THE CHALLENGE OF PROVIDING HEALTH CARE FOR THE POOR: PUBLIC HOSPITAL PERSPECTIVE

Asa G. Yancey, Sr., MD
Atlanta, Georgia

The impending, or allegedly existing, "doctor glut" in America does not apply to health care for the poor. Hospitals that have as their primary purpose the treatment of no- and low-income people have large medical staffs and house staffs, but most would benefit from the services of additional physicians, especially to decrease the time factor in making medical decisions and in treating patients.

In a recent survey of the Surgical Emergency Clinic at Grady Memorial Hospital, 15 physicians and six physician assistants cared for about 600 patients in a 48-hour period. On an average, each physician was responsible for or treated approximately 20 surgical patients each day during his or her tour of duty. Peak loads occur during the 24-hour period, which accentuate the waiting time during the busiest period of the day.

From Grady Memorial Hospital and Emory University School of Medicine, Atlanta, Georgia. Presented at the National Conference on Health Care for the Poor, Meharry Medical College, Nashville, Tennessee, October 7-8, 1985. Requests for reprints should be addressed to Dr. Asa G. Yancey, Sr, 2845 Engle Road NW, Atlanta, GA 30318.

GRADY MEMORIAL HOSPITAL

Grady Memorial Hospital, Atlanta, Georgia, is a 918-bed (plus 116 bassinets) public teaching hospital, owned by The Fulton-DeKalb Hospital Authority. It was established in 1892 for the purpose of providing medical care to individuals who were unable to pay for their treatment. This continues to be Grady Hospital's primary goal. I frequently state that one cannot dump a patient on Grady Hospital, because our reason for being is to provide therapy for the unfortunate. Of course, a patient may be untimely, insensitively or even with poor judgment transferred from another hospital to Grady Hospital, for example, without controlling obvious secondary shock. This may be regarded as being dumped upon. Nevertheless, Grady Hospital welcomes the patient who is inadequately funded.

Approximately 46,412 patients are admitted[1] to Grady each year, and there are about 813,461 patient visits in approximately 200 outpatient clinic sites each year. Atlanta has a percentage of poor people that is among the highest for large cities in the nation. There are about 965,000 people living below the poverty level in the State of Georgia. Only about 50 percent (450,000) of these persons, living below the poverty level, have Medicaid. Fifty-five percent of this number are black, though the percentage of black people in Georgia is 26 percent. Georgia increased its benefits to Medicaid recipients in 1985, and will recognize low income and pregnancy as factors for inclusion.

The total number of transfers from other hospitals to Grady Hospital for the first seven months of the calendar year 1985 (January 1985 through July 1985, inclusive) was 312. This was about the same number of transfers for a similar period in 1984. The relatively small number of transfers from other hospitals to Grady Hospital may be, in part, accounted for in that Grady operates a fleet of 20 ambulances, and indigent patients are often brought to Grady initially rather than being transported elsewhere. We do not have records at this time on the number of outpatients that are sent or transferred to Grady Hospital.

Grady Hospital is the only public hospital in metropolitan Atlanta that is dedicated to the therapy of

poor patients. Several counties in Georgia have no public hospital or ongoing financial arrangements for the health care of their county poor, and doubtless some of these persons come to Grady with a relative or friend claiming residence. These counties should be required to pay promptly for the health care costs of their constituents.

EMORY UNIVERSITY SCHOOL OF MEDICINE

The Emory University School of Medicine Graduate Medical Education Program had 737 residents and fellows for the 1985-1986 academic year, and most of the patient care was performed by these house officers. There were about 479 active staff and 485 visiting staff members at Grady from the Emory University faculty for 1985. The supervision of all house officers has been the duty and responsibility of Emory University for well over 50 years, and continues to be.

The Morehouse School of Medicine became an official partner at Grady Hospital on July 1, 1984. Morehouse School of Medicine faculty are members of the active medical staff at Grady and are expected to participate increasingly in the supervision of residents. At present, there are 10 to 12 Morehouse faculty members on the active Grady medical staff, with Morehouse continuing to seek and appoint clinical faculty.

Of the total residents and fellows, approximately 56 (7.6 percent) were of the black minority for the academic year 1985 to 1986. The maximum percentage of black minority residents in the Emory-Grady Graduate Medical Education Program was 11.0 percent during the academic year 1980 to 1981, with approximately 69 of 622 house officers. The Association of American Medical Colleges recommended that Afro-American students should constitute 12 percent (to approximate the Afro-American percentage of the national population) of the medical students in the nation's 127 schools of medicine. This percentage has never been reached, but the percentage of black minority residents at Emory-Grady has been higher than the student percentage in the nation's medical schools for over eight years, which is a laudable situation. Afro-Americans represent 26 percent of the population of the State of Georgia; thus, the accomplishments have been impressive, but there are goals yet to be attained.

