The future of the limited purchase-of-service program that the Philadelphia Department of Public Health launched in 1958 may depend on the development and administration of standards mutually acceptable to the purchaser and the supplier.

Contract Care for Indigent Mothers in Philadelphia

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IN Philadelphia, an indigent expectant mother may deliver her baby free of charge, by courtesy of the city's maternity contract hospitalization program. Now in its second year, this program has reaped immediate practical and political advantages. Whether this limited purchase-of-service program will be expanded to a long-range program of tax-supported hospital and medical care for the needy is likely to depend upon the development and refinement of relevant standards of medical care and the comparative costs of the contract and a municipal program for the medically indigent one-fifth of the city's population.

Over the years the interests of various professional and lay groups foreshadowed a tax-supported and privately administered method of caring for medically needy citizens. The Community Policy Committee on Health and Hospital Services, the Duane committee, a group of 20 citizens appointed by the mayor from government, hospitals, medical schools, the nursing and medical professions, minority groups, industry, and organized labor, concluded in April 1959 that the care of the medically needy, formerly supported by private charity in voluntary hospitals and clinics, had become a "proper public responsibility." Underscoring this policy, the Community Chest announced in April 1959 that starting in 1961 the chest would no longer pay some 18 voluntary hospitals their annual grant of $1,300,000 for "charity" cases, because donations from private sources were insufficient to fulfill this essentially governmental obligation.

Despite this "transfer of financial responsibility," the Duane committee did not foresee a similar transfer of administrative responsibility. It recommended that the city purchase service from voluntary hospitals, simultaneously providing care, bolstering to a modest degree the financial condition of the voluntary hospitals (*1*), and utilizing the community's hospital resources.

The alternative to a purchase-of-service program was to care for these patients at the Blockley Division of Philadelphia General Hospital with accompanying increases in the hospital's capital and operating budgets. Faced with this alternative and supported by various powerful professional, lay, and religious groups with a stake in continuing traditional community patterns of hospital practice, the city embarked on its contract maternity hospitalization program under the impetus of the closing in January 1958 of the uneconomic Northern Division of the Philadelphia General Hospital.

Designed to care initially for the Northern Division's maternity patients, the new agree-

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ments in 1958 provided maternity care at the Temple University Hospital for 1,400 patients at a total cost of $217,000. In 1959 the department expanded the program to cover 2,000 patients at a total cost of $300,000 at Hahnemann Hospital as well as Temple. Other indigent maternity patients, about 25 percent of the estimated universe of medically needy maternity patients, are delivered at the Blockley Division and the rest find their way to voluntary hospitals supported by fees, private funds, and State aid, which are not in the contract program.

In 1955 the Philadelphia Board of Health estimated that 21.7 percent, or 462,618 persons, of the total 2,100,000 population could be defined as medically needy. The 1959 expansion of the maternity hospitalization program parallels the recommendation of the Community Policy Committee on Health and Hospital Services that the city council provide "additional financial assistance to voluntary hospitals initially in the field of additional care for maternity cases and for out-patient service" (*1*). Therefore, the issues of the current program are viewed in the light of a possible expansion in maternity and other hospital and clinic services, perhaps to the extent of a comprehensive tax-supported medical care and hospitalization program for the needy.

The Agreements

The agreements between the city and Temple and Hahnemann Hospitals provide for the payment of $150 per confinement provided no payment is received from any other sources for complete care of indigent maternity patients. Benefits include a minimum of five prenatal visits to the clinic, treatment of special conditions of pregnancy, delivery including use of operating room, if needed, a minimum of 5 days of hospitalization, care of the infant, and postnatal care.

Eligibility for the program is determined by the same tests applied to persons who seek free care at Philadelphia General Hospital which has worked out a standard of eligibility based on income, family size, resources, age, duration and severity of illness, employment opportunities, and past medical expenses, plus a schedule for part payment applied to all hospital patients (*2,3*). City interviewers, stationed in the areas where most of the patients live, interview applicants and direct eligibles to the proper clinic for prenatal care. A faculty committee of the University of Pennsylvania found that the Philadelphia General Hospital was the only hospital in the State with a carefully rationalized and professionally administered procedure for determining eligibility (*4*).

Standards of Care

One critical factor of a purchase-of-service program is its quality or standard. The cooperative establishment of standards requires a far more intimate knowledge of and an index to the problems of a maternal health program than now exists. Under the health code the department permits only fully accredited hospitals to operate maternity and infant services, whether or not they participate in the contract program, and accreditation provides a basic minimum standard below which no hospital maternity or pediatric department is allowed to fall. But above the minimum standard a wide area of discretion exists.

The chief of the maternal and child health section of the department of health, who administers the contract program, is concerned most with the health of the pregnant, nonwhite woman, the majority of the city's patients, and the high fetal death rate in this group. However, the traditional crude system of reporting rates of live births, fetal deaths, maternal deaths, and neonatal deaths does not develop adequately the relationship between death and disability and relevant medical, economic, and sociological factors such as medical and hospital facilities, economic distribution, extent of prenatal care, method of delivery, occupation, race, literacy, education, and incidence of toxemia. Recently, the department adopted a regulation requiring reporting information as a basis for the development of a refined index to the management of deficient infants, the complications of pregnancy, and the complications and conditions of maternity. Using the data obtained in this way the department hopes to be able to secure the cooperation of the hospitals and of the obstetric and pediatric chiefs

in establishing better standards of maternity care and compliance with them.

