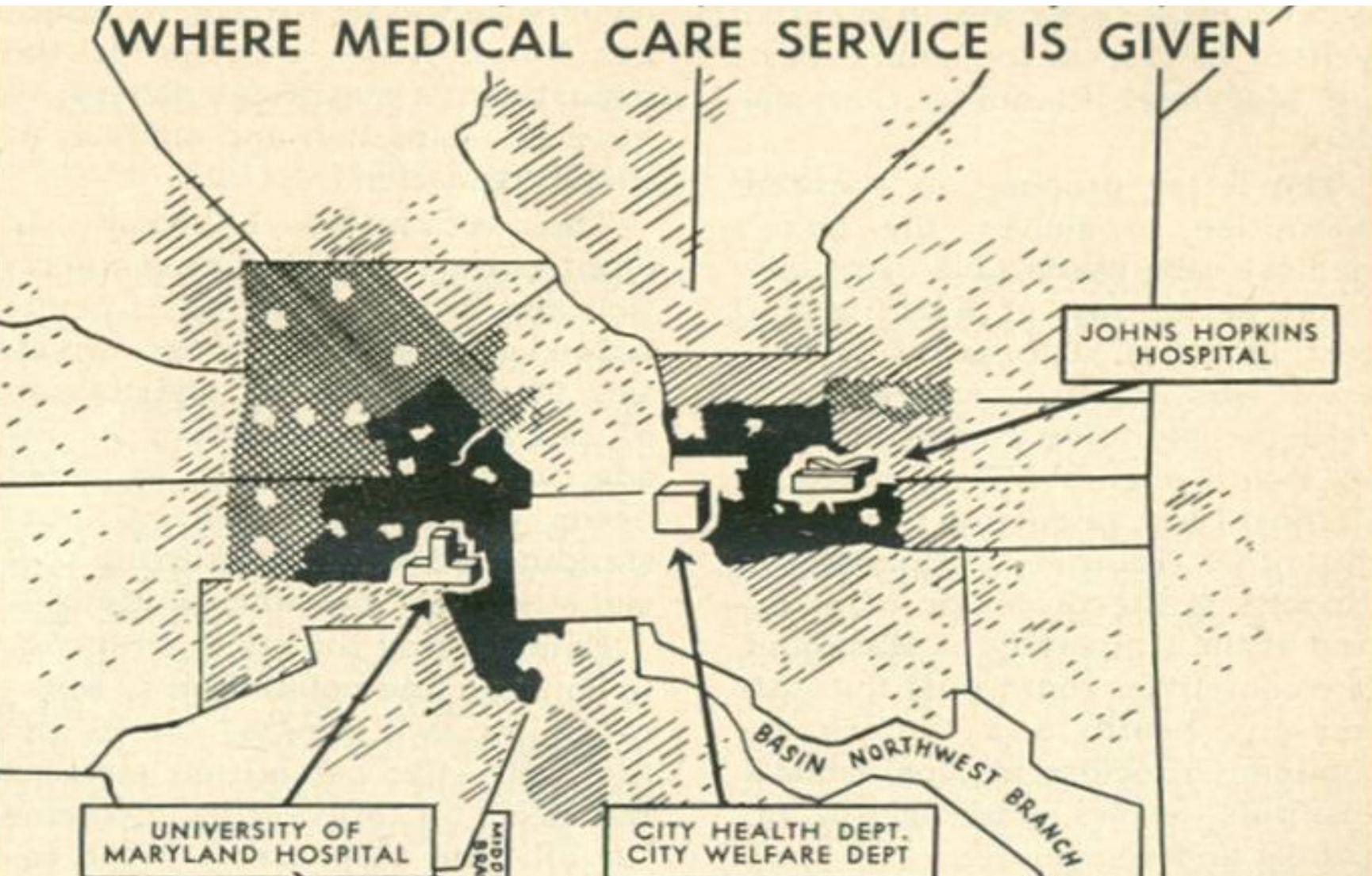
public health departments should provide a basic level of service for society's poorest communities. Yet by screening people even when they were apparently well, publicly funded medical care was encroaching on private medicine.