PROGRAMS AT GRADY MEMORIAL HOSPITAL

The Grady Sickle Cell Center treats patients with this chronic illness and its many complications. The State of Georgia funds the Grady Sickle Cell Center, which treated 1,755 adults and children during the three-month period of April through June 1985. The care for this special segment of low-income people of our community adds to their comfort and well-being and reduces the frequency of inpatient hospital therapy. This permits them to have more time at home with relatives and friends.

Grady Hospital, by virtue of being a large, public, teaching institution, has many services that a small hospital would have difficulty in maintaining. There are five specialized emergency clinics (medicine, surgery, gynecology-obstetrics, pediatrics, and psychiatry); multiple, specialized intensive care units; disaster-preparedness units, with as many as 335 residents present during the day and significantly large numbers at night; high-risk premature infant intensive care unit; high-risk maternity care unit; nephrology intensive care unit; burn center; 24-hour emergency psychiatric clinic; rehabilitation medicine ward; trauma teams; Sickle Cell Disease Center; and State Poison Control Center.

The Gynecology and Obstetrics Service reported a total of 6,585 hospital deliveries during the calendar year 1984. Of these, 1,527 (23.2 percent) were by cesarean section.[2] There was a perinatal mortality rate of 21.9/1,000 births, and a maternal mortality rate of 75.9/100,000 total births; these statistics are the lowest in the history of the institution. Of the 6,585 deliveries, 496 were to mothers 11 through 16 years of age, and 1,589 were of mothers 17 through 19 years of age, for a total of 2,048 mothers 11 through 19 years of age.

The neonatal high-risk intensive care unit has one of the best records for the care of high-risk neonates in the Southeast. There has been an increasing survival rate over the past 10 years from 18.6 to 47.7 percent in the newborn whose birthweight is less than 1,000 g. There were 291 admissions to the neonatal high-risk intensive care unit in the calendar year 1984, and 2,137 infants were admitted to the special care nurseries of the hospital (Office of A. W. Brann, Jr., September 3, 1984, unpublished data).

Funds are being sought for an outpatient clinic for AIDS.

Fulton and DeKalb Counties (from taxes on property within the two counties) paid into the Grady Memorial Hospital budget, for the calendar year 1984, $51,084,750. Total expenses were $131,620,450. Patient eligibility allowance was $30,869,250 for 1984, which means that patients were allowed $30.8

million off of their hospital charges if they were unable to pay.

For the year 1983, 22.0 percent of Grady Hospital patients had Medicaid, 20.0 percent had Medicare and 17.4 percent had private or other hospitalization, but 37.4 percent had *no* third-party coverage whatsoever. If the uninsured group had had Medicaid, hospital revenues would have been significantly increased, allowing for the purchase of more sophisticated diagnostic and therapeutic equipment and increased physician and nurse staff positions.

Public teaching hospitals throughout the nation should have the best and latest equipment in order to provide high-quality care for the poor and the best instruction for young doctors and nurses. Accordingly, funding should be from federal, state, and local origins. The counties and State of Georgia would be aided by an expansion of Medicaid in which each state dollar brings in two federal dollars for health care for the poor. Many hard working, well-motivated, low-income persons, such as maids, barbers, beauty parlor workers, small shop owners, and minimum wage earners, should pay a small amount—based on a reasonable schedule or scale—into Medicaid. This maintains their human dignity and thus provides them with a third-party pay source for their health care needs.

This large group of approximately 25 million indigent people should be accorded health insurance. Counties in Georgia without a public hospital for the poor would better serve their constituents, by placing a much larger number, or preferably all, of these low-income people on Medicaid. These low-income individuals have inadequate means of paying for their health care and often delay seeking aid until they are seriously ill. These severely ill persons constitute a significant factor in causing disproportionate complications among patients in public hospitals. The higher mortality rate among black people because of uncontrolled cancer is likely the result of delays in seeking medical assistance.

Grady Hospital maintains a financial eligibility scale of charges for services rendered. This schedule of charges varies with income and number of persons in the family. Patients with a "G" card pay nothing for inpatient or outpatient care. An individual with an "A" card would pay a $5.00/day maximum-inpatient charge and $2.00 to $4.00/day for outpatient or emergency clinic visit.

Poor people are more likely to live in houses with faulty electrical wiring and use heating methods that are conducive to fire. The Grady Hospital Burn Center provides this special care to not only residents of Fulton and DeKalb Counties, but to burn victims from other counties as well. Most of these counties do not have a burn unit, but poor persons of have-not counties must, and do have their burn therapy supported by individuals of other regions. Medicaid, or a similar third-party pay source for low-income people, could aid in the funding of this burn center that admits approximately 300 patients per year.