Even before developing a maternal health profile the maternal and child health section attacked one of the major defects of the program, the extremely low standards of prenatal care. Part of the difficulties stems from faulty administrative scheduling of prenatal visits, part from weak motivation of the patients, and part from a lack of coordination between the prenatal clinic and the hospital. As a result the city has been purchasing a delivery service rather than a maternal health program. By decentralizing the clinic program, putting it directly under the jurisdiction of the chief of obstetrical service in whose hospital the patients are delivered, and by refusing to reimburse for patients who are not registered for prenatal care, the city hopes to facilitate clinic visits, fix responsibility, and instill in both patients and attending physicians and nurses a sense of the urgent need for prenatal care.

The limited experience of earlier purchase-of-service programs indicates that the development and administration of mutually acceptable standards may become the critical factor in the success of the program. For example, the wartime Federal Emergency Maternal and Infant Care Program, which started out on a strict indemnity payment basis, concluded by insisting on rigid standards for reimbursement for dependents' medical care in order to assure its beneficiaries of even minimal standards. In many cases, where possible, EMIC took dependents into service hospitals, rather than subject them to the uncertain conditions of voluntary civilian institutions.

The most thorough study of the administrative and financial aspects of tax-supported hospital care for the medically needy in Pennsylvania (*4*) gives only "incidental consideration to the qualitative and quantitative adequacy of medical institutional facilities." However, the authors of the study state emphatically that the Commonwealth should get full value for every dollar expended through rigorous licensing and inspection procedures, periodic filing of financial reports, and imposition of regular audits; that its own medical staff attached to the department of public assistance enforce standards of medical care with regard to length of stay, elective procedures, and long-term care; and that local medical staffs undertake medical audits according to State standards.

Costs of Care

The city is taking measures to control the costs of the contract program as well as the costs of its hospital insurance plan for municipal employees. Moving to insure payment only for services received, the department revised its maternity agreements in 1959 to discourage the practice of cutting short the hospitalization period by both patients and hospital. Formerly providing for lump-sum payment, the agreements now establish a sliding scale of reimbursement based on the number of days the patient is in the hospital: $50 for the first day, $25 for the second day, and the balance at the rate of approximately $22.50 a day until the full $150 is earned.

As subscriber to hospital insurance with the Associated Hospital Service for some 8,000 municipal employees, the city is further concerned with costs of hospital care reflected in premium rates. Between June 1958 and August 1959, AHS premium rates jumped 71.14 percent because of increased utilization and rising hospital costs. In 1958 the city's vigorous participation in the rate hearings of the State Insurance Commission produced the first public record of the complex relationships of the carrier, the participating hospitals, and the subscribers, embracing varying costs among hospitals, establishment of hospital rates and charges, and reimbursements to hospitals, and laid the groundwork for future regulation.

Meeting increasing hospital costs through hospitalization premiums or through reimbursement without exercising direct control of medical care standards and administration may challenge the city as it has already challenged other purchasers of hospital and medical care. For example, the deputy executive medical officer of the Welfare and Retirement Fund, United Mine Workers Association, concludes after 10 years of attempting to purchase hospital and medical care from voluntary hospitals and private practitioners in the Appalachian Mountain mining areas that "contracting out" has resulted in expensive and inferior medicine. He found that construction and operation of its

own hospitals and group practice clinics in some areas was the fund's only satisfactory method of assuring its member beneficiaries quality medicine (*5*).

In Philadelphia, the administrator of the American Federation of Labor Medical Plan, a diagnostic clinic serving 64,000 members of 30 affiliates, who is a member of the Duane committee, shares this point of view and finds a parallel in it for the city's program. He supported wholeheartedly the closing of the uneconomic Northern Division and the purchase of maternity care for a limited group of indigent maternity patients. Nevertheless, he is concerned about the consequences, both to standards and costs, if and when the contract program is extended into a general medical care program. Contracting out to voluntary hospitals, he believes, will result in the hospitals and other medical care agencies telling the city what kind of medical care they are willing to provide instead of providing the care the city requires and may well push the cost of the program beyond the financial limits set by the city council. He would prefer to see the city develop its own hospital and group practice program to care for the needy and simultaneously serve as a yardstick for the rest of the community.

Meanwhile the AFL Medical Plan and Center is going forward with its program for the construction and operation of its own hospital because its affiliated unions are dissatisfied with the benefits provided for their members through AHS under their collective bargaining agreements. Evidence leading to a similar conclusion on the comparative cost in 1947 of providing care for veterans in civilian hospitals and constructing and operating more Veterans Administration hospitals was given by Admiral Joel T. Boone, M.D., in testimony at the 1947 hearings of the Senate Subcommittee on Labor and Public Welfare on "National Health Programs" (*6*).

Nevertheless, government purchase of service to provide medical care for the needy is used widely in many jurisdictions, for example, New York State, New York City, and the Federal Government's share of funds spent by the State for vendor payments to public assistance clients. In the private sector, the UMWA continues to contract out a sizable proportion of hospital care for its fund beneficiaries where no other alternative is practicable. The experience of these entities is timely and relevant in this critical area of Philadelphia's health programs, the establishment and administration of standards of hospital and medical care.

Conclusion

Philadelphia's modest purchase of hospital care for indigent maternity patients contains within it the ingredients of any future expanded tax-supported hospital and medical care program for its needy citizens, the development and enforcement of standards, and the immediate and ultimate costs of care. Perhaps in this program, as former Health Commissioner James P. Dixon hopes, the department of public health may become a "bridge between conventional institutions of medical care and the community as a whole, can assure the community that standards of medical care in these institutions are being maintained (and that they are) capable of meeting health needs . . ." (*7*). Whether the department achieves this goal depends not only on its own leadership but also on the talents, imagination, and social responsibility of the medical community.

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