The fanfare that occurred in the 1940s is comparable to what is now being given to the PPACA in Maryland. The American Journal of Public Health hailed the state program as a first in the U.S., which was significant at a time when the goal of "public health [was to] fulfill its destiny of meeting the total challenge of the people's health."¹⁰ A vote by the Baltimore City Medical Society in 1947 overwhelmingly

approved the city's proposals.¹¹

This enthusiasm should not mask the fact that a number of salutary lessons can be learned from some of the programs' insurmountable problems. The first was the programs' vulnerability to the vagaries of economic cycles, industrial decline in the city, the increasing costs of medical care itself, and the politics of public finance. The state legislature cut funding on more than one occasion, emergency cutbacks in services were made, and waiting lists had to be temporarily introduced.¹²

In addition, the program in Baltimore never seriously addressed the unequal



University of Maryland and Johns Hopkins Hospitals and the distribution of welfare clients in Baltimore. *Photo courtesy of Rivin AA. A new plan in Baltimore for indigent medical care. Hospitals 1948; 22:39.*

provision for African-Americans. It should be remembered that at that time white family physicians did not treat black patients.¹³ In post-World War II Baltimore, there were 701 white people for every white physician; the corresponding number for African-Americans was almost four times as high at 2,675 people per physician.¹⁴ In 1951, African-Americans constituted 24 percent of Baltimore's population, but made up 74 percent of the 26,000 welfare clients in the city and there were only 80 black family physicians.

The problem was compounded for the BCMP by the spatial concentration of poverty in the city, which made it difficult to locate private physicians willing to participate in the program. In the first months of the program, a family physician could not be found for at least 2,000 blacks who lived close to Johns Hopkins Hospital.¹⁵ Even up until the 1960s, the BCMP workload for some black physicians was staggering: 30 percent of BMCP's 44,316 clients were registered with just 11 black physicians. Under such circumstances, it was extremely difficult to maintain anything close to a professionally high standard of health care for these black patients on the welfare rolls who disproportionately suffered compared to whites. The BMCP program never resolved this issue; the introduction of Medicare and Medicaid saved it from ever having to.

Seamless patient care never quite materialized in the BMCP. Clinics complained about the great variations in care provided by family physicians; family physicians grumbled about the failures of clinics in communicating the results of exams and consultations. In the mid-1950s, the *Baltimore Sun* reported that 'the vast majority' of participating practitioners were practically inactive in the clinics.¹⁶ Not surprisingly, the continuity of care is one of the focal points of the new health co-op initiatives.

The physicians' reluctance was partly due to the capitated payments. Many doctors thought the payment of \$7 per patient was too low and that the system represented a "trend towards socialism." When the BMCP shifted to a fee-for-service in 1962, thus bringing it into line with the payment system of the state's program, the number of participating physicians in Baltimore jumped from 285 to 510 in 1965. As history has shown, sufficient financial compensation for health care professionals is absolutely critical if standards of care are to be maintained.

Finally, it should be noted that these programs were not set up simply as an altruistic response to the health care needs of impoverished populations. By not participating in the program, private physicians were given a convenient and painless way of removing poor patients from their lists or at least recovering some of the costs these patients incurred.

Furthermore, it was explicitly recognized that these programs were "steps away from rather than toward socialized medicine" as maintained by Dr. Dean Roberts, the deputy state director of health in 1950. Roberts predicted that programs of the type adopted in Maryland would help stave off federal action in the medical field. When he spoke of indigent patients he said, "If we can meet their needs... that will take the pressure off for a sweeping federalized program."¹⁷

Roberts continues to be proven correct. The PPACA is social health insurance and will take millions of Americans off the 'uninsured' list; but it is a far cry from a socialized health care system. Evidence suggests that racial and ethnic minorities continue to receive lower quality care compared to non-minorities even when income and insurance status are controlled.¹⁶ Moving forward, the public health sector needs to be persistent in resolving the clear disparities between the health care received by different races and ethnicities.

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