Friends, relatives, and patients grow impatient waiting in emergency clinics. The average time spent for examination and treatment in the Surgical Emergency Clinic was 3.69 hours in 1972. More staff is currently available, and the great majority of cases are cared for from beginning to completion of care within two to six hours. There are many delays beyond six hours, but some patients are served in less than two hours. Two trauma teams alternate days at Grady Hospital and for the severely injured (gunshot wound or automobile accident), the rapidity and effectiveness of response are highly satisfactory. These trauma surgeons are constantly present within the hospital. Many patients and relatives do not fully appreciate the battery of x-rays, electrocardiograms, and blood chemistries that patients receive within the space of a few hours, which would require one to three days in some private and other settings.

Malpractice-asserted claims and lawsuits have increased in recent years. They are at a crisis state throughout the nation and are a serious matter for public teaching hospitals. Low-income and illiterate people are well informed as to how to secure compensation when medical therapy goes awry, or is perceived as having gone awry. They are becoming more adept at filing claims for small mishaps in order to collect relatively small sums, realizing hospitals often will pay rather than assume the possibility of higher expense and of time-consuming trials.

Federal and state legislation are needed to control contingency fees, exhorbitant awards for pain, suffering, and loss of consortium. There is a need to place a higher percentage of the appropriate malpractice award in the hands of the injured and devise a means of reducing the expense for litigation through settlement and reform of tort laws. Individual physician insurance premiums are out of control. Patients entering a hospital may very well, in the future, be required to register for misadventure insurance.

Physicians and nurses must exert ever-stronger efforts to document the practice of logical, high-quality medicine. The standards of care in medicine are not always clearly defined (eg, restraint of patients on stretchers and in wheelchairs) and need to be more clearly defined.

All persons, inclusive of the poor, should be compensated when unjustly injured; however, means must be found to prevent the destruction of public teaching hospitals, other health institutions, and private physicians because of disastrously high professional liability awards and high insurance premiums. How would poor people, without a third-party pay source, secure therapy for their illnesses and injuries without the public teaching hospitals? Disabling illness and death without available high-quality health care simply must not be tolerated in our nation.

The Diabetic Day Care Program at Grady Hospital has been an effective cost-containment program and therapeutic and education resource for poor and funded diabetic patients in the prevention of ketoacidosis, lower extremity amputation, and end-stage renal disease. Approximately 11,000 patients[3] have been treated in this clinic from 1971 through 1982. Through greatly improved therapy and education of diabetic patients, there has been a reduction in amputations from 13.3/1,000 patients to 6.72 amputations per 1,000 patients, and a reduction in ketoacidosis from 41.2 episodes per 1,000 patients to 20.6 episodes per 1,000 patients. These improvements occurred in the late 1970s.

The association of this public teaching hospital with the Emory University Graduate Medical Education Program provides excellence of medical care using methods that are in the vanguard of medical knowledge. The public recognizes the know-how of the young house officers, and many not-so-poor patients elect to choose public hospitals.

The Poison Control Center at Grady assists the poor, the wealthy, the uneducated, and the physicians of Georgia. Persons in most states of the nation, and beyond, frequently seek the services of this Poison Control Center. In 1984, the Poison Control Center responded to 5,964 professional calls and 33,265 nonprofessional calls, totaling 39,229 inquires regarding toxic exposures. These calls were from 42 states, Puerto Rico, Saudi Arabia, Canada, and the Virgin Islands. Follow-up calls produced a total of 91,430 inquires, of which 42,559 were from the 159 counties of the State of Georgia.

The Emory-Grady Family Planning Program served 23,008 patient visits during the year, July 1, 1984 to June 30, 1985. Ages of patients involved ranged from 9 years to patients in their 50s, with the maximum number of patient visits occurring between the ages of 15 to 34 years.

There is a fundamental and cogent need to have skilled nursing homes to admit patients promptly that require extra care, such as those with tracheotomies and colostomies and obese patients or patients with decubitus ulcers who are not candidates for reconstructive surgery. Many nursing homes with an empty bed will pick and choose easy-to-care-for patients and refuse to accept difficult cases. This is especially the situation with the poor, because only the fixed rates of a third-party source are available. Legislation may have to be used to remedy this situation, if education does not suffice. There is a negative impact on public hospitals as social workers labor to find beds to provide hospital space for new patients in need of acute hospital care.

Grady Memorial Hospital has an audiovisual department for patient education in health care. This department develops printed discharge instructions, teaching booklets, slides, and numerous videotapes, which are projected on closed-circuit television for patient education purposes.

Education to minimize the occurrence of obesity, and drug, alcohol, and tobacco abuse, and purposeful and accidental trauma would add to the quality and longevity of life. The high homicide statistics across the nation, notably in our major cities, are not reflective of the much larger numbers of efforts by one human being to take another's life. Intentional trauma is a significant factor in reduced longevity in the black man. So many people have not yet learned to walk away—in dignity—as a disagreement degenerates into a quarrel. A poised leavetaking is an effective way to reduce intentional trauma. Homicide rates do not reflect the true attack rate with the intention to maim or kill, for surgical trauma teams conserve the lives of approximately 80 percent of those attacked. Public teaching hospitals are exceedingly effective in the promptness of response and procedural care of patients severely traumatized by guns, knives, or blunt instruments.

A courteous, empathetic, sensitive approach is essential for the health care of poor people and for individuals at all levels of education and income. Patients in public hospitals are there primarily for diagnosis and treatment, with the

education of medical students and residents serving in a supportive role. The best medical education accompanies excellent patient care, be it in internal medicine or procedural techniques; and all medications and procedures must be foremost for the benefit of the patient—and not primarily for the learning and education of a health care person. Patients must be admitted on need for care, not for the interest of the admitting house officer. Health care providers are reminded at intervals that rich and poor, educated and illiterate people react similarly to excellent, considerate health services. Practice does not make for perfection in medicine; only excellent practice permits a close approximation to perfection.

Poor people know of the presence and accessibility of the public teaching hospital in their community, yet they report to the hosiptal later than the higher income, private hospital individuals for care of conditions such as breast cancer and carcinoma of the cervix. Six times[4,5] more Grady breast cancer patients present with distant spread of the cancer than in other metropolitan Atlanta, Fulton, and DeKalb Counties hospitals. The reasons for delay are complex: less personal attention; frequently a different physician on each visit; long waiting periods for service; difficulty in travel to and from the hospital; less education regarding the value of prevention and early treatment of disease; realization that there will be some expense associated with a visit to the hospital, which may diminish significantly patients' hand-to-mouth monetary existences; fear of being told of the presence of a devastating disease; a false human hope that all will be well tomorrow; and factors of motivation within human beings that are unknown at this time.

SUMMARY

Listed below are suggested solutions to the needs of public teaching hospitals to meet the challenge of providing high-quality care to the poor.

1. Medicaid or some similar third-party pay source should be expanded to provide hospitalization insurance based on family and individual income. Approximately 25 million people without hospitalization and health insurance, but with some income, should pay a reduced fee. (Persons with no income or monetary source would continue to be provided for at no cost.) Thus, the income to public hospitals would be enhanced so that they could provide additional physicians, nurses, and improved diagnostic and therapeutic equipment.

2. Medicare, Medicaid, and diagnosis-related groups should continue to compensate public hospitals for the higher costs associated with poor persons with multisystem illnesses, graduate medical education, and patients with severe trauma.

3. Urge and, if necessary, require nursing homes to accept patients that need extra care, such as those with colostomies, tracheostomies, and obese patients and those with inoperable decubitus ulcers that preclude plastic and reconstructive surgery.

4. Reduce waiting times and provide more privacy.

5. Further and improve attention to factors of empathy, courtesy, and sensitivity to the needs of low-income people.

6. Augment health education.

7. State and federal governments should be urged to adopt measures to control the medical liability crisis due to the numerous malpractice claims and lawsuits with exhorbitant awards.

8. Increase the number of black and other minority physicians and others who will serve the poor.

9. Educate patients about the tests, x-rays, and electrocardiograms they might need, which may take several hours. The therapy provided by medical school-associated hospitals is in the vanguard of medical knowledge.

The impending, or allegedly existing, "doctor glut" in America does not apply to health care for the poor.

Acknowledgment

Many administrators at Grady Memorial Hospital provided data for this article. Sincere appreciation is expressed to the many administrators at Grady Memorial Hospital who were most helpful in accumulating these data.

Literature Cited

1. Thirty-ninth Annual Report—1984. Grady Memorial Hospital, Atlanta, Ga.

2. 1984 Annual Report. The Obstetric Service and Perinatal Pathology Service, Grady Memorial Hospital. Prepared by the Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta.

3. Davidson JK. The Grady Memorial Hospital Diabetes Unit Ambulatory Care Program. Proceedings of the Second European Symposium of the Diabetes Education Study Group, Geneva, June 3-6, 1982, and selected topics held at workshops of the DESG. Excerpta Medica, 1983.

4. Knutsen P, Petrek JA. Early and late detection of cancer in Metropolitan Atlanta. J Med Assoc Ga; 1981; 70:753-755.

5. Murray W. A Retrospective Study of Squamous Cell Carcinoma of Cervix Uteri. Presented at Gynecology-Obstetrics Residents' Research Day Program, Grady Memorial Hospital, Atlanta, 1